

1 Monday, 11 November 2024

2 (10.00 am)

3 **LADY JUSTICE THIRLWALL:** Mr De La Poer.

4 **MR DE LA POER:** My Lady, thank you. Our first
5 witness today is Ms Claire McLaughlan and I wonder if
6 she might come forward, please.

7 MS CLAIRE McLAUGHLAN (affirmed)

8 Questions by MR DE LA POER

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

10 **A.** Thank you.

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

13 **A.** Claire-Louise McLaughlan.

14 **Q.** Ms McLaughlan, is it correct that you provided
15 the Inquiry with a witness statement dated 23 May of
16 this year?

17 **A.** Yes, that's correct.

18 **Q.** In terms of its content, I think you have
19 identified that you made an error in relation to
20 an interview which you were not present at but that you
21 had thought you were --

22 **A.** Yes.

23 **Q.** -- when the phrase "gut feeling" was used?

24 **A.** That's correct.

25 **Q.** Does it come to this: you have realised that

1

1 **Q.** Now, broadly concurrent with the period that
2 you were an associate lecturer at the Open University,
3 so here I am talking about 2001 to 2005, did you
4 complete a law degree?

5 **A.** Yes.

6 **Q.** Did you complete the Bar Vocational Course?

7 **A.** Yes.

8 **Q.** Were you called to the Bar in 2005?

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

10 **Q.** We will come back to that topic in more detail
11 in a moment. But just in terms of qualifications, is it
12 right that you never undertook pupillage?

13 **A.** That's correct.

14 **Q.** And that you never practised as a barrister?

15 **A.** Correct.

16 **Q.** In your witness statement, you describe
17 yourself as an unregistered barrister?

18 **A.** (Nods)

19 **Q.** At the time, looking at the CVs that were
20 circulated, did you describe yourself as
21 a non-practising barrister?

22 **A.** That's correct. Yes.

23 **Q.** Just tell us briefly, please, why the change
24 in description?

25 **A.** I understand that "non-practising" wasn't

3

1 you thought you were present because "CM" was used, but
2 in fact that is a different CM to you and you were not
3 present?

4 **A.** That's correct.

5 **Q.** Save for that correction, which I think
6 applies in two places, is the content of your witness
7 statement true to the best of your knowledge and belief?

8 **A.** Yes, it is.

9 **Q.** I am going to run through your background.
10 Did you qualify as a nurse in 1983?

11 **A.** That's correct.

12 **Q.** Did you gain qualifications in intensive care
13 and teaching in 1998?

14 **A.** That's correct.

15 **Q.** Between 2002 and 2008, were you an associate
16 lecturer with the Open University?

17 **A.** Yes.

18 **Q.** What subject did you lecture in?

19 **A.** It was a foundation course in healthcare.

20 **Q.** During that period, that is to say in 2004,
21 did you cease practising as a nurse?

22 **A.** Yes.

23 **Q.** I believe you stayed on the NMC register until
24 2016?

25 **A.** I think that's correct, yes.

2

1 being used any more, and that the term was
2 "unregistered".

3 **Q.** Returning to your background. Did you become
4 the Head of Fitness to Practise at the NMC in 2005?

5 **A.** I think so, yes.

6 **Q.** And did you undertake that role for two years?

7 **A.** That's right.

8 **Q.** Did you then move to the National Clinical
9 Assessment Service?

10 **A.** Yes.

11 **Q.** So that we understand what that organisation
12 is, is that a service that provides impartial advice to
13 healthcare organisations?

14 **A.** It does.

15 **Q.** And whilst there, did you rise to the position
16 of Associate Director?

17 **A.** I did.

18 **Q.** So does that account for the period
19 approximately 2007 to 2014?

20 **A.** It does. Could I just add that it only
21 provides advice about doctors, dentists and pharmacists.

22 **Q.** Yes. Thank you. In 2014, were you made
23 redundant and did you start work as an independent
24 consultant?

25 **A.** I did.

4

1 Q. So that I describe this accurately, I am just
2 going to read out from your statement what you say about
3 yourself, as a consultant:

4 "[You] provided bespoke holistic services and
5 access to resources relating to performance management
6 including investigations and reviews, revalidation
7 remediation, reskilling and rehabilitation for
8 individual and teams of health professionals and
9 organisations that they work in"?

10 A. That's correct.

11 Q. In as succinct a summary as you can give, what
12 did that mean in practice?

13 A. I was contracted by a number of organisations
14 to look at the dynamics within a team, perhaps, or an
15 individual's performance within a team, so it could be
16 the whole team or within a team and help them, the
17 organisation, to better -- better work with the team or
18 the individual and vice versa.

19 I did some investigations around complaints about
20 doctors and dentists and pharmacists and sometimes
21 nurses, mainly about their behaviours and attitudes.

22 Q. So not competence?

23 A. No.

24 Q. What you say in your witness statement is
25 you've worked with over 300 NHS and private healthcare

5

1 Now, to set the scene, and it's not important that
2 you have seen this but Dr Gibbs when he read your CV
3 said in an email that he noted that you had trained as
4 a barrister and that was one of the features of your CV
5 that he pointed out, no doubt that will be because you
6 included what you told us in your CV that was sent by
7 the Royal College?

8 A. Okay. Sorry, I don't know who Dr Gibbs is.

9 Q. Dr Gibbs is one of the Consultants that you
10 spoke to upon the visit?

11 A. Okay.

12 Q. So far as Ms Eardley is concerned, it would
13 appear that she attributed some significance to that
14 qualification. On Thursday, I asked her about what she
15 thought about your experience of legal process was and
16 the first part of her answer was to describe you as
17 a qualified barrister?

18 A. (Nods)

19 Q. And in her statement, she says this about you
20 as a lay reviewer, that you had:

21 "... vast experience in objective investigations
22 from her barrister training and career at NCAS"?

23 A. (Nods)

24 Q. Do you recognise that it's important that
25 everybody that you interacted with understood what your

7

1 organisations and people?

2 A. That included my time with the National
3 Clinical Assessment Service which did look at competence
4 and as well as behaviours.

5 Q. Whilst holding yourself out as an independent
6 consultant, did you begin work with the RCPCH --

7 A. Yes.

8 Q. -- as lay reviewer?

9 A. Yes.

10 Q. And did you begin in that role in 2014?

11 A. I think so, yes.

12 Q. Again we will come back to the RCPCH but just
13 to complete what you tell us about yourself. Did you
14 also work for NHS England as a lay panel member for the
15 Performance Advisory Group?

16 A. Yes.

17 Q. And as a lay chair of the Performance List
18 Decision-Making Panel?

19 A. Yes.

20 Q. And finally as a lay member of the
21 Royal College of Veterinary Surgeons?

22 A. Correct.

23 Q. Now, before we go further, I just want to ask
24 you a little bit more about what you say about yourself
25 as a barrister.

6

1 qualification as a barrister meant and what it didn't
2 mean?

3 A. (Nods)

4 Q. Do you agree with that?

5 A. Yes.

6 Q. At the time, did you identify that there may
7 be a risk that people would read too much into the fact
8 that you had been called to the Bar or was that not
9 something that you considered at the time?

10 A. I was always very careful to make sure that
11 everybody knew, at the time, that I was non-practising.

12 It's only in the last, I don't know, year or so
13 that I came to understand that I should -- should now
14 say I am unregistered to make it clear to people that
15 I am not a practising barrister, but right -- right from
16 the very beginning I always made it very clear I was
17 non-practising.

18 Q. Now, in terms of that phrase and I am not --
19 do not understand that I am criticising you for using
20 that phrase in and of itself, but by saying that you are
21 non-practising may leave open the question that you
22 practised in the past, do you see by saying "I am
23 non-practising today" might allow for the possibility in
24 somebody's mind that you had practised in the past; do
25 you see that that's a possibility?

8

1 A. I -- yes, yes.
 2 Q. To what extent was that in your mind at the
 3 time; that people might think: oh she is not practising
 4 now but she has practised?
 5 A. If anybody ever asked me about it, I would say
 6 that I had never practised and people did ask me. So it
 7 was in my mind, I suppose, that that's -- I -- I never
 8 tried to hide that I had never practised and I was very
 9 clear about it if people asked me. Otherwise I wouldn't
 10 have thought about it.
 11 Q. If we just think about what Ms Eardley's
 12 perception, and this is very much in her mind but she
 13 interacted with you. She appears to have ascribed some
 14 considerable significance, bearing in mind it was the
 15 first part of her answer, to the fact that you were
 16 a qualified barrister when being asked about your
 17 experience of legal process.
 18 In fact, is this fair: your experience as
 19 a barrister would not have involved you engaging in any
 20 legal process, you have academic training as law
 21 degree --
 22 A. (Nods)
 23 Q. -- and you undertook the Bar Vocational Course
 24 which is an academic qualification --
 25 A. Yes.

9

1 A. No, I cannot answer that.
 2 Q. And do you think there's any possibility that
 3 you overstated or overemphasised the relevance and
 4 significance of your barrister training?
 5 A. No.
 6 Q. We are going to move now to your role with the
 7 RCPCH and you have told us that it was as a lay reviewer
 8 and you had approximately two years' experience before
 9 the Countess of Chester inspection?
 10 A. I think that's right.
 11 Q. Or review, rather.
 12 You describe that role as having a number of
 13 functions: to represent patient and public interest is
 14 one part of it?
 15 A. (Nods)
 16 Q. We will come back to that. It's also to stop
 17 there being too much jargon being used, is that right,
 18 particularly in the final report, to make it more
 19 accessible?
 20 A. Yes.
 21 Q. To stop the tendency of professionals who all
 22 know each other to talk in a cosy way but to recognise
 23 that there needs to be proper boundaries; is that
 24 another part of it?
 25 A. Yes, I think I call it critical -- being

11

1 Q. -- not even involving placements --
 2 A. Sure.
 3 Q. -- albeit that you may occasionally go to
 4 court as part of that course?
 5 A. Sure.
 6 Q. So to what degree do you think the fact that
 7 you were a qualified barrister was relevant to your
 8 experience of legal process?
 9 A. That's not how I would have described it.
 10 Q. Similarly, Ms Eardley says that you had vast
 11 experience in objective investigations from your
 12 barrister training and career at NCAS. NCAS aside,
 13 plainly that did give you very considerable experience,
 14 but did you in fact gain experience of objective
 15 investigations from your barrister training?
 16 A. No.
 17 Q. So again would you say that's not a way that
 18 you would have described it?
 19 A. I wouldn't have described it.
 20 Q. So again acknowledging that this is
 21 Ms Eardley's perception and her words, but she's
 22 somebody that you had interactions with and spoke to,
 23 are you able to shed any light on how it may be that she
 24 placed that level of emphasis on something that you
 25 yourself wouldn't say it justifies?

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1 a critical friend.
 2 Q. Yes.
 3 A. Yes.
 4 Q. Yes, and if it was just as a friend, you would
 5 sit there passively and let them get on with it. Being
 6 a critical friend involves you needing to challenge
 7 people and say: hang on a minute, I am sitting here as
 8 a layperson, this doesn't feel right to me, can you
 9 explain it?
 10 A. Yes.
 11 Q. Now, in terms of representing patient and
 12 public interest, does that mean that in the context of
 13 the Countess of Chester review, you were there
 14 representing the interests of the Families of the
 15 children who died?
 16 A. I can't, I don't, I don't -- it was broader
 17 than that. It was -- I think is also the patients who
 18 were still there.
 19 Q. So I have drawn it too narrowly. It includes
 20 the category that I have spoken about, but you say it --
 21 A. Wider.
 22 Q. -- is wider than that.
 23 In terms of your conduct of that role representing
 24 the bereaved families and patients who are still alive
 25 and on the unit, how do you say you discharged that

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1 particular function of your role as lay reviewer when it
 2 came to the Countess of Chester inspection?
 3 **A.** I was there as part of the panel to try to
 4 decipher. So to go into -- into the final report what
 5 was going on and how -- how it was going on.
 6 I was involved in a number of interviews separately
 7 from the main group. I can't answer any more than that.
 8 **Q.** Speaking generally, is there, in your
 9 experience, a risk that sometimes in an NHS setting,
 10 people become very focused upon internal disputes,
 11 internal politics, internal relationships and that
 12 sometimes they are not thinking about the patient first?
 13 **A.** I think that can happen.
 14 **Q.** Yes. So would your role be to, when that is
 15 happening in front of you, say: hang on a minute,
 16 everybody, this is about the patients. That's who we
 17 should be thinking about first?
 18 **A.** It could be. Yes.
 19 **Q.** Do you think that in the course of the
 20 Countess of Chester inspection -- or review, forgive me,
 21 my mistake, in the course of the Countess of Chester
 22 review, you ever said: I know we have got this two sides
 23 of this issue, but don't we need to take a step back,
 24 everybody, and think about the patients?
 25 **A.** I don't remember.

13

1 have seen, you have no recollection of having said it?
 2 It would be quite a significant moment in any
 3 meeting, wouldn't it, it is a big challenge to people
 4 participating to say: everyone, just stop for a moment,
 5 let's think about the patients. Do you agree?
 6 **A.** It's hard to say because it was such a long
 7 time ago. There are -- having looked through all of the
 8 information that I was given in preparation for this,
 9 there were lots of things I didn't recall.
 10 So ...
 11 **Q.** Well, in terms of your recollection, and
 12 granting that we are now 2024 and it was 2016, in fact
 13 this was a unique experience for you in all of the
 14 reviews that you had conducted; is that fair?
 15 **A.** In retrospect, yes.
 16 **Q.** But at the time it's the only time you tell us
 17 that they had any issue raised about the possibility of
 18 criminality being committed by a member of staff?
 19 **A.** Yes.
 20 **Q.** There are other reasons for it to be unique
 21 which is that you thought it was going to be one kind of
 22 inspection?
 23 **A.** Yes.
 24 **Q.** When you turned up, you found it was rather
 25 different?

15

1 **Q.** You don't remember?
 2 **A.** No.
 3 **Q.** By saying that, are you allowing for the
 4 possibility that you did say it?
 5 **A.** (Nods)
 6 **Q.** You are?
 7 **A.** Yes. Either I did or I didn't, I don't
 8 recall.
 9 **Q.** Well, have you seen any note or record of you
 10 having said that or anything to that effect?
 11 **A.** No.
 12 **Q.** Does that indicate to you that that is
 13 unlikely to have happened then, or would you not draw
 14 that conclusion?
 15 **A.** I -- I couldn't draw that conclusion. I --
 16 I haven't got a note of it.
 17 **Q.** You haven't got a note?
 18 **A.** I haven't seen anybody else's note of it
 19 either but that doesn't mean it didn't happen but, but
 20 it may not have done. I just don't know.
 21 **Q.** No. Well, just examining that for a moment.
 22 You didn't make a note of you saying that, nobody else
 23 has made a note of you saying that --
 24 **A.** That I have seen.
 25 **Q.** -- that you have seen, of the notes that you

14

1 **A.** It was a review.
 2 **Q.** A review, forgive me, thank you, I welcome
 3 that correction, please ensure that I get that right?
 4 **A.** Yes, you are right.
 5 **Q.** But, yes. It was: you thought it was going to
 6 be one kind of review and it turned out to be another?
 7 **A.** Yes.
 8 **Q.** So there were reasons at the time for it to be
 9 memorable, do you agree?
 10 **A.** Yes.
 11 **Q.** Then it's not just that we are looking back
 12 from 2024, because presumably you will have heard about
 13 the arrest or charge or trial of Letby?
 14 **A.** Yes.
 15 **Q.** All of which were some time ago now.
 16 Presumably that would have caused you to bring to mind
 17 your involvement in this review?
 18 **A.** Of course.
 19 **Q.** Your thoughts at the time, so we aren't just
 20 looking back over eight years, in fact there have been
 21 opportunities in the past for you to think about it. So
 22 again just doing the best that you can, with those
 23 opportunities and the fact that it was memorable in the
 24 way it was, do you think that you did give that
 25 challenge at any point about thinking about patients or

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1 do you think it is likely that you didn't?
 2 **A.** I can't recall.
 3 **Q.** In terms of your overall experience of the
 4 RCPCH inspections, I think you believe that you did 14
 5 in total over the time?
 6 **A.** I -- I think so.
 7 **Q.** That this was number 6; is that right?
 8 **A.** I think that's what I said, yes.
 9 **Q.** In terms of the RCPCH training, did the RCPCH
 10 give you any safeguarding training?
 11 **A.** I don't think it was done directly through the
 12 RCPCH. No.
 13 **Q.** Did they have any requirement of you that you
 14 had a minimum level of safeguarding training in order to
 15 participate?
 16 **A.** I don't recall. But I was always in date for
 17 the required level of training that I would -- that
 18 I needed for the other jobs that I was doing so I will
 19 always have been in date as I am now.
 20 **Q.** Did the training that you had received give
 21 you a familiarity with Working Together?
 22 **A.** No, it didn't, I don't think.
 23 **Q.** In terms of what amounts to a safeguarding
 24 allegation; in other words, an allegation that should
 25 trigger safeguarding concerns. We will just bring up
 17

1 will have included that.
 2 **Q.** So your expectation is that that you would
 3 have been operating on --
 4 **A.** Under this.
 5 **Q.** -- the basis that we see there?
 6 **A.** (Nods)
 7 **Q.** Thank you. We can take that down.
 8 Now, the Invited Review guidance published by the
 9 RCPCH talks about when a review may not be appropriate.
 10 We can bring it up, INQ0010214 and it's page 8 and we
 11 are looking at paragraph 7.5.
 12 We can see that the College will not take on cases
 13 where the expected scope, the third one down:
 14 "Includes behaviour or misconduct, bullying,
 15 harassment or possible mental health concerns."
 16 Does that accord with your understanding at the
 17 time that that's not what the College would be
 18 investigating as part of its review?
 19 **A.** Yes, yes.
 20 **Q.** Do you agree that the suggestion that somebody
 21 may, a member of staff may be murdering babies falls
 22 four square within behavioural or misconduct issues?
 23 **A.** Yes.
 24 **Q.** If we go over the page to 7.7, we can see
 25 that:

19

1 what Working Together says about it and see whether it
 2 accorded with your definition at the time.
 3 INQ0013235, and we are going to go to page 54.
 4 So the third bullet, although it's the widest
 5 indented bullet towards the top, talks about clear
 6 policies being required and then it says this:
 7 "An allegation may relate to a person who works
 8 with children who has behaved in a way that has harmed
 9 a child or may have harmed a child, possibly committed
 10 a criminal offence against or related to a child, or
 11 behaved towards a child or children in a way that
 12 indicates they may pose a risk of harm to children."
 13 So before I ask you to agree or disagree with this
 14 as being consistent with your understanding at the time,
 15 just to pick out some things, we are here framing things
 16 in terms of possibilities. So "may pose a risk" or
 17 "possibly committed a criminal offence". So that is
 18 what Working Together in 2015, which was the current
 19 version of the statutory guidance, said.
 20 Was that consistent or inconsistent with your
 21 understanding of the threshold for safeguarding?
 22 **A.** At the time?
 23 **Q.** At the time.
 24 **A.** I can't recall but the training was provided
 25 by, I think, the NHS at the time so I am sure that it
 18

1 "If any of the issues listed in 7.5 come to light,
 2 the Review should be completed in relation to its
 3 original remit, unless advised to the contrary, in order
 4 to avoid prejudicing other investigations by public
 5 authority or regulator."
 6 Now, you had experience working for a regulator,
 7 the NMC, in their Fitness To Practise Directorate?
 8 **A.** Yes.
 9 **Q.** No doubt as part of your legal training you
 10 gained some understanding of the powers of police and
 11 investigating, it is a standard part of law degrees and
 12 Bar Vocational Course?
 13 **A.** Sure.
 14 **Q.** So just drawing upon that experience, do you
 15 recognise that there is a risk to both regulatory and
 16 police investigations if the Royal College continues to
 17 investigate in a space which is rarely their remit?
 18 **A.** Yes.
 19 **Q.** What would you say the risk of prejudice is to
 20 those investigations if the College carries on?
 21 **A.** That it's going to slow things down, it's
 22 going to put -- give false assurance to people.
 23 **Q.** In fact the very process of interviewing
 24 people can muddy the waters, can't it?
 25 **A.** Yes.

20

1 Q. It can involve for example getting lots of
2 people into a room as you would without a problem in an
3 Invited Review and have them all share their
4 perspectives?

5 A. Sure, of course.

6 Q. But in principle, that's not a good way of
7 conducting a regulatory or police investigation, is
8 it --

9 A. No.

10 Q. -- when taking accounts?

11 So, again, that exists as a possible prejudice?

12 A. Yes.

13 Q. Do you think that in 2016, based on your
14 experience with the NMC and the training you got on your
15 law degree and in the BBC, that you understood those
16 risks?

17 A. I did. However, if I may --

18 Q. Of course.

19 A. -- could we go back to 7.5?, please.

20 Q. Yes, of course. It's the page preceding.

21 A. The preceding. In taking on the review, I had
22 personally believed that we would not have been taking
23 on the review if this was the case. So I -- I assumed
24 that this work had been done before --

25 Q. Absolutely.

21

1 Q. No, but you had an understanding unique to the
2 team about the particular potential damage to
3 a regulatory or police proceeding, you had that in your
4 mind. You have told us that; that you knew that?

5 A. Okay.

6 Q. Would it not be the right thing to do, to draw
7 that to people's attention so that they could consider
8 that as part of whether the review should continue?

9 A. I think in the -- in the moment, we were under
10 the impression that no red flags had been raised by
11 a number of different organisations in relation to the
12 allegations that had been made and I suppose we were
13 given a -- a false assurance that that had been
14 considered and dealt with, I suppose.

15 Q. We are going to get to the detail of when that
16 assurance was given and what you recollect. But at any
17 point in this process, did you contemplate the police
18 might need to get involved?

19 A. As I say, we were given -- we were on a -- you
20 know, given false assurance, I think, so --

21 Q. If I can just ask you to focus on my question.

22 A. Sure.

23 Q. At any point in this process, did you
24 anticipate that the police might need to get involved?

25 A. I don't recall the conversations.

23

1 A. -- we got there.

2 Q. If I can give you this reassurance: Ms Eardley
3 has accepted that she did know that the issues in
4 relation to Letby, although her position was that that
5 was not going to be part of what was going to be
6 considered and she has suggested that she doesn't think
7 she told any of the rest of you --

8 A. No.

9 Q. -- about that. So that is not a disputed
10 fact; it accords with your recollection as well.

11 Absolutely, 7.5 is about taking on a review. What 7.7
12 is about the situation you found yourself in which is
13 that once it has started, if we go back over the page --

14 A. Thank you.

15 Q. -- if it comes to light, is how it's framed,
16 during an Invited Review, then it should be completed;
17 is what the language says?

18 A. (Nods)

19 Q. Unless it's advised to the contrary in order
20 to avoid prejudicing, so it's understanding that?

21 A. And we weren't advised to the contrary.

22 Q. Well, did you offer any advice based upon your
23 experience?

24 A. That was not my place. I was not there in
25 a legal capacity.

22

1 Q. Well, we can go to it in your witness
2 statement. But what you tell us is, jumping all the way
3 to the end, that you thought that by recommending an HR
4 investigation, a disciplinary investigation, that the
5 police would quickly get involved after that. So that's
6 what you tell us in your witness statement?

7 A. Well, if, if -- if they then found that they
8 needed to get involved.

9 Q. Yes. So does it follow that the answer is
10 that you did anticipate that the police may need to get
11 involved during this process?

12 A. Yes.

13 Q. Understanding as you did at the time about the
14 potential risk to the police investigation, do you think
15 that you should have said, "I think we should all
16 consider the possibility here of stopping because this
17 might damage a police investigation that may happen"?

18 A. No, I didn't.

19 Q. Do you think you should have?

20 A. I think I probably should have, in retrospect.
21 But it didn't occur to me at the time.

22 Q. Well, you have added two caveats to that
23 "probably" and "retrospect".

24 Just thinking about the question. At the time,
25 with the information you had, bearing in mind you

24

1 foresaw the police might get involved and you knew from
 2 your previous experience about the potential prejudice,
 3 do you think you should have spoken up and said,
 4 "I think we should stop because of that risk"?

5 **A.** I wish I had. But, again it's a different --
 6 you are -- I am answering a different question.
 7 I understand that, but In --

8 **Q.** You --

9 **A.** Yes, I should.

10 **Q.** We will turn now please to the beginning of
 11 your involvement. You have looked at your records and
 12 you think the first contact you had was at the end of
 13 June of 2016?

14 **A.** I think so.

15 **Q.** Is this how it worked, that effectively you
 16 told the RCPCH you were willing to act as a reviewer but
 17 that was subject to your diary and other commitments so
 18 it would be entirely unremarkable for them to reach out
 19 to you and say: are you free to agent as a lay reviewer?

20 **A.** That is how it worked.

21 **Q.** That is essentially what happened here?

22 **A.** (Nods)

23 **Q.** What you say in your witness statement about
 24 your understanding at the start of this process was:
 25 "It was my understanding that ahead of the Countess
 25

1 **A.** Because they had already identified something
 2 that linked the death, or they thought they had
 3 identified something that had linked the deaths.

4 **Q.** Yes, and so you read that fourth term of
 5 reference as implying that no link had been identified
 6 yet?

7 **A.** Yet. Yes.

8 **Q.** You say:
 9 "I would have advised the Countess of Chester to
 10 follow its own internal processes for dealing with such
 11 serious allegations made, I believe, in good faith such
 12 as clarifying the concerns, taking them seriously,
 13 seeking HR legal advice, considering a formal
 14 restriction of practice or exclusion from practice was
 15 required and following that process. That would have
 16 included beginning a conduct or capability investigation
 17 and appointing an independent investigator as well as
 18 discussing the matter with the police and with the NMC."

19 **A.** (Nods)

20 **Q.** So if we understand what you are saying here
 21 is, if the night before you had been told "the
 22 Consultants have identified that there is a nurse who is
 23 on duty for most of these deaths" and we will just limit
 24 it to that, "and they are concerned that she may be
 25 deliberately harming babies", if that was said to you,
 27

1 of Chester Invited Review taking place there were no
 2 known circumstances or allegations highlighted to the
 3 Review Team."

4 **A.** That's correct.

5 **Q.** That's your very clear understanding, is it?

6 **A.** Yes.

7 **Q.** Could you turn up paragraph 36, because it
 8 should be in the witness statement in front of you. Do
 9 you have that?

10 **A.** Yes.

11 **Q.** What you say in paragraph 36 is:
 12 "Had I been aware of the concerns about Ms Letby
 13 prior to the visit during the preparatory stage, or even
 14 the evening before, I would not have participated in the
 15 review."
 16 Then you go on to say:
 17 "I would have advised the RCPCH that in the
 18 circumstances the Terms of Reference, especially the
 19 fourth bullet point [and you go on to quote it] were
 20 misleading and that it was inappropriate to start
 21 a service review until these matters had been dealt with
 22 and the situation clarified."
 23 We will just pause there for a moment. Why do you
 24 describe the term of reference as "misleading", what was
 25 it that caused you to describe it in that way?
 26

1 you would have said number one, we mustn't do this
 2 review?

3 **A.** (Nods)

4 **Q.** Is that right?

5 **A.** Yes.

6 **Q.** Number two, we need to tell the Countess of
 7 Chester that they need to engage some kind of HR process
 8 and/or take legal advice; is that right?

9 **A.** Yes, yes.

10 **Q.** Three, that they should consider whether or
 11 not it is necessary for that nurse to be excluded from
 12 practice?

13 **A.** Yes.

14 **Q.** And four, that they should discuss the matter
 15 with the police and the Nursing and Midwifery Council?

16 **A.** Yes.

17 **Q.** That's the night before.

18 **A.** Or previous.

19 **Q.** Or earlier than that?

20 **A.** Yes.

21 **Q.** 12 hours or so later, you were given that
 22 information, weren't you?

23 **A.** Yes.

24 **Q.** At that stage, did you say: we should stop?

25 **A.** No.
 28

1 Q. At that stage, did you say: you should
2 consider some formal restriction or exclusion from
3 practice?
4 A. No.
5 Q. At that stage, did you say that they should
6 undertake an HR process and/or take legal advice?
7 A. No.
8 Q. At that stage, did you say: you need to
9 discuss this with the police and the NMC?
10 A. No.
11 Q. So I suppose the question really is --
12 A. Why.
13 Q. -- what changed over those 12 hours that you
14 were -- you are so clear, if I may say so, about the
15 precise steps that would have been taken the night
16 before, you accept you didn't take any of those steps 12
17 or so hours later when you were possessed of that
18 information.
19 Why not?
20 A. Again we were given a false level of assurance
21 and we were hearing about -- it was sort of dropped into
22 the conversation as a "by the way" ... it wasn't given
23 any level of importance or credence and it was given to
24 us as part of almost a breakdown in relations.
25 Q. But what -- that was what the Executives were
29

1 assurance" given by the Executives. But the doctors
2 weren't giving you that assurance, were they?
3 A. Well, they gave us a mixed picture because
4 they told us in one breath about their concerns and the
5 allegations they were making.
6 But in the next breath they were telling us what
7 a good nurse she was.
8 Q. Well, it's possible to be a good nurse and
9 a murderer?
10 A. I am not saying it isn't and I am not
11 downplaying this.
12 Q. They weren't suggesting to you that their
13 worry was that through incompetence she was killing the
14 babies?
15 A. But they found it hard to believe as well.
16 Q. Well, but they still entertained in good
17 faith, to use your phrase, that suspicion?
18 A. They did.
19 Q. That is that --
20 A. But they hadn't called the police either.
21 Q. Well, they can answer for that.
22 A. Sure. But that was -- that was part of the
23 false assurance that we were given. The whole picture
24 of the false assurance.
25 Q. But they -- on the subject of the police they
31

1 saying?
2 A. Yes.
3 Q. But you immediately went to speak at some
4 length with Dr Brearey and Dr Jayaram who gave you their
5 perspective?
6 A. Sure.
7 Q. What was being said was an allegation of the
8 very most serious type?
9 A. (Nods)
10 Q. Do you agree with that?
11 A. Yes.
12 Q. I would just like to -- I asked Ms Eardley
13 this same question, I would just like to reflect on it.
14 If it had been, to use your phrase, just dropped into
15 the conversation, that doctors were worried about
16 a member of staff sexually assaulting a patient, and if
17 you then went to see the doctors and they said, "Yes,
18 that is what we are worried about", do you think you
19 would have reacted any differently?
20 A. I don't know. I don't know.
21 Q. I am just trying to unpick what you say here
22 because you have accepted that --
23 A. Yes.
24 Q. -- it is an allegation of the most extreme
25 type, albeit played down or whatever phrase, "false
30

1 had told the Executives in the expectations the
2 Executives would call the police and so in the doctors'
3 minds, do you agree, the police should be called, but
4 they were following a process, tell the Executives, and
5 at that point what they had thought would happen didn't
6 happen.
7 So it wasn't as if they were telling you: we don't
8 think the police need to be involved. They told you
9 they thought the police should be involved but the
10 people they thought should call the police were the
11 Executives and the Executives weren't doing it.
12 So again is it fair to describe that as a false
13 reassurance?
14 A. Yes, I think so because they had -- they had
15 the ability to call the police themselves individually.
16 So this was all a pattern of -- of having looked at the
17 information, this one piece of information that we were
18 given which was uncorroborated against all the other
19 information that we had been given as a package that
20 looked at the Coroner's reports and the CDOP reports and
21 the network review, looking in, in the whole of the
22 context that there were no red flags, that this was the
23 only piece of evidence that we were -- well, the only
24 piece of information, I wouldn't at that stage even have
25 called it evidence, that there was something else going
32

1 on.

2 **Q.** Well, you have described it as uncorroborated
3 and that is a phrase you use a number of times in your
4 witness statement?

5 **A.** Yes.

6 **Q.** So let's just see if we can understand what
7 you mean by that. So if we go to paragraph 108, that is
8 an occasion where you use that phrase. Do you have
9 paragraph 108?

10 **A.** I do, yes.

11 **Q.** What you say:

12 "In my opinion I cannot speak for the whole team.
13 This was the personal view, feelings, interpretation of
14 one person regarding Ms Letby, it was not based on fact
15 and was uncorroborated. Even now I would not consider
16 his view as objective or impartial as he was too
17 involved, too close to the situation and had a conflict
18 of interest."

19 I just want to look at some of the language you
20 have used there to try and understand it.

21 You start by using the word "personal". You don't
22 say it was his view or his professional view or his
23 expert view or his view as a Consultant. You say
24 "personal". Why did you choose the word "personal"
25 there?

33

1 duty rosters and --and an interpretation of the duty
2 rosters for the doctors and nurses that were present
3 during the period that the babies died.

4 It's not normally the role of somebody of that
5 doctor's status and experience to have any involvement,
6 is my understanding, in the rostering of staff. And
7 therefore I would not have -- I wouldn't have called it
8 his professional role for him to take on the analysis
9 that he apparently did of those rosters.

10 **Q.** Wasn't what you in fact were told rather more
11 complicated than that; that what you had was
12 a Consultant, the head of the neonatal unit if we just
13 talk about the one individual you are referring to, who
14 using his professional expertise looked at the deaths
15 and could not understand, applying all of that medical
16 knowledge, why there had been an increase in the deaths.
17 So that is absolutely 100%, would you agree, his
18 professional expertise being exercised?

19 **A.** Absolutely.

20 **Q.** That he as any reasonable person would start
21 from the fact there could be any number of possibilities
22 for this, but I need to work my way through to exclude
23 the ones which it definitely isn't? And that he had
24 undertaken that process and that he had using that
25 expertise excluded lots of common explanations, again

35

1 **A.** My understanding was that that the -- it was
2 one person who I -- it was one person who had put the
3 information together.

4 **Q.** We will come on to the one in a moment.
5 Why personal?

6 **A.** Because he -- that, that's how it was
7 presented; this is what I have done ...

8 **Q.** Can I invite you to reflect on this. Within
9 a professional setting, it's quite common to distinguish
10 between personal views and professional views.
11 A professional view is somebody offering their opinion,
12 which is just their opinion, based upon their
13 professional knowledge and expertise. A personal view
14 is usually understood to mean a view that they are
15 giving outside of the parameters of their professional
16 expertise or outside of their job.

17 Are you familiar with the distinction?

18 **A.** I can understand where you are coming from,
19 yes.

20 **Q.** Now, you have used the word "personal" here?

21 **A.** Sure.

22 **Q.** Do you not think that giving that opinion the
23 appropriate respect that it was entitled to, that
24 actually it was a professional or expert view?

25 **A.** The information we were given was of --of the

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1 all exercising his professional judgment, would you
2 agree?

3 **A.** Yes.

4 **Q.** And it was absolutely part of that exercise of
5 his professional judgment to consider whether staffing
6 may have been responsible for the increase in the
7 deaths, do you agree?

8 **A.** I agree.

9 **Q.** When he came to look at that area, he found
10 what he thought was a surprising state of affairs in the
11 first instance which was that there was one person,
12 unexpectedly in his mind, associated with every single
13 one of the deaths bar one?

14 **A.** Yes.

15 **Q.** In addition, the cohort of babies he was
16 considering he knew, based upon his professional
17 expertise, were not expected to die and so weren't
18 just talking about an increase in the deaths. He was
19 looking at babies who he expected to survive and so he
20 was dealing with an unexpected cohort and he didn't have
21 an explanation beyond the commonality that he had
22 identified.

23 Is that all fair about the information you were
24 told?

25 **A.** That's fair.

36

1 Q. So do you see that or do you think that in
2 fact it might in fact be absolutely his provisional
3 judgment that is being involved here?

4 A. I -- yes.

5 Q. The fact that you used the word "personal", do
6 you think that that is a reflection of the fact that
7 perhaps even until this very moment, you had not seen
8 what you were being told in those terms?

9 A. Yes.

10 Q. Again, do you think that's a reason why you
11 might have used for example the word "feeling" in your
12 list of three personal attributes where you said this
13 was the "personal view/feeling/interpretation"?

14 A. Yes.

15 Q. Because if we are going to be real about it,
16 describing something as a personal feeling is not
17 terribly persuasive; describing something as
18 a professional interpretation is rather more persuasive?
19 Do you agree?

20 A. I agree.

21 Q. But you were -- when you wrote this, which was
22 in fact I think only in May of this year, your take on
23 it was that this was capable of being described as
24 a personal feeling?

25 A. Yes.

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1 one voice about their concerns, weren't they?

2 A. In the meeting, yes.

3 Q. Yes. So the starting point is that bearing in
4 mind that, do you think it is fair and accurate to
5 suggest that this is the professional opinion of one
6 person or do you think that in fact one person is not
7 the correct description?

8 A. My understanding was that the tables, the --
9 the Excel spreadsheet had been done by one person and
10 that's what I mean by that.

11 Q. But as we have discussed already, it's not
12 just about that table, it's about the expertise that was
13 brought to bear to understand how common causes were not
14 an explanation and the fact that the deaths were
15 unexpected, so you were dealing with a particular cohort
16 of deaths?

17 A. I am, in this paragraph I am talking about
18 that one piece of information, that one Excel
19 spreadsheet.

20 Q. But you are here summarising, aren't you, your
21 overall view of the information that you were provided
22 with?

23 A. I believe I am talking about that one piece of
24 information, which was the Excel spreadsheet.

25 Q. I understand that that is what you are

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1 **LADY JUSTICE THIRLWALL:** Now, Mr De La Poer, is
2 that a convenient moment?

3 **MR DE LA POER:** It absolutely is, my Lady. Thank
4 you very much.

5 **LADY JUSTICE THIRLWALL:** I should have mentioned
6 earlier, I hope you have been told. We are going to
7 take the break now. There is a service going on outside
8 and obviously we will be observing the two minutes'
9 silence and it seemed to me more appropriate that if we
10 break now and we will come back in at 10 past 11.

11 (10.49 am)

(A short break)

12 (11.10 am)

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

15 **MR DE LA POER:** Ms McLaughlan, we are looking at
16 paragraph 108 and we have dealt with personal and
17 feelings and we are I think agreed that the correct
18 analysis is "professional opinion", and then we read on,
19 "of one person".

20 Now, in fact, Dr Brearey who I think is the one
21 person you are referring to sat in a meeting with you
22 and other reviewers together with Dr Jayaram; is that
23 correct?

24 A. I believe so, yes.

25 Q. The two of them were speaking effectively with

38

1 referring to. But are you not offering that

2 characterisation as being the overall -- your overall
3 assessment?

4 A. No, no, my -- that, that is about that -- the
5 uncorroborated evidence I am talking about is that Excel
6 spreadsheet.

7 Q. Well, let's read the whole paragraph. At
8 paragraph 3.12 it is stated that:

9 "The paediatric lead and all the Consultant
10 paediatricians had become convinced by the link between
11 Letby and the deaths but it is stated this was
12 a subjective view with no other evidence or reports of
13 clinical concerns about the nurse beyond this simple
14 correlation. In section 4 it is stated there was no
15 other evidence or history to link Nurse L to the
16 deaths"?

17 A. Yes.

18 Q. Then you give "in my opinion", so ...

19 A. Yes. That is what I am referring to. That is
20 the link to Nurse L is that spreadsheet.

21 Q. But --

22 A. That's exactly what I am referring to there.

23 Q. But the link to Nurse L, Letby, is in the
24 context of the wider information that you are being
25 provided with?

40

1 A. I am talking here about that one piece of
 2 evidence which was the Excel spreadsheet. I am very
 3 clear about that, that's what I am talking about.
 4 Q. Well, I invite you to consider an alternative
 5 interpretation, because if we look on to what you say:
 6 "There had been no independent review or oversight
 7 of the allegations and the information provided in
 8 support of the allegations."
 9 A. Yes, that's that one piece of evidence which
 10 was the Excel spreadsheet.
 11 Q. It was -- I'm sorry, I don't want to stop you
 12 saying something you want to say.
 13 A. Nobody else had looked at that spreadsheet.
 14 We were just given the spreadsheet with the analysis
 15 undertaken. We didn't even get to see the underpinning
 16 rosters and rotas on which that was based. That's what
 17 I am talking about there.
 18 Q. So --
 19 A. That's what --
 20 Q. The spreadsheet that Dr Brearey created was
 21 attached as appendix 1 to the thematic review, that was
 22 a meeting at which a number of people visited. It was
 23 based on the work of the nursing manager of the unit,
 24 Eirian Powell, who had created that spreadsheet earlier.
 25 It was reviewed by the Executives and nobody ever

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1 with them?
 2 A. Not later. But at that time, which is what
 3 I am talking about here, that's all I was aware of --
 4 Q. So --
 5 A. -- was that Excel spreadsheet.
 6 Q. The Executives told you that a nurse had been
 7 identified by a Consultant, that is what they told you?
 8 A. Yes, a nurse had been identified by
 9 a Consultant.
 10 Q. Yes, yes. And they also told you in that
 11 first meeting that they had conducted their own
 12 investigation, Ian Harvey is noted as recalling "it's
 13 all been investigated".
 14 We can look at that note if you would like to?
 15 A. I would like to, please, yes, just to remind
 16 myself.
 17 Q. Yes, of course.
 18 A. Thank you.
 19 Q. Of course. INQ0014604. We will look at the
 20 first page. Just four lines up you see against
 21 Ian Harvey's name:
 22 "Been through all the evidence."
 23 And he then starts talking about another aspect of
 24 the evidence.
 25 It's just the first part that's the important bit;

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1 suggested that its content was wrong. The dispute was
 2 about its interpretation?
 3 A. I am not aware of the thematic review that you
 4 are talking about other than in -- in the broadest
 5 terms. I was presented with the Excel spreadsheet in
 6 isolation.
 7 Q. So the thematic review was a document that was
 8 provided to all reviewers beforehand and it was the
 9 document that the lead reviewer commented upon in that
 10 email which you say you didn't see?
 11 A. Yes.
 12 Q. So that is --
 13 A. Yes.
 14 Q. So that is Dr Brearey's work in February that
 15 you were told about and the document that you received?
 16 A. I only remember seeing the Excel spreadsheet.
 17 That's what I am talking about there, I am not talking
 18 about the thematic review.
 19 Q. Well, did you think that there was in fact any
 20 dispute of fact over whether or not Letby had been
 21 correctly identified at nine out of the ten deaths?
 22 A. The -- sorry, can you say that again?
 23 Q. Yes, of course. Did you think that there was
 24 any dispute of fact about the contention that Letby was
 25 present at nine out of the ten deaths, or associated

42

1 that, do you agree, Ms McLaughlan, that at no time did
 2 the Executives suggest to you that the analysis which
 3 suggested an association was wrong?
 4 A. I don't know that he's referring to the Excel
 5 spreadsheet or --
 6 Q. I will just ask my question again. Do you
 7 agree that at no time the Executives suggested to you
 8 that the analysis indicating that Letby was associated
 9 with nine out of ten deaths was wrong?
 10 A. No.
 11 Q. They are here saying that they had been
 12 through all the evidence, that's what the note records.
 13 So do you agree it would be quite a surprising state of
 14 affairs if there was actually any dispute about
 15 something which could be so readily checked if you
 16 hadn't been told about it?
 17 A. Sorry, say that again, please?
 18 Q. Of course. It would be quite a surprising
 19 state of affairs, given how easy it would be to check
 20 that, if the Executives had checked it, found that it
 21 was wrong, and then didn't tell you?
 22 A. That's right. But we hadn't seen it for
 23 ourselves.
 24 Q. But --
 25 A. That's what I am talking about in that -- in

44

1 that paragraph 108; that it was at that point it was
 2 uncorroborated, it's that simple.
 3 **Q.** But uncorroborated by whom?
 4 **A.** Anybody.
 5 **Q.** Well, it had been corroborated by the
 6 Executives.
 7 **A.** But I don't know that that's what he's
 8 referring to four lines up on that page.
 9 **Q.** Well, if you were uncertain about whether that
 10 underlying very simple analysis was correct or not, did
 11 you ever ask?
 12 **A.** We didn't get that at that point.
 13 **Q.** Well, you --
 14 **A.** We didn't have it at that point.
 15 **Q.** You had received the thematic review which
 16 said the same thing?
 17 **A.** I don't recall seeing that Excel spreadsheet
 18 before we received it -- I believe I received it on that
 19 first day of the review.
 20 **Q.** When the Executives told you that the doctors
 21 had or the doctor had identified this association, did
 22 you say to them, "Have you checked to see whether that's
 23 right?"
 24 **A.** I don't recall.
 25 **Q.** Well, is there any record of you having said
 45

1 time when we were given that document -- that I was
 2 given that document to see that that's all we had.
 3 **Q.** On what basis could you assert that it wasn't
 4 based on fact?
 5 **A.** So the -- the doctor that I understand
 6 completed that was one person who may, who could have
 7 and -- manipulated the data without seeing the
 8 underlying rotas. We had seen the doctors' rotas,
 9 I understand, but not the nursing rotas.
 10 **Q.** I'm afraid I am going to have to ask you to
 11 look at your assertion: you weren't saying maybe it
 12 wasn't based on fact, you have asserted in terms it was
 13 not based on fact. How were you in a position to hold
 14 that view in circumstances, particularly as this is
 15 a doctor who's done the analysis, and that analysis has
 16 been available for everybody to check at the hospital
 17 and nobody in the 48 hours you conducted this inspection
 18 suggested it was wrong, so how is it that you come to be
 19 asserting it was not based on fact?
 20 **A.** I was wrong to do that.
 21 **Q.** Well, just taking a step back. Do you think
 22 until this moment, in this hearing, you had rather
 23 underestimated the significance of the information you
 24 were provided with by the doctors?
 25 **A.** That --
 47

1 so?
 2 **A.** No.
 3 **Q.** Do you have any recollection of having said
 4 so?
 5 **A.** I just said I don't recall.
 6 **Q.** Well, I think -- so you don't have
 7 a recollection of saying so?
 8 **A.** No.
 9 **Q.** So does it seem likely that you didn't say
 10 that?
 11 **A.** I didn't ask.
 12 **Q.** Could the explanation for that be because
 13 everybody at all of the meetings that you had were
 14 proceeding on the basis that underlying facts were
 15 correct, that it was a dispute about the interpretation
 16 of those facts that represented the difference between
 17 the different sides?
 18 **A.** Yes.
 19 **Q.** So if that is the basis on which the entire
 20 review was conducted, just help us with why in your
 21 reflection in May of 2024 you are talking about that
 22 particular chart as not being based on fact and being
 23 uncorroborated?
 24 **A.** Because we hadn't seen -- I hadn't seen the
 25 evidence on which it was based. It was that moment in
 46

1 **Q.** The overall significance of it, do you think
 2 that at the time you ascribed too little significance to
 3 it?
 4 **A.** Yes.
 5 **Q.** Why do you think it has taken until now for
 6 you to see that?
 7 **A.** I can't answer that specifically. I --
 8 I can't -- I -- I don't know.
 9 **Q.** Well, what additional factors were you,
 10 incorrectly as it must be, weighing in the balance to --
 11 to cause you to think less of that information at the
 12 time?
 13 **A.** The circumstances in which I was given that
 14 information were that there was a lot of assertions at
 15 the time that Ms Letby was being scapegoated.
 16 **Q.** Do you think that you placed too great an
 17 emphasis upon that?
 18 **A.** In retrospect, yes.
 19 **Q.** Did you have enough information at the time to
 20 make the balanced judgment that you are now making?
 21 **A.** No.
 22 **Q.** Why not?
 23 **A.** Because a lot has happened since then.
 24 **Q.** But on the one hand of course you are mindful
 25 of the individual employee and the possibility of being
 48

1 scapegoated. On the other hand you have got two
2 doctors, as we will come to in a moment, sitting in
3 front of you telling you that they are, having exercised
4 their professional expertise, dealing with an unusual
5 cohort of patients and they cannot see any other
6 explanation and they are worried.

7 Why is that not enough to weigh in the balance and
8 say; well, obviously it's not for me to determine which
9 is right, but we need to act on the basis that the
10 frankly more serious of those risks is right?

11 A. In the context we were at the time we also had
12 had -- we had knowledge that the cases had been through
13 a Coroner's investigations who had, they had been
14 through network reviews. So I don't think we were in
15 a place at that time to think the unthinkable.

16 Q. Well, you presumably -- and in fact you tell
17 us in your witness statement, you are aware of the case
18 of Beverley Allitt?

19 A. But not -- we weren't in that context at the
20 time.

21 Q. Well, the context is that somebody was saying
22 a nurse may be killing babies.

23 A. That wasn't until afterwards, I think.

24 Q. Wasn't that exactly what Dr Brearey and
25 Dr Jayaram were saying that that was their worry;

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1 Q. Well, look, let's have a look at some of what
2 you were told in more detail. We can deal with the
3 preparation fairly briefly. You saw both sets of Terms
4 of Reference but I think that not knowing the
5 information that Ian Harvey provided to Sue Eardley you
6 didn't perceive a difference between the two of them?

7 A. There was a slight difference in one of the
8 Terms of Reference about the common themes I think,
9 but --

10 Q. You also tell us that you didn't see the lead
11 reviewer's email in which he identified the commonality
12 of Letby?

13 A. Yes.

14 Q. I mean, if we just pause to think about that.
15 The lead reviewer on the information that you had all
16 been sent had identified that for himself?

17 A. I'm not sure that that was in ...

18 Q. He saw the thematic review --

19 A. Okay.

20 Q. -- which identified Letby as being present at
21 nine out of the ten deaths which is?

22 A. I don't recall seeing that.

23 Q. Was it your practice to read every document
24 that you were sent?

25 A. Not every single document, no.

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1 somebody may be killing babies?

2 A. Yes. But I think that -- I can't speak for
3 everybody else but I think at that time we thought that
4 had been excluded because of all of the other work that
5 had gone on around before the College was involved.

6 Q. What did you think that had been done to
7 exclude that possibility?

8 A. That there had been no red flags raised by the
9 organisations I had already talked about, so the
10 Coroners had been involved and the CDOP and the network
11 review had all looked at those babies' deaths.

12 Q. The network review had concluded that they
13 couldn't identify a common theme, that was in the
14 thematic review --

15 A. (Nods)

16 Q. -- that was sent to you.

17 But what organisation is capable of determining
18 whether or not murder has been committed?

19 A. So the -- well, of course that would be the
20 police.

21 Q. You knew the police hadn't been involved?

22 A. Yes.

23 Q. Although the doctors wanted the police to be
24 involved?

25 A. Yes.

50

1 Q. If a document was identified as thematic
2 review, would that be the sort of document that you
3 would think may be important?

4 A. I am surprised that I didn't look at it, yes.

5 Q. Are you able to take it from me because I know
6 that you read Ms Eardley's evidence from Thursday or we
7 can look at the references, that in her email
8 circulating it to you all access to the material, she
9 specifically drew attention to the thematic review as
10 being one the documents that should be considered?

11 A. Could I see that, please?

12 Q. Yes, of course. INQ0012846. This is
13 12 August and what she says here, it is the third
14 paragraph:

15 "Key things to look at but probably the Mortality
16 Reviews. There are some concerns coming out of
17 Transport Service. Please keep the Terms of Reference
18 in mind."

19 A. That is, is that I -- I thought you said it
20 was entitled "Thematic Review"?

21 Q. "Of Neonatal Mortality" is the full title of
22 the document?

23 A. Okay. Okay. I -- I don't remember seeing the
24 email. I obviously received it. I don't recall.

25 Q. Well, let's move forward to day one and it's

52

1 in your first meeting with Ian Harvey and Alison Kelly
2 that you are told about the doctors' concerns.

3 **A.** Yes.

4 **Q.** What was your overall impression of
5 Mr Harvey's attitude towards the seriousness of the
6 allegations and the calling of the police?

7 **A.** I don't recall the conversation specifically
8 and the detail of the conversation. I think the feeling
9 that I got was that he didn't want to do that.

10 **Q.** Are you able to give us any more detail about
11 where that feeling might have come from? Is that just
12 an impression of the overall conversation?

13 **A.** Yes.

14 **Q.** And so far as Alison Kelly was concerned, the
15 other person present at that first meeting, what was
16 your overall impression of her attitude towards the
17 seriousness of the allegations and calling the police?

18 **A.** I don't recall. I recall her being supportive
19 of Ms Letby.

20 **Q.** Now, one of the notes, and we will bring it up
21 on screen, we are not going to look at all of it,
22 INQ0014604, this is a note by Ms Eardley who was acting
23 as notetaker, and this is really just to prompt your
24 collection, I hope.

25 We can see halfway down the text, so it's about

53

1 **A.** Yes, go back to the top.

2 **Q.** Go back to the first page, I have got up in
3 front of me --

4 **A.** It must be.

5 **Q.** -- the transcription.

6 **A.** Yes. Sorry, it's halfway down on that first
7 page.

8 **Q.** Yes.

9 **A.** So it says "the Director of Corporate Affairs
10 was DCI before" and then there is the bit that is
11 redacted.

12 **LADY JUSTICE THIRLWALL:** Before he retired.

13 **MR DE LA POER:** He retired.

14 **A.** Yes, and then the arrow down below that is
15 "rely on him reference police" I think that says, rather
16 than "not police". So it would appear to me that they
17 took advice from the Director of Corporate Affairs about
18 going to the police.

19 **Q.** At that time what did you understand
20 Ian Harvey and Alison Kelly's attitude towards going to
21 the police was?

22 **A.** Not to do that because they had taken advice
23 from the DCI. But this is my -- the previous DCI. This
24 was my interpretation now as I don't recall that from
25 the time.

55

1 two-thirds of the way down:

2 "Director of Corporate Affairs was DCI before he"
3 and then "huge nettle to grasp, need to unpick things
4 around", then "rely on him".

5 So these are handwritten notes transcribed so they
6 are not always easy to interpret. But do you have
7 a recollection of being told that the Director of
8 Corporate Affairs was a former Detective Chief
9 Inspector?

10 **A.** I don't recall that. However, could it -- is
11 it possible to see the handwritten note because I looked
12 at this again last night and I think the -- this
13 transcript is not quite accurate?

14 **Q.** If you just bear with me a moment.

15 **A.** Thank you, sorry.

16 **Q.** Not at all. INQ0010124. So you will just
17 have to help us to navigate where it was that you --

18 **A.** It's down further down the notes where there
19 is an indent.

20 **Q.** So if we go to the next page.

21 **A.** And further down, sorry. And further down
22 again. Oh, where was it?

23 Sorry. Further down. No, it must be --

24 **Q.** I think we are going to need to go back
25 because we are moving off that meeting?

54

1 **Q.** Thank you. I wonder if we can go back to the
2 typed notes, INQ0014604.

3 We are going to need to go to page 2. This is
4 something that your colleague Ms Mancini says. In the
5 middle of the page, "Alex", do you see that that
6 reference, "Can we see PM reports?"

7 **A.** Yes.

8 **Q.** Now, would it be normal for an Invited Service
9 Review to be reviewing the postmortem reports for
10 individual patients?

11 **A.** I don't know. I don't think so but I don't
12 know.

13 **Q.** Well, just -- I appreciate this is what the
14 nursing member of the panel is saying, but you have an
15 understanding of what the purpose of such reviews is
16 for?

17 **A.** (Nods)

18 **Q.** Do you think that was an opportunity for you
19 to say: I just think we all need to take stock here?

20 **A.** Yes.

21 **Q.** That we are not here to look at the postmortem
22 reports for individual children, we are here to do
23 a service review?

24 **A.** I think we were all a bit shocked about what
25 we had heard. Yes, it was a missed opportunity.

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1 Q. So that's a wrong turn, isn't it, for the
2 whole review process?

3 A. Okay.

4 Q. If we go to page 3, just above "CM's process"
5 which I think we will come to in a moment, which is
6 a reference to you, we see what it says is:

7 "Need details of nurses who looked after the babies
8 at the time."

9 Again this appears to be the reviewer's, and it is
10 not ascribed to any particular individual, asking for
11 the details of individual nurses who were looking after
12 the babies?

13 A. (Nods)

14 Q. Again is that something that you would expect
15 at an Invited Service Review?

16 A. Given the information -- it goes back to what
17 I said before about not having had the information until
18 this point.

19 It's getting a bit muddled.

20 Q. Well, it rather looks like you are suggesting
21 to the Executives that you will carry out some kind of
22 investigation of which nurses were on duty or associated
23 with the deaths and when I say "you", I mean you
24 collectively, not you personally?

25 A. Yes, yes.

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1 A. Yes.

2 Q. Is that what they were telling you at that
3 time?

4 A. I think that was the impression we got which
5 gave us the impression that they hadn't given any
6 credence to the allegations.

7 Q. Page 5. We can see right at the bottom:
8 "CMC parents complaints", which appears to be you
9 asking whether the parents had complained, and then what
10 appears to be an answer from the Executives:

11 "Contacted as many parents as possible before it
12 went to the paper. No extra complaints."

13 Then over the page:

14 "Accepted we are doing the right thing. Nobody had
15 raised concerns."

16 And no -- and there is a triangle signalling no
17 draining, presumably, before that in terms of complaints
18 or no warning."

19 Did you think that the views of the parents were
20 important to your review?

21 A. Sorry, could we go back down to the previous
22 page?

23 Q. Yes, of course.

24 A. Because I think this was about the unit being
25 downgraded.

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1 Q. So again would you say that is another wrong
2 turn that the review is taking in that first meeting?

3 A. It could be seen like that, yes.

4 Q. Well, do you see it that way?

5 A. Yes.

6 Q. We then see "CM's process", and was this you
7 with your background and experience trying to understand
8 for yourself what had been done so far as the nurse who
9 you had been told about was the subject of suspicion?

10 A. Yes. I believe I was asking about what
11 process had been undertaken.

12 Q. Yes. And if we go over to page 4, we can see
13 again it is not attributed to anybody but what seems to
14 be said is:

15 "Just taken out of duties. How to get her back in
16 again."

17 A. Yes.

18 Q. That seems perhaps more likely that that's the
19 Executives speaking --

20 A. Yes.

21 Q. -- rather than the reviewer. But on the basis
22 of that note, what seems to be being said to you, the
23 reviewers, on 1 September by the Executives is that they
24 have taken her out of the duties, but what they are
25 looking to do is get her back?

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1 Q. I think the preceding topic is discussion
2 about Occupational Health as recorded in these notes.

3 A. I don't -- I don't know, I can't recall the
4 context that I would have asked about that.

5 Q. Bearing in mind that Ms Mancini appears to
6 have asked to see the postmortem results in relation to
7 those babies, what was the ethical position so far as
8 the RCPCH were concerned and consent? Would you have
9 regarded yourself as needing to get the parents' consent
10 before you could see a postmortem on their baby or would
11 you have regarded that as something, I mean, I saw your
12 expression there and quizzical perhaps is the right way
13 of describing it?

14 A. Yes.

15 Q. I mean, you were there representing the
16 interests of patients and parents --

17 A. Yes.

18 Q. -- and so on, so invading their privacy is
19 something that you would have an eye on presumably as
20 part of that function to make sure that their
21 confidentiality was respected. What did you understand
22 the position about whether they needed to consent to
23 postmortem reports about their babies being given to the
24 reviewers?

25 A. I can't say I gave it thought at the time.

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1 Q. Do you think that's something you should have
2 been thinking about?

3 A. I should have done.

4 Q. Do you think that there's a possibility at
5 least that you were for whatever reason perhaps not
6 putting the parents of those babies at the centre of
7 your thinking as you were conducting this review?

8 A. I can't, I can't, I can't say. Perhaps they
9 weren't at the centre.

10 Q. Is it fair to say that of all the people who
11 were there, and everybody should have that in mind, but
12 it was your role to be the check and balance on that and
13 ensure that that happened?

14 A. But -- yes.

15 Q. The next discussion -- thank you, we can take
16 that down and again I am certainly not trying to rush
17 you, but we have been over some of this already in terms
18 of what you were told. You had a discussion with
19 Dr Brearey and Dr Jayaram and in summary, they told you
20 that things had been fine until June 2015 when they had
21 had three deaths?

22 A. (Nods)

23 Q. And that at that stage, the fact that there
24 was a common nurse was noted but not thought to be
25 significant?

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1 they?

2 A. Yes.

3 Q. So whatever --

4 A. Yes, yes.

5 Q. Well, they also told you that they conducted
6 research into how Letby might have killed the babies
7 because they told you that they had looked up air
8 embolism, didn't they?

9 A. Yes.

10 Q. And the notes record the word "chilling"
11 against Dr Jayaram as he described the process of him
12 conducting that research. Do you remember him using the
13 word "chilling"?

14 A. No.

15 Q. Do you have an impression of the emotion or
16 lack of emotion that he spoke about this with?

17 A. No.

18 Q. The note also makes it absolutely clear
19 "injecting air into babies", that's the handwritten note
20 of what was being said.

21 A. (Nods)

22 Q. So is it fair to say that at the end of that
23 meeting, you had had communicated to you very clearly
24 that they at that moment in time suspected -- no more
25 than that, suspected -- that Letby may have murdered

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1 A. Yes.

2 Q. Dr Jayaram told you how it was the way in
3 which the babies collapsed which was the concern to him?

4 A. (Nods)

5 Q. And they told you about the thematic review
6 that had been conducted and said that the deaths --
7 increase in the mortality rate was still unexplained?

8 A. Yes.

9 Q. They told you about the fact that the nurse
10 that they were concerned about had been on shift at all
11 the times and that that had been something that they had
12 told the Executives; is that right?

13 A. Yes.

14 Q. And they told you that Letby had been moved
15 from night shifts to day shifts and that the pattern had
16 then changed?

17 A. Yes.

18 Q. Now, Dr Stewart's note of that meeting
19 includes this:

20 "Paeds worried about foul play."

21 And that is something that you looked in your
22 statement to reflect upon. Do you recall the phrase
23 "foul play" being used?

24 A. I don't think so.

25 Q. But they were worried about murder, weren't

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1 babies?

2 A. Could you take me to that note, please?

3 Q. Yes, of course.

4 A. Sorry.

5 Q. INQ0014604. Which particular part of it? Is
6 it the embolism?

7 A. Yes.

8 Q. Yes, of course. So we will go to page 10 for
9 this. So we see at the bottom:

10 "When thinking forensic what happens with air
11 embolism? Looked at case studies and last [query]
12 observation: chilling. Just like what happened. Babies
13 [and then if we go over the page] unresponsive to any
14 inputs."

15 And lists them:

16 "Odd skin discolouration, blue with eyelids of pink
17 in the ..."

18 And then this:

19 "Injecting air into the babies" with "??" against
20 it.

21 So that is what I was suggesting the notes record?

22 A. Sure.

23 Q. My question was whether you agree that at the
24 end of that meeting, they had communicated to you and
25 the other reviewers that they were suspicious of whether

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1 Letby had murdered babies?
 2 **A.** I'm not sure. I don't remember those words
 3 being said. So I'm not sure whether they those words
 4 were said or whether that is Ms Eardley's interpretation
 5 of what was being said.
 6 **Q.** Well --
 7 **A.** I'm sorry, I just don't remember that and
 8 I don't remember the word "chilling" being used.
 9 **Q.** Well, there are a number of possibilities that
 10 arise, if you don't remember.
 11 One of them is that it wasn't said, although we do
 12 know what Ms Eardley has recorded?
 13 **A.** Yes.
 14 **Q.** Another is that you didn't really in light of
 15 what the Executives had told you, perhaps, think that
 16 what they were saying was important or significant?
 17 **A.** I don't recall it. That's the problem.
 18 **Q.** But if somebody had told you that they thought
 19 somebody else was murdering babies, that's quite
 20 a memorable thing to be told, isn't it?
 21 **A.** It is, which is --
 22 **Q.** So can you help us at all?
 23 **A.** I am trying to help. I don't recall.
 24 **Q.** We know that the meeting -- thank you, we can
 25 take that down -- which followed was with the other

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1 What I suggest is that effectively what happened at
 2 lunchtime based upon the notes of what Ms Eardley told
 3 us was that the doctors war gamed how Letby may have
 4 been murdering the babies.
 5 Do you remember such a conversation?
 6 **A.** No.
 7 **Q.** Well, let's have a look at the note
 8 INQ0010124, page 23. This is the typed note and I am
 9 going to make a correction based upon what we know to be
 10 right and can I say that you will see that two words are
 11 redacted, we are not going to mention those words?
 12 **A.** Okay.
 13 **Q.** If you need to see them to remind yourself,
 14 then I will find a way for you to do that?
 15 **A.** Okay, thank you.
 16 **Q.** But it may very well be that we don't need to
 17 in order for you to understand the flavour of what we
 18 are talking about.
 19 So page 23, please. So right at the bottom under
 20 the line, the word is "team" that is what we understand
 21 from Ms Eardley, it actually in the typed notes says
 22 "Tom" but it is team?
 23 **A.** Thank you.
 24 **Q.** She told us these are her notes of the
 25 lunchtime meeting and that's where they fit in the

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1 Consultants and they were all concerned, weren't they,
 2 between them, about the deaths, that was the impression
 3 they were giving, and did they appear to you to be
 4 supportive of Dr Brearey and Dr Jayaram?
 5 **A.** Yes.
 6 **Q.** So now we are up to seven Consultants who
 7 appear to be crediting this possibility; do you agree?
 8 **A.** Yes.
 9 **Q.** Then there is a discussion at lunchtime. Do
 10 you know what the phrase "war gaming" means?
 11 **A.** I -- I know what I think.
 12 **Q.** Yes, well, I want to make sure we are on the
 13 same page, so an unusual phrase --
 14 **A.** Would you explain it from your perspective?
 15 **Q.** Yes, of course it is the notion, and it's
 16 often used in the context of military medicine because
 17 of the overlap, of where doctors -- military doctors --
 18 come together and they come up with scenarios as to how
 19 you might treat a patient or how a particular piece of
 20 surgery might happen, they just talk about it in terms
 21 of "war gaming" that, so it is the idea that you talk
 22 about multiple scenarios in a constructive way?
 23 **A.** Okay.
 24 **Q.** You are familiar at least with the idea of
 25 doing that

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1 sequence and she told us this was the first opportunity
 2 that the team had had to sit in private and discuss
 3 everything that they had been told, much of which was
 4 new to many of them. And that there are two words that
 5 you can simply take it from me that those are chemicals.
 6 **A.** Okay.
 7 **Q.** Okay so two different types of chemical:
 8 "... or insulin injection or air embolism but all
 9 had different presentation."
 10 That is what her note records. This was
 11 a conversation she told us at which the team was
 12 together at lunchtime and at which the doctor members of
 13 the team were having a discussion about how it could be
 14 that there were different presentations for each of
 15 these babies if somebody was murdering them and they
 16 were war gaming how that might have occurred by making
 17 suggestions about embolism, insulin injection, and those
 18 two other matters that we are not going to publicise.
 19 Do you remember that conversation?
 20 **A.** No.
 21 **Q.** Do you know why you wouldn't remember that
 22 conversation, is it because that's not something that
 23 you would have paid attention to or do you think that
 24 you were not present, or what -- what explanation might
 25 that be --

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1 A. I do not recall that at all.
 2 Q. Because would you agree that's quite an
 3 extraordinary conversation for the Review Team to be
 4 having at lunchtime on day one of the RCPCH visit?
 5 A. I don't recall. I -- I -- I may not have been
 6 there, I may have been doing something else but I do not
 7 recall. I was not participating in that conversation.
 8 Q. Forgive me. My question was: do you agree
 9 that that is an extraordinary conversation?
 10 A. Yes.
 11 Q. Do you agree that the very fact of that
 12 conversation, whether or not you were present, the very
 13 fact of that conversation is itself the clearest
 14 indication that at that stage the reviewers should have
 15 said --
 16 A. Yes.
 17 Q. -- if we are getting into a conversation about
 18 how you might murder babies, we just need to walk away
 19 from this and the police need to be involved?
 20 A. Yes.
 21 Q. So would you say that anybody involved in that
 22 conversation ought to have been saying that?
 23 A. Yes.
 24 Q. We can take that down, thank you very much.
 25 After that lunchtime break, the next meeting was

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1 Q. Would that have been an appropriate question
 2 to ask?
 3 A. Yes.
 4 Q. Now, there is no record, you can take from me,
 5 that that question was asked. Do you think it should
 6 have been?
 7 A. Yes.
 8 Q. Although it's a collective responsibility, do
 9 you accept that you had some responsibility in that?
 10 A. Of course.
 11 Q. Now, Alison Kelly was the Executive Lead for
 12 safeguarding and we know that because that's within the
 13 material that was provided to the reviewers. Do you
 14 have any recollection of her being asked in the context
 15 of this allegation; you are the safeguarding lead, how
 16 is that being dealt with from a safeguarding
 17 perspective?
 18 A. I don't recall that question being asked.
 19 Q. Well, do you think that the reason for that is
 20 because it wasn't asked?
 21 A. Yes.
 22 Q. And do you think it should have been?
 23 A. Yes.
 24 Q. Letby was spoken to by you and Ms Mancini?
 25 A. Yes.

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1 with the safeguarders. Do you remember meeting some of
 2 the safeguarding team, Dr Mittal --
 3 A. If I was there then I was.
 4 Q. -- and Dr Isaac. So I believe this isn't one
 5 of the meetings you suggested you weren't present at.
 6 Now, one of the functions of your Invited Review
 7 was to look at how well policies and procedures were
 8 implemented and how robust things were around process.
 9 Is that right?
 10 A. Yes.
 11 Q. One of the policies and areas that was being
 12 investigated was what was the approach to safeguarding;
 13 is that right?
 14 A. Yes.
 15 Q. No doubt that explains why the safeguarders
 16 were spoken to.
 17 We will circle back to the start of my questions.
 18 What the doctors told you, the Consultants told
 19 you, do you agree fits into the definition of
 20 a safeguarding allegation?
 21 A. Yes, it would.
 22 Q. A meeting took place with the safeguarders and
 23 one way to test how robust procedures would be would be
 24 to say: are you aware of this concern?
 25 A. Yes.

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1 Q. She wasn't originally scheduled to be spoken
 2 to. It has been suggested by Ms Eardley that it was
 3 your idea, that is her recollection, and she says it was
 4 to give Letby an opportunity to give her perspective,
 5 that is Ms Eardley's recollection.
 6 Do you know whose idea it was?
 7 A. I cannot recall how the idea materialised,
 8 I don't know.
 9 Q. Do you agree it was a wrong turn?
 10 A. I do now.
 11 Q. Well, did you have enough information at the
 12 time to realise that that was a wrong turn?
 13 A. No.
 14 Q. You didn't?
 15 A. No.
 16 Q. Well, you had a couple of hours earlier spoken
 17 to some Consultants who told you they thought she was
 18 a murderer, or she may be.
 19 Was that not sufficient reason to think: probably
 20 shouldn't be going to speak to her?
 21 A. No.
 22 Q. Why not?
 23 A. Because of all the other information that we
 24 had that muddied the waters around her as a person.
 25 Q. But you were conducting a service review. Why

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1 were you investigating an individual case?
 2 **A.** We weren't investigating her. We were
 3 interviewing her as part of the -- the nursing cohort.
 4 **Q.** Well, my question was to suggest that you were
 5 investigating her. It was her case, I was suggesting,
 6 putting it as broadly as that, whether from an HR
 7 perspective or any other perspective; you weren't there
 8 to look at individual situations, were you?
 9 **A.** No, but we didn't ask her about the case, her
 10 case.
 11 **Q.** Well, you were asking her about how she had
 12 been treated?
 13 **A.** And relationships on the unit and those type
 14 of questions. It was much broader than that.
 15 **Q.** But you had already identified all the people
 16 that you needed to speak to for that purpose, hadn't
 17 you, they were already rostered?
 18 **A.** Yes.
 19 **Q.** So presumably the only reason that you wanted
 20 to speak to her was because of what you had been told
 21 about her in the morning?
 22 **A.** She would have been in with the other group
 23 otherwise, with the other group of nurses otherwise.
 24 **Q.** So you think that Letby would have been spoken
 25 to the following day?

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1 about that and you made notes so we can refer to those.
 2 I want to ask you about what may not have been
 3 recorded in the notes, certainly what is suggested by
 4 Letby, who we must not lose sight of the fact is
 5 a convicted murderer, but she sent contemporaneous
 6 messages to Dr U which I think you have seen and had
 7 a chance to refresh your memory from.
 8 INQ0000569 and it's page 34. Page 34. Can I just
 9 give the reference INQ0000569. Well, can we just take
 10 that down from the screen for the moment. I am going to
 11 need just to read this out to you. I know you have had
 12 a chance to, but I don't want to create any unfairness
 13 but I am not going to have that entire document up on
 14 the screen so can we take it down, please.
 15 The first message sent at 18:14. She says to Dr U:
 16 "Thank you for your help. The two members were
 17 nice."
 18 Presumably a reference to you and Ms Mancini:
 19 "They didn't ask much about the babies, it was more
 20 about the unit as a whole, et cetera."
 21 In brief it looks as though there is potential for
 22 this to go further over a long period of time. H
 23 [presumably Hayley Cooper who was her
 24 RCN representative] thinks we need to look at taking out
 25 a grievance case."

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1 **A.** Had -- had she not been moved from the unit
 2 and she wasn't allowed to contact people on the unit.
 3 **Q.** How do you know that she would have been
 4 spoken to the following day; you didn't speak to all of
 5 the neonatal nurses?
 6 **A.** Well, she, she -- okay, she could have been
 7 spoken to the next day as part of the group of nurses
 8 that we spoke to.
 9 **Q.** But the only reason that you would need to
 10 speak to her as opposed to whichever nurses were
 11 available to speak to you was because of what you had
 12 been told in that morning?
 13 **A.** It felt like the right thing to do at the
 14 time.
 15 **Q.** Well, I am not disputing that. But did you
 16 not have sufficient information to realise that you were
 17 now moving in a direction that you ought not to have
 18 been moving?
 19 **A.** We didn't think that at the time.
 20 **Q.** Again, but did you have enough information to
 21 realise that as a reasonable conclusion?
 22 **A.** Clearly not, otherwise we wouldn't have done
 23 it.
 24 **Q.** Now, in terms of the discussion we have
 25 a record of that, I don't want to ask you any questions

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1 That is her first message to Dr U.
 2 About 15 minutes later she sends another one:
 3 "The report will take a minimum of six weeks with
 4 the preliminary tomorrow. They 'off the record' told me
 5 they think an investigation into the deaths will be
 6 a recommendation and I need to prepare myself that as
 7 I would play a big part in that over due to being
 8 a common factor and it could take several months."
 9 All right, so I know you have seen those messages
 10 before and you weren't in fact a party to them at the
 11 time.
 12 **A.** Yes.
 13 **Q.** I just want to ask about that. Was there an
 14 off-the-record conversation involving you, Ms Mancini
 15 and Letby?
 16 **A.** Not that I recall, no.
 17 **Q.** Did you discuss whether she should take
 18 a grievance?
 19 **A.** I believe her Union representative mentioned
 20 that in our conversation.
 21 **Q.** I mean, it was in your mind at the end of that
 22 day one that there would be a recommendation for an
 23 investigation, wasn't it?
 24 **A.** Yes, I -- I guess, yes.
 25 **Q.** And what she seems to be saying is there was

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1 some discussion about the impact upon her because she
 2 said "I need to prepare myself". So that is what she's
 3 reporting that she's being told. So that is
 4 a discussion about how she should cope with it. That is
 5 her characterisation of it?
 6 **A.** Sure.
 7 **Q.** Do you have any recollection at all?
 8 **A.** No.
 9 **Q.** Now, it appears that Letby ended up with your
 10 telephone number. Do you know how that happened?
 11 **A.** No.
 12 **Q.** Did you give her your telephone number?
 13 **A.** No.
 14 **Q.** You suggest in your witness statement:
 15 "It appears that if my number was given to them it
 16 was by the Invited Review manager."
 17 Who do you mean by the Invited Review manager?
 18 **A.** Ms Eardley.
 19 **Q.** Ms Eardley. What do you base that upon?
 20 **A.** The way the -- the one of the notes was
 21 written the next day, I think.
 22 **Q.** Well, let's have a look at that.
 23 **A.** Gave -- I think it said "Gave Claire's
 24 number".
 25 **Q.** INQ0014605, page 6. We will just come back to
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1 is."
 2 So by that stage, that conclusion had been reached
 3 that there needed effectively two processes, one
 4 Casenote Review and one formal process for Letby?
 5 **A.** Yes.
 6 **Q.** Then if we see further down, about two-thirds
 7 of the way down:
 8 "We were worried to let her go home."
 9 That is just picking up:
 10 "Hayley to take her home, gave Claire's number to
 11 Hayley plus Lucy worried about her mental health as
 12 feels that everyone has turned their backs on her."
 13 **A.** Yes.
 14 **Q.** That is the reference in the notes to your
 15 number?
 16 **A.** Yes.
 17 **Q.** So you were present at this meeting?
 18 **A.** (Nods)
 19 **Q.** Did you have any concerns about the fact that
 20 your number had been given to Letby?
 21 **A.** I don't -- I don't recall that, the only
 22 reason I know about this is from the note, not from
 23 giving my number. I -- I didn't give her my number.
 24 **Q.** But what appears to be occurring is that at
 25 a meeting that you are present at, somebody is talking
 79

1 that issue in a moment. We will take it in order that
 2 it appears. Somebody appears to say:
 3 "Not sure if the review will give you the answers
 4 you are looking for. Considered aborting and starting
 5 again but Terms of Reference to be important to get the
 6 background."
 7 Do you see that at the top?
 8 **A.** Yes, sorry.
 9 **Q.** Do you recollect a discussion in which the
 10 team considered aborting?
 11 **A.** I think there was a discussion, yes.
 12 **Q.** What -- who was in favour, who was against?
 13 **A.** I -- I don't recall.
 14 **Q.** What consideration, if any, was given to the
 15 possible impact upon a regulatory or police
 16 investigation if you carried on?
 17 **A.** I don't recall the conversation so I couldn't
 18 say.
 19 **Q.** Well, do you have any reason to think that
 20 that was mentioned by anybody?
 21 **A.** I -- it would be speculation to say so.
 22 **Q.** We can see that it continues:
 23 "Need independent Casenote Review of all the deaths
 24 by two independent people. Big concerns about Lucy plus
 25 need formal process to be started so she knows where she
 78

1 about having given your telephone number to Letby?
 2 **A.** I don't recall it being said. I only know
 3 about it from the note.
 4 **Q.** Then we can see last paragraph:
 5 "Needs to be put into a process for her protection
 6 and yours. Disciplinary process to get to the bottom."
 7 This appears to be that she is going to be
 8 disciplined on the basis of the allegations of the
 9 Consultants; is that right?
 10 **A.** Well a process to be put in place to --
 11 **Q.** Well, a disciplinary process?
 12 **A.** I don't remember saying "disciplinary process"
 13 so a process needed to be put in place because she had
 14 been moved from her place of work to another place of
 15 work, within the -- within the Trust without any process
 16 being put in place to do that.
 17 And then something needed to be done in order to
 18 investigate the allegations that were made about her.
 19 **Q.** Do you agree that a disciplinary process to
 20 investigate the Consultants' allegations would be
 21 completely inappropriate?
 22 **A.** But this is the type of process that needed to
 23 be put into -- in place that the Invited Guide Review
 24 I believe it is that we looked at earlier talks about
 25 for misconduct.
 80

1 Q. They weren't just talking about misconduct?

2 A. No, no.

3 Q. Murder is a form of misconduct, they are
4 talking about murder so --

5 A. I appreciate --

6 Q. I'm sorry, I don't want to talk across you but
7 can I just ask my question: do you agree that
8 a disciplinary process to get to the bottom of the
9 Consultants' allegations would be inappropriate?

10 A. Yes. But something had to be started in order
11 to put a formal process in place.

12 Q. Well, would calling the police be enough to
13 start it?

14 A. Not without other things happening. So she
15 should in my view have been put through a process that
16 would have suspended her from practice, referred to the
17 NMC, referred to the police, and the processes allowed
18 to take their course.

19 Q. Why don't you phone the police first?

20 A. The order in which it happened wouldn't --
21 just -- it's hard to explain that this all should have
22 been done way before the College was involved in this
23 process. By just moving Ms Letby to another place of
24 work without doing anything, without inform -- putting
25 any formal process in place, left everybody at risk

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1 herself for?

2 A. I don't know who said that. I can't answer
3 the --

4 Q. Well, what other explanation can you offer for
5 why it was said either by you or in your presence "she
6 knows it will be horrid"?

7 A. But without knowing whether those were the
8 actual words that were said, I -- I don't know.

9 Q. We are going to move away from the content the
10 review, there were obviously other meetings that you had
11 including with senior nurse, we have the notes for that.

12 I would just like to move to the letter of
13 5 September. But before we do, we just need to go,
14 while we still have this on screen, to page 34. So this
15 is the feedback session which -- we can go up if you
16 need to, but I hope you will be able to take from me
17 that this is the feedback session involving Mr Chambers
18 right at the very end of the process?

19 A. Thank you.

20 Q. We can see "Tony, were these unexpected" is
21 right in the middle of the page there just to anchor you
22 where we are?

23 A. Yes, thank you.

24 Q. Immediately above that "CM", so presumably
25 you:

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1 including other patients in the hospital, her access to
2 records, all sorts of things.

3 Q. My question was: why not call the police
4 first?

5 A. I agree.

6 Q. So we then read on. There's reference to
7 a grievance which you tell us you knew about.

8 "If nothing happens good case for constructive
9 dismissal. She knows it will be horrid."

10 So that appears to be somebody at this meeting
11 telling the Executives that they have, that
12 inferentially Letby must know about the fact that there
13 is a process to come and that it's not going to be very
14 pleasant for her which is very much the tenor of her
15 message to Dr U the night before about how she needed to
16 prepare herself for it.

17 Just seeing --

18 A. Yes, I can see that.

19 Q. Just seeing this note now, bearing in mind
20 this is something either said by you or said by
21 Ms Mancini because you were the only two people who
22 could speak to Letby's state of mind, does it look in
23 fact as if there was this off-the-record conversation in
24 which you and Ms Mancini told Letby that there was going
25 to be an investigation that she needed to prepare

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1 "... will list some areas of point to check in the
2 detailed review what needs looking at."

3 So ascribed to you in this note that's not your
4 note, it is Ms Eardley's note, in the context of a more
5 in-depth review of cases, you appear to be recorded to
6 be saying:

7 "Will list some areas of point to check in detailed
8 review."

9 A. I don't recall. I don't know what that means.

10 Q. Well, let's see if we can have a look and see
11 the recommendation. INQ0009611, this is the letter of
12 5 September, where the detailed Casenote Review is
13 recommended.

14 If we go to page 2. We can see that there are some
15 points to check to use the language of that note. This
16 investigation should include as a minimum the following
17 elements ..."

18 Then there are four listed.

19 A. Yes.

20 Q. So what we appear to have is a meeting three
21 days earlier in which the record indicates that you
22 said: we are going to give you some points to check for
23 the forensic Casenote Review and then we have a letter
24 which provides that. My question will come as no
25 surprise. What contribution did you make to those

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1 items?
 2 **A.** I don't recall making any contribution to
 3 those items.
 4 **Q.** If we look at (d), for example:
 5 "Details of staff with access to the unit from four
 6 hours before the death of each infant."
 7 Are you able to recognise that that is an
 8 inappropriate recommendation for the RCPCH to be making?
 9 **A.** Yes.
 10 **Q.** Because that's a matter for the police, isn't
 11 it?
 12 **A.** Yes.
 13 **Q.** Now, you were involved in the drafting of the
 14 report in that you made some comments, but presumably
 15 you read it through thoroughly and were signed up to the
 16 finished product?
 17 **A.** Yes.
 18 **Q.** INQ0010131. What we are just going to have
 19 a look at now is page 6, please. Are we able to crop in
 20 towards the right-hand side? So just the centre middle,
 21 please, thank you.
 22 This is a part about the deaths in the report and
 23 you have added a comment:
 24 "I think we should mention here that some of these
 25 were actually congenital abnormalities which were

85

1 as a result of congenital abnormalities?
 2 **A.** No.
 3 **Q.** What explanation do you offer for proposing
 4 that change, bearing in mind it's a medical issue?
 5 **A.** As I explained in my witness statement, it was
 6 to provide balance.
 7 **Q.** What do you mean by balance?
 8 **A.** We had been told by some of the senior nurses,
 9 I think, that the cluster of babies included some of
 10 those with congenital ...
 11 **Q.** Is that something the doctors had told you?
 12 **A.** Abnormalities.
 13 **Q.** Or that they thought were significant?
 14 **A.** No.
 15 **Q.** Well, let's imagine the balance that you have
 16 described. On the one hand you have got the fact that
 17 these are unexplained and unexpected. Are you
 18 suggesting that there is a countervailing factor to
 19 somehow balance out that fact?
 20 **A.** Well, yes, because if some of them were as a
 21 result or some had congenital abnormalities then it
 22 would be remiss not to add that balance in.
 23 **Q.** Well --
 24 **A.** As I understand it, my comment was removed so
 25 it didn't happen.

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1 counted as unexplained and unexpected."
 2 Now, first of all, that's very much a medical
 3 issue, isn't it, that is under discussion there?
 4 **A.** Yes.
 5 **Q.** And your function wasn't to make a medical
 6 contribution --
 7 **A.** No.
 8 **Q.** -- to this report; is that right?
 9 **A.** That's correct.
 10 **Q.** One interpretation of what you are doing there
 11 is to diminish the potential significance of the
 12 apparently unexplained and unexpected by implying that
 13 some of them may be a result of congenital
 14 abnormalities. That is one interpretation. Do you
 15 recognise that at least --
 16 **A.** Yes, yes.
 17 **Q.** -- as an interpretation?
 18 **A.** Yes.
 19 **Q.** What you say in your witness statement is:
 20 "I thought it would be appropriate to provide some
 21 balance ..."
 22 **A.** Yes.
 23 **Q.** "... in connection with this."
 24 Were you seeking to diminish the significance of
 25 those factors by implying that perhaps the deaths were

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1 **Q.** Well, it is about your state of mind that we
 2 are looking at, not what was ultimately in the report
 3 because an interpretation of this proposal was that you
 4 were trying to minimise the seriousness of what the
 5 doctors were suggesting --
 6 **A.** No.
 7 **Q.** -- by suggesting that there was a natural
 8 explanation for the increase in neonatal mortality?
 9 **A.** No. I was just trying to provide some
 10 balance.
 11 **Q.** The overall report did not provide an answer
 12 to the question at term of reference 4, did it?
 13 **A.** No.
 14 **Q.** Finally, you say in your witness statement
 15 that the fact that there were two reports was
 16 inappropriate --
 17 **A.** Yes.
 18 **Q.** -- or not appropriate. Why do you say that?
 19 **A.** It lacks transparency.
 20 **Q.** Is that something that you said at the time?
 21 **A.** I think I spoke to Sue Eardley about it.
 22 **Q.** Before the report was released?
 23 **A.** I can't remember when. But yes, I think, yes
 24 at some point during that process.
 25 **Q.** What did you say to Sue Eardley?

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1 A. I don't recall. But I have had a conversation
2 with her about being -- there being more than one
3 report.

4 Q. Was the thrust of the conversation as you have
5 told us that you thought that was inappropriate because
6 it lacked transparency?

7 A. Yes, and it's confusing around version control
8 and who sees what.

9 MR DE LA POER: Ms McLaughlan, those are my
10 questions.

11 LADY JUSTICE THIRLWALL: Just wait there.
12 Mr Sharghy, you have some questions.

13 Questions by MR SHARGHY

14 MR SHARGHY: Ms McLaughlan, good afternoon,
15 I represent one of the Families whose child was murdered
16 by Lucy Letby and I also ask questions on behalf of six
17 other Families as well.

18 I am not going to go over, you will be glad to
19 hear, a lot of the issues.

20 A. Sorry I am having real trouble hearing you.

21 Q. I am so sorry.

22 Is that better?

23 A. That's much better, thank you.

24 Q. Thank you, I am not going to go over a lot of
25 the issues that you have already been asked questions

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1 the feeling amongst the team was that there was some
2 limitations in gathering the detailed information from
3 the Trust within the remit of the Terms of Reference.

4 Does that ring true to your knowledge as to that
5 discussion?

6 A. I don't recall a discussion like that.

7 Q. Do you recall any discussions at all whether
8 with the entire Review Team, or indeed with one or two
9 members, where the concept of additional documents was
10 raised?

11 A. Not specifically, no.

12 Q. Did you believe when you received the
13 information from the Trust that was placed on the Huddle
14 system --

15 A. Yes.

16 Q. -- that it contained all of the relevant
17 information for you and your colleagues to undertake the
18 review?

19 A. I assumed it did but then again looking
20 through the pack, the bundle that we received,
21 afterwards there was obviously additions later on that
22 I don't recall seeing.

23 Q. In relation to the process as it unfolds from
24 the morning of 1 September, when the review begins, you
25 say in your witness statement it became quite clear

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1 about but there are a couple of matters that I do want
2 to just press further, if I may.

3 As lay member of the Review Team it is fair to say,
4 isn't it, that you are not just there to make up the
5 numbers?

6 A. Yes.

7 Q. That your role would be integral to any
8 discussions or indeed meetings that take place either
9 before the review starts or indeed during the review
10 process?

11 A. Yes.

12 Q. Are you comfortable that you were involved in
13 all discussions between the Review Team or indeed any
14 meetings that took place?

15 A. I was, but I understand from looking at this
16 information that there were discussions between the lead
17 reviewer or email exchanges between the lead reviewer
18 and Ms Eardley that I believe the rest of us weren't
19 party to.

20 Q. The reason I am asking you this is because
21 Mrs Mancini is going to give oral evidence just after
22 you, but she has said in her written witness statement
23 to the Inquiry that there was a discussion before the
24 review actually began in relation to additional evidence
25 that the Review Team believed would be of assistance but

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1 early on in the interviews -- and I think there you are
2 referring to those with the Consultants Dr Brearey and
3 Dr Jayaram -- that there are these concerns raised in
4 particular regarding a connection between increase in
5 neonatal deaths on the unit and a particular individual
6 on the unit; is that fair?

7 A. I think that was raised actually in the very
8 first meeting with the Medical Director, but then again
9 with the Consultants, yes.

10 Q. I am just going to press you a little bit
11 further in relation to the decision thereafter made to
12 interview Lucy Letby, knowing what you then knew, on
13 that morning.

14 Given that there were other nurses who you could
15 have interviewed as a team, whether on that day or the
16 day after, and putting aside that the service review was
17 not going to consider any allegations against
18 Lucy Letby, why was she so integral to the interview
19 process that she was interviewed on that first day?

20 A. I think it was about availability, but I --
21 I don't know. I didn't arrange the -- the interview so
22 whether it was about availability, timing, I -- I can't
23 answer that.

24 Q. But specifically given what you were aware of
25 by that stage, as a patient and public interest

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1 representative on this panel, did you not even begin to
 2 imagine that there could be a conflict here?
 3 **A.** I clearly didn't.
 4 **Q.** We heard from Hayley Griffiths, you may have
 5 known her as Hayley Cooper at the time, who was the RCN
 6 rep that accompanied Lucy Letby to that meeting. It was
 7 a fairly short meeting she indicated?
 8 **A.** (Nods)
 9 **Q.** Fairly shortly after the questioning had
 10 started Lucy Letby becomes very emotional and she leaves
 11 the room. What Mrs Griffiths said to this Inquiry is
 12 that one of the members, either yourself or Mrs Mancini
 13 said something along the lines of: does she realise the
 14 gravity or the severity of the allegations that are
 15 being made against her?
 16 Was that you who said that?
 17 **A.** I don't recall that happening at all. I don't
 18 recall Ms Letby leaving the meeting.
 19 **Q.** You don't recall --
 20 **A.** No.
 21 **Q.** -- Lucy Letby becoming very emotional, leaving
 22 the room and being followed by her representative?
 23 **A.** No.
 24 **Q.** And you have no recollection that one of the
 25 two interviewers had said anything along the lines of:

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1 I can see why you would say that, but from the
 2 inside it didn't feel like that.
 3 **Q.** On reflection, you don't believe that that is
 4 exactly what happened, the shutters were kept down and
 5 the situation was contained, ie the police weren't
 6 called?
 7 **A.** That is your interpretation of that.
 8 **MR SHARGHY:** Okay, my Lady, thank you those are my
 9 questions?
 10 **LADY JUSTICE THIRLWALL:** Thank you, Mr Sharghy. Ms
 11 Scolding?
 12 **MS SCOLDING:** I have no questions of this witness,
 13 thank you very much.
 14 Questions by LADY JUSTICE THIRLWALL
 15 **LADY JUSTICE THIRLWALL:** Thank you very much
 16 indeed.
 17 Just one matter from me just in relation to the end
 18 of the meeting with Ms Letby. I just want to check my
 19 own note.
 20 Do you have any memory of speaking to Ms Cooper --
 21 **A.** Not.
 22 **LADY JUSTICE THIRLWALL:** She has a memory of
 23 thinking she had forgotten her coat and so went back in
 24 to the room and spoke to you without Ms Letby being
 25 there.

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1 do you realise how severe that those allegations are?
 2 **A.** No. She was very upset in the meeting which
 3 was why I was concerned for her mental health at that
 4 time. But I don't recall her leaving the meeting at
 5 all.
 6 **Q.** Final question.
 7 At paragraph 81 of your witness statement, you say
 8 that although you weren't involved in this discussion
 9 you did look at the transcript of what Andrew Higgins,
 10 who was a non-executive director, had said in relation
 11 to issues about why the police were not being called and
 12 why an independent review, effectively your review, is
 13 the most appropriate concept.
 14 The words that are ascribed there is that:
 15 "He indicated that: it's important to keep the
 16 shutters down and contain the situation."
 17 Do you now understanding not just what you knew at
 18 the time, but also on reflection, appreciate that that
 19 is precisely what the review that you were part of did?
 20 **A.** I wouldn't put it like that.
 21 **Q.** How would you put it?
 22 **A.** We were doing our best to help the Countess of
 23 Chester Hospital to discover what was going on. We were
 24 in a long line of organisations who were asked to look
 25 at those problems that they had got.

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1 **A.** No, I have no recollection of them being
 2 separate at all.
 3 **LADY JUSTICE THIRLWALL:** No, all right.
 4 One final thing. When you were talking much
 5 earlier in your evidence about the evidence of the rota
 6 which you were attributing to Dr Brearey, although we
 7 note its genesis was with Eirian Powell, you said the
 8 doctor was one person who may or could have manipulated
 9 that information.
 10 What was your basis for saying that?
 11 **A.** Well, I was hesitant in saying it but
 12 I couldn't think of another word but we hadn't seen --
 13 we had seen I think we had seen the doctors' rotas on
 14 Huddle.
 15 **LADY JUSTICE THIRLWALL:** Yes, and you told us about
 16 that. I just want to know what you meant, or whether on
 17 reflection you don't want to repeat it, that he was one
 18 person who may or could have manipulated it and I was
 19 puzzled about that. What do you mean?
 20 **A.** We -- because we didn't see the original data
 21 we had only got the interpretation of the data which can
 22 be, it can be manipulated is what I meant.
 23 **LADY JUSTICE THIRLWALL:** So that you didn't have
 24 a basis for saying it had been manipulated?
 25 **A.** No, no it wasn't a -- it was -- it, the --

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1 it's easy to even make a mistake in putting data into an
2 Excel spreadsheet to get that information back out
3 again.

4 **LADY JUSTICE THIRLWALL:** So he may have made
5 an error would have been another way to put it?

6 **A.** I wasn't suggesting that he had, but we
7 didn't -- because we only had that Excel spreadsheet
8 that had already been -- the data had already been
9 entered to, we hadn't seen the source data.

10 **LADY JUSTICE THIRLWALL:** Thank you. Anything you
11 want to ask, Mr De La Poer?

12 **MR DE LA POER:** My Lady, no, thank you very much.

13 **LADY JUSTICE THIRLWALL:** Thank you very much
14 indeed, Ms McLaughlan. You are free to go.

15 **A.** Thank you.

16 **MR DE LA POER:** My Lady the next witness is
17 Ms Mancini and subject to my Lady's better view we were
18 proposing to move on with her evidence now.

19 **LADY JUSTICE THIRLWALL:** Yes.

20 **MR DE LA POER:** Albeit that I think Mr Carr will be
21 asking for a shortened lunch break today when we get to
22 it.

23 **LADY JUSTICE THIRLWALL:** Yes. Thank you,
24 Mr De La Poer. So if you would like to re-organise the
25 front bench. If you would like to come straight up to

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1 **A.** Yes.

2 **Q.** So do you want to read those sentences and
3 tell us what the correction is?

4 **A.** Yes, read them first as they are?

5 **Q.** Read the final two sentences first and then
6 tell us what the correction is.

7 **A.** Okay:

8 "I wasn't actively involved in discussions with
9 Ian Harvey about involving the police. The Review Team
10 recommended that the Medical Director and senior
11 management contact the police directly."

12 **Q.** Yes, that is what it says at present. What is
13 the correction?

14 **A.** Okay, the correction is that:

15 "The Review Team had a discussion about
16 recommending that the Medical Director and senior
17 management contact the police directly. We had that
18 discussion and we made a decision that we wouldn't
19 recommend that in the recommendations of the report."

20 I think that this is an absolute oversight on my
21 part as I was preparing my witness statement, that this
22 is one of the questions that was put to me and I haven't
23 taken it out of the witness statement.

24 **Q.** Subject to that correction, are the two
25 statements true, to the best of your best knowledge and

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1 the desk.

2 MS ALEXANDRA MANCINI (sworn)
3 Questions by MR CARR

4 **LADY JUSTICE THIRLWALL:** Do sit down.

5 **A.** Thank you.

6 **MR CARR:** Can we start with your full name, please.

7 **A.** Alexandra Mancini.

8 **Q.** You have prepared two statements for the
9 purposes of this Inquiry, the first dated 26 June 2024
10 and that deals with your involvement in the RCPCH
11 review?

12 **A.** Yes.

13 **Q.** A second more recent statement dated
14 6 November 2024, addressing recent work you have carried
15 out, developing a framework for BAPM?

16 **A.** Yes.

17 **Q.** Now, in respect of your first witness
18 statement, and that's the one that I am going to be
19 asking you questions about, I understand there is
20 a correction you want to make?

21 **A.** Yes.

22 **Q.** It's at paragraph 87 of that statement. where
23 you deal with discussions about police involvement and
24 I think it's the last two sentences that you want to
25 correct?

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1 belief?

2 **A.** Yes.

3 **Q.** Before I start asking questions, I think there
4 is something that you wish to say.

5 **A.** Thank you. I would like to speak directly to
6 the parents and offer my deepest and sincerest
7 condolences that your babies have died and this -- I can
8 only imagine how distressing this must be for you, so
9 I am very, very sorry for what's happened.

10 Thank you.

11 **Q.** By profession you are a neonatal nurse?

12 **A.** Yes.

13 **Q.** You tell us in your statement that you
14 qualified in New Zealand. There were two dates of
15 qualification in your statement. Paragraph 1 suggests
16 1991; paragraph 2, 1990.

17 **A.** Okay. I do apologise. It should read 1990
18 for both.

19 **Q.** In 1993 you started working as a paediatric
20 nurse?

21 **A.** Yes.

22 **Q.** Since 1998, you've worked as a neonatal nurse?

23 **A.** Yes.

24 **Q.** You have held -- and this is set out in your
25 witness statement -- a number of senior leadership

100

1 positions?
 2 **A.** Yes.
 3 **Q.** You spent around six years working as a matron
 4 on a neonatal intensive care unit?
 5 **A.** Yes.
 6 **Q.** You explain at paragraph 4 of your statement
 7 that at the time of the RCPCH review, in 2016, you were
 8 the Pan London Regional Lead Nurse for national
 9 palliative care?
 10 **A.** For Neonatal Palliative Care.
 11 **Q.** You weren't a member of the RCPCH, were you?
 12 **A.** No.
 13 **Q.** Your Royal College was?
 14 **A.** The Royal College of Nursing.
 15 **Q.** You were nominated by the RCN --
 16 **A.** Yes.
 17 **Q.** -- to serve on this review and you say, it is
 18 paragraph 4 again, that was due to your nursing
 19 experience, clinical governance experience as matron and
 20 expertise as Pan London Lead Nurse for Neonatal
 21 Palliative Care?
 22 **A.** Yes.
 23 **Q.** What did you understand to be the nursing
 24 perspective or the reason for a nursing perspective
 25 being required for this review?

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1 Safeguard Children?
 2 **A.** Yes.
 3 **Q.** It was a 2015 edition that would have applied
 4 at the time of the review and it was a requirement,
 5 wasn't it, of that guidance that it was read and applied
 6 by healthcare workers?
 7 **A.** Yes.
 8 **Q.** If we can have up on screen, please,
 9 INQ0013235, page 54. We are going to look at a part of
 10 the statutory guidance.
 11 The guidance sets out, doesn't it, the process to
 12 be followed in respect of allegations made against
 13 people who work with children and if we look at the top
 14 of the page, page 54, the third paragraph down, that
 15 starts:
 16 "Clear policies ..."
 17 Then if you go to the final sentence of that
 18 paragraph, it reads, it has been highlighted:
 19 "An allegation may relate to a person who works
 20 with children who has ..."
 21 Then there are a number of subparagraphs:
 22 "Behave in a way that has harmed a child or may
 23 have harmed a child, possibly committed a criminal
 24 offence against or related to a child or behaved towards
 25 a child or children in a way that indicates they may

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1 **A.** I understood it to be I was part of a team,
 2 I was being asked to be part of an expert team to bring
 3 expertise and experience to a review process and so the
 4 nursing perspective will always consider the nurse
 5 staffing, the nursing culture and really ensure that
 6 there's a multi-disciplinary approach within that team.
 7 **Q.** If we can turn to safeguarding, knowledge and
 8 training, please. You say at paragraph 6 of your
 9 statement that you have not received specific
 10 safeguarding training in respect of what to do where
 11 abuse on the part or a member of staff towards babies or
 12 children in hospital is suspected.
 13 Do you recognise as a broad principle of
 14 safeguarding that concerns relating to the harm of
 15 children should be escalated?
 16 **A.** Yes.
 17 **Q.** That is something that you would have
 18 appreciated at the time?
 19 **A.** Yes.
 20 **Q.** Did you consider there was any reason that
 21 that broad principle wouldn't apply to staff members in
 22 hospital?
 23 **A.** No.
 24 **Q.** Were you aware at the time of the review of
 25 the statutory guidance contained in Working Together to

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1 pose a risk of harm to children."
 2 In respect of those definitions, the explanation of
 3 an allegation, each of them sets a relatively low bar,
 4 doesn't it, it's "possibly", "may" ...
 5 **A.** (Nods)
 6 **Q.** The requirement, and we will see this at the
 7 bottom of the page, paragraph 7, is for any allegation
 8 to be reported immediately to a senior manager?
 9 **A.** (Nods)
 10 **Q.** Do you have that, where it's highlighted:
 11 "Any allegation against people who work with
 12 children should be reported immediately to senior
 13 manager within the organisation"?
 14 **A.** (Nods)
 15 **Q.** Then the next sentence:
 16 "A designated officer or team of officers [going on
 17 to the next page, please] should also be informed within
 18 one working day of all allegations."
 19 The reference there to the designated officer, that
 20 is the Local Authority Designated Officer, isn't it?
 21 **A.** Yes.
 22 **Q.** So taking all of that together, where there is
 23 allegation of possible criminal offending, involving
 24 somebody who works with children, it must immediately be
 25 reported within the organisation and within 24 hours

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1 escalated to the local authority?
 2 **A.** (Nods)
 3 **Q.** Did you understand that process --
 4 **A.** Yes.
 5 **Q.** -- at the time of this review?
 6 Turning, please, to your recruitment for the review
 7 and your experience and training. Paragraph 29 of your
 8 statement.
 9 **A.** Sorry, did you say 79?
 10 **Q.** 29.
 11 **A.** Sorry. Yes.
 12 **Q.** You state there:
 13 "Prior to the Countess of Chester Hospital Invited
 14 Review I had not participated as a member of a Review
 15 Team."
 16 **A.** Yes.
 17 **Q.** To be clear, you are referring to not having
 18 participated in a Review Team for any College, so not
 19 simply the RCPCH, also the RCN or anybody else?
 20 **A.** Yes.
 21 **Q.** So this was your very first --
 22 **A.** First time.
 23 **Q.** -- Invited Review.
 24 At paragraph 33, you note that in your wider
 25 practice, you had experience of reviewing individual

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1 **Q.** Had you had experience within your practice --
 2 I know you hadn't reviewed a cohort but had you had
 3 experience within your practice of a cohort of
 4 unexpected and unexplained deaths, is that something
 5 that you had seen before?
 6 **A.** Not a cohort; individual cases.
 7 **Q.** Do you consider -- you explain that you raised
 8 with both Fiona Smith and Sue Eardley your lack of
 9 experience. Do you consider that your lack of
 10 experience both in undertaking reviews and your limited
 11 experience of unexpected and unexplained deaths meant
 12 that this was an unsuitable first review for you to
 13 undertake?
 14 **A.** We didn't discuss that.
 15 **Q.** Do you think it may have been beyond your
 16 competence and experience, too complex to undertake as
 17 a first review?
 18 **A.** I think that the experience that I brought to
 19 the Review Team was as a senior neonatal nurse thinking
 20 about culture of the unit, thinking about staffing,
 21 about how neonatal units are run and those were the
 22 other Terms of Reference.
 23 But I agree that I didn't have the experience of
 24 reviewing a cohort of babies with unexplained or
 25 unexpected deaths.

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1 deaths but not of reviewing a cohort of unexpected or
 2 unexplained deaths?
 3 **A.** Yes.
 4 **Q.** Did you raise with either the RCN or the RCPCH
 5 your lack of experience in assessing or reviewing
 6 a cohort of cases?
 7 **A.** Yes. From a perspective that I said this was
 8 the first time that I had participated in a review of
 9 this kind, so I said that both to Fiona Smith at the RCN
 10 and to Sue Eardley.
 11 **Q.** Reflecting on your own practice, your own
 12 experience as a neonatal nurse, how common -- if it was
 13 common -- were unexpected and unexplained deaths of
 14 neonates?
 15 **A.** In my experience --
 16 **Q.** Yes.
 17 **A.** -- it wasn't common.
 18 **Q.** Would you agree that it was extremely unusual
 19 for newborns to die unexpectedly and without a clear
 20 diagnosis or explanation?
 21 **A.** Yes.
 22 **Q.** So would the fact that there was a cohort of
 23 unexpected and unexplained deaths by itself be a cause
 24 for concern?
 25 **A.** Yes.

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1 However, within the team we all bring different
 2 experiences and expertise to it and there were two very
 3 experienced paediatricians within that team as well.
 4 **Q.** In preparing for the review, you were sent --
 5 you deal with this in your statement -- by Sue Eardley
 6 written guidance, so a copy of the guide on Invited
 7 Reviews and you have set out a number of the provisions
 8 in there in your statement.
 9 You note at paragraph 12 that according to the
 10 guidance:
 11 "Invited Review reviewers must undertake RCPCH
 12 approved training when they are selected for role."
 13 **A.** Yes.
 14 **Q.** The position is, as you explain later in your
 15 statement, you didn't receive any training, did you?
 16 **A.** No.
 17 **Q.** You didn't receive any induction?
 18 **A.** No.
 19 **Q.** Why didn't you undergo training or induction
 20 as required?
 21 **A.** Because I was signposted to the Handbook For
 22 Reviewers, which I thought was the training, an element
 23 of training to read through what was expected of me as
 24 part of the Review Team.
 25 **Q.** So you consider that you did undergo the

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1 relevant training by reading the guidance?

2 **A.** Yes, I wasn't aware there was any other type
3 of training.

4 **Q.** If you look at paragraph 133 of your
5 statement, it's there you deal with the lack of training
6 for the role and you say:

7 "I didn't receive [second sentence] specific
8 training and induction for reviewers by the RCN or RCPCH
9 I was sent the link to the Handbook For Reviewers For
10 Invited Reviews."

11 Indeed it's within that handbook, isn't it, that
12 your reference from paragraph 12 comes which suggests
13 that RCPCH approved training must be undertaken when
14 joining a Review Team?

15 **A.** I'm sorry, could you repeat the question?

16 **Q.** Yes. So at paragraph 133 you make the point
17 that you didn't receive any specific training or undergo
18 an induction for reviewers?

19 **A.** Yes.

20 **Q.** I think when I put this point to you a few
21 moments ago you said: Well, I was sent the handbook and
22 I thought that amounted to undergoing training.

23 But the handbook itself has a provision which sets
24 out that reviewers must undergo RCPCH approved training?

25 **A.** Yes.

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1 "If issues of patient safety are raised at any time
2 the reviewers will advise the client immediately and
3 discuss what urgent action should be taken if any."

4 Then the final sentence of that paragraph:

5 "For concerns about safety service beyond the scope
6 of the review, the regulatory authority should be
7 advised with consideration as to whether temporary
8 suspension of a service is appropriate."

9 So do you agree that this paragraph is setting out
10 two levels of concern: firstly dealing with a concern
11 which can be managed with the client, so a discussion
12 with the client to determine what action should be
13 taken, if action is required, but then that final
14 sentence is addressing a more serious concern and where
15 that more serious concern arises, on this guidance, it
16 provides for the regulatory authority to be told of that
17 concern?

18 **A.** (Nods)

19 **Q.** Looking at that paragraph, do you consider
20 that this enabled the Review Team to escalate
21 sufficiently serious categories of safety concern?

22 **A.** (Nods)

23 **Q.** Did you appreciate that at the time of this
24 review?

25 **A.** I didn't.

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1 **Q.** So it would have been clear from receiving the
2 handbook and seeing that provision which requires
3 reviewers to undergo training that reading the book
4 alone didn't amount to training?

5 **A.** I have to say that when I read that I took it
6 as the RCPCH reviewers. There is a process for applying
7 to the RCPCH to be a recognised reviewer. I wasn't that
8 person, I was a person that had been asked. I think
9 there is a paragraph within the handbook or the guide
10 that does say at times there will be the need for
11 a nursing perspective and so the Royal College of
12 Nursing will provide that.

13 So I wouldn't -- I am not a recognised reviewer on
14 the RCPCH team as such. I have been called in as
15 needed.

16 **Q.** So because you were a nominee --

17 **A.** Yes.

18 **Q.** -- by the RCN you thought specific training
19 wasn't required for you?

20 **A.** Yes.

21 **Q.** If we can consider some of the guidance,
22 please, it's INQ0010214 and if we can turn to page 7.

23 I want to consider with you the paragraphs under
24 the heading "Where Serious Concerns Are Raised".

25 Dealing first with paragraph 6.1. It reads:

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1 **MR CARR:** I am going to deal with one more point,
2 if I may, my Lady.

3 **LADY JUSTICE THIRLWALL:** Very well, yes.

4 **MR CARR:** Staying in the guidance before breaking,
5 I do want to keep that up, sorry.

6 So it's back to page -- we were at page 7, if we go
7 to page 8, please. The section is dealing with process.

8 At paragraph 7.5 you will see the section dealing
9 with the circumstances in which the College would not
10 take on cases.

11 Now, it's right that by the time you became
12 involved with the review, the case had already been
13 taken on?

14 **A.** Sorry, can you repeat the question?

15 **Q.** By the time you were recruited to the
16 review --

17 **A.** Yes.

18 **Q.** -- the case had already been taken on?

19 **A.** Yes.

20 **Q.** This section however is useful in indicating
21 the limits of a service review?

22 **A.** (Nods)

23 **Q.** Do you agree?

24 **A.** Yes.

25 **Q.** If we go to page 9, please. At paragraph 7.7,

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1 it sets out that:

2 "If any of the issues raised in 7.5 [which we just
3 looked at] come to light during an Invited Review, the
4 review should be completed in relation to its original
5 remit unless advised to the contrary in order to avoid
6 prejudicing other investigations by a public authority
7 or regulator."

8 Now, included amongst the issues listed at
9 paragraph 7.5 are where the expected scope includes
10 behavioural misconduct, bullying, harassment or possible
11 mental health concerns.

12 Now, do you agree that allegations or concerns that
13 a member of staff is murdering babies would be a very
14 extreme example of that sort of conduct?

15 A. Yes.

16 Q. At paragraph 7.5, so those cases that the
17 College will not take on, includes cases where the
18 police or counter fraud service are involved and that's
19 another indication, isn't it, that matters of
20 criminality go beyond the scope of an Invited Review?

21 A. Yes, but I didn't know this information at the
22 time.

23 Q. Forgive me, you were sent a copy of this?

24 A. I was sent a copy, yes, but I didn't know the
25 information about the allegations.

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1 A. Yes.

2 Q. What did you understand might be the
3 circumstances in which other investigations may be
4 prejudiced by continuing an investigation where the
5 issues set out at 7.5 have arisen?

6 A. Are you asking what I think now or what
7 I thought at the time?

8 Q. At the time?

9 A. Okay.

10 Q. We will come on to the issues that arose.

11 A. So at the time, I would have thought it would
12 prejudice possibly an investigation into safeguarding
13 concerns or possibly the police.

14 Q. Did you understand why that is something that
15 it was desirable to avoid?

16 A. Yes.

17 Q. And why there needed to be an assessment if
18 those issues arose to ensure that such prejudice would
19 be avoided?

20 A. Yes.

21 Q. Finally this: if the review was going to
22 continue, then this section makes clear, doesn't it,
23 that the reviewers firstly can't investigate those sorts
24 of issues of concern set out at paragraph 7.5?

25 A. Sorry, where are you reading from?

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1 Q. No, I understand but just in terms of
2 understanding the process, because you didn't undergo
3 formal training but you have indicated that --

4 A. Yes.

5 Q. -- reading this guidance.

6 If we stick with 7.7 and before we break, I want to
7 understand your interpretation of this. Did you
8 consider this section either before the review or whilst
9 you were at the review?

10 A. I read it before the review in preparation.

11 I didn't refer to it during the review.

12 Q. It contains a number of elements, doesn't it?
13 So the first sentence which I have already read suggests
14 that the review should be completed unless advised to
15 the contrary. Who do you understand would be giving
16 that advice?

17 A. I would see that the person that is the most
18 senior within the review would be the lead reviewer and
19 the invited head of reviews.

20 Q. The circumstances in which the advice may be
21 given to stop the review is in order to avoid
22 prejudicing other investigations. So that would appear
23 to call for an assessment, wouldn't it, of whether
24 carrying on when such issues arise will or won't
25 prejudice other investigations?

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1 Q. Four lines down, "but the reviewers cannot
2 investigator suggest solutions for any of the above"?

3 A. (Nods) Yes.

4 Q. So the point that appears to be being made in
5 the guidance is that if you are going to continue with
6 an investigation, you cannot investigate those issues of
7 concern that have arisen, first point, you cannot
8 suggest solutions for them, and then the following
9 sentence:

10 "Clear scope boundaries should be agreed before
11 further work takes place."

12 A. Yes.

13 Q. Again that would appear to be for the purposes
14 of ensuring that other investigations won't be
15 prejudiced?

16 A. Yes.

17 MR CARR: My Lady, thank you, that is a convenient
18 time.

19 LADY JUSTICE THIRLWALL: Thank you, Mr Carr.

20 We will adjourn now and we will start again at
21 a quarter to 2.

22 (1.05 pm)

23 (The luncheon adjournment)

24 (1.45 pm)

25 LADY JUSTICE THIRLWALL: Mr Carr.

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1 **MR CARR:** I want to turn now to the steps that you
 2 took to prepare for the review visit. Your evidence in
 3 your statement is that prior to arriving at the
 4 hospital, you were not aware of the submissions that the
 5 doctors had there about Letby; is that correct?
 6 **A.** Yes, that's correct.
 7 **Q.** You were not told of those suspicions by
 8 Sue Eardley?
 9 **A.** No.
 10 **Q.** You don't remember any discussion amongst the
 11 team or with any members of the team about Letby?
 12 **A.** Before we met?
 13 **Q.** Before, yes?
 14 **A.** No.
 15 **Q.** You have seen in the RCPCH chronology
 16 document, that is the document prepared by Sue Eardley,
 17 it contains an email from David Milligan, the lead
 18 reviewer, dated 26 August 2016 in which he identifies
 19 there are a number of questions arising from the data,
 20 including the fact that one individual appears to have
 21 been present for all but one of them. You know the
 22 email that I am referring to?
 23 **A.** I know the email you are talking about,
 24 referring to.
 25 **Q.** But you say you didn't receive that --

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1 **A.** Yes.
 2 **Q.** It shows that Letby was on duty or on the
 3 shift before for 10 of the 11, all but one, as you say
 4 in your statement?
 5 **A.** (Nods)
 6 **Q.** What view did you form about that correlation?
 7 We can take it down now, please, thank you.
 8 **A.** I think this -- this is one element of all the
 9 numerous documents we were looking at. I didn't form
 10 a view at that time that there was anything particularly
 11 unusual.
 12 **Q.** Did you turn your mind as to why somebody had
 13 carried out that analysis?
 14 **A.** I think there was a problem with -- we know
 15 that there was a problem with an increased number of
 16 deaths and people were trying to get to the bottom of
 17 it, so looking at various processes, looking at various
 18 information that was available and this was one element
 19 of a document that might give some information.
 20 But at that stage I was looking at it I wasn't
 21 thinking that it might be what we now know: somebody
 22 causing harm to babies.
 23 **Q.** Did you think there might be a connection
 24 between that correlation and the number of deaths, so
 25 did you consider that the fact somebody had carried out

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1 **A.** I didn't receive it.
 2 **Q.** -- prior to --
 3 **A.** No.
 4 **Q.** But what you do explain in your statement,
 5 it's paragraph 50, at page 10, that in your own
 6 preparation ahead of the review, you had identified
 7 yourself that Letby was present for a number of the
 8 deaths?
 9 **A.** Yes.
 10 **Q.** The document that you refer to is -- and can
 11 we have it up please, INQ0001072, that's not correct.
 12 So we can take that down, the reference is INQ0010072.
 13 It's a spreadsheet, yes.
 14 There we go. It's a spreadsheet with -- we can see
 15 at the bottom a number of tabs analysing nurse staff on
 16 duty, medical staff on duty and marking whether
 17 individuals were on shift at the time of unexpected
 18 deaths and whether they were on shift before.
 19 **A.** Yes.
 20 **Q.** In your statement you cite this as being the
 21 document you saw, as I understand it, prior to the
 22 review?
 23 **A.** Yes.
 24 **Q.** It deals with 11 deaths in total, doesn't it,
 25 11 deaths?

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1 that analysis and what it revealed there may be
 2 a connection between the individual and --
 3 **A.** Okay, so what I would see as a nurse with my
 4 experience is looking at the members of staff that are
 5 on any shift and looking at skill mix. I would also
 6 take that view when you are looking at a spreadsheet of
 7 members of staff to look at might that have contributed
 8 to some of the elements of babies dying more -- more
 9 than they were used to having on their unit.
 10 **Q.** You have explained that you weren't told that
 11 the doctors had any suspicions about Letby prior to
 12 arriving at the hospital?
 13 **A.** No.
 14 **Q.** Was that a possibility that occurred to you in
 15 your analysis, a possible explanation for the unexpected
 16 and unexplained deaths?
 17 **A.** Do you mean by looking at this spreadsheet?
 18 **Q.** Looking either at this spreadsheet or any of
 19 the other documents --
 20 **A.** No.
 21 **Q.** -- that you looked at, did you consider that
 22 one explanation for the increase in deaths might be
 23 deliberate harm?
 24 **A.** No.
 25 **Q.** If we can look, please, at INQ0012846, what's

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1 about to come on screen is an email from Sue Eardley to
2 you and the other members of the team dated
3 12 August 2016.

4 Now, the third paragraph of that email, reads:
5 "Key things to look at are probably the Mortality
6 Reviews and there are some concerns coming out over the
7 transport service."

8 It's the first part of this email that I -- of that
9 paragraph, sorry, of this email that I want to deal
10 with. What did you understand to be key about the
11 Mortality Reviews?

12 **A.** Well, I think the information that was
13 included in the Mortality Reviews and if there was
14 anything that we were having to look through this
15 methodically, there were so many documents we had to
16 look at, but to draw our attention to look at the
17 Mortality Reviews and as one of the Terms of Reference
18 was looking at any commonalities seeing if there was
19 anything within those reviews that looked immediately
20 obvious to us.

21 **Q.** Did you look at the thematic review from 2016?
22 February 2016 -- sorry, Mortality Review February 2016,
23 it's the one that involved, Dr Subhedar from Liverpool
24 Women's Hospital?

25 **A.** Okay, I can't remember that document exactly
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1 with mortality. Then I understand again because of
2 really not understanding why these babies were
3 collapsing and there were these unexpected and
4 unexplained deaths, these Mortality Reviews were taken
5 a step further to look at in further detail and to look
6 at them together.

7 **Q.** So is this a fair summary: the importance of
8 the Mortality Reviews, one, was to ensure that processes
9 were being followed properly?

10 **A.** Yes.

11 **Q.** Two, to consider the content of the reviews --

12 **A.** Yes.

13 **Q.** -- and what they told you about the deaths?

14 Finally, so far as the preparation is concerned,
15 before we turn to the review itself, if you look at your
16 paragraph 48, please. You describe there a meeting
17 prior to the review visit and you describe a discussion
18 with Sue Eardley and the final couple of sentences of
19 that paragraph read:

20 "I think we identified that the Review Team would
21 be limited in gathering this detailed information within
22 the remit and the Terms of Reference provided. I have
23 no contemporaneous notes of this given the passage of
24 time."

25 You say that in the context of a discussion as to
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1 without seeing it. But if it was included in these

2 I would have looked at it in detail.

3 **Q.** When dealing with the Mortality Reviews in
4 your statement, it's paragraph 44, the fourth sentence?

5 **A.** Sorry.

6 **Q.** Paragraph 44?

7 **A.** 44, thank you.

8 **Q.** It's on page 9.

9 **A.** Yes.

10 **Q.** Your fourth sentence reads:

11 "I recall that it was important to consider any
12 Mortality Reviews to ensure that appropriate processes
13 were being followed in conducting Mortality Reviews".

14 Can you explain what you mean by that sentence?

15 **A.** What I mean is that they followed a robust
16 process. So when a Mortality Review is conducted, and
17 again sometimes the terminology may be used quite
18 loosely, but when a baby dies, there is -- there's the
19 postmortem, there is a whole process that happens.
20 There are multi-disciplinary meetings that we have
21 together called Mortality and Morbidity Meetings where
22 they would be discussed in detail within obstetrics, the
23 maternity teams and neonatal with the postmortem
24 results.

25 So that's one way of looking at the reviews to do
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1 whether or not the team did have enough information.

2 **A.** Sorry, could you repeat that last sentence,
3 I couldn't hear very well?

4 **Q.** Yes, I am trying to summarise your paragraph
5 for you.

6 **A.** Thank you.

7 **Q.** As I understand it, you are describing here
8 a discussion amongst the team with Sue Eardley where the
9 team is considering whether there is sufficient
10 documentation or not?

11 **A.** Yes.

12 **Q.** The final part of the paragraph that I'll read
13 to you says:

14 "I think we identified that the Review Team would
15 be limited in gathering this detailed information within
16 the remit and the Terms of Reference provided."

17 Now, the suggestion appears to be that the team
18 thought further detailed information was required but
19 you wouldn't be able to get it?

20 **A.** So I think what I mean by that sentence, yes,
21 is that gathering further information would be difficult
22 within the time that we had within the remit and the
23 Terms of Reference provided that there were significant
24 number of elements that we had to consider within the
25 Terms of Reference in a short space of time.

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1 Q. There are three different factors there, so
 2 time, remit, Terms of Reference?
 3 A. Yes.
 4 Q. Firstly, before we look at those, what was the
 5 further detailed information that you and the team
 6 considered was required?
 7 A. I think when -- when you are reviewing as, as
 8 we have already discovered this was my first review but
 9 I have experience of being a clinical adviser for the
 10 ombudsman, so when there are those situations you gather
 11 the information that you have, you read it, you check
 12 it, and then new questions will come up and then you
 13 need to have -- you will request further information on
 14 that basis.
 15 But if you are limited for time, that's very
 16 difficult to do that.
 17 Q. So was time the reason that the Review Team
 18 felt they couldn't request the further documentation
 19 required?
 20 A. Yes. Well, we put in the request and it took
 21 time for the Trust to share that information.
 22 Q. Did you feel a sense of pressure or did you
 23 feel hurried to start the review?
 24 A. I think the pressure was felt because this was
 25 very serious. There was -- babies were dying, this was
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1 heard evidence from her?
 2 A. Yes.
 3 Q. She was the Review Team manager. There were
 4 two neonatal doctors, one of those was the lead
 5 reviewer, that's right, isn't it, David Milligan and
 6 Graham Stewart?
 7 A. Yes.
 8 Q. Then the final member of the team in addition
 9 to yourself was Ms Claire McLaughlan?
 10 A. Yes.
 11 Q. She was a lay reviewer and had you ever worked
 12 with her or met her prior to this review?
 13 A. No.
 14 Q. What was your understanding of her
 15 professional background?
 16 A. Claire's?
 17 Q. Yes.
 18 A. That she had -- she had a nursing background,
 19 she was a qualified barrister and I can't remember
 20 without looking at my notes exactly the nature of her
 21 work at that time but I think that she was supporting
 22 doctors when there had been difficult situations at
 23 work, I think, so I am not 100% certain about that.
 24 Q. So far as her being a qualified barrister, was
 25 your understanding of that based on a discussion with
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1 very, very serious and we had been in discussions since
 2 July about organising the team and the dates that we
 3 could meet in person and because of work commitments
 4 that did add to a delay of us starting on 1 and
 5 2 September.
 6 So I don't think the pressure felt so much so that
 7 we didn't have the right information at the time that we
 8 needed it.
 9 Q. So you would say you were content to proceed
 10 with --
 11 A. Yes.
 12 Q. -- the review, notwithstanding the missing
 13 information?
 14 A. Yes.
 15 Q. Are you able to help us with the nature of the
 16 information that was missing, what was it that you felt
 17 or the team felt they didn't have?
 18 A. I think that there was certain elements that
 19 were missing and I am -- I can't remember exactly but it
 20 was thinking about details from the Child Death Overview
 21 Panel and information about the babies that were
 22 discussed within those meetings.
 23 Q. We are about to turn to the review visit.
 24 I want to ask you a question about the rest of the team.
 25 You have made mention already to Sue Eardley and we have
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1 her or was it based on documentation you had seen?
 2 A. Documentation.
 3 Q. Did you understand from that that she had
 4 worked as a barrister at some point?
 5 A. No. I think, no. I -- because she hadn't
 6 written it, I am, I am talking, I am making reference to
 7 our biographies that were shared with us via email.
 8 So a qualified barrister, I didn't take that as she
 9 was currently working as a barrister or had done.
 10 Q. Turning to the review visit, which is made up
 11 for the most part of interviews of different members of
 12 staff--
 13 A. Yes.
 14 Q. -- over the course of two days, 1 and
 15 2 September.
 16 I am not going to go through every single interview
 17 but there are some I am going to look at --
 18 A. Yes.
 19 Q. In detail --
 20 In terms of the structure of day one, my
 21 understanding is that you had a first meeting with
 22 Ian Harvey and Alison Kelly --
 23 A. Yes.
 24 Q. -- followed then by a meeting with Dr Brearey
 25 and Dr Jayaram?
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1 A. Yes.
 2 Q. Then there was a morning break.
 3 A. Yes.
 4 Q. It was that initial meeting -- and you deal
 5 with this in paragraph 60 of your statement -- that
 6 concerns amongst the paediatricians in relation to Letby
 7 were raised with the Review Team?
 8 A. Yes.
 9 Q. Do you have that? If I understand the
 10 sequence of events as you describe them in your
 11 statement, that was the first time you became aware --
 12 A. Yes.
 13 Q. -- of those concerns.
 14 There is a suggestion in the evidence that there
 15 would have been a pre-meeting amongst the Review Team
 16 the evening before --
 17 A. Yes.
 18 Q. -- the review started but you don't have any
 19 recollection of the team discussing Letby or the nurse
 20 at that meeting?
 21 A. No.
 22 Q. If we can look it is INQ0014604, we are going
 23 to start here, so this is the first page of
 24 Sue Eardley's handwritten notes. This is a transcript
 25 of her handwritten notes?

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1 Q. The next sentence:
 2 "Pattern of babies' collapse don't seem to follow
 3 normal pattern and respond to resuscitation in normal
 4 way."
 5 Now, there are two points to make. Firstly, this
 6 report of the elephant in the room, the paediatricians'
 7 concern, it appears right at the start of the meeting,
 8 isn't it, it is what Ian Harvey is opening the
 9 discussion with?
 10 A. Yes.
 11 Q. Did that primacy indicate or signal to you
 12 a level of significance or importance of that issue for
 13 the Trust?
 14 A. Sorry, can you repeat the question, please?
 15 Q. Yes. So the point that I am making is that
 16 this is the first issue, first topic raised by
 17 Ian Harvey?
 18 A. Yes.
 19 Q. Did the fact that you have gone to this
 20 meeting, you say you weren't aware of the concerns, did
 21 the fact that this was what Ian Harvey was opening with,
 22 did that indicate that it was a significant and
 23 important point?
 24 A. Yes.
 25 Q. The second observation to make is that the

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1 A. Okay.
 2 Q. This is the start of the review visit. And
 3 the meeting commences with DM, that appears to be
 4 a reference to David Milligan, doesn't it, lead
 5 reviewer:
 6 "... said that we may not be able to explore the
 7 detail of the deaths."
 8 So right from the start, that fourth term of
 9 reference which required the Review Team to consider
 10 factors or failings which may have caused the death and
 11 any common factors or failings, that was something that
 12 David Milligan was saying was essentially off the table,
 13 you weren't going to explore the deaths?
 14 A. Yes.
 15 Q. And then after "deaths", in the transcript it
 16 says "IA", the written note looks more like "IH",
 17 Ian Harvey, what he said:
 18 "Correlation of one nurse paediatricians see as
 19 elephant in the room. Lucy Letby."
 20 You agree, don't you and you make this point in
 21 your statement, that that note by Sue Eardley reflects
 22 what you were told by --
 23 A. Yes.
 24 Q. -- Ian Harvey.
 25 A. (Nods)

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1 note refers to paediatricians in the plural, doesn't it?
 2 A. Yes.
 3 Q. It does not suggest that it is just a single
 4 doctor who has that view?
 5 A. Yes, I agree.
 6 Q. In fact the reference appears to be to the
 7 paediatricians as a body, doesn't it, it seems to be
 8 referring to the collection of paediatricians?
 9 A. Yes.
 10 Q. If we can go to page 2, please, and about
 11 two-thirds of the way down the section underlined, we
 12 see it is recorded:
 13 "Clinicians threatened to go to the police."
 14 A. (Nods)
 15 Q. Now, what did that indicate to you as to the
 16 degree of seriousness with which the paediatricians held
 17 their concerns?
 18 A. Very serious.
 19 Q. If we can go forward, please, to page 4 and we
 20 are still within the interview with Ian Harvey and
 21 Alison Kelly. Third line down:
 22 "IH [that is Ian Harvey] had to intervene with the
 23 neonatal lead as junior doctors had been referring to
 24 her as "Nurse Death". Ripples through the team and
 25 trying to function. Can't see how it is concluded

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1 without calling the police. Unless there is something
2 to satisfy the medical staff, they can call the police."

3 Now, what I want to ask is, what did you understand
4 by that final reference:

5 "Unless there is something to satisfy the medical
6 staff ..."

7 **A.** I would -- thinking about this now, I would
8 think that suggests that unless there is another cause
9 for this increased number of deaths, then the medical
10 staff may follow their concerns in contacting the
11 police.

12 **Q.** Was the suggestion that unless you as a Review
13 Team came up with something, the police would be called?

14 **A.** No. I didn't -- from what I understand from
15 your question is that unless we found something and we
16 were being urged to find something, then the medical
17 staff would call the police.

18 I -- I don't agree with that. I --

19 **Q.** Forgive me, sorry.

20 **A.** No. I think that may be interpreted in that
21 way but I didn't feel that at the time. We would find
22 what we found.

23 **Q.** Yes.

24 **A.** Which was the truth.

25 **Q.** Put aside the suggestion then of being urged

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1 **A.** (Nods)

2 **Q.** Did you get the impression that they were
3 treating the allegations seriously and recognised the
4 seriousness?

5 **A.** No.

6 **Q.** The next meeting, and I think it followed
7 immediately afterwards, was with Dr Brearey and
8 Dr Jayaram. We are staying in the same document but
9 going forward to page 7, please.

10 The entry roughly in the middle of the page, next
11 to the name "Steve", that is a reference to Dr Brearey.
12 You see there that he reports:

13 "Things okay until last June, were comparable to
14 other units et cetera" and "didn't feel they were much
15 of an outlier.

16 "Three neonatal deaths in June. Reviewed in
17 detail. Met Alison and SI Panel to discuss them.

18 "Learning from every case but no overarching
19 deficiency in practice. Identified one nurse present at
20 all collapses."

21 Just pausing there, you knew at this stage that
22 that nurse was Letby?

23 **A.** Yes.

24 **Q.** "Didn't think it was significant. Agreed to
25 keep an eye on things. As the year progressed each

135

1 to find something. But did you or did the team
2 understand that whether or not the police were to be
3 called depended on whether or not you as a team deliver
4 something to satisfy the medical staff?

5 **A.** So if I can repeat back to understand it.

6 Do you mean that unless -- it was dependent on what
7 we found in the report, and what we wrote in the report
8 was dependent on whether they went to the police or not?

9 **Q.** What I am trying to understand is what you,
10 what impression you had and what you understood from the
11 suggestion that unless there is something to satisfy the
12 medical staff, they can call the police, what is the
13 something as you understood it, that would satisfy the
14 medical staff?

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

16 **Q.** What was your impression of the attitude of
17 Ian Harvey and Alison Kelly to the doctors' concerns and
18 their suspicions?

19 **A.** I think his attitude was disbelieving.

20 **Q.** You said "his attitude", is that a reference
21 to Ian Harvey?

22 **A.** Also I believe that Alison Kelly felt that as
23 well.

24 **Q.** So you got the impression that they didn't
25 believe the allegations?

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1 subsequent mortality not a huge concern but by end of
2 2015 numbers stacked up a little."

3 So what Dr Brearey is describing there is
4 a realisation as mortality increased of the connection,
5 correlation between Letby and that increase in
6 mortality?

7 **A.** Yes.

8 **Q.** Now, that is something that you had already
9 identified in your own preparation?

10 **A.** (Nods)

11 **Q.** If you go forward, please, to page 9, and the
12 first entry by the name "Steve" and the final couple of
13 lines:

14 "Even after PM [postmortem] unexplained."

15 So do you have that?

16 **A.** Yes.

17 **Q.** It's a little bit further down, so it's that
18 entry that has the red arrow but it but yes, the final
19 section "even after [postmortem] unexplained".

20 So did you understand from this that in addition to
21 the increase in mortality, in addition to the
22 correlation with Lucy Letby, you had Dr Brearey
23 explaining that even after postmortem examination there
24 was no explanation for --

25 **A.** Yes.

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1 Q. -- the deaths.
 2 You explained at the beginning that unexplained
 3 unexpected deaths is something that is rare in neonatal
 4 practice and to have a cluster in itself would be
 5 a concern?
 6 A. (Nods)
 7 Q. Then the penultimate entry from Dr Jayaram, do
 8 you see that:
 9 "Nurse on shift at all times. Spoke to Ian and
 10 Alison."
 11 That is a reference to Ian Harvey and Alison Kelly,
 12 isn't it?
 13 A. (Nods)
 14 Q. What you would have understood from that is
 15 that there were -- there was a concern which had been
 16 escalated to senior --
 17 A. Yes.
 18 Q. -- managers.
 19 The next page, page 10, at the top of the page
 20 there is reference to Letby's changing of shift
 21 patterns. So if you look five lines down, the sentence
 22 that starts: "no U/E collapses", do you have that?
 23 A. Yes.
 24 Q. "No [unexpected] collapses at night when she
 25 was on days but collapses happened in daytime. All
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1 So what is clear from this discussion that you had
 2 with Dr Jayaram is the level of their concern was such
 3 that they had been looking up medical literature --
 4 A. (Nods).
 5 Q. -- for methods of deliberate harm to babies.
 6 And upon doing so, they had found consistency
 7 between what was reported in the medical literature and
 8 what they had been seeing on their ward?
 9 A. Mm-hm.
 10 Q. The final point, it's dealt with later in the
 11 interview but you were aware, weren't you, that since
 12 Letby had been moved off the shift, no more unexpected
 13 collapses had occurred, so since she had been moved off
 14 the unit --
 15 A. Yes.
 16 Q. -- no further unexpected collapses had
 17 occurred.
 18 Now, in light of your discussions with Dr Brearey
 19 and Dr Jayaram, and in light of the matters that they
 20 were raising, did you have any reason to doubt the
 21 sincerity of their views?
 22 A. No.
 23 Q. Did you consider that their concerns were
 24 genuine?
 25 A. Yes.
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1 never individually realise they had thought the same
 2 thing."
 3 What the doctors were explaining to you is that the
 4 unexpected collapses had been happening during the night
 5 shift when Letby was working during nights?
 6 A. (Nods)
 7 Q. She had been moved to day shifts and
 8 unexpected collapses stopped at night and started
 9 occurring at the daytime?
 10 A. Yes.
 11 Q. Then in the bottom third of the page, just two
 12 lines above the redaction box that contains Child A it
 13 says:
 14 "Thinking about it, what could she be doing?
 15 Postmortems gave no cause. Not checked for
 16 electrolytes, levels OK beforehand."
 17 Then there's a reference to "inject".
 18 The bottom two lines:
 19 "When thinking forensic, what happens with air
 20 embolism? Looked at case studies and last observations.
 21 Chilling."
 22 Over on to page 11, please:
 23 "What had happened? Babies unresponsive to any
 24 inputs, odd skin discolouration. Blue with eyelids of
 25 pink, [query] injecting air into the babies."
 138

1 Q. Did you have any reason to doubt their
 2 expertise as Consultants?
 3 A. No.
 4 Q. Did you have any concern as to the factual
 5 accuracy of their analysis, whether that's to do with
 6 rotas, the correlation, their consideration of the
 7 medical literature?
 8 A. No.
 9 Q. Now, there was a discussion amongst the Review
 10 Team at which consideration was given as to whether or
 11 not the review should be aborted?
 12 A. Mm-hm.
 13 Q. It was at some point following this interview?
 14 A. Yes.
 15 Q. I think your statement says you can't recall
 16 exactly when it was. Graham Stewart in his statement
 17 suggests that the discussion happened during the first
 18 morning break, morning coffee break, so it would have
 19 been shortly after the interview with Brearey and
 20 Jayaram?
 21 A. Yes.
 22 Q. Now, I know you weren't responsible for taking
 23 any notes during the review visit, but that discussion
 24 to abort is not documented in the notes, is it?
 25 A. No.
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1 Q. None of the notes that we have seen. It is
 2 something that should have been recorded in the notes?
 3 A. Yes.
 4 Q. Was this a discussion involving the whole
 5 team?
 6 A. As far as I can remember, yes.
 7 Q. And the conclusion was that the review should
 8 continue?
 9 A. Yes.
 10 Q. The conclusion of the team and in particular,
 11 this is dealt with at paragraph 86 of your statement,
 12 you say:
 13 "I didn't think the review should be aborted and
 14 I shared this view with the others. I can't remember
 15 any other member saying we should abort the review."
 16 Now, what I want to ask you about is your view that
 17 the review should continue --
 18 A. Yes.
 19 Q. -- notwithstanding the matters that you had
 20 heard in your first two interviews. Why in your view
 21 was the information that you had received which amounted
 22 to criminal activity of a serious kind, why was that an
 23 insufficient reason to stop the review?
 24 A. Whilst we had a discussion amongst ourselves
 25 and I can remember why I thought that we should continue
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1 unexpected and unexplained deaths.
 2 You identified in your evidence earlier that
 3 a cohort of such -- because unexplained deaths are so
 4 rare in neonatal practice, that in itself would be
 5 a concern?
 6 A. (Nods)
 7 Q. You knew that there had been a correlation
 8 with Letby and that persisted when she changed shifts,
 9 it followed her when she changed shifts from night to
 10 days?
 11 A. (Nods)
 12 Q. Then the unexpected deaths stopped --
 13 A. (Nods)
 14 Q. -- when she was moved off the unit?
 15 A. (Nods)
 16 Q. You knew that experienced doctors you
 17 described as being sincere and genuine in their views
 18 were concerned that she was responsible for murdering
 19 babies?
 20 A. (Nods)
 21 Q. You had been told of threats to call the
 22 police?
 23 A. (Nods)
 24 Q. You had been told that the doctors had gone so
 25 far as researching medical literature and had found
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1 because it was still a very valuable fact finding
 2 review/exercise. We were there, we had our Terms of
 3 Reference and I have to say being guided by the two most
 4 senior people which was the head of the Invited Reviews
 5 and the lead reviewer, that it was the right thing to
 6 continue finding further information.
 7 I do feel that if I disagreed it would not be
 8 a problem. I felt able to speak up if I disagreed with
 9 them, so I wasn't blindly guided, but I took their
 10 expertise and their experience as part of the
 11 decision-making process.
 12 Q. When you say the two senior members of the
 13 team, who are you referring to?
 14 A. The lead reviewer, David Milligan and the
 15 invited head of review, Sue Eardley.
 16 Q. Graham Stewart, in his statement, and you will
 17 have seen this, he suggests that he raised the view that
 18 the review should be aborted. Do you remember there
 19 being discussion or anybody being of the opinion that
 20 the review ought to end?
 21 A. I don't remember that.
 22 Q. Can we go through the factors that were
 23 present during this discussion? So following the
 24 interviews of Kelly and Harvey and then Brearey and
 25 Jayaram, you knew as a team there was a pattern of
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1 consistency with what they had seen?
 2 A. (Nods)
 3 Q. In light of all those factors, didn't you
 4 think this: this really is well beyond the scope of an
 5 Invited Review, this needs the police?
 6 A. I didn't think that at the time.
 7 Q. Why did you think a police investigation was
 8 not warranted in light of all of those factors?
 9 A. It wasn't something we had considered as
 10 a team or individually at that time.
 11 Q. Do you agree that in light of all those
 12 factors we have just gone through, that the serious
 13 nature of the alleged offending, the fact that the views
 14 were genuinely and sincerely held by expert doctors,
 15 that the police ought to have been involved and that the
 16 review should have been aborted?
 17 A. I think on reflection, I think on reflection
 18 the review could have been stopped at that time and
 19 aborted and further advice taken from the RCPCH, that's
 20 where I think the advice should have been taken from.
 21 Q. The question is: do you think it should have
 22 been stopped at that point in light of the serious
 23 nature of the concerns that had been raised?
 24 A. I think I would still maintain that we were
 25 trying to find information and gathering information for
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1 the other Terms of Reference at that point and that's
2 why we decided collectively that we should continue.
3 **Q.** The notes of the team meeting at lunch on day
4 one, it's INQ0014604 and it's page 25 -- which should be
5 the redacted version before we put it up.

6 The note is about to come up but, as I understand
7 it, the discussion to abort the review occurred in the
8 morning and then at lunchtime there was a further team
9 discussion?

10 **A.** I genuinely don't remember that.

11 **Q.** In the middle of this page, we see reference,
12 it starts "Tom" underlined, but in the handwritten
13 version of the notes that reads "team", and this appears
14 to be a note of a team discussion:

15 "Were RMs ..."

16 That should be "PM".

17 "Were [postmortems] done by perinatal
18 pathologists?"

19 Then the next line has two matters which have been
20 redacted or where it says "no" that should say "insulin"

21 "... or insulin injection or air embolism."

22 It appears, and we have heard evidence from
23 Sue Eardley on this point, that the team were discussing
24 at lunchtime various different methods by which
25 deliberate harm could be caused to babies by members of

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1 "I do not consider an Invited Service Review to be
2 an appropriate means of investigating an increase in
3 unexpected, unexplained death in circumstances where
4 clinicians suspected a nurse of criminality."

5 That is the position that emerged on the morning of
6 the first day of the review, isn't it?

7 **A.** Yes.

8 **Q.** In those circumstances, the review should have
9 been stopped, shouldn't it?

10 **A.** On reflection, yes.

11 **Q.** The advice should have been given to the Trust
12 to call the police, who were the appropriate agency to
13 investigate the concerns that emerged?

14 **A.** An appropriate agency, yes.

15 **Q.** In deciding as a team to continue, and just
16 before the lunch break we looked at the Invited Reviews
17 guidance, was any advice sought, did you seek any advice
18 from the RCN, did any of your colleagues on your team
19 seek advice from the RCPCH?

20 **A.** I didn't physically see that, no.

21 **Q.** In your discussions as to whether or not to
22 abort the review, was consideration given as to whether
23 continuing might prejudice other investigations?

24 **A.** I don't remember discussing that.

25 **Q.** When we were looking at the guidance, one of

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1 staff. Do you recall that discussion?

2 **A.** I don't.

3 **Q.** Were you present at --

4 **A.** I can't remember.

5 **Q.** Do you agree that if the team had got to the
6 position where they are discussing amongst themselves
7 different potential methods of murdering babies, it is
8 a clear signal that the review has to stop and it's
9 inappropriate?

10 **A.** I agree.

11 **LADY JUSTICE THIRLWALL:** Mr Carr, I think we
12 probably should take this page off I think there is some
13 information on there that should have been redacted?

14 **MR CARR:** Please remove.

15 **LADY JUSTICE THIRLWALL:** So it shouldn't be
16 reported, not the passages that you have taken us to,
17 but that which follows, so if we can just --

18 **MR CARR:** If we can take that down, please.

19 Towards the end of your statement in your

20 reflections, it's your paragraph 135, you say:

21 "I do not consider ..."

22 Sorry, are you there, it is page 31?

23 Do you have it?

24 **A.** Yes.

25 **Q.** It reads:

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1 the provisos was that if an Invited Review is to
2 continue when serious concerns emerge, clear scope
3 boundaries should be agreed before further work is
4 undertaken.

5 Were any clear scope boundaries agreed?

6 **A.** I don't remember that there was a different
7 scope than the one that we started off with with the
8 Terms of Reference and our plan to interview the members
9 of staff that we did and speak with different
10 departments.

11 **Q.** Yes, but the fact of the guidance that we
12 looked at which dealt with circumstances -- and I can
13 get it back up if you would like to see it again --
14 circumstances in which the College would not take on
15 a review, so it is those categories of cases listed at
16 7.5. Then it gives guidance on what to do if those
17 sorts of issues arise during a review?

18 **A.** (Nods)

19 **Q.** Okay, we will get it up. It's INQ0010214. If
20 we go, please, to page 8. 7.5 lists those categories of
21 cases that the College would not take on.

22 The first subparagraph includes:

23 "Where the expected scope includes behavioural
24 misconduct, bullying, harassment or possible mental
25 health concerns."

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1 At the penultimate paragraph:
 2 "The police or counter fraud service are involved."
 3 It's clear, isn't it, that an Invited Review or
 4 a request for an Invited Review looking into allegations
 5 of attempted murder would not be taken on under this
 6 terms of this guidance?
 7 **A.** I agree, they wouldn't be taken on.
 8 **Q.** Then if we go to the next page, page 9,
 9 paragraph 7.7, that deals with the situation where
 10 a case has been taken on and during a review, the sort
 11 of issues we see at paragraph 7.5 emerge so this is
 12 a situation that you and the team found yourselves in?
 13 **A.** Yes.
 14 **Q.** Paragraph 7.7.
 15 Now, you decide as a team to continue. What this
 16 paragraph of the guidance provides is:
 17 "The reviewers cannot investigate or suggest
 18 solutions for any of the above."
 19 Okay, so that is the issues that we looked at just
 20 at the previous paragraph.
 21 **A.** Yes.
 22 **Q.** The next sentence:
 23 "Clear scope boundaries should be agreed before
 24 further work takes place in order to avoid prejudicing
 25 other investigations."

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1 **A.** We -- we didn't agree any.
 2 **Q.** If the Review Team had considered this
 3 paragraph and there had been discussion of clear scope
 4 boundaries, would one very obvious clear scope boundary
 5 be: well, we mustn't interview Letby, the person against
 6 whom these allegations are being made?
 7 **A.** I agree with you.
 8 **Q.** Do you consider looking at that paragraph it
 9 was a mistake for the Review Team to decide following
 10 the interviews that morning on the first day of the
 11 review visit, it was a mistake to decide to interview
 12 Letby?
 13 **A.** In relation to this paragraph, yes.
 14 **Q.** If you look, please, at your paragraph 54 in
 15 your statement.
 16 **A.** 54?
 17 **Q.** Yes, 5-4. It's a long paragraph but what you
 18 set out there is that upon hearing that Letby had been
 19 removed from practice, during the morning of the first
 20 day of the review visit, you wanted to know what reasons
 21 were given for removing her from clinical practice, what
 22 HR process had been followed, what support had been
 23 given and you go on to identify in that paragraph the HR
 24 considerations that you had in mind.
 25 Why was your immediate concern in respect to

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1 So what this paragraph seems to be envisaging is in
 2 circumstances where a serious concern emerges
 3 mid-review, firstly you need to consider whether you are
 4 going to continue at all --
 5 **A.** Yes.
 6 **Q.** -- in light of the possibility of prejudicing
 7 other investigations. If you are going to continue,
 8 don't investigate or suggest solutions for the serious
 9 conduct issues that may arise and agree clear scope
 10 boundaries?
 11 **A.** Yes.
 12 **Q.** Now, do you understand the reason why it's
 13 suggesting or advising clear scope boundaries?
 14 **A.** Absolutely, yes.
 15 **Q.** What I am asking you is what clear scope
 16 boundaries, if any, in accordance with that paragraph
 17 did the Review Team agree?
 18 **A.** When -- when we had our discussion, our focus
 19 was on continuing to fact-find and gather information
 20 that we thought would be helpful even --
 21 **Q.** Forgive me, sorry.
 22 **A.** Even in light of the information that we had
 23 been given.
 24 **Q.** I am asking very specifically about clear
 25 scope boundaries.

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1 Letby's removal, HR processes and not safeguarding
 2 processes?
 3 **A.** I haven't included safeguarding processes
 4 within my statement but I agree it should be
 5 safeguarding primarily.
 6 **Q.** What consideration did you give to
 7 safeguarding processes?
 8 **A.** Thinking that when there are allegations and
 9 the safeguarding policy and a safeguarding process is
 10 when the allegations are made there's a very clear
 11 framework to follow in the first instance contacting
 12 your manager or designated doctor or nurse for
 13 safeguarding within the institution and then a whole
 14 process follows about fact finding and information
 15 finding.
 16 So primarily from this aspect as well, as much as
 17 the safeguarding process wasn't followed, neither was an
 18 HR process of removing somebody from clinical practice
 19 which is a very intentional move and what I was
 20 concerned about was in not having an HR process,
 21 disciplinary process or other similar, is that it might
 22 interfere with future investigations or fact-finding
 23 reviews.
 24 My experience is that following HR processes are
 25 absolutely vital to ensuring patient safety. But you

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1 have to follow those processes rigidly, so that it
2 protects the patients and there's no room for, as
3 I said, influencing future investigations.

4 **Q.** Did you ask anybody at the Trust during the
5 review whether a referral to the Local Authority
6 Designated Officer had been made?

7 **A.** I think I did when we first -- I think I did
8 see it when we first met when Ian Harvey told us that
9 she had been removed from practice. I think I asked
10 then.

11 **Q.** What was your understanding as to whether
12 a referral had been made?

13 **A.** None.

14 **Q.** Did you advise that a referral should have
15 been made?

16 **A.** No.

17 **Q.** Why not?

18 **A.** I had just heard that information, I was
19 processing the information about Letby and we were
20 gathering information there as a team and it's something
21 that I thought we would discuss at a later point.

22 **Q.** Can we turn please to the actual interview of
23 Letby, it was conducted by you and Ms Claire McLaughlan?

24 **A.** Is it coming up on the screen?

25 **Q.** It will do in a moment.

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1 But what I mean by paragraph 70 is we didn't
2 change -- ask anything specific or we weren't
3 investigating.

4 **Q.** One of the Terms of Reference required the
5 team to consider whether there were common factors or
6 failings contributing to the increase death rate?

7 **A.** We didn't -- we didn't ask that directly.

8 **Q.** Did you determine before speaking to Letby
9 that you wouldn't ask her about that?

10 **A.** No.

11 **Q.** The document is INQ0014602. This is again
12 a transcript of the notes made by Claire McLaughlan, as
13 I understand it, you will have seen her handwritten
14 notes, of your interview with Lucy Letby and also we can
15 see at the top there that in attendance was
16 Hayley Cooper, or Hayley Griffiths as you may have known
17 her.

18 Now, on the basis of this note, and we will go to
19 page 3, please, we can see there in the first paragraph
20 that you discussed with Letby or there is a note
21 indicating a discussion with Letby, her redeployment and
22 the reasons for it.

23 **A.** Yes.

24 **Q.** We can see in the second paragraph on the page
25 a reference to her being scapegoated.

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1 **A.** Okay.

2 **Q.** What I want to ask you first is in respect of
3 your own witness statement, paragraph 70, you say:
4 "As a Review Team we discussed topics to put to
5 Lucy Letby and decided that they should be the same as
6 everyone else we interviewed."

7 Do you see that?

8 **A.** (Nods)

9 **Q.** But you interviewed a number of different
10 people with a number of different specialisms?

11 **A.** Yes.

12 **Q.** So you discussed different issues with
13 different people?

14 **A.** Yes.

15 **Q.** So in respect of Letby, can you be more
16 specific in explaining what it was decided that you
17 would be discussing with her?

18 **A.** Well, along the Terms of Reference of thinking
19 about staffing, relationships within the team, the
20 culture of the unit, anything that they wanted to share
21 with us and that was very much our approach with all the
22 interviews and of course as you say there is different
23 specialisms and people chose to share different things
24 with us, different information with us, so that did
25 change.

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1 **A.** Yes.

2 **Q.** Again, you have indicated that if the team had
3 turned their mind to clear scope boundaries, Letby
4 wouldn't have been interviewed at all.

5 If you and Ms Claire McLaughlan had clear scope
6 boundaries in your mind going into this interview, you
7 would have stayed well away from --

8 **A.** Yes.

9 **Q.** -- issues concerning her redeployment and
10 issues connected to the increase in unexpected deaths?

11 **A.** So we didn't ask her about her redeployment.

12 She offered that information. Because how the --
13 I haven't unfortunately got a list of the questions that
14 we asked but you can see from how the interview has
15 gone, tell us a little bit about yourself, about your
16 nursing background, and then she offered up that she
17 was, she exactly this on this page, about having been
18 removed clinically for a period of 10 weeks, not knowing
19 why.

20 But also --

21 **Q.** Does that -- forgive me, sorry, I thought you
22 had finished.

23 **A.** I was going to say but Claire and I didn't
24 explore further when she offered this information, that
25 wasn't our purpose.

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1 Q. Does that perhaps underline the reason why --
 2 A. Yes.
 3 Q. -- she shouldn't have been interviewed because
 4 of the danger of trespassing into areas of discussion
 5 you would or should not have been ...
 6 A. (Nods)
 7 Q. Now, Hayley Griffiths, or Hayley Cooper, the
 8 RCN representative, she describes -- has described that
 9 Lucy Letby left the meeting with you in a distressed
 10 state. Do you remember Lucy Letby getting into
 11 a distressed state?
 12 A. No.
 13 Q. Do you remember her leaving the meeting?
 14 A. I can't remember her exactly leaving the
 15 meeting.
 16 Q. Do you recall having a discussion with
 17 Hayley Griffiths following your meeting with Letby?
 18 A. No.
 19 Q. Do you remember having any discussion with
 20 Hayley Griffiths?
 21 A. Not alone, no.
 22 Q. No.
 23 A. No.
 24 **LADY JUSTICE THIRLWALL:** By "alone", you mean
 25 without?

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1 a grievance case."
 2 Then the second entry further down on that page:
 3 "The report will take a minimum of six weeks with
 4 a preliminary tomorrow. They 'off the record' told me
 5 they think an investigation into the deaths will be
 6 a recommendation and I need to prepare myself that as
 7 I would play a big part in that over due to being
 8 a common factor and it could take several months."
 9 Now, just going through the substance of that. The
 10 report will take a minimum of six weeks. Did you tell
 11 --
 12 A. No.
 13 Q. -- Letby that's how long it would take? Did
 14 you hear Ms McLaughlan tell her that's how long it will
 15 take?
 16 A. No.
 17 Q. A turnaround time of six weeks for the report
 18 is about right, isn't it?
 19 A. Yes. According to the Review Handbook, but
 20 I didn't say that.
 21 Q. So she is accurate in her understanding of how
 22 long?
 23 A. Sorry?
 24 Q. She is accurate in her understanding of how
 25 long the report will take?

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1 A. Without Lucy Letby.
 2 **LADY JUSTICE THIRLWALL:** Yes, thank you.
 3 **MR CARR:** The evidence from Hayley Griffiths is
 4 that she was told words along the lines after Letby had
 5 left the room -- she was told words along the lines of:
 6 Does she know what is going on here and what she's
 7 potentially being accused of?
 8 A. I don't remember that at all.
 9 Q. Do you remember hearing Claire McLaughlan say
 10 that --
 11 A. No.
 12 Q. -- to Hayley?
 13 Can we get up please, INQ0000569, it's the same
 14 document from before but it's the restricted, the
 15 one-page version, please, thank you.
 16 We might need to zoom in so that we can see that.
 17 These are text messages sent by Letby to Dr U the
 18 evening of 1 September, so shortly following your
 19 interview with her.
 20 Do you see in the first one it says:
 21 "The team members were nice. They didn't ask much
 22 about the babies. It was more about the unit as
 23 a whole, et cetera. In brief it looks as though there
 24 is a potential for this to go further over a long period
 25 of time. H thinks we need to look at taking out

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1 A. Yes.
 2 Q. But you say she didn't get that from you?
 3 A. No.
 4 Q. And she didn't get it from Claire McLaughlan?
 5 A. No.
 6 Q. As to the reference of the "off the record"
 7 discussion, did you have an off the record discussion
 8 with her?
 9 A. No.
 10 Q. Did you have an off the record discussion with
 11 Hayley Griffiths?
 12 A. No.
 13 Q. Did you advise her there was going to be an
 14 investigation?
 15 A. No.
 16 Q. Did Claire McLaughlan advise her?
 17 A. No.
 18 Q. It is correct, isn't it, and we can look at
 19 the other notes from that day, that the plan was for
 20 a recommendation for further investigation by the Review
 21 Team to the hospital?
 22 A. Yes.
 23 Q. That is ultimately what was advised?
 24 A. Sorry, what do you mean advised? To Letby?
 25 Q. No, to the hospital.

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1 A. Yes.
 2 Q. So Letby is accurate in her description of
 3 there being an investigation into the deaths because
 4 that's what you as a team were proposing?
 5 A. Yes, but we hadn't made that decision until
 6 the next day.
 7 Q. We can take the messages down.
 8 No, I understand that. Yet we have the text
 9 messages and I understand you say -- well, you didn't
 10 tell Letby that there was going to be an investigation
 11 into the deaths, but that was your plan, so she has
 12 accurately reflected?
 13 A. She -- she has but I haven't -- I haven't told
 14 her that.
 15 Q. Did you tell her that she had been identified
 16 as a common factor --
 17 A. No.
 18 Q. -- in the deaths?
 19 Is that an accurate description of your
 20 understanding of the evidence?
 21 A. Sorry, what do you mean?
 22 Q. Did you consider that she was going to play
 23 a big part in the investigation, that the RCPCH was
 24 recommended because of the correlation that you had
 25 identified?

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1 Ian Harvey and Alison Kelly; it is a meeting earlier
 2 with Ian Harvey and Alison Kelly?
 3 A. Okay.
 4 Q. There is discussion of your interview with
 5 Letby the previous day. I am looking at the bottom of
 6 the page about six lines up where it says:
 7 "Needs to be put into a process for her protection
 8 and yours. Disciplinary process to get to the bottom.
 9 Can't understand why RCN have let this go on. Suspect
 10 there will be a grievance. If nothing happens good case
 11 for constructive dismissal. She knows it will be
 12 horrid."
 13 The reference there to "she knows it will be
 14 horrid", that is a reference to Letby, isn't it?
 15 A. I -- yes, I assume so. But I didn't say that.
 16 Q. No, but what did you understand or can you
 17 help us to understand what it is that Letby would know
 18 or knows is going to be horrid?
 19 A. I don't remember having a conversation that
 20 this would have been mentioned, certainly not with
 21 Letby.
 22 Q. Well, looking, we have looked at the text
 23 messages and there was actually one interpretation of
 24 those text messages is that Letby has been tipped off
 25 about the fact that the RCPCH are going to recommend an

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1 A. I -- I wouldn't have said that. I didn't say
 2 that.
 3 Q. Did Claire McLaughlan have a discussion with
 4 her as to --
 5 A. No.
 6 Q. Did you advise her to prepare herself?
 7 A. No, they are also words that I just wouldn't
 8 use.
 9 Q. (Pause) Forgive me, I needed to find
 10 a reference. The next document I want to take you to is
 11 INQ0014605. These are the transcripts of Sue Eardley's
 12 note for the second day of the visit and it is page 6
 13 that I want to take you to, please.
 14 This appears to be notes from a discussion that
 15 morning with Ian Harvey and Alison Kelly. Do you recall
 16 being present at this meeting, so it is the day two
 17 meeting with Ian Harvey and Alison Kelly, it's not the
 18 feedback session at the end of the day?
 19 A. Is that the end of the day, yes?
 20 Q. Sorry?
 21 A. The end of the day?
 22 Q. No, it is not the feedback session at the end
 23 of the day, it is earlier in the day.
 24 A. Okay.
 25 Q. So it is not the meeting with Tony Chambers,

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1 investigation into the deaths and she's going to be
 2 a part of it and the reference here to "She knows it'll
 3 be horrid"?
 4 A. I don't know where she got that information
 5 from. But also she was under the impression and I can't
 6 remember where it's written she was under the impression
 7 that following the review, she would be reinstated.
 8 Q. So you don't know where she got the
 9 information from. She didn't speak to anybody else from
 10 the RCPCH Review Team, did she?
 11 A. Not that I can remember.
 12 Q. So the possibilities appear to be either she
 13 was told directly by you, she was told directly by
 14 Claire McLaughlan, she was told directly by both of you,
 15 Hayley Griffiths has told her, or it's just a lucky
 16 guess?
 17 A. I don't know the answer to that. I know that
 18 I didn't have that conversation with her.
 19 Q. I am going to deal more briefly now with some
 20 of the other discussions that you had over the course of
 21 the review visit. You spoke to the other Consultants,
 22 Dr V, Dr Gibbs, Dr Saladi, Dr Holt and Dr ZA on
 23 1 September. During that meeting with those doctors,
 24 again, you were told about the unexplained nature of the
 25 deaths?

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1 A. Yes.

2 Q. It's right to say that those doctors expressed
3 concern --

4 A. Yes.

5 Q. -- about the situation on the unit.
6 Dr Saladi is noted in Sue Eardley's notes to
7 describe mottling of some of the babies?

8 A. Yes.

9 Q. So that is further evidence of what you had
10 been told by Dr Jayaram. The Inquiry has already heard
11 evidence from Dr Saladi and Dr ZA. Both of those
12 doctors describe informing your team that they had
13 concerns with Letby, so Dr Saladi's evidence was that he
14 and the other Consultants told you they were worried
15 about a nurse on the unit potentially causing deliberate
16 harm?

17 A. Yes.

18 Q. Do you remember that?

19 A. Yes.

20 Q. Dr ZA's evidence was:
21 "We were very open from the beginning of our
22 meeting that our concern was that Lucy Letby was doing
23 something deliberate to harm babies".

24 Do you recall Dr ZA disclosing that?

25 A. I can't remember that it was him or her. But
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1 he would then contact the doctors on the unit.

2 Q. Let's look at the note. It is INQ0014604 and
3 it's page 28. This is notes from the discussion with
4 Dr Mittal and it is a point at which he's talking about
5 the increased deaths and can you see five lines down:
6 "None of these deaths raised concern for Rajiv or
7 the panel, accepted as natural death even though some
8 had PMs but nothing found."

9 Then further down the page there is a line that
10 reads:
11 "Have discussed deaths with Steve et cetera didn't
12 find any patterns."

13 You will have known by the time of being in this
14 interview that that wasn't correct because there were
15 patterns and there were patterns that were concerning
16 the doctors on the neonatal unit?

17 A. Yes.

18 Q. Now, given your familiarity that you described
19 at the beginning of your evidence with Working Together
20 to Safeguard Children, you would know that the matters
21 that had been described to you are matters that it was
22 mandatory to escalate within the hospital and then to
23 the local authority?

24 A. Yes.

25 Q. That hadn't been done?
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1 I do remember that being said.

2 Q. You spoke to Dr Mittal, the designated
3 safeguarding doctor?

4 A. Yes.

5 Q. I can bring the notes up if necessary but
6 I can't see in the notes of that discussion that there
7 was any exploration with him as to whether he was aware
8 of the concerns that the doctors on the neonatal unit
9 had, the suspicions that they had in respect of Letby?

10 A. From what I can remember, without looking at
11 documents, he wasn't aware of their concerns.

12 Q. Did it ring any alarm bells for you that the
13 safeguarding doctor was not alert to the suspicions that
14 several doctors on the neonatal --

15 A. Yes.

16 Q. -- unit had shared with you?

17 A. Yes, it did -- it did cause alarm.

18 Q. Was there any discussion or advice to him as
19 to his need to engage with the doctors on the neonatal
20 unit as to their concerns?

21 A. Sorry, can you repeat that please?

22 Q. Did you tell Dr Mittal that he needed to speak
23 to the neonatal doctors about their suspicions?

24 A. I don't think I said that directly, more that
25 it was assumed because we had had that discussion that
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1 A. No.

2 Q. That is something that should have been
3 explored with Dr Mittal?

4 A. Yes.

5 Q. It does not appear from the notes that it was
6 explored with him?

7 A. No.

8 Q. The final interview in the notes that I want
9 to go to, please, it is the interview with
10 Andrew Higgins, it is a different document the following
11 day, INQ0014605. It's page 22. And the second line
12 down, the sentence that begins "Long debates ..." and
13 Andrew Higgins, he was a member of the board, wasn't he,
14 and he was telling you about what had gone on at board
15 level in respect of these concerns?

16 A. Yes.

17 Q. The note reads:
18 "Long debates about how to deal with it for that
19 point, eg, involvement of police after internal
20 briefings from Exec. PAV and board needed to get an
21 external view. View came from doctors' team itself so
22 needed an external opinion."

23 Something is crossed out:
24 "I know what it was based on. Took a bit of time
25 then about [a word that's hard to decipher] and whether
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1 to involve the police. Wanted to try and unpick this as
2 best we could. Exec recommendation, independent review
3 is the best way to challenge, corroborate, need to keep
4 shutters down and contain situation."

5 Firstly, the reference to an independent review
6 being the best way to challenge and corroborate, was the
7 independent review being referred to the RCPCH review
8 that you were engaged in?

9 **A.** I'm not sure but I think so.

10 **Q.** What was your understanding of the reference
11 "to challenge and corroborate"?

12 **A.** I think the "corroborate" is to find proof and
13 I make -- I am making assumptions here because I am
14 interpreting this -- "corroborate" is to corroborate
15 with the doctors' view that there is Letby causing harm
16 to the babies. "Challenge" I would assume means that
17 there's something completely different that's found,
18 another reason why babies were dying.

19 **Q.** Were you concerned that a member of the board
20 saw the independent review as an alternative to police
21 involvement?

22 **A.** I can't comment what the board's views were.

23 **Q.** Were you concerned that a member of the board
24 was reporting that the shutters need to be kept down and
25 the situation contained?

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1 To be clear, the allegations I have asked you
2 several questions about is that Letby is murdering
3 babies and it's clear from the evidence that you have
4 given that one member of staff is not an accurate
5 description of the level of concern you received, was
6 it?

7 **A.** I agree.

8 **Q.** Now, it's the second page of this letter that
9 contains the two action points, one the HR
10 investigation, secondly a case review and the paragraph
11 under the heading "Action by HR investigation", second
12 sentence:

13 "Our understanding is that an allegation has been
14 made and therefore a process of investigation needs to
15 be put in place which sets out nature of the allegation
16 and the process you will follow to investigate it."

17 Now, as somebody with experience in HR matters, did
18 you consider an HR investigation an appropriate
19 mechanism for investigating the allegations that had
20 been made by the doctors?

21 **A.** No, I think in the context of this it's
22 a safeguarding investigation.

23 **Q.** Are you saying it should be a safeguarding
24 investigation?

25 **A.** Yes.

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1 **A.** I was concerned. I don't know what is meant
2 by "keep the shutters down", but "contain the situation"
3 I think is clear.

4 **Q.** Well, again, did that ring any alarm bells for
5 you from a safeguarding point of view?

6 **A.** Yes. But we didn't explore it further.

7 **Q.** Now, at the end of the second day there was
8 a feedback session with Tony Chambers, Ian Harvey and
9 Alison Kelly and the advice given was in respect of the
10 investigation I have asked you questions about and an HR
11 process.

12 I am not going to take you to the notes of that
13 meeting. The advice is contained in the letter that
14 followed the review visit. It's INQ0009611.

15 It's already dated 5 September, written by
16 Sue Eardley. You have seen this --this letter in the
17 preparation --

18 **A.** (Nods)

19 **Q.** -- of your evidence?

20 It's three days after the review visit. Fourth
21 paragraph deals with Letby being moved off the neonatal
22 unit. The final sentence reads:

23 "These steps appear to have been taken on the basis
24 of an allegation made by one member of medical staff
25 supported by his medical colleagues."

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1 **Q.** Because it says "HR investigation" doesn't it?

2 **A.** But the HR investigation is specifically about
3 her being removed and redeployed, removed from clinical
4 practice and redeployed for 10 weeks without a process
5 in place. But that -- that sentence, that paragraph is
6 that specifically safeguarding, that is a safeguarding
7 process that should be followed.

8 **Q.** It doesn't say that, does it, in the letter?

9 **A.** It doesn't.

10 **Q.** It ought to have --

11 **A.** Yes.

12 **Q.** -- made recommendations to safeguarding and in
13 light of the evidence that we have already dealt with,
14 in fact the Review Team had heard enough to be
15 recommending in strong terms contact the police?

16 **A.** Yes.

17 **Q.** Can I deal with the clarification you made in
18 your witness statement right at the beginning of your
19 evidence. It's paragraph 87 and you have corrected your
20 statement so it no longer states that the Review Team
21 recommended that the Medical Director and senior
22 management contact the police directly.

23 As I understand it from your corrections, tell me
24 if I am wrong, the sentence before that remains in that
25 your evidence is there was some discussion amongst the

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1 team as to whether or not --
 2 **A.** Yes.
 3 **Q.** -- to recommend the police be contacted but
 4 that recommendation wasn't made.
 5 However, you weren't involved in those discussions?
 6 **A.** No, both of those are incorrect. That
 7 sentence and that starts "I wasn't actively
 8 involved ..."
 9 **Q.** Yes.
 10 **A.** And "The Review Team ... "
 11 Those two sentences are incorrect.
 12 **Q.** So you were involved in the discussions and
 13 the conclusion of those discussions was not to contact
 14 the police.
 15 **A.** I was, yes.
 16 **Q.** What was the justification for not contacting
 17 the police?
 18 **A.** There needed to be the safeguarding process
 19 followed first and the HR process and those were the
 20 recommendations that were made.
 21 **Q.** Why was the HR process or a safeguarding
 22 process required before the police were contacted?
 23 **A.** From what I can remember, the safeguarding
 24 process had been followed with those allegations was the
 25 correct first course, first point to follow. The HR

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1 first point because of the allegations. We had only --
 2 as far as I was aware we had only heard those -- I had
 3 only heard those allegations that morning. And it was
 4 throughout the morning and the two days that I had found
 5 out that this had been going on for a while.
 6 **Q.** The final point I want to deal with with you
 7 is the preparation of the report and I am not going to
 8 take you to the final report, I want to take you to the
 9 comments that you made in the drafting process.

10 **A.** Sure.
 11 **Q.** There are two points. Firstly quite early in
 12 the process your recommendation was that all deaths at
 13 the hospital should be subject to further investigation,
 14 not just those which had been classified as unexpected?

15 **A.** Yes.
 16 **Q.** The reason that you give for that is you were
 17 concerned that the classification may have been wrong or
 18 inconsistent, so you wanted to cast the net quite wide?

19 **A.** Yes.
 20 **Q.** Then secondly, if we can look please at
 21 INQ0010147, and if you turn to page 7, please, we may
 22 need to zoom in, it is the comment box, the fourth one
 23 down which is slightly orange. Thank you.

24 This comment on the right is a comment made by you,
 25 isn't it, on the report?

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1 process was separate, that was because she had been
 2 removed from clinical practice and there needed to be
 3 a robust process in place.

4 **Q.** You say it was a correct process to follow but
 5 what process are you referring to?

6 **A.** HR or the safeguarding?

7 **Q.** Either.

8 **A.** Safeguarding is when you make a referral.

9 **Q.** No, I understand the two processes that you
 10 are referring to. My question is about contacting the
 11 police --

12 **A.** Yes.

13 **Q.** -- and why it wasn't done and your answer is:
 14 well, there needed to be an HR process, there needed to
 15 be a safeguarding process. I am asking you on what
 16 basis why couldn't there be?

17 **A.** The safeguarding process is the correct way to
 18 -- when there is an allegation of harm to babies or
 19 patients, other patients, is that's the first step.

20 **Q.** Do you or did the team consider it would have
 21 been inappropriate to contact the police in light of the
 22 lack of a safeguarding process?

23 **A.** I can't speak for the rest of the team but
 24 following the discussion that we had, it was deemed
 25 appropriate to recommend the safeguarding process as the

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1 **A.** Yes.

2 **Q.** You have added in a section of the report
 3 dealing with the allegations against Letby.

4 "The significance of this one nurse being rostered
 5 on shift at the time of each of the deaths had not been
 6 investigated via a thorough process and is only
 7 individual senior Consultant's subjective view".

8 Now, just on that point, individual senior
 9 Consultant's subjective view, that is not accurate, is
 10 it?

11 **A.** Not with all the other information that became
 12 evident within those two days that we were interviewing
 13 other people and a range of people. But what I mean by
 14 that, and when I say "individual senior Consultant",
 15 I do mean the -- the Consultant Dr Jayaram who was
 16 possibly more forthcoming in his views and when I say
 17 "subjective" is because again we weren't there to
 18 investigate this nurse but on the surface it very much
 19 appeared that it was from the commonality rather than
 20 from proof or evidence but that was also not our role to
 21 investigate that.

22 So that's why I have put "subjective" and then I go
 23 on further to say ...

24 **Q.** It's not accurate firstly because it wasn't
 25 just one individual, it wasn't an individual senior

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1 Consultant?

2 **A.** No.

3 **Q.** Dr Brearey, Dr Jayaram, the other Consultants,
4 all of them raise their concerns. You had been told by
5 Ian Harvey that the paediatricians as a body had those
6 concerns?

7 **A.** (Nods)

8 **Q.** So it was wrong to diminish the concerns as if
9 it was just one individual, do you agree?

10 **A.** It wasn't my intention to diminish his
11 concerns.

12 **Q.** It wasn't a subjective view. You considered
13 and heard a lot of evidence over the course of the
14 two days and although we have not gone through it, there
15 were a number of comments made about Letby from her
16 nursing colleagues which were quite supportive?

17 **A.** Yes.

18 **Q.** But so far as the doctors were concerned, what
19 they were referring to was what they had experienced,
20 their medical expertise, the fact that the deaths were
21 unexpected and unexplained, and consistency with medical
22 literature.

23 None of that was subjective, was it?

24 **A.** No, but in relation to this particular nurse
25 there wasn't any definitive proof other than the

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1 the RCPCH but you had actually not undertaken in fact
2 any refresher process at all?

3 **A.** No.

4 **Q.** At paragraph 33 of your witness statement, you
5 specifically say that at that time, ie in 2016, you
6 lacked the experience of reviewing a cohort of
7 unexpected or unexplained deaths or indeed where
8 concerns of criminal conduct are raised; is that fair?

9 **A.** Yes.

10 **Q.** So not only had you not received any specific
11 training from the Royal College or indeed had
12 an opportunity of speaking to people who had previously
13 carried out reviews, but your own professional
14 experience meant that even on a cursory glance of the
15 Terms of Reference you were not the right individual to
16 be part of this Review Team; is that fair?

17 **A.** I think it's fair to say that, yes.

18 **Q.** Thank you.

19 Can I move on now to looking at views or
20 conclusions that you reached as part of the review
21 process. For this can I take you to paragraph 47 of
22 your witness statement, please. It's on page 9. In the
23 preceding paragraph you deal with a number of documents,
24 tables of documents that you had reviewed and in
25 paragraph 47 you say:

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1 commonality that she was present for the majority of the
2 collapses and deaths.

3 **Q.** You commenced your evidence with an apology to
4 the -- thank you that can come down -- parents for the
5 deaths of their babies.

6 Is there anything in respect of your own role that
7 you would wish to say sorry for?

8 **A.** I think the -- being part of the Review Team
9 and for the enormity of the Terms of Reference I was
10 possibly quite naive in thinking it was possible to
11 address all of those Terms of Reference and the
12 significance of them within two days. And on
13 reflection, it's thinking about having a different
14 thought process and really listening to what people were
15 saying.

16 **MR CARR:** My Lady, I have no further questions,
17 thank you.

18 **LADY JUSTICE THIRLWALL:** Thank you. Mr Sharghy.

19 Questions by MR SHARGHY

20 **MR SHARGHY:** Mrs Mancini, I ask questions on behalf
21 of the Families of seven babies who Lucy Letby either
22 murdered or attempted to murder. I will ask you
23 questions on about three specific areas, if I may.

24 You said to counsel to the Inquiry that not only
25 had you not been provided with any induction training by

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1 "Following consideration of the documents you
2 reached a view that although the number of deaths were
3 higher than in previous years, I [that is you] did not
4 identify evidence of unexpected, unexplained deaths or
5 collapses or any common factors in increased mortality."

6 Given what you have just accepted, that you had no
7 experience previously in looking into a cohort or as we
8 have referred to it --

9 **A.** Yes.

10 **Q.** -- previously as clusters in this Inquiry, how
11 were you able to come to that view simply by reviewing
12 documents?

13 **A.** I couldn't. But what I would say is that
14 exploring and reviewing unexplained and unexpected
15 deaths requires the time and the expertise to be able to
16 do that over a period of time and that was just not
17 possible within the Terms of Reference of the review.

18 **Q.** Yes. Mrs Mancini, isn't there a danger that
19 if you do come to a view just based on documentation
20 then you fall into the trap of confirmatory bias? In
21 other words, the more you learn about a process and
22 a review and an inquiry, the more you look for evidence
23 that tends to support your initial view?

24 **A.** Yes, that's correct.

25 **Q.** Thank you. And matters in terms of the

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1 process, your thought process in particular, didn't just
 2 stop there because can I take you to paragraph 102 of
 3 your witness statement as well, please. This is
 4 a description of what you did having read the draft?
 5 **A.** Yes.
 6 **Q.** Then you provided a comment. You specifically
 7 wanted a comment put in or some form of wording that
 8 indicated that:
 9 "It was important that we as the group recognise
 10 that these allegations are only hearsay and have no
 11 substance."
 12 **A.** (Nods)
 13 **Q.** Did you truly believe that at the time you
 14 made this suggestion?
 15 **A.** No, I think that I should have reworded it,
 16 worded it differently and what I meant was as I have
 17 previously said that we weren't given any proof that
 18 this had in fact been happening by this member of staff.
 19 That's what I meant by that comment and I haven't
 20 written it in correct language.
 21 **Q.** But you can see the danger that it influences
 22 what the final report ends up suggesting --
 23 **A.** I can see that.
 24 **Q.** -- and the false reassurance it provides to
 25 the reader, ie in this case the Trust?

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1 **Q.** The final question: when Counsel to the
 2 Inquiry asked why the team decided to continue with
 3 a review even though there was outstanding information
 4 you said: well, there were serious allegations. It was
 5 quite urgent that the work started.
 6 But in fact didn't it become even more urgent and
 7 more concerning at the end of the pre-session when you
 8 were having this discussion that rather than suggesting
 9 there should be a further review and potentially further
 10 delay, that the police needed to be called or at least
 11 the Trust told, "We have got serious concerns here you
 12 need to contact the police"?
 13 **A.** I understand what you are saying but our
 14 decision was that we would advise that the safeguarding
 15 process should be the first point of call.
 16 **Q.** Did you at any point think about the
 17 repercussions of that to patient safety, these very
 18 vulnerable babies who could be exposed to further harm?
 19 **A.** We, we had the babies absolutely uppermost in
 20 our mind and patient safety. We knew that that member
 21 of staff had been removed from clinical practice.
 22 I know that there's lots of other elements about that
 23 not being done appropriately.
 24 But we felt that that was -- we discussed it and we
 25 thought consensus that that was right thing to do.

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1 Final issue is in relation to the discussion that
 2 took place with the team and you have helpfully
 3 clarified you were part of that discussion as regards
 4 whether the police should be called based on, for some,
 5 the new information that had been discovered?
 6 **A.** (Nods)
 7 **Q.** Can you just take us into that room for
 8 a moment. Were all the members of the Review Team
 9 present for this discussion?
 10 **A.** I think so. But I can't remember exactly.
 11 **Q.** Can you assist with how and which side of the
 12 fence the various professionals fell in; other words,
 13 the nurses on one side and the doctors on the other? Or
 14 was it a mixture?
 15 **A.** I think it was a mixture. I can't remember
 16 clearly, I have to say that, but I think it was
 17 a mixture. It wasn't an obvious divide as far as I can
 18 remember.
 19 **Q.** How finely balanced was that divide?
 20 **A.** I don't remember -- as I said earlier,
 21 I didn't remember that there was one of the doctors that
 22 had suggested we should abort the review. And I can't
 23 remember that conversation in detail, honestly. So
 24 I don't think I can give you any further information on
 25 that.

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1 **Q.** Okay. Did you ever consider that having
 2 received your review, that the Trust might reintegrate
 3 Lucy Letby back on to the neonatal unit?
 4 **A.** No, not for a minute.
 5 **MR SHARGHY:** Thank you, my Lady.
 6 **LADY JUSTICE THIRLWALL:** Thank you, Mr Sharghy.
 7 Ms Scolding.
 8 Questions by MS SCOLDING
 9 **MS SCOLDING:** I only have one question, my Lady, to
 10 Ms Mancini.
 11 Good afternoon, Ms Mancini, I obviously ask
 12 questions on behalf of the Royal College of Paediatrics
 13 and Child Health. I just have one question in the light
 14 of everything that has been discussed today: what would
 15 you do differently if you were faced with a similar
 16 situation to the situation you were faced with in 2016?
 17 **A.** I would gain advice myself about processing --
 18 sorry, continuing with the process of the review and if
 19 that was the correct thing to do, I would get that
 20 advice directly.
 21 **Q.** Who would you have got that advice from, which
 22 body or organisation?
 23 **A.** The first point, I would have gone to the
 24 Royal College of Nursing and I know that they would have
 25 then directed me to the Royal College of Paediatrics and

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1 Child Health.
 2 **MS SCOLDING:** Thank you very much, I have no
 3 further questions.
 4 Questions by LADY JUSTICE THIRLWALL
 5 **LADY JUSTICE THIRLWALL:** Thank you, Ms Scolding.
 6 I just have one question and it is in relation to the
 7 letter that went to Mr Harvey on 5 September. I will
 8 get it up so that you can see it. It is 0009611 and
 9 then it's page 2.
 10 We have looked at it already.
 11 **A.** Thank you.
 12 **LADY JUSTICE THIRLWALL:** It's in relation to the
 13 first heading because I just want to make sure that
 14 I have understood your evidence correctly. It's -- this
 15 is the first action point and it's headed "HR
 16 Investigation".
 17 Now, that might be thought --
 18 **A.** Yes.
 19 **LADY JUSTICE THIRLWALL:** -- to connote an HR
 20 investigation but, as I understand it, your evidence is
 21 that this meant safeguarding.
 22 **A.** Safeguarding plus HR investigation for the
 23 redeployment of Letby.
 24 **LADY JUSTICE THIRLWALL:** Where's the clue in this
 25 paragraph that it's --

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1 **LADY JUSTICE THIRLWALL:** I see. Then the next
 2 sentence:
 3 "No doubt you have your own policies for this ..."
 4 So that is not a safeguarding policy?
 5 **A.** Yes.
 6 **LADY JUSTICE THIRLWALL:** "... but the MHPS process
 7 used for doctors provides a helpful framework."
 8 That is not a safeguarding policy?
 9 **A.** No.
 10 **LADY JUSTICE THIRLWALL:** So we have this one
 11 sentence in the middle of a paragraph which the hospital
 12 were to understand was a reference to safeguarding
 13 rather than an HR investigation?
 14 **A.** Yes, it's unclear.
 15 **LADY JUSTICE THIRLWALL:** Well, it's either unclear
 16 or it means something different from what appears on the
 17 page, isn't it? I just wonder how you think someone
 18 would know that was safeguarding in that middle section.
 19 **A.** I think it's open for interpretation but it
 20 should have a heading of "Safeguarding", we should
 21 have a process of safeguarding investigation.
 22 **LADY JUSTICE THIRLWALL:** Thank you very much.
 23 Mr Carr, have you any questions arising out of my
 24 questions?
 25 **MR CARR:** No, I don't, thank you.

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1 **A.** It's not there, I'm sorry.
 2 **LADY JUSTICE THIRLWALL:** No. And in fact if we
 3 look at it, second sentence. First of all you have got
 4 to formalise the actions you are taking with the nurse?
 5 **A.** Yes.
 6 **LADY JUSTICE THIRLWALL:** So it's about her.
 7 **A.** Yes.
 8 **LADY JUSTICE THIRLWALL:** Then:
 9 "An allegation has been made and a process needs to
 10 be put in place which sets out nature of the allegation
 11 and the process you will follow to investigate it" and
 12 that is what you were saying in your evidence earlier.
 13 **A.** The safeguarding.
 14 **LADY JUSTICE THIRLWALL:** No, I'm sorry, no.
 15 **A.** Sorry.
 16 **LADY JUSTICE THIRLWALL:** The allegation made,
 17 process of investigation to be put in place which sets
 18 out nature of the allegation and the process you will
 19 follow to investigate it.
 20 So that is a different thing from investigating the
 21 nurse, is it?
 22 **A.** No, that's starting the safeguarding process.
 23 That's specifically for the safeguarding process. The
 24 first sentence alludes to the HR process for her having
 25 been redeployed.

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1 **LADY JUSTICE THIRLWALL:** All right. Thank you very
 2 much indeed, Ms Mancini, you are free to go.
 3 Now, Mr Carr, is that a good time to take a short
 4 break?
 5 **MR CARR:** It is, yes.
 6 **LADY JUSTICE THIRLWALL:** There isn't any pressure
 7 because we can come back to evidence, but have you any
 8 idea how long the next two witnesses are likely to take?
 9 **MR CARR:** They will be much shorter. I am going to
 10 try and keep to less than half an hour per witness.
 11 **LADY JUSTICE THIRLWALL:** Very good, okay. In that
 12 case shall we take 15 minutes and start again at 5 to 4.
 13 **(3.41 pm)**
 14 **(A short break)**
 15 **(3.55 pm)**
 16 **LADY JUSTICE THIRLWALL:** Mr Carr.
 17 **MR CARR:** My Lady, may I call Dr David Shortland,
 18 please.
 19 **LADY JUSTICE THIRLWALL:** Dr Shortland, would you
 20 like to come forward.
 21 **DR DAVID SHORTLAND (sworn)**
 22 Questions by MR CARR
 23 **LADY JUSTICE THIRLWALL:** Thank you, Dr Shortland.
 24 Do sit down.
 25 **MR CARR:** Can we start with your full name, please?

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1 A. Dr David Shortland.
 2 Q. You have prepared a statement for this Inquiry
 3 dated 20 May 2024, haven't you?
 4 A. Yes.
 5 Q. Are the contents of that statement true to
 6 your best knowledge and belief
 7 A. They are, yes.
 8 Q. I am going to summarise your professional
 9 background, but tell me if I have got anything wrong.
 10 You qualified as a doctor in 1979, you became
 11 a Consultant in 1989?
 12 A. (Nods)
 13 Q. And you retired from NHS practice in 2021; is
 14 that correct?
 15 A. Yes.
 16 Q. You have held a number of leadership roles
 17 including being clinical lead of a neonatal unit for
 18 a decade and clinical director for 12 years in the
 19 course of your career?
 20 A. Yes.
 21 Q. At the time of the RCPCH review of the
 22 Countess of Chester Hospital, you were the clinical
 23 adviser for the Invited Review Board?
 24 A. (Nods)
 25 Q. I have also seen reference in your statement

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1 was a member of staff or family or whoever, really.
 2 Q. You were very experienced in Invited Reviews,
 3 you have undertaken approximately 50 Invited Reviews
 4 each time as lead reviewer?
 5 A. Yes. Yes.
 6 Q. But you had never done a review involving
 7 unexpected or unexplained deaths --
 8 A. Yes, that's correct.
 9 Q. -- had you?
 10 A. Yes.
 11 Q. Never been involved in a review where the
 12 Terms of Reference looked at mortality of individual
 13 cases?
 14 A. That's correct, yes.
 15 Q. Is an overview of your involvement of the
 16 Countess of Chester Hospital Invited Review as follows:
 17 you had no involvement in devising or agreeing the Terms
 18 of Reference or the arrangements or preparation for the
 19 review?
 20 A. Not quite correct. I think I said in my
 21 statement that a few days before the review, I had
 22 an email from Sue telling me that the review was about
 23 to take place and mentioning that one of the issues was
 24 increase in unexpected deaths in the unit.
 25 So it was on a Saturday morning and I telephoned

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1 to you being the clinical lead, those two roles are the
 2 same, aren't they?
 3 A. Same, yes.
 4 Q. Two interchangeable terms?
 5 A. Yes, they are.
 6 Q. That is one of several roles that you have had
 7 at the RCPCH?
 8 A. (Nods)
 9 Q. For the purposes of your evidence today I am
 10 going to be asking you about that review. Before I do,
 11 in respect of safeguarding training you make the point
 12 that you undertook regular mandatory safeguarding
 13 training as part of your NHS practice?
 14 A. Yes, it was a standard part of the mandatory
 15 training.
 16 Q. There was no specific safeguarding training as
 17 part of the Invited Review programme?
 18 A. Yes, that's correct, yes.
 19 Q. Your statement states paragraph 8, you have
 20 never had safeguarding training about abuse suspected by
 21 a member of staff but is there any reason to think that
 22 different principles would apply?
 23 A. No, I think if you look at the documentation
 24 I think -- excuse me, I think if there are safeguarding
 25 concerns you would follow the same principles whether it

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1 Sue which would be quite unusual for me to do that, so
 2 I had slight further information about the review before
 3 it took place but I wasn't -- I didn't see the formal
 4 Terms of Reference but I recognise one of the Terms of
 5 Reference, the fourth Terms of Reference which we
 6 discussed.
 7 Q. You are slightly getting away from my
 8 question, I was just giving an overview of your
 9 involvement?
 10 A. Sorry.
 11 Q. The second point I was going to come to was
 12 that there was a telephone conversation with Sue Eardley
 13 a few days before the review, but the first point I was
 14 making is that you had no involvement, as I understand
 15 it, from your evidence, in devising the Terms of
 16 Reference or arrangements or preparations for the
 17 review?
 18 A. Yes, that's correct, yes.
 19 Q. The telephone call with Sue Eardley you've
 20 alluded to.
 21 You were not approached for advice during the
 22 course of the Invited Review?
 23 A. (Nods)
 24 Q. Following the review visit, you read the final
 25 draft of the report before it was sent to the hospital

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1 and you made a brief comment on it which we will come
2 to?

3 **A.** Yes, that's correct.

4 **Q.** That is the extent of your involvement.

5 The first topic of questions is whether your
6 involvement should have been greater. You have
7 described in your statement, it's paragraph 29, you
8 describe your role as clinical adviser for the Invited
9 Review programme was "to Chair the programme board
10 meeting at which, from memory, occurred every
11 four months".

12 So you are describing quite a limited role?

13 **A.** Yes.

14 **Q.** You have seen and you will be familiar with
15 the guide to Invited Reviews and you were sent a copy of
16 it to prepare your evidence and I am not going to put it
17 up on screen but you were asked questions about it.

18 It's right, isn't it, that the guide to Invited
19 Reviews suggests that it is for the clinical adviser to
20 agree Terms of Reference?

21 **A.** (Nods)

22 **Q.** Where there is to be a pre-visit review, that
23 is something that would be carried out by the clinical
24 adviser or the lead reviewer; is that right?

25 **A.** Yes, that's correct, yes.

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1 know exactly when David Milligan was approached about
2 being the lead reviewer.

3 **Q.** The point is this: you will have seen from the
4 documents you have considered that the Terms of
5 Reference were discussed and agreed on behalf of the
6 RCPCH solely by Sue Eardley weren't they?

7 **A.** Yes, that's correct, yes.

8 **Q.** It's clear on the guidance that shouldn't have
9 occurred?

10 **A.** Yes.

11 **Q.** There should have been input either from the
12 lead reviewer and until he was appointed it should have
13 been you?

14 **A.** Yes, yes. Yes.

15 **Q.** So far as your discussion with Sue Eardley in
16 the days prior to the Invited Review visit, you have
17 described that she told you that a nurse had been
18 suspended and part of the reason for the Invited Review
19 was increased deaths?

20 **A.** Yes, the -- the three things that I do
21 definitely remember was the cluster of unexplained
22 deaths. I knew that the police hadn't been involved and
23 I knew that one of the Terms of Reference was trying to
24 look for clinical explanations for the cluster of
25 deaths.

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1 **Q.** So far as defining the issues and determining
2 the methodology of a review, again the guide suggests
3 that that should be done by either the clinical lead or
4 the lead reviewer?

5 **A.** Yes, that's correct according to the guide.
6 Yes.

7 **Q.** So for all the important preparatory steps for
8 an Invited Review the guidance is clear, isn't it, that
9 there needs to be a clinical person taking those steps;
10 it should not be left to the Invited Review manager
11 alone?

12 **A.** Yes.

13 **Q.** In circumstances where a lead reviewer hasn't
14 been appointed, then it would fall to you to take those
15 steps?

16 **A.** Yes, I think that's correct, yes.

17 **Q.** In terms of the Countess of Chester Hospital
18 review, the Terms of Reference were agreed and were
19 discussed before a lead reviewer was appointed, weren't
20 they; you would have seen that from the chronology?

21 **A.** Yes. So could you just repeat the question,
22 Mr Carr, was it the Terms of Reference were agreed
23 before the --

24 **Q.** Lead reviewer was appointed?

25 **A.** I'm not sure I can answer that because I don't

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1 I -- I think I am right in saying that I knew
2 a nurse had been suspended. But that is from my memory
3 and it would depend I think on when Sue Eardley knew
4 that because obviously if she didn't know, I couldn't
5 have known that, so it's possible that part is -- is
6 faulty recollection.

7 **Q.** Yes, you make the point in your statement,
8 don't you, that you don't have a note of this telephone
9 discussion and you are recalling it as best as you can?

10 **A.** Yes.

11 **Q.** But your best recollection, it's paragraph 49
12 if you want to look at it, paragraph 49 in your
13 statement.

14 **A.** Yes, I have got it, yes.

15 **Q.** Four lines down you describe there your
16 recollection that a few days before the review you
17 received an email from the College that the review was
18 about to take place and then over the page you describe
19 in the rest of the paragraph the discussion you had by
20 telephone?

21 **A.** Yes.

22 **Q.** Five lines down:

23 "A nurse had been suspended by the hospital and the
24 primary purpose of this review was to look at other
25 factors on the neonatal unit which would have led to

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1 an increase in mortality?"

2 **A.** (Nods)

3 **Q.** And another three lines down:

4 "It was not clear that the presence of this nurse
5 had been linked to the increase in mortality."

6 Did Ms Eardley tell you that there was a potential
7 link between the suspended nurse and the increased
8 mortality?

9 **A.** Sorry?

10 **Q.** Did Ms Eardley tell you that there was
11 a potential link between the suspended nurse and the
12 increase in mortality?

13 **A.** No. I think all we knew at that time, if I am
14 remembering this correctly is a nurse had been taken
15 away taken off clinical duties. But we didn't know why
16 she was taken off clinical duties.

17 **Q.** Just specifically about what you recall that
18 you knew. You knew that she had been moved. Did you
19 understand that that was completely unrelated to the
20 increase in deaths or did you understand that there was
21 or there might be a connection?

22 **A.** I -- I think my recollection of this was that
23 the -- or my assumption was that the nurse had been
24 moved because it was linked because a conversation
25 followed that the -- the Trust Management Team were

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1 **A.** Yes, yes.

2 **Q.** During the review we have heard evidence from
3 some of the reviewers and we have got written statements
4 from others, we know that there was a discussion amongst
5 some members of the Review Team as to whether or not the
6 review should be aborted when details emerged on the
7 morning of the first day of the review visit of the
8 suspicions that the doctors had and the reasons for
9 those suspicions.

10 Your advice was not sought. In your view should it
11 have been, given the complexity and unusual nature of
12 the review and the matters that emerged?

13 **A.** I think it should, I think I am probably clear
14 about that having seen the -- you know, the witness
15 statements. In fact, Helen Crisp interviewed the
16 reviewers and it struck me that there was a clear high
17 level anxiety amongst reviewers even down to the, you
18 know, professional qualifications in terms of taking on
19 the review.

20 So I -- I think it my view is yes, they should have
21 escalated it. I think in mitigation, the 2016 guidance
22 was actually put much more emphasis on to the Review
23 Team themselves about decisions. I mean, clearly the
24 new guidance is very different, but I do understand
25 these are an incredibly senior Review Team and they made

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1 looking for potential clinical explanations for the
2 change in mortality.

3 So I don't think Sue ever said explicitly to me
4 that the nurse had been excluded because of, you know,
5 clearly we had no ideas of the concerns at the time and
6 I think I have mentioned it could have been a competence
7 issue or a training issue. But I -- I inferred from
8 that that there was some relationship between the nurse
9 and the -- and the events, yes.

10 **Q.** And the possibility if there was
11 a relationship would be either an issue with her
12 competence, so errors in competence leading to increased
13 deaths, something malevolent, a deliberate harm causing
14 increased deaths or just a statistical anomaly and there
15 being no causative link between increased correlation.

16 **A.** Yes.

17 **Q.** It's right to say, isn't it, that an Invited
18 Review was not designed to carry out investigations into
19 those sorts of links, or to exclude --

20 **A.** Yes, exactly.

21 **Q.** -- those sorts of links?

22 **A.** Yes.

23 **Q.** If there were any concerns about criminality
24 or potential criminality you are clear in your evidence,
25 aren't you, that the answer is to contact the police?

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1 a decision amongst themselves which was the normal as
2 part of a review, we did that all the time but it was
3 just in this particular case I think the level of
4 anxiety probably would have been to -- or should have
5 been to escalate it, yes.

6 **Q.** At paragraph 61 you set out the advice that
7 you would have been given -- sorry, you set out the
8 advice that you would have given if the Review Team had
9 raised concerns with you. You say four lines down:

10 "My response would be to have explained that the
11 allegations were so concerning that the police should be
12 involved given that this had been the request of the
13 paediatric team. In my professional experience it would
14 have been very unusual for any paediatric team to make
15 such a suggestion and so I would have taken it
16 seriously."

17 **A.** (Nods)

18 **Q.** And so if you had been contacted and if you
19 had been told and you have seen the notes of the
20 interviews with the paediatricians, if you had been told
21 that the concerns that they had, then you are clear in
22 your mind the police ought to be contacted?

23 **A.** Yes, I mean I think the guidance at the time
24 was they would have continued with the non-contentious
25 issues of the review. So I think had I been involved

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1 I think the question of should the police be involved at
2 that point and you see from my evidence that I felt they
3 should have been involved at probably -- well, at an
4 earlier stage than the review took place actually. But
5 I think that the escalation process now is very much
6 tighter than it was at the time this review took place.

7 **Q.** Yes, I am asking only about -- only about the
8 policies and approach at the time the review took place.

9 But even on the guidance that was in place at the
10 time, and we have looked at it in the course of the
11 evidence today, it certainly doesn't mandate a Review
12 Team to continue, does it, it provides circumstances in
13 which a review may continue?

14 **A.** Yes, exactly.

15 **Q.** But there will be circumstances where the
16 safety concerns are such or the risk of prejudice to
17 further investigations are such that it shouldn't
18 continue?

19 **A.** Yes, I agree with that actually. Yes. I
20 mean, I think it's a safeguarding issue, isn't it,
21 really, you know, what the -- the Review Team were told.

22 So it should have been really escalated along
23 safeguarding concerns but, I mean, there are some other
24 factors you may ask me in due course. But I think
25 the -- you know, this would have been pursued in
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1 just considered, in light of the allegations that were
2 being raised, in light of the fact that the RCPCH is not
3 a criminal investigatory body and the guidance that was
4 in place at the time, do you consider that there was
5 a risk of prejudicing any future investigation by
6 interviewing her?

7 **A.** Well, I think there definitely was the risk
8 and I think the other issue was there would have been
9 the HR issues I would have thought involved in one of
10 the nurses being suspended from clinical duties, I would
11 have thought that we shouldn't be interviewing somebody
12 in that situation because of the HR processes.

13 So I think for both reasons I think it was probably
14 in retrospect something that we shouldn't have done.

15 **Q.** The final versions of the report -- I say
16 versions, you know that there were two different
17 versions?

18 **A.** Yes.

19 **Q.** There was the full version the confidential
20 copy and the dissemination copy?

21 **A.** Yes.

22 **Q.** They were sent out under a letter in your
23 name, weren't they --

24 **A.** (Nods)

25 **Q.** -- in your role as clinical lead?
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1 a safeguarding approach, you know, if the Review Team
2 had severe concerns that babies were being harmed.

3 **Q.** On a connected but more general point. At
4 paragraph 39 earlier in your statement, when dealing
5 with the question of the policy in place at 2016, you
6 make two points that I am going to read out. On the
7 third line you make the point:

8 "We are not a criminal investigatory body and would
9 not have wished to have interfered in any such
10 allegations."

11 Four further lines down:

12 "If I had been asked about situations where there
13 may be criminality, my advice would have been not to
14 undertake any review where there may be criminal
15 allegations."

16 So there is a clear dividing line for you in terms
17 of when to undertake reviews and when to stop any review
18 that was in progress?

19 **A.** Yes, that's true, yes. Yes.

20 **Q.** As to the decision to interview Letby during
21 the Invited Review, you have addressed this in your
22 statement and the position is you think it was wrong to
23 interview her?

24 **A.** Yes, that's correct.

25 **Q.** Is that for the very same reason that we have
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1 **A.** (Nods)

2 **Q.** You have explained that before it was sent you
3 would have received a copy, a final version of the
4 report and you would have read it?

5 **A.** Mmm.

6 **Q.** We have the comments that you made having read
7 the report. They are contained in the RCPCH chronology.
8 It's reference 0012748 and it's page 4, please. It's
9 the entry in the middle of the page, 28 November.
10 David S -- thank you -- QA of final report.

11 Now before I read it, to be clear, you didn't
12 conduct quality assurance of the report?

13 **A.** No, I didn't. It was Dr Dorling and Dr Wilson
14 that did it, it wasn't me.

15 **Q.** It was Dr Wilson. As for Dr Dorling,
16 Dr Dorling was instructed to make quality assurance, did
17 he in fact undertake quality assurance?

18 **A.** I think I have seen that actually, because
19 there was some suggestion that I QA it, but I didn't --

20 **Q.** Forgive me, carry on?

21 **A.** No, I was going to say I have seen somewhere
22 in the papers that was it was Dr Wilson and Dr Dorling,
23 I may be wrong but my memory is I -- I saw the report
24 but I didn't QA it because I think at the -- it would
25 have been QAd before that date, so I think my email
204

1 wouldn't have been on the same date as I had seen it.

2 **Q.** So you were looking at the final version of
3 the report as it was about to be sent out?

4 **A.** Yes. I can't be clear which version I saw
5 because I think there were two. There was the October
6 and the November version. So I can't be sure whether
7 I saw the redacted or the unredacted one. I am guessing
8 I saw the unredacted one.

9 **Q.** The confidential dissemination versions are
10 both the same date, so they are both sent in October.
11 There are subsequent editions dated November but the
12 versions, as I understand it, sent under copy of your
13 letter were the October versions, a full and a redacted.

14 What you say or what you are noted to say in this
15 chronology is as follows:

16 "Quite an interesting and complex review. Good to
17 have David M [that is a reference to David Milligan]
18 leading that one. Almost felt a bit like the Grantham
19 situation 30 years ago and my only question is why they
20 didn't involve the police if they had those suspicions,
21 otherwise looks like a good report with very clear
22 recommendations."

23 Now, firstly to put this into context. You have
24 explained in your statement that you were a Senior
25 Registrar working in Nottingham in 1988 to 89, weren't
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1 **A.** They are not in the version I have as the
2 November version. But they were in the October version.

3 **Q.** Despite those references having been removed
4 for the final draft, based on what you read, you saw
5 similarities in what was being described in that report
6 to another incident of a nurse killing and harming
7 children?

8 **A.** (Nods)

9 **Q.** You make the point when explaining this
10 comment in your statement, it's paragraph 77, that can
11 come down now, thank you:

12 "In my experience as a paediatrician and
13 neonatologist, it is extremely unusual for newborn
14 infants to die without a clear diagnosis or evidence of
15 a clinical deterioration and I can understand why
16 I would have written that comment in relation to
17 a review of unexplained neonatal deaths."

18 The point that you are making there is it seems --
19 but correct me if I am wrong -- is that the cluster or
20 the cohort of deaths in itself because they were
21 unexpected and unexplained, that would have been
22 a matter for concern?

23 **A.** Yes, yes, that's correct. Yes.

24 **Q.** But there is the additional factor here and it
25 is dealt with to some extent in the final full version
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1 you?

2 **A.** I was, yes.

3 **Q.** You retrieved sick babies from the Grantham
4 unit?

5 **A.** (Nods)

6 **Q.** That is the unit where Beverley Allitt worked?

7 **A.** Yes.

8 **Q.** Now, looking at that comment, Dr Shortland,
9 the first point to make and you said a few moments ago
10 you are not sure if you saw the redacted report or the
11 full report, isn't the fact that you are referring to
12 the Grantham situation here, doesn't that indicate it
13 was probably the full report?

14 **A.** Yes, I think yes, I think --

15 **Q.** With reference to Letby and you must have
16 seen --

17 **A.** Exactly right, yes. My assumption as well.

18 **Q.** It was the version of the report that was
19 about to be sent to the Trust so it was the final
20 version of the report, you hadn't seen the earlier
21 iterations and drafts with track changes?

22 **A.** That's correct, yes.

23 **Q.** So by the time you see the report, references
24 to police involvement, threats to call the police; they
25 are not contained in that final version are they?
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1 of the report, is the allegations against a nurse?

2 **A.** (Nods)

3 **Q.** Now, in light of the concern that you would
4 have had because of the cluster of deaths, and in light
5 of the parallel that you draw with Beverley Allitt, why
6 didn't you ensure that there was a positive
7 recommendation to call the police in the report? Or
8 going to the Trust?

9 **A.** Yes, yes, okay. I mean, the comment that
10 I made actually was it was -- the email was to Sue and
11 it was actually referenced to the conversation that
12 I had had with her two months previously where I had
13 made the comment because the conversation we had had is
14 that they had thought about calling the police but had
15 decided not to wait for the College review and I felt
16 that was really counterintuitive at the time, that if
17 you think about calling the police you probably should
18 call them and that -- that reference was really
19 directing back to the -- to conversations I had with
20 Sue.

21 I think the answer to your broader question is
22 I think when you look at this review it was a really
23 complicated one because you had the doctors, this was my
24 view at the time, based on my recollection. You had the
25 doctors concerned that a nurse was harming babies, you
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1 had the nursing staff really vehemently denying that.
 2 You had a management structure that wasn't probably
 3 fully engaged, you had a governance system that wasn't
 4 fully engaged and you had some issues around the
 5 clinical service which probably was a risk too in terms
 6 of the shared rotas and the lack of, you know, the
 7 concerns around escalation.

8 So I think my thought at the time was I had this
 9 anecdotal thing in my mind from something that happened
 10 30 years ago and actually you had had a review from five
 11 very senior reviewers who had come to a different
 12 conclusion and I think the proviso within that of course
 13 is that as far as I am aware, the paediatricians did
 14 suggest that the police were involved, I don't think
 15 they followed that through though as they perhaps could
 16 have done and they asked for another review.

17 So I think my recollection of seeing this review
 18 was that there was still potential explanations for why
 19 the mortality was higher.

20 But it clearly is -- and, you know, perhaps on
 21 reflection there's different ways of looking at this.
 22 But I think it was just a review that -- I had had no
 23 involvement after the conversation with Sue, so it
 24 just --

25 **Q.** Dr Shortland, can I just stop you there. You
 209

1 entry in the chronology dated 28 November, had you had
 2 a discussion with Sue Eardley or anybody else on the
 3 Review Team relating to the police being contacted about
 4 matters at the Countess of Chester Hospital?

5 **A.** No. What I knew was the police hadn't been
 6 contacted.

7 **Q.** You raise your only question was why they
 8 didn't involve the police, did you receive an answer to
 9 that question?

10 **A.** Sorry, when you say I raised the question, do
 11 you mean in that email?

12 **Q.** Yes, forgive me, it has been taken down but we
 13 can put it back up, it is INQ0012748.

14 Forgive me, page 4.

15 **A.** Yes. Yes, I think my interpretation of my
 16 email would be that it was a complicated review; that
 17 for the reasons I have explained I think it was a very
 18 complex review to actually, you know, read and I think
 19 I just came back to the comment I had said to Sue at the
 20 initial conversation before the review took place was:
 21 basically, if you think about involving the police, you
 22 probably need to do it and I think that's what the
 23 referral is back to.

24 So it wasn't having read the review itself
 25 I thought the police should be involved because I think
 211

1 might be moving slightly away from my question.

2 The first point of clarification, when explaining
 3 this email that you refer to a conversation that you had
 4 had with Ms Eardley, if I heard you correctly about
 5 police involvement, do I understand that? Was there
 6 a previous conversation?

7 **A.** There was a first conversation I had with Sue
 8 a few days before the review.

9 **Q.** Before the review visit?

10 **A.** Yes, it was when I received the email from Sue
 11 it was I think the Saturday, the review was on
 12 a Thursday, wasn't it? So about five days before the
 13 review I had an email from Sue.

14 **Q.** Was there a discussion as to police
 15 involvement at that stage?

16 **A.** I had a telephone -- I telephoned Sue which
 17 would be unusual for me at the weekend and my
 18 recollection of that was the things that I definitely
 19 knew was there was a cluster of unexplained deaths, the
 20 police weren't involved and the main purpose of the
 21 review, or one of the purposes of the review was to look
 22 at, you know, I suppose what you might call clinical
 23 explanations for the high -- the apparent increase in
 24 mortality.

25 **Q.** Dr Shortland, just to be clear, prior to this
 210

1 the review, a lot of it is generic and there was so many
 2 complicated factors that I don't think the review made
 3 me make that comment. It was the fact that I had made
 4 the comment relating to a conversation I had had
 5 two months previously.

6 **Q.** Dr Shortland, thank you, but I'm not sure if
 7 there was an answer to my question in that.

8 You say my only question was why they didn't
 9 involve the police if they had those suspicions. So it
 10 appears you are raising as a query why haven't the
 11 police been contacted?

12 **A.** Yes, yes.

13 **Q.** My question is: did you receive an answer to
 14 that?

15 **A.** No, no --

16 **Q.** Were you told --

17 **A.** Sorry, I misunderstood the question.

18 As far as I know that email wasn't circulated and
 19 as -- I don't remember receiving a -- I think if I had
 20 probably the College would have, I am assuming, found
 21 the email.

22 **Q.** Nobody replied? Nobody replied?

23 **A.** No, as far as I know, no.

24 **Q.** The question went unanswered.

25 **A.** Exactly, yes.
 212

1 **Q.** The report was sent out without making that
2 recommendation.

3 **A.** (Nods)

4 **MR CARR:** My Lady, thank you. I have nothing
5 further for this witness.

6 **LADY JUSTICE THIRLWALL:** Thank you. Mr Sharghy?
7 Questions by MR SHARGHY

8 **MR SHARGHY:** I know you have been sitting,
9 Dr Shortland, in the hearing room so I will skip the
10 introductions because you have already heard it and
11 I just want to ask you questions in relation to two
12 specific areas.

13 The first is looking at your experience, and you
14 spent I think 10, 12 years as clinical lead on
15 a neonatal unit and at the time of this review you were
16 working as a Consultant paediatrician at Poole Hospital,
17 it is quite rare, isn't it, in a neonatal setting to
18 actually catch someone who's causing a form of harm --

19 **A.** (Nods)

20 **Q.** -- in the act?

21 **A.** Oh, yes, yes. Definitely.

22 **Q.** So the only thing that as clinicians one is
23 left with is trying to piece together information and
24 evidence in order to create a picture; is that fair?

25 **A.** Mmm (Nods)

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1 information and the evidence that had been gathered?

2 **A.** Yes, I am yes.

3 **Q.** Is that not precisely what these Consultants
4 had done?

5 **A.** Yes. Yes, I mean -- I think -- yes, the
6 problem I think is that if someone's harming babies
7 I think it's highly likely that the medical staff that
8 detect that because they will see idiosyncrasies within
9 what's happening and I don't mean that disrespectfully
10 to any other health professional, but doctors tend to
11 approach things diagnostically. So I think if your
12 consultants are of the view that someone is harming
13 babies -- and I don't say that lightly -- but I think
14 what I mean is that they have looked at other
15 possibilities which I think your question's leading.
16 I think, you know, maybe this is an anecdotal comment,
17 but it is very rare as I mentioned in my witness report,
18 for babies to die or children to die without
19 an explanation. I mean, it is quite unusual. You know,
20 they might become ill and they might deteriorate but the
21 doctors usually know. So I think if your clinicians
22 cannot find an alternative explanation, it's probably at
23 that point that you have to take those comments very
24 seriously.

25 **Q.** They are suspicions of crimes, aren't they,

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1 **Q.** And one of the ways in which one does that
2 from a clinician's point of view is you look at common
3 factors between them to see if there's a cluster cohort
4 or theme --

5 **A.** (Nods)

6 **Q.** -- you look at idiosyncratic issues between
7 babies, you exclude environmental factors, is that all
8 right so far?

9 **A.** (Nods)

10 **Q.** And once you have done that and perhaps you
11 can tell me any more, you start to see a trend, don't
12 you?

13 **A.** Mmm.

14 **Q.** You start to see some element of commonality
15 to explain the unexplainable and the unexpected events;
16 is that fair?

17 **A.** Yes, it is fair, yes.

18 **Q.** Given what you reviewed before you actually
19 attended the hospital on 1 September and what you
20 learned over the period of the 1 and 2 September, isn't
21 that precisely what these Consultants, in particular
22 Dr Brearey as the clinical lead, had done?

23 **A.** Yes. Just to be clear I didn't -- I didn't do
24 the review.

25 **Q.** I am so sorry. But you are aware of the

214

1 they are not simply medical factors that need further
2 exploration?

3 **A.** Yes. I mean, I think, you know, these babies
4 are monitored massively, extensively when they are in
5 a neonatal unit. I mean, they are going to be covered
6 in monitors and I think to have very sudden collapses is
7 very unusual not to be able to resuscitate a baby if
8 they have collapsed and if they have deteriorated
9 massively, clinically that is usually evident why they
10 have done it. So I think this pattern is actually
11 unusual, yes.

12 **Q.** So undertaking a service review of the type
13 that we know was undertaken would never have actually
14 got to answer the concerns of the Consultants would it?

15 **A.** No, no I think -- I think that's right.

16 I think if your Consultants as a group have considered
17 harm and, you know, your Consultants are respected by
18 the, you know, the hospital and their opinions are taken
19 seriously, it's almost difficult in my opinion to know
20 how you can approach that other than with a forensic
21 inquiry. Because I don't think a clinical -- I mean,
22 the Terms of Reference of this review, as you
23 appreciate, as I have mentioned to Mr Carr, was very
24 much about is there a clinical explanation for this and
25 in itself that is a sensible question.

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1 But the other question may be more important.
 2 **Q.** Final question: you have carried out a large
 3 number of these reviews?
 4 **A.** Yes.
 5 **Q.** The Inquiry has heard from the other members
 6 and will hear from one more later this afternoon.
 7 What would it take to stop a review either shortly
 8 before it starts or once it's started. How significant
 9 does the concern have to be to stop a Invited Service
 10 Review?
 11 **A.** I mean, the current guidance would put that
 12 threshold very low actually, because the --
 13 **Q.** Back in 2016?
 14 **A.** Yes, the guidance in 2016 was -- I mean,
 15 I have to be honest, I was involved in writing these
 16 documents. I don't think we ever considered this
 17 scenario. But, you know, the level I think at that
 18 point, the advice was: you carry on with the
 19 non-contentious issues but I think with something like,
 20 you know, had the Review Team considered that a criminal
 21 act was highly likely, I think the review would have
 22 stopped.
 23 **Q.** So the judgement call is very much dependent
 24 on the quality and the experience of a Review Team as
 25 a whole in order to make that call to stop it back in
 217

1 sufficient in your view to have stopped?
 2 **A.** I mean definitely on their judgement. I mean
 3 arguably if you escalate the review, you sort of take
 4 that decision more as a College-wide decision, I guess,
 5 really. So I think it was perfectly -- you know
 6 perfectly reasonable for a Review Team to decide to stop
 7 a review. I don't think there is any question about
 8 that.
 9 **MR SHARGHY:** Thank you. My Lady, thank you very
 10 much. Those are my questions.
 11 **LADY JUSTICE THIRLWALL:** Thank you very much
 12 Mr Sharghy. Ms Scolding.
 13 Questions by MS SCOLDING
 14 **MS SCOLDING:** My Lady, I just have two
 15 clarificatory questions arising.
 16 Good afternoon, Dr Shortland. I am Fiona Scolding,
 17 I represent the Royal College of Paediatrics and Child
 18 Health.
 19 I just have two clarificatory questions arising
 20 from the questions that have just been posed by you by
 21 Mr Sharghy.
 22 Firstly, did you see any notes of interview or any
 23 of the background information in respect of the review
 24 when you were looking at the report in November 2016?
 25 **A.** Sorry, do you mean did I see anything as well
 219

1 2016?
 2 **A.** I think it is. I mean, when you do reviews,
 3 you probably talk to a hundred people with a hundred
 4 different views and sometimes something crystallises at
 5 that review and it might be a person or group of people
 6 that review and that changes your perspective and
 7 I think it's that that happens in a review. Because
 8 College reviews are not fact-finding reviews, they are
 9 assimilation of information that you are being given, so
 10 you are assimilating -- you are not really genuinely
 11 looking at original facts, you are hearing what people
 12 say and there is a great strength in that. But there
 13 would have to be something about I think if a Review
 14 Team from the masses of information they are receiving
 15 suddenly taking a piece of information so seriously that
 16 they actually felt that that was the crystallisation of
 17 the review. In which case, you know, the action in my
 18 opinion in this situation would have been to stop the
 19 review, yes.
 20 **Q.** Would one of the reasons back in 2016 to have
 21 stopped a review have been if the team or indeed
 22 individuals within that team realised this was too
 23 complex?
 24 **A.** Yes.
 25 **Q.** Outwith their experience, would that have been
 218
 1 as the review?
 2 **Q.** Yes.
 3 **A.** No, no, I just saw the review, yes, yes.
 4 **Q.** Okay. So you would not have seen the
 5 conversation that took place between Dr Brearey and
 6 Jayaram?
 7 **A.** No.
 8 **Q.** The reviewers on the morning of the
 9 1 September?
 10 **A.** No, no definitely not, yes.
 11 **MS SCOLDING:** Those are the only questions I have,
 12 my Lady.
 13 Questions by LADY JUSTICE THIRLWALL
 14 **LADY JUSTICE THIRLWALL:** Thank you very much,
 15 Ms Scolding.
 16 Dr Shortland, is it a fair summary heading of your
 17 evidence that this review could never deal with the
 18 issues that the doctors had raised?
 19 **A.** Yes, I think that's --
 20 **LADY JUSTICE THIRLWALL:** This was a service review?
 21 **A.** Yes.
 22 **LADY JUSTICE THIRLWALL:** It wasn't a fact-finding
 23 review.
 24 **A.** (Nods)
 25 **LADY JUSTICE THIRLWALL:** And it didn't produce any
 220

1 answers to the questions raised by the doctors?

2 **A.** Yes. I think that's a fair -- you know,
3 I agree.

4 **LADY JUSTICE THIRLWALL:** Yes. Then I was just
5 looking at the summary right at the end of the report
6 before the recommendations at page 25, INQ0009618,
7 page 25.

8 We have looked at this before with other witnesses,
9 I think Ms Eardley. But there are a number of
10 recommendations included which are summarised there.

11 So the first is staffing levels --

12 **A.** Yes.

13 **LADY JUSTICE THIRLWALL:** -- being inadequate, which
14 was a common problem, frankly, wasn't it? That's not
15 an explanation and, secondly, escalation of concerns to
16 tertiary units but again that wasn't an answer to the
17 problems and then there are two recommendations about
18 postmortems, but again they wouldn't -- they wouldn't
19 address the questions that had been raised in respect of
20 what was causing the deaths of these babies?

21 **A.** Yes, yes, that does -- that's correct, yes.

22 **LADY JUSTICE THIRLWALL:** Yes. Thank you very much
23 indeed, Dr Shortland. Does anybody else want to ask
24 anything else?

25 No. Thank you for coming. We are very grateful.

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1 with, which is when you undertook quality assurance of
2 the service review report of the Countess of Chester
3 Hospital, were you familiar with the statutory guidance
4 contained in Working Together to Safeguard Children in
5 2015?

6 **A.** I was.

7 **Q.** Did you understand when a referral to the
8 Local Authority Designated Officer was required?

9 **A.** I was.

10 **Q.** Turning to the Invited Review. Your role was
11 to undertake quality assurance of the report?

12 **A.** Yes.

13 **Q.** The guidance in place at the time required
14 quality assurance to be undertaken by two people, didn't
15 it?

16 **A.** Yes.

17 **Q.** Another doctor, a Dr Dorling was instructed to
18 undertake quality assurance. Do you know if he did
19 undertake that?

20 **A.** I don't, no.

21 **Q.** Is the quality assurance process independent
22 so there is no working between two quality assurers?

23 **A.** That's true. We don't contact each other.

24 **Q.** So far as your experience at the time, in your
25 witness statement, it's your paragraph 12, you state

223

1 It is Dr Wilson next, isn't it?

2 **MR CARR:** My Lady, may I call our final witness for
3 today, Dr Nicholas Wilson.

4 **DR NICHOLAS WILSON (sworn)**

5 **Questions by MR CARR**

6 **LADY JUSTICE THIRLWALL:** Thank you. Do sit down,
7 Dr Wilson.

8 **A.** Yes.

9 **LADY JUSTICE THIRLWALL:** Mr Carr.

10 **MR CARR:** Tell us your full name, please.

11 **A.** Nicholas Robert Wilson.

12 **Q.** You have prepared a statement, haven't you,
13 dated 29 May 2024 for this Inquiry?

14 **A.** Yes.

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

17 **A.** They are.

18 **Q.** You are a Consultant paediatrician and
19 neonatologist and have held that position since 1998,
20 haven't you?

21 **A.** This is true.

22 **Q.** And you have also been named doctor for
23 safeguarding children since 2003?

24 **A.** Yes.

25 **Q.** Did you, at the time that we are concerned

222

1 that the Countess of Chester Hospital review was one of
2 the earliest roles of this kind that you undertook?

3 **A.** This is true.

4 **Q.** And further in your statement, paragraph 14,
5 you state you had perhaps been involved in one review as
6 quality assurance reviewer prior to the Countess of
7 Chester?

8 **A.** This is true.

9 **Q.** So the Countess of Chester review was either
10 your first or second as quality assurance reviewer. Had
11 you done other reviews before that as part of a Review
12 Team?

13 **A.** Yes, I had been a reviewer and visited other
14 hospitals before that.

15 **Q.** As for preparation and training for the role
16 of quality assurance, you state in paragraph 17 of your
17 statement, the final sentence, that you do not believe
18 you received any specific training with regards to
19 carrying out a quality assurance review?

20 **A.** That is correct.

21 **Q.** You have described in your statement the
22 process for raising and escalating concerns as part of
23 the Invited Review process?

24 **A.** Yes.

25 **Q.** And there's categorisations of concern up

224

1 to immediate risk and you deal with that in your witness
2 statement.

3 It's right to say, isn't it, that what you are
4 describing there is an escalation process which
5 postdates the Countess of Chester review?

6 **A.** I'm sorry, I don't fully understand the --

7 **Q.** Forgive me. If you look at your statement.

8 **A.** Yes.

9 **Q.** Paragraph 18, final sentence. When dealing
10 with --

11 **A.** Yes.

12 **Q.** -- escalation process, you say:

13 "We would grade our response as a concern ..."

14 **A.** Yes.

15 **Q.** "... a serious concern or as evidence of
16 an immediate risk."

17 **A.** That's right, yes.

18 **Q.** And what you are referring to, we can look at
19 it, INQ0012813, I will get the section up in the
20 guidance --

21 **A.** Yes.

22 **Q.** -- but the point is it comes from the 2023
23 guidance?

24 **A.** Yes.

25 **Q.** And that categorisation didn't exist in 2016?
225

1 page 6, please. If you look at paragraph 4.3, there is
2 a summary of the different individuals involved in the
3 review process and do you see the final subparagraph of
4 4.3 states:

5 "There is a clear quality assurance process to
6 challenge the report, content and conclusions."

7 Were you familiar with that provision?

8 **A.** Yes, I have seen that.

9 **Q.** And what did you understand by "to challenge
10 the report, content and conclusions."

11 **A.** Well, again, if conclusions had been arrived
12 at which I did not think were fitting with the statutory
13 guidance we have from our professional organisations
14 like the -- like BAPM, then I would suggest that it
15 wasn't appropriate for the College to be making those
16 recommendations.

17 **Q.** And then looking at the letter of instruction
18 to you, it's INQ0009631. This is the letter from
19 Sue Eardley to you of 7 October 2016, and you will see
20 at the bottom of the letter under the heading "Your
21 role" a description of a quality assurance reviewer.

22 **A.** (Nods)

23 **Q.** The second sentence:

24 "You are not expected to have visited the site or
25 conducted interviews and the role is as an objective
227

1 **A.** Yes, that's different, no, that's right.

2 **Q.** Forgive me. We can take that down.

3 So far as the role of quality assurance

4 particularly where there are no -- there's no training
5 for the role, what was your understanding of what was
6 required of a quality assurer?

7 **A.** So in a conversation, I was told that the main
8 role was to read the report and make sure it was easy to
9 understand, that there were not too many technical terms
10 which might be confusing for a wider audience, because
11 it's being looked at by managers as well as clinicians,
12 to make sure that it met the requirements of the Terms
13 of Reference.

14 I think that was it: readability and making sure --
15 and also if there were recommendations within the report
16 that they were justified on the evidence presented
17 within the report. So if conclusions were arrived at
18 that there was evidence supporting that conclusion.

19 **Q.** Okay. So readable, coherent and
20 substantiated?

21 **A.** Yes, yes.

22 **Q.** Two references. First INQ0010214. I am going
23 to take you to the guidance from August 2016 on Invited
24 Reviews, so this is the guidance that would have been in
25 place at the time of your quality assurance. It's
226

1 external critical friend both to the reviewers and to
2 the RCPCH Review Team."

3 Now, that term or phrase "critical friend", what
4 did you understand by that?

5 **A.** Well, whilst one is looking at work made by
6 a -- by a colleague who is -- we may or may not know
7 each other, but we are all colleagues within the same
8 field, we, we have respect for each other. So we would
9 not want to be I think excessively critical. We would
10 understand how our comments might affect our colleagues.

11 Notwithstanding that, if we thought something in
12 the report was, you know, factually inaccurate or
13 clearly wrong then we would still bring that up.

14 So I think as a -- it would be a critical friend,
15 a critical colleague I guess is how I interpreted that.

16 **Q.** And both to the reviewers and to the RCPCH
17 Review Team. What's the difference or the distinction
18 that's being drawn there?

19 **A.** Yes, I think the -- the problem as a quality
20 assurance person is that I wasn't sure where my -- what
21 route my comments were actually taking. So I would make
22 my comments, I wasn't sure who was seeing those
23 comments. So it is here saying it's going to the
24 College and to the team. I wasn't actually aware how
25 that was taking place, whether my comments would go
228

1 directly to the leader of the team or to somebody within
2 the College itself. So that wasn't clear to me.
3 **Q.** I see. So when there is a reference to being
4 a critical friend both to the reviewers and to the RCPCH
5 Review Team, is the distinction there that the reviewers
6 are the people conducting the review?
7 **A.** Yes.
8 **Q.** So the Review Team for an individual review
9 and the RCPCH Review Team are the people at the RCPCH --
10 **A.** Yes.
11 **Q.** -- who oversee the service.
12 So far as your quality assurance, there are three
13 sources, aren't there? There is a quality assurance
14 form that you completed, there is a version/iteration of
15 the draft report, which you added some comments to, and
16 then there is an email containing some additional
17 commentary?
18 **A.** Yes.
19 **Q.** We will consider each of those. Please can we
20 deal first with the comments added to the draft report,
21 the reference INQ0010145 and the page we want is
22 page 18.
23 If we can zoom in on the text at the bottom, which
24 is in orange and, Dr Wilson, this is the commentary that
25 you added to the report --

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1 deaths must be referred to the Child Death Overview
2 Panel.
3 **A.** Yes.
4 **Q.** And you query the role of the CCG and you
5 think five times a year is too infrequent for lessons to
6 be learnt and you are describing there five times
7 a year. What's that a reference to?
8 **A.** Yes.
9 **Q.** What is it a reference to?
10 **A.** Oh, I think the -- I think the panel was
11 meeting five times a year, that's ... I'm used to it
12 happening maybe monthly in my experience, but ...
13 **Q.** And over the page, page 19, yes, the top of
14 the page, in orange your final comment there:
15 "The ODN could have an annual death meeting (if not
16 already)."
17 **A.** Yes.
18 **Q.** So those are observations that you made so far
19 as the systems in place particularly as they related to
20 deaths --
21 **A.** Yes.
22 **Q.** -- at the hospital.
23 Can I ask you within the same document, if we go
24 back to page 7, please. There are a number of changes
25 or added text to the document in orange. It looks like

231

1 **A.** Yes, I believe so.
2 **Q.** -- that you reviewed?
3 You make a number of points in that first
4 paragraph:
5 "All deaths should be raised as a Serious
6 Incident."
7 You make reference to investigations internally or
8 externally and the decision to step down. Can you
9 explain why you added this, why you identified this as
10 a point that needed to be put into the report?
11 **A.** From my interpretation, when I read the report
12 I did not think that certainly early on the Trust was --
13 was doing this. I think the Trust was -- if they felt
14 that a death was not -- was explicable and they did not
15 think that there been any failure of their service they
16 were not raising it as a possible Serious Incident.
17 And the organisation I work within, the -- I think
18 it's the management team really want quality assurance,
19 want assurance about our practice. So they would expect
20 us always to bring each death to a specific risk
21 assessment meeting so we could go over the death and
22 discuss it with colleagues, with management colleagues,
23 with other professionals, so there was more openness and
24 people could challenge our -- our practice.
25 **Q.** And you go on to observe that unexpected

230

1 a similar colour to the colour that you use and so my
2 query: is are these your additions?
3 **A.** I think -- I commented that I thought most of
4 the references towards child death I had added to the
5 report. I'm not sure if these were my comments.
6 **Q.** But at the bottom of the --
7 **A.** Yes.
8 **Q.** -- page, we see a reference:
9 "Circumstances in the unit were not materially
10 different..."
11 And then it goes over the page to the next page to
12 say:
13 "... from those which might be found in many other
14 neonatal units within the UK."
15 Now, is that a observation that you made and do you
16 think you added this to the --
17 **A.** Yes, I remember that reference. That was
18 the -- the unit prior to its change in designation was
19 a unit which was looking after an excessive number of
20 very small, sick babies with staffing levels not at
21 a safe point. That was what my reference was. I was
22 making that reference, yes.
23 **Q.** And the point that you were making is those
24 lower staffing levels were not atypical --
25 **A.** That's right.

232

1 Q. -- it was something that was -- would be
2 a feature of similar units?
3 A. Certainly at that point, of the development of
4 the neonatal networks, yes.

5 Q. So those were the comments on the report. But
6 it would appear, and again we go to the RCPCH
7 chronology, that there were some additional comments
8 made. It's INQ0012748, sorry, page 3.

9 The entry, the penultimate entry dated 15 October.

10 A. Yes.

11 Q. And what you write is:

12 "I hope my contribution was useful. I felt only
13 that you might tone down your justifiable high dudgeon
14 about how badly the Trust had dealt with the exclusion
15 and the supine behaviour of the Union rep. Your
16 conclusions were entirely sound. Their governance is
17 flawed. Green for Danger, before your time of course,
18 in neonatal medicine death is one of the few clearly
19 definable outcome measures and should be closely
20 monitored not just by the doctors. As has been well
21 said if you want to drain the pond don't ask the frogs."

22 Now, I want to ask you about different elements of
23 that commentary. Firstly, the reference to toning down
24 justifiable high dudgeon and how badly the Trust had
25 dealt with the exclusion; is this a reference to the

233

1 refers to those green sections --

2 A. Yes.

3 Q. -- so to the Letby sections?

4 A. Yes.

5 Q. Supine behaviour of the Union rep. What do
6 you mean by that?

7 A. I think there was a criticism of the way that
8 this had been dealt with by -- the individual's
9 Union representative had not been supportive,
10 sufficiently supportive, I think or -- or something
11 about that Union rep had been inappropriate in terms of
12 dealing with the process.

13 Q. And justifiable high dudgeon?

14 A. I got the impression that the Review Team --
15 well, there was some emotion coming across that they
16 were unhappy about the situation they found themselves
17 in and I think in a College report we wouldn't want that
18 emotion to be expressed in that way. It wasn't
19 appropriate for these emotive terms to be used in the
20 report.

21 Q. In light of what was contained in the green
22 text, what consideration did you give, particularly in
23 light of your safeguarding roles, to the safeguarding
24 implications of the allegations?

25 A. I wasn't clear that there were allegations

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1 allegations relating to Letby in the reports, the green
2 text in the version of the report you reviewed?

3 A. The report had sections which were redacted
4 and I think it's a reference to parts of those redacted
5 texts where there was a comment from the Review Team and
6 I knew that and it was difficult to understand those
7 sections, not having visited the unit.

8 But, yes, it was referring to that and the Review
9 Team were unhappy about the way the HR process had been
10 followed within the Trust and I thought and I --

11 Q. To be clear, when you say the report had
12 redactions, you saw a version that wasn't redacted?

13 A. Although they were -- those sections were
14 highlighted differently.

15 Q. Yes.

16 A. And it was pointed out to me, when I took on
17 the report, that those sections would not be necessarily
18 clear to understand not having visited the Trust.

19 Q. Was it your understanding that those comments
20 were going to be removed altogether from the report or
21 did you appreciate there were going to be two different
22 versions of the report?

23 A. My impression was there were going to be two
24 different versions of the report.

25 Q. Yes. So back to my question. This comment

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1 that any individual had wilfully done anything harmful.
2 I thought it was more issues of competence rather than
3 any high level of concern.

4 There's nothing explicit in the report which made
5 me think that that was what they were referring to.

6 Q. Within the version of the report that you
7 considered in the green text, it states, doesn't it,
8 that this was removed from the final version but -- or
9 it was amended in the final version:

10 "The Consultants apparently threatened to call the
11 police unless the nurse was removed from the unit."

12 A. Mmm.

13 Q. So that would convey a seriousness of their
14 concern and that their concern was of criminal
15 behaviour?

16 A. Yes, this would.

17 Q. And so I return to my question about what
18 consideration you gave to the safeguarding implications?

19 A. Yes. I think as the reviewer, I was looking
20 at other people who had been there and if that hadn't
21 been their conclusion, I didn't feel I was going to
22 contradict their opinion. They did know more about the
23 situation than I did. So if they had not raised their
24 concerns, I must admit I did not feel I would do that
25 myself.

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1 Q. Thinking about the letter that you received
2 from Sue Eardley defining the role, the suggestion of
3 being a critical friend, if you were being a critical
4 friend then this is the sort of topic that you could be
5 critical on?

6 A. Yes.

7 Q. You could depart from those who were visiting?

8 A. I think it was also partly because I wasn't
9 clear how my comment -- what direction my comments would
10 take, this is quite true.

11 I think it did -- we did all have opportunities to
12 say in a way whatever we felt was important to say. So
13 we could have said anything if we felt that was
14 necessary.

15 Q. Do you consider that as part of the quality
16 assurance, and you only looked at the report as
17 I understand it, you didn't look at all the notes, but
18 from you had seen should -- in the same way you flagged
19 issues about the Child Death Overview Panel and Serious
20 Incident investigations, shouldn't you have flagged the
21 need to ensure that the hospital was complying with its
22 safeguard obligations when serious allegations of
23 deliberate harm against children were made?

24 A. Yes. I was aware of that process, certainly
25 as a named doctor for safeguarding and it would have

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1 deaths. And on reading, on reading the draft report,
2 did it create a parallel in your mind with this film?

3 A. So reading the redacted sections it -- I got
4 the impression that something unusual, unexplained,
5 inexplicable was going on in this hospital; this is
6 true. And the film is more about it's not clear whether
7 anything has -- whether there's a crime been committed
8 or not but it's -- no -- it's a situation, yes, where
9 a member of staff is suspicious, is suspected of having
10 harmed a patient.

11 So, yes, I thought that from the redacted text that
12 was -- that was, to some extent that conclusion was
13 mentioned within the -- within those sections, yes.

14 That was a worry.

15 Q. And in light of safeguarding practice and
16 safeguarding principles in place at the time, the fact
17 that there is a low bar to -- there's a low bar before
18 there needs to be escalation and referral where there
19 are those suspicions, there needs to be onward
20 escalation?

21 A. Yes, if that suspicion exists then escalation
22 should take place.

23 Q. And then the final point about neonatal
24 medicine and "... death being one of our few clearly
25 definable outcome measures" and the reference to

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1 been appropriate for me to bring that to their attention
2 at the time -- at that time.

3 Q. "Your conclusions were entirely sound. Their
4 governance is flawed."

5 The reference to their governance being flawed,
6 does that arise from the text that you added to the
7 draft report?

8 A. Around the death process and investigating
9 deaths.

10 Q. Are there any other additional points in
11 respect of which you considered their governance flawed?

12 A. That was what I was most concerned about, yes.

13 Q. "Green for Danger, before your time."

14 You explain in your statement Green for Danger is
15 a film where a patient is killed by a doctor using
16 surreptitious means swapping an oxygen cylinder for
17 something --

18 A. Yes.

19 Q. -- presumably noxious.

20 We are just going to get it back up it is page,
21 yes. Now, you explain in your statement that the reason
22 that you refer to this film is because of what was
23 contained in that green text and the suggestion that --

24 A. Yes.

25 Q. -- a member of staff was responsible for the

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1 draining the pond, what you explain in your statement is
2 that you were referring here to the fact that sometimes
3 local neonatal units can be resistant to reconfiguration
4 because they are protective of their own interests?

5 A. Yes.

6 Q. But the situation here wasn't that the doctors
7 were resisting reconfiguration. In fact, the
8 reconfiguration had occurred because of the increase in
9 deaths?

10 A. Yes.

11 Q. So what was the relevance of the draining the
12 pond?

13 A. Having thought about that, I think it's also
14 a general point about people sometimes very close to
15 a problem not necessarily being the best people to
16 understand the problem, well, the -- what is actually
17 going on in, in that problem.

18 So it's true sometimes neonatal doctors want to
19 protect their patches, but also people close to
20 a problem aren't the ones who are able to see what
21 what's going on most clearly. That could be the
22 doctors, that could be other people within the unit.

23 Q. Finally this, Dr Wilson, it's a form that you
24 filled out for the purposes of quality assurance. It is
25 INQ0009628. There's a series of questions that you have

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1 responded to?
 2 **A.** Yes.
 3 **Q.** And the two that I want to take you to are 2
 4 and 8 -- sorry, 4 and 8. Number 4:
 5 "Are the elements of the Terms of Reference clearly
 6 addressed?"
 7 You have answered yes. One of the Terms of
 8 Reference, term of reference 4, asked whether or not
 9 there were identifiable factors or failings which were
 10 common and causative of the death and the report doesn't
 11 address that one way or the other, does it?
 12 **A.** It doesn't directly, but it makes the
 13 recommendation that a further investigation should take
 14 place, which is why I felt that was a reasonable
 15 conclusion to come to.
 16 **Q.** A connected question. Second page, number 8:
 17 "Are the recommendations achievable and realistic?"
 18 What did you understand the main recommendations to
 19 be of the report?
 20 **A.** Yes. That was -- my concern was around the
 21 increased activity on the unit and inadequate staffing.
 22 So the recommendations were about, you know, the
 23 redesignation of the unit, which had already taken place
 24 as you say, and also improving the management structure,
 25 making the clinicians have closer connection with their
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1 I had made that reference because I was concerned and
 2 I didn't take it further and that, it may well have been
 3 some --
 4 Well, it was something I should have taken further,
 5 yes.
 6 **MR SHARGHY:** Thank you very much. My Lady, thank
 7 you.
 8 **LADY JUSTICE THIRLWALL:** Thank you, Mr Sharghy.
 9 Ms Scolding.
 10 **MS SCOLDING:** I have no further questions, my Lady.
 11 **LADY JUSTICE THIRLWALL:** Thank you very much.
 12 You have nothing else? Thank you very much.
 13 Thank you, doctor, you are free to go.
 14 **A.** Thank you very much.
 15 **LADY JUSTICE THIRLWALL:** Now, we've got two
 16 witnesses tomorrow, I think, Dr Hawdon and
 17 Dr McPartland?
 18 **MR CARR:** Yes, my Lady.
 19 **LADY JUSTICE THIRLWALL:** Yes, and we will start at
 20 10 o'clock. Thank you, all.
 21 **(5.12 pm)**
 22 (The Inquiry adjourned until 10.00 am
 23 on Tuesday, 12 November 2024)
 24
 25

1 senior managers. I think it was around those areas.
 2 **Q.** On your review and your reading of the report,
 3 did you consider that it made any recommendation to
 4 commence a safeguarding process?
 5 **A.** No.
 6 **MR CARR:** Thank you, my Lady. I have no further
 7 questions.
 8 Questions by MR SHARGHY
 9 **MR SHARGHY:** Just two questions, my Lady.
 10 Dr Wilson, I think you have also been sitting in
 11 the room as well, so you will know I will ask questions
 12 on behalf of seven Families who Lucy Letby harmed the
 13 babies of.
 14 Green for Danger. I have just done a very quick
 15 Google search; a 1946 movie. The police were called in
 16 that movie, weren't they --
 17 **A.** They were.
 18 **Q.** -- to investigate?
 19 **A.** Yes.
 20 **Q.** And in relation to making the reference in
 21 your comments as you did, do you think you could and
 22 perhaps should have been more explicit about the police
 23 potentially being called?
 24 **A.** Now it seems, yes. Something about when
 25 I read the report I was concerned, yes. So clearly
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