

Thursday, 21 November 2024

1
2 (10.00 am)
3 **LADY JUSTICE THIRLWALL:** Good morning.
4 Mr De La Poer.
5 **MR DE LA POER:** My Lady, our first witness today is
6 Ms Lyn Simpson and I wonder if she might come forward,
7 please.
8 MRS LYN SIMPSON (sworn)
9 Questions by MR DE LA POER
10 **LADY JUSTICE THIRLWALL:** Do sit down.
11 **A.** Thank you.
12 **MR DE LA POER:** Please could you state your full
13 name?
14 **A.** Mrs Lyn Simpson.
15 **Q.** Mrs Simpson, is it right that you provided to
16 the Inquiry a witness statement dated 11 June of this
17 year?
18 **A.** That's correct.
19 **Q.** Now, in a moment I am going to ask you to
20 confirm the content of that statement to be true but
21 before we get to that, can I just flag two corrections
22 that you have drawn to my attention.
23 The first is at paragraph 9, where you state that
24 you are a member of the Royal College of Nursing; in
25 fact that isn't the correct position, is that right?

1

1 **Q.** Moving forward in time, by 1998, did you
2 become an Executive Director of a Hospital Trust?
3 **A.** I did.
4 **Q.** Then to a period of about six years in that
5 role; is that right?
6 **A.** I -- that is correct, yes, yes.
7 **Q.** Then if we move forward in time, between
8 October 2007 and February 2010, did you have two roles,
9 Department of Health Director of NHS Operations and
10 Director of Operations Regional Nurse at the Northeast
11 Strategic Health Authority?
12 **A.** I did, yes.
13 **Q.** From there, in February 2010, for a period of
14 approximately a year, were you the Chief Operating
15 Officer; that is to say the Deputy Chief Executive of
16 South London Healthcare NHS Trust?
17 **A.** I was seconded into that role for a year.
18 **Q.** Then back to the Department of Health in the
19 role of Director of NHS Operations, NHS Finance
20 Performance and Operations?
21 **A.** That's right.
22 **Q.** October 2013 to May 2016, were you the
23 Delivery and Development Director for the north, for the
24 NHS Trust Development Director (North)?
25 **A.** I was.

3

1 **A.** That's correct.
2 **Q.** So that's a correction that needs to be made
3 to the statement.
4 The second is that at paragraph 32, you give a date
5 which included 2016, that is a typo, it should be 2018;
6 is that right?
7 **A.** That's correct.
8 **Q.** Other than those two corrections, is the
9 content of that witness statement true to the best of
10 your knowledge and belief?
11 **A.** It is.
12 **Q.** We will just introduce you before we come to
13 the substantial part of my questioning. Did you qualify
14 as a nurse in 1978?
15 **A.** I did.
16 **Q.** Did you thereafter work as a hospital nurse?
17 **A.** I did for a short period of time.
18 **Q.** Then I believe you trained as a midwife?
19 **A.** I did.
20 **Q.** Indeed you worked as a health visitor as well?
21 **A.** I am.
22 **Q.** I think that I am right in saying that you
23 started in a hospital management position around 1987;
24 is that right?
25 **A.** That's correct, yes.

2

1 **Q.** Then coming to the period that we are going to
2 be focused upon, between May 2016 and April 2019, were
3 you the Executive Regional Managing Director for the
4 north for NHS Improvement?
5 **A.** I was.
6 **Q.** Now, in your witness statement you tell us
7 about what that role involved and you say this, and I am
8 looking here at paragraph 11 if you want to follow
9 along:
10 "In summary, my role primarily focused on
11 supporting organisations to an improved sustainable
12 position which offered the highest standards for
13 patients and the public."
14 So that is the way in which you would summarise the
15 primary focus, as you term it, of your role?
16 **A.** I would, yes.
17 **Q.** Now, putting a little more detail on it, you
18 go on to say that you were responsible for 72 NHS
19 organisations; is that right?
20 **A.** I was.
21 **Q.** Your focus was on "working with organisations
22 to enable them to exit quality and/or financial special
23 measures". I was just wondering if you could help us
24 with that?
25 **LADY JUSTICE THIRLWALL:** What does it mean?

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

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

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

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

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

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

21 A. That's absolutely correct.

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

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

5

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

3 That's the statement.

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

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

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

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

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

25 Q. Well, we will unpack --

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

3 A. Yes.

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

8 A. That's absolutely correct.

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

12 A. I am.

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

20 So the statement is this, that:

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

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1 A. Sure.

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

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

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

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

13 A. I agree with that.

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

16 A. Correct, correct.

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

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

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

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

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

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

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

25 **A.** No, I didn't.

9

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

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

5 **A.** Yes.

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

8 **A.** No, I haven't.

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

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

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

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

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

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

5 **Q.** So you knew of him but --

6 **A.** I knew of him.

7 **Q.** -- you had never spoken to him?

8 **A.** No, no.

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

11 **A.** No.

12 **Q.** -- a reputation?

13 **A.** No.

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

16 You say at paragraph 22:

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

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

25 **Q.** Yes.

10

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

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

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

10 **A.** Yes.

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

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

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

20 **A.** I was, yes.

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

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

12

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

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

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

12 A. No.

13 Q. -- or something similar?

14 A. No.

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

19 A. No.

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

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1 events the police were investigating".

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

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

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

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

19 A. Yes.

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

22 A. Yes.

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

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1 just work through what Mr Dalton told you.

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

4 A. He was, yes.

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

6 A. That's right.

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

10 A. That amongst other things, yes.

11 Q. I beg your pardon?

12 A. That amongst other things, yes.

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

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

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

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

14

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

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

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

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

20 A. I did.

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

16

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

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

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

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

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

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

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

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

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

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

19

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

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

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

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

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

11 **A.** That's right.

12 **Q.** Then you add this:

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

16 **A.** (Nods)

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

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

18

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 **Q.** Well, we have got a board that's dysfunctional
22 and a department that is extremely unhappy, a department
23 which itself is the subject of a police investigation.

24 Is it not common sense that Sir Duncan may have been
25 involved at some stage in the management of the concerns

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

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

5 **A.** I was, yes.

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

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

12 **A.** (Nods)

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

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

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

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

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

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

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

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

25 **A.** No.

24

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

5 A. Okay, thank you.

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

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

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

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

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

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

25

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

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

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

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

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

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

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

25 A. That's correct.

27

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

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

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

10 A. It is.

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

15 A. Yes.

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

21 A. It is.

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

26

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

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

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

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

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

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

15 Q. Well.

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

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

20 A. No, we don't.

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

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

28

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

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

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

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

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

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

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

29

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

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

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

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

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

19 **A.** Yes.

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

22 **A.** Yes, yes.

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

31

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

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

6 **Q.** What does --

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

14 **Q.** What does the word "prevent" mean?

15 **A.** It literally means to stop something.

16 **Q.** That's what you wrote?

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

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

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

23 **Q.** B:

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

30

1 had lost his confidence?

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

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

8 **A.** Yes.

9 **Q.** So they want something done about Mr Chambers.

10 **A.** Yes.

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

13 **A.** Yes.

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

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

19 **Q.** Sir Duncan?

20 **A.** It could have been a range of issues.

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

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

32

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

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

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

12 **A.** Yes.

13 **Q.** -- about the paediatricians pushing for a vote
14 of no confidence is why didn't you ask

15 Sir Duncan Nichol: what is it that's upset the
16 paediatricians so much?

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

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

21 **A.** No.

22 **Q.** -- to carry out the instruction?

23 **A.** No.

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

33

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

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

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

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

19 **A.** (Nods)

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

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

35

1 **A.** No, that would not be the case.

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

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

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

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

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

34

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

3 **A.** A temporary placement for Mr Chambers, yes.

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

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

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

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

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

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

23 **Q.** The top line on screen:

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

36

1 was separate to the vote of no confidence issue"?

2 **A.** Yes, yes.

3 **Q.** That is what I just drew to your attention.

4 So were you telling Mr Chambers that the police

5 investigation was separate to the vote of no confidence

6 issue?

7 **A.** I was relaying to Mr Chambers what my

8 understanding was, which that there was a police

9 investigation, that the vote of no confidence I wasn't

10 aware was linked to the police investigation.

11 **Q.** What did Mr Chambers say to that?

12 **A.** I really don't recollect what he said to that.

13 **Q.** Then we see we the return to this subject of

14 vote of no confidence:

15 "Paediatricians are keen to go down the route of

16 a vote of no confidence and [Sir Duncan Nichol] was

17 trying to prevent this."

18 So we see the word "prevent" again?

19 **A.** I do. Inappropriate use of language in my --

20 my log. I accept that.

21 **Q.** But you have twice used the word that means to

22 stop when you meant something different; that is one

23 explanation?

24 **A.** Yes.

25 **Q.** The alternative is that that is what is

37

1 him to see how other boards operate, how other parts of

2 the system work and maybe get some personal insight as

3 to how he operated within Countess of Chester.

4 **Q.** Did he need to be rehabilitated?

5 **A.** I'm sorry?

6 **Q.** Did he need to be rehabilitated?

7 **A.** It's -- it's a form of words that could be

8 used. I think it was more about personal insight and

9 understanding and thoughtfulness about things that he

10 may not wish to replicate in terms of his skillset in

11 the future.

12 **Q.** Because rehabilitation generally goes hand in

13 glove with the fact that you have done something wrong.

14 **A.** It does, yes.

15 **Q.** So why would that be an appropriate

16 description?

17 **A.** Well, I have just tried to explain what I --

18 I hoped was the purpose of the facilitated move.

19 I wasn't apportioning blame, I wasn't using words that

20 are descriptive and synonymous with other words.

21 Again, I would go back to this being a log for my

22 use, it might be my shorthand in terms of how that's

23 interpreted.

24 **Q.** We will look at something you record

25 Mr Chambers saying to you at item 3. I'm not sure what

39

1 happening and that is what you are recording?

2 **A.** No, I don't think that was what was happening.

3 I do think on reflection it was an inappropriate word

4 used because that was not what I was implying at the

5 time.

6 **Q.** Why did you use it twice?

7 **A.** I'm sorry, I don't recollect why I used it

8 twice. These were my notes, my log. It was simply an

9 aide memoire for me.

10 **Q.** So we then see the advice that you tendered,

11 which was Mr Chambers to work off-site over the next

12 week or so, which would give you time to look for

13 alternative options, that you are to talk to Mr Chambers

14 about this as not sure another CEO post would be right,

15 or bring Mr Chambers into NHS Improvement.

16 Why would a CEO post not be right?

17 **A.** Because I think it was about time, it was

18 a timing issue, it was about the opportunity for Tony to

19 reflect on his behaviour, his actions within the board,

20 what had created the tensions, the dysfunctionality of

21 the board.

22 Therefore, moving directly to another CEO role in

23 my view he wouldn't have time to reconsider that and

24 think about his future career to go into a role which

25 didn't have the accountable officer status would enable

38

1 the first part is, "TC con med", maybe "commented",

2 possibly?

3 **A.** I think so.

4 **Q.** Anyway:

5 "... he would step aside and be as flexible towards

6 this as he can be. However, TC advised he would not

7 want ['it', I think that should be] to be a cost towards

8 his career and he would want to maintain his status as

9 CEO."

10 **A.** Yes.

11 **Q.** Is that what he said to you?

12 **A.** Yes.

13 **Q.** What did you understand him to mean by

14 maintaining his status?

15 **A.** My interpretation of that was that he would be

16 willing to participate in a facilitated move, but he

17 wanted to operate as an accountable officer as a Chief

18 Executive into a role that he would be moved into.

19 **Q.** Well, maintaining status, he is not saying he

20 wants to be a CEO, he's saying he wants to maintain the

21 status of the CEO, in other words be perceived by the

22 world in those terms, to have the plaudits and the

23 accolades that go, the recognition that go with being

24 a CEO.

25 Is that what he was telling you?

40

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

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

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

10 Q. He doesn't want this to damage his career:
11 "... advised he would not want it to be a cost
12 towards his career ..."

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

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

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

22 Q. Let's look at 4:

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

41

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

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

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

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

11 A. I would need to think about that.

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

14 A. Thank you.

15 Q. If you need time, so be it.

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

20 A. Apart from one which was NHS England.

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

24 A. Yes.

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

43

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

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

6 A. I have.

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

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

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

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

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

25 Q. You used the word "prevent"?

42

1 A. Yes.

2 Q. Do you agree?

3 A. I agree.

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

6 A. I would agree.

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

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

17 Then it goes on to say his employment.

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

21 A. Yes.

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

44

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

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

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

9 A. Yes.

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

18 Do you see?

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

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

45

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

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

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

7 A. Sure.

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

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

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

16 A. Yes.

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

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

47

1 Graham here in the centre paragraph:

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

9 So let's just understand what this is saying.

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

13 A. Yes.

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

18 A. I -- I wasn't aware of that at the time.

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

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

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

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

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

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

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

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

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

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

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

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

49

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

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

5 **A.** Yes.

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

10 **A.** Yes.

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

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

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

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

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

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

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

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

16 **A.** Absolutely not.

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

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

50

1 **Q.** Well --

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

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

10 **A.** Yes.

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

17 **A.** That's right.

18 **Q.** Then we get to 5:

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

21 Now, the Countess of Chester was a Foundation
22 Trust?

23 **A.** Yes.

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

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

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1 forgive me for a moment.
 2 If we could go to 24 November -- sorry, page 24,
 3 29 November. Just a phrase that I have already
 4 telegraphed to you that I would just like to ask, this
 5 is a conversation with Sir Duncan Nichol and the context
 6 of this, as you will be able to tell, Ms Simpson, that
 7 there has been some toing and froing about how long
 8 Mr Chambers should be on his placement. He wanted
 9 12 months, NHS Improvement thought six months, there was
 10 talk about when he should be given his notice to make
 11 sure that if he hadn't found another job, it would be
 12 terminated and that's the context, isn't it, for what we
 13 are looking at?
 14 **A.** Yes.
 15 **Q.** I understand that you write in this email in
 16 the large paragraph that:
 17 "Tony Chambers is potentially looking to be
 18 seconded to a different organisation to that of our
 19 previous discussions ..."
 20 Just pause there for a moment. You understood that
 21 in fact that he was going to go somewhere differently,
 22 he went to Northern Care Alliance. So he didn't in fact
 23 take up either of the placements you had found for him.
 24 **A.** Correct
 25 **Q.** "... and for a longer period. While overall

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

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

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

3 **A.** Correct.

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

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

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

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

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

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

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

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

10 **Q.** Yes.

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

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

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

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

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

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

3 **A.** Yes, yes, I did.

4 **Q.** -- didn't you?

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

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

14 **Q.** You say:

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

19 That is what you said in your statement.

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

23 **A.** Yes, there does, there does.

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

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1 that been addressed by the board, et cetera.

2 **Q.** All questions you could have asked?

3 **A.** I accept that.

4 **Q.** All questions you should have asked?

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

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

13 **A.** No, I wouldn't say that.

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

15 **A.** I do accept I should have asked some more
16 questions.

17 **Q.** Two reflections to conclude.

18 Should senior managers in the NHS be regulated?

19 **A.** We absolutely should be.

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

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

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

4 **A.** Absolutely.

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

9 Questions by LADY JUSTICE THIRLWALL

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

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

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

16 **A.** Yes.

17 **LADY JUSTICE THIRLWALL:** That was your focus.

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

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

23 **LADY JUSTICE THIRLWALL:** So what does that actually
24 mean?

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

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

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

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

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

14 **LADY JUSTICE THIRLWALL:** No, I appreciate that.

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

17 **LADY JUSTICE THIRLWALL:** That was Tony Chambers?

18 **A.** It was.

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

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

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

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

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

22 **A.** Sorry.

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

25 **A.** I --

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1 was working.

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

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

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

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

12 **LADY JUSTICE THIRLWALL:** Yes.

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

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

22 **A.** I'm sorry, I -- I can't say which one it was.

23 I have the impression that it was the majority of the,
24 the Non-Executive Directors. But I -- I don't know
25 which ones or which specific issues it was.

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1 It was a more of a generic feeling and supposition
 2 that people were articulating.
 3 **LADY JUSTICE THIRLWALL:** I understand. Thank you.
 4 **A.** If I may just offer something supplementary.
 5 **LADY JUSTICE THIRLWALL:** Yes.
 6 **A.** When I talked about having 72 organisations to
 7 have oversight, that was a large number. There were
 8 a small number within that, talked about 10
 9 organisations which required an awful lot of
 10 intervention. There were examples there of where there
 11 were dysfunctional boards and I would -- was dealing
 12 with two at the time and what was happening there was
 13 a similar position to people felt unable to speak out,
 14 people felt that they weren't able to convey their
 15 strength of convictions in relation to an issue they
 16 were discussing and the board just wasn't able to
 17 provide the leadership to the organisation and the
 18 confidence then generally across the organisation about
 19 the services it was providing.
 20 So it does happen in other organisations and, as
 21 I say, at that time I was involved with at least two
 22 other organisations where that was the case.
 23 **LADY JUSTICE THIRLWALL:** But so far as this
 24 organisation is concerned, you were satisfied that you
 25 had sufficient information to make the judgment that the
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1 paediatricians rather than the board itself.
 2 **LADY JUSTICE THIRLWALL:** Right. Thank you very
 3 much. If that matters, I am sure we can clarify that.
 4 Does anybody want to ask anything arising out of
 5 that?
 6 **MR DE LA POER:** No thank you.
 7 **LADY JUSTICE THIRLWALL:** Thank you very much
 8 indeed. Ms Simpson, you are free to go now.
 9 **A.** Thank you.
 10 **LADY JUSTICE THIRLWALL:** Is that a convenient
 11 moment to take the break?
 12 **MR DE LA POER:** My Lady, yes, thank you.
 13 **LADY JUSTICE THIRLWALL:** So we will start again
 14 just after quarter to.
 15 (11.32 am)
 16 (A short break)
 17 (11.49 am)
 18 **LADY JUSTICE THIRLWALL:** Just before we continue
 19 with the next witness, there was a document which had
 20 been redacted which we looked at quite near the end of
 21 the evidence of the last witness, it was a figure and
 22 I have asked that that be unredacted because it is
 23 plainly relevant and ought to be a matter of public
 24 record. Now, Mr Bershadski.
 25 **MR BERSHADSKI:** Yes, thank you, my Lady, if I could
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1 board was dysfunctional, in the way that you have
 2 described?
 3 **A.** At the time I believe I did. With hindsight
 4 now, I can see that it would have been helpful to have
 5 asked for some further information.
 6 **LADY JUSTICE THIRLWALL:** Thank you. When we were
 7 looking earlier at the note about the paediatricians and
 8 the vote of no confidence, and it said there was a note
 9 which said there is going to be a secret ballot of the
 10 members. Who was going to be voting in the vote of no
 11 confidence? That is reflecting my own ignorance but who
 12 would vote? Would it be the members of the board?
 13 **A.** No, I think -- I think that was referring to
 14 the clinicians, namely the paediatricians --
 15 **LADY JUSTICE THIRLWALL:** Yes.
 16 **A.** -- who would have a secret vote which would
 17 I am saying this as a personal opinion now which to me
 18 would mean that not everybody was of the same view,
 19 hence you would do it as a secret ballot and you would
 20 be able to discuss, you would be able to, as an
 21 individual, put your view forward there.
 22 **LADY JUSTICE THIRLWALL:** Very well. It's just that
 23 it was referred to members and I was wondering what the
 24 members were. Was that just your --
 25 **A.** I -- I think on reflection that was the
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1 call Mr Pace, please.
 2 MR IAN PACE (affirmed)
 3 Questions by MR BERSHADSKI
 4 **LADY JUSTICE THIRLWALL:** Do sit down, Mr Pace.
 5 **MR BERSHADSKI:** Could you confirm your name please
 6 for the Inquiry?
 7 **A.** Yes, it's Ian Pace.
 8 **Q.** Have you made a statement dated 9 August 2024?
 9 **A.** Yes, I have.
 10 **Q.** Is that statement true and accurate to the
 11 best of your knowledge and belief?
 12 **A.** Yes, it is.
 13 **Q.** Is it correct that in 2016 you were an
 14 associate solicitor in the Employment and Pensions Group
 15 at DAC Beachcroft?
 16 **A.** That's correct.
 17 **Q.** I think you had been with DAC Beachcroft since
 18 2011; is that correct?
 19 **A.** That's right.
 20 **Q.** You were initially a solicitor there and then
 21 promoted to an associate solicitor in May 2016; is that
 22 correct?
 23 **A.** That's correct.
 24 **Q.** Is it right that you would have dealt with
 25 disciplinary, grievance, sickness, performance
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1 management and Employment Tribunal proceedings in your
2 role there?

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

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

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

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

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

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

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

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

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

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

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1 whether a referral should be made.

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

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

12 **A.** That's right, yes.

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

18 **A.** That's correct.

19 **Q.** Is that right?

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

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

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1 been familiar with those safeguarding principles from
2 your work.

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

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

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

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

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

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

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

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

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

12 **A.** Correct.

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

15 **A.** Yes, I am familiar with Beverley Allitt.

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

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

20 **Q.** Somebody who had been deliberately --

21 **A.** Yes.

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

24 **A.** Yes, I understood who Beverley Allitt was,
25 yes.

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

5 A. That's correct.

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

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

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

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

25 A. Absolutely, absolutely I wanted to effectively

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

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

6 A. Correct.

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

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

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

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

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

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

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

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

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

17 A. Yes.

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

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

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

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

6 A. Yes.

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

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

14 A. Yes.

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

17 A. Yes.

18 Q. Then you say:

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

23 A. Yes.

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

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1 conclusion that there's a risk of there being
 2 a Beverley Allitt on the unit, why did you not simply
 3 recommend an immediate suspension at that point?
 4 **A.** The position simply wasn't clear. The, the --
 5 the evidence was scarce, very limited information. On
 6 the one hand we were to paint a picture it seemed to be
 7 all very confusing on, on the NNU at the time. Fingers
 8 were being pointed to one another, doctors were pointing
 9 the fingers at nurses, nurses were pointing the fingers
 10 at nurses, nurses were providing clinical explanations
 11 for increase in deaths.
 12 It, and among all of this, there was a suggestion
 13 that one individual may be involved, it was quite
 14 a confusing picture at the time.
 15 Based on the very limited information at the time
 16 it would have been quite difficult to simply go forward
 17 and say "we must suspend that individual", we needed
 18 more information, hence why we arranged that call with
 19 Corinne and the regulatory team.
 20 **Q.** You say in your statement that you felt that
 21 the advice that you gave as regards suspension was in
 22 line with ACAS guidance?
 23 **A.** Yes.
 24 **Q.** Which says that suspension should not be used
 25 automatically?

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1 ought to investigate the issues before taking any
 2 further steps; is that right?
 3 **A.** To investigate, to understand more about the
 4 situation which was unclear, that's right.
 5 **Q.** Did it occur to you that there might be
 6 problems with the Trust itself investigating
 7 an allegation of deliberate harm by a nurse?
 8 **A.** Yes, of course. But that was the reason why
 9 I needed to seek further advice from the regulatory
 10 team, from Corinne, in terms of how that investigation
 11 may look, and I am sure you will be coming on to, it was
 12 recommended that an external investigation was
 13 undertaken.
 14 **Q.** Yes. Yes. Absolutely. So I think you tell
 15 us in your statement that after you finished this phone
 16 call with Dee Appleton-Cairns you first discussed the
 17 matter with another partner in the employment team?
 18 **A.** Yes.
 19 **Q.** You say that you explained your concerns about
 20 what you had been told to her?
 21 **A.** Yes.
 22 **Q.** What is it that you said to her, if you can
 23 recall?
 24 **A.** I don't specifically recall the conversation.
 25 I do recall that as a junior associate at the time

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1 **A.** Yes.
 2 **Q.** Was complying with ACAS employment guidance
 3 one of the matters that you were taking into account
 4 when advising in this call?
 5 **A.** Yes, yes, of course I was acting in my
 6 capacity as an employment lawyer and so the purpose of
 7 the -- my -- my instruction was to provide employment
 8 law advice as part of that advice in relation to
 9 suspension, yes.
 10 **Q.** Was the situation that was being described to
 11 you on the neonatal unit would it be fair to say that it
 12 was fairly extreme compared to the sort of employment
 13 matters you would ordinarily be called up about on the
 14 employment line?
 15 **A.** Yes, absolutely. It was a very extreme
 16 situation. That said, I have previously, without
 17 disclosing details, provided advice in relation to
 18 another NHS Trust in relation to another very serious
 19 matter which doesn't have too much of a dissimilarity to
 20 this.
 21 **Q.** I am not going to ask you about any details of
 22 any other matter --
 23 **A.** No.
 24 **Q.** -- of course.
 25 You also advised Dee Appleton-Cairns that the Trust

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1 I received regular supervision and this was clearly
 2 potentially quite a serious matter, the red flag had
 3 been raised and it was absolutely something that I would
 4 have discussed and did discuss with the partner.
 5 The concerns, I can't recall the specific nature of
 6 the conversation, but I expect it would have been along
 7 the lines of the focus doesn't seem to be on the
 8 potentially quite serious nature of the issues here.
 9 And that was on Kirsty's advice that I -- I needed to
 10 obtain further advice regulatory advice and she
 11 recommended me to Corinne.
 12 **Q.** Do you recall whether you explained to Kirsty
 13 that there was a risk that there was essentially
 14 a murderer on the neonatal unit?
 15 **A.** I would have explained everything that had
 16 been provided to me during the call.
 17 **Q.** So that would have included the reference to
 18 Beverley Allitt?
 19 **A.** I can't remember the conversation itself but,
 20 I -- it wouldn't surprise me if that's been mentioned,
 21 yes.
 22 **Q.** Okay. So is it right that on the advice of
 23 Kirsty MacDonald, you then immediately contacted
 24 Corinne Slingo, who is the head of the regulatory team?
 25 **A.** That's correct, yes.

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1 Q. What did you say to Ms Slingo?

2 A. I again can't recall the exact detail of the
3 conversation but it would have been to recollect the
4 conversation that I had had with Dee Appleton-Cairns as
5 is set out on the attendance note.

6 Q. So would it have probably included the fact
7 that there was a concern at least by somebody on the
8 neonatal unit that there was in effect a murderer on
9 there?

10 A. It would have referred to everything that Dee
11 had told me.

12 Q. Including the reference to Beverley Allitt?

13 A. I expect so. I can't recall the exact
14 conversation but I expect so.

15 Q. Can you recall what Corinne Slingo's response
16 was?

17 A. We agreed that we needed to arrange a call.
18 We agreed that it was a matter for regulatory to be
19 involved in. We agreed that it was an urgent matter for
20 regulatory and that we needed to speak to the client to
21 understand and obtain further information.

22 Q. You say at paragraph 37 of your statement that
23 you recall Corinne telling you that she thought it was
24 too early to get the police involved?

25 A. Yes, that is right.

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1 situation for a lawyer to be in.

2 You summarise your understanding of the position.
3 She says to her -- I think you explain to her that from
4 the previous call you had with Dee Appleton-Cairns you
5 understood that there had been a rise in the number of
6 patient deaths on the unit and that a particular
7 individual had been prevalent on the unit at all of the
8 relevant times; is that right?

9 A. Yes, that is right, yes.

10 Q. Is it right that Sue Hodgkinson explained to
11 you that Letby had been on annual leave for some time
12 until this call?

13 A. Yes, I think -- well, the note refers to her
14 being on annual leave for about two weeks which would
15 have taken her just before my initial call with Dee on
16 5 July.

17 Q. After she returned the Trust had considered
18 placing her under clinical supervision?

19 A. Yes, that's right. I seem to understand that
20 she was placed on clinical supervision when she returned
21 to work from annual leave I think around about 14 July
22 which was a Thursday.

23 Q. The Consultants had said that in fact they
24 didn't want her working back on the ward?

25 A. That's now my understanding, although that

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1 Q. Is that what you think she told you in that
2 initial conversation that you had with her?

3 A. I do recall that, yes.

4 Q. Is it right that she told you that calling the
5 police may disrupt any internal investigation?

6 A. I do recall that, yes.

7 Q. Is it right that she told you that it might be
8 appropriate to approach one of the Royal Colleges to
9 undertake a review?

10 A. Yes and from recollection the conversation
11 went along the lines of -- based on the very limited
12 information we have at the moment it looks to me to be
13 too early to call the police so we may have to call in
14 the Royal College to do an external investigation but we
15 will need to speak to the clients and obtain further
16 information.

17 Q. Thank you.

18 I am now going to move on to the next call that you
19 have with the Trust and that's on 18 July. If we could
20 please have up on the screen INQ0102205.

21 Now, you receive a phone call from Sue Hodgkinson at
22 the Trust on the morning of 18 July and I think from
23 this note it's at around 8.40 in the morning and she's
24 seeking advice ahead of a management meeting that is due
25 to start in 20 minutes' time, not the most positive

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1 wasn't the case at the time, yes. I was told at the
2 time that the focus of my question is: well, why would
3 you place her on supervision on a Thursday and call me
4 on a Monday, bearing in mind there is a weekend in
5 between to now change your mind and put her on
6 redeployment?

7 Q. Was it your understanding during this
8 telephone call on the morning of the 18 July that the
9 Trust was considering calling the police at that point?

10 A. Yes, yes. That's recorded in the -- in the
11 note.

12 Q. You record the Trust is now considering
13 calling the police?

14 A. That is recorded in the note which I would
15 have made after the telephone conversation.

16 Q. Was it your understanding from this call that
17 there appeared to be a significant body of staff on the
18 neonatal unit saying "it's her" about Letby?

19 A. The -- the -- the picture is by this point
20 slightly different to the 5 July. The 5 July call was
21 quite a messy picture with lots of fingers being pointed
22 to lots of people.

23 And that picture, that fog, seems to be clearing
24 a little bit by 18 July with more of a focus on that one
25 individual.

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

4 A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 Q. Yes, it would, of course.

21 A. Thank you.

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

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

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1 A. Sure.

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

9 A. No. I was a junior employment lawyer.

10 Corinne was a senior partner in the firm, head of
11 healthcare regulatory. If it was her view and her
12 advice at the time that the police should not be called,
13 then as an employment lawyer with not -- doesn't have
14 a specialism in that area, it would have been unusual
15 for me to question that advice, I would say.

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

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

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

25 A. Approximately once a month or so, yes.

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

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

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

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

17 Q. Not that they were unexpected or unexplained?

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

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

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

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

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

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

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

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

22 A. Yes.

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

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

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

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

8 A. No.

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

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

13 Q. Thank you. The next occasion I think on which
14 you are contacted by the Trust is on 2 August and is it
15 right that you are told at that point that the external
16 review, which is the Royal College review, the RCPCH
17 review, that it had been delayed until 1 and
18 2 September?

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

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

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

25 Q. Yes. Do you recall being told that the Trust
90

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

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

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

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

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

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1 it to the redesignation of the unit or are you now
2 thinking back as to --
3 **A.** I would probably say I would be thinking back,
4 but it was absolutely identified that that may be
5 a correlation in Corinne's advice which I would have
6 seen at the time.

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

11 **A.** Yes.

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

15 **A.** No, that's right.

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

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

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1 **A.** Yes, that is right, yes.

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

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

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

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

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

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

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

25 There -- there did appear to be an increasing risk

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

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

5 **Q.** Yes, okay.

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

8 **A.** Yes.

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

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

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

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

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

11 **A.** Yes.

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

13 **A.** Yes.

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

17 **A.** Yes, yes.

18 **Q.** It underwent a rebranding later on down the
19 line.

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

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

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

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

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

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

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

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

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1 to that policy.

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

3 **A.** That's correct, yes.

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

11 **A.** That's right.

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

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

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

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1 **A.** Yes, yes.

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

4 **A.** Yes.

5 **Q.** -- with an appropriate individual under the
6 policy?

7 **A.** Absolutely.

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

10 **A.** No.

11 **Q.** -- or any particular other format?

12 **A.** No.

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

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

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

23 **A.** Absolutely and if I had been instructed
24 12 months previously that I expectation would be my
25 investigation that they should be investigated pursuant

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

8 **Q.** You give some further advice on or around
9 26 October 2016 and you tell us in your witness
10 statement at paragraph 100, that during that
11 conversation Sue Hodgkinson tells you that an external
12 review had by then been completed and that there is no
13 suggestion within the external review that Lucy Letby
14 was involved.

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

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

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

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

100

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

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

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

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

20 A. Yes.

21 Q. Is that right?

22 A. That's right, yes.

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

101

1 Letby?

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

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

13 A. Thank you, my Lady.

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

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

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

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1 it?

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

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

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

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

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

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

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1 has played no part."

2 A. Yes.

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

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

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

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

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1 It would have been quite unusual for me as a junior
 2 associate to have disputed her advice.
 3 **MR BERSHADSKI:** My Lady, those are my questions for
 4 this witness. I understand that there are no longer any
 5 questions from any other parties; is that right?
 6 **LADY JUSTICE THIRLWALL:** Very good and I have no
 7 questions, so thank you very much indeed for coming,
 8 Mr Pace, and giving your evidence, you are free to go
 9 now.
 10 **A.** Thank you, my Lady.
 11 **MR BERSHADSKI:** My Lady the next witness is
 12 Ms Slingo. I am entirely in your hands as to whether
 13 you wish to move straight into the next witness.
 14 **LADY JUSTICE THIRLWALL:** Let us do that, yes, if
 15 she's here.
 16 **MR BERSHADSKI:** I think the indication is that
 17 there needs to be a short five-minute break in order to
 18 get the next witness in place.
 19 **LADY JUSTICE THIRLWALL:** Do we need five minutes,
 20 is she coming a long way? We will just wait unless
 21 anyone wants a break? No. We will just wait.
 22 (Pause)
 23 **LADY JUSTICE THIRLWALL:** There is no rush, do sit
 24 down and catch your breath and you will be sworn in.
 25

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1 **Q.** You have experience, do you, of police
 2 investigations in healthcare, is that right?
 3 **A.** Yes.
 4 **Q.** And in particular, is it right that you have
 5 some experience of a police investigation relating to
 6 Stepping Hill?
 7 **A.** So I've referenced Stepping Hill as one of the
 8 matters our firm has dealt with. I wasn't personally
 9 advising on that matter, but I was aware and, and
 10 supportive of a colleague who was.
 11 **Q.** And were you involved with giving any advice
 12 in relation to the police investigation of Maidstone and
 13 Tunbridge Wells NHS Trusts?
 14 **A.** So, yes, I was again supportive of a partner
 15 who led that, Tracey Longfield. But I was involved with
 16 going to present to the Trust's board following the
 17 charges that were brought against that organisation.
 18 **Q.** Did that relate to the David Fuller issues or
 19 was it a different police investigation?
 20 **A.** So yes, it was -- it was the corporate
 21 manslaughter prosecution involving the death of
 22 a patient involved in obstetric care.
 23 **Q.** Now, is it right that as part of your role you
 24 will have had an understanding of a Trust's safeguarding
 25 responsibilities?

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1 MS CORINNE SLINGO (sworn)
 2 Questions by MR BERSHADSKI
 3 **LADY JUSTICE THIRLWALL:** Do sit down, Ms Slingo.
 4 **MR BERSHADSKI:** Could you confirm your name for the
 5 Inquiry, please?
 6 **A.** Yes, Corinne Dawn Slingo.
 7 **Q.** Is it right that you have made a statement
 8 dated 13 June 2024?
 9 **A.** That's correct.
 10 **Q.** Is that statement true and accurate to the
 11 best of your knowledge and belief?
 12 **A.** Yes, it is.
 13 **Q.** If we could start with some background,
 14 please. You are a partner currently at DAC Beachcroft;
 15 is that right?
 16 **A.** That's correct, yes.
 17 **Q.** You were the Head of Healthcare Regulatory
 18 until May 2021, in which capacity you led a team of
 19 healthcare regulatory lawyers across six locations?
 20 **A.** That's correct, yes.
 21 **Q.** Now, I am going to be asking you questions
 22 about advice that you gave in 2016/2017. At that point,
 23 is it right that you had been practising as a solicitor
 24 for almost 20 years?
 25 **A.** Yes, that's correct.

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1 **A.** That's correct.
 2 **Q.** I think you say that you have advised on
 3 high-profile public Inquiries including the Savile
 4 Inquiry insofar as it touched on safeguarding concerns
 5 within NHS bodies to which Jimmy Savile was linked?
 6 **A.** So I was involved when the Inquiry was
 7 established and it had a separate arm that looked at the
 8 NHS in particular. I was instructed by one NHS Trust to
 9 provide information and statements to the Inquiry and to
 10 that extent that was my involvement.
 11 **Q.** And they related to safeguarding issues, is
 12 that right?
 13 **A.** To the best of my recollection, they involved
 14 providing statements as to when Savile was involved with
 15 patients and/or staff on that particular Trust site and
 16 what measures were taken in relation to him.
 17 "Safeguarding" is a rather global term for that
 18 particular Inquiry and that line of evidence.
 19 **Q.** So what safeguarding measures were or were not
 20 taken in response to him?
 21 **A.** I don't know if it was in response to him
 22 particularly, but it was around the presence for example
 23 of people who were on site doing voluntary or good works
 24 as was perceived at the time. So, yes.
 25 **Q.** You say at paragraph 8 of your statement that

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1 you helped develop and train boards in understanding
 2 their obligations. Would that be boards of NHS Trusts?
 3 **A.** Both NHS Trusts and independent sector health
 4 providers and it covers a range of topics often, for
 5 example, the Care Quality Commission and board
 6 assurance.
 7 **Q.** And would that include their safeguarding
 8 obligations?
 9 **A.** So not specifically, no. I haven't personally
 10 delivered to a board training on safeguarding to my
 11 recollection over 27 years. It would be included as
 12 a general subject but not as a specific one.
 13 **Q.** When you say included as a general subject,
 14 what would be said typically in training as regards
 15 safeguarding to a board?
 16 **A.** I actually can't recall now specifically over
 17 that period. I haven't delivered anything recently that
 18 includes safeguarding.
 19 **Q.** You mention in one of your emails to the Trust
 20 that a Trust has Regulation 17 governance obligations
 21 and that's a statutory obligation in relation to good
 22 governance --
 23 **A.** It is.
 24 **Q.** -- is that right? And is it right also that
 25 a Trust has an obligation under Regulation 13 to protect

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1 healthcare professionals on the ground is that they
 2 collate a number of different pieces of information to
 3 work out whether they have sufficient to make that
 4 referral because although it sounds a very neutral act
 5 and it's a very important act, there are often concerns
 6 around making that the right decision.
 7 So, for example, if there are concerns around
 8 a parent attending with a child in an emergency
 9 department, they -- the healthcare professionals work
 10 hard to make sure that they aren't overreacting to what
 11 they are seeing but are making a sensible reasoned
 12 choice around referral. Given the impact it will have
 13 inevitably on that family dynamic, they just try and
 14 make the right decisions.
 15 **Q.** And is it right that safeguarding
 16 responsibilities apply just as much to members of staff
 17 who may pose a risk of harm as they would do to family
 18 members of a child?
 19 **A.** Yes, that's right.
 20 **Q.** Now obviously, if the subject of a concern is
 21 a member of staff, then there isn't that risk of
 22 interrupting a family dynamic --
 23 **A.** (Nods)
 24 **Q.** -- thank you just described.
 25 Would you agree that patient safety is always

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1 service users from abuse and improper treatment?
 2 **A.** That's correct.
 3 **Q.** And is that something that you would have been
 4 aware of at the time that you provided advice to the
 5 Trust in 2016 and 2017?
 6 **A.** I would have been aware of it. Those
 7 particular regulations were generated around 2014 and
 8 relate to the creation of the Care Quality Commission at
 9 the time, so they were relatively new.
 10 But as a general concept of course safeguarding has
 11 run through the health service throughout its existence.
 12 **Q.** Now, I am going to ask you a couple of the
 13 same questions that I put to Mr Pace about safeguarding
 14 principles that you may have, may have heard.
 15 Is it correct that one of the safeguarding
 16 principles is that a safeguarding referral needs to be
 17 made if there is a risk that someone has harmed or may
 18 harm a child?
 19 **A.** Yes.
 20 **Q.** And there is no evidential threshold that
 21 needs to be met before a safeguarding referral is made,
 22 is that correct?
 23 **A.** That's correct.
 24 **Q.** All that's needed is a concern of a risk?
 25 **A.** It -- it is. I think the reality for

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1 paramount when making a decision as to whether to make
 2 a safeguarding referral and that, for example, the
 3 feelings of a member of staff or the impact on them of
 4 making a referral is not something that is weighed in
 5 the balance: it is patient safety that is paramount?
 6 **A.** I absolutely agree with that in, in general
 7 concept. Just note that I am not the person making
 8 those decisions. Others have to do that.
 9 **Q.** Yes. And is it another principle of
 10 safeguarding that safeguarding is everybody's
 11 responsibility?
 12 **A.** Yes.
 13 **Q.** And does that mean that an individual cannot
 14 assume that somebody else has complied with their
 15 safeguarding responsibilities and on that basis not take
 16 safeguarding action?
 17 **A.** In the context of how healthcare operations
 18 work internally, yes, I would agree with that.
 19 **Q.** Thank you. I am just going to ask you some
 20 questions now, if I may, about the first occasion on
 21 which you would have heard about any of the issues on
 22 the neonatal unit at the Countess of Chester Hospital.
 23 Is it right that you were contacted by Ian Pace,
 24 a colleague within your firm, working in the Employment
 25 and Pensions Department on 5 July 2016?

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1 A. I believe so, yes.

2 Q. Now, Ian Pace's recollection is that he was
3 very concerned and had identified a red flag after
4 a conversation he had had earlier that day with
5 Dee Appleton-Cairns at the Trust. Do you recall
6 a conversation in which he expressed to you that he had
7 real concerns and a red flag as a result of that
8 conversation?

9 A. So I have no recollection now of the
10 conversation, but I have no reason to doubt Mr Pace's
11 account of that. I recall that I was contacted and
12 asked, as I am on many occasions, by my employment
13 colleagues to contribute to some advice being given to
14 a health client and that the reason for some additional
15 separate advice to that being employment was that there
16 was a concern from a patient safety perspective.

17 In fairness, I don't, in 2024, recall the detail of
18 that conversation with Mr Pace.

19 Q. Well, do you recall having the conversation
20 with him at all?

21 A. I think from the email searches carried out
22 for this process, I would be very comfortable that we
23 had that conversation, yes.

24 Q. But do you recall now, as you sit here giving
25 evidence, do you recall having a conversation with

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1 partly add I guess some flavour to that, which is that
2 for a healthcare lawyer reference to Beverley Allitt
3 would be very significant and would, would put matters
4 in a more concerning tone than what we are going to
5 discuss shortly.

6 Q. Well, can you just expand on that? What is it
7 that you would have understood a reference to
8 Beverley Allitt at the time to mean?

9 A. So I think for any healthcare lawyer at that
10 time, one would regard a reference to Beverley Allitt as
11 suggesting that there was a deliberate harm element to
12 the patient safety concern --

13 Q. Yes.

14 A. -- which places it in a very, very different
15 category to the vast majority of calls I have of that
16 nature.

17 Q. Yes, an extremely serious category?

18 A. Yes.

19 Q. Which demands immediate action?

20 A. It demands a conversation to find out what's
21 going on, yes.

22 Q. Well, would you agree that it demands more
23 than just a conversation to find out what's going on if
24 there is a concern by somebody who appears on their face
25 to be a professional person that there is a

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1 Ian Pace on 5 July or not?

2 A. I recall I will have had a conversation with
3 him.

4 Q. Yes. Now, Ian Pace has told the Inquiry that
5 during that conversation, he will have communicated to
6 you that there was a concern that there was a
7 Beverley Allitt-type situation on the neonatal unit at
8 the Countess of Chester Hospital. Presumably you are
9 not able now to recall one way or the other whether he
10 said that to you or not?

11 A. No. But I have -- I have seen a file note
12 that Ian Pace created from his conversation on 5 July
13 with a member of the Trust staff and I have seen
14 reference within that file note to him being told that
15 various members of staff were pointing the fingers at
16 each other and that one Consultant had suggested that
17 a nurse was referred to as Beverley Allitt. But I see
18 from the rest of that file note that the member of the
19 Trust was very clear with Ian that she didn't believe
20 that to be a situation that they faced and that there
21 was, I think she used the words no malicious issue.

22 So I will I believe have seen that file note. But,
23 I can't now recall Ian specifically referencing
24 Beverley Allitt in a call with me and, and I can partly,
25 although I can't remember the detail of his call, I can

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1 Beverley Allitt situation that demands immediate action
2 to ensure that there isn't such a situation continuing
3 any longer?

4 A. Sorry. The conversation and the discussion
5 I made reference to is as a legal adviser.

6 Q. Yes.

7 A. Simply referencing that, doesn't give me
8 enough information to advise, it doesn't tell me
9 anything else. So the nature of the discussion or
10 conversation was I would want to know more about what
11 was going on.

12 I wasn't being asked on 5 July to immediately give
13 a view as to what should or shouldn't happen next. It
14 was I was being asked to have a conversation.

15 Q. Yes. Well, Ian Pace's recollection is that on
16 5 July when he speaks to you, he tells you that there is
17 a concern about a specific individual that reference has
18 been made to Beverley Allitt, and that your response in
19 that conversation with him is that: the police don't
20 need to be called in straight away, that it's too early
21 and that further investigation needs to be done by way
22 of a Royal College review.

23 Do you recall expressing those views to Ian Pace in
24 that initial conversation?

25 A. I don't recall that because I don't recall the

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

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

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

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

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

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

4 **MR BERSHADSKI:** Yes.

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

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

9 And he said that he couldn't recall the detail.

10 Agreed to arrange... And then your response was:

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

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

14 **MR BERSHADSKI:** Yes. Yes, my Lady, I think the
15 evidence was of initially a conversation with

16 Kirsty MacDonald.

17 **LADY JUSTICE THIRLWALL:** Yes.

18 **MR BERSHADSKI:** And then following that
19 conversation --

20 **LADY JUSTICE THIRLWALL:** Yes.

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

24 **LADY JUSTICE THIRLWALL:** Yes, after the first
25 conversation.

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

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

10 **Q.** Yes.

11 **A.** -- a couple of weeks later.

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

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

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

22 **MR BERSHADSKI:** Sorry, my Lady.

23 **A.** I can't hear.

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

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1 **MR BERSHADSKI:** After the first conversation with
2 Kirsty MacDonald.

3 **LADY JUSTICE THIRLWALL:** Yes.

4 **MR BERSHADSKI:** Thank you.

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

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

10 **MR BERSHADSKI:** I would hope to be within
11 40 minutes with this witness.

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

16 **MR BERSHADSKI:** It depends.

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

19 **(12.59 pm)**

(The luncheon adjournment)

21 **(2.00 pm)**

22 **LADY JUSTICE THIRLWALL:** Mr Bershadski.

23 **MR BERSHADSKI:** Ms Slingo, we were just talking
24 about the conversation you had had with Ian Pace on
25 5 July 2016 after his call. Is it right that you then

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

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

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

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

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

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

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

25 **Q.** Of course and that conversation with Ian Pace
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1 whether or not the police ought to be contacted in
2 a situation where somebody had made an allegation of
3 deliberate harm by a member of staff?

4 **A.** So at this point I had been advising for
5 20 years, I couldn't tell you the detail of every advice
6 or indeed very much of it. I would also say the call
7 was not about somebody alleging deliberate harm, the
8 call was about some anomalies with some mortality data
9 and a Trust trying to understand what that was about.

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

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

18 **Q.** Yes.

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

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

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

24 **Q.** Yes.

25 **A.** You will appreciate over the years and
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1 wasn't documented anywhere?

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

3 **Q.** So the first time that you speak directly with
4 anybody at the Trust then is on the afternoon of
5 18 July?

6 **A.** It's around 5 pm, yes.

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

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

24 **Q.** Of course. So would this have been the first
25 occasion that you were called upon yourself to advise on
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1 everything that's happened since I have reflected very
2 heavily on was -- was it about deliberate harm, that
3 conversation? And I have -- I have struggled to recall
4 that it was -- that was the tone. I don't think it was
5 the tone. Obviously I had read Ian Pace's file note of
6 5 July, but nothing else. So the conversation that was
7 had was very -- and I think that sort of maps through
8 the notes that were taken -- it was very much we have
9 had this data issue, we are taking the following steps,
10 there's some concern about whether an individual is part
11 of that.

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

22 So I will have had calls with clients about does
23 there need to be police involvement over my previous
24 years of advising. But that would be at the level of
25 routinely, you know, gross negligence manslaughter,
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1 corporate manslaughter issues rather than is somebody
2 deliberately killing neonatal babies. That's not
3 something I would have encountered at that point, no.

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

6 **A.** Yes.

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

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

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

23 **A.** So I -- I yes, I think -- again I don't, eight
24 years on, remember reading the file note but I am --
25 I am clear from us checking our time recording systems
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1 42-minute call then I wrote my email and sent it. So
2 I sent the email at 6.15, I must have been drafting it
3 immediately following the call.

4 **Q.** We will pull up the email, it's INQ0101942.
5 I think certainly in this version of the email, it
6 appears that it's sent at 17.15?

7 **A.** Okay.

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

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

14 **Q.** Yes.

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

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

22 **A.** The tricky issue was that they had some
23 mortality data that appeared to be of concern or had
24 created an outlier situation and that they needed to
25 understand the basis for that and explore what was going
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1 that I looked at something briefly before the call.

2 **Q.** Yes.

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

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

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

16 **Q.** Yes.

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

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

20 **A.** Yes.

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

25 **A.** It's 6.15. So 5 o'clock telephone call,
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1 on.

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

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

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

23 Do you think this would have been a complete list
24 of the information you were given by the Trust during
25 your call about the reasons for a concern?
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1 **A.** I think to the best to the best of my
 2 recollection, yes. I mean the situation that I was
 3 faced with was -- was speaking to an individual I had
 4 never advised before, an organisation I had never
 5 advised before about a situation that they appeared
 6 during the call to be at the start of in terms of the
 7 things they knew or certainly the things they told me.
 8 It tends to be my practice particularly where
 9 I know the individuals receiving of my advice better,
 10 sort of less well, so if I -- if I talk to them on
 11 a weekly basis I will understand what they understand
 12 I've said, but if I'm advising someone who I simply
 13 don't know and -- and don't really have any other
 14 information than in that call then it would be my
 15 practice to try and just capture the essence of what
 16 I have been told as the basis for the advice that I am
 17 giving.
 18 And for all the reasons you will understand, since
 19 everything that has now happened I am very pleased that
 20 I did at least do that so that I could look back and
 21 understand why I advised them the way I advised at the
 22 time. So to the best of my knowledge those bullet
 23 points are the sort of at the very least the headlines
 24 of what was important information given to me but
 25 I think I would be confident I would have included

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1 a concern about --
 2 **A.** I had -- and I checked my handwritten notes
 3 I had no names of any individuals involved, no idea who
 4 anybody was that was looking at this. So, no, I had
 5 no -- no information on that.

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

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

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

24 **Q.** Yes.

25 **A.** And I mean incidents in the clinical incident

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

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

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

12 **A.** Absolutely not.

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

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

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

24 **A.** By who, sorry?

25 **Q.** By Dr Brearey, one of the Consultants with

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

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

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

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

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

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

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

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

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

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

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

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1 incidents being investigated.

2 **Q.** The advice you give in this email is that:
3 "There does not currently appear to be any reason
4 to formally alert the police to these issues as there is
5 upon which one might reasonably base a suspicion of
6 a criminal offence having been committed."

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

9 **A.** That is correct, yes.

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

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

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

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

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1 **Q.** You say in your paragraph 2 that:

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

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

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

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

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

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

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

23 What did you mean by that advice?

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

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

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

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

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

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

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

20 **Q.** Yes.

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

23 **Q.** Yes.

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

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1 thing which was a link to the staff internal briefing.

2 **Q.** Yes.

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

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

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

15 So I was in the same position I had been in
16 eight months earlier which is I had no additional
17 information and was reliant on the same length,
18 42-minute call with the Trust.

19 **Q.** If we go to your note of the call that you
20 have with Sue Hodgkinson, that is INQ0101944, this is
21 your handwriting, is it?

22 **A.** It is.

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

25 "Consultant concerned re a number of cases where

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

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

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

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

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

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

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

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1 'unnatural/ ..."

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

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

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

9 **A.** This was potentially, sorry?

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

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

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

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

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1 happened."

2 **A.** Yes.

3 **Q.** What did you mean by "He believes something
4 has happened"?

5 **A.** That that section is me recounting what I was
6 being told by Ms Hodgkinson. So I think those will be
7 her words not mine. And I -- at this point, I didn't
8 know what the something would be and, again, the range
9 at that point -- now, of course, we would always think
10 of deliberate harm but, at the time, somebody, some
11 individual being, you know, repeatedly incompetent or,
12 or performing so poorly that they might be grossly
13 negligent would be part of the mix there.

14 **Q.** You then record in the next section:
15 "Consultant not saying if you don't do it we will
16 but ..."

17 Does that read "but threatening resignation"?

18 **A.** Yes, I think that is what I have written.
19 Again, this is information. If it helps navigate
20 slightly, although it's not entirely consistent, where
21 there is a little asterisk, it's often me having
22 a reminder to myself to ask something or to note
23 something; where it's written as sort of arrows it
24 almost me capturing what I am being told.

25 That's not an absolute blanket rule because I have
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1 patterns have been considered and this individual is
2 there a lot.

3 Has that not raised your level of concern such
4 that, by this point, you had said in your previous
5 email, back from July 2016, that there needs to be
6 a very low threshold and it's a fine balance of
7 decision-making. Why does this further information not
8 tip you into saying, "Well, actually, you have done what
9 you can, there's still this concern, now's the time to
10 contact the police"?

11 **A.** Well, that's what my advice is: it's that they
12 should take steps to further engage the Coroner and
13 include the police in that engagement, so that there is
14 no doubt that they have looked at everything in the way
15 they should, involved the right people and also could
16 reassure the Consultant that that's been done.

17 **Q.** Well, if we go to your email that follows this
18 call, it's at INQ0101937, if we go over to page 2, we
19 can see that you write:
20 "The question the Trust is now considering is
21 whether and, if so, how to liaise with the police in
22 this matter ..."

23 Then under "I advise the following", the first
24 bullet point is:
25 "If the matter is to be referred to the police.
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1 noticed later that I have flagged bits with an asterisk
2 that I'm clearly being told.

3 So, for example, further down the page, I have
4 said -- I have noted that the MD -- sorry:
5 "The MD [so Medical Director] has always reviewed
6 cases against shift patterns. She is there a lot but
7 ..."

8 And then I haven't finished the sentence. Then the
9 next line down says:
10 "MD considers satisfies incident investigated."

11 **Q.** Yes.

12 **A.** So this call was largely around have we done
13 enough? That was the essence of the call: is there
14 anything else we need to do; anywhere else we need to
15 go?

16 **Q.** Well, did this not raise your index of concern
17 about these events because a review -- from what you are
18 told, and I appreciate you didn't have the document
19 itself, you weren't able to read it therefore, but you
20 are being told that a Royal College review has been done
21 but the way a Consultant is reading it is that it's
22 a service review, it hasn't actually achieved any
23 forensic conclusions. He still believes something has
24 happened and the Consultant appears to feel so strongly
25 about this that he is threatening to resign. Shift
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1 Then a few bullet points down again:
2 "If a decision is made to actively engage the
3 police ..."

4 Similarly, over the page on page 3, you say, in the
5 middle:
6 "The decision currently faced regarding police
7 referral ..."

8 So would it be fair to say that it was still an
9 "if" rather than "how", at this point?

10 **A.** Yes, I mean, again, this is going to sound
11 wrong in the context of everyone hearing this from the
12 outside but we were advising, it's not my decision that
13 they should go to the police. But the email very
14 clearly talks through, if the Trust do decide to go to
15 the police, this is how I would recommend they go about
16 it.

17 So my expectation is that they take from that that
18 this is something that shouldn't be closed down without
19 the police being aware and, again, if I can just put it
20 in context and this is just to help, not to defend,
21 because that's not what we are here for, the call was
22 much more -- the call eight months in was much more "We
23 have done X, Y and Z, how do we bring this to its
24 natural conclusion?"
25 It wasn't -- it felt very much that there was
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1 a view that enough had been done and I think my -- my
 2 reference to the Medical Director having reviewed things
 3 and having done things and feels enough's been done,
 4 I was almost being asked as an almost check and balance,
 5 was my impression, and part of my advice on the check
 6 and balance was, you know, actually you have had some
 7 apparently encouraging and useful conversations with the
 8 Coroner, I think you should continue that, but include
 9 the police in that, so that all the people that need to
 10 know, know and then decisions can be made by those
 11 people as to whether there's more to do.

12 And I appreciate that is subtly different from "You
 13 must go and refer this to the police now", I absolutely
 14 see that.

15 **Q.** Thank you. That email can come down off the
 16 screen, thank you very much.

17 If I might just ask you to reflect on a couple of
 18 matters. Do you think now, looking back on matters,
 19 given what you knew at the time, so I am not asking you
 20 to use the benefit of hindsight and include matters
 21 which you have only become aware of since, but do you
 22 think, looking back, given what you knew at the time,
 23 that there should have been stronger advice given,
 24 either stronger advice given that if there is a concern
 25 by any professional person you need to go straight to

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1 safety and trying to help the healthcare service. So
 2 it's enormously devastating to find out what happened
 3 next.

4 Should I have said categorically "Refer to the
 5 police"? As I sit here, I wish I had but, actually,
 6 even with the benefit of hindsight, looking really
 7 closely at what I was told, it didn't feel like that at
 8 the time and that was the basis of the advice I gave
 9 both in the July and the following April.

10 I feel more comfortable that in the April I made it
 11 very clear that I expected there to be police
 12 involvement, rather than this matter just be shut down.
 13 But I don't think, even looking at the July time I had
 14 information that would have led me to very robustly
 15 advise that a police referral was, was mandated.

16 I have advised clients since. I have over-advised
 17 clients since, in situations that have been mere
 18 clinical incidents, not anything more sinister.

19 But I did my best based on what I had.

20 **MR BERSHADSKI:** My Lady, thank you, those are my
 21 questions.

22 I think there are some questions from Mr Skelton.

23 **LADY JUSTICE THIRLWALL:** Mr Skelton.

24 **Questions by MR SKELTON**

25 **MR SKELTON:** Ms Slingso, I ask questions on behalf

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1 the police, or that you simply shouldn't have advised
 2 without seeing much more information yourself?

3 **A.** I think both of those are relevant reflections
 4 and they are -- they are reflected in my statement.

5 If I am talking now to colleagues that I am
 6 training and developing, of course we always want to get
 7 the best information upon which to then advise. The
 8 nature of being a healthcare lawyer is such that you do
 9 get called on the hoof and you get called to give your
 10 views. That can be very, very challenging. We run
 11 an out-of-hours service so 24/7, we are called to give
 12 advice, having been woken up and all sorts of things.
 13 So it's -- part of what we do is to try and advise based
 14 on information we have.

15 But, in this case, as I think you are aware from
 16 the parts of my statement where -- and I think you just
 17 popped it up on screen -- I was expressing internally
 18 a real professional discomfort that we didn't have any
 19 information and certainly not sufficient information to
 20 really get into some detailed and substantive advice.

21 I gave the advice to the best of my knowledge at
 22 the time. If I had had my time again, would I have
 23 simply said no? I am probably not that person, I am
 24 probably somebody who is used to trying to help and get
 25 through this. My entire job and career is about patient

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1 of one of the Family Groups.

2 Am I right in understanding that you had briefly
 3 looked at Ian Pace's notes before your call, the July
 4 call?

5 **A.** On 18 July?

6 **Q.** Yes.

7 **A.** I believe I had seen his note of 5 July before
 8 I had the call with Sue Hodgkinson.

9 **Q.** Can we just briefly have that up on screen
 10 again, please, INQ0101934. Excuse me. So without going
 11 through this again in detail, this is about an alarm
 12 going off about increased mortality previously and then
 13 the alarm going again about increased mortality and then
 14 there is, in the second paragraph, after the sentence
 15 about "the third baby is now failing":

16 "The midwives are saying this is because of
 17 congenital issues. From an employment respect, staff
 18 were turning themselves. They are all pointing fingers
 19 at each other. There has been an instance where a
 20 consultant referred to a midwife as Beverley Allitt.
 21 Dee is satisfied there are no malicious issues
 22 involved."

23 So from those sentences, it does appear that, at
 24 least in somebody's mind, there is consideration of
 25 malice or foul play?

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1 A. From that note, yes.
 2 Q. So that was raised in Ian's conversation?
 3 A. Yes.
 4 Q. Can we now see your note, please, of the
 5 conversation that you had, and that's INQ0101941?
 6 A. Could I just note that there is a line in
 7 that, that note, that can't be right, which is that it
 8 says that I spoke to Dee Appleton-Cairns. I didn't.
 9 I pursued her for a date for us to speak by email and
 10 then we had the Sue conversation. I didn't speak
 11 directly to Dee Appleton-Cairns following that call.
 12 Q. Understood. Thank you. So just again, by way
 13 of context, it's well understood that you are coming at
 14 this relatively cold. You have read a note and you are
 15 bounced into a conversation with someone you don't know
 16 about an issue you have not heard of before?
 17 A. Yes, exactly that.
 18 Q. You make some handwritten notes?
 19 A. Yes.
 20 Q. You can see them on the screen, and it is just
 21 the bit really at the bottom where I think it says
 22 "15/16 anomaly"?
 23 A. Mm-hm.
 24 Q. "Mortality", is that?
 25 A. Yes.

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1 A. This is just what Sue is telling me.
 2 Q. Okay. So the nurse is connected or correlated
 3 with the deaths but there is no evidence that her
 4 clinical practice is substandard in the context of the
 5 deaths --
 6 A. Yes.
 7 Q. -- as far as you are being told?
 8 A. That is what that would say to me.
 9 Q. So this isn't a negligence issue, it seems;
 10 it's not medical negligence, incompetence?
 11 A. Well, that, that's -- they are saying there is
 12 no evidence.
 13 Q. Yes.
 14 A. Sorry, my note just says "Clinically no
 15 evidence re staff member", so I take that in the round.
 16 I don't know if -- we certainly didn't discuss whether
 17 there was a sort of medical malpractice, a clinical
 18 negligence issue about the care given. It just says
 19 "Clinically no evidence re staff member", but I would,
 20 I would, yes, I would assume that what they have done is
 21 said, "We have looked at the clinical information and
 22 there's nothing to see about that staff member and their
 23 care".
 24 Q. She's done nothing wrong clinically?
 25 A. That, I can't remember that but that's my

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1 Q. "Review", what data is that?
 2 A. Clinical data.
 3 Q. "Review staffing data"?
 4 A. Yes.
 5 Q. What for?
 6 A. I am -- this is me being told by -- given
 7 a sort of narrative by Sue.
 8 Q. They have reviewed the clinical data, they
 9 have reviewed the staffing data?
 10 A. Yes.
 11 Q. Then "prevalent in shifts supported when
 12 deaths have arisen", so this is to do with the nurse, is
 13 it?
 14 A. Yes.
 15 Q. She is generally around on the shifts and
 16 supported when the deaths have arisen?
 17 "Clinically no evidence re staff member."
 18 So that is the same staff member?
 19 A. I am so sorry. I can't hear you very well.
 20 Q. Sorry:
 21 "Clinically no evidence re staff member."
 22 A. Yes, and I seem to have underlined the "no
 23 evidence" because, obviously, that was something that
 24 I would be looking out for.
 25 Q. Whose view was it there was no evidence?

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1 interpretation of what's being said there.
 2 Q. Okay. So why are the police being mentioned?
 3 A. Why, sorry?
 4 Q. Why are the police being mentioned? If there
 5 is a high number of deaths, correlation with a nurse,
 6 but no concern about her clinical practice, why are the
 7 police being mentioned?
 8 A. Well, I assumed the police were being
 9 considered in order to check whether there had been any
 10 offences and, as I said earlier, gross negligence
 11 manslaughter would be part of that and would be much
 12 more normal for me to encounter.
 13 Q. I appreciate it would be much more normal but
 14 there is other offences that occur --
 15 A. Yes.
 16 Q. -- particularly in multiple cases. Gross
 17 negligence does occur, usually it is a single event, the
 18 classic anaesthetist not putting in the tube the Adomako
 19 case, with which law students are familiar, but multiple
 20 deaths: why did you assume it was gross negligence
 21 manslaughter and not murder?
 22 A. So I think I answered that earlier but I am
 23 happy to go over it again.
 24 Q. Do.
 25 A. In my world, murder is not something that is

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1 seen very often at all. So very, very common is a range
2 of poor competence clinicians who have sometimes on
3 multiple patients -- so had difficulties with the care.
4 So there are -- I get involved a lot in re-calls of
5 patients, people who have been treated repeatedly by
6 people in a poor way, that isn't necessarily obvious
7 from the clinical data or clinical records even, but
8 which comes to light over the course of looking at
9 outcomes or some other raised concern.

10 So you are absolutely right, clearly murder is one
11 of those issues. It wasn't at the forefront of my mind
12 as a result of this conversation and, if it should have
13 been, then of course it should have been, but it wasn't.

14 **Q.** I am going to put it to you that it should
15 have been --

16 **A.** Okay.

17 **Q.** -- because you have read the note of Ian Pace,
18 it is mentioning Beverley Allitt, so it's dropped a seed
19 of suggestion that you are dealing with deliberate harm;
20 you have multiple deaths of children; you have no
21 suggestion of incompetence; and you have a clear
22 potential cause of calling the police, somebody wants to
23 call the police. So, in those circumstances, it had to
24 be in your mind that there was a potential serious
25 criminal offence as a possibility?

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1 it is a very unusual situation, it is a sort of red-flag
2 conversation?

3 **A.** It is unusual. I think it's, it's --
4 increasingly people -- we all have open minds to has
5 some care gone to the point where there is a criminal
6 issue. So the increase in criminality, if you like, of
7 poor clinical care is something that I am -- as was and
8 am very familiar with.

9 So the idea of the police being involved in
10 healthcare where there are adverse incidents or issues
11 of concern is not as unusual, as you might think. It's
12 not every day by any stretch. It's becoming more
13 common.

14 **Q.** What did you think the phrase "Clinicians are
15 saying it's her" meant?

16 **A.** Yes, I mean, I have written that down as
17 something that Sue has clearly said to me. I --
18 I didn't seek to interpret that other than this
19 individual is still someone being considered as is she
20 involved in this or not.

21 **Q.** The reading to the person coming at it cold --

22 **A.** Yes.

23 **Q.** -- looks like they are pointing the finger and
24 saying "She killed those children"?

25 **A.** Okay. I --

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1 **A.** So I can only do my best with my evidence here
2 and, and I can honestly say it wasn't -- it wasn't
3 I don't think it was even in my mind at that point, it
4 wasn't something that was -- I mean, the idea of
5 somebody killing neonatal -- neonatal patients was not
6 the thrust of that conversation at all and I absolutely
7 understand why everybody would now wonder why not.

8 But it genuinely wasn't. So I -- I can't explain
9 it any better than that, I am terribly sorry, but I have
10 explained why I advised in the way I advised.

11 **Q.** Can you explain who was considering calling
12 the police?

13 **A.** Not a specific individual, no.

14 **Q.** So was it Sue, or was it someone else?

15 **A.** I -- I wasn't given that information.

16 **Q.** Did you ask?

17 **A.** No, I didn't. I took it, I advised people
18 corporately, so I took it as the Trust was wanting some
19 advice or some, some view on what to do next. So
20 I didn't take it as an individual calling me because we
21 are not instructed by individuals.

22 **Q.** So just in terms of your curiosity about why
23 the police are being mentioned, because it is highly
24 unusual, isn't it, in the context of neonatal care to be
25 thinking about calling the police in respect of a nurse,

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1 **Q.** Do you see that?

2 **A.** I see it here and now absolutely. I --
3 I didn't take from that call that they were accusing her
4 of murdering neonatal babies because that's not the
5 advice I would have given had that been my belief at the
6 time or what I had taken on board. That wasn't in the
7 way in which that was put to me at all.

8 **Q.** I wonder if you should have asked more
9 questions, in the circumstances?

10 **A.** I am absolutely open to people suggesting
11 that. We only do our best.

12 **Q.** Your advice, I think, had you understood it to
13 be that the doctors were accusing a nurse of killing
14 patients, would have been very different, no doubt?

15 **A.** Of course. Of course.

16 **Q.** Call the police?

17 **A.** Yes. But this, this whole call, it was
18 a 42-minute call, where we went over a lot of ground
19 that Sue Hodgkinson was trying to convey to me cold and
20 I took away from that call -- I did not take away from
21 that call the idea of there is a nurse potentially
22 killing babies in this hospital.

23 That, it simply would not have been my advice if
24 that was what I came away from that call thinking.

25 **Q.** Knowing what you now know, I don't know

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1 whether you have followed this Inquiry in any detail but
2 there was a lot of evidence being gathered over the
3 preceding year about the deaths as they continued and
4 increased and, certainly within the doctors' minds, by
5 this time of this call, they were suspecting that Lucy
6 Letby was killing babies.

7 Do you feel that you were misled by Sue Hodgkinson
8 in this call, about the nature of the concerns about
9 which you were being asked to advise?

10 **A.** So I think there is a couple of things I would
11 like to respond on that. So firstly, although of course
12 natural curiosity means that one follows an Inquiry like
13 this, because I knew I was giving evidence I have not
14 read through all the material and the evidence because
15 I didn't want to put things in my mind that I simply
16 didn't know when I was advising. So I am not all over
17 the detail of who knew what and when.

18 However, I -- I do think that I didn't have all the
19 information that you suggest it was available by the
20 July period in 2016, because it doesn't feature in my
21 note as part of the narrative and the history given by
22 Sue. I think it would be unfair of me to sit here and
23 suggest that she misled me because I don't know,
24 I genuinely don't know. I think she would have to
25 answer that for herself.

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1 **MS LANGDALE:** My Lady, may I call the next witness
2 please, Mr Medland.

3 **LADY JUSTICE THIRLWALL:** Do come forward.

4 **MR SIMON MEDLAND (sworn)**

5 **Questions by MS LANGDALE**

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

7 **A.** Thank you.

8 **MS LANGDALE:** Mr Medland, you have provided
9 a statement to the Inquiry dated 2 July 2024. Can you
10 confirm that the contents are true and accurate as far
11 as you are concerned?

12 **A.** Yes, I can.

13 **Q.** You tell us in the statement that you were
14 called to the Bar in 1991, you were appointed then
15 Queen's Counsel in 2011, working from Exchange Chambers
16 from that time in silk; is that correct?

17 **A.** That's correct.

18 **Q.** You were instructed for our purposes in April
19 2017 by Mr Stephen Cross, on behalf of the Countess of
20 Chester Hospital. We know from your statement that
21 there was a conversation between yourself and Mr Cross
22 on the telephone and subsequently a number of documents
23 sent to you.

24 Can you tell us, first of all, about the
25 conversation and then we will look at some of the

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1 **Q.** Well, if she knew that the Consultants thought
2 Lucy Letby had killed the babies and she didn't tell you
3 that in a conversation in which you were being asked to
4 advise about calling the police, then that would be
5 a serious omission, wouldn't it?

6 **A.** I would be disappointed to learn that, yes.

7 I -- I am trying to be really fair to somebody that

8 I don't know and I know is going to be called to give

9 evidence to account for herself. I can only tell you

10 what I was told and, if I wasn't told everything that

11 was known, then that would be disappointing to find out

12 and that appears to be the case.

13 **MR SKELTON:** Thank you. Thank you, my Lady.

14 **LADY JUSTICE THIRLWALL:** Thank you, Mr Skelton.

15 **MR BERSHADSKI:** I think, my Lady, if there could be
16 a short break now before the next witness is called.

17 **LADY JUSTICE THIRLWALL:** Yes, certainly, I think we

18 can infer from that, Ms Slingo, that your evidence has

19 been completed. Thank you very much for coming and you

20 are free to go.

21 We will just take a short break and start again at

22 3.00.

23 **(2.50 pm)**

24

(A short break)

25 **(3.00 pm)**

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1 documents that were sent to you. What do you remember
2 now about the contact or telephone contact from
3 Mr Cross?

4 **A.** Nothing other than that which I have put in my

5 statement, really. It was a general conversation to

6 talk to me about the impending instructions which he

7 intended to give and a general scene setting. I'm

8 afraid I am unable to assist with anything more detailed

9 than that, above and beyond what I have put in my

10 statement, namely a general conversation. There was

11 concern amongst some of the Consultants about serious

12 occurrences in their part of the hospital and he wanted

13 me to consider those and then report to the board, and

14 he indicated in that conversation that the Consultants

15 were not content with the way the hospital had dealt

16 with the matters that they had raised.

17 And that there was dissatisfaction in the working

18 relationship. As I have termed it in my statement, it

19 was not at all harmonious.

20 **Q.** Had you worked with Mr Cross previously?

21 **A.** A few times, yes, I had been instructed on

22 behalf of the hospital to attend certain Coroners'

23 Inquests and the like not very many, perhaps half

24 a dozen, I think, and therefore I had been instructed by

25 him before.

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1 Q. Half a dozen over what period of time?
 2 A. Probably a couple of years, something like
 3 that.
 4 Q. You say:
 5 "He was instructing me to bring independent common
 6 sense and wisdom to bear on the situation in which he
 7 stated he had considerable concerns as to what was
 8 unfolding in front of him and the hospital but in which
 9 there was some tension arising from the various duties
 10 of care which he had."

11 A. Yes.

12 Q. Would you like to expand on that: what was his
 13 concerns?

14 A. Throughout my involvement in this, and
 15 certainly subsequently, as the court cases became public
 16 news and then the Inquiry was under way, I have
 17 reflected many times that the -- there was a series of
 18 not always aligned duties of care, which he and others
 19 found themselves rather caught in, was my impression.

20 For example, he had a duty of care to the hospital
 21 but also to the patients and the staff. The staff had
 22 duties of care to each other and the hospital but also
 23 the patients. And this internal problem, where the
 24 whole thing seemed internalised to me, was one of the
 25 features which I felt did not help and certainly he

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1 Q. So you understood that he felt conflicted by
 2 various duties of care. We know -- I will just put it
 3 on the screen so people can see. INQ0088716, page 1 is
 4 an email and it's an email that identifies:

5 "Please find attached papers as discussed to you
 6 from Stephen ..."

7 At the bottom, if we look at the bottom page 1 and
 8 then 2, over the page?

9 A. Yes.

10 Q. "Please find attached papers ..."

11 A. I think this was the packet I was given this
 12 morning -- this afternoon when I arrived.

13 Q. That's right, yes. When we asked you in your
 14 Rule 9 what material you had received, there was less
 15 clarity than this email appears to help us with because
 16 we see this was forwarded by Claire Raggett to the
 17 organisation Facere Melius, at the top of the page, who
 18 were examining events and providing a report to the
 19 hospital.

20 So we see at the top this email reflecting with the
 21 attachments that may have or appear to have accompanied
 22 your email. So if I can take the documents in turn --

23 A. Yes.

24 Q. -- those attachments referred to. The first
 25 one suggests that you received the Countess of Chester

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1 expressed those views to me that he felt rather pulled,
 2 as it were, from pillar to post.

3 Q. Did you know Mr Cross personally in any
 4 capacity?

5 A. A little. I mean, in the sense that Chester
 6 is a small city. His brother had been and possibly
 7 still was, at that time, a defence solicitor, who
 8 I don't think I ever was instructed by, in North Wales
 9 but was certainly a personality there, and I was aware
 10 of him. So I had met Mr Cross a few times but --

11 Q. In social occasions?

12 A. In social occasions, in the sense that he was
 13 someone who helped at the cathedral. I would see him
 14 there and around at various events as might occur in
 15 that sort of ...

16 Q. Would you have characterised him as a personal
 17 friend --

18 A. No.

19 Q. -- or a colleague with whom you were friends
 20 or how would you categorise it?

21 A. A colleague with who I was friends, an
 22 acquaintance. For example, we had never been out
 23 together privately, we had never been to each other's
 24 houses or anything like that, but I knew him and was on
 25 first name terms with him.

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1 RCPCH Neonatal Final Confidential Report. We know the
 2 RCPCH reported, and if we can have on the screen
 3 INQ0009618, page 9, this is the page from the RCPCH
 4 report. First of all, do you remember that you had got
 5 the Royal College report?

6 A. I'm afraid I couldn't say that I definitely
 7 did but plainly I did.

8 Q. Okay.

9 A. I just have no recollection of it.

10 Q. You say in your statement you thought you had
 11 the Jane Hawdon report?

12 A. Yes.

13 Q. The Dr Hawdon report. That is not referred to
 14 here?

15 A. No.

16 Q. Might you have got more information
 17 subsequently or do you think you got one batch of
 18 information. I appreciate it's a long time ago, you may
 19 have confused the two reports or not?

20 A. It is and I'm afraid I couldn't say with any
 21 certainty one way or the other, I'm sorry.

22 Q. You tell us that in your statement: it's
 23 difficult to recall now?

24 A. Yes.

25 Q. Obviously, you don't have the records from

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1 that time now, but you recall Jane Hawdon's name?
 2 **A.** Yes.
 3 **Q.** And you're confident in answering that you did
 4 have a "report?" from her.
 5 But looking at this page for us, if you can, this
 6 is a page in a confidential report from the RCPCH. Do
 7 you remember if you saw this page of this report?
 8 **A.** I have to say I'm sorry I don't remember it.
 9 But I am certainly not going to say I didn't see it.
 10 **Q.** No, fair enough. But if we look at what it
 11 says in any event at paragraph 4, about a nurse,
 12 an individual nurse?
 13 **A.** Yes.
 14 **Q.** "The directors understood there was nothing
 15 about her background that was suspicious. Her nursing
 16 colleagues were reported to think highly of her and how
 17 she responded to emergencies and other difficult
 18 situations, especially when the transport team were
 19 involved. Apparently no issues of competency or
 20 training issues. Very professional and asked relevant
 21 questions demonstrating an enthusiasm to learn along
 22 with a high level of professionalism."
 23 If we go to the next paragraph at the end:
 24 "There was no other evidence or history to link
 25 Nurse L to the deaths and her colleagues expressed no
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1 **Q.** "Sequence of events. Highlighted at the
 2 meeting there was one member of the nursing staff who
 3 had been present at more of the cases than any other
 4 member. No evidence other than coincidence."
 5 **A.** Yes.
 6 **Q.** "Nurse noted to work full time, have the
 7 qualification and specialty. More likely to be looking
 8 after the sickest infant on the unit. Regularly worked
 9 overtime when the acuity was high or the unit was over
 10 capacity. No performance issues, no members of staff
 11 had complained."
 12 **A.** Yes.
 13 **Q.** If we go to the next page, page 2. Reference
 14 to two triplets at the top.
 15 **A.** Yes.
 16 **Q.** "Exacerbated concerns there being no obvious
 17 cause for the babies' collapse and it was alleged that
 18 the nurse referred to above was involved in the care of
 19 these babies and that unnatural causes had to be
 20 considered."
 21 We see further down the page an internal review.
 22 The third paragraph:
 23 "... correlated with the increased demand for
 24 higher level of care over the same period."
 25 **A.** Yes. I see that.
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1 concerns about her practice."
 2 **A.** Yes. Well, as I said --
 3 **Q.** You don't remember seeing it, in any event?
 4 **A.** -- I have no collection of seeing that, I am
 5 quite prepared to accept that I did. Not least because
 6 it tends to chime with the ultimate written advice
 7 I gave and, if one looks at the next --
 8 **Q.** Let me take you to the next one. So that is
 9 the first one.
 10 **A.** Okay.
 11 **Q.** Let that one go down, if we can.
 12 **A.** Yes.
 13 **Q.** So it appears you have seen that and then if
 14 we can go, please, to INQ0014378, page 1.
 15 **A.** Yes.
 16 **Q.** This is something from Mr Harvey, "Neonatal
 17 Services Summary"?
 18 **A.** Yes, yes.
 19 **Q.** Let people have a look at page 1, I want to
 20 ask you about something at page 3 but to give people
 21 a chance to have a look at it.
 22 **A.** Yes.
 23 **Q.** We see there "no evidence" at the bottom:
 24 "No evidence other than coincidence."
 25 **A.** Yes.
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1 **Q.** If we go to page 3 at the top,
 2 "Consultants" -- sorry, I should have begun at the
 3 bottom of page 2 before:
 4 "The Consultants explained that their allegation
 5 was based on the nurse being on shift on each occasion
 6 an infant died, although not necessarily caring for the
 7 infant, combined with gut feeling."
 8 **A.** Yes.
 9 **Q.** "There was no other evidence or history to
 10 link the nurse to the deaths and her colleagues had
 11 expressed no concerns about her practice."
 12 **A.** Yes.
 13 **Q.** Then we see, at the bottom of that page:
 14 "The Trust Director of Corporate and Legal Affairs
 15 and Medical Director met with the Coroner on 8 February
 16 following publication of the College review. They met
 17 again on 15 February. The Deputy Coroner was also in
 18 attendance. This followed a receipt of a letter from
 19 the Consultant paediatricians in which they asked that
 20 we ask the Coroner to undertake a full investigation of
 21 all the deaths and unexpected collapses (this latter
 22 isn't within the Coroner's remit) between June 2015 and
 23 July 2016 because they were not reassured that all the
 24 deaths were due to natural causes."
 25 **A.** Yes.
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1 Q. "This letter, together with Dr Hawdon's report
2 was shared to the Coroner and Deputy and a detailed
3 conversation was had regarding the paediatricians'
4 specific concerns. The paediatricians' letter was
5 shared with the College reviewers and Dr Hawdon, since
6 in that letter the paediatricians highlighted that they
7 felt that the concerns they had expressed were not
8 included in the report."

9 A. No.

10 Q. So did you see that at the time, this -- do
11 you remember seeing this?

12 A. Well, again, I do not remember it but it's
13 part of the email that was sent. It was plainly sent to
14 me and I, as it were, must therefore have seen it.

15 Q. If we look at page 4 under the summary:
16 "We can demonstrate that we have taken the concerns
17 raised seriously and have been open and transparent with
18 the Coroner, our regulators, parents and the public.
19 However, despite extensive and intensive review, the
20 paediatric Consultants still feel there are questions to
21 be answered and we feel that we need to share the
22 details and discuss it with the police."

23 A. Yes.

24 Q. Would you take that, that "we have been open
25 and transparent with the Coroner, our regulators,

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1 Q. We see repetition at 11, 12 and 13:

2 "The nurse is one of a few who are full time and
3 regularly worked overtime. Highly qualified, tended to
4 look after the sicker babies. No concerns regarding
5 performance, she had not been involved in any other
6 incidents."

7 A. Yes.

8 Q. "The Trust has demonstrated that it has taken
9 the concerns raised seriously and has been open and
10 transparent with the Coroner, regulators, parents and
11 the public."

12 A. Yes.

13 Q. The last document you are sent, it would
14 appear, is INQ0002926, page 1. This is a timeline not
15 described by the author for you on the document but it
16 appears that this is Ms Hodkinson's timeline that you
17 were also sent, and we see at the bottom of that 8 July,
18 "SPC phone call with Mr Moore, Deputy Coroner", who was
19 updating the Coroner on the 11th.

20 So chiming with what you have been told about the
21 Coroner, on its face?

22 A. Namely that the Coroner, do you mean that the
23 Coroner had looked at such as was referred to him or
24 them and concluded that there was no clear outcome;
25 there were unascertained reasons for death.

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1 parents and the public", as fact, if you had read that?

2 A. If I had read that, which I am prepared to
3 accept that I did, then I would take that as being fact,
4 and it certainly chimed with my understanding of
5 their -- of the hospital's approach, what they thought
6 they had done, how they thought they had behaved.

7 Certainly.

8 Q. There is another document, that one can come
9 down, in the ones you were sent INQ0003226, page 1.

10 A. Yes.

11 Q. This is a document prepared by Mr Cross,
12 3 April?

13 A. Yes.

14 Q. All chiming with your instruction from the
15 4th?

16 A. Yes.

17 Q. We see this document entitled "Rationale", and
18 it begins with number 1:

19 "In our view, there is no evidence to justify
20 a criminal investigation. However, in the spirit of
21 openness and transparency the matter is being reported
22 to the police having regard to the fact that a number of
23 Consultant paediatricians are not satisfied with the
24 very thorough investigations and reviews undertaken."

25 A. Yes.

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1 Q. There's also a reference, but I am not going
2 to ask that it goes on the screen, but for those in the
3 room or CPs, at page 5 there is also a reference to
4 a call with a parent as well. I don't need to take you
5 to that but, on its face, reflecting a call to parents
6 that you had been told there is transparency with
7 parents, the public and the Coroner. Did anything
8 within the documents you were sent suggest anything
9 else?

10 A. No.

11 Q. You then have a meeting on 4 April with
12 Sir Duncan Nichol, Mr Chambers, Mr Harvey and Mr Cross.
13 If we can go please to INQ0003351, page 1. First of
14 all, can you remember why you were meeting with the
15 Chair of the board, Mr Harvey and Mr Cross first at this
16 point?

17 A. No. My, my only recollection or imagining is
18 that it was in order to equip me the better to speak to
19 the Consultants, I think, which came subsequently,
20 didn't it?

21 Q. Do you remember at the beginning if you were
22 asked to do that from the off or were you asked to just
23 advise the board at the outset; did you know?

24 A. What to meet with the Consultants, do you
25 mean?

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1 Q. Yes, which was it: were you supposed to be
2 advising the board as to what to do or when did it
3 become ...

4 A. Well, I can't -- I cannot now remember
5 whether, whether the hospital said I was to meet with
6 the Consultants or whether it was my idea to do so.

7 Q. This meeting might assist with that, if we
8 look at the meeting minutes on 4 April?

9 A. Yes.

10 Q. It says at the top, "Mr Chambers outline", so
11 it looks as though he outlined the meeting. Do you
12 remember anything of that now, what he outlined as the
13 purpose of the meeting?

14 A. I am, I'm afraid not, I'm sorry.

15 Q. Then says:

16 "Do not use para 1 re no evidence to justify
17 a criminal investigation."

18 Do you know what that meant we have seen that
19 reference in Mr Cross' document rationale document, but?

20 A. Yes, and I think I referred to in my statement
21 because I think I was asked -- was I asked a specific
22 question about this, or am I misremembering.

23 Q. No, you may have been. We will have asked
24 I about these handwritten notes, yes, but can you
25 remember now?

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1 It certainly refers to paragraph 1 of a document.

2 Q. We then see further down reference to 13
3 deaths, five explainable, eight not explained?

4 A. Yes, yes.

5 Q. Do you know who said that and what did you
6 understand from that at the time?

7 A. I don't know who said it. That was my
8 understanding of the -- it chimes with my understanding
9 of how the hospital saw the medical outcomes, if I can
10 put it in that rather bland way, that they were faced
11 with. That they understood there to be five explainable
12 deaths and five unexplained.

13 Q. Then right thing to report to police?

14 A. Yes.

15 Q. Do you know who said that?

16 A. Again, I am afraid not. There appears -- is
17 the letters "IH" on the line below?

18 Q. Yes.

19 A. Now, whether that was Mr Harvey who said all
20 those things or some combination of them, I don't know
21 I'm afraid. I'm sorry.

22 Q. Then under "Advice", it said:

23 "Any mileage in speaking to the Consultants again?"

24 A. Yes, right.

25 Q. May that have been -- you said that might have

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1 A. Let me -- if I can just have a moment to
2 remind myself because it sticks in my mind that I was
3 asked a question about this in devising my -- writing my
4 statement.

5 Q. If you look at paragraph, on page 4 of your
6 statement, 95. You say:

7 "I do not know what para 1 was nor do I know of
8 which document it was. It was my view, having been
9 instructed by Mr Cross, and hearing his summarised
10 account that I needed to keep an open mind and
11 I certainly never formed any conclusions before meeting
12 the Consultants."

13 A. Yes.

14 Q. Is it that you are thinking of?

15 A. It may well be.

16 Q. That is where you were asked about it.

17 A. Yes.

18 Q. So when you say "Do not use paragraph 1", so?

19 A. Whether that was -- it may have been -- it
20 obviously refers to para 1 of something, a document.
21 Now, whether it was my saying that it was not correct to
22 say that there was no evidence at the time because
23 I hadn't seen the Consultants, I'm afraid I am rather at
24 a loss to know without seeing the surrounding
25 documentation. But it may have been that.

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1 been your suggestion?

2 A. Yes.

3 Q. Could that have been your suggestion?

4 A. It could have been.

5 Q. "No evidence, no lead. Agree we need to get
6 to the bottom of this."

7 A. Yes.

8 Q. "If you force us to, same team best outcomes."
9 Doing the best you can, can you help us with what may
10 have been said by you then?

11 A. Rather in line with my answer in respect to
12 the question earlier on, "do not use paragraph 1 re no
13 evidence", I have it in my mind that there was, there
14 was a document somewhere in which somebody had written
15 something along the lines of: if you force us to ... or
16 I was saying that that would be an incorrect impression
17 to give, that the hospital were being forced into acting
18 thus implying that they had taken a view that they ought
19 not to if that rather opaque answers makes any sense to
20 anybody.

21 But what exactly I was referring to, perhaps what
22 I was saying there was that the hospital ought not to be
23 seen to be forced into action which might imply that
24 they didn't want to take action which was not my
25 impression at all, or that that they weren't willing to

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1 take action, something along those lines I think is the
 2 only explanation I can give to it.

3 **Q.** Indeed when you say it wasn't your impression
 4 that they weren't going to be forced, the two documents
 5 we have gone to, both from Mr Cross and Mr Harvey say at
 6 the end that they are considering going to the police,
 7 they want to go to the police?

8 **A.** Yes, indeed and although the precise date of
 9 it is not something that I know very shortly after my
 10 report to the board they did call the police in, I'm not
 11 entirely sure exactly when but it was shortly
 12 thereafter.

13 But this brings me back to the point I made a few
 14 minutes ago about the "not always aligned duties of
 15 care", the feeling that Mr Cross and I am sure others in
 16 the hospital had, that they were -- they didn't quite
 17 know what to do for the best because they had some very
 18 highly qualified well-informed people who were reporting
 19 very serious concerns about outcomes, fatal outcomes, on
 20 the unit, and then on the other hand they had a series
 21 of highly qualified, well-informed investigators,
 22 Royal College and the like, Coroner, who had come in and
 23 none of them could find a problem to -- on which you
 24 could definitely put your thumb.

25 And of course the pressing question was whether the

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1 **Q.** -- of opinions, was that in this meeting, this
 2 is the first time you sit with the Executive Team, as it
 3 were --

4 **A.** Yes.

5 **Q.** -- and Sir Duncan Nichol. Did you pick it up
 6 then in this meeting or in your conversation over the
 7 telephone with Mr Cross or when you met the
 8 paediatricians, when did you realise?

9 **A.** So overall in my personal involvement in this
 10 was a fairly short period of time, I think about
 11 10 days. I wouldn't say it was necessarily at one point
 12 as opposed to another but it was certainly by the time
 13 of this, by the time I had spoken to Mr Cross, seen what
 14 I was able to see in documentary form and then had the
 15 meeting, it was obvious that the Consultants were
 16 feeling overlooked and not being taken seriously.

17 **Q.** So you go and meet the Consultants and we are
 18 going to go to your minutes on 12 April.

19 **A.** Yes.

20 **Q.** The Consultants who have given evidence,
 21 Dr Jayaram says accept the minutes, and Dr Brearey, in
 22 terms of what they state. But it was a long meeting,
 23 wasn't it, 90 minutes was the meeting?

24 **A.** Yes.

25 **Q.** One of the things they took issue with was the

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1 problems they might have been training problems, or
 2 negligence problems or poor working practice problems or
 3 they might have been problems inherent in the infant
 4 patients or it might have been a terrible series of
 5 crimes, as we subsequently find out it was. And at this
 6 stage the hospital, bearing in mind -- my impression of
 7 them was that they didn't really know what.

8 **Q.** "Any mileage in speaking to Consultants
 9 again?"

10 You suggest that. What were you thinking the
 11 purpose of speaking to the Consultants would be or --

12 **A.** Because I was actually quite surprised at what
 13 appeared to be the -- which I hadn't anticipated,
 14 appeared to be the considerable antagonism between the
 15 hospital and the Consultants which became apparent to me
 16 quite quickly once I had become involved in this but
 17 I hadn't anticipated it and it was strongly underlined
 18 and emphasised when I did actually meet them again.

19 Because they -- they were collectively angry.

20 **Q.** Let's just look at this meeting for a minute.
 21 I will take you to the Consultants' meeting.

22 **A.** Yes.

23 **Q.** But when you say you became quickly aware of
 24 the difference --

25 **A.** Yes.

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1 purpose of the meeting and their understanding was
 2 different from yours they thought about the purpose of
 3 the meeting. Can I ask you just to have a look an email
 4 from Dr Jayaram to Mr Harvey --

5 **A.** Yes.

6 **Q.** -- which you wouldn't have seen at the time
 7 but INQ0006136, page 1. You see here Dr Jayaram to
 8 Ian Harvey he says at the top:

9 "We are happy with the minutes. However, at the
 10 start we had a discussion about our respective
 11 understandings of the purpose of the meeting which
 12 highlighted a discrepancy. We had been led to believe
 13 that the purpose of the meeting was to help the Trust to
 14 frame what needed to be said to the police whereas
 15 Mr Medland told us that his brief was to discuss whether
 16 there was enough in our articulated concerns to make
 17 reporting to the police worthwhile."

18 **A.** Yes.

19 **Q.** Can you remember now what you said about the
 20 purpose of the meeting and whether there was
 21 a difference between you, as Dr Jayaram explains,
 22 because their understanding at this point was you were
 23 going to the police and that was the case?

24 **A.** Yes.

25 **Q.** And it was a question of how it was done

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1 whereas you were asking the question --

2 **A.** Yes.

3 **Q.** -- effectively whether there was enough in the
4 concerns to go to the police, do you see the
5 distinction?

6 **A.** Yes, I do.

7 **Q.** So what do you say about that? Was there
8 a difference of opinion about that or how did you
9 approach it?

10 **A.** Well, it is -- it is obvious from the email
11 letter that there was a difference in understanding.

12 I am sure that his record of what I said as to my
13 understanding of why I was there was accurate. I --

14 I can't I'm afraid shed any light on the Consultants'
15 understanding or where they had got that from.

16 Presumably from their dealings with the hospital,
17 that was their understanding. I -- I don't know why.

18 **Q.** Was your understanding at that meeting we have
19 just gone to with Mr Harvey, Sir Duncan Nichol, Mr Cross
20 and Mr Chambers, was your understanding within that
21 meeting that you were going to look at whether there was
22 enough when you had that meeting with the Consultants,
23 let's go have a look to see if there's enough?

24 **A.** That was, that was essentially my
25 understanding.

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1 and --

2 **A.** No, I mean the Consultants in that and I think
3 part of the problem may be -- may be -- that by the time

4 I became involved there had been so many internal
5 difficulties which had been thrown up by this
6 investigation of human resources nature and problems
7 with colleagues and personnel in that regard that really
8 it had become anything but clear.

9 **Q.** Let's have a look at the minutes of meeting,
10 thank you.

11 **A.** Yes.

12 **Q.** That can come down. So INQ0003091, page 1.

13 **A.** Yes.

14 **Q.** So these are your minutes --

15 **A.** Yes.

16 **Q.** -- of a 90-minute meeting so you have
17 obviously drawn together threads afterwards. We see
18 page 1 there, if people can read those first and then we
19 will go to the next page?

20 **A.** Yes, thank you.

21 Yes.

22 **Q.** You see the next page:

23 "We all agreed that if there was an identifiable
24 common thread between some of the deaths (cf
25 Beverley Allitt) then this would be powerful prima facie

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1 **Q.** Do you think that was their understanding too
2 on 4 April that you were going to have that conversation
3 or discussion to see if there was enough in their
4 concerns to make a report to the police worthwhile?

5 **A.** Essentially, yes, because -- and it goes back
6 to the internal non-aligned duties of care point that
7 I made, the hospital as far as I knew would have been
8 all too keen to go to the police if they could be sure
9 that by doing so that they had every reason to do so.
10 Whereas by the time I became involved and this was
11 obviously months after the first concerns had been
12 raised, the matter had already been looked at by several
13 different people or groups of people and every time it
14 was looked at, it didn't seem to get any clearer.

15 Therefore, the non-aligned duties of care under
16 which Mr Cross, Sir Duncan and the others were working
17 never seemed to get any less difficult to resolve. One
18 way might have been for me to go to speak to the
19 Consultants and that was how I ended up doing so, to
20 crystallise it. Because rather going with the point
21 that I think I have made in my statement to the Inquiry,
22 this wasn't a situation where they were coming with
23 a very particular case and saying to me this is our
24 evidence to justify it or not quite that I could see.

25 **Q.** When you say "they" do you mean the Executives
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1 evidence that there was potentially a crime or series of
2 crimes which had been committed"?

3 **A.** Yes.

4 **Q.** Do you remember now whether one of the
5 Consultants mentioned the case of Beverley Allitt or you
6 did or how the discussion landed there?

7 **A.** I can't say who mentioned it. I think that it
8 was just to draw a distinction between the
9 Beverley Allitt case and this which seemed to be
10 relevant at the time. That is to say it was clearer in
11 that case than it seemed at this moment.

12 **Q.** Then we see at paragraph 6, you gave your
13 view:

14 "The police, being strapped for resources in any
15 event, can only sensibly investigate cases where there
16 is at the very least reasonable grounds for suspecting
17 that a criminal offence has been committed. He
18 emphasised this was very different from there being mere
19 suspicion and also very different from where there were
20 questions about hospital procedures and processes as
21 distinct from criminal actions."

22 **A.** Yes.

23 **Q.** "SM remarked that officially reporting any
24 matters to the police was a condign step which was
25 effectively a public action and would incur adverse

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1 publicity and raise matters for the families of the
2 neonates which might be seriously disturbing."
3 Just going back to page 6 and the beginning of that
4 advice. Of course the police do investigate where there
5 is a mere suspicion, don't they? They should and can
6 investigate where suspicions and concerns are brought to
7 them?

8 **A.** Yes.

9 **Q.** So do you think that was overstating that in
10 this difficult meeting to say they need at the very
11 least reasonable grounds for suspecting a criminal
12 offence has been committed?

13 **A.** Yes, I do.

14 **Q.** So looking back now, saying a suspicion is
15 enough may have been a better way of summarising that?

16 **A.** Yes, I think it would have been.

17 **Q.** You comment at the end a condign step, which
18 is effectively a public action and would incur adverse
19 publicity?

20 **A.** Yes.

21 **Q.** Obviously baby safety is first and foremost,
22 isn't it, and paramount in all of this?

23 **A.** (Nods)

24 **Q.** So what is it that took you to the "condign
25 step" and "incur adverse publicity", what did you think

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1 of their babies.

2 **Q.** Paragraph 10, you were involved in discussing
3 a broader forensic review and what that might amount to
4 and you record they were not blindly pressing for the
5 matter to be reported but wondered who else might
6 conduct such a review?

7 **A.** Yes.

8 **Q.** The Coroner, Mr Rheinberg, had effectively
9 declined to do so and in any event a probable conflict
10 of interest was identified.

11 What was the conflict of interest that you
12 understood may have been identified or you identified,
13 I don't know, how was that arrived at?

14 **A.** I'm afraid to say I can't help. I re-read
15 these when I was compiling my statement and I wasn't
16 entirely sure, frankly, what I was referring to there.

17 But as I recall, the Coroner had declined to conduct an
18 investigation but what the probable conflict of interest
19 was identified, I'm afraid I can't now say, I'm sorry.

20 **Q.** You repeat at paragraph 12 you didn't see as
21 the material, as things stand, gave rise to reasonable
22 grounds for suspecting?

23 **A.** Yes.

24 **Q.** And I think you agree that that was overstated
25 at the time?

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1 the impact of that was set against baby safety
2 generally?

3 **A.** It was a matter which prayed on the minds of
4 the hospital. It is not I think to be divorced from the
5 not always aligned duties of care point. One of the
6 matters which seemed to concern the hospital
7 considerably was the prospect of starting a criminal
8 investigation which would have impacted on families who
9 had already undertaken the grieving process and what if
10 the bringing in of the police was to give an indication
11 of criminal action and criminal investigation when
12 actually it had been sadly a course of nature or
13 something less than crime, for example bad practice or
14 negligence or something of that nature.

15 **Q.** Was it the Executives who were concerned about
16 that second point, that if it wasn't the case that Letby
17 was responsible for causing deliberate harm there would
18 be adverse publicity and they were worried about that?

19 **A.** They were worried about it for the reasons
20 that I have stated. I don't wish to imply that they
21 took a -- I had -- nothing gave me the impression that
22 they took a light view of publicity in the sense that
23 they just didn't want nasty headlines.

24 Their concern was directed towards the outcomes for
25 the Families who had already had to deal with the death

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1 **A.** It was.

2 **Q.** The police would have been and should have
3 been interested with the level of information the
4 Consultants had?

5 **A.** Yes.

6 **Q.** To be clear, I mean, Dr Brearey told us in his
7 statement they were giving you examples. For example,
8 they were talking about one baby, we know the baby as
9 Child I, and they explained that she was transferred
10 between hospitals, the Countess of Chester and another
11 hospital on a number of occasions improving at the other
12 hospital and deteriorating rapidly at their hospital.
13 That was one of the examples they gave you, wasn't it?

14 **A.** It was and another one was the repeated highly
15 unexpected outcomes for Twins, I remember.

16 **Q.** Did they mention rashes as well, was something
17 said to you?

18 **A.** Did they mention what, sorry?

19 **Q.** Anything said about rashes on babies?

20 **A.** Yes, I am sure that there was, but ...

21 **Q.** Dr Jayaram describes you at one point saying
22 "now you have piqued my interest". Is that a phrase you
23 would have used, "now you have piqued my interest" when
24 they were telling you, for example, about Baby I or
25 details, that they were interesting and important

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1 points?

2 **A.** It might well have been, yes.

3 **Q.** Because you appear at paragraph 14 listening
4 to them, you then say:

5 "What was needed, they should make short notes
6 setting out their best points, those matters which they
7 say most clearly indicate in their minds reasonable
8 grounds for suspecting that a criminal offence has been
9 committed. It would help to crystallise matters and
10 push them forward to a sensible conclusion. It would
11 help everyone to deal with the matter head on in an
12 inclusive, collegiate way."

13 **A.** Yes. Yes.

14 **Q.** Then at paragraph 16, you thank everyone for
15 their time, emphasise:

16 "... had there had been clear information leading
17 to reasonable grounds for suspecting criminal offence he
18 would have no hesitation advising the hospital it is
19 their public duty to report the matter. He indicated
20 his view the Hospital Trust would agree with this course
21 was cautious of proceeding along that path in the
22 apparent absence of such material given the serious
23 public and irrevocable nature of such a step?"

24 **A.** Yes.

25 **Q.** We know subsequent to this meeting the
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1 Death Overview Panel although it's possible he may say
2 he is unable to help due to his position. He also
3 suggested the Coroner, Mr Rheinberg, but there would be
4 a conflict of interest."

5 You have expanded upon that earlier because you
6 understood he wasn't inquiring into the deaths?

7 **A.** Yes.

8 **Q.** You say in the paragraph below:

9 "Mr Medland added that you need to accept that if
10 something is still unanswered or there are still genuine
11 concerns in well-minded people, you should go to the
12 police?"

13 **A.** Yes.

14 **Q.** On the next page, page 3, penultimate
15 paragraph, you say it may help to sit down with the
16 Consultants, not ignoring their concerns. We are going
17 to do this with you as one team.

18 **A.** Yes.

19 **Q.** Need to bring the Consultants back to the
20 fold. Here is the action plan and you want to work with
21 them.

22 You might want to have Dr Hawdon be asked what's
23 the forensic review and why the Level 2 cases?

24 You say candidly in your statement, Mr Medland, you
25 were not a clinical negligence barrister or a medico-law
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1 Consultants did email each other and put together

2 a document --

3 **A.** Yes.

4 **Q.** -- of concerns. Indeed it was Dr Brearey who
5 said had they been asked to do that earlier by no one in
6 this pre-session the crystallisation for others, if it
7 hadn't been obvious by what the Consultants had been
8 saying along the way --

9 **A.** Yes.

10 **Q.** -- may have been clearer?

11 **A.** Yes.

12 **Q.** Can we please now go to the minutes of the
13 board meeting held on 13 April, that can go down,
14 INQ0003236, page 1. This is the meeting that you attend
15 on 13 April we see the attendees on the front the
16 chairman, Sir Duncan Nichol, Non-Executive Directors?

17 **A.** Yes.

18 **Q.** Chief Executive, Mr Harvey, and yourself in
19 attendance.

20 If we go over to the page, please, and if we could
21 all have a read of paragraphs 2 and 3, you repeat at
22 paragraph 3:

23 "No evidence of crime but the Consultant view is to
24 go to the police. He suggested an alternative approach
25 would be to approach the police member of the Child
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1 barrister or a family safeguarding law barrister, so
2 that recommendation, what she said wasn't something you
3 scrutinised for yourself or unpacked to see what was
4 required --

5 **A.** No.

6 **Q.** -- there?

7 **A.** That's correct.

8 **Q.** And you are suggesting the Consultants and the
9 Execs did that together or thought about that?

10 **A.** Yes, because they certainly weren't working
11 together was my impression because quite -- quite the
12 contrary.

13 **Q.** You say at paragraph -- page 4, the third
14 paragraph up from the bottom, Mr Chambers asked you
15 about paragraph 14 in the minutes and paragraph 14 was
16 where you had suggested they put their best points
17 together. So Mr Chambers asked you about that?

18 **A.** Yes.

19 **Q.** "Mr Medland said the Consultants have swirling
20 ideas about potential crime. I said it would be helpful
21 for them to think about what crime they thought had
22 happened, ie, did it always happen at 2am? It is about
23 designing a process to shed light on any issues as you
24 cannot just go to the police with some detail."

25 We know that in the Thematic Review Dr Brearey had
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1 identified a pattern of deaths at night?

2 **A.** Yes.

3 **Q.** It sounds as though you are coming up with
4 2.00~am. May they have said that to you as well
5 something about that?

6 **A.** Yes, it may well have been and I am prepared
7 to accept that it was, to be -- to be balanced against
8 the previous inquiries and investigations of a medical
9 nature which had taken place, which never seemed to come
10 to a conclusion that crime as opposed to anything else
11 had occurred.

12 So that was why I thought it would help because the
13 Consultants, obviously brilliant and experienced people,
14 well-intentioned people, they were clearly of a view
15 which was not clearly the view of other people, of
16 similar quality and experience and insight and
17 therefore, my idea that the Consultants put together
18 their own, as it were, best points to put their case
19 clearly was, I hope, of some help.

20 **Q.** If we go to page 5, three paragraphs from the
21 bottom, towards the end of the meeting:

22 "Sir Duncan asked if everyone was comfortable that
23 the Trust explores with Dr Hawdon to take the forensic
24 review forward. Everyone confirmed that they were
25 content with this approach.

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1 You would know. But they -- they ended up doing that.

2 **Q.** Sorry I turned my back, Mr Medland, sorry.

3 **A.** Not at all. I was just saying I didn't have
4 any further dealings with them after this. I left the
5 meeting once I had made my report to them and that was,
6 as it were, the last involvement I think I had.
7 Although they did go to the police fairly shortly
8 afterwards.

9 **Q.** They did and we know that Dr Jayaram sent
10 a letter directly to Mr Wenham who gave evidence
11 yesterday. There was further meetings between
12 Executives and Mr Wenham later?

13 **A.** Right.

14 **MS LANGDALE:** Those are my questions, there may be
15 others.

16 **A.** Thank you.

17 **LADY JUSTICE THIRLWALL:** Mr Baker.

18 Questions by MR BAKER

19 **MR BAKER:** Thank you, my Lady.

20 Mr Medland, I ask questions on behalf of the
21 Families of 12 of the babies who were affected.

22 Can I just ask about the circumstances in which you
23 were instructed by Stephen Cross?

24 **A.** Yes.

25 **Q.** He called you directly in chambers, is that

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1 "Mrs Hopwood asked would it be 4 or 8 cases?

2 "Mr Medland replied it states Class 2 cases.

3 "Sir Duncan added that it would not be limited as
4 it is not yet known what the forensic review means."

5 So there appears to be general confusion around
6 what that review meant in this meeting, the forensic
7 review?

8 **A.** There may well have been. It was a very large
9 number of people, I recall, at the meeting. So I think
10 there probably was.

11 **Q.** And then we go over the page, page 6,
12 paragraph 3 below.

13 "Sir Duncan said that one consequence, as LL is
14 expecting to come back to work and what we do say to her
15 about the delays are not for the whole board to discuss
16 but it is important to get it right when explaining the
17 further delay."

18 **A.** Yes.

19 **Q.** So that's where the meeting left. When you
20 left the meeting, did you know what they were going to
21 do next, what did you think they were going to do next
22 and did you have any further communication on the topic?

23 **A.** I don't recall any further communication from
24 them. I am aware that they did go to the police fairly
25 shortly afterwards, although I can't put a date on that.

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1 your evidence?

2 **A.** I think so.

3 **Q.** Is that a common way to receive instructions?

4 **A.** No, not for me and certainly not then.

5 Normally it would be presumably a telephone call to the
6 clerk in chambers and then a letter from the solicitors.
7 But I think he called direct having spoken to my clerk,
8 I think.

9 **Q.** Your relationship with him beforehand, it's
10 correct to say, isn't it, you are a very senior
11 Freemason?

12 **A.** It is.

13 **Q.** Within his witness statement to the Inquiry,
14 Mr Cross lists some directorships that he holds?

15 **A.** Right.

16 **Q.** He's a director of both the Chester Masonic
17 Development Freemasons' Hall (Chester) Limited?

18 **A.** Yes.

19 **Q.** And the Masonic Hall, Cheshire View Limited?

20 **A.** Right

21 **Q.** Also a trustee of the Cheshire Masonic
22 Benevolent Association?

23 **A.** Right.

24 **Q.** So it is clear that he also has connections
25 with the Freemasons as well?

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1 A. Yes.
 2 Q. Dr Brearey gave evidence yesterday about his
 3 concerns about the nature of your instruction in the
 4 case?
 5 A. Right.
 6 Q. And his belief or rumours that he had heard
 7 that there were Freemasons on the board of the Countess
 8 of Chester and that that connection had led to your
 9 instruction?
 10 A. Well, there was no Masonic context to my
 11 instruction. I mean, if I can try to deal with this.
 12 As it happens, Stephen Cross is a Freemason and as it
 13 happens, I am a Freemason. We are not members of the
 14 same Masonic Lodge. We are not close friends. I have
 15 been a guest of his I think once, many years ago at his
 16 Lodge and I don't think he's ever been a guest at mine.
 17 There is no Masonic context to this to my mind at
 18 all. Had there been, I can assure you, and anybody
 19 who's concerned with this Inquiry, that I would have
 20 been entirely candid about that. To my mind it is of no
 21 more impact or relevance than if, for example, we had
 22 both had an interest in Crown Green Bowls or church bell
 23 ringing, to my mind, but I will happily deal with any
 24 concerns in that regard.
 25 So over to you.

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1 Q. You have no experience in healthcare
 2 investigations?
 3 A. No.
 4 Q. Did you see any issues at all with the
 5 Royal College report or the Hawdon report?
 6 A. Did I what, sorry?
 7 Q. See any issues at all with the structure or
 8 scope of the Royal College report or indeed the report
 9 by Jane Hawdon?
 10 A. Insofar as I understand the question you put,
 11 no, I didn't. But I am not quite sure what issues
 12 I might have seen with them.
 13 Q. Sorry, I beg your pardon. You didn't, when
 14 you reviewed the Royal College report --
 15 A. Yes.
 16 Q. -- feel any concern that it didn't address
 17 directly the question of whether there were acts of
 18 homicide or suspected acts of homicide or investigate
 19 the basis for those?
 20 A. At -- at the time, no.
 21 Q. Did that surprise you?
 22 A. At what point?
 23 Q. At any point?
 24 A. It certainly surprises me now.
 25 Q. Yes.

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1 Q. Well, in that case why did he instruct you?
 2 A. He instructed me I assume because he thought
 3 I would be able to do a good job.
 4 Q. Of -- of what? What was the nature of your
 5 instructions, what were you being asked to do?
 6 **LADY JUSTICE THIRLWALL:** We have been through that.
 7 **MR BAKER:** Well, I can put it a different way.
 8 A. I -- I think I have fairly stated the nature
 9 and extent of my instructions and just pausing there for
 10 a minute. And dealing finally with the point you made
 11 rather surprisingly a few moments ago about Freemasons.
 12 I am not aware of anybody else on the hospital
 13 board, at all who is a member of the Freemasons, either
 14 a man or a woman, I think I should say that.
 15 Moving back to my instructions, I think I have
 16 dealt as fully as I can in my witness statement with
 17 what my instructions were.
 18 Q. Well, Mr Medland, it is not a surprising thing
 19 to put, it was raised by a witness --
 20 A. Yes.
 21 Q. -- and the Families who I represent are
 22 concerned by it?
 23 A. Right, I will happily deal with it.
 24 Q. It is put for the right reasons.
 25 A. No, I am sure it is, I am sure it is.

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1 A. Because as I repeatedly stated in my witness
 2 statement in general terms, looking at matters then it's
 3 very different from looking at matters now after an
 4 exhaustive police investigation and a very high profile,
 5 very long trial.
 6 I can only, say, speak to matters concerning my
 7 involvement then rather than now but it certainly
 8 surprises me now, if "surprise" is the right word, that
 9 such investigations as there had been by qualified
 10 people, by the time I became involved, had all rather
 11 led to a lack of clarity, not a clear picture.
 12 Q. When you were reviewing those reports at the
 13 time, I think your position in answering questions from
 14 Counsel to the Inquiry a moment ago was that you saw
 15 that investigations had been carried out?
 16 A. Yes.
 17 Q. May have taken some reassurance from the fact
 18 that they had not exposed any evidence of deliberate
 19 wrongdoing?
 20 A. Yes, they had not come to the conclusion that
 21 there was clear evidence of crime as opposed to anything
 22 else.
 23 Q. But when you read them, you must have realised
 24 that those reports did not address directly or at all
 25 the question of whether or not a crime had been

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1 committed?

2 **A.** Yes, I -- I think I see the point that you are
3 asking about. Prior to the Consultants crystallising
4 their particular best points, as it were, the case that
5 they were pressing, it was all dealt with on a much more
6 diffuse basis, I imagine. And the Consultants were
7 not -- the Royal College, for example, and other people
8 who had investigated the matters were not tasked with
9 putting together a criminal case.

10 **Q.** Or indeed even investigating crime on the face
11 of it, they were Casenote Reports into causes of death
12 in the case of Jane Hawdon's evidence, and in the RCPCH,
13 effectively a service quality review.

14 So looking at those pieces of evidence when you
15 reviewed the case, what reassurance could you take from
16 those as to whether or not a crime had been committed or
17 not?

18 **A.** I don't know. I mean, I am not quite sure
19 what -- what you are asking me to speak about. I read
20 the reports such as I could and put them in my mind and
21 built them into my understanding together with the other
22 aspects of my involvement. I was not charged with
23 making a critical analysis of the quality of those
24 reports.

25 **Q.** Were you possessed of the necessary experience
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1 **Q.** -- and that the police needed to be called?

2 **A.** Indeed and that they felt, I think, that they
3 had been drawing had been saying that for some months.

4 **Q.** Yes.

5 **A.** And had not been listened to from their point
6 of view.

7 **Q.** Did you have the skills or experience to weigh
8 up and understand the basis for their concerns which
9 must have been founded in their significant collective
10 medical experience?

11 **A.** Yes, they were not the only processors of
12 significant medical experience that I encountered in
13 this process. I have freely conceded that I had no
14 specialist knowledge of medical law or hospital law or
15 anything like that but I felt I was in a good position
16 to judge their concerns, especially if they were, as it
17 were, reduced into a clear set of their best points.

18 **Q.** But how are you in a position to arbitrate
19 between these two groups of people? On the one hand the
20 Consultants, on the other hand Stephen Cross,
21 Duncan Nichol, Ian Harvey, Tony Chambers? Yes, are
22 these the two sides of the dispute?

23 **A.** Well, I am not entirely sure I would agree
24 with that as being a characterisation of the two sides
25 at all and neither was I charged with arbitrating
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1 to make a critical analysis of those reports?

2 **A.** Arguably not.

3 **Q.** When you listened to the concerns of the
4 Consultants, what level of proof were you anticipating
5 that they would provide with regard to the question of
6 whether or not police should or should not be called?

7 **A.** It seemed to me that the potential outcomes of
8 the various investigations would have been to see
9 whether there was, for example, mere bad practice or
10 poor training or poor supervision or some combination of
11 things like that.

12 The difference between those and whether there was
13 in fact a series of very serious crimes which were being
14 committed, as we now know undoubtedly there had been,
15 was really the -- the distinction between the two.

16 **Q.** The Consultants were quite clear with you that
17 they were concerned that criminal acts had taken place?

18 **A.** I'm sorry, that they ...?

19 **Q.** That they were concerned?

20 **A.** Yes.

21 **Q.** It may be the microphones.

22 **A.** Not at all.

23 **Q.** They were concerned that criminal acts may
24 have taken place --

25 **A.** Yes.
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1 between those people. I was invited in because by that
2 stage there was obviously a very significant set of
3 concerns which had been looked at many times by many
4 different people and had always ended up in the same
5 point; namely, aside from the Consultants' view we can't
6 be clear that a crime has been committed, to summarise
7 it. Those are my words, not theirs so I was not charged
8 with arbitrating between them and I think I had
9 sufficient abilities to understand if there was clear
10 evidence of a crime.

11 Now as it happens, as it happens, it has been
12 manifestly proved that on the basis of the information
13 I was given -- on the basis of the information I was
14 given I got it very badly wrong.

15 **Q.** Yes.

16 **A.** On the basis of the information I had, as we
17 all now know.

18 **Q.** But on reflection, the answer to the question:
19 should the police be called?, is about understanding
20 whether an investigatory threshold has been overcome?

21 **A.** Yes.

22 **Q.** Now, in criminal practice, you will have no
23 doubt been asked at various times to make a decision as
24 to whether somebody should be prosecuted or whether
25 a case should go to trial based upon evidence and that
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1 is a very different exercise from triggering an
2 investigation because it requires a whole different
3 level of evidence in order to be overcome?

4 **A.** Yes.

5 **Q.** The answer was the only way in which the
6 question could be determined: is there enough evidence
7 of a crime or has a crime been committed?, is by
8 bringing to bear the forensic powers of the police force
9 in investigating crime, isn't it? It can't possibly be
10 determined absolutely on any of the evidence that could
11 be cobbled together within the hospital?

12 **A.** Well, I'm not sure I like the sound of the
13 phrase "cobbled together", that wasn't --

14 **Q.** Putting that to one side --

15 **A.** That wasn't my impression of how things were
16 being done. I am not, I think, taking a pedantic point
17 in respect of the question which you raised because
18 I understand why you do. The only time a decision is
19 made finally as to whether a crime has been committed or
20 not is when a trial is held and the jury says so.

21 The investigatory process is different, the
22 investigatory process at the beginning will decide
23 whether there is any evidence, some evidence, sufficient
24 evidence. Then there are decisions as to whether to
25 charge, which is a two-fold test. With respect, I am

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1 aligned duties of care" and that was the way which
2 I found best described what I am trying to describe and
3 I am not prepared to change that to priorities.

4 **Q.** They all owed the same duty to the patients in
5 the hospital, the primary duty was always patient
6 safety; do you agree?

7 **A.** I am sure that that must be right.

8 **Q.** But the argument or the not well-aligned
9 positions, if I call it that --

10 **A.** You may; I said "not always aligned".

11 **Q.** Not always aligned, was about a conflict
12 between the need to call the police, one group saying:
13 "We need to call the police we think a crime has been
14 committed" and another group saying or worrying about
15 the impact upon the reputation of the Trust in doing
16 that?

17 **A.** Those were some of the matters that were of
18 concern together also with the issues of personnel,
19 human resources, the general reputation of the hospital,
20 the thought which was vocalised to me severally, that if
21 the police were brought in when they ought not to be,
22 how on earth are we going to justify that to the parents
23 of babies? Which I have already spoken about.

24 **Q.** Yes, I mean the counterpoint to that is if the
25 police aren't called in and this person is a criminal,

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1 not entirely sure I agree that the only people who could
2 have decided at that stage would have been the police
3 because the Consultants themselves, as we now know, once
4 it was crystallised had assembled a very clear picture
5 to justify that but the police had not been called in by
6 then and were shortly thereafter called in.

7 **Q.** Yes, and commenced an investigation --

8 **A.** Yes.

9 **Q.** -- that revealed further evidence --

10 **A.** Correct.

11 **Q.** -- that led to a trial and led to
12 a conviction?

13 **A.** Correct.

14 **Q.** Finally on a slightly different topic, you
15 spoke about not well-aligned duties of care.

16 **A.** Not always aligned.

17 **Q.** Not always aligned duties of care?

18 **A.** Yes.

19 **Q.** Again without wanting to be pedantic, rather
20 than duties of care, is the correct categorisation
21 priorities that were not necessarily aligned in the same
22 direction?

23 **A.** No. I -- I don't agree with that. I was
24 trying to think of how best I could describe at this

25 hearing that point which I have described as "not always

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1 she will harm more babies?

2 **A.** That -- that is certainly one possibility.

3 **Q.** Yes.

4 **A.** Yes.

5 **Q.** I think the language, and it may be a phrase
6 that you used, is that "once the police are called, the
7 toothpaste is out of the tube", which is a part of your
8 note?

9 **A.** Yes.

10 **Q.** Was that an underlying priority for the

11 Executives of the Trust, that once the police are called
12 the cat is out of the bag when it comes to publicity?

13 **A.** Well, I sought perhaps inadequately earlier to
14 make the point, I hope fairly, that concerns about
15 publicity and the hospital were not of a superficial
16 nature, they were not just concerned about bad headlines
17 because they didn't want them; they were concerned about
18 what might underlie the headlines. So it wasn't
19 a selfish concern, so far as I could make out at all.

20 Their concerns -- I think I have stated them in my
21 witness statement and in answers to questions to Counsel
22 to the Inquiry and you, I think I have stated them
23 several times now, the list of them, it -- it may not be
24 everything that they said, but -- but those were

25 a series of not always aligned duties of care which they

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1 had to their staff, to the patients, to the hospital, to
 2 the doctors, they didn't always run in perfect
 3 alignment.
 4 **Q.** Do you think that the question of reputational
 5 harm is overstated in this context against when balanced
 6 against the risk to patient safety?
 7 **A.** Who has in what sense overstated and by whom?
 8 **Q.** Well, doesn't reputation or isn't reputational
 9 harm inferior to risks that come in relation to patient
 10 safety?
 11 **A.** Yes, I would have thought so.
 12 **MR BAKER:** Excuse me a moment. Thank you, my Lady,
 13 I have no more questions.
 14 **LADY JUSTICE THIRLWALL:** Thank you, Mr Baker.
 15 **A.** Thank you.
 16 **MS LANGDALE:** No further questions, my Lady.
 17 **LADY JUSTICE THIRLWALL:** No, and I have no
 18 questions. Thank you very much Mr Medland, you are free
 19 to go.
 20 **A.** Thank you.
 21 Thank you.
 22 **LADY JUSTICE THIRLWALL:** So that concludes the
 23 evidence --
 24 **MS LANGDALE:** Until Monday.
 25 **LADY JUSTICE THIRLWALL:** -- for today so we will
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1 reconvene at 10 o'clock on Monday morning.
 2 **(4.08 pm)**
 3 (The Inquiry adjourned until
 4 Monday, 25 November 2024 at 10.00 am)
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