Thursday, 21 November 2024

(10.00 am)

LADY JUSTICE THIRLWALL: Good morning.

Mr De La Poer.

MR DE LA POER: My Lady, our first witness today is Ms Lyn Simpson and I wonder if she might come forward, please.

MRS LYN SIMPSON (sworn)

Questions by MR DE LA POER

LADY JUSTICE THIRLWALL: Do sit down.

A. Thank you.

MR DE LA POER: Please could you state your full name?

A. Mrs Lyn Simpson.

Q. Mrs Simpson, is it right that you provided to the Inquiry a witness statement dated 11 June of this year?

A. That's correct.

Q. Now, in a moment I am going to ask you to confirm the content of that statement to be true but before we get to that, can I just flag two corrections that you have drawn to my attention.

The first is at paragraph 9, where you state that you are a member of the Royal College of Nursing; in fact that isn't the correct position, is that right?

A. That's correct.

Q. So that's a correction that needs to be made to the statement.

The second is that at paragraph 32, you give a date which included 2016, that is a typo, it should be 2018; is that right?

A. That's correct.

Q. Other than those two corrections, is the content of that witness statement true to the best of your knowledge and belief?

A. It is.

Q. We will just introduce you before we come to the substantial part of my questioning. Did you qualify as a nurse in 1978?

A. I did.

Q. Did you thereafter work as a hospital nurse?

A. I did for a short period of time.

Q. Then I believe you trained as a midwife?

A. I did.

Q. Indeed you worked as a health visitor as well?

A. I am.

Q. I think that I am right in saying that you started in a hospital management position around 1987; is that right?

A. That's correct, yes.

Q. Moving forward in time, by 1998, did you become an Executive Director of a Hospital Trust?

A. I did.

Q. Then to a period of about six years in that role; is that right?

A. I -- that is correct, yes, yes.

Q. Then if we move forward in time, between October 2007 and February 2010, did you have two roles, Department of Health Director of NHS Operations and Director of Operations Regional Nurse at the Northeast Strategic Health Authority?

A. I did, yes.

Q. From there, in February 2010, for a period of approximately a year, were you the Chief Operating Officer; that is to say the Deputy Chief Executive of South London Healthcare NHS Trust?

A. I was seconded into that role for a year.

Q. Then back to the Department of Health in the role of Director of NHS Operations, NHS Finance Performance and Operations?

A. That's right.

Q. October 2013 to May 2016, were you the Delivery and Development Director for the north, for the NHS Trust Development Director (North)?

A. I was.

Q. Then coming to the period that we are going to be focused upon, between May 2016 and April 2019, were you the Executive Regional Managing Director for the north for NHS Improvement?

A. I was.

Q. Now, in your witness statement you tell us about what that role involved and you say this, and I am looking here at paragraph 11 if you want to follow along:

"In summary, my role primarily focused on supporting organisations to an improved sustainable position which offered the highest standards for patients and the public."

So that is the way in which you would summarise the primary focus, as you term it, of your role?

A. I would, yes.

Q. Now, putting a little more detail on it, you go on to say that you were responsible for 72 NHS organisations; is that right?

A. I was.

Q. Your focus was on "working with organisations to enable them to exit quality and/or financial special measures". I was just wondering if you could help us with that?

LADY JUSTICE THIRLWALL: What does it mean?

A. So the -- part of the role in NHSI was to focus on those organisations who were Foundation Trust and those who hadn't achieved Foundation Trust status.

For the ones who hadn't achieved Foundation Trust status, there was a pipeline to move through to become a more autonomous body which was an NHS Foundation Trust.

As part of that process, there was monitoring of the organisation's performance, its quality metrics, its leadership ability and making decisions about how quickly it could improve and move through that pipeline to becoming authorised as a Foundation Trust.

MR DE LA POER: I daresay it's only me in this room Ms Simpson but I wonder if you can just help me to understand the phrase "to enable them to exit quality"?

A. It's to exit special measures, rather than quality.

Q. So put in perhaps slightly plainer English, to leave a position where they are in special measures to a better position, is that what it means?

A. That's absolutely correct.

Q. Right. Fine. So perhaps not quality, but special measures is what that should read?

A. And special measures would include quality, safety, financial issues and leadership issues.

Q. I see. So it is to exit 'quality and financial special measures'?

A. Yes.

Q. Yes, I understand. Now, at that time, you tell us that there were ten organisations approximately in your area that required close attention but that the Countess of Chester was not one of them; is that right?

A. That's absolutely correct.

Q. Just completing your CV, I think at present you are the Chief Executive of North Cumbria Integrated NHS Foundation Trust?

A. I am.

Q. And so we are now just going to start with a general proposition which I would seek your comment upon before we come to the detail of this. I am going to put it by way of a statement and I am going to invite your comment upon it, including if in any way you think the statement does not accurately capture the substance of what we are going to be looking at.

So the statement is this, that:

"Some people may be surprised that it appears that there was a safety net for Executive Directors when there were signs that their organisation had lost faith in them, that that safety net would consist of a well-paid job for which they did not need to compete

and which would be good for their CV which would be found for them."

That's the statement.

If that does not reflect in any way what we are about to see, then please correct it. Otherwise, could I please seek your comment upon whether you think that that does reflect the position that you were operating in?

A. I believe it reflects partly the position but not in totality.

Q. Which part of the position has been omitted from that statement?

A. So the -- there was -- I wouldn't describe it as a safety net. There were organisations which were having difficulty where sometimes the removal of an individual enabled the organisation to readjust and get back on track and the individual would be given a short term opportunity, not in the same type of role, but to reconsider their position, to reflect on what had occurred, to see if they could rebuild their -- their career going forward.

It was often not as such a highly paid role as the one that they were leaving and there were checks and balances in the system.

Q. Well, we will unpack --

A. Sure.

Q. -- a lot of that in our questions.

I mean, not necessarily such a high paid role implies that sometimes it would be equally well paid as their previous role, do you agree? That's what "sometimes" means in that sentence?

A. I understand that. But from my experience, where I have facilitated any moves it hasn't been at the same level of pay.

Q. Also the fact that it is not as well paid as their previous job still may mean that it is a very considerable amount of public money; do you agree?

A. I agree with that.

Q. Not to put too fine a point on it, a six-figure sum potentially?

A. Correct, correct.

Q. In other sectors, where an individual has for good reason been removed from their position, they can't expect that there will be sitting above them an organisation that will ensure that they continue to get paid for the next six months at a substantial rate but it appears that in the world that you were operating on, that did occur; is that fair?

A. That, that's -- that's -- that's fair and it is part of the contractual arrangements of individuals,

the terms and conditions that need to be adhered to as part of the -- a process for anyone leaving an organisation.

Q. Well, if a person is dismissed from their work for acceptable employment reasons, which can include that they have entirely lost the faith of their organisation and they are in an untenable position due to that loss of faith, and there I am paraphrasing, not giving an expert employment opinion, but in, in that situation, the contract doesn't require them to be paid anything for the next six months?

A. So this is straying into an area which is not my expertise, that's where we have legal advice and HR advice around the contractual arrangements for an individual.

When we come on to discuss this particular individual, advice was sought as to what was appropriate and within the contract. And if they are dismissed it's quite different to leaving employment or having a facilitated move for a period of time.

Q. Well, we'll come to the detail of it. And we will start, please, by just discovering, did you know Tony Chambers before you became involved in the situation you were invited to help manage?

A. No, I didn't.

Q. Did you know Sir Duncan Nichol before that situation arose?

A. I knew of him, but I didn't know him from his previous roles that he had held in the NHS.

Q. So you knew of him but --

A. I knew of him.

Q. -- you had never spoken to him?

A. No, no.

Q. Tony Chambers first. Did you know of him in terms of --

A. No.

Q. -- a reputation?

A. No.

Q. You see, you do tell us in your witness statement that you knew something about Mr Chambers.

You say at paragraph 22:

"My impression which I would have picked up from colleagues [and it may be that this impression only arose once you were asked to be involved] was that Mr Chambers had quite a strong personality and was known for being very demanding and at times could be perceived as somewhat arrogant."

A. So, again, I am very clear, I did not know Tony Chambers before I moved into that role --

Q. Yes.

A. -- in 2016. As things emerged, I was made aware of people's views and opinions of him.

Q. Yes, and you have summarised the views and opinions of him there.

A. Yes.

Q. I mean, you haven't identified anything that might be described as a positive quality there?

A. No, I haven't.

Q. Indeed the negative qualities that you have identified might be thought by some to mean that he was not ideal leadership material?

A. It could be perceived that way. But then if we looked at other metrics, the organisation, which is under his stewardship and leadership, was rated "good" by CQC. The performance metrics were good.

So there was -- from a positive perspective, there wasn't anything in 2016 that I was aware of that would lead me to believe that -- I know these conversations around the negativity of Mr Chambers weren't outweighed by some of the positives from the organisation.

Q. Learning that reputation, and that's simply you acting upon what you knew about, did you at any point say to anybody: I just wonder whether or not we need to pause here in terms of this particular individual and look a little bit more carefully at what

might have gone on, given that he is perceived to be very demanding and somewhat arrogant? Did that, did that thought process cross your mind?

A. No, it didn't, because these were conversations. They weren't evidence-based statements. They were people offering their views about Mr Chambers.

Q. We will come back to, in a little more detail in a moment with Mr Chambers, but let's just return to Sir Duncan Nichol?

A. Yes.

Q. You knew of him. What did you know of Sir Duncan Nichol before you first spoke to him?

A. That he had been a very senior manager in the NHS, that he had credibility, that he understood the workings of the NHS and that he had taken a role as chairman where he could bring a lot of his experience to bear to managing an organisation.

Q. Were you aware of the police investigation at the Countess of Chester once it began in May 2017?

A. I was, yes.

Q. Did you understand that that related to the neonatal unit or at least the paediatric department?

A. I was very vaguely aware of what the police investigation was, but not the detail and substance of it.

Q. I am not suggesting any level of detail, but just in generality that it related to babies or young children being murdered?

A. I don't think -- I don't think I understood it to babies and young children being murdered. I knew there was a police investigation into a number of concerns in the neonatal unit.

Q. Neonatal unit. Did you at that time understand if it wasn't so specific to murder that the police investigation might include corporate manslaughter --

A. No.

Q. -- or something similar?

A. No.

Q. Did that thought ever cross your mind in the course of all your dealings, that that might be something that they were looking at, given that you didn't know the detail of it?

A. No.

Q. So we are going to look at your contemporaneous log that you have kindly provided us with. But before we do, the first entry in the timeline in fact isn't in your log because I think it was a phone call that came in and it was before you started logging from your colleague Mr Dalton, is that right, so let's

just work through what Mr Dalton told you.

Firstly, he was at the time the Chief Executive of NHS Improvement?

A. He was, yes.

Q. It was 17 September of 2018; is that right?

A. That's right.

Q. You were told by Mr Dalton as you recount in your statement that there was to be a vote of no confidence by the clinicians in Mr Chambers?

A. That amongst other things, yes.

Q. I beg your pardon?

A. That amongst other things, yes.

Q. Amongst other things, what else did he tell you?

A. That there were concerns about the relationships in the board which was becoming dysfunctional at Countess of Chester and his instruction was to work with Sir Duncan Nichol to resolve that, which was to facilitate a move of Tony Chambers.

Q. Now, the dysfunctional relationships, you put in your statement that your assumption was that:

"... the vote of no confidence was due to a breakdown in the relationships between the clinicians, the Executive and the board" and you go on to say "rather than anything specifically relating to the

events the police were investigating".

Now, I just want to invite you to consider that assumption. I mean, at the time, the Countess of Chester was really in an almost unique position, certainly a unique position for any Trust in that year, wasn't it, that it was the subject of a very intense police investigation?

A. It was but the police investigation was being dealt with by another part of the NHS. It -- it was a separate investigation which I wasn't aware of the details of and my instruction was clearly about a dysfunctional board.

The police investigation or the concerns by the clinicians was almost a separate issue but led me to believe this was contributing to the dysfunction of the board.

Q. Well, it was the clinicians who were driving the vote of no confidence?

A. Yes.

Q. And just, again, to return to this point about the police investigation?

A. Yes.

Q. I appreciate you say that it's being dealt with by someone else but here you are being told about a board or an organisation which is the subject of

a police investigation. Did it not occur to you that the two might be related in some way, that the one might be related to the other?

A. Absolutely not. At that time, what was conveyed to me was that there was a board that was struggling, there were relationship problems within the board, it was dysfunctional. In addition, there was a potential vote of no confidence from clinicians, which does happen, and I was instructed to go in and to help resolve that.

There was never any information given about aligning the police investigation with the dysfunctionality of the board, details of that police investigation. It was said almost in passing the main focus of the conversation with my superior, the Chief Executive, was this board was dysfunctional, it was getting worse, we needed to go in and support the chair.

Q. You have been calling them clinicians so far, but you knew it was the paediatricians, didn't you?

A. I did.

Q. So again, just reflect on that. The neonatal unit is the subject of a police investigation. The paediatricians are pushing for a vote of no confidence. You made no connection whatsoever in your mind at the time that there may be a relationship between the two?

A. No, I didn't. And when I have said there about paediatricians, I didn't say neonatologists, which are linked much more to a neonatal unit. Paediatricians can be community paediatricians, hospital-based paediatricians, it doesn't always link to them being involved with the neonatal unit.

Q. Given all of your experience in the NHS and bearing in mind this is a district hospital which didn't in fact have any neonatologists, in fact all of the paediatricians will work on the neonatal unit which is we know what happened. So is that really a line of reasoning that is sustainable in terms of you thinking about whether the two are connected?

A. I believe it to be so. I had 72 organisations for which I had oversight. I wasn't familiar with the Countess of Chester. I wasn't familiar with the workings or the sort of services they provided other than in oversight, I had a team of people who were working more closely with that.

So I think it was reasonable at the time on the information I was given not to make that association.

Q. So in the balance of things in that first conversation, was it the paediatricians that were causing the need for intervention by NHS Improvement or was it the other board members?

A. My belief was it was the other board members.

Q. All right. We will have a look through the contemporaneous notes and see which appears to be talked about the most.

But Mr Dalton, you tell us, asked you to speak to Sir Duncan?

A. That's right.

Q. And the purpose of that conversation as you tell us was to assist him with the relocation of Mr Chambers?

A. That's right.

Q. Then you add this:

"It was not unusual for NHS Improvement to take the lead in supporting Trusts to resolve these types of situations."

A. (Nods)

Q. Just help us to understand why it was for NHS Improvement to relocate members of staff?

A. In part, my understanding is that is a function that had developed over a period of time. It was to secure the retention of highly skilled, highly trained managers in the service if that was appropriate. It was sometimes to enable a board to move on, where it had become dysfunctional, so that it continued to do its daily business and providing services for patients.

So NHSI had taken on that role as a facilitator from one organisation to another. It wasn't something that was done on a regular basis. We didn't do it every week. But there were occasions when it needed to step into that space and act as the intermediary between the organisation where the difficulties were and providing a space where somebody could reflect and determine what was right for them with the skillset they had in terms of moving on.

Q. You tell us that you use this important phrase that it is to move people on 'if appropriate'.

What investigative steps did you take to check that it was appropriate in this situation?

A. So the first -- the first step in that was being clearly instructed and advised by the Chief Exec of NHSI. So my relationship with him was one where I was trusting, I was believing, I sought the information from him, I listened to what he said and then I acted on that.

Steps that I took to enable that to make sense in the world within which we were working was further conversations with the Chair of Countess of Chester, and what I heard from the chair of the Countess of Chester was aligned to what I heard from the Chief Exec of the NHS.

I then sought information and advice from my regional team who were working more closely with that organisation, that there wasn't a -- a checklist of questions that would be asked specifically to satisfy whether a -- a move was an appropriate move to take at that time.

Q. Because if we think about it, I mean, what we are going to see that you do is find a role that hadn't been advertised, was not going to be the subject of any competition or rigorous examination and you were going to facilitate, to use your word, Mr Chambers going into that role.

Now, he didn't in fact take it up but that is besides the point. What you were doing was effectively moving him into that role without any oversight, transparency or governance about his suitability to do that job; do you agree?

A. No, I don't agree with that. I think the -- the movement of Mr Chambers to another part of the organisation was something that was well thought through. I was seeking roles which were not the equivalent status of the role that he was in, so it was not a Chief Executive role he was going into.

It was a role and a function that needed to be undertaken in the areas that I sought so I looked at

STP, who were developing at that time and required assistance with the work that they were doing. The organisation that he would go to needed to be satisfied themselves that a) he could add value to that role and that they were satisfied that he could work with the team, et cetera.

So although not overt tests against a checklist, there was lots of information that was sought to satisfy myself, to satisfy NHS England, that this move would be an appropriate move.

Q. This was not a robust process, was it?

A. On reflection it wasn't a robust process as it could have been.

Q. Well, what you tell us at the end of your statement is if you had known what you know now, you wouldn't have done it?

A. That's correct. Yes.

Q. And there's an awful lot of information that you could have found out at the time which would have told you quite a lot more about what was really going on, wasn't there?

A. My job at the time was to respond to the request from the Chief Exec who had had a discussion with the chair of Countess of Chester and who had determined between them that the best route for their

Chief Exec to enable the organisation to move forward was for him to move out for a period of time.

Q. You yourself were an extremely senior person within NHS Improvement, aren't you, at that time?

A. I was, yes.

Q. You would be expected to use your judgement and act with a degree of autonomy, and it wasn't a: you must make this happen at all costs instruction.

You would be expected by your Chief Executive that if any warning signs came up in the course of you doing it, to raise those?

A. (Nods)

Q. But you didn't yourself seek to verify the exact circumstances behind the vote of confidence, did you -- vote of no confidence?

A. No, I didn't seek that, no.

Q. You see, we know that Sir Duncan Nichol was involved in a to and fro between the Consultant paediatricians and Mr Chambers and there were documents exchanged setting out a long list of grievances. You may have become aware of a table that was created, setting out all of the different ways in which Mr Chambers was said by the paediatricians to have mismanaged and mishandled their concerns.

And that was all going on in the Countess. But how

was it that you didn't ask questions that might have revealed that?

A. So I am very disappointed that that information was not shared with me. That should have been something from the discussions that I was having with Sir Duncan that I had had with Ian Dalton that should have been brought to my attention.

I didn't know what I didn't know at that time. I wasn't aware that there was a full list of tables. It was never presented to me that this is an organisation that's dysfunctional now, there are board issues, there are relationship issues, and there's a big driver here around the paediatricians. That was -- those, those two issues were not brought together and shared with me at the time. So I acted in good faith in terms of the information that was presented.

Q. Well, did it occur to you that in fact Sir Duncan Nichol may himself have been involved in the problems that gave rise to the paediatricians' concerns?

A. No, I had no reason to suspect that.

Q. Well, we have got a board that's dysfunctional and a department that is extremely unhappy, a department which itself is the subject of a police investigation. Is it not common sense that Sir Duncan may have been involved at some stage in the management of the concerns

of the paediatricians, that he might have attended some meetings and been notified about things at board level?

A. So there was a complete disconnect between what I was told in terms of the board and the dysfunctionality of the board and the work with the neonatal unit and the paediatricians. That was not brought into the conversations in terms of this is the full picture that's emerged, this is why we need to take some action.

Sir Duncan may well have spoken about that to Ian Dalton but it was never conveyed to me. I was acting on the information that was available at the time.

Q. So let's move on to the first item within your chronology. It's having been given this instruction by the Chief Executive, we go to the following day forgive me, two days later, 19 September, INQ0101357 and we will start at page 1, that is going to come up on your screen in a moment but I am sure, Ms Simpson, that you can tell us that this doesn't necessarily end up in exactly chronological order when one looks at the dates down the left-hand side, I don't know if that's something that you were aware of before I have drawn it to your attention. Did you realise that?

A. No.

Q. Well, it's not a criticism, sometimes these documents can re-organise themselves, but we will just be alert that as we move through the document, sometimes the dates are going to move around a little bit?

A. Okay, thank you.

Q. Please, there's no criticism implied by that whatsoever.

We can see the first entry is a call between you and Sir Duncan Nichol. You are recorded as advising that it was in no one's interest to go ahead with a vote of no confidence against the CEO and it would be helpful if it could be prevented.

So firstly, the substance of your focus here is the -- the vote of no confidence, isn't it, by the paediatricians, not the dysfunction at board level. That's what's being talked about here; is that right?

A. Yes, these were my notes, I may not have captured everything, but you are quite right, that is what I have got as the first item, yes.

Q. Yes. Why was it in no one's interests for that vote to go ahead if that vote was well-founded?

A. I was thinking of that from the -- the public's, the patients' perspective. Once it is out in the public domain that there's a vote of no confidence then the general public who are attending the hospital

tend to become quite anxious. There's -- there's lots of misinformation that can go around and for me it was about the stability of the organisation continuing to provide services for patients.

So the vote of no confidence would have destabilised things in my view.

Q. I mean, a vote of no confidence is a transparent part of due process, well recognised, isn't it?

A. It is.

Q. And my question deliberately had the phrase "if well-founded" because sometimes it's necessary for an organisation to make clear to an individual who is failing, if that be the case, that they are failing?

A. Yes.

Q. So that the whole matter can be brought to a head and transparently set out that there is no confidence in that individual from the organisation. I mean, that's an important part of how organisations operate, isn't it?

A. It is.

Q. So again, I just -- with the emphasis on the words that I included last time, how is it in no one's interests for that vote to go ahead if it is well-founded?

A. It would be if it was well-founded. But, again, it was based on the information that I had available to me which was there's a potential vote of no confidence. That sometimes happens in organisations.

I -- I was not clear to what level that had got to. In my mind I was thinking about, as I said, the -- the impact of that on the population that Countess of Chester served.

Q. I mean, at this stage you didn't have enough information to assess one way or the other about whether the vote of no confidence was well-founded, did you?

A. No, I didn't. But again I would have expected that to have come through from the earlier conversation with Ian Dalton if that was a lot of information to support that, that assertion.

Q. Did Mr Dalton give you the contrary position, that in fact this was a group of malcontents who were causing trouble and that there was nothing in their concerns?

A. Mr Dalton didn't give me any information about the paediatricians' vote of no confidence et cetera.

Q. So you had insufficient information to assess one way or the other whether or not the vote of no confidence was well-founded?

A. That's correct.

Q. And yet your first piece of advice is to say that it's not in anybody's interests?

A. Yes, and that was -- that was only a piece of advice in a range of issues that were discussed on that call.

Q. It goes on to identify at point 1, the second part:

"It was recognised that Tony Chambers could not continue in his current role."

Now, is that because it was known to you at that time that it was expected that the vote of no confidence would succeed?

A. No. That was on the basis of the information that the board was dysfunctional.

Q. Well.

A. It was -- it was separate to the issues about the clinicians and the vote of no confidence.

Q. We don't -- we don't see anything about board dysfunction in this note, do we?

A. No, we don't.

Q. And in fact if we look at point 2 we return to the topic of vote of no confidence:

"DN confirmed that 72 hours previously to this call the clinicians brought to his attention that they wished to press on with a vote of no confidence. DN convened

the NEDS and they were made aware of the emerging position. Lyn Simpson was made to believe that there may be a secret ballot of members this afternoon."

So mention of the Non-Executive Directors but no suggestion of dysfunction, the focus is upon avoiding the clinicians' vote of no confidence, isn't it?

A. But these notes were made for my benefit in order for me to refer back to them. They weren't a detailed transcript of the discussions that I had had on those calls.

I believe that I have highlighted the points that I would need to come back to over time. The dysfunctionality of the board was something I was familiar with from a number of other organisations that I had worked with.

Q. But if the focus was the dysfunctionality of the board, it would be odd, would it not, to leave out mention of the focus?

A. I -- I can't respond to that now. I can only see what I've recorded at the time. But to assure you that was my driving force in terms of the interaction with the Countess of Chester.

Q. We can then go on to 3. You and Sir Duncan Nichol agree that the suggested way forward was to prevent the vote of no confidence and that

Sir Duncan Nichol -- so this is you agreeing that the chair should try and talk the paediatricians out of their vote of no confidence; is that right?

A. I'm not sure that's what was fully meant by that.

Q. What does --

A. I am suggesting that to -- he understands the rationale for the vote of no confidence, what alternatives there might be and whether that needed to take place. He needed to be sure, he was the leader of that organisation of the chair and he needed to be sure that if that was going to occur, that there was no other route than a vote of no confidence.

Q. What does the word "prevent" mean?

A. It literally means to stop something.

Q. That's what you wrote?

A. It is. But, again, these were my notes, that's not what I was meaning to stop a vote of no confidence.

Q. So you wrote "prevent", but you meant investigate the reasons behind?

A. Yes, some of this was shorthand notes for me.

Q. B:

"To ensure that Tony Chambers does not go back on site."

Why were you agreeing that Mr Chambers shouldn't go on site?

A. Because I was trying to defuse -- create an environment that would defuse the situation where the board members were very unhappy with each other and were not focusing on providing the direction and leadership that the organisation required.

Q. You said the board members are unhappy with each other. Isn't it that the board members were unhappy with Mr Chambers?

A. In part, yes. But I think my understanding was they were unhappy with each other and the different routes that were being taken in terms of the options available to them to deal with Mr Chambers, which is why we had been asked to be involved.

Q. So the extent of the disagreement between everyone but Mr Chambers was: how do we deal with Mr Chambers?

A. Yes.

Q. But they were united that something needed to be done about Mr Chambers?

A. Yes, yes.

Q. They were united with the paediatricians who also thought that something needed to be done about Mr Chambers, and that the world should know that they

had lost his confidence?

A. I -- I really can't comment on that second piece because I wasn't aware that they were united about the paediatricians. That was not brought to my attention.

Q. Well, the paediatricians are driving this vote of no confidence; is that right?

A. Yes.

Q. So they want something done about Mr Chambers.

A. Yes.

Q. The board members all want something done about Mr Chambers, they just can't agree on what?

A. Yes.

Q. So they are united that something must be done about Mr Chambers?

A. They may well have been but at that time I was -- I wasn't aware of what the issues were with the paediatricians.

Q. Sir Duncan?

A. It could have been a range of issues.

Q. Did you say to Sir Duncan, what is it that's upset the paediatricians so much that they are talking about secret ballots and insistent upon a vote of no confidence?

A. I'm sorry to keep labouring the point but

I must say again the -- the issue about the paediatricians was not the issue why I was requested to get involved with the organisation and help facilitate the move of Tony.

So I couldn't bring the two issues together because I wasn't aware that -- I was aware there was a police investigation going on but very loosely aware of that. That was taking its own course of action and I was not the lead officer in that role.

Q. My question in the context of the discussion that you were having --

A. Yes.

Q. -- about the paediatricians pushing for a vote of no confidence is why didn't you ask Sir Duncan Nichol: what is it that's upset the paediatricians so much?

A. I can't respond to that. I -- I don't recollect why I didn't ask that.

Q. Was it the position that you just didn't want to know the detail, because you were simply concerned --

A. No.

Q. -- to carry out the instruction?

A. No.

Q. And it did not matter to you what the reason was, you just needed to get the position sorted?

A. No, I don't think it was. I -- I believe that I said the situation was getting difficult. That was about the board relationships, that was about the interactions and in addition, although I haven't put in there in addition, there was the potential for a vote of no confidence.

Q. All right. Well, we will put aside the position of no confidence, we will just go back to that first call, please.

So we can see we are working our way down 3, we have got the prevent vote of no confidence, we have looked at that. We have looked at Mr Chambers not going back on site.

You are now considering alternative options. We see that at the end of B. To agree that if an alternative option for six months could be found that Mr Chambers would not go back to the Countess of Chester?

A. (Nods)

Q. That if a substantive post could not be found then Mr Chambers would need to be made redundant from the Trust and that you were going to seek some expert advice.

So right at this very early stage, you are explaining to Sir Duncan what you have been told to do

A. No, that would not be the case.

Q. Can you offer an alternative explanation for why you did not show curiosity about what was driving this?

A. I can only advise that it was not raised as an issue in terms of its importance. I was not given the full details behind that. It wasn't raised by my superior in terms of the rationale for going in and supporting the organisation.

So it was in my view a police investigation taking place, a potential vote of no confidence by paediatricians. I did not know the reason for that. That was being dealt with separately. This was about I am struggling, we have got board problems, relationship problems, I need to find a way to help Tony move to a different place.

Q. Next entry that I will ask you to look at is the third one. This is a call with you and Tony Chambers and the summary of your report to Mr Chambers of what you had heard from Mr Dalton was to advise the situation at the Countess of Chester was getting difficult and potentially a vote of no confidence.

So, again, the focus here is on the vote of no confidence, isn't it?

by Mr Dalton which is that you will find a place for Mr Chambers to go?

A. A temporary placement for Mr Chambers, yes.

Q. A temporary placement that will be good for his CV?

A. Not good for his CV but would enable him to reflect, to reconsider and to determine where his career would go in the future in the health service.

Q. Did you ever say to anybody in the course of this that this would be -- that the potential placement that you were going to find would be good for Mr Chambers's CV?

A. I am not aware that I said that, no.

Q. So let's just go back to the telephone call that we were looking at. Mr Chambers, we have covered the bit about the vote of no confidence. Let's go over the page. You are here acknowledging in the course of your conversation with Mr Chambers, the police investigation, you are asserting it's separate from the vote of no confidence issue?

A. Can you -- can you just point out where that is for me, please?

Q. The top line on screen:

"LS recognised that the investigation piece was going on its own route with the police involved and that

was separate to the vote of no confidence issue"?
A. Yes, yes.
Q. That is what I just drew to your attention.
So were you telling Mr Chambers that the police investigation was separate to the vote of no confidence issue?
A. I was relaying to Mr Chambers what my understanding was, which that there was a police investigation, that the vote of no confidence I wasn't aware was linked to the police investigation.
Q. What did Mr Chambers say to that?
A. I really don't recollect what he said to that.
Q. Then we see we the return to this subject of vote of no confidence:
"Paediatricians are keen to go down the route of a vote of no confidence and [Sir Duncan Nichol] was trying to prevent this."
So we see the word "prevent" again?
A. I do. Inappropriate use of language in my -- my log. I accept that.
Q. But you have twice used the word that means to stop when you meant something different; that is one explanation?
A. Yes.
Q. The alternative is that that is what is

happening and that is what you are recording?
A. No, I don't think that was what was happening. I do think on reflection it was an inappropriate word used because that was not what I was implying at the time.
Q. Why did you use it twice?
A. I'm sorry, I don't recollect why I used it twice. These were my notes, my log. It was simply an aide memoire for me.
Q. So we then see the advice that you tendered, which was Mr Chambers to work off-site over the next week or so, which would give you time to look for alternative options, that you are to talk to Mr Chambers about this as not sure another CEO post would be right, or bring Mr Chambers into NHS Improvement.
Why would a CEO post not be right?
A. Because I think it was about time, it was a timing issue, it was about the opportunity for Tony to reflect on his behaviour, his actions within the board, what had created the tensions, the dysfunctionality of the board.
Therefore, moving directly to another CEO role in my view he wouldn't have time to reconsider that and think about his future career to go into a role which didn't have the accountable officer status would enable

him to see how other boards operate, how other parts of the system work and maybe get some personal insight as to how he operated within Countess of Chester.
Q. Did he need to be rehabilitated?
A. I'm sorry?
Q. Did he need to be rehabilitated?
A. It's -- it's a form of words that could be used. I think it was more about personal insight and understanding and thoughtfulness about things that he may not wish to replicate in terms of his skillset in the future.
Q. Because rehabilitation generally goes hand in glove with the fact that you have done something wrong.
A. It does, yes.
Q. So why would that be an appropriate description?
A. Well, I have just tried to explain what I -- I hoped was the purpose of the facilitated move. I wasn't apportioning blame, I wasn't using words that are descriptive and synonymous with other words.
Again, I would go back to this being a log for my use, it might be my shorthand in terms of how that's interpreted.
Q. We will look at something you record Mr Chambers saying to you at item 3. I'm not sure what

the first part is, "TC con med", maybe "commented", possibly?
A. I think so.
Q. Anyway:
"... he would step aside and be as flexible towards this as he can be. However, TC advised he would not want ['it', I think that should be] to be a cost towards his career and he would want to maintain his status as CEO."
A. Yes.
Q. Is that what he said to you?
A. Yes.
Q. What did you understand him to mean by maintaining his status?
A. My interpretation of that was that he would be willing to participate in a facilitated move, but he wanted to operate as an accountable officer as a Chief Executive into a role that he would be moved into.
Q. Well, maintaining status, he is not saying he wants to be a CEO, he's saying he wants to maintain the status of the CEO, in other words be perceived by the world in those terms, to have the plaudits and the accolades that go, the recognition that go with being a CEO.
Is that what he was telling you?

A. I don't know, that would be making assumptions on my part. My understanding of it was he would prefer to move to a role which was the a Chief Executive role in another provider organisation that would be his preference.

Q. Well, wouldn't your notes have read he wanted to be a CEO rather than maintain his status?

A. Again, that's, that's how I would record something as an aide memoire for future meetings.

Q. He doesn't want this to damage his career:

"... advised he would not want it to be a cost towards his career ..."

A. That's -- I have recorded that, that must have been something he said that's led me to believe that.

Q. It would be good for his CV, is that what he was communicating to you, I don't want this to be a black mark against my name. It needs to -- I need to have something on my CV that looks good. So that this isn't --

A. Yes, that is an interpretation of what he would have meant.

Q. Let's look at 4:

"LS advised Duncan Nichol has a meeting with the clinicians and that he would be looking to get them to pull back from the vote of no confidence."

So just reflect upon how sustainable your suggestion is that Sir Duncan Nichol was not trying to prevent.

You have used a different phrase here: get them to pull back?

A. I have.

Q. That is what's going on here, isn't it?

A. There was never -- there was never a request from me to stop a vote of no confidence. I was asking -- maybe some loose language in my log, but my recollection was that I was asking Duncan Nichol to pursue -- be clear that he was confident that he pursued all avenues, to support the clinicians and that a vote of no confidence was still what they wished to pursue.

Q. I just want to invite you to reflect upon the loose language. You have twice used the word "prevent" and then you have used the phrase "get them to pull back".

They all mean the same thing. You have used them across two meetings in three different parts of -- across your notes; isn't that the reality here?

A. No, because I think if I had truly meant to stop, I would have used the word to stop a vote of no confidence. I didn't use the word "stop".

Q. You used the word "prevent"?

A. I did. Because when I was using the word "prevent" I was asking him to look at a range of options.

Q. "Prevent" means exactly the same as "stop", doesn't it?

A. It depends in the context I think in which it's used.

Q. Well, I'm sorry I am going to have to challenge you on that. You give me an example of where it means something different?

A. I would need to think about that.

Q. All right. Well, I don't want to put you on the spot, further about it?

A. Thank you.

Q. If you need time, so be it.

We will move on. Page 4, please. In fact, I think we need to go back to page 3 just to see the timing of this. This is on the 20th and we have now got five people on this call, are they all NHS Improvement?

A. Apart from one which was NHS England.

Q. So this is quite a substantial amount of the resources of very highly powered people at NHS England --

A. Yes.

Q. -- that are being expended on this issue?

A. Yes.

Q. Do you agree?

A. I agree.

Q. So a separate cost to the public purse in this meeting, would you agree?

A. I would agree.

Q. Let's go and have a look at what's said on the call. We are not going to look at it all. We can see that:

"Maria advised that if after the allocated time period with a new role the CEO did not secure substantive employment elsewhere, the Trust [the Countess of Chester] would find it difficult to make him redundant as he would still be considered as the CEO post and the issue would be what he is being made redundant from. It would be a case of terminating ..."

Then it goes on to say his employment.

So this is a meeting you are at. The context for this there is a discussion about moving him to a temporary position?

A. Yes.

Q. Then making him redundant at the end of that, but that effectively whilst in that temporary position he would still have the status of CEO, even though he wouldn't be a CEO; is that right?

A. Yes, I think we were exploring the options then of what the alternative position would be. If he did go to another CEO role what that would mean and this is the legal HR advice that Maria was providing.

But it was never my intention to facilitate a move for Tony to the equivalent of a CEO role.

Q. We can see what the alternative arrangements are at 2.

A. Yes.

Q. You made it clear to the chair that when looking at alternative arrangements this would not be a CEO post and within NHS Improvement and you list the options. So when we see what Maria is advising about she is advising about something which is not a CEO role, that is the alternative arrangements, but she is saying that he would still be considered to be a CEO in that alternative role.

Do you see?

A. I think I understand what you are's saying and in the context of me recording this, I think this was a note for me to say this was legal HR advice that we -- that the Countess of Chester would need to take a view on. That was something that I was not qualified to offer an opinion on.

Q. Let's look at page 5. So your colleague

Graham here in the centre paragraph:

"There is the police inquiry ongoing and Graham queried what would happen at the end of the Inquiry if there was to be an accusation against the senior leadership. Confirmed that this would be one to think about when the investigation comes to a close, however the interim placement would not dissolve the CEO's responsibility."

So let's just understand what this is saying.

There's a police inquiry that might, it is being hypothesised, end in an accusation against the senior leadership?

A. Yes.

Q. An allegation of corporate manslaughter. What other accusations would the police be making against the senior leadership, given that they were investigating deaths?

A. I -- I wasn't aware of that at the time. I did not -- I wasn't fully aware of what the police investigation was, hence the conversation to say we would need to see what the police investigation found and then what the allegations were as a result.

Q. What did you think your colleague was meaning when he said that at the end of the investigation there may be an accusation against the senior leadership?

What did you think he was saying the senior leadership would be accused of by the police?

A. I really can't recollect what he would be thinking of.

Q. Well, this is a moment in your discussions where somebody -- not you, but Graham --

A. Sure.

Q. -- has brought together the idea that the police investigation may be relevant to how the senior leadership has behaved, including Mr Chambers?

A. But then if he had some information that would lead him to believe that he should have shared that at the time.

Q. It's not whether he has information, he is setting out a hypothetical scenario, 'what if'?

A. Yes.

Q. So you are now -- everyone in the room is now forced to contemplate: well, what we do if that turned out? So you need to think about what happens if they are accused by the police of some crime at the end of it? What seems to be -- it is not attributed to you, but it seems to be attributed to the meeting in some way:

"Confirmed that this would be one to think about when the investigation comes to a close."

Now, do you agree that what that's saying is that's not a problem for today, it's only a problem if -- at the time that that accusation is made; that's what that means, isn't it?

A. That is what that interpretation of the statement means.

Q. Doesn't that need to be challenged as a way of thinking about this?

A. But the responsibility would lie with the organisation with the Countess of Chester, the police investigation was taking its own route. It was not -- it was not my responsibility to probe that police investigation. It was being dealt with by another arm within the NHS.

There was a responsibility for those individuals to share with the Countess of Chester, to share with me in terms of facilitating this move. None of that information was brought to the attention. So hypothetically they are saying in this: what we need to be aware of and cognisant of that there is a police investigation but we will be advised of that at the appropriate time, we can't interfere with that, we need to move on with focusing on the primary purpose which is a dysfunctional board and moving this gentleman on.

Q. Doesn't it require you, given that you are

moving someone who is being contemplated as potentially accused of a crime in the context of his leadership -- that's what's being contemplated as a possibility: that you don't need to wait to find out if that comes to pass before you move him on. Instead you need to find out if that's a possibility at all in the real world, that you need to investigate to make sure that it doesn't turn out that you moved somebody who is then accused of a serious crime. Isn't that the correct way of thinking about it?

A. I push back slightly on that because the police investigation, the individual was not accused of anything until the police investigation had come to an end. We were working in good faith that the primary focus of the problem was the board and he was being moved because of his involvement, his leadership in the board.

To make assumptions about an outcome of a police investigation at that time would in my view be inappropriate.

Q. So we are just going to move forward in our timeline, we are going to come briefly off this page and just come to page 10. As I say we are not looking at every single one of these entries, but this is an email to Sir Duncan Nichol, and we can see that you:

"Continued conversations ... to advise. Likely that we will direct him to [a placement], and [you] would like to do that by the end of the week."

Then made arrangements to discuss things. Then the note underneath:

"Lyn subsequently responded and shared the note above sent to the chair and asked MP and MR whether they should send anything more formal to the chair at this stage? MP confirmed that at this stage there is really nothing else to add. Recognising the Trust's foundation status, our guidance/advice is just that, but we hope it will be accepted and followed."

I mean, was NHS Improvement placing pressure on the Trust to act as NHS Improvement wanted rather than how the Trust wanted?

A. Absolutely not.

Q. We are going to come off this document. At the same time we are going to see a message that you sent, INQ0017183. It's just a perhaps a flavour of the emails that you were sending. This is to Mr Barker.

"Forgot to pick up in our conversation today whether you would be amenable to accommodating Tony Chambers in the STP for 6 to 12 months supporting Simon. Not heard back from Simon as to how he feels about the request. Would like to land something for Tony if

possible before having a conversation with Duncan Nichol tomorrow/Thursday."

This is, would you agree, an extremely informal message?

A. Yes.

Q. What you are effectively saying is can Mr Chambers be accommodated in a role that hasn't been advertised for which he will not have to compete; is that right?

A. Yes.

Q. This isn't a terribly transparent process, would you agree?

A. This was in a role which was a temporary role. It was to provide some additional capacity to the STPs which were new and were forming and it wouldn't be a role that was substantive, where you would need to go through an open and a fair process. This was as you do on many occasions second someone in to give some extra capacity, breadth and depth to a particular function.

Q. Is this the sort of treatment that any doctor or nurse could expect if they lost the confidence of their organisation?

A. I'm disassociating the -- the loss of confidence, the vote of no confidence because that wasn't what I was asked to address.

Q. Well --

A. But we do move doctors and nurses around, normally within their own organisation if they are having difficulty in their particular ward or department for a facilitated period of time.

Q. We are going to go back to your note INQ0101357 and we will go to page 11, 3 October. So we have two people from NHS Improvement I think on this call?

A. Yes.

Q. Three senior people from NHS Improvement talking to Sir Duncan Nichol. We have got a placement being sought for him and then two opportunities and you list the two and you had understood from Mr Chambers by this point that his preference was for Cumbria; is that right?

A. That's right.

Q. Then we get to 5:

"This placement would be funded by the Countess of Chester for a period of six months."

Now, the Countess of Chester was a Foundation Trust?

A. Yes.

Q. You will know much better than me, Ms Simpson, but would it be right to say that that meant that it was

given a very high degree of financial autonomy?
A. Yes.
Q. The money was given to it for it to spend in the best interests of the patients that it served?
A. That's right.
Q. What was being contemplated here is that the Countess of Chester would spend the money that had been given to it for the best interests of the patients that it served to pay for Mr Chambers to work somewhere else?
A. (Nods)
Q. Is that an accurate description of what was going on?
A. That's an accurate description. But it would be consistent with what was in his contractual arrangement.
Q. Well, consistent with his contractual arrangement if everybody consents to it but if a different process is followed, a vote of no confidence, some kind of performance or disciplinary investigation which -- into the matters, dismissal if that's how it all ends up, might be a different position?
A. It may be, yes.
Q. Who did you understand at the Countess of Chester would have to agree to spend this money

benefiting Cumbria?
A. In my understanding that would be the small committee of the board which would be the Remuneration Committee which would be chaired by the chair of the organisation.
Q. Had they, as you understood it, agreed to that at this point?
A. I'm -- I am not familiar with what was discussed in their Rem Com committees, et cetera. I would expect that it would have been that's not a decision that an individual would take.
Q. No, certainly it wouldn't be for Sir Duncan Nichol on his own --
A. No, no.
Q. -- to sign off --
A. No.
Q. -- what may be a six-figure sum out of the budget?
A. No, I don't think it would be that level, six figures but --
Q. High five figures?
A. Yes. But he wouldn't make that decision himself. He would need to get his non-executive colleagues to agree with that.
Q. Now, just one other matter, if you will

forgive me for a moment.
If we could go to 24 November -- sorry, page 24, 29 November. Just a phrase that I have already telegraphed to you that I would just like to ask, this is a conversation with Sir Duncan Nichol and the context of this, as you will be able to tell, Ms Simpson, that there has been some toing and froing about how long Mr Chambers should be on his placement. He wanted 12 months, NHS Improvement thought six months, there was talk about when he should be given his notice to make sure that if he hadn't found another job, it would be terminated and that's the context, isn't it, for what we are looking at?
A. Yes.
Q. I understand that you write in this email in the large paragraph that:
"Tony Chambers is potentially looking to be seconded to a different organisation to that of our previous discussions ..."
Just pause there for a moment. You understood that in fact that he was going to go somewhere differently, he went to Northern Care Alliance. So he didn't in fact take up either of the placements you had found for him.
A. Correct
Q. "... and for a longer period. While overall

approval of the terms of settlement sit with you and your Remuneration Committee I would advise that rehabilitation periods linked to similar settlements in the NHS seldom last more than one year especially where these are funded solely by the employing Trust and please remember as his current salary is above [a figure is given] the host organisation for his secondment will need to seek approval or comment for his salary whilst on secondment."
It will come as no surprise to you, Ms Simpson, that I am going to ask you about this notion that there is a standard rehabilitation period within the NHS. Can you help us with that concept?
A. I don't believe that there is a -- a standard period of time that an individual would be seconded to another organisation to reassess their position. It very much depends on the context, the situation, the individual, the role that they are going to, how that can be funded, whether that's supported by the regulator, et cetera, so there's not a lift and shift for a six, nine, 12-month period.
Q. But there is recognised concept of the rehabilitation period --
A. My terminology, rehabilitation period.
Q. -- in an email, so presumably you would expect

Sir Duncan Nichol to know what that meant. You wouldn't have said it if you didn't?

A. Correct.

Q. So this is bread and butter parlance for senior Execs within the NHS is it?

A. Yes, that that's why I would have used that I agree.

Q. Yes. So rehabilitation period, this is a recognised thing, is it?

A. Well, it's an opportunity because sometimes the individual concerns, if we go right back to the beginning, a dysfunctional board, poor relationships, lack of direction, spilling out into the organisation as a general view is not helpful to patients.

Trying to defuse that situation and moving an individual to another organisation, whether we call that rehabilitation, whether we call that a reflection period, can often be the opportunity for the individual who may have had a part to play in the dysfunctionality of the board, but may not be the sole cause of that, to then move on and do something differently. They may move out of the NHS completely. Or they may consider what is right for them and what they can offer in terms of their experience, their competency, in a different place.

Q. You say it may be called a number of things, you chose to call it rehabilitation period --

A. Yes, yes, I did.

Q. -- didn't you?

You say that they may or may not have been partly responsible for the situation they are leaving. But there's been no scrutiny of whether or not they have been, has there, in this whole process?

A. So I would -- I would suggest that the scrutiny had taken place at a more senior level in those earlier discussions between Sir Duncan and Ian Dalton and that I was acting as the agent to execute that decision.

Q. You say:

"I think it is poor practice to help move managers around where there have been allegations made about misconduct and I have never moved managers where there has been misconduct that I have been aware of."

That is what you said in your statement.

Doesn't there need to be a robust process of establishing whether there may be misconduct before people are moved?

A. Yes, there does, there does.

Q. Because otherwise the fact that you don't know about it doesn't mean that it isn't there and there were

a number of markers in this situation, weren't there, that there may be -- put it no higher than that, that there may have been misconduct by Mr Chambers, he has lost the confidence of the paediatric department, it would seem certainly the doctors, the board all want to get rid of him.

An explanation for that could be that he has misconducted himself in some way?

A. Yes, that is, it's one explanation.

Q. Yes.

A. Again, I was not aware that he had lost the confidence of the paediatricians.

Q. They were pushing for a vote of no confidence, what else does that mean?

A. Well, it -- it doesn't particularly mean that I understood the rationale and explanation behind that.

Q. Well, people don't ask for a vote of no confidence, do they, in order that somebody is expressed to the confidence of the organisation? They ask for a vote of no confidence because they expect or they hope that it will be found that the individual has lost the confidence of the organisation, isn't that how it works?

A. It is how it worked but there has to be a lot of information behind that. What avenues have been explored, what's the evidence to suggest that, how has

that been addressed by the board, et cetera.

Q. All questions you could have asked?

A. I accept that.

Q. All questions you should have asked?

A. I think they are questions that should have been asked before I was involved in the process to execute an action.

Q. So you would say you have -- despite the fact that you were speaking to Mr Chambers and speaking to Sir Duncan Nichol, despite your seniority, you would say you have no responsibility whatsoever for failing to be more curious?

A. No, I wouldn't say that.

Q. So should you have -- should you have asked?

A. I do accept I should have asked some more questions.

Q. Two reflections to conclude.

Should senior managers in the NHS be regulated?

A. We absolutely should be.

Q. So you should be the subject of a separate independent regulator in the same way as doctors and nurses, do you think?

A. We should and I am regulated still as a nurse but I -- I do firmly believe that managers should be regulated.

Q. Do you think that senior managers in the NHS should be obliged to hold to a written Code of Conduct that has as its first duty keeping patients safe?

A. Absolutely.

MR DE LA POER: Ms Simpson, thank you very much indeed for answering my questions. I will just look to the back to see if there's -- no, my Lady, I don't think that there are any other questions for this witness.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Thank you.

I have got one or two, if I may, Mrs Simpson, and then you will be able to go.

You mentioned a number of times the dysfunctionality of the board and that was the thing that was preoccupying or concerning you the most.

A. Yes.

LADY JUSTICE THIRLWALL: That was your focus.

Can I just ask you what was nature of the dysfunctionality, what did you know about it?

A. That they were -- there was a lot of concerns around the sense of purpose, the leadership and the direction of the organisation.

LADY JUSTICE THIRLWALL: So what does that actually mean?

A. So when they are making -- when they are

having their routine discussions about strategically do we move the board in this direction, apart from good, high quality challenging questions they were becoming dysfunctional, because there was just views thrown in. Depending on who you were in the board you were able to try and influence more heavily a direction or an outcome that you wanted to achieve instead of operating as a unified board.

If you operate as the unified board you take into account individual's views, you have a clear sense of purpose, you articulate the outcome and then you agree an execution pathway. When you are dysfunctional or not operating as a board you are not making those decisions -- you are not making them in the best interests of the patients, you are not listening to other information that's percolating to the board whether that's through information from wards, departments, through Speak Ups, through a range of things --

LADY JUSTICE THIRLWALL: Sorry, just to cut across you.

A. Sorry.

LADY JUSTICE THIRLWALL: In this case, which of those elements applied?

A. I --

LADY JUSTICE THIRLWALL: Perhaps deal first of all with the individual views coming from different members of the board, depending on what their role was, what was happening there?

A. So my understanding was that some members of the board -- of the board felt that they weren't able to articulate their views, that they were closed down before the full range of skills and interests were taken into account.

LADY JUSTICE THIRLWALL: Who was shutting them down, who was closing them down?

A. My understanding was -- and I wasn't present at the board meetings --

LADY JUSTICE THIRLWALL: No, I appreciate that.

A. This is secondhand, was that on many occasions that was the Chief Executive who was --

LADY JUSTICE THIRLWALL: That was Tony Chambers?

A. It was.

LADY JUSTICE THIRLWALL: Who were you getting that information from?

A. From my team who were in NHSI, so that was the Senior Delivery and Improvement Director, the Delivery Improvement Director, where they were working across organisations and beginning to elicit information about how the board and the leadership in that organisation

was working.

LADY JUSTICE THIRLWALL: You got that information when, was that after you spoke to Sir Duncan Nichol for the first time or afterwards, or before?

A. It was -- it was afterwards because prior to that, I had no intelligence that this was anything other than, you know, a well-performing organisation.

LADY JUSTICE THIRLWALL: But Sir Duncan told you, did he, that the board was dysfunctional? Or was it in fact that came from your people.

A. I -- I think that that is my terminology.

LADY JUSTICE THIRLWALL: Yes.

A. Based on the discussion that I had with Ian Dalton in terms of the board is not, not operating as a unitary board, there are problems we need to help Sir Duncan Nichol, the problem is primarily the Chief Executive, he needs to be moved to a different place.

LADY JUSTICE THIRLWALL: Thank you. Are you able to remember which groups or which people on the board, either by their role or their name, were being felt that they were being shut down?

A. I'm sorry, I -- I can't say which one it was. I have the impression that it was the majority of the, the Non-Executive Directors. But I -- I don't know which ones or which specific issues it was.

It was a more of a generic feeling and supposition that people were articulating.

LADY JUSTICE THIRLWALL: I understand. Thank you.

A. If I may just offer something supplementary.

LADY JUSTICE THIRLWALL: Yes.

A. When I talked about having 72 organisations to have oversight, that was a large number. There were a small number within that, talked about 10 organisations which required an awful lot of intervention. There were examples there of where there were dysfunctional boards and I would -- was dealing with two at the time and what was happening there was a similar position to people felt unable to speak out, people felt that they weren't able to convey their strength of convictions in relation to an issue they were discussing and the board just wasn't able to provide the leadership to the organisation and the confidence then generally across the organisation about the services it was providing.

So it does happen in other organisations and, as I say, at that time I was involved with at least two other organisations where that was the case.

LADY JUSTICE THIRLWALL: But so far as this organisation is concerned, you were satisfied that you had sufficient information to make the judgment that the

board was dysfunctional, in the way that you have described?

A. At the time I believe I did. With hindsight now, I can see that it would have been helpful to have asked for some further information.

LADY JUSTICE THIRLWALL: Thank you. When we were looking earlier at the note about the paediatricians and the vote of no confidence, and it said there was a note which said there is going to be a secret ballot of the members. Who was going to be voting in the vote of no confidence? That is reflecting my own ignorance but who would vote? Would it be the members of the board?

A. No, I think -- I think that was referring to the clinicians, namely the paediatricians --

LADY JUSTICE THIRLWALL: Yes.

A. -- who would have a secret vote which would I am saying this as a personal opinion now which to me would mean that not everybody was of the same view, hence you would do it as a secret ballot and you would be able to discuss, you would be able to, as an individual, put your view forward there.

LADY JUSTICE THIRLWALL: Very well. It's just that it was referred to members and I was wondering what the members were. Was that just your --

A. I -- I think on reflection that was the

paediatricians rather than the board itself.

LADY JUSTICE THIRLWALL: Right. Thank you very much. If that matters, I am sure we can clarify that.

Does anybody want to ask anything arising out of that?

MR DE LA POER: No thank you.

LADY JUSTICE THIRLWALL: Thank you very much indeed. Ms Simpson, you are free to go now.

A. Thank you.

LADY JUSTICE THIRLWALL: Is that a convenient moment to take the break?

MR DE LA POER: My Lady, yes, thank you.

LADY JUSTICE THIRLWALL: So we will start again just after quarter to.

(11.32 am)

(A short break)

(11.49 am)

LADY JUSTICE THIRLWALL: Just before we continue with the next witness, there was a document which had been redacted which we looked at quite near the end of the evidence of the last witness, it was a figure and I have asked that that be unredacted because it is plainly relevant and ought to be a matter of public record. Now, Mr Bershadski.

MR BERSHADSKI: Yes, thank you, my Lady, if I could

call Mr Pace, please.

MR IAN PACE (affirmed)

Questions by MR BERSHADSKI

LADY JUSTICE THIRLWALL: Do sit down, Mr Pace.

MR BERSHADSKI: Could you confirm your name please for the Inquiry?

A. Yes, it's Ian Pace.

Q. Have you made a statement dated 9 August 2024?

A. Yes, I have.

Q. Is that statement true and accurate to the best of your knowledge and belief?

A. Yes, it is.

Q. Is it correct that in 2016 you were an associate solicitor in the Employment and Pensions Group at DAC Beachcroft?

A. That's correct.

Q. I think you had been with DAC Beachcroft since 2011; is that correct?

A. That's right.

Q. You were initially a solicitor there and then promoted to an associate solicitor in May 2016; is that correct?

A. That's correct.

Q. Is it right that you would have dealt with disciplinary, grievance, sickness, performance

management and Employment Tribunal proceedings in your role there?

A. Yes, that's correct.

Q. You tell us in your statement that you didn't have any safeguarding training as such; is that correct?

A. That's correct, as far as -- to the best of my recollection, yes.

Q. There wasn't any safeguarding policy at DAC Beachcroft at the time?

A. That's correct, to the best of my recollection.

Q. I think you say that that's in line with your experience working at other firms as well; is that correct?

A. That's right, that's certainly right.

Q. Is it likely that you would have been familiar with safeguarding principles because they are often contained within employment policies that you would be applying in your role as an employment solicitor?

A. Yes, I think that's fair to say and also from experience of advising other health clients. I advised clients in the health sector and the wider commercial sector and safeguarding often came up as an issue.

Q. Now, I just want to briefly go over a number of principles and just ask you whether you would have

been familiar with those safeguarding principles from your work.

Firstly, it's correct, isn't it, that a safeguarding referral ought to be made if there is a risk of harm to a child?

A. Yes, that -- that would be my overall understanding. What I would say, and as I think I've referred to in my witness statement, I was employed by DACB as an employment lawyer and DACB is a full service law firm, it is an international firm and it has a regulatory team, a healthcare regulatory team, specifically a healthcare regulatory team.

I would say that my understanding of safeguarding was such that it was enough to raise a red flag or an alarm, if we can put it that way, so much so that I would get in touch with the regulatory team for more specialist advice.

Q. Now, was it your understanding that there was any particular evidential threshold to make a safeguarding referral or was it simply a question of if there is a concern about a possible risk then a safeguarding referral needs to be made?

A. Again, I would say that there was clearly a concern and enough so that I would get in touch with the regulatory team for further advice in terms of

whether a referral should be made.

Q. Yes. Now I am going to come on to the telephone call that you received from Dee Appleton-Cairns at the Trust on 5 July 2016, if I may, and it might be helpful if we just put up the attendance note that you make of that call, that is INQ0101934.

Now, Dee Appleton-Cairns tells you that there's been an increased death rate on the neonatal unit which had previously been investigated with no issues found; is that correct?

A. That's right, yes.

Q. You tell us at paragraph 22 of your statement that she told you that on that previous occasion an external investigator had been called in to investigate and reached the conclusion that there were no issues to address?

A. That's correct.

Q. Is that right?

A. We weren't -- or I certainly wasn't involved in that investigation, nor was I aware of it, but that is what I was told on the call.

Q. Yes, and do you recall what Dee Appleton-Cairns said to you about who had conducted that previous external review?

A. No, no, no information was given at the time. The call was received on the helpline, the helpline was intended for very short brief advice and as such and that information wasn't provided at that time.

Q. Is it right that Dee Appleton-Cairns told you that an alarm had gone again, although not a physical alarm, but essentially a reporting of again an increased death rate?

A. That's correct, that's correct.

Q. She told you that a Consultant had referred to somebody on the unit as "Beverley Allitt"?

A. Correct.

Q. Is that right, did you understand that reference to Beverley Allitt?

A. Yes, I am familiar with Beverley Allitt.

Q. What did you understand that reference to mean or to indicate?

A. That there was potentially a Beverley Allitt was responsible for patient deaths.

Q. Somebody who had been deliberately --

A. Yes.

Q. -- killing patients and you understood that at the time?

A. Yes, I understood who Beverley Allitt was, yes.

Q. Dee Appleton-Cairns, you record in your note, told you that she was satisfied that there were no malicious issues but that she didn't provide any reason to support that position; is that right?

A. That's correct.

Q. Is it right that you were still concerned, notwithstanding the fact that she seemed to think there were no malicious issues?

A. Very, very much. So the purpose of the call -- and this is why it was received on the helpline -- was really to address what they perceived to be a breakdown in working relationships on -- on the unit. That's a typical type of call to receive on the helpline where there is a breakdown in working relationships and that was the main focus of her request for advice, how to resolve the breakdown in working relationships.

But I did identify from that that actually there was more to this, that red flag that I mentioned earlier was certainly triggered.

Q. I think you are recorded in your note as saying to her that you thought that the employment aspects pale into insignificance compared to the patient safety risks involved; is that correct?

A. Absolutely, absolutely I wanted to effectively

switch the focus from effectively what was a relatively minor issue of breakdown in working relationships to clearly a very serious -- potentially very serious matter.

Q. Did it surprise you that a fairly senior person at the Trust was calling you up about the employment aspect of things rather than the rather more serious patient safety issue?

A. I -- I wasn't surprised that she was calling me about the employment aspect, that was my role, but yes, I was surprised by the focus and really the need for me to really tease out that information to try and refocus the purpose of the call, if that makes sense.

Q. Given that you say that you were very concerned by this call and I think you say in your statement that you identified a red flag --

A. Yes.

Q. -- you call it, at paragraph 28, is it fair to say that you considered that there was at least some risk of there being an individual who had deliberately been harming children on the ward?

A. Yes, yes. That's fair to say. The information was limited that was provided, the -- the call lasted -- well, probably 15 to 20 minutes so it was very limited information. But certainly that red flag

was triggered and it was a very serious issue, yes.

Q. Now, you tell Dee Appleton-Cairns on this call that you think she needs some additional support and that you are going to re-direct her to the regulatory team --

A. Correct.

Q. -- I think, don't you?

Did you consider yourself suggesting straight away that a safeguarding referral or a referral directly to the police be made when you received this call?

A. No, as I have said, the information was very limited, it was extremely limited information during the call and it was actually information that I had to tease out on the call and I thought it was important to obtain specialist regulatory advice from the lead healthcare regulatory partner.

Q. What do you mean that you felt that you had to tease out information, are you saying that you perceived there to be a reluctance by Ms Appleton-Cairns to provide you with information?

A. I wouldn't say it was a reluctance as such. I think maybe it was a -- maybe -- maybe perhaps not a recognition, perhaps I think that's referred to in the attendance note, how can you be sure? I think -- I can't specifically, but how can you be sure? I just

don't think there is -- I just don't think there was a recognition, perhaps, of the issue.

Q. You go on in your note in the second paragraph to then deal with some of the employment law aspects of what you had been told?

A. Yes.

Q. You say to Dee Appleton-Cairns that the Trust should put in place steps to justify a satisfied position that there's a suggestion or evidence that there's a link between the two.

Now, the link between the two you mean between the individual who's been called referred to as a Beverley Allitt --

A. Yes.

Q. -- and the deaths on the neonatal unit presumably?

A. Yes.

Q. Then you say:

"The Trust may therefore have a defence although it may be difficult to establish that there is sufficient evidence to put the allegations to her (for example if we decide to suspend)."

A. Yes.

Q. Why did you -- given that you had been told that there might possibly be and you had come to the

conclusion that there's a risk of there being a Beverley Allitt on the unit, why did you not simply recommend an immediate suspension at that point?

A. The position simply wasn't clear. The, the -- the evidence was scarce, very limited information. On the one hand we were to paint a picture it seemed to be all very confusing on, on the NNU at the time. Fingers were being pointed to one another, doctors were pointing the fingers at nurses, nurses were pointing the fingers at nurses, nurses were providing clinical explanations for increase in deaths.

It, and among all of this, there was a suggestion that one individual may be involved, it was quite a confusing picture at the time.

Based on the very limited information at the time it would have been quite difficult to simply go forward and say "we must suspend that individual", we needed more information, hence why we arranged that call with Corinne and the regulatory team.

Q. You say in your statement that you felt that the advice that you gave as regards suspension was in line with ACAS guidance?

A. Yes.

Q. Which says that suspension should not be used automatically?

A. Yes.

Q. Was complying with ACAS employment guidance one of the matters that you were taking into account when advising in this call?

A. Yes, yes, of course I was acting in my capacity as an employment lawyer and so the purpose of the -- my -- my instruction was to provide employment law advice as part of that advice in relation to suspension, yes.

Q. Was the situation that was being described to you on the neonatal unit would it be fair to say that it was fairly extreme compared to the sort of employment matters you would ordinarily be called up about on the employment line?

A. Yes, absolutely. It was a very extreme situation. That said, I have previously, without disclosing details, provided advice in relation to another NHS Trust in relation to another very serious matter which doesn't have too much of a dissimilarity to this.

Q. I am not going to ask you about any details of any other matter --

A. No.

Q. -- of course.

You also advised Dee Appleton-Cairns that the Trust

ought to investigate the issues before taking any further steps; is that right?

A. To investigate, to understand more about the situation which was unclear, that's right.

Q. Did it occur to you that there might be problems with the Trust itself investigating an allegation of deliberate harm by a nurse?

A. Yes, of course. But that was the reason why I needed to seek further advice from the regulatory team, from Corinne, in terms of how that investigation may look, and I am sure you will be coming on to, it was recommended that an external investigation was undertaken.

Q. Yes. Yes. Absolutely. So I think you tell us in your statement that after you finished this phone call with Dee Appleton-Cairns you first discussed the matter with another partner in the employment team?

A. Yes.

Q. You say that you explained your concerns about what you had been told to her?

A. Yes.

Q. What is it that you said to her, if you can recall?

A. I don't specifically recall the conversation. I do recall that as a junior associate at the time

I received regular supervision and this was clearly potentially quite a serious matter, the red flag had been raised and it was absolutely something that I would have discussed and did discuss with the partner.

The concerns, I can't recall the specific nature of the conversation, but I expect it would have been along the lines of the focus doesn't seem to be on the potentially quite serious nature of the issues here. And that was on Kirsty's advice that I -- I needed to obtain further advice regulatory advice and she recommended me to Corinne.

Q. Do you recall whether you explained to Kirsty that there was a risk that there was essentially a murderer on the neonatal unit?

A. I would have explained everything that had been provided to me during the call.

Q. So that would have included the reference to Beverley Allitt?

A. I can't remember the conversation itself but, I -- it wouldn't surprise me if that's been mentioned, yes.

Q. Okay. So is it right that on the advice of Kirsty MacDonald, you then immediately contacted Corinne Slingo, who is the head of the regulatory team?

A. That's correct, yes.

Q. What did you say to Ms Slingo?
A. I again can't recall the exact detail of the conversation but it would have been to recollect the conversation that I had had with Dee Appleton-Cairns as is set out on the attendance note.
Q. So would it have probably included the fact that there was a concern at least by somebody on the neonatal unit that there was in effect a murderer on there?
A. It would have referred to everything that Dee had told me.
Q. Including the reference to Beverley Allitt?
A. I expect so. I can't recall the exact conversation but I expect so.
Q. Can you recall what Corinne Slingo's response was?
A. We agreed that we needed to arrange a call. We agreed that it was a matter for regulatory to be involved in. We agreed that it was an urgent matter for regulatory and that we needed to speak to the client to understand and obtain further information.
Q. You say at paragraph 37 of your statement that you recall Corinne telling you that she thought it was too early to get the police involved?
A. Yes, that is right.

Q. Is that what you think she told you in that initial conversation that you had with her?
A. I do recall that, yes.
Q. Is it right that she told you that calling the police may disrupt any internal investigation?
A. I do recall that, yes.
Q. Is it right that she told you that it might be appropriate to approach one of the Royal Colleges to undertake a review?
A. Yes and from recollection the conversation went along the lines of -- based on the very limited information we have at the moment it looks to me to be too early to call the police so we may have to call in the Royal College to do an external investigation but we will need to speak to the clients and obtain further information.
Q. Thank you.
I am now going to move on to the next call that you have with the Trust and that's on 18 July. If we could please have up on the screen INQ0102205.
Now, you receive a phone call from Sue Hodkinson at the Trust on the morning of 18 July and I think from this note it's at around 8.40 in the morning and she's seeking advice ahead of a management meeting that is due to start in 20 minutes' time, not the most positive

situation for a lawyer to be in.
You summarise your understanding of the position. She says to her -- I think you explain to her that from the previous call you had with Dee Appleton-Cairns you understood that there had been a rise in the number of patient deaths on the unit and that a particular individual had been prevalent on the unit at all of the relevant times; is that right?
A. Yes, that is right, yes.
Q. Is it right that Sue Hodkinson explained to you that Letby had been on annual leave for some time until this call?
A. Yes, I think -- well, the note refers to her being on annual leave for about two weeks which would have taken her just before my initial call with Dee on 5 July.
Q. After she returned the Trust had considered placing her under clinical supervision?
A. Yes, that's right. I seem to understand that she was placed on clinical supervision when she returned to work from annual leave I think around about 14 July which was a Thursday.
Q. The Consultants had said that in fact they didn't want her working back on the ward?
A. That's now my understanding, although that

wasn't the case at the time, yes. I was told at the time that the focus of my question is: well, why would you place her on supervision on a Thursday and call me on a Monday, bearing in mind there is a weekend in between to now change your mind and put her on redeployment?
Q. Was it your understanding during this telephone call on the morning of the 18 July that the Trust was considering calling the police at that point?
A. Yes, yes. That's recorded in the -- in the note.
Q. You record the Trust is now considering calling the police?
A. That is recorded in the note which I would have made after the telephone conversation.
Q. Was it your understanding from this call that there appeared to be a significant body of staff on the neonatal unit saying "it's her" about Letby?
A. The -- the -- the picture is by this point slightly different to the 5 July. The 5 July call was quite a messy picture with lots of fingers being pointed to lots of people.
And that picture, that fog, seems to be clearing a little bit by 18 July with more of a focus on that one individual.

Q. If that's right, then would it be fair to say that your index of concern that there may be a person deliberately causing harm on the unit would have risen?

A. Yes.

Q. You say in your statement at paragraph 45 that you then update Corinne Slingo immediately following this call; is that right?

A. Yes, it would have been my call straight after this, probably around about 9 o'clock.

Q. Presumably when you spoke to her you would have told her that your index of concern had now increased further, that there might be an individual causing deliberate harm on the neonatal unit; is that right?

A. I expect I would have recalled everything that was discussed during my call with Sue which had happened five or ten minutes earlier.

Q. Do you recall now -- that note can come down off the screen now, thank you.

Do you recall now whether you were party to the second conversation that took place on 18 July?

A. No, I don't -- I don't recall that, whether I was a part of that call and I really have tried my best, it's obviously been some years. I -- I expect at the very least Corinne had a call with Sue I can't

recall whether I was part of that call or not but I was copied into a subsequent email following it.

Q. Yes. I am not going to ask that that email be put up on screen at this stage because it's going to come up later, I suspect, with another witness. But do you recall receiving the email which followed that second call at the time?

A. I received it, I absolutely clearly received that email, I was copied into it.

Q. In short, in summary, that was an email from Corinne Slingo which advised that at that stage there wasn't a need to formally alert the police?

A. Yes, and very detailed reasons for it based on our instructions at the time.

Q. Yes. Were you at all surprised by the advice contained within that email, that there wasn't a need formally to alert the police, given your concerns?

A. Would it be possible to see a copy of that email?

Q. Yes, it would, of course.

A. Thank you.

Q. If we can please put up on screen INQ0101942.

A. Thank you. So the email clearly sets out Corinne's reasoning at the time. They were our instructions at the time. Paragraph 1 specifically sets

out the -- her reasoning as to why -- it was her view at the time not to call the police.

If we -- you know, if there's a way of summarising those six bullet points, it will be there is very little evidence at the moment to whilst there may be a -- a concern, an increase in concern in the unit from a hard evidential point of view, there is very little evidence to support those concerns.

Q. Yes, but it's -- I mean, it's for the police to gather evidence if there's a suspicion of a crime trial having been committed, isn't it?

A. Yes, it was Corinne's role and in her role as head of healthcare regulatory, that was her specialism as to whether or not there was sufficient -- that threshold had been crossed to call the police.

Q. Yes, and I think you agreed with me earlier that your understanding of safeguarding principles was that a safeguarding referral, which would include the police by definition, it only needs to be made if there is a concern that somebody poses a risk that it doesn't have any evidential threshold as such?

A. Again, that was Corinne's area of specialism.

Q. I'm just asking you about your own view and of course I will be putting questions to Ms Slingo later on today?

A. Sure.

Q. But I am just asking your view at the time that you received this email, given the two conversations, or possibly three, that you had had with people at the Trust and your concerns which you described as a red flag, as serious concerns, were you surprised by the advice that Ms Slingo was giving that there wasn't a need to contact the police?

A. No. I was a junior employment lawyer. Corinne was a senior partner in the firm, head of healthcare regulatory. If it was her view and her advice at the time that the police should not be called, then as an employment lawyer with not -- doesn't have a specialism in that area, it would have been unusual for me to question that advice, I would say.

Q. So you are you saying you effectively took no view one way or the other whether it was correct or not; you assumed it was correct because she was the person best placed to give that advice?

A. Yes, that is right, that is fair to say.

Q. I am just going to ask you -- thank you, that email can come down off the screen now -- were you told at any point that you advised the Trust, and I think you gave advice to the Trust up until January 2017?

A. Approximately once a month or so, yes.

Q. There or thereabouts. Were you told at any point by anybody that you spoke to, whether it was Sue Hodkinson or Dee Appleton-Cairns, or indeed anybody else, that the majority of deaths had occurred between midnight and 4 o'clock in the morning when Lucy Letby was on shift?

A. No. I was -- I was given very general instructions, that being very much in line with the initial call, that there had been an increase in deaths. I wasn't provided with details of the identity of the babies, the age of the babies, when the deaths had occurred, nor the Families.

Q. Presumably then you also weren't told that the deaths were unexpected and unexplained; is that right?

A. I was told there had been an increase above the usual rate for the unit.

Q. Not that they were unexpected or unexplained?

A. No, I wasn't provided with that information, no.

Q. Were you given any information about a Thematic Review that had been conducted by one of the Consultants who had raised concerns?

A. No, I wasn't provided that information. I was told that an external review had taken place 18 months previously.

Q. Were you told that the deaths had stopped once -- that they had stopped occurring at night once Lucy had been moved to day shifts?

A. No, I wasn't provided with that information either.

Q. Were you told that two babies had died within a day of each other --

A. No.

Q. -- on the day shift whilst Lucy Letby was present?

A. No, I was given very general instructions, I wasn't provided with specific details.

Q. Thank you. The next occasion I think on which you are contacted by the Trust is on 2 August and is it right that you are told at that point that the external review, which is the Royal College review, the RCPCH review, that it had been delayed until 1 and 2 September?

A. Yes, yes that's recorded on the attendance note, yes.

Q. That the team still felt that an employee was responsible for the deaths?

A. Yes, I seem to recall there was a reference to a feeling a gut feeling on the unit.

Q. Yes. Do you recall being told that the Trust

was following Corinne Slingo's advice that the Trust was now much more comfortable?

A. Yes, I understand that Corinne had had a telephone conversation involving the Chief Executive to give advice.

Q. What was your understanding of what it was that the Trust was now much more comfortable about following Corinne Slingo's advice?

A. I think it was the threshold in terms of whether or not to contact the police and ensure whether or not the Trust should contact the police at that point in time. I think it was -- a reference was made to I think it was the 18 July email advice, and that it was agreed there would be a very low threshold and if the evidential position became clearer and suggested that one individual was involved, then that threshold would be crossed but at that present moment in time there was very limited information.

Q. You were told I think that the neonatal unit was being kept under daily review to ensure patient safety?

A. Yes.

Q. Now, were you told whether there had been any more deaths or unexpected deteriorations since Letby's redeployment?

A. No, I wasn't. I was -- although it was my understanding from that that there hadn't been any further deaths.

Q. Now, obviously it's a good thing that there haven't been any deaths or unexpected deteriorations, but did you give any thought to what implications that might have for the possible link to Lucy Letby, the fact that there had not been any more deaths or unexpected deteriorations since her redeployment away from the unit?

A. Yes, yes, of course and one of the risks, one of the areas that was set out in Corinne's email advice was at that moment in time around 18 July the unit stopped taking particularly vulnerable babies, those under 32 weeks.

So I think Corinne's advice refers to the potential on that basis that because the number of vulnerable patients, very vulnerable patients coming into the unit was going to reduce perhaps the death rate may -- may reduce at the same point, so that there was potentially that reason for explanation for that.

Q. Are you saying that you gave this matter thought at the time and that you reasoned as to why it might be that the death rate and unexpected deterioration rate had dropped and that you attributed

it to the redesignation of the unit or are you now thinking back as to --

A. I would probably say I would be thinking back, but it was absolutely identified that that may be a correlation in Corinne's advice which I would have seen at the time.

Q. Now, I think you have told us already that you didn't know any details about the deaths that had taken place, for example the age, the gestation of the babies --

A. Yes.

Q. -- who had died. So would it be fair to say that you weren't in a position -- and obviously you have got no clinical experience yourself; is that right?

A. No, that's right.

Q. So were you in any position to come to a view one way or the other as to whether the redesignation of the unit in relation to the gestation of babies accepted whether that could or could not produce any explanation for the reduction in deaths and deteriorations?

A. No, no, absolutely not. But clearly that is as a matter of common sense, if -- if the unit is taking fewer very vulnerable patients who are from a layman's perspective will be at increased risk of death then the likelihood of there being a correlation is possible.

Q. So you were relying on your common sense in terms of -- of matters?

A. Yes, and that's me reviewing the evidence eight years later now, yes.

Q. Yes, okay.

Now, on I think you give some more advice between 7 and 9 September --

A. Yes.

Q. -- in both a meeting and a telephone call with the Trust and you are told that Letby had been removed from the neonatal unit and placed in the Risk Management Team, the Risk and Patient Safety Team. Did you have any concerns about Letby who was suspected by some of deliberately harming babies being moved into a Risk and Patient Safety Team?

A. Yes. The advice from the very outset was she should be placed in a role, in an administrative role, that she would have no access to patient records and again that's -- sorry to keep referring to it -- set out in Corinne's email advice of 18 July and it was our understanding up until that point in time that that was the case. We were told that she had been placed in a -- in a clerical role.

Q. Yes. You are also told at this time that Letby's has raised a grievance; is that right?

A. Yes, that is right, yes.

Q. You advise responding to that grievance in accordance with the Trust's grievance policy?

A. Yes, that's correct.

Q. Now, were you aware of the Trust's grievance policy and how familiar were you with it?

A. Yes, I would have been familiar with the grievance policy.

Q. So you would have been familiar with the fact that the Trust isn't mandated to deal with somebody's grievance if there are other Trust policies which overall are more appropriate to be applied in the situation; is that fair?

A. I think it would be an unusual -- it would be a very -- it would be a commercial decision for the Trust to take not to acknowledge nor respond nor deal with a grievance once that has been raised, particularly in the context of what appeared to be an increasing risk of a constructive dismissal claim.

A constructive dismissal claim is when there has been a breach of contract, whether that be an express breach of the express terms or a breach of the implied terms and an individual resigns as a consequence of that.

There -- there did appear to be an increasing risk

that of a constructive dismissal claim and with that in mind, the ACAS guidance is that a failure to deal with a grievance can uplift compensation by 25%. It's very, very usual to deal with a grievance once it's received and that's the line that we went down and again with -- with the agreement of the partners in the employment team.

Q. I think you say that a number of points you advised the Trust that they needed to deal with the Consultants' concerns that they had raised --

A. Yes.

Q. -- under the Trust's Speak Out Safely policy?

A. Yes.

Q. I think in some of your documents you refer to the Freedom to Speak Up policy; in fact, at the time, it was the Speak Out Safely policy?

A. Yes, yes.

Q. It underwent a rebranding later on down the line.

Now, as far as you are aware, had the Trust followed the Speak Out Safely policy?

A. No. The -- I think the -- my recollection of the reasons for that was because the -- the concerns hadn't been formalised by the Consultants. At that point in time the concerns had been raised on, as

I understood now, a relatively informal ad hoc basis for a period of time.

Now, clearly if we had been I think my advice at the time, if I had been aware of that, would have been to encourage those concerns to be formalised so they could be investigated. That clearly didn't happen before my involvement.

But we -- I did advise the Trust that that, that is something that should happen so that an investigation could be undertaken to consider those concerns and get more detail.

Q. So did you consider that there was some requirement of formality in order for a concern to trigger the Speak Out Safely process?

A. No. The -- but what is needed for investigation is some clarity in relation to the issues and allegations to be investigated and, really, if that advice or, sorry, those concerns are coming in in piecemeal fashion, that can be quite difficult to form Terms of Reference for that investigation.

Q. Is it right that all that is required -- all that was required under the Trust's Speak Out Safely policy and similar policies, because I think these are fairly standard across the healthcare sector; is that right?

A. Yes, yes.

Q. All that is required is for somebody to raise a concern --

A. Yes.

Q. -- with an appropriate individual under the policy?

A. Absolutely.

Q. There isn't any requirement within the policy of it being in writing --

A. No.

Q. -- or any particular other format?

A. No.

Q. So isn't it correct that what ought to have -- well, isn't it firstly correct simply that a Consultant or a number of Consultants had raised their concerns with the Executive Team?

A. Yes, and they had been raised for 12 months before my instruction.

Q. They had been. Now, that should have been sufficient to trigger taking those concerns seriously under the Speak Out Safely policy in and of itself, shouldn't it?

A. Absolutely and if I had been instructed 12 months previously that I expectation would be my investigation that they should be investigated pursuant

to that policy.

Q. As far as you are aware, that wasn't done?

A. That's correct, yes.

Q. Now, I want to turn another matter that's discussed with you between 7 and 9 September. Dee Appleton-Cairns and Sue Hodkinson I think expressed to you that they have concerns about the behaviour of some of the Consultants and they want to consider whether they can engineer the removal of that Consultant from the unit; is that right?

A. That's right.

Q. Did it concern you that Executives at the Trust were approaching you for advice about how to engineer the removal of somebody who appeared to be raising patient safety concerns?

A. Very much. Very much from two angles, at the very least, from a patient safety angle that concerns about patient safety clearly needs to be investigated, that is the priority and that was first and foremost in my mind.

As an employment lawyer, I was also concerned by the -- the possibility that there is some sort of restructure or engineering should happen on the grounds of whistleblowing legislation. The concerns that had been raised by the Consultants no doubt would amount to

Protected Disclosures under the Protected Disclosure legislation and any detriment or dismissal as a consequence would have resulted no doubt in a successful claim for the tribunal. So both from a priority of patient safety perspective, yes it caused me concerns and as an employment lawyer, yes, it caused me concerns.

Q. You give some further advice on or around 26 October 2016 and you tell us in your witness statement at paragraph 100, that during that conversation Sue Hodkinson tells you that an external review had by then been completed and that there is no suggestion within the external review that Lucy Letby was involved.

Can you just tell us, please, what it is that you recall Sue Hodkinson telling you about the conclusions of the RCPCH review?

A. Yes, it's -- it's as set out in the -- in the witness statement and I think there's an attendance note as well, if I recall, of the 26th.

Q. So you don't have any independent recollection now at this stage of what it is that was said?

A. I don't -- I don't, unfortunately. But the attendance note would have been made immediately after the telephone call.

Q. Is it right that you didn't personally see any of the reports that had been conducted into the neonatal unit at any point.

A. Yes, that, that's correct. There was however -- I had previously asked to see a copy of the report. That wasn't forthcoming and I wasn't provided with copies of the report or reports.

I would say however that I had worked with Sue since really starting at DACB in 2011, she was a senior member of the Executive Team, she was a fellow of the CIPD, and she had a number of -- significant number of years' experience and I felt able and no reason to doubt what she was telling me specifically that there was nothing in that external review that suggested one individual -- individual's involvement.

Q. You were told, I think, weren't you, that the Consultants, after they had received the external report, that they were going around saying that it had basically vindicated the medical team?

A. Yes.

Q. Is that right?

A. That's right, yes.

Q. So is it fair to say that you would have understood at the time that the clinicians had read the report very differently from how Sue Hodkinson had read

it?

A. I think there is a slightly different angle, the information that I was being provided by Sue was that there was a systemic failure on the NNU and a management failure of the NNU, I think there was reference to short staffing of the NNU being causes.

The instructions were that there was no one individual responsible for that and from what I was being told about what the Consultants were saying they were saying we are not at fault.

So I think there is a different perhaps perspective of what the report was saying at the time by two different parties.

Q. But did it concern you at all that the Consultants were deriving a very different message from the report from Sue --

A. The Consultants I would say were looking at it from their own personal perspective and it would appear that there was no evidence to point the finger of blame at the individual Consultants. It was more of a wider systemic failing, more general systemic failing of the NNU.

Q. Do you recall whether Sue Hodkinson or anybody else at the Trust, whether they positively said to you that the report had or that the reports had cleared

Letby?

A. They didn't use the term "cleared", no. But the reference was that there was nothing at all, sorry, I don't have it in front of me but there was nothing at all to implicate Letby or something along those lines or one individual. So the instructions were quite clear. This was a general systemic failing of the NNU, management of the NNU and there was no evidence to implicate one individual, so that was the closest you could say it got to that.

LADY JUSTICE THIRLWALL: It is paragraph 101, isn't it?

A. Thank you, my Lady.

MR BERSHADSKI: I think the last occasions on which you advised the Trust are 25 and 26 January 2017. If I could just ask for the 25 January note to be put up, that is INQ0102280.

If we look just towards the end of that large paragraph in the middle of the page, this is a telephone call with Sue Hodkinson:

"The Trust should explain that it was prepared to listen to any concerns raised in respect of patient safety and Sue agreed that she would be able to support this by the fact that the three investigations have been raised and considered and each have concluded that LL

has played no part."

A. Yes.

Q. Is that likely to be an accurate record of what you were told by Sue Hodkinson?

A. Yes, I expect so, these -- these attendance notes were dictated immediately after the call.

Q. I am just going to ask you now reflecting back on the situation that you were faced with in 2016 to early 2017, with the information that you were being given at the time, do you think that applying the safeguarding principles that you were familiar with that you should have advised Sue Hodkinson or Dee Appleton-Cairns that it would be appropriate if there was any concern by anybody that somebody posed a risk to children and babies that a referral ought to be made under the safeguarding principles?

A. As -- as I have previously said, it was certainly a red flag and in my capacity as an employment lawyer a red flag is something to the extent that I needed to seek specialist regulatory advice as to whether that threshold had been crossed and that's what I did immediately. I contacted the head of the firm's healthcare regulatory team who had specialist knowledge in that area. I was a junior associate at the time and Corinne was a senior partner in the firm.

It would have been quite unusual for me as a junior associate to have disputed her advice.

MR BERSHADSKI: My Lady, those are my questions for this witness. I understand that there are no longer any questions from any other parties; is that right?

LADY JUSTICE THIRLWALL: Very good and I have no questions, so thank you very much indeed for coming, Mr Pace, and giving your evidence, you are free to go now.

A. Thank you, my Lady.

MR BERSHADSKI: My Lady the next witness is Ms Slingo. I am entirely in your hands as to whether you wish to move straight into the next witness.

LADY JUSTICE THIRLWALL: Let us do that, yes, if she's here.

MR BERSHADSKI: I think the indication is that there needs to be a short five-minute break in order to get the next witness in place.

LADY JUSTICE THIRLWALL: Do we need five minutes, is she coming a long way? We will just wait unless anyone wants a break? No. We will just wait.

(Pause)

LADY JUSTICE THIRLWALL: There is no rush, do sit down and catch your breath and you will be sworn in.

MS CORINNE SLINGO (sworn)

Questions by MR BERSHADSKI

LADY JUSTICE THIRLWALL: Do sit down, Ms Slingo.

MR BERSHADSKI: Could you confirm your name for the Inquiry, please?

A. Yes, Corinne Dawn Slingo.

Q. Is it right that you have made a statement dated 13 June 2024?

A. That's correct.

Q. Is that statement true and accurate to the best of your knowledge and belief?

A. Yes, it is.

Q. If we could start with some background, please. You are a partner currently at DAC Beachcroft; is that right?

A. That's correct, yes.

Q. You were the Head of Healthcare Regulatory until May 2021, in which capacity you led a team of healthcare regulatory lawyers across six locations?

A. That's correct, yes.

Q. Now, I am going to be asking you questions about advice that you gave in 2016/2017. At that point, is it right that you had been practising as a solicitor for almost 20 years?

A. Yes, that's correct.

Q. You have experience, do you, of police investigations in healthcare, is that right?

A. Yes.

Q. And in particular, is it right that you have some experience of a police investigation relating to Stepping Hill?

A. So I've referenced Stepping Hill as one of the matters our firm has dealt with. I wasn't personally advising on that matter, but I was aware and, and supportive of a colleague who was.

Q. And were you involved with giving any advice in relation to the police investigation of Maidstone and Tunbridge Wells NHS Trusts?

A. So, yes, I was again supportive of a partner who led that, Tracey Longfield. But I was involved with going to present to the Trust's board following the charges that were brought against that organisation.

Q. Did that relate to the David Fuller issues or was it a different police investigation?

A. So yes, it was -- it was the corporate manslaughter prosecution involving the death of a patient involved in obstetric care.

Q. Now, is it right that as part of your role you will have had an understanding of a Trust's safeguarding responsibilities?

A. That's correct.

Q. I think you say that you have advised on high-profile public Inquiries including the Savile Inquiry insofar as it touched on safeguarding concerns within NHS bodies to which Jimmy Savile was linked?

A. So I was involved when the Inquiry was established and it had a separate arm that looked at the NHS in particular. I was instructed by one NHS Trust to provide information and statements to the Inquiry and to that extent that was my involvement.

Q. And they related to safeguarding issues, is that right?

A. To the best of my recollection, they involved providing statements as to when Savile was involved with patients and/or staff on that particular Trust site and what measures were taken in relation to him. "Safeguarding" is a rather global term for that particular Inquiry and that line of evidence.

Q. So what safeguarding measures were or were not taken in response to him?

A. I don't know if it was in response to him particularly, but it was around the presence for example of people who were on site doing voluntary or good works as was perceived at the time. So, yes.

Q. You say at paragraph 8 of your statement that

you helped develop and train boards in understanding their obligations. Would that be boards of NHS Trusts?

A. Both NHS Trusts and independent sector health providers and it covers a range of topics often, for example, the Care Quality Commission and board assurance.

Q. And would that include their safeguarding obligations?

A. So not specifically, no. I haven't personally delivered to a board training on safeguarding to my recollection over 27 years. It would be included as a general subject but not as a specific one.

Q. When you say included as a general subject, what would be said typically in training as regards safeguarding to a board?

A. I actually can't recall now specifically over that period. I haven't delivered anything recently that includes safeguarding.

Q. You mention in one of your emails to the Trust that a Trust has Regulation 17 governance obligations and that's a statutory obligation in relation to good governance --

A. It is.

Q. -- is that right? And is it right also that a Trust has an obligation under Regulation 13 to protect

service users from abuse and improper treatment?

A. That's correct.

Q. And is that something that you would have been aware of at the time that you provided advice to the Trust in 2016 and 2017?

A. I would have been aware of it. Those particular regulations were generated around 2014 and relate to the creation of the Care Quality Commission at the time, so they were relatively new.

But as a general concept of course safeguarding has run through the health service throughout its existence.

Q. Now, I am going to ask you a couple of the same questions that I put to Mr Pace about safeguarding principles that you may have, may have heard.

Is it correct that one of the safeguarding principles is that a safeguarding referral needs to be made if there is a risk that someone has harmed or may harm a child?

A. Yes.

Q. And there is no evidential threshold that needs to be met before a safeguarding referral is made, is that correct?

A. That's correct.

Q. All that's needed is a concern of a risk?

A. It -- it is. I think the reality for

healthcare professionals on the ground is that they collate a number of different pieces of information to work out whether they have sufficient to make that referral because although it sounds a very neutral act and it's a very important act, there are often concerns around making that the right decision.

So, for example, if there are concerns around a parent attending with a child in an emergency department, they -- the healthcare professionals work hard to make sure that they aren't overreacting to what they are seeing but are making a sensible reasoned choice around referral. Given the impact it will have inevitably on that family dynamic, they just try and make the right decisions.

Q. And is it right that safeguarding responsibilities apply just as much to members of staff who may pose a risk of harm as they would do to family members of a child?

A. Yes, that's right.

Q. Now obviously, if the subject of a concern is a member of staff, then there isn't that risk of interrupting a family dynamic --

A. (Nods)

Q. -- thank you just described.

Would you agree that patient safety is always

paramount when making a decision as to whether to make a safeguarding referral and that, for example, the feelings of a member of staff or the impact on them of making a referral is not something that is weighed in the balance: it is patient safety that is paramount?

A. I absolutely agree with that in, in general concept. Just note that I am not the person making those decisions. Others have to do that.

Q. Yes. And is it another principle of safeguarding that safeguarding is everybody's responsibility?

A. Yes.

Q. And does that mean that an individual cannot assume that somebody else has complied with their safeguarding responsibilities and on that basis not take safeguarding action?

A. In the context of how healthcare operations work internally, yes, I would agree with that.

Q. Thank you. I am just going to ask you some questions now, if I may, about the first occasion on which you would have heard about any of the issues on the neonatal unit at the Countess of Chester Hospital.

Is it right that you were contacted by Ian Pace, a colleague within your firm, working in the Employment and Pensions Department on 5 July 2016?

A. I believe so, yes.
Q. Now, Ian Pace's recollection is that he was very concerned and had identified a red flag after a conversation he had had earlier that day with Dee Appleton-Cairns at the Trust. Do you recall a conversation in which he expressed to you that he had real concerns and a red flag as a result of that conversation?
A. So I have no recollection now of the conversation, but I have no reason to doubt Mr Pace's account of that. I recall that I was contacted and asked, as I am on many occasions, by my employment colleagues to contribute to some advice being given to a health client and that the reason for some additional separate advice to that being employment was that there was a concern from a patient safety perspective.
In fairness, I don't, in 2024, recall the detail of that conversation with Mr Pace.
Q. Well, do you recall having the conversation with him at all?
A. I think from the email searches carried out for this process, I would be very comfortable that we had that conversation, yes.
Q. But do you recall now, as you sit here giving evidence, do you recall having a conversation with

Ian Pace on 5 July or not?
A. I recall I will have had a conversation with him.
Q. Yes. Now, Ian Pace has told the Inquiry that during that conversation, he will have communicated to you that there was a concern that there was a Beverley Allitt-type situation on the neonatal unit at the Countess of Chester Hospital. Presumably you are not able now to recall one way or the other whether he said that to you or not?
A. No. But I have -- I have seen a file note that Ian Pace created from his conversation on 5 July with a member of the Trust staff and I have seen reference within that file note to him being told that various members of staff were pointing the fingers at each other and that one Consultant had suggested that a nurse was referred to as Beverley Allitt. But I see from the rest of that file note that the member of the Trust was very clear with Ian that she didn't believe that to be a situation that they faced and that there was, I think she used the words no malicious issue.
So I will I believe have seen that file note. But, I can't now recall Ian specifically referencing Beverley Allitt in a call with me and, and I can partly, although I can't remember the detail of his call, I can

partly add I guess some flavour to that, which is that for a healthcare lawyer reference to Beverley Allitt would be very significant and would, would put matters in a more concerning tone than what we are going to discuss shortly.
Q. Well, can you just expand on that? What is it that you would have understood a reference to Beverley Allitt at the time to mean?
A. So I think for any healthcare lawyer at that time, one would regard a reference to Beverley Allitt as suggesting that there was a deliberate harm element to the patient safety concern --
Q. Yes.
A. -- which places it in a very, very different category to the vast majority of calls I have of that nature.
Q. Yes, an extremely serious category?
A. Yes.
Q. Which demands immediate action?
A. It demands a conversation to find out what's going on, yes.
Q. Well, would you agree that it demands more than just a conversation to find out what's going on if there is a concern by somebody who appears on their face to be a professional person that there is a

Beverley Allitt situation that demands immediate action to ensure that there isn't such a situation continuing any longer?
A. Sorry. The conversation and the discussion I made reference to is as a legal adviser.
Q. Yes.
A. Simply referencing that, doesn't give me enough information to advise, it doesn't tell me anything else. So the nature of the discussion or conversation was I would want to know more about what was going on.
I wasn't being asked on 5 July to immediately give a view as to what should or shouldn't happen next. It was I was being asked to have a conversation.
Q. Yes. Well, Ian Pace's recollection is that on 5 July when he speaks to you, he tells you that there is a concern about a specific individual that reference has been made to Beverley Allitt, and that your response in that conversation with him is that: the police don't need to be called in straight away, that it's too early and that further investigation needs to be done by way of a Royal College review.
Do you recall expressing those views to Ian Pace in that initial conversation?
A. I don't recall that because I don't recall the

conversation. However, I don't think I would have enough information to have given that thought on 5 July. I would -- I understood I was being asked to have a conversation with the Trust to find out more.

So it would be unusual I think for me to have given that view there and then. It's not unusual for me to talk about things like Royal College reviews because those happen and those are part of my day-to-day activity advising clients.

Q. Would you agree that it's very rare for an allegation to be made by a Consultant that there is a Beverley Allitt on the unit? That's not an allegation that you come across frequently in your role as a healthcare lawyer?

A. I think, if, if I -- you're right. That, that is rare, thankfully very rare.

But as I said earlier if my reference point was the file note, which is the written version of what you are describing, that wasn't, that wasn't written in that way. It was that a Consultant had made that reference and that the client was telling us that that wasn't at all what was going on. So I think it's just about the balance of that information. Yes, it would be very serious if that were accurate but that wasn't the way in which it was portrayed.

Q. Well, Ms Slingo, I was just asking you about the content of a conversation that you had with Ian Pace on 5 July. Presumably you hadn't reviewed the file note that Ian Pace had made of that conversation that he had had by the time that you spoke with him?

A. I don't know when I reviewed that and when I had access to that. I may not have done, but I -- I clearly saw it at some point before I had the call with the Trust --

Q. Yes.

A. -- a couple of weeks later.

Q. I mean, Ian Pace's evidence is that he called you immediately after he had the conversation with Dee Appleton-Cairns. So would it be fair to say that you are highly unlikely to have seen a file note or have read a file note that he had made if you'd had an immediate conversation?

LADY JUSTICE THIRLWALL: I am sorry to interrupt you, Mr Bershadski. I think he said he called the partner first, Kirsty, immediately after the call.

A. I'm so sorry, my Lady, I can't hear.

MR BERSHADSKI: Sorry, my Lady.

A. I can't hear.

LADY JUSTICE THIRLWALL: I'm sorry, I will move my microphones because I usually look that way. I thought,

and I may have misunderstood this, but I thought Mr Pace first of all discussed it with the partner who supervised him.

MR BERSHADSKI: Yes.

LADY JUSTICE THIRLWALL: And she recommended that he should call Ms Slingo and then he said:

"I would have told her everything I had heard. It wouldn't surprise me if I referred to Beverley Allitt"

And he said that he couldn't recall the detail. Agreed to arrange... And then your response was:

"Agreed to arrange a call with the clients to understand and obtain further information."

So it sounds like it was a two-stage process.

MR BERSHADSKI: Yes. Yes, my Lady, I think the evidence was of initially a conversation with Kirsty MacDonald.

LADY JUSTICE THIRLWALL: Yes.

MR BERSHADSKI: And then following that conversation --

LADY JUSTICE THIRLWALL: Yes.

MR BERSHADSKI: -- then immediate contact with Ms Slingo. So there does appear to have been, the evidence was of immediate contact following --

LADY JUSTICE THIRLWALL: Yes, after the first conversation.

MR BERSHADSKI: After the first conversation with Kirsty MacDonald.

LADY JUSTICE THIRLWALL: Yes.

MR BERSHADSKI: Thank you.

My Lady, I see the time. I wonder if now would be a convenient moment to take the lunchtime adjournment.

LADY JUSTICE THIRLWALL: Yes, certainly. How much longer do you think you will be, Mr Bershadski? That's only to determine the length of the lunch break.

MR BERSHADSKI: I would hope to be within 40 minutes with this witness.

LADY JUSTICE THIRLWALL: Very well. Are there any other questions? Perhaps that's not known yet, I suppose. There might be. There might be. That's fine.

MR BERSHADSKI: It depends.

LADY JUSTICE THIRLWALL: Very good. We will take an hour, so we will start again at 2 o'clock.

(12.59 pm)

(The luncheon adjournment)

(2.00 pm)

LADY JUSTICE THIRLWALL: Mr Bershadski.

MR BERSHADSKI: Ms Slingo, we were just talking about the conversation you had had with Ian Pace on 5 July 2016 after his call. Is it right that you then

don't have any further involvement with advising the Trust on this issue between 5 July and 18 July?

A. That's correct, yes, I think a call was to be arranged and that was then arranged I think on the 18th.

Q. Is it right that prior to speaking directly to anybody at the Trust on the 18 July, you first again received a phone call from Ian Pace updating you on the call he had had that morning on the 18th?

A. So I don't recall that, which is why it's not in my statement.

Q. His evidence to the Inquiry this morning was that he thinks he would have updated you in full on the matters he discussed with Sue Hodkinson on the morning of the 18th, including the fact that by the 18th, the focus seemed to have shifted much more on to the one individual rather than everybody else.

Presumably since you can't recall the details of that conversation with him, you can't say whether that's correct or not one way or the other?

A. I think it's, it's fair to say that eight years on I am very reliant upon what was written down and what I wrote, both at the time and in my emails around that call. And I am really sorry, I -- I don't recall what he would have told me.

Q. Of course and that conversation with Ian Pace

wasn't documented anywhere?

A. Not as far as I am aware, no.

Q. So the first time that you speak directly with anybody at the Trust then is on the afternoon of 18 July?

A. It's around 5 pm, yes.

Q. Around 5 pm. You had mentioned at the start of your evidence that although -- that it's other members of your firm who had previously been involved with advising on police investigations and that you weren't directly involved with those matters, albeit that you had some knowledge of them, simply via the fact that it was your colleagues at your firm who were dealing with them, I think that was the import of your evidence; is that fair?

A. Yes, I mean, my role was very much around clinical incidents, Trusts and other providers dealing with very difficult challenging situations and the like and of the mass of advice over those years, a small percentage translating to potential criminal matters and of that very, very small amount I think in the country, healthcare lawyers get involved in what we now find out to be a potential murder situation vanishingly rarely.

Q. Of course. So would this have been the first occasion that you were called upon yourself to advise on

whether or not the police ought to be contacted in a situation where somebody had made an allegation of deliberate harm by a member of staff?

A. So at this point I had been advising for 20 years, I couldn't tell you the detail of every advice or indeed very much of it. I would also say the call was not about somebody alleging deliberate harm, the call was about some anomalies with some mortality data and a Trust trying to understand what that was about.

So albeit we see through a lens now which is wholly different, that wasn't the essence of the discussion that we were having. It was part of it, but it wasn't, and I think you will see that from my notes, the idea of deliberate harm wasn't the central focus and I -- I don't say that coming to this Inquiry today to defend anything about my position; I am here to help.

But it's the -- the context is really important --

Q. Yes.

A. -- for that -- for that 42-minute call.

Q. So I think you just said that although the focus wasn't on possible deliberate harm, it was a part of it?

A. So referral to the police was a part of it.

Q. Yes.

A. You will appreciate over the years and

everything that's happened since I have reflected very heavily on was -- was it about deliberate harm, that conversation? And I have -- I have struggled to recall that it was -- that was the tone. I don't think it was the tone. Obviously I had read Ian Pace's file note of 5 July, but nothing else. So the conversation that was had was very -- and I think that sort of maps through the notes that were taken -- it was very much we have had this data issue, we are taking the following steps, there's some concern about whether an individual is part of that.

But an individual being part of some unusual clinical outcomes in my world doesn't take you straight to murder. It takes you to the far more common place that I encounter professionally which is about competence and clinical competence and is there, is there a theme, is there someone who is so bad at their job that these issues are developing and apologies for the very lengthy answer, but it's, the context going into that conversation is very much around that and that was the nature of the conversation.

So I will have had calls with clients about does there need to be police involvement over my previous years of advising. But that would be at the level of routinely, you know, gross negligence manslaughter,

corporate manslaughter issues rather than is somebody deliberately killing neonatal babies. That's not something I would have encountered at that point, no.

Q. Because obviously the whole context of this conversation was about possible police referral?

A. Yes.

Q. That was -- is it fair to say that that was -- was that your understanding of the primary issue on which you were being asked to advise on 18 July, whether there ought to be referral at that point to the police or not?

A. It was certainly part of the conversation. I think you will see from, from the advice email and the -- the notes taken at the time, it was a broader, it was a funnel effect. It was a broader conversation that -- that included within it matters of engagement of other stakeholders and that would include the police.

Q. You would have been aware by that point of this allegation that somebody had likened the situation to the Beverley Allitt situation because that was included within Ian Pace's file note of 5 July; is that right?

A. So I -- I yes, I think -- again I don't, eight years on, remember reading the file note but I am -- I am clear from us checking our time recording systems

that I looked at something briefly before the call.

Q. Yes.

A. And therefore I can only assume as that was all that existed that I will have seen Ian's file note and that's where there is reference to, as I said earlier, staff blaming each other, pointing fingers at each other, a Consultant -- I think it even says calling an individual "Beverley Allitt" rather than a Beverley Allitt situation. But -- but that was then discounted by the person talking to Ian.

So it was a -- it wasn't -- it's very easy to focus now on that being really, really important and I totally understand it is in hindsight.

At the time that wasn't the only thing being looked at --

Q. Yes.

A. -- and the only piece of information we had been given.

Q. If we go to your email that you wrote --

A. Yes.

Q. -- very shortly I think after the call, because I think you said that the call was at 5 o'clock in the afternoon, from your recollection. Your email is at 5.15 that afternoon --

A. It's 6.15. So 5 o'clock telephone call,

42-minute call then I wrote my email and sent it. So I sent the email at 6.15, I must have been drafting it immediately following the call.

Q. We will pull up the email, it's INQ0101942.

I think certainly in this version of the email, it appears that it's sent at 17.15?

A. Okay.

Q. So is it possible then that your conversation was actually earlier in the afternoon?

A. I think the timing is very odd then because I had thought it was a 5 o'clock call and that seems to be what the emails suggest that lead to the setting of the time.

Q. Yes.

A. So I am not quite sure why that time doesn't correlate there but my understanding was my email was around 18.15; either way, it was within an hour of the call, an hour and a quarter.

Q. You begin saying that this is a really tricky issue for the Countess. What was it that was the -- what was the really tricky issue?

A. The tricky issue was that they had some mortality data that appeared to be of concern or had created an outlier situation and that they needed to understand the basis for that and explore what was going

on.

Q. Was the really tricky issue the issue of whether to call the police or not because that appears to then be the focus of your email given that your second sentence is to summarise a few key elements of our conversation particularly re the police?

A. I think -- I think it's difficult for me to now know what I meant by that, but I think the whole issue appeared to be very tricky. "Tricky" is a very informal word for which I apologise now, but I think I was summarising the -- the -- the way that conversation had gone, that there seemed to be a lot of different things that needed to be looked at.

Q. Your numbered list begins with a set of bullet points where you set out elements of concern at that point. The only -- your first one, the only current evidence of any clinical concern is the potentially circumstantial fact that one particular nurse was on shift. The second one is there are also deaths/deteriorations when she's not on shift. No incidents have been linked to her practice is the third one.

Do you think this would have been a complete list of the information you were given by the Trust during your call about the reasons for a concern?

A. I think to the best to the best of my recollection, yes. I mean the situation that I was faced with was -- was speaking to an individual I had never advised before, an organisation I had never advised before about a situation that they appeared during the call to be at the start of in terms of the things they knew or certainly the things they told me.

It tends to be my practice particularly where I know the individuals receiving of my advice better, sort of less well, so if I -- if I talk to them on a weekly basis I will understand what they understand I've said, but if I'm advising someone who I simply don't know and -- and don't really have any other information than in that call then it would be my practice to try and just capture the essence of what I have been told as the basis for the advice that I am giving.

And for all the reasons you will understand, since everything that has now happened I am very pleased that I did at least do that so that I could look back and understand why I advised them the way I advised at the time. So to the best of my knowledge those bullet points are the sort of at the very least the headlines of what was important information given to me but I think I would be confident I would have included

anything else that was important in that analysis in that list.

Q. There are a number of matters that aren't included in that list of which we are now aware, the Inquiry is now aware, constituted reasons for concern on the part of the Consultants and I just want to ask you whether you recall them being mentioned to you.

So firstly is that the majority of the deaths had occurred between midnight and 4 am when Letby was on shift, is that something that to the best of your recollection you were aware of?

A. Absolutely not.

Q. The fact that the deaths were unexpected and unexplained?

A. No, I -- I didn't know that and I think I have made that clear in my statement. Whether the second call that we will no doubt come on to goes any further with that, because I did expressly explore whether there had been deaths reported to the Coroner. But no, I wasn't otherwise aware of that beyond what I have put in my statement.

Q. Were you aware of a Thematic Review that had been undertaken by Dr Brearey?

A. By who, sorry?

Q. By Dr Brearey, one of the Consultants with

a concern about --

A. I had -- and I checked my handwritten notes I had no names of any individuals involved, no idea who anybody was that was looking at this. So, no, I had no -- no information on that.

Q. Were you aware that at some point prior to this conversation Lucy Letby had been switched to day shifts away from night shifts?

A. No, I -- I reference the only thing that I knew which is that I think it's -- I think it's paragraph 2, I was aware that an individual had been taken into a non-clinical role at that point and I was simply confirming that from a patient safety perspective that had to be absolutely right since nobody knew what was going on.

And that also I made the point there that when an individual is under some sort of investigation or suspicion or there's an incident being investigated, it can create its own patient safety risk if the individual under suspicion or being investigated in some way continues with their clinical practice which is why people are suspended, excluded and moved to other roles throughout healthcare when incidents happen.

Q. Yes.

A. And I mean incidents in the clinical incident

setting that I would normally be working in rather than the extraordinary situation in this case.

Q. Well, if we go to that paragraph, that number 2, from a patient safety perspective you write:

"The decision to move the individual to a non-clinical role is absolutely right irrespective of the right or wrongs of the suspicions cast upon her involvement in the heightened mortality issue."

If we just take that sentence. What did you mean by:

"... the suspicions cast upon her involvement in heightened mortality issue"?

A. Well, there had clearly been some communication that an individual was being considered as involved. The involvement there, and again I have -- I have, you know, looked back with as objective a heart as I can at what's gone on, that would be the same form of words whether I was thinking about someone with a clinical competence issue as anything more sinister than that.

I am sure it doesn't help at this stage, and again I would apologise to the families for anything -- that anything I might say might cause distress, but the entire tone of this call wasn't that there is a deliberate harm situation. The entire tone was very

much there's this data anomaly they are trying to work through and they are trying to take steps to investigate in a number of avenues.

Q. From your bullet point list at the top, we can see that you have recorded that no incidents have been linked to her practice and no previous concerns or whistleblowing has arisen in respect of the individual or the unit. That would suggest that it doesn't appear to be a clinical competence issue on the part of the nurse, wouldn't it?

A. I don't think that suggests that at all. Those are objective markers that I would look for in the event that there was concern about individual practice in any direction. They are just part of the piecing together of a factual jigsaw to try and understand what's going on upon which to then advise and just I guess again apologies to not wait for the question but this is the first conversation and in any other setting I would expect this to be a conversation that is the start of many conversations. As it turned out this -- this was a conversation in complete isolation for another eight months.

So these are things that are advising on the best of one's ability at the time based on what information one has. It wouldn't normally be the end of the story.

Q. You say in your paragraph 2 that:

"It's correct that she's been moved off from clinical duties. It will be important to ensure she would not have access to any medical records for the unit in case there is any risk of her accessing them to investigate matters herself or (worst case) to tamper with them."

Again, is it fair to say that that is more consistent with a -- or this is potentially somebody who's been doing something deliberately, reading of the situation?

A. Again, I can -- I can totally see why now looking backwards that might be right but sadly at the time I would have experienced clinical incident cases where those involved have gone to access records and sadly we have also seen matters where individuals involved have changed records and that's not whilst the act of changing them is a criminal matter, the incident that they are trying to deal with isn't necessarily a criminal matter, it's just they are going to obviously be in trouble from a professional conduct perspective or some other perspective and they have accessed them.

So that -- that's the thrust of why I am saying it is good practice not to make these records available to anyone, frankly, that is potentially involved in the

incidents being investigated.

Q. The advice you give in this email is that:

"There does not currently appear to be any reason to formally alert the police to these issues as there is upon which one might reasonably base a suspicion of a criminal offence having been committed."

You yourself don't have clinical expertise; is that correct?

A. That is correct, yes.

Q. And you, by this stage, hadn't heard at all directly or in any form from the doctors, from any doctors, who appeared to have suspicions likening this individual to Beverley Allitt, had you?

A. No. But that was also not the thrust of the conversation that I was giving advice on.

Q. Yes. Yes. I mean, given that it did appear that at least one Consultant did have a suspicion of deliberate harm, why not at that stage say: well, whilst the evidence is limited, if there is a professional person who does have a suspicion, the police ought to be called in so that they can investigate and actually consider the evidence?

A. I -- I think that is a very good question and as we sit here, I absolutely wish I had done that for all the reasons you will understand.

But I -- I had to make some suggestions based on the information I had and the information I had was incredibly limited. I could certainly have -- and I have mentioned this in my statement in hindsight -- not have advised at all but simply said I need more information to understand what's going on and I think the -- the focus is naturally now for all the reasons we understand, a concern around deliberate harm.

But in all conscience that wasn't the -- the thrust of that conversation at all. The conversation was far more akin to many, many that I have had over the years around concerns with clinical outcomes, for example, or concerns about incident trends. So it wasn't -- it wasn't in my forefront actually that there was a deliberate harm situation and had there been any concern that there was, you know, deliberate harm or killing of babies, there would be no question that my advice would have been very different.

Q. You went on to advise that this fine balance of decision-making be kept under very close review with a very low threshold for moving this to a decision to notify the police.

What did you mean by that advice?

A. So I think as we will come on to with my 2017 email, the -- the consideration around clinical

competence or incidents that might be landing at a particular individual healthcare professional's door needs to consider whether there is a sort of gross negligence/manslaughter risk here.

At that date there was nothing I was being told that would suggest that for a moment. But I encouraged through my use of very low threshold referral to the police finally balanced decision and daily review, I was trying to encourage the Trust that if anything emerged that might amount to a criminal matter, that they didn't hesitate.

The challenging part was that I wasn't being given anything that suggested that that day.

Q. Your next -- that can come down off the screen now, thank you very much.

The next occasion on which you have any contact with the Trust is on 30 March 2017; is that right?

A. So there was a brief moment in September 2016 when I understand the Trust wanted an additional call.

Q. Yes.

A. I was in a court hearing and therefore took no part in that call.

Q. Yes.

A. I think Mr Pace dealt with that so I wasn't aware of anything in that period. But yes, eight months

or so goes by before I get any further contact from -- from the Trust.

Q. You -- I think the chronology is that one of your colleagues, Deborah Healey, she is somebody who worked in the employment team; is that right?

A. She was a partner in the Manchester office, in the employment team, yes.

Q. In the -- thank you. So she contacted you I think on 28 March to ask that you have a further call with Sue Hodkinson at the Trust; is that right?

A. That -- that's right, yes.

Q. Prior to that call taking place, you didn't see any documents or reports into the matters at the Trust; is that correct?

A. That's right. You will have seen from the end of my email from the July encounter that I had asked foresight of documents. The Terms of Reference for the Royal College review that was about to happen, anything really that would help me fill in any gaps and again that sort of positions, the expectation that this was an ongoing engagement that the Trust would be instructing us effectively on an ongoing basis to help navigate whatever they were dealing with. But I heard nothing following the July email and yes, I had absolutely nothing before, well, absolutely nothing, I had one

thing which was a link to the staff internal briefing.

Q. Yes.

A. But otherwise, no other materials and had asked for that ahead of the call so that we could talk in context because I didn't know what had happened in the last eight months.

Q. Well, did you -- excepting the July email, did you ask for further documents when you knew that you would be having this second call?

A. Yes, so when we arranged the call time, I had asked if they could -- I think there is an email from myself to Sue Hodkinson saying: please feel free to send me documentation ahead of the call, including any of the reviews that have been done but I didn't receive that.

So I was in the same position I had been in eight months earlier which is I had no additional information and was reliant on the same length, 42-minute call with the Trust.

Q. If we go to your note of the call that you have with Sue Hodkinson, that is INQ0101944, this is your handwriting, is it?

A. It is.

Q. You are told in this call, aren't you, that if we look at the first -- what's next to the first arrow:

"Consultant concerned re a number of cases where

'unnatural/ ...'"

I think that reads "'unanswered' causes of death"; is that right?

A. At this point, my apologies for my writing, it will either be unanswered or unascertained?

Q. Yes. Now, was that not an indication that a Consultant was concerned that this was potentially a deliberate act?

A. This was potentially, sorry?

Q. That this was potentially a deliberate act with the use of an unnatural cause of death?

A. No because an unnatural cause of death will include a very wide range of things. It doesn't mean deliberate harm. So I deal with many, many inquest cases and have done over the course of my career and they only appear before the Coroner where they are an unnatural cause of death. So, to my mind, that was a -- that wasn't triggering what is now, of course, understood to be the case.

Q. If we go to page 3, you are told, as well, that:

"The Consultant feels [I think that reads, correct me if I am wrong, of course, please] feels that the Royal College review was a service review, not an in-depth forensic review. He believes something has

happened."
A. Yes.
Q. What did you mean by "He believes something has happened"?
A. That that section is me recounting what I was being told by Ms Hodkinson. So I think those will be her words not mine. And I -- at this point, I didn't know what the something would be and, again, the range at that point -- now, of course, we would always think of deliberate harm but, at the time, somebody, some individual being, you know, repeatedly incompetent or, or performing so poorly that they might be grossly negligent would be part of the mix there.
Q. You then record in the next section:
"Consultant not saying if you don't do it we will but ..."
Does that read "but threatening resignation"?
A. Yes, I think that is what I have written. Again, this is information. If it helps navigate slightly, although it's not entirely consistent, where there is a little asterisk, it's often me having a reminder to myself to ask something or to note something; where it's written as sort of arrows it almost me capturing what I am being told.
That's not an absolute blanket rule because I have

noticed later that I have flagged bits with an asterisk that I'm clearly being told.
So, for example, further down the page, I have said -- I have noted that the MD -- sorry:
"The MD [so Medical Director] has always reviewed cases against shift patterns. She is there a lot but ..."
And then I haven't finished the sentence. Then the next line down says:
"MD considers satisfies incident investigated."
Q. Yes.
A. So this call was largely around have we done enough? That was the essence of the call: is there anything else we need to do; anywhere else we need to go?
Q. Well, did this not raise your index of concern about these events because a review -- from what you are told, and I appreciate you didn't have the document itself, you weren't able to read it therefore, but you are being told that a Royal College review has been done but the way a Consultant is reading it is that it's a service review, it hasn't actually achieved any forensic conclusions. He still believes something has happened and the Consultant appears to feel so strongly about this that he is threatening to resign. Shift

patterns have been considered and this individual is there a lot.
Has that not raised your level of concern such that, by this point, you had said in your previous email, back from July 2016, that there needs to be a very low threshold and it's a fine balance of decision-making. Why does this further information not tip you into saying, "Well, actually, you have done what you can, there's still this concern, now's the time to contact the police"?
A. Well, that's what my advice is: it's that they should take steps to further engage the Coroner and include the police in that engagement, so that there is no doubt that they have looked at everything in the way they should, involved the right people and also could reassure the Consultant that that's been done.
Q. Well, if we go to your email that follows this call, it's at INQ0101937, if we go over to page 2, we can see that you write:
"The question the Trust is now considering is whether and, if so, how to liaise with the police in this matter ..."
Then under "I advise the following", the first bullet point is:
"If the matter is to be referred to the police.

Then a few bullet points down again:
"If a decision is made to actively engage the police ..."
Similarly, over the page on page 3, you say, in the middle:
"The decision currently faced regarding police referral ..."
So would it be fair to say that it was still an "if" rather than "how", at this point?
A. Yes, I mean, again, this is going to sound wrong in the context of everyone hearing this from the outside but we were advising, it's not my decision that they should go to the police. But the email very clearly talks through, if the Trust do decide to go to the police, this is how I would recommend they go about it.
So my expectation is that they take from that that this is something that shouldn't be closed down without the police being aware and, again, if I can just put it in context and this is just to help, not to defend, because that's not what we are here for, the call was much more -- the call eight months in was much more "We have done X, Y and Z, how do we bring this to its natural conclusion?"
It wasn't -- it felt very much that there was

a view that enough had been done and I think my -- my reference to the Medical Director having reviewed things and having done things and feels enough's been done, I was almost being asked as an almost check and balance, was my impression, and part of my advice on the check and balance was, you know, actually you have had some apparently encouraging and useful conversations with the Coroner, I think you should continue that, but include the police in that, so that all the people that need to know, know and then decisions can be made by those people as to whether there's more to do.

And I appreciate that is subtly different from "You must go and refer this to the police now", I absolutely see that.

Q. Thank you. That email can come down off the screen, thank you very much.

If I might just ask you to reflect on a couple of matters. Do you think now, looking back on matters, given what you knew at the time, so I am not asking you to use the benefit of hindsight and include matters which you have only become aware of since, but do you think, looking back, given what you knew at the time, that there should have been stronger advice given, either stronger advice given that if there is a concern by any professional person you need to go straight to

the police, or that you simply shouldn't have advised without seeing much more information yourself?

A. I think both of those are relevant reflections and they are -- they are reflected in my statement.

If I am talking now to colleagues that I am training and developing, of course we always want to get the best information upon which to then advise. The nature of being a healthcare lawyer is such that you do get called on the hoof and you get called to give your views. That can be very, very challenging. We run an out-of-hours service so 24/7, we are called to give advice, having been woken up and all sorts of things. So it's -- part of what we do is to try and advise based on information we have.

But, in this case, as I think you are aware from the parts of my statement where -- and I think you just popped it up on screen -- I was expressing internally a real professional discomfort that we didn't have any information and certainly not sufficient information to really get into some detailed and substantive advice.

I gave the advice to the best of my knowledge at the time. If I had had my time again, would I have simply said no? I am probably not that person, I am probably somebody who is used to trying to help and get through this. My entire job and career is about patient

safety and trying to help the healthcare service. So it's enormously devastating to find out what happened next.

Should I have said categorically "Refer to the police"? As I sit here, I wish I had but, actually, even with the benefit of hindsight, looking really closely at what I was told, it didn't feel like that at the time and that was the basis of the advice I gave both in the July and the following April.

I feel more comfortable that in the April I made it very clear that I expected there to be police involvement, rather than this matter just be shut down. But I don't think, even looking at the July time I had information that would have led me to very robustly advise that a police referral was, was mandated.

I have advised clients since. I have over-advised clients since, in situations that have been mere clinical incidents, not anything more sinister.

But I did my best based on what I had.

MR BERSHADSKI: My Lady, thank you, those are my questions.

I think there are some questions from Mr Skelton.

LADY JUSTICE THIRLWALL: Mr Skelton.

Questions by MR SKELTON

MR SKELTON: Ms Slingo, I ask questions on behalf

of one of the Family Groups.

Am I right in understanding that you had briefly looked at Ian Pace's notes before your call, the July call?

A. On 18 July?

Q. Yes.

A. I believe I had seen his note of 5 July before I had the call with Sue Hodkinson.

Q. Can we just briefly have that up on screen again, please, INQ0101934. Excuse me. So without going through this again in detail, this is about an alarm going off about increased mortality previously and then the alarm going again about increased mortality and then there is, in the second paragraph, after the sentence about "the third baby is now failing":

"The midwives are saying this is because of congenital issues. From an employment respect, staff were turning themselves. They are all pointing fingers at each other. There has been an instance where a consultant referred to a midwife as Beverley Allitt. Dee is satisfied there are no malicious issues involved."

So from those sentences, it does appear that, at least in somebody's mind, there is consideration of malice or foul play?

A. From that note, yes.
Q. So that was raised in Ian's conversation?
A. Yes.
Q. Can we now see your note, please, of the conversation that you had, and that's INQ0101941?
A. Could I just note that there is a line in that, that note, that can't be right, which is that it says that I spoke to Dee Appleton-Cairns. I didn't. I pursued her for a date for us to speak by email and then we had the Sue conversation. I didn't speak directly to Dee Appleton-Cairns following that call.
Q. Understood. Thank you. So just again, by way of context, it's well understood that you are coming at this relatively cold. You have read a note and you are bounced into a conversation with someone you don't know about an issue you have not heard of before?
A. Yes, exactly that.
Q. You make some handwritten notes?
A. Yes.
Q. You can see them on the screen, and it is just the bit really at the bottom where I think it says "15/16 anomaly"?
A. Mm-hm.
Q. "Mortality", is that?
A. Yes.

Q. "Review", what data is that?
A. Clinical data.
Q. "Review staffing data"?
A. Yes.
Q. What for?
A. I am -- this is me being told by -- given a sort of narrative by Sue.
Q. They have reviewed the clinical data, they have reviewed the staffing data?
A. Yes.
Q. Then "prevalent in shifts supported when deaths have arisen", so this is to do with the nurse, is it?
A. Yes.
Q. She is generally around on the shifts and supported when the deaths have arisen?
"Clinically no evidence re staff member."
So that is the same staff member?
A. I am so sorry. I can't hear you very well.
Q. Sorry:
"Clinically no evidence re staff member."
A. Yes, and I seem to have underlined the "no evidence" because, obviously, that was something that I would be looking out for.
Q. Whose view was it there was no evidence?

A. This is just what Sue is telling me.
Q. Okay. So the nurse is connected or correlated with the deaths but there is no evidence that her clinical practice is substandard in the context of the deaths --
A. Yes.
Q. -- as far as you are being told?
A. That is what that would say to me.
Q. So this isn't a negligence issue, it seems; it's not medical negligence, incompetence?
A. Well, that, that's -- they are saying there is no evidence.
Q. Yes.
A. Sorry, my note just says "Clinically no evidence re staff member", so I take that in the round. I don't know if -- we certainly didn't discuss whether there was a sort of medical malpractice, a clinical negligence issue about the care given. It just says "Clinically no evidence re staff member", but I would, I would, yes, I would assume that what they have done is said, "We have looked at the clinical information and there's nothing to see about that staff member and their care".
Q. She's done nothing wrong clinically?
A. That, I can't remember that but that's my

interpretation of what's being said there.
Q. Okay. So why are the police being mentioned?
A. Why, sorry?
Q. Why are the police being mentioned? If there is a high number of deaths, correlation with a nurse, but no concern about her clinical practice, why are the police being mentioned?
A. Well, I assumed the police were being considered in order to check whether there had been any offences and, as I said earlier, gross negligence manslaughter would be part of that and would be much more normal for me to encounter.
Q. I appreciate it would be much more normal but there is other offences that occur --
A. Yes.
Q. -- particularly in multiple cases. Gross negligence does occur, usually it is a single event, the classic anaesthetist not putting in the tube the Adomako case, with which law students are familiar, but multiple deaths: why did you assume it was gross negligence manslaughter and not murder?
A. So I think I answered that earlier but I am happy to go over it again.
Q. Do.
A. In my world, murder is not something that is

seen very often at all. So very, very common is a range of poor competence clinicians who have sometimes on multiple patients -- so had difficulties with the care. So there are -- I get involved a lot in re-calls of patients, people who have been treated repeatedly by people in a poor way, that isn't necessarily obvious from the clinical data or clinical records even, but which comes to light over the course of looking at outcomes or some other raised concern.

So you are absolutely right, clearly murder is one of those issues. It wasn't at the forefront of my mind as a result of this conversation and, if it should have been, then of course it should have been, but it wasn't.

Q. I am going to put it to you that it should have been --

A. Okay.

Q. -- because you have read the note of Ian Pace, it is mentioning Beverley Allitt, so it's dropped a seed of suggestion that you are dealing with deliberate harm; you have multiple deaths of children; you have no suggestion of incompetence; and you have a clear potential cause of calling the police, somebody wants to call the police. So, in those circumstances, it had to be in your mind that there was a potential serious criminal offence as a possibility?

A. So I can only do my best with my evidence here and, and I can honestly say it wasn't -- it wasn't I don't think it was even in my mind at that point, it wasn't something that was -- I mean, the idea of somebody killing neonatal -- neonatal patients was not the thrust of that conversation at all and I absolutely understand why everybody would now wonder why not.

But it genuinely wasn't. So I -- I can't explain it any better than that, I am terribly sorry, but I have explained why I advised in the way I advised.

Q. Can you explain who was considering calling the police?

A. Not a specific individual, no.

Q. So was it Sue, or was it someone else?

A. I -- I wasn't given that information.

Q. Did you ask?

A. No, I didn't. I took it, I advised people corporately, so I took it as the Trust was wanting some advice or some, some view on what to do next. So I didn't take it as an individual calling me because we are not instructed by individuals.

Q. So just in terms of your curiosity about why the police are being mentioned, because it is highly unusual, isn't it, in the context of neonatal care to be thinking about calling the police in respect of a nurse,

it is a very unusual situation, it is a sort of red-flag conversation?

A. It is unusual. I think it's, it's -- increasingly people -- we all have open minds to has some care gone to the point where there is a criminal issue. So the increase in criminality, if you like, of poor clinical care is something that I am -- as was and am very familiar with.

So the idea of the police being involved in healthcare where there are adverse incidents or issues of concern is not as unusual, as you might think. It's not every day by any stretch. It's becoming more common.

Q. What did you think the phrase "Clinicians are saying it's her" meant?

A. Yes, I mean, I have written that down as something that Sue has clearly said to me. I -- I didn't seek to interpret that other than this individual is still someone being considered as is she involved in this or not.

Q. The reading to the person coming at it cold --

A. Yes.

Q. -- looks like they are pointing the finger and saying "She killed those children"?

A. Okay. I --

Q. Do you see that?

A. I see it here and now absolutely. I -- I didn't take from that call that they were accusing her of murdering neonatal babies because that's not the advice I would have given had that been my belief at the time or what I had taken on board. That wasn't in the way in which that was put to me at all.

Q. I wonder if you should have asked more questions, in the circumstances?

A. I am absolutely open to people suggesting that. We only do our best.

Q. Your advice, I think, had you understood it to be that the doctors were accusing a nurse of killing patients, would have been very different, no doubt?

A. Of course. Of course.

Q. Call the police?

A. Yes. But this, this whole call, it was a 42-minute call, where we went over a lot of ground that Sue Hodkinson was trying to convey to me cold and I took away from that call -- I did not take away from that call the idea of there is a nurse potentially killing babies in this hospital.

That, it simply would not have been my advice if that was what I came away from that call thinking.

Q. Knowing what you now know, I don't know

whether you have followed this Inquiry in any detail but there was a lot of evidence being gathered over the preceding year about the deaths as they continued and increased and, certainly within the doctors' minds, by this time of this call, they were suspecting that Lucy Letby was killing babies.

Do you feel that you were misled by Sue Hodkinson in this call, about the nature of the concerns about which you were being asked to advise?

A. So I think there is a couple of things I would like to respond on that. So firstly, although of course natural curiosity means that one follows an Inquiry like this, because I knew I was giving evidence I have not read through all the material and the evidence because I didn't want to put things in my mind that I simply didn't know when I was advising. So I am not all over the detail of who knew what and when.

However, I -- I do think that I didn't have all the information that you suggest it was available by the July period in 2016, because it doesn't feature in my note as part of the narrative and the history given by Sue. I think it would be unfair of me to sit here and suggest that she misled me because I don't know, I genuinely don't know. I think she would have to answer that for herself.

Q. Well, if she knew that the Consultants thought Lucy Letby had killed the babies and she didn't tell you that in a conversation in which you were being asked to advise about calling the police, then that would be a serious omission, wouldn't it?

A. I would be disappointed to learn that, yes. I -- I am trying to be really fair to somebody that I don't know and I know is going to be called to give evidence to account for herself. I can only tell you what I was told and, if I wasn't told everything that was known, then that would be disappointing to find out and that appears to be the case.

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

LADY JUSTICE THIRLWALL: Thank you, Mr Skelton.

MR BERSHADSKI: I think, my Lady, if there could be a short break now before the next witness is called.

LADY JUSTICE THIRLWALL: Yes, certainly, I think we can infer from that, Ms Slingo, that your evidence has been completed. Thank you very much for coming and you are free to go.

We will just take a short break and start again at 3.00.

(2.50 pm)

(A short break)

(3.00 pm)

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

LADY JUSTICE THIRLWALL: Do come forward.

MR SIMON MEDLAND (sworn)

Questions by MS LANGDALE

LADY JUSTICE THIRLWALL: Do sit down.

A. Thank you.

MS LANGDALE: Mr Medland, you have provided a statement to the Inquiry dated 2 July 2024. Can you confirm that the contents are true and accurate as far as you are concerned?

A. Yes, I can.

Q. You tell us in the statement that you were called to the Bar in 1991, you were appointed then Queen's Counsel in 2011, working from Exchange Chambers from that time in silk; is that correct?

A. That's correct.

Q. You were instructed for our purposes in April 2017 by Mr Stephen Cross, on behalf of the Countess of Chester Hospital. We know from your statement that there was a conversation between yourself and Mr Cross on the telephone and subsequently a number of documents sent to you.

Can you tell us, first of all, about the conversation and then we will look at some of the

documents that were sent to you. What do you remember now about the contact or telephone contact from Mr Cross?

A. Nothing other than that which I have put in my statement, really. It was a general conversation to talk to me about the impending instructions which he intended to give and a general scene setting. I'm afraid I am unable to assist with anything more detailed than that, above and beyond what I have put in my statement, namely a general conversation. There was concern amongst some of the Consultants about serious occurrences in their part of the hospital and he wanted me to consider those and then report to the board, and he indicated in that conversation that the Consultants were not content with the way the hospital had dealt with the matters that they had raised.

And that there was dissatisfaction in the working relationship. As I have termed it in my statement, it was not at all harmonious.

Q. Had you worked with Mr Cross previously?

A. A few times, yes, I had been instructed on behalf of the hospital to attend certain Coroners' Inquests and the like not very many, perhaps half a dozen, I think, and therefore I had been instructed by him before.

Q. Half a dozen over what period of time?
A. Probably a couple of years, something like that.
Q. You say:
"He was instructing me to bring independent common sense and wisdom to bear on the situation in which he stated he had considerable concerns as to what was unfolding in front of him and the hospital but in which there was some tension arising from the various duties of care which he had."
A. Yes.
Q. Would you like to expand on that: what was his concerns?
A. Throughout my involvement in this, and certainly subsequently, as the court cases became public news and then the Inquiry was under way, I have reflected many times that the -- there was a series of not always aligned duties of care, which he and others found themselves rather caught in, was my impression.
For example, he had a duty of care to the hospital but also to the patients and the staff. The staff had duties of care to each other and the hospital but also the patients. And this internal problem, where the whole thing seemed internalised to me, was one of the features which I felt did not help and certainly he

expressed those views to me that he felt rather pulled, as it were, from pillar to post.
Q. Did you know Mr Cross personally in any capacity?
A. A little. I mean, in the sense that Chester is a small city. His brother had been and possibly still was, at that time, a defence solicitor, who I don't think I ever was instructed by, in North Wales but was certainly a personality there, and I was aware of him. So I had met Mr Cross a few times but --
Q. In social occasions?
A. In social occasions, in the sense that he was someone who helped at the cathedral. I would see him there and around at various events as might occur in that sort of ...
Q. Would you have characterised him as a personal friend --
A. No.
Q. -- or a colleague with whom you were friends or how would you categorise it?
A. A colleague with who I was friends, an acquaintance. For example, we had never been out together privately, we had never been to each other's houses or anything like that, but I knew him and was on first name terms with him.

Q. So you understood that he felt conflicted by various duties of care. We know -- I will just put it on the screen so people can see. INQ0088716, page 1 is an email and it's an email that identifies:
"Please find attached papers as discussed to you from Stephen ..."
At the bottom, if we look at the bottom page 1 and then 2, over the page?
A. Yes.
Q. "Please find attached papers ..."
A. I think this was the packet I was given this morning -- this afternoon when I arrived.
Q. That's right, yes. When we asked you in your Rule 9 what material you had received, there was less clarity than this email appears to help us with because we see this was forwarded by Claire Raggett to the organisation Facere Melius, at the top of the page, who were examining events and providing a report to the hospital.
So we see at the top this email reflecting with the attachments that may have or appear to have accompanied your email. So if I can take the documents in turn --
A. Yes.
Q. -- those attachments referred to. The first one suggests that you received the Countess of Chester

RCPCH Neonatal Final Confidential Report. We know the RCPCH reported, and if we can have on the screen INQ0009618, page 9, this is the page from the RCPCH report. First of all, do you remember that you had got the Royal College report?
A. I'm afraid I couldn't say that I definitely did but plainly I did.
Q. Okay.
A. I just have no recollection of it.
Q. You say in your statement you thought you had the Jane Hawdon report?
A. Yes.
Q. The Dr Hawdon report. That is not referred to here?
A. No.
Q. Might you have got more information subsequently or do you think you got one batch of information. I appreciate it's a long time ago, you may have confused the two reports or not?
A. It is and I'm afraid I couldn't say with any certainty one way or the other, I'm sorry.
Q. You tell us that in your statement: it's difficult to recall now?
A. Yes.
Q. Obviously, you don't have the records from

that time now, but you recall Jane Hawdon's name?
A. Yes.
Q. And you're confident in answering that you did have a "report?" from her.
But looking at this page for us, if you can, this is a page in a confidential report from the RCPCH. Do you remember if you saw this page of this report?
A. I have to say I'm sorry I don't remember it. But I am certainly not going to say I didn't see it.
Q. No, fair enough. But if we look at what it says in any event at paragraph 4, about a nurse, an individual nurse?
A. Yes.
Q. "The directors understood there was nothing about her background that was suspicious. Her nursing colleagues were reported to think highly of her and how she responded to emergencies and other difficult situations, especially when the transport team were involved. Apparently no issues of competency or training issues. Very professional and asked relevant questions demonstrating an enthusiasm to learn along with a high level of professionalism."
If we go to the next paragraph at the end:
"There was no other evidence or history to link Nurse L to the deaths and her colleagues expressed no

concerns about her practice."
A. Yes. Well, as I said --
Q. You don't remember seeing it, in any event?
A. -- I have no collection of seeing that, I am quite prepared to accept that I did. Not least because it tends to chime with the ultimate written advice I gave and, if one looks at the next --
Q. Let me take you to the next one. So that is the first one.
A. Okay.
Q. Let that one go down, if we can.
A. Yes.
Q. So it appears you have seen that and then if we can go, please, to INQ0014378, page 1.
A. Yes.
Q. This is something from Mr Harvey, "Neonatal Services Summary"?
A. Yes, yes.
Q. Let people have a look at page 1, I want to ask you about something at page 3 but to give people a chance to have a look at it.
A. Yes.
Q. We see there "no evidence" at the bottom:
"No evidence other than coincidence."
A. Yes.

Q. "Sequence of events. Highlighted at the meeting there was one member of the nursing staff who had been present at more of the cases than any other member. No evidence other than coincidence."
A. Yes.
Q. "Nurse noted to work full time, have the qualification and specialty. More likely to be looking after the sickest infant on the unit. Regularly worked overtime when the acuity was high or the unit was over capacity. No performance issues, no members of staff had complained."
A. Yes.
Q. If we go to the next page, page 2. Reference to two triplets at the top.
A. Yes.
Q. "Exacerbated concerns there being no obvious cause for the babies' collapse and it was alleged that the nurse referred to above was involved in the care of these babies and that unnatural causes had to be considered."
We see further down the page an internal review. The third paragraph:
"... correlated with the increased demand for higher level of care over the same period."
A. Yes. I see that.

Q. If we go to page 3 at the top, "Consultants" -- sorry, I should have begun at the bottom of page 2 before:
"The Consultants explained that their allegation was based on the nurse being on shift on each occasion an infant died, although not necessarily caring for the infant, combined with gut feeling."
A. Yes.
Q. "There was no other evidence or history to link the nurse to the deaths and her colleagues had expressed no concerns about her practice."
A. Yes.
Q. Then we see, at the bottom of that page:
"The Trust Director of Corporate and Legal Affairs and Medical Director met with the Coroner on 8 February following publication of the College review. They met again on 15 February. The Deputy Coroner was also in attendance. This followed a receipt of a letter from the Consultant paediatricians in which they asked that we ask the Coroner to undertake a full investigation of all the deaths and unexpected collapses (this latter isn't within the Coroner's remit) between June 2015 and July 2016 because they were not reassured that all the deaths were due to natural causes."
A. Yes.

Q. "This letter, together with Dr Hawdon's report was shared to the Coroner and Deputy and a detailed conversation was had regarding the paediatricians' specific concerns. The paediatricians' letter was shared with the College reviewers and Dr Hawdon, since in that letter the paediatricians highlighted that they felt that the concerns they had expressed were not included in the report."

A. No.

Q. So did you see that at the time, this -- do you remember seeing this?

A. Well, again, I do not remember it but it's part of the email that was sent. It was plainly sent to me and I, as it were, must therefore have seen it.

Q. If we look at page 4 under the summary:

"We can demonstrate that we have taken the concerns raised seriously and have been open and transparent with the Coroner, our regulators, parents and the public. However, despite extensive and intensive review, the paediatric Consultants still feel there are questions to be answered and we feel that we need to share the details and discuss it with the police."

A. Yes.

Q. Would you take that, that "we have been open and transparent with the Coroner, our regulators,

parents and the public", as fact, if you had read that?

A. If I had read that, which I am prepared to accept that I did, then I would take that as being fact, and it certainly chimed with my understanding of their -- of the hospital's approach, what they thought they had done, how they thought they had behaved. Certainly.

Q. There is another document, that one can come down, in the ones you were sent INQ0003226, page 1.

A. Yes.

Q. This is a document prepared by Mr Cross, 3 April?

A. Yes.

Q. All chiming with your instruction from the 4th?

A. Yes.

Q. We see this document entitled "Rationale", and it begins with number 1:

"In our view, there is no evidence to justify a criminal investigation. However, in the spirit of openness and transparency the matter is being reported to the police having regard to the fact that a number of Consultant paediatricians are not satisfied with the very thorough investigations and reviews undertaken."

A. Yes.

Q. We see repetition at 11, 12 and 13:

"The nurse is one of a few who are full time and regularly worked overtime. Highly qualified, tended to look after the sicker babies. No concerns regarding performance, she had not been involved in any other incidents."

A. Yes.

Q. "The Trust has demonstrated that it has taken the concerns raised seriously and has been open and transparent with the Coroner, regulators, parents and the public."

A. Yes.

Q. The last document you are sent, it would appear, is INQ0002926, page 1. This is a timeline not described by the author for you on the document but it appears that this is Ms Hodkinson's timeline that you were also sent, and we see at the bottom of that 8 July, "SPC phone call with Mr Moore, Deputy Coroner", who was updating the Coroner on the 11th.

So chiming with what you have been told about the Coroner, on its face?

A. Namely that the Coroner, do you mean that the Coroner had looked at such as was referred to him or them and concluded that there was no clear outcome; there were unascertained reasons for death.

Q. There's also a reference, but I am not going to ask that it goes on the screen, but for those in the room or CPs, at page 5 there is also a reference to a call with a parent as well. I don't need to take you to that but, on its face, reflecting a call to parents that you had been told there is transparency with parents, the public and the Coroner. Did anything within the documents you were sent suggest anything else?

A. No.

Q. You then have a meeting on 4 April with Sir Duncan Nichol, Mr Chambers, Mr Harvey and Mr Cross. If we can go please to INQ0003351, page 1. First of all, can you remember why you were meeting with the Chair of the board, Mr Harvey and Mr Cross first at this point?

A. No. My, my only recollection or imagining is that it was in order to equip me the better to speak to the Consultants, I think, which came subsequently, didn't it?

Q. Do you remember at the beginning if you were asked to do that from the off or were you asked to just advise the board at the outset; did you know?

A. What to meet with the Consultants, do you mean?

Q. Yes, which was it: were you supposed to be advising the board as to what to do or when did it become ...

A. Well, I can't -- I cannot now remember whether, whether the hospital said I was to meet with the Consultants or whether it was my idea to do so.

Q. This meeting might assist with that, if we look at the meeting minutes on 4 April?

A. Yes.

Q. It says at the top, "Mr Chambers outline", so it looks as though he outlined the meeting. Do you remember anything of that now, what he outlined as the purpose of the meeting?

A. I am, I'm afraid not, I'm sorry.

Q. Then says:

"Do not use para 1 re no evidence to justify a criminal investigation."

Do you know what that meant we have seen that reference in Mr Cross' document rationale document, but?

A. Yes, and I think I referred to in my statement because I think I was asked -- was I asked a specific question about this, or am I misremembering.

Q. No, you may have been. We will have asked I about these handwritten notes, yes, but can you remember now?

A. Let me -- if I can just have a moment to remind myself because it sticks in my mind that I was asked a question about this in devising my -- writing my statement.

Q. If you look at paragraph, on page 4 of your statement, 95. You say:

"I do not know what para 1 was nor do I know of which document it was. It was my view, having been instructed by Mr Cross, and hearing his summarised account that I needed to keep an open mind and I certainly never formed any conclusions before meeting the Consultants."

A. Yes.

Q. Is it that you are thinking of?

A. It may well be.

Q. That is where you were asked about it.

A. Yes.

Q. So when you say "Do not use paragraph 1", so?

A. Whether that was -- it may have been -- it obviously refers to para 1 of something, a document. Now, whether it was my saying that it was not correct to say that there was no evidence at the time because I hadn't seen the Consultants, I'm afraid I am rather at a loss to know without seeing the surrounding documentation. But it may have been that.

It certainly refers to paragraph 1 of a document.

Q. We then see further down reference to 13 deaths, five explainable, eight not explained?

A. Yes, yes.

Q. Do you know who said that and what did you understand from that at the time?

A. I don't know who said it. That was my understanding of the -- it chimes with my understanding of how the hospital saw the medical outcomes, if I can put it in that rather bland way, that they were faced with. That they understood there to be five explainable deaths and five unexplained.

Q. Then right thing to report to police?

A. Yes.

Q. Do you know who said that?

A. Again, I am afraid not. There appears -- is the letters "IH" on the line below?

Q. Yes.

A. Now, whether that was Mr Harvey who said all those things or some combination of them, I don't know I'm afraid. I'm sorry.

Q. Then under "Advice", it said:

"Any mileage in speaking to the Consultants again?"

A. Yes, right.

Q. May that have been -- you said that might have been your suggestion?

A. Yes.

Q. Could that have been your suggestion?

A. It could have been.

Q. "No evidence, no lead. Agree we need to get to the bottom of this."

A. Yes.

Q. "If you force us to, same team best outcomes." Doing the best you can, can you help us with what may have been said by you then?

A. Rather in line with my answer in respect to the question earlier on, "do not use paragraph 1 re no evidence", I have it in my mind that there was, there was a document somewhere in which somebody had written something along the lines of: if you force us to ... or I was saying that that would be an incorrect impression to give, that the hospital were being forced into acting thus implying that they had taken a view that they ought not to if that rather opaque answers makes any sense to anybody.

But what exactly I was referring to, perhaps what I was saying there was that the hospital ought not to be seen to be forced into action which might imply that they didn't want to take action which was not my impression at all, or that that they weren't willing to

take action, something along those lines I think is the only explanation I can give to it.

Q. Indeed when you say it wasn't your impression that they weren't going to be forced, the two documents we have gone to, both from Mr Cross and Mr Harvey say at the end that they are considering going to the police, they want to go to the police?

A. Yes, indeed and although the precise date of it is not something that I know very shortly after my report to the board they did call the police in, I'm not entirely sure exactly when but it was shortly thereafter.

But this brings me back to the point I made a few minutes ago about the "not always aligned duties of care", the feeling that Mr Cross and I am sure others in the hospital had, that they were -- they didn't quite know what to do for the best because they had some very highly qualified well-informed people who were reporting very serious concerns about outcomes, fatal outcomes, on the unit, and then on the other hand they had a series of highly qualified, well-informed investigators, Royal College and the like, Coroner, who had come in and none of them could find a problem to -- on which you could definitely put your thumb.

And of course the pressing question was whether the

problems they might have been training problems, or negligence problems or poor working practice problems or they might have been problems inherent in the infant patients or it might have been a terrible series of crimes, as we subsequently find out it was. And at this stage the hospital, bearing in mind -- my impression of them was that they didn't really know what.

Q. "Any mileage in speaking to Consultants again?"

You suggest that. What were you thinking the purpose of speaking to the Consultants would be or --

A. Because I was actually quite surprised at what appeared to be the -- which I hadn't anticipated, appeared to be the considerable antagonism between the hospital and the Consultants which became apparent to me quite quickly once I had become involved in this but I hadn't anticipated it and it was strongly underlined and emphasised when I did actually meet them again.

Because they -- they were collectively angry.

Q. Let's just look at this meeting for a minute. I will take you to the Consultants' meeting.

A. Yes.

Q. But when you say you became quickly aware of the difference --

A. Yes.

Q. -- of opinions, was that in this meeting, this is the first time you sit with the Executive Team, as it were --

A. Yes.

Q. -- and Sir Duncan Nichol. Did you pick it up then in this meeting or in your conversation over the telephone with Mr Cross or when you met the paediatricians, when did you realise?

A. So overall in my personal involvement in this was a fairly short period of time, I think about 10 days. I wouldn't say it was necessarily at one point as opposed to another but it was certainly by the time of this, by the time I had spoken to Mr Cross, seen what I was able to see in documentary form and then had the meeting, it was obvious that the Consultants were feeling overlooked and not being taken seriously.

Q. So you go and meet the Consultants and we are going to go to your minutes on 12 April.

A. Yes.

Q. The Consultants who have given evidence, Dr Jayaram says accept the minutes, and Dr Brearey, in terms of what they state. But it was a long meeting, wasn't it, 90 minutes was the meeting?

A. Yes.

Q. One of the things they took issue with was the

purpose of the meeting and their understanding was different from yours they thought about the purpose of the meeting. Can I ask you just to have a look an email from Dr Jayaram to Mr Harvey --

A. Yes.

Q. -- which you wouldn't have seen at the time but INQ0006136, page 1. You see here Dr Jayaram to Ian Harvey he says at the top:

"We are happy with the minutes. However, at the start we had a discussion about our respective understandings of the purpose of the meeting which highlighted a discrepancy. We had been led to believe that the purpose of the meeting was to help the Trust to frame what needed to be said to the police whereas Mr Medland told us that his brief was to discuss whether there was enough in our articulated concerns to make reporting to the police worthwhile."

A. Yes.

Q. Can you remember now what you said about the purpose of the meeting and whether there was a difference between you, as Dr Jayaram explains, because their understanding at this point was you were going to the police and that was the case?

A. Yes.

Q. And it was a question of how it was done

whereas you were asking the question --
A. Yes.
Q. -- effectively whether there was enough in the concerns to go to the police, do you see the distinction?
A. Yes, I do.
Q. So what do you say about that? Was there a difference of opinion about that or how did you approach it?
A. Well, it is -- it is obvious from the email letter that there was a difference in understanding. I am sure that his record of what I said as to my understanding of why I was there was accurate. I -- I can't I'm afraid shed any light on the Consultants' understanding or where they had got that from.
Presumably from their dealings with the hospital, that was their understanding. I -- I don't know why.
Q. Was your understanding at that meeting we have just gone to with Mr Harvey, Sir Duncan Nichol, Mr Cross and Mr Chambers, was your understanding within that meeting that you were going to look at whether there was enough when you had that meeting with the Consultants, let's go have a look to see if there's enough?
A. That was, that was essentially my understanding.

Q. Do you think that was their understanding too on 4 April that you were going to have that conversation or discussion to see if there was enough in their concerns to make a report to the police worthwhile?
A. Essentially, yes, because -- and it goes back to the internal non-aligned duties of care point that I made, the hospital as far as I knew would have been all too keen to go to the police if they could be sure that by doing so that they had every reason to do so. Whereas by the time I became involved and this was obviously months after the first concerns had been raised, the matter had already been looked at by several different people or groups of people and every time it was looked at, it didn't seem to get any clearer.
Therefore, the non-aligned duties of care under which Mr Cross, Sir Duncan and the others were working never seemed to get any less difficult to resolve. One way might have been for me to go to speak to the Consultants and that was how I ended up doing so, to crystallise it. Because rather going with the point that I think I have made in my statement to the Inquiry, this wasn't a situation where they were coming with a very particular case and saying to me this is our evidence to justify it or not quite that I could see.
Q. When you say "they" do you mean the Executives

and --
A. No, I mean the Consultants in that and I think part of the problem may be -- may be -- that by the time I became involved there had been so many internal difficulties which had been thrown up by this investigation of human resources nature and problems with colleagues and personnel in that regard that really it had become anything but clear.
Q. Let's have a look at the minutes of meeting, thank you.
A. Yes.
Q. That can come down. So INQ0003091, page 1.
A. Yes.
Q. So these are your minutes --
A. Yes.
Q. -- of a 90-minute meeting so you have obviously drawn together threads afterwards. We see page 1 there, if people can read those first and then we will go to the next page?
A. Yes, thank you.
Yes.
Q. You see the next page:
"We all agreed that if there was an identifiable common thread between some of the deaths (cf Beverley Allitt) then this would be powerful prima facie

evidence that there was potentially a crime or series of crimes which had been committed"?
A. Yes.
Q. Do you remember now whether one of the Consultants mentioned the case of Beverley Allitt or you did or how the discussion landed there?
A. I can't say who mentioned it. I think that it was just to draw a distinction between the Beverley Allitt case and this which seemed to be relevant at the time. That is to say it was clearer in that case than it seemed at this moment.
Q. Then we see at paragraph 6, you gave your view:
"The police, being strapped for resources in any event, can only sensibly investigate cases where there is at the very least reasonable grounds for suspecting that a criminal offence has been committed. He emphasised this was very different from there being mere suspicion and also very different from where there were questions about hospital procedures and processes as distinct from criminal actions."
A. Yes.
Q. "SM remarked that officially reporting any matters to the police was a condign step which was effectively a public action and would incur adverse

publicity and raise matters for the families of the neonates which might be seriously disturbing."

Just going back to page 6 and the beginning of that advice. Of course the police do investigate where there is a mere suspicion, don't they? They should and can investigate where suspicions and concerns are brought to them?

A. Yes.

Q. So do you think that was overstating that in this difficult meeting to say they need at the very least reasonable grounds for suspecting a criminal offence has been committed?

A. Yes, I do.

Q. So looking back now, saying a suspicion is enough may have been a better way of summarising that?

A. Yes, I think it would have been.

Q. You comment at the end a condign step, which is effectively a public action and would incur adverse publicity?

A. Yes.

Q. Obviously baby safety is first and foremost, isn't it, and paramount in all of this?

A. (Nods)

Q. So what is it that took you to the "condign step" and "incur adverse publicity", what did you think

the impact of that was set against baby safety generally?

A. It was a matter which prayed on the minds of the hospital. It is not I think to be divorced from the not always aligned duties of care point. One of the matters which seemed to concern the hospital considerably was the prospect of starting a criminal investigation which would have impacted on families who had already undertaken the grieving process and what if the bringing in of the police was to give an indication of criminal action and criminal investigation when actually it had been sadly a course of nature or something less than crime, for example bad practice or negligence or something of that nature.

Q. Was it the Executives who were concerned about that second point, that if it wasn't the case that Letby was responsible for causing deliberate harm there would be adverse publicity and they were worried about that?

A. They were worried about it for the reasons that I have stated. I don't wish to imply that they took a -- I had -- nothing gave me the impression that they took a light view of publicity in the sense that they just didn't want nasty headlines.

Their concern was directed towards the outcomes for the Families who had already had to deal with the death

of their babies.

Q. Paragraph 10, you were involved in discussing a broader forensic review and what that might amount to and you record they were not blindly pressing for the matter to be reported but wondered who else might conduct such a review?

A. Yes.

Q. The Coroner, Mr Rheinberg, had effectively declined to do so and in any event a probable conflict of interest was identified.

What was the conflict of interest that you understood may have been identified or you identified, I don't know, how was that arrived at?

A. I'm afraid to say I can't help. I re-read these when I was compiling my statement and I wasn't entirely sure, frankly, what I was referring to there. But as I recall, the Coroner had declined to conduct an investigation but what the probable conflict of interest was identified, I'm afraid I can't now say, I'm sorry.

Q. You repeat at paragraph 12 you didn't see as the material, as things stand, gave rise to reasonable grounds for suspecting?

A. Yes.

Q. And I think you agree that that was overstated at the time?

A. It was.

Q. The police would have been and should have been interested with the level of information the Consultants had?

A. Yes.

Q. To be clear, I mean, Dr Brearey told us in his statement they were giving you examples. For example, they were talking about one baby, we know the baby as Child I, and they explained that she was transferred between hospitals, the Countess of Chester and another hospital on a number of occasions improving at the other hospital and deteriorating rapidly at their hospital. That was one of the examples they gave you, wasn't it?

A. It was and another one was the repeated highly unexpected outcomes for Twins, I remember.

Q. Did they mention rashes as well, was something said to you?

A. Did they mention what, sorry?

Q. Anything said about rashes on babies?

A. Yes, I am sure that there was, but ...

Q. Dr Jayaram describes you at one point saying "now you have piqued my interest". Is that a phrase you would have used, "now you have piqued my interest" when they were telling you, for example, about Baby I or details, that they were interesting and important

points?
A. It might well have been, yes.
Q. Because you appear at paragraph 14 listening to them, you then say:
"What was needed, they should make short notes setting out their best points, those matters which they say most clearly indicate in their minds reasonable grounds for suspecting that a criminal offence has been committed. It would help to crystallise matters and push them forward to a sensible conclusion. It would help everyone to deal with the matter head on in an inclusive, collegiate way."
A. Yes. Yes.
Q. Then at paragraph 16, you thank everyone for their time, emphasise:
"... had there had been clear information leading to reasonable grounds for suspecting criminal offence he would have no hesitation advising the hospital it is their public duty to report the matter. He indicated his view the Hospital Trust would agree with this course was cautious of proceeding along that path in the apparent absence of such material given the serious public and irrevocable nature of such a step?
A. Yes.
Q. We know subsequent to this meeting the

Consultants did email each other and put together a document --
A. Yes.
Q. -- of concerns. Indeed it was Dr Brearey who said had they been asked to do that earlier by no one in this pre-session the crystallisation for others, if it hadn't been obvious by what the Consultants had been saying along the way --
A. Yes.
Q. -- may have been clearer?
A. Yes.
Q. Can we please now go to the minutes of the board meeting held on 13 April, that can go down, INQ0003236, page 1. This is the meeting that you attend on 13 April we see the attendees on the front the chairman, Sir Duncan Nichol, Non-Executive Directors?
A. Yes.
Q. Chief Executive, Mr Harvey, and yourself in attendance.
If we go over to the page, please, and if we could all have a read of paragraphs 2 and 3, you repeat at paragraph 3:
"No evidence of crime but the Consultant view is to go to the police. He suggested an alternative approach would be to approach the police member of the Child

Death Overview Panel although it's possible he may say he is unable to help due to his position. He also suggested the Coroner, Mr Rheinberg, but there would be a conflict of interest."
You have expanded upon that earlier because you understood he wasn't inquiring into the deaths?
A. Yes.
Q. You say in the paragraph below:
"Mr Medland added that you need to accept that if something is still unanswered or there are still genuine concerns in well-minded people, you should go to the police"?
A. Yes.
Q. On the next page, page 3, penultimate paragraph, you say it may help to sit down with the Consultants, not ignoring their concerns. We are going to do this with you as one team.
A. Yes.
Q. Need to bring the Consultants back to the fold. Here is the action plan and you want to work with them.
You might want to have Dr Hawdon be asked what's the forensic review and why the Level 2 cases?
You say candidly in your statement, Mr Medland, you were not a clinical negligence barrister or a medico-law

barrister or a family safeguarding law barrister, so that recommendation, what she said wasn't something you scrutinised for yourself or unpacked to see what was required --
A. No.
Q. -- there?
A. That's correct.
Q. And you are suggesting the Consultants and the Execs did that together or thought about that?
A. Yes, because they certainly weren't working together was my impression because quite -- quite the contrary.
Q. You say at paragraph -- page 4, the third paragraph up from the bottom, Mr Chambers asked you about paragraph 14 in the minutes and paragraph 14 was where you had suggested they put their best points together. So Mr Chambers asked you about that?
A. Yes.
Q. "Mr Medland said the Consultants have swirling ideas about potential crime. I said it would be helpful for them to think about what crime they thought had happened, ie, did it always happen at 2am? It is about designing a process to shed light on any issues as you cannot just go to the police with some detail."
We know that in the Thematic Review Dr Brearey had

identified a pattern of deaths at night?
A. Yes.
Q. It sounds as though you are coming up with 2.00~am. May they have said that to you as well something about that?
A. Yes, it may well have been and I am prepared to accept that it was, to be -- to be balanced against the previous inquiries and investigations of a medical nature which had taken place, which never seemed to come to a conclusion that crime as opposed to anything else had occurred.
So that was why I thought it would help because the Consultants, obviously brilliant and experienced people, well-intentioned people, they were clearly of a view which was not clearly the view of other people, of similar quality and experience and insight and therefore, my idea that the Consultants put together their own, as it were, best points to put their case clearly was, I hope, of some help.
Q. If we go to page 5, three paragraphs from the bottom, towards the end of the meeting:
"Sir Duncan asked if everyone was comfortable that the Trust explores with Dr Hawdon to take the forensic review forward. Everyone confirmed that they were content with this approach.

"Mrs Hopwood asked would it be 4 or 8 cases?
"Mr Medland replied it states Class 2 cases.
"Sir Duncan added that it would not be limited as it is not yet known what the forensic review means."
So there appears to be general confusion around what that review meant in this meeting, the forensic review?
A. There may well have been. It was a very large number of people, I recall, at the meeting. So I think there probably was.
Q. And then we go over the page, page 6, paragraph 3 below.
"Sir Duncan said that one consequence, as LL is expecting to come back to work and what we do say to her about the delays are not for the whole board to discuss but it is important to get it right when explaining the further delay."
A. Yes.
Q. So that's where the meeting left. When you left the meeting, did you know what they were going to do next, what did you think they were going to do next and did you have any further communication on the topic?
A. I don't recall any further communication from them. I am aware that they did go to the police fairly shortly afterwards, although I can't put a date on that.

You would know. But they -- they ended up doing that.
Q. Sorry I turned my back, Mr Medland, sorry.
A. Not at all. I was just saying I didn't have any further dealings with them after this. I left the meeting once I had made my report to them and that was, as it were, the last involvement I think I had. Although they did go to the police fairly shortly afterwards.
Q. They did and we know that Dr Jayaram sent a letter directly to Mr Wenham who gave evidence yesterday. There was further meetings between Executives and Mr Wenham later?
A. Right.
MS LANGDALE: Those are my questions, there may be others.
A. Thank you.
LADY JUSTICE THIRLWALL: Mr Baker.
Questions by MR BAKER
MR BAKER: Thank you, my Lady.
Mr Medland, I ask questions on behalf of the Families of 12 of the babies who were affected.
Can I just ask about the circumstances in which you were instructed by Stephen Cross?
A. Yes.
Q. He called you directly in chambers, is that

your evidence?
A. I think so.
Q. Is that a common way to receive instructions?
A. No, not for me and certainly not then. Normally it would be presumably a telephone call to the clerk in chambers and then a letter from the solicitors. But I think he called direct having spoken to my clerk, I think.
Q. Your relationship with him beforehand, it's correct to say, isn't it, you are a very senior Freemason?
A. It is.
Q. Within his witness statement to the Inquiry, Mr Cross lists some directorships that he holds?
A. Right.
Q. He's a director of both the Chester Masonic Development Freemasons' Hall (Chester) Limited?
A. Yes.
Q. And the Masonic Hall, Cheshire View Limited?
A. Right
Q. Also a trustee of the Cheshire Masonic Benevolent Association?
A. Right.
Q. So it is clear that he also has connections with the Freemasons as well?

A. Yes.
Q. Dr Brearey gave evidence yesterday about his concerns about the nature of your instruction in the case?
A. Right.
Q. And his belief or rumours that he had heard that there were Freemasons on the board of the Countess of Chester and that that connection had led to your instruction?
A. Well, there was no Masonic context to my instruction. I mean, if I can try to deal with this. As it happens, Stephen Cross is a Freemason and as it happens, I am a Freemason. We are not members of the same Masonic Lodge. We are not close friends. I have been a guest of his I think once, many years ago at his Lodge and I don't think he's ever been a guest at mine.
There is no Masonic context to this to my mind at all. Had there been, I can assure you, and anybody who's concerned with this Inquiry, that I would have been entirely candid about that. To my mind it is of no more impact or relevance than if, for example, we had both had an interest in Crown Green Bowls or church bell ringing, to my mind, but I will happily deal with any concerns in that regard.
So over to you.

Q. Well, in that case why did he instruct you?
A. He instructed me I assume because he thought I would be able to do a good job.
Q. Of -- of what? What was the nature of your instructions, what were you being asked to do?
LADY JUSTICE THIRLWALL: We have been through that.
MR BAKER: Well, I can put it a different way.
A. I -- I think I have fairly stated the nature and extent of my instructions and just pausing there for a minute. And dealing finally with the point you made rather surprisingly a few moments ago about Freemasons.
I am not aware of anybody else on the hospital board, at all who is a member of the Freemasons, either a man or a woman, I think I should say that.
Moving back to my instructions, I think I have dealt as fully as I can in my witness statement with what my instructions were.
Q. Well, Mr Medland, it is not a surprising thing to put, it was raised by a witness --
A. Yes.
Q. -- and the Families who I represent are concerned by it?
A. Right, I will happily deal with it.
Q. It is put for the right reasons.
A. No, I am sure it is, I am sure it is.

Q. You have no experience in healthcare investigations?
A. No.
Q. Did you see any issues at all with the Royal College report or the Hawdon report?
A. Did I what, sorry?
Q. See any issues at all with the structure or scope of the Royal College report or indeed the report by Jane Hawdon?
A. Insofar as I understand the question you put, no, I didn't. But I am not quite sure what issues I might have seen with them.
Q. Sorry, I beg your pardon. You didn't, when you reviewed the Royal College report --
A. Yes.
Q. -- feel any concern that it didn't address directly the question of whether there were acts of homicide or suspected acts of homicide or investigate the basis for those?
A. At -- at the time, no.
Q. Did that surprise you?
A. At what point?
Q. At any point?
A. It certainly surprises me now.
Q. Yes.

A. Because as I repeatedly stated in my witness statement in general terms, looking at matters then it's very different from looking at matters now after an exhaustive police investigation and a very high profile, very long trial.
I can only, say, speak to matters concerning my involvement then rather than now but it certainly surprises me now, if "surprise" is the right word, that such investigations as there had been by qualified people, by the time I became involved, had all rather led to a lack of clarity, not a clear picture.
Q. When you were reviewing those reports at the time, I think your position in answering questions from Counsel to the Inquiry a moment ago was that you saw that investigations had been carried out?
A. Yes.
Q. May have taken some reassurance from the fact that they had not exposed any evidence of deliberate wrongdoing?
A. Yes, they had not come to the conclusion that there was clear evidence of crime as opposed to anything else.
Q. But when you read them, you must have realised that those reports did not address directly or at all the question of whether or not a crime had been

committed?
A. Yes, I -- I think I see the point that you are asking about. Prior to the Consultants crystallising their particular best points, as it were, the case that they were pressing, it was all dealt with on a much more diffuse basis, I imagine. And the Consultants were not -- the Royal College, for example, and other people who had investigated the matters were not tasked with putting together a criminal case.
Q. Or indeed even investigating crime on the face of it, they were Casenote Reports into causes of death in the case of Jane Hawdon's evidence, and in the RCPCH, effectively a service quality review.
So looking at those pieces of evidence when you reviewed the case, what reassurance could you take from those as to whether or not a crime had been committed or not?
A. I don't know. I mean, I am not quite sure what -- what you are asking me to speak about. I read the reports such as I could and put them in my mind and built them into my understanding together with the other aspects of my involvement. I was not charged with making a critical analysis of the quality of those reports.
Q. Were you possessed of the necessary experience

to make a critical analysis of those reports?
A. Arguably not.
Q. When you listened to the concerns of the Consultants, what level of proof were you anticipating that they would provide with regard to the question of whether or not police should or should not be called?
A. It seemed to me that the potential outcomes of the various investigations would have been to see whether there was, for example, mere bad practice or poor training or poor supervision or some combination of things like that.
The difference between those and whether there was in fact a series of very serious crimes which were being committed, as we now know undoubtedly there had been, was really the -- the distinction between the two.
Q. The Consultants were quite clear with you that they were concerned that criminal acts had taken place?
A. I'm sorry, that they ...?
Q. That they were concerned?
A. Yes.
Q. It may be the microphones.
A. Not at all.
Q. They were concerned that criminal acts may have taken place --
A. Yes.

Q. -- and that the police needed to be called?
A. Indeed and that they felt, I think, that they had been drawing had been saying that for some months.
Q. Yes.
A. And had not been listened to from their point of view.
Q. Did you have the skills or experience to weigh up and understand the basis for their concerns which must have been founded in their significant collective medical experience?
A. Yes, they were not the only processors of significant medical experience that I encountered in this process. I have freely conceded that I had no specialist knowledge of medical law or hospital law or anything like that but I felt I was in a good position to judge their concerns, especially if they were, as it were, reduced into a clear set of their best points.
Q. But how are you in a position to arbitrate between these two groups of people? On the one hand the Consultants, on the other hand Stephen Cross, Duncan Nichol, Ian Harvey, Tony Chambers? Yes, are these the two sides of the dispute?
A. Well, I am not entirely sure I would agree with that as being a characterisation of the two sides at all and neither was I charged with arbitrating

between those people. I was invited in because by that stage there was obviously a very significant set of concerns which had been looked at many times by many different people and had always ended up in the same point; namely, aside from the Consultants' view we can't be clear that a crime has been committed, to summarise it. Those are my words, not theirs so I was not charged with arbitrating between them and I think I had sufficient abilities to understand if there was clear evidence of a crime.
Now as it happens, as it happens, it has been manifestly proved that on the basis of the information I was given -- on the basis of the information I was given I got it very badly wrong.
Q. Yes.
A. On the basis of the information I had, as we all now know.
Q. But on reflection, the answer to the question: should the police be called?, is about understanding whether an investigatory threshold has been overcome?
A. Yes.
Q. Now, in criminal practice, you will have no doubt been asked at various times to make a decision as to whether somebody should be prosecuted or whether a case should go to trial based upon evidence and that

is a very different exercise from triggering an investigation because it requires a whole different level of evidence in order to be overcome?

A. Yes.

Q. The answer was the only way in which the question could be determined: is there enough evidence of a crime or has a crime been committed?, is by bringing to bear the forensic powers of the police force in investigating crime, isn't it? It can't possibly be determined absolutely on any of the evidence that could be cobbled together within the hospital?

A. Well, I'm not sure I like the sound of the phrase "cobbled together", that wasn't --

Q. Putting that to one side --

A. That wasn't my impression of how things were being done. I am not, I think, taking a pedantic point in respect of the question which you raised because I understand why you do. The only time a decision is made finally as to whether a crime has been committed or not is when a trial is held and the jury says so.

The investigatory process is different, the investigatory process at the beginning will decide whether there is any evidence, some evidence, sufficient evidence. Then there are decisions as to whether to charge, which is a two-fold test. With respect, I am

not entirely sure I agree that the only people who could have decided at that stage would have been the police because the Consultants themselves, as we now know, once it was crystallised had assembled a very clear picture to justify that but the police had not been called in by then and were shortly thereafter called in.

Q. Yes, and commenced an investigation --

A. Yes.

Q. -- that revealed further evidence --

A. Correct.

Q. -- that led to a trial and led to a conviction?

A. Correct.

Q. Finally on a slightly different topic, you spoke about not well-aligned duties of care.

A. Not always aligned.

Q. Not always aligned duties of care?

A. Yes.

Q. Again without wanting to be pedantic, rather than duties of care, is the correct categorisation priorities that were not necessarily aligned in the same direction?

A. No. I -- I don't agree with that. I was trying to think of how best I could describe at this hearing that point which I have described as "not always

aligned duties of care" and that was the way which I found best described what I am trying to describe and I am not prepared to change that to priorities.

Q. They all owed the same duty to the patients in the hospital, the primary duty was always patient safety; do you agree?

A. I am sure that that must be right.

Q. But the argument or the not well-aligned positions, if I call it that --

A. You may; I said "not always aligned".

Q. Not always aligned, was about a conflict between the need to call the police, one group saying: "We need to call the police we think a crime has been committed" and another group saying or worrying about the impact upon the reputation of the Trust in doing that?

A. Those were some of the matters that were of concern together also with the issues of personnel, human resources, the general reputation of the hospital, the thought which was vocalised to me severally, that if the police were brought in when they ought not to be, how on earth are we going to justify that to the parents of babies? Which I have already spoken about.

Q. Yes, I mean the counterpoint to that is if the police aren't called in and this person is a criminal,

she will harm more babies?

A. That -- that is certainly one possibility.

Q. Yes.

A. Yes.

Q. I think the language, and it may be a phrase that you used, is that "once the police are called, the toothpaste is out of the tube", which is a part of your note?

A. Yes.

Q. Was that an underlying priority for the Executives of the Trust, that once the police are called the cat is out of the bag when it comes to publicity?

A. Well, I sought perhaps inadequately earlier to make the point, I hope fairly, that concerns about publicity and the hospital were not of a superficial nature, they were not just concerned about bad headlines because they didn't want them; they were concerned about what might underlie the headlines. So it wasn't a selfish concern, so far as I could make out at all. Their concerns -- I think I have stated them in my witness statement and in answers to questions to Counsel to the Inquiry and you, I think I have stated them several times now, the list of them, it -- it may not be everything that they said, but -- but those were a series of not always aligned duties of care which they

had to their staff, to the patients, to the hospital, to the doctors, they didn't always run in perfect alignment.

Q. Do you think that the question of reputational harm is overstated in this context against when balanced against the risk to patient safety?

A. Who has in what sense overstated and by whom?

Q. Well, doesn't reputation or isn't reputational harm inferior to risks that come in relation to patient safety?

A. Yes, I would have thought so.

MR BAKER: Excuse me a moment. Thank you, my Lady, I have no more questions.

LADY JUSTICE THIRLWALL: Thank you, Mr Baker.

A. Thank you.

MS LANGDALE: No further questions, my Lady.

LADY JUSTICE THIRLWALL: No, and I have no questions. Thank you very much Mr Medland, you are free to go.

A. Thank you.

Thank you.

LADY JUSTICE THIRLWALL: So that concludes the evidence --

MS LANGDALE: Until Monday.

LADY JUSTICE THIRLWALL: -- for today so we will

reconvene at 10 o'clock on Monday morning.

(4.08 pm)

(The Inquiry adjourned until Monday, 25 November 2024 at 10.00 am)

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