

1 Monday, 25 November 2024

2 (10.00 am)

3 **LADY JUSTICE THIRLWALL:** Good morning.

4 Mr De La Poer.

5 **MR DE LA POER:** My Lady, our witness today is
6 Ms Alison Kelly. I wonder if she could come forward,
7 please.

8 MS ALISON KELLY (sworn)

9 Questions by MR DE LA POER

10 **LADY JUSTICE THIRLWALL:** Do sit down, Ms Kelly.
11 Yes.

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

14 **A.** Alison Kelly.

15 **Q.** Ms Kelly, is it right that you gave to the
16 Inquiry a witness statement dated 13 August of this
17 year?

18 **A.** I did.

19 **Q.** Is the content of that witness statement true
20 to the best of your knowledge and belief?

21 **A.** It is.

22 **Q.** At the time with which the Inquiry is
23 concerned, you were the Director of Nursing and Quality;
24 is that right?

25 **A.** Apologies, before we start, may I say

1

1 **Q.** This is not at the Countess but at a different
2 hospital?

3 **A.** Yes.

4 **Q.** The following year, were you promoted at that
5 hospital to Deputy Chief Nurse?

6 **A.** Yes, I was.

7 **Q.** In 2013, did you undertake the aspiring
8 Director of Nursing programme facilitated by the NHS
9 Academy?

10 **A.** Yes.

11 **Q.** We will come to the Countess in a moment. But
12 just before we get to the detail of that, in 2014,
13 whilst at the Countess of Chester, were you identified
14 as being in the top 50 national nurse leaders by the
15 Nursing Times?

16 **A.** Yes.

17 **Q.** So let's look at the Countess of Chester.

18 You joined as Director of Nursing and Quality in
19 2013; is that right?

20 **A.** That's correct.

21 **Q.** It was your first role as an Executive
22 Director?

23 **A.** It was.

24 **Q.** Your key responsibilities included -- you have
25 given a long list in your statement but I will pick some

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1 something, before we get into the formalities? I would
2 like to express my condolences to all the Families and
3 I am really sorry for all the distress that Families
4 have -- have experienced over the last few years and are
5 currently experiencing as we sit here today. I didn't
6 get everything right at the time. However, the
7 decisions I made were done with the best intentions.
8 I do really appreciate having the opportunity to be part
9 of this Inquiry and to share my reflections and to
10 contribute to recommendations going forward. Thank you.

11 **Q.** At the time with which this Inquiry is
12 concerned, were you the Director of Nursing and Quality?

13 **A.** I was.

14 **Q.** In that role, were you an Executive Director
15 of the Trust?

16 **A.** Yes.

17 **Q.** We will just deal with how you came to be in
18 that role. Did you qualify as a nurse in 1991?

19 **A.** Yes, as a Registered Nurse.

20 **Q.** Did you then work as a nurse in adult care
21 until 2007?

22 **A.** Yes.

23 **Q.** In 2007, did you take on a management role,
24 namely Divisional Head Nurse?

25 **A.** Yes.

2

1 of them out -- providing strong leadership to the
2 nursing workforce?

3 **A.** Yes.

4 **Q.** Ensuring nursing standards were maintained?

5 **A.** Yes.

6 **Q.** Also as part of your role, were you the
7 Executive Lead for Safeguarding Children?

8 **A.** Yes.

9 **Q.** In that position, did you chair the Trust's
10 Safeguarding Strategy Board?

11 **A.** Yes.

12 **Q.** So just to move past the period that we are
13 focused upon, to complete your CV, in October 2018 to
14 April 2019, did you act as the Deputy Chief Executive
15 Officer for the Trust?

16 **A.** I did.

17 **Q.** Did you also take on the role of Visiting
18 Professor in Healthcare Leadership at the University of
19 Chester between 2019 and 2021?

20 **A.** I did.

21 **Q.** In 2021, did you leave the Trust to take up
22 a position with Northern Care Alliance?

23 **A.** I did.

24 **Q.** Now, we have heard on the subject of Northern
25 Care Alliance that Mr Chambers went to work there in

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1 2018. Was there any connection between the two of you
 2 at Northern Care Alliance?
 3 **A.** No, none at all.
 4 **Q.** The first topic we are going to deal with,
 5 Ms Kelly, is safeguarding. As you have just told us,
 6 you were the Executive Lead for Safeguarding; is that
 7 right?
 8 **A.** I was.
 9 **Q.** What you say in your witness statement, you
 10 don't need to turn it up but I can take you to it, but
 11 I will just quote:
 12 "The increase in mortality was never viewed as
 13 a safeguarding matter."
 14 That is the assertion you make in your statement;
 15 is that correct?
 16 **A.** That's correct, at the time, yes.
 17 **Q.** Does that cover the full period that the
 18 Inquiry will be looking at all the way through to when
 19 the police were notified?
 20 **A.** Yes.
 21 **Q.** As you might imagine, we are going to look at
 22 the detail of particular meetings in due course. At
 23 this stage I would just like to establish some fairly
 24 high level propositions.
 25 You had a meeting on 11 May of 2016 which included

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1 possibilities, do you agree? One, that she is doing so
 2 inadvertently, potentially through incompetence; or two,
 3 she is doing so deliberately?
 4 **A.** Yes.
 5 **Q.** So although -- and we can come to the
 6 detail -- it may not have been said out loud, Dr Brearey
 7 was raising with you the possibility that Letby may be
 8 deliberately harming babies; is that fair?
 9 **A.** I would push back on that and say there was
 10 never any clarity in him articulating his true concerns
 11 at that time.
 12 **Q.** No. But we have established that he -- what
 13 he has articulated to you is he is concerned Letby may
 14 be the cause and you have accepted that that can only be
 15 in one of two ways?
 16 **A.** Yes.
 17 **Q.** So it must be the case, surely, that what he
 18 was saying is that Letby may -- he was raising the
 19 possibility that Letby may be deliberately harming
 20 babies?
 21 **A.** May be, yes.
 22 **Q.** Of course as to the issue of inadvertent or
 23 incompetent harm, you had very strong reassurance,
 24 didn't you, in that meeting from Eirian Powell and
 25 Anne Murphy that incompetence was unlikely?

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1 Dr Brearey; is that right?
 2 **A.** That's correct, yes.
 3 **Q.** He attended that meeting in his capacity as
 4 a Consultant paediatrician and the lead for the neonatal
 5 unit; is that right?
 6 **A.** That's correct.
 7 **Q.** He was concerned about the increase in
 8 neonatal mortality; is that right?
 9 **A.** That's correct.
 10 **Q.** Among the things said by Dr Brearey at that
 11 meeting was that he had a concern that Letby may be the
 12 cause of that increase; is that correct?
 13 **A.** We discussed at length the detail of the
 14 Thematic Review that he had undertaken with a number of
 15 colleagues including external stakeholders in addition
 16 to Eirian Powell's points that she had brought to that
 17 meeting.
 18 He never at that meeting talked about deliberate
 19 harm but he was worried about the increase in mortality.
 20 **Q.** So we are just going to focus upon my question
 21 which didn't include the phrase "deliberate harm". It
 22 was that he was concerned that the increase in neonatal
 23 mortality may be due to Letby?
 24 **A.** May be due to Letby, yes.
 25 **Q.** If it is due to her, there are only two

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1 **A.** Yes.
 2 **Q.** Because they were telling you what a good
 3 nurse she was?
 4 **A.** Yes.
 5 **Q.** So on that basis if Dr Brearey was correct in
 6 his concern, or may be, if anything, does that not
 7 increase the fact the possibility that it is deliberate?
 8 **A.** From his perspective there was a possibility
 9 that that was deliberate. But as we were talking
 10 through the information that we had to hand at that
 11 meeting, including detailed analysis of cases which
 12 pointed to some clinical issues, we were open at that
 13 meeting to what the causes could be. From
 14 a perspective -- from a nursing perspective, that could
 15 have been a competency issue.
 16 **Q.** You were in a unique position that day in that
 17 meeting, weren't you, because you were the Executive
 18 Lead for Safeguarding?
 19 **A.** Yes.
 20 **Q.** The only safeguarding role person in the
 21 meeting?
 22 **A.** Yes.
 23 **Q.** Was that an extremely important duty that you
 24 had that day?
 25 **A.** Yes.

8

1 Q. Did that duty trump or should be treated as
2 a priority over any duty that you had to the staff?

3 A. At that time, it -- it wasn't clear to me that
4 this was a safeguarding issue.

5 Q. My question is: was your duty to safeguarding
6 your primary duty?

7 A. At that time as the lead, yes.

8 Q. You have told us it didn't even occur to you
9 to treat it as a safeguarding issue; is that right?

10 A. That's correct.

11 Q. Do you accept that you should have thought
12 about it in those terms on 11 May?

13 A. I have reflected a lot about my safeguarding
14 role in all of this case and reflecting back, maybe
15 I should have done, yes.

16 Q. Now, within safeguarding, where there is
17 a concern that somebody may be causing harm, in this
18 case to babies, is it ever appropriate as an action plan
19 just to wait and see if the harm is caused again from
20 a safeguarding perspective?

21 A. From a safeguarding perspective, no, that
22 wouldn't be appropriate. However, I had assurance at
23 that meeting from my senior nursing team that there were
24 no concerns with that individual at that time.

25 Q. They had no concerns that she might

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1 and potential competency issues.

2 Q. So if you had thought to raise it as
3 a safeguarding issue to say this may be a safeguarding
4 concern, if you had said that at the meeting, you would
5 have expected there to have been a discussion based upon
6 that?

7 A. Yes.

8 Q. If in those circumstances you had said to
9 Dr Brearey: do you think she might be causing harm
10 deliberately and he had said yes, what would you have
11 done?

12 A. We -- I probably would have took different
13 action but that conversation never took place.

14 Q. Now, had you treated it as a safeguarding
15 issue, would you have spoken to the named doctor,
16 Dr Isaac, immediately following that meeting?

17 A. I would have probably gone to my safeguarding
18 team, as in the nursing team first, Dr Isaac was based
19 on the unit. So I probably would have gone to my
20 corporate nursing team first.

21 Q. Isn't this a matter for the named doctor?

22 A. It -- it is but the first place I would have
23 gone would have been my team, which are the safeguarding
24 team.

25 Q. At that stage, would there have been

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1 incompetently be causing harm, that is what they were
2 telling you?

3 A. Yes.

4 Q. Now, we are talking about safeguarding, which
5 is about deliberate harm. Your strategy from that
6 meeting was to wait and see if harm was caused again,
7 wasn't it?

8 A. I think we all agreed at that meeting that
9 there was nothing clear -- clearly articulated at that
10 meeting because there were clinical concerns in terms of
11 outcomes and practice versus what I was hearing from my
12 senior team, which was we had no competency issues.

13 So we all felt by the end of that meeting that we
14 could review the situation in a number of weeks' time.

15 And everybody -- as far as I'm aware, everybody left
16 that meeting feeling happy with those actions.

17 Q. Had you thought about what was being said to
18 you as a safeguarding concern, would you have viewed it
19 as appropriate just to wait to see if harm was caused
20 again?

21 A. If it was being viewed and we had had
22 a collaborative conversation at that time about
23 safeguarding, then actions may have been different.

24 But we didn't have a safeguarding conversation
25 because it was more about clinical outcomes and practice

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1 a discussion about whether Letby should be placed under
2 formal supervision or even suspended or moved to deal
3 with less sick babies? Is that the sort of discussion
4 that would have happened had you treated it as
5 a safeguarding concern?

6 A. Potentially. Potentially if it had been
7 discussed as a safeguarding issue at that time.

8 Q. And a referral to the LADO so that they knew
9 what was going on would have happened?

10 A. Yes, that would have been part of the process.

11 Q. Through that, the police would have been
12 notified as part of the multi-agency response, wouldn't
13 they?

14 A. Potentially, yes.

15 Q. Well, is there any potential about it?

16 A. Part of the process is the police, yes.

17 Q. Yes. Now, do you accept that it was your
18 responsibility as lead for safeguarding to ensure that
19 proper consideration was given in that meeting to
20 safeguarding?

21 A. Looking back, and reflecting on that meeting,
22 there should have been a safeguarding conversation. But
23 it never came up and I never approached it as
24 a safeguarding issue. We talked about in detail the
25 clinical reviews that had been undertaken as part of the

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1 Thematic Review; that had pointed to some clinical
2 deficiencies at unit level.

3 There was a comprehensive action plan that provided
4 training to meet competencies of not just nurses but
5 doctors as well and there was also a conversation about
6 Letby herself, about her competencies as a nurse
7 practitioner which I took from Eirian to give me some
8 assurance that there was nothing to be concerned about.

9 **Q.** There was no concern she was doing it
10 inadvertently?

11 **A.** No. We didn't have that actual conversation.

12 **Q.** But that asking about somebody's competence
13 can only reassure you that they are not doing it
14 incompetently?

15 **A.** Not doing it deliberately, yes.

16 **Q.** Now, you say it never came up. I would like
17 you to just deal directly, please, with this. Did you
18 have a responsibility to bring it up because you were
19 the Executive lead?

20 **A.** On reflection, yes, as a lead at that time.
21 But I wasn't at that meeting thinking about safeguarding
22 at that time.

23 **Q.** I am going to move to another opportunity. At
24 the end of June, so again we are going to look in more
25 detail at the timeline, but when you were notified about

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1 not complicated, is it?

2 **A.** No.

3 **Q.** If somebody says: I think X is causing
4 deliberate harm to Y, that is immediately safeguarding,
5 isn't it?

6 **A.** It is and in the cold light of day now it's
7 easy to look back on that but when we were dealing with
8 issues that were being raised that were really not being
9 clearly articulated it just didn't feel like
10 a safeguarding concern to me.

11 **Q.** What is the first and most obvious step you do
12 with a member of staff if they pose a risk to patients?

13 **A.** You remove them from the clinical area.

14 **Q.** What did the Consultants say they wanted to
15 happen to Letby?

16 **A.** They did want her removing from the clinical
17 area but we had no basis to do that, no evidence to do
18 that.

19 **Q.** Well, you had information from a series of
20 experts in the field that they were concerned that she
21 may be deliberately causing harm; that's correct isn't
22 it?

23 **A.** Concerns, yes, but they never actually
24 articulated what that was.

25 **Q.** Well, as I say, we are going to go into the

15

1 the deaths of O and P, you heard about the concerns of
2 the Consultants wanting Letby off the ward, and where
3 the police was being talked about and you also had
4 a meeting with Dr Brearey and Dr Jayaram along with your
5 fellow Executives in which they talked about air
6 embolism, at that stage you were having presented to you
7 a safeguarding issue, weren't you?

8 **A.** There was never any -- in June there was never
9 any clarity and there was certainly -- again, nobody was
10 treating this as a safeguarding issue.

11 **Q.** Can I just --

12 **A.** There was no -- sorry.

13 **Q.** No, no, I cut across you, you finish your
14 answer, please?

15 **A.** There was no articulation of the actual
16 issues, nobody had seen her do anything. There was
17 terms used like "gut feeling" and "drawer of doom" which
18 didn't pinpoint any particular issues to do with Letby.

19 So on the basis of that, I didn't have any facts or
20 evidence that I could have based my decisions on.

21 **Q.** You just needed the possibility of deliberate
22 harm to trigger the thought process "this is
23 a safeguarding issue", didn't you?

24 **A.** Yes, in looking back on that, yes.

25 **Q.** Yes, that is all that safeguarding is; it is

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1 detail of exactly what was said but they told you that
2 there were more babies who had died than had been
3 expected, didn't they?

4 **A.** My understanding at the time was that there
5 was no unexpected or unnatural deaths at that time.

6 **Q.** Well, no. My question was about the total
7 number: that there was an unexpected number of babies
8 who had died; that the mortality rate had increased?

9 **A.** The mortality rate had increased, yes.

10 **Q.** But it hadn't been expected, that increase?

11 **A.** From what the doctors were saying, that is
12 correct.

13 **Q.** Yes, so that's -- that's them giving you

14 an expert opinion, isn't it?

15 **A.** Yes.

16 **Q.** They told you as was recorded in the Thematic
17 Review that there were sudden and unexpected
18 deteriorations so far as many of those babies were
19 concerned, didn't they?

20 **A.** That was in that report, yes.

21 **Q.** That is what they were telling you in June?

22 **A.** There were lots of other factors though from
23 the Thematic Review.

24 **Q.** Did they tell you that in June?

25 **A.** Can you just be --

16

1 Q. That there were sudden and unexpected
2 deteriorations in many of the babies?
3 A. Which part of June are we talking about?
4 Q. Well, we will take an example 29 June the
5 meeting that Dr Brearey and Dr Jayaram were at?
6 A. Okay in the bigger meeting.
7 Q. Yes.
8 A. The 29th June. Yes, I think they did say that
9 at that meeting.
10 Q. And that was them offering an expert opinion,
11 wasn't it?
12 A. Yes.
13 Q. And they told you that there had been
14 a pattern that these deaths, six out of nine of them,
15 had occurred at night and that that pattern had stopped
16 when Letby was moved to days, didn't they?
17 A. They did say that, yes.
18 Q. So that is a further piece of information that
19 is relevant to weigh in the balance, isn't it?
20 A. Yes.
21 Q. Because that is what you would expect to
22 happen, if she was responsible for the harm?
23 A. If she was responsible for the harm, yes.
24 Q. Yes. Well, at the moment you are not acting
25 as judge, jury and executioner; you are just identifying

17

1 Q. In June, the possibility was made express that
2 she was causing harm deliberately, wasn't it?
3 A. That's what the medical staff said, yes.
4 Q. Yes. So you have got to confront that
5 possibility, don't you?
6 A. Yes.
7 Q. So the fact that she was a highly competent
8 nurse, do you agree, is irrelevant to that question?
9 A. Yes.
10 Q. Now, do you think in fact you did treat it as
11 irrelevant or do you think that you relied heavily on
12 that, even though it was irrelevant?
13 A. I think at the time there was lots of
14 different factors that we were trying to pull together
15 and aside to the term "deliberate harm" which was the
16 first time that we had heard that time in June '16,
17 there were lots of other elements that we needed to
18 consider, particularly out of the Thematic Review which
19 was around the clinical reviews that had been done of
20 the care.
21 So there was some care omissions with those babies
22 as well.
23 Q. It was a safeguarding issue to be confronted,
24 wasn't it?
25 A. Looking back, yes.

19

1 whether there is a basis for concern and that is
2 something to add into the mix, isn't it?
3 A. Yes.
4 Q. You were told that the babies, some of them,
5 had not responded to resuscitation as had been expected?
6 A. Yes.
7 Q. That is another expert opinion?
8 A. Yes.
9 Q. Were you told about the unexplained rashes?
10 A. No.
11 Q. So you have there, we have just been through,
12 four expressions of expert opinion plus a fact which is
13 consistent with the concerns that you are being told
14 about?
15 A. Yes.
16 Q. That is an adequate basis for action, isn't
17 it?
18 A. Yes. But we were balancing that with the
19 nursing view of her practice and of how highly she was
20 thought of on the unit as well.
21 Q. Which is irrelevant, is it not, to the issue
22 of whether she is doing this deliberately?
23 A. Well, we needed to get -- we needed to get
24 more facts, we needed to pull things together to see
25 what the fuller picture was at the time.

18

1 Q. Well, and you did not treat it as such at the
2 time?
3 A. Not at the time, no, and neither did anybody
4 else.
5 Q. Well, nobody else was the Lead for
6 Safeguarding, were they?
7 A. I know, but I rely -- I take my duties very,
8 very seriously and the structure, as you would expect,
9 with -- with other elements of a director's portfolio
10 relies on the structures beneath them to be able to
11 report upwards and even though I had -- was part of
12 those meetings in May 16, I was still relying on the
13 teams from the unit upwards to bring any safeguarding
14 concerns to my attention and nobody did.
15 Q. But it is part of your role to listen to what
16 people are saying to you and to think: gosh, that sounds
17 an awful lot like a safeguarding concern, even if they
18 haven't not used the S word; isn't that right?
19 A. It is my responsibility. Yes, but there was
20 also designated safeguarding doctors and nurses
21 connected to that unit that didn't bring any concerns to
22 me.
23 Q. Well, did they know about it in June of 2016?
24 A. I don't know.
25 Q. Did you ask them?

20

1 A. No.

2 Q. Well, how can you rely upon the fact that they
3 haven't come to you if you don't even know if they know?

4 A. Because -- well, they were, they were on the
5 unit at the time, so I would expect the clinicians to
6 talk to each other there were designated doctors that
7 were holding a role for safeguarding.

8 Q. Did they ever say they had spoken to the
9 designated or named doctor?

10 A. The clinicians didn't, no, not to my
11 knowledge.

12 Q. So wasn't the obligation on you to flush that
13 issue out by saying: have you spoken to the named doctor
14 or even going to speak to the named doctor yourself,
15 isn't that your obligation?

16 A. At the time if we would have been discussing
17 it as a safeguarding role, yes, that would have been my
18 role. But I was also relying on others within the
19 structures beneath me to also raise those concerns.

20 Q. Do you accept you should have been discussing
21 it as part of your safeguarding role?

22 A. On reflection, yes, because but at the time we
23 were talking about clinical outcomes for babies and it
24 was more around a rise in mortality as opposed to
25 an actual safeguarding case. I know that sounds

21

1 there was a discussion about the cluster of three deaths
2 that happened in 2015 --

3 Q. Yes?

4 A. -- I think it was.

5 It wouldn't be a forum where we would talk about an
6 individual member of staff, so it wasn't discussed at
7 the safeguarding meeting.

8 Q. You wouldn't say "there is a major
9 safeguarding concern which is currently being dealt
10 with", you wouldn't even tell the board that that was
11 happening?

12 A. We -- we would talk about that but as I say,
13 we were not considering it as a safeguarding issue at
14 that time.

15 Q. Now, the Local Children's Safeguarding Board,
16 we are just going to bring up three documents here,
17 7 July, if we bring up INQ0004320, and we are going to
18 go to page -- we are just going to bring that up,
19 please. This is one of your notes, Ms Kelly, it is
20 7 July. Just take a moment to look at it.

21 If we look a third of the way down on the
22 right-hand side we can see "safeguarding referral" in
23 your handwriting; is that right?

24 A. That's correct.

25 Q. So it does appear that on 7 July 2016 you had

23

1 difficult to -- to comprehend because we now know much
2 more about what happened compared to what we were
3 dealing with at the time.

4 Q. You knew at the time that the Consultants
5 thought she was murdering babies; that's -- that was
6 their central message to you, wasn't it?

7 A. In June they talked about deliberate harm,
8 yes.

9 Q. Yes. And -- and deliberate harm to a human
10 being who is now dead is murder, isn't it?

11 A. Yes.

12 Q. So you knew that that was their central
13 concern and therefore you don't need hindsight or what
14 we know now, do you; that is a safeguarding issue to be
15 confronted, do you agree?

16 A. Yes, at the time. But it wasn't -- it wasn't
17 at the time.

18 Q. Now, at no stage during 2016 or 2017 did you
19 speak to the named doctor for safeguarding, is that
20 right, about this issue?

21 A. About this issue, no, not that I can recall.

22 Q. At no stage during 2016 and 2017 did you raise
23 this matter with the hospital Safeguarding Strategy
24 Board, did you?

25 A. I recall -- I think on one of the agendas

22

1 in mind to make a referral to the LADO?

2 A. I can't recall the actual conversation about
3 that. That was with CCG and specialist commissioning
4 colleagues.

5 I have written it there. I don't know whether it
6 was consideration that we talked about in the meeting,
7 I don't recall myself being given an action to leave
8 that meeting and go and do that referral.

9 Q. It's not for them to give you an action; it is
10 for you to decide as safeguarding lead whether you need
11 to make a referral, isn't it?

12 A. Yes, but some of the people that were in that
13 meeting were also leads for safeguarding as well so I'm
14 not sure what the conversation was entirely.

15 Q. Was this you telling NHS England that you were
16 going to make a safeguarding referral?

17 A. I don't recall.

18 Q. Do you agree that's what it looks like?

19 A. I have written notes, yes, bullet points of
20 things that were discussed in that meeting but the
21 context, I'm not sure of.

22 Q. Were you seeking to reassure NHS England that
23 you were responding to this appropriately?

24 A. We were really clear about the concerns that
25 we had in raised mortality and I have written there

24

1 "Thematic Review". I honestly can't remember the
2 safeguarding conversation.
3 **Q.** Well, you say that you were really clear. Did
4 you tell NHS England that in the two weeks before the
5 Consultants had come to you and said that they believed
6 that a member of staff may be deliberately harming
7 babies?

8 **A.** I don't recall that, no.

9 **Q.** Well, there's no indication whatsoever in your
10 notes that you raised that?

11 **A.** No.

12 **Q.** Should you have told NHS England --

13 **A.** I think -- sorry.

14 **Q.** Should you have told NHS England in that
15 meeting?

16 **A.** Again I have reflected on the information that
17 we were giving to our regulators at the time and I think
18 it was a really fine balance between trying to really
19 understand what the cause for the raised mortality was,
20 versus whether an individual was actually doing
21 deliberate harm. And trying to balance the two was --
22 was quite tricky at the time in terms of communication.

23 **Q.** Where is the balance in saying: we are giving
24 active consideration to, among other things, whether
25 deliberate harm has been caused, which was the truth?

25

1 **Q.** You did have a telephone conversation,
2 INQ0106930, page 125. This is I think a continuation of
3 this note in terms of the action points.

4 So we can see here again your note Mortality
5 Reviews, it is a call with Gill Frame and she connected
6 with the Local Children's Safeguarding Board?

7 **A.** Yes, she was the chair at the time.

8 **Q.** Yes. So it appears that you had a telephone
9 conversation at some point shortly after this meeting.
10 You didn't make a referral. You appear to have noted
11 "doing the right things: advised of actions being
12 taken", I think. "A review next week, police action may
13 be required."

14 You don't appear to record telling Ms Frame that
15 you were investigating whether or not a member of staff
16 had caused deliberate harm?

17 **A.** This meeting was part of a communications plan
18 cascade and I had responsibility for informing a number
19 of -- of external agencies including the Local
20 Children's Safeguarding Board.

21 This was at a time when we were trying to gather as
22 much information as possible to understand what exactly
23 was going on. So at this time, I didn't talk about
24 a member of staff.

25 Again, we were trying to balance what we were

27

1 **A.** Yes, I -- I could have said that, I can't

2 recall --

3 **Q.** Why didn't you?

4 **A.** -- the conversation.

5 I don't know.

6 **Q.** Well, were you trying to withhold that
7 deliberately from --

8 **A.** No. I have, I -- as I said in my opening
9 statement there were -- on reflection there were actions
10 that I didn't get right but the actions I did take at
11 that time were done with good intention. I was not
12 withholding anything from anybody at that time.

13 **Q.** Now, making a safeguarding referral is
14 a formal act, isn't it?

15 **A.** It is.

16 **Q.** It's not having a chat on the phone, it's
17 filling out a form and formally placing something before
18 the safeguarding board?

19 **A.** Yes.

20 **Q.** And you understand that that's what the phrase
21 "safeguarding referral" imports?

22 **A.** Yes.

23 **Q.** You didn't make a safeguarding referral, did
24 you, at that time?

25 **A.** No.

26

1 trying to action within the organisation versus thinking
2 of the welfare of an individual and that -- that was
3 difficult because we needed to really get to the bottom
4 of what was going on.

5 So hence the communication plan but making sure
6 that Gill Frame knew what we were doing but I didn't
7 talk about an individual at that meeting because we were
8 still gathering information.

9 **Q.** She didn't know that you were conducting an
10 investigation into whether an individual may have caused
11 deliberate harm?

12 **A.** She -- we talked about an individual, we
13 talked about an investigation that we were doing across
14 the board but I didn't talk about an individual, no.

15 **Q.** Because one of the things that you were doing
16 at this time as a hospital was looking at the staffing
17 rota to look to see whether Letby's name was associated
18 with the deaths?

19 **A.** That was just a very small part of what we
20 were doing internally, but yes.

21 **Q.** It was part of your investigation.

22 **A.** It was part --

23 **Q.** Why not tell Ms Frame that that's what you
24 were doing?

25 **A.** I think it was difficult at the time because

28

1 we needed to be really sure of what was going on and
2 there was still not clarity on that and the rota review
3 was only one -- like I said, one small part of a much
4 bigger piece of work that we were doing to try and
5 understand the rise in mortality.

6 **Q.** Why did you need to be sure? In
7 a safeguarding context you only need possibility before
8 it is a safeguarding issue, don't you?

9 **A.** Yes. But at the time nobody, including
10 myself, was looking at it through a safeguarding lens.

11 **Q.** So why were you telling the Safeguarding Board
12 anything if this wasn't safeguarding?

13 **A.** Because we were making sure that all our
14 external partners, which were part of that
15 communications plan, understood that we were looking at
16 a rise in mortality and that coincided with the
17 downgrading of the unit and a number of other actions
18 that we took.

19 So we all had a responsibility to make sure that
20 all stakeholders knew what we were doing.

21 **Q.** Did you deliberately hold that from --

22 **A.** No.

23 **Q.** -- Ms Frame?

24 **A.** No.

25 **Q.** Can you suggest any other reason why you
29

1 **Q.** Well, you have mentioned it. Can we just be
2 clear: is welfare any part of your thinking as to why
3 you did not tell the safeguarding board what you were in
4 fact doing?

5 **A.** I think we were just trying to balance the
6 two.

7 **Q.** So does it follow from that, "yes"?

8 **A.** Yes.

9 **Q.** Just consider that for a moment.

10 How does it impact in any way on the welfare of
11 that person if you truthfully tell the safeguarding
12 board that you are -- one of the things you are
13 investigating is whether an individual is responsible?

14 **A.** It probably doesn't have any impact on that
15 individual but I would just like to re-emphasise there
16 was no deliberate withholding of information at that
17 time. We were just trying to get the bigger picture.

18 **Q.** You did submit a referral to the Local
19 Children's Safeguarding Board on 29 March 2018, didn't
20 you?

21 **A.** Yes.

22 **Q.** You did so after you had been contacted by the
23 LADO; is that right?

24 **A.** Yes, we had a conversation.

25 **Q.** Yes. The LADO have learned of the police
31

1 didn't tell her?

2 **A.** Because we were gathering information at the
3 time and I didn't think it was appropriate to share that
4 when we didn't have a full picture.

5 **Q.** You have mentioned some harm to the
6 individual. Why would there have been any consequence
7 to Letby if you had told the Safeguarding Board that you
8 were investigating a concern that an individual may be
9 implicated?

10 **A.** Can you repeat that, sorry?

11 **Q.** Yes. You have suggested in an earlier answer
12 that one of the balances you were doing was -- operating
13 at that time was to protect the member of staff from any
14 harm?

15 **A.** It was more around her welfare really. So
16 just making sure that we were trying to get the balance
17 between understanding what was going on in mortality
18 versus the care for our staff and the duty of care to
19 our staff.

20 **Q.** What has the member of staff's welfare got to
21 do with you truthfully telling the safeguarding board
22 that you are investigating whether an individual may be
23 responsible for some of the deaths?

24 **A.** It just didn't feel the right time to do that
25 because we just needed to get a fuller picture.
30

1 investigation and phoned you up to ask why has there
2 been no safeguarding referral?

3 **A.** Yes.

4 **Q.** So that was not something that you thought to
5 do yourself, but you had to be told that it was
6 necessary; is that right?

7 **A.** I think at the time, as I mentioned earlier,
8 I wasn't looking at this through a safeguarding lens and
9 LADO referrals usually in practice come alongside a HR
10 investigation and the two are done together, and because
11 of the way that concerns were raised, an HR
12 investigation never actually took place. So it -- it
13 didn't -- I didn't think at the time that a LADO
14 referral was required to be done.

15 I do accept, and there is an email to evidence
16 that, that it was much, much later than it should have
17 been.

18 **Q.** INQ0013064. This is the referral that you
19 submitted. Now, firstly, is it extremely important to
20 provide full and accurate information in a referral to
21 the LADO?

22 **A.** Yes.

23 **Q.** Is it capable, the quality of the information
24 you provide, capable of determining whether the LADO
25 says: well, this is something that I am going to
32

1 formally accept and investigate, or whether they say:
 2 this doesn't seem to me to be quite appropriate?
 3 **A.** Yes, they would do that.
 4 **Q.** Yes. So extremely important to be full and
 5 accurate?
 6 **A.** Yes.
 7 **Q.** Let's look at page --
 8 **A.** I do recall -- sorry, I do recall having
 9 a conversation I think before I submitted this with the
 10 lead at the local authority.
 11 **Q.** Well, let's have a look and see what you put
 12 in, reminding ourselves that this is some nine months or
 13 so after the police have begun their investigation.
 14 Page 2, please.
 15 You start the special chronology at 27 June,
 16 concerns raised formally by the paediatricians.
 17 In fact, concerns about Letby had been raised with
 18 you in March of 2016, hadn't they?
 19 **A.** We had the Thematic Review, there is
 20 iterations of that from February through to May but no
 21 mention of deliberate harm was in that document.
 22 **Q.** Were concerns --
 23 **A.** So I took my chronology from that weekend in
 24 June.
 25 **Q.** Were concerns about Lucy Letby first raised

33

1 in.
 2 **Q.** "No evidence to suggest this was
 3 a contributing factor to increased mortality".
 4 Now, I am not going to go through the list again of
 5 all of the expert opinions that you had received but you
 6 did have evidence, didn't you, in June of 2016?
 7 **A.** Only on the say-so of paediatricians. We had
 8 no actual evidence as in nobody could see her do
 9 anything. There was broadbrush statements. There was
 10 no evidence provided to us at that time.
 11 **Q.** That is evidence, isn't it? If a person
 12 exercising their professional judgment says "this death
 13 should not have happened" and you have no basis
 14 whatsoever to suggest that they are wrong about that
 15 because they are the expert on the subject, that's
 16 evidence, isn't it?
 17 **A.** But when you look at the clinical reviews that
 18 were undertaken and if you look at the Thematic Review
 19 there were very senior clinicians as part of that Review
 20 Team. There were care concerns as well. So there was
 21 a much broader picture and it wasn't very clear at the
 22 time.
 23 **Q.** But you are focusing here on whether there is
 24 evidence. The plain fact of it was that you did have
 25 evidence, you just didn't treat it in that way; is that

35

1 with you in March?
 2 **A.** Yes.
 3 **Q.** So why did you not say that? Why did you give
 4 a later date?
 5 **A.** I just took it in terms of the chronology for
 6 me in terms of deliberate harm, that is where my
 7 chronology started.
 8 **Q.** Now, what you go on to say is: monitoring
 9 undertaken of the unit, 27th -- that's reference to
 10 27 June, it is the second line.
 11 In fact, the monitoring of the unit all took place
 12 before 27 June, didn't it? That's the period from
 13 11 May through to the end of June?
 14 **A.** I think that's referring to the actual
 15 monitoring that we were then taking as an Executive Team
 16 of how the unit was being operated at that time, not
 17 monitoring from the conversation that we had in May.
 18 **Q.** "Individual named at the time Lucy Letby as
 19 allegedly being on duty a number of times when incidents
 20 had taken place."
 21 I mean "allegedly". I mean, she was on duty,
 22 wasn't she; there wasn't any doubt about that?
 23 **A.** She was on duty, yes.
 24 **Q.** So why have you used the word "allegedly"?
 25 **A.** I can't -- I can't comment on why I put that

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1 fair?
 2 **A.** I wouldn't agree with that.
 3 **Q.** So you don't think that the expert opinion
 4 offered in those four areas amounts to evidence?
 5 **A.** I think we needed to look at everything in the
 6 round in terms of the clinical outcomes as well as
 7 looking at one individual.
 8 **Q.** But the fact that there are other things as
 9 well doesn't answer the point, does it? Was there
 10 evidence and what I am inviting you to consider is
 11 whether the expert opinion of the paediatricians was
 12 evidence?
 13 **A.** You could, you could say that. But when you
 14 have babies that have had postmortems and various
 15 reviews that were undertaken in very close detail that
 16 gave other options of the contributing factors to their
 17 death, then I -- I didn't take the hearsay of
 18 Consultants as evidence at that time.
 19 **Q.** It may not be proof but it is information
 20 which suggests that they may be telling the truth, isn't
 21 it?
 22 **A.** Information to suggest that, yes.
 23 **Q.** Yes. And that's just another name for
 24 evidence, isn't it?
 25 **A.** At the time I didn't take that as evidence.

36

1 Q. Now, you had by March 2018 seen the document
2 that the Consultants had prepared for the police, hadn't
3 you?

4 A. No, I never saw that.

5 Q. You never saw that?

6 A. No.

7 Q. Were you aware that they had sent one?

8 A. Yes, I was, but it was never shared as far as
9 mine were to the Executive Team.

10 Q. So as you were preparing this referral, did it
11 occur to you to think to say: well, I wonder if I should
12 go and have a look at that document that the Consultants
13 have prepared so that I can put forward the concerns
14 that they have in the most persuasive way that I can?

15 A. That -- at the time, that would have been
16 a good idea. But I didn't do that.

17 Q. Well, is that because at this time you had
18 a feeling of hostility towards the Consultants and that
19 you did not think the police investigation was going
20 anywhere?

21 A. That's not true.

22 Q. Because this is a safeguarding referral, it's
23 important, isn't it, to state their concerns at their
24 highest?

25 A. Yes.

37

1 did not investigate Letby was inconclusive is
2 misleading, isn't it?

3 A. I think it's just language that was used by me
4 in that -- in that referral. It wasn't miss, I didn't
5 feel at the time it was misleading.

6 Q. Well, it might be read by a reader, do you
7 agree, as suggesting, well, somebody has looked into it
8 and they couldn't find anything?

9 A. I think when the College review was undertaken
10 they chose to interview Letby.

11 Q. I am here talking about what the reader of
12 this --

13 A. Oh, the reader of this, sorry.

14 Q. The reader of this, that what you said may be
15 read as suggesting that the Royal College had
16 investigated it and had not reached any definitive
17 conclusion on the point?

18 A. You -- you could read that from there but
19 I would have assumed if it wasn't clear, the LADO could
20 have called me and to clarify.

21 Q. Well, is the problem --

22 A. I suppose I have just done that in a bullet
23 point list, it may have needed more detail.

24 Q. The problem is that it may be perfectly clear
25 to what -- to the LADO what you are saying it is exactly

39

1 Q. This isn't determinative of whether there are
2 any consequences to anyone; it's just important that
3 everybody understands the worst case scenario?

4 A. Yes.

5 Q. Let's have a look and see what you say about
6 the College review --

7 A. Could I --

8 Q. The 29 June:

9 "External review commissioned. No definitive
10 conclusions could be drawn from the Royal College
11 review."

12 Do you think that that was a misleading statement
13 for you to make?

14 A. I think the external review came out with
15 a number of different recommendations that were very
16 wide, varying at the time.

17 I don't -- I don't see that as being misleading.

18 Q. Well, we will consider it from this
19 perspective: you were told in terms by the Royal College
20 at the end of their review that they had not
21 investigated whether Letby had done it; isn't that
22 correct?

23 A. I can't recall that but I think that might
24 have been said, yes.

25 Q. So telling the safeguarders that a report that

38

1 what I have suggested that you have commissioned the
2 Royal College to investigate the concerns about Letby,
3 that they had done so and their conclusions were not
4 conclusive?

5 A. You could deduce that from that, yes, but
6 maybe I should have put more detail into that --

7 Q. Well --

8 A. -- section.

9 Q. In fact, the Royal College recommended that
10 Dr Hawdon, as it turned out to be, conduct a Casenote
11 Review?

12 A. Yes.

13 Q. By this stage you knew that Dr Hawdon had
14 recommended a local forensic review in relation to four
15 babies?

16 A. Yes.

17 Q. Because she was concerned about each of those
18 four babies?

19 A. That a further review was required, yes.

20 Q. Yes, because she was concerned about those
21 four babies?

22 A. Yes.

23 Q. You don't mention that here?

24 A. No. And -- and looking at that referral it --
25 it obviously did need more detail.

40

1 Q. You don't say anything about the fact that
2 following Dr Hawdon, the network intervened through
3 Dr Subhedar and he said he actually thought there were
4 seven babies?

5 A. Yes, he did have further comments to make.

6 Q. The Consultants then built on that and said
7 they thought there were eight babies.

8 All of that fell out of the Royal College review,
9 didn't it?

10 A. Yes. But there were lots of other elements to
11 that review.

12 Q. Now, if we go over the page, we will see that
13 you say that she hasn't undertaken any clinical duties
14 or be permitted to go on to the neonatal unit.

15 Presumably that's to reassure the safeguarders that
16 nobody has been exposed to risk of harm?

17 A. Yes.

18 Q. Yes. You don't say anything about the fact
19 that she's been going to Alder Hey --

20 A. I was not aware of that.

21 Q. -- by March 2018?

22 A. There was something that was brought to my
23 attention about Alder Hey and myself and Sue Hodgkinson
24 the HR Director found out about it and it was stopped.

25 Q. That was in the summer of 2017.

41

1 Q. Do you think on that occasion you discharged
2 that obligation adequately?

3 A. Knowing what we know now compared to what we
4 knew then, I don't think I did fulfil that role.

5 However, as I mentioned before myself and others did not
6 look at this as a safeguarding issue. It was about
7 clinical outcomes, a raise in mortality and concerns
8 raised by clinicians about an individual and we needed
9 to get more information.

10 Q. I am going to move to the second part of my
11 questioning which is Speak Out Safely and Freedom to
12 Speak Up. In addition to being the Executive Lead for
13 Safeguarding, you were a designated officer for Speak
14 Out Safely; is that right?

15 A. I was one of a few people, yes.

16 Q. INQ0014171. As that's coming up, can you
17 confirm that you sat on the Speak Out Safely committee?

18 A. I did.

19 Q. So you were one of seven people identified at
20 the hospital, four members of staff as being someone to
21 speak to if they had concerns?

22 A. That's correct.

23 Q. And your role as a designated officer included
24 ensuring that there were no recriminations for good
25 faith reports of matters of concern; is that right?

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1 A. I don't recall the date.

2 Q. Well, you can take it from me that that was
3 before March 2018.

4 A. Okay.

5 Q. If you just think about the chronology. I am
6 sure you will see that that must be right?

7 A. (Nods)

8 Q. Was that something that you should have told
9 the safeguarding panel about so that they could be aware
10 of it and potentially investigate it?

11 A. If that chronology is correct then there would
12 have been perhaps more detail required on that, yes.

13 Q. I would just like you to respond to
14 a characterisation of this document, for your comment.

15 Do you think that this is a misleading and highly
16 defensive document?

17 A. I would not say it's defensive or misleading.
18 I think it lacked detail and on reflection I should have
19 put more detail in there. I did have a phone call with
20 the LADO at the same time that this was going in.

21 Q. This is the one time that in this whole
22 chronology we have you acting expressly in your role as
23 the Executive with lead responsibility for safeguarding,
24 isn't it?

25 A. Yes.

42

1 A. That's correct.

2 Q. If we look at page 2, we can see that it deals
3 at the second paragraph under the heading "Raising
4 Concerns":

5 "By implication this policy is concerned with the
6 possibility that a member or members of staff are not
7 delivering the standard of patient care expected of
8 them."

9 So again this is about people raising the
10 possibility that something might not be right?

11 A. Yes.

12 Q. We can see the language used just to take an
13 example, "all concerns", so we are talking here about
14 people saying "I have a concern", that is the
15 appropriate language to use in this context; is that
16 right?

17 A. Yes.

18 Q. Now, if we look at page 9, we can see here:

19 "Consideration of referral to the Local Authority
20 Designated Officer ... If there is a concern raised or
21 an allegation made about a person who works with
22 children, whether a professional staff member, foster
23 carer or volunteer that they may have: behaved in a way
24 that has harmed a child or may have harmed a child;
25 possibly committed a criminal offence against or related

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1 to a child; or behaved towards a child or children in
 2 the way it indicates she/he is unsuitable to work with
 3 children, then the process outlined below should be
 4 followed."
 5 We can see that that process includes liaison with
 6 the LADO, do you see?
 7 **A.** Yes.
 8 **Q.** Now, that is exactly what the Consultants said
 9 to you in late June of 2016, wasn't it? That they were
 10 concerned that she may have behaved in a way that harmed
 11 a child, possibly committed a criminal offence, may be
 12 unsuitable to work with children?
 13 **A.** Yes.
 14 **Q.** And that should have triggered an immediate
 15 contact with the LADO, shouldn't it?
 16 **A.** Yes.
 17 **Q.** You didn't do that. Why did you not follow
 18 this policy?
 19 **A.** I -- I don't know why I didn't follow this
 20 policy. It -- it was under the safeguarding banner for
 21 me and I have explained why I didn't consider it to be
 22 safeguarding at the time.
 23 **Q.** But this is a separate responsibility that you
 24 have for safeguarding?
 25 **A.** But this was part of -- I was one of many
 45

1 **A.** No.
 2 **Q.** So you were the one who had that knowledge and
 3 information in this meeting?
 4 **A.** Yes.
 5 **Q.** This was an action for you to go and look at
 6 the Speak Out Safely process?
 7 **A.** Yes, I think we did talk about consideration
 8 of that.
 9 **Q.** Well, you have talked about it but this is an
 10 action, isn't it --
 11 **A.** Yes.
 12 **Q.** -- for you to go and have a look at the
 13 policy?
 14 **A.** It doesn't actually say "policy" there but
 15 I think it was about more of a conversation with the
 16 other designated leads for Speak Out Safely at the time.
 17 **Q.** If you had gone away and given serious thought
 18 to the Speak Out Safely process, wouldn't that have led
 19 you to realising that the LADO needs to be contacted?
 20 **A.** I think at the time Speak Out Safely, the
 21 processes around that weren't fully embedded in the
 22 organisation. But I do recognise that that note there
 23 is about consideration of that process at that time --
 24 **Q.** It --
 25 **A.** -- and that the LADO was never a consideration
 47

1 others in the organisation that held this role. We did
 2 talk about the neonatal unit concerns at meetings.
 3 I don't know why the LADO element was never discussed.
 4 **Q.** Was that because you just weren't taking these
 5 concerns seriously?
 6 **A.** That's not true. We absolutely were taking
 7 the concerns seriously.
 8 **Q.** Was it -- was it because you thought you would
 9 lose control if an external body was notified?
 10 **A.** No.
 11 **Q.** So you have mentioned that it was discussed at
 12 meetings. We are going to just whip through some of
 13 them now. INQ0015537, page 4.
 14 Bottom right-hand corner, third bullet from the
 15 bottom:
 16 "Consider SOS process re: meeting."
 17 Do you see that?
 18 **A.** Yes.
 19 **Q.** Speak Out Safely process. So it would appear
 20 that consideration was being given at a meeting which
 21 I think is recorded as having you, Ian Harvey and
 22 Eirian Powell at; is that right?
 23 **A.** Yes, notes at the top.
 24 **Q.** Neither Ian Harvey nor Eirian Powell, were
 25 they Speak Out Safely designated officers?
 46

1 in those meetings.
 2 **Q.** Is there any note that you have seen between
 3 there and September 2016, so in other words the next two
 4 or three months, where you actually sat down and
 5 considered the Speak Out Safely process?
 6 **A.** We had Speak Out Safely meetings with various
 7 members and I do recall that neonatal unit was
 8 discussed. I can't recall -- do you have the meeting
 9 note?
 10 **Q.** We are going to look at it.
 11 **A.** Okay.
 12 **Q.** You can take it from me not at any point
 13 during 2016?
 14 **A.** 16, okay.
 15 **Q.** So this is a note for yourself to sit down and
 16 work something out. You are, if I may say so, a good
 17 maker of notes, you write reflections for yourself and
 18 so on, don't you?
 19 **A.** (Nods)
 20 **Q.** Is that just something that got forgotten?
 21 **A.** Possibly. Yes. There was lots going on at
 22 that time. You can see by those notes there were lots
 23 of things to consider.
 24 **Q.** Well, that's an important one, isn't it, in
 25 terms of priorities, do you agree?
 48

1 A. Yes, yes.
 2 Q. You are the only person in that meeting who's
 3 going to be able to do that, aren't you, as a designated
 4 officer?
 5 A. Yes, in that role, yes.
 6 Q. Yes. So let's come forward to 8 September,
 7 INQ0015537, we are going to go to page 19.
 8 So this is an Execs' meeting on 8 September and we
 9 can see again, bottom right-hand corner, penultimate
 10 bullet:
 11 "SOS process IH [Ian Harvey] to discuss with
 12 Stephen Brearey as he initially raised concerns would be
 13 consistent of other cases."
 14 So it appears that we are no further forward other
 15 than an agreement in September that Mr Harvey is going
 16 to speak to Dr Brearey about it.
 17 Now, why does it need a conversation? If a concern
 18 has been raised that fits within the policy, it should
 19 be treated within the policy, shouldn't it?
 20 A. Yes.
 21 Q. So it doesn't require the consent or
 22 permission of the person raising the concern, no
 23 conversation is necessary, is it?
 24 A. I think the conversation at that time was to
 25 gain clarity from the doctors of their actual concerns.

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1 through the Speak Out Safely process didn't happen in
 2 a timely way.
 3 Q. It's extremely important for the protection of
 4 the individual for it to be managed properly, isn't it?
 5 A. Yes.
 6 Q. It gives them reassurance that they have the
 7 protections of the policy; that's right, isn't it?
 8 A. Yes.
 9 Q. It means that they have the practical barrier
 10 of being able to say: you can't mistreat me or put
 11 pressure on me as a result of me having raised this in
 12 good faith?
 13 A. That's correct.
 14 Q. That is a key part of, it isn't it?
 15 A. Yes.
 16 Q. It empowers people?
 17 A. Yes.
 18 Q. It ensures that people don't just get
 19 silenced, doesn't it?
 20 A. Yes.
 21 Q. 21 September, INQ0002976.
 22 So if we go to the bottom, the next page down we
 23 will see that Ms Appleton-Cairns at the top of this:
 24 "As part of this we were going to ask Ian to speak
 25 to Stephen Brearey and ask him to formally voice his

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1 Most of the -- as I say, the Speak Out Safely process
 2 wasn't fully embedded, it was in a transition period
 3 into Freedom to Speak Up processes.
 4 Previous issues would have been raised in writing
 5 in an email, in a phone call, but recognised that
 6 because there were so many actions being undertaken at
 7 that time, formalising the doctors' concerns under Speak
 8 Out Safely didn't happen.
 9 Q. Well, in the end of June they had said "we are
 10 worried that she may be murdering babies", that was the
 11 import. They may not have used the word "murder" but
 12 deliberate harm to babies who are dead.
 13 At that moment that should immediately have been
 14 logged, shouldn't it, under the Speak Out Safely policy?
 15 A. On reflection, looking back, yes, in practice.
 16 Q. Well, do you need any of the hindsight? At
 17 the time you had enough information to know to do that
 18 didn't you?
 19 A. We did have information to enact the policy at
 20 the time. However, I think we were a little bit
 21 bewildered at some of the things that were being said
 22 and it -- it took a while to kind of get that straight
 23 in our minds really to get actions under way and there
 24 was so much going on in a very short space of time.
 25 But I accept that formalising those concerns

50

1 concerns under Speak Out Safely."
 2 So that is what she is saying. In fact, no
 3 formality is required, is it, under the policy; people
 4 just have to raise concerns?
 5 A. Yes.
 6 Q. So if we then go to the top of the page we
 7 will see your and Sue Hodkinson's response. "I will
 8 check with Ian" says Ms Hodkinson and you say you are
 9 unsure.
 10 So several months have passed, you are being asked
 11 a direct question about it. Still unsure.
 12 A. Yes.
 13 Q. What was the problem of just writing it down
 14 on the list and having a meeting about it?
 15 A. I -- I can't recall why that didn't happen.
 16 It -- it was discussed at future meetings. I can't --
 17 I can't recall why that didn't happen.
 18 Q. So if we then come to the grievance
 19 investigation report, and I have the reference for the
 20 September meeting, if you would like to have a look at
 21 it which took place two days before that; would that be
 22 help to you?
 23 A. Yes please.
 24 Q. INQ0098689.
 25 Bearing in mind this email rather tends to suggest

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1 it hasn't been talked about, because two days later you
 2 are still not certain what's going on but we can bring
 3 it up.
 4 So we just move through this and we are really
 5 looking for what isn't there but that's the first page,
 6 that is the second page, third page, fourth page.
 7 Now, I am sure everyone's got the reference and
 8 people can go away and check it and make sure I haven't
 9 missed anything, but perhaps you will take it from me
 10 for now that it's just not mentioned in that meeting?
 11 **A.** No, I do see that I wasn't at that meeting
 12 either.
 13 **Q.** Even so, it hasn't even been put on the
 14 agenda. So we can take that down.
 15 So let's move forward to 22 November, staying with
 16 Speak Out Safely. INQ0002879, page 222. What you are
 17 going to see now is the investigation report from
 18 Dr Green. This is the final version of that report and
 19 it has this addition, among others, after it had been
 20 sent to Lucy Sementa and then sent back, so that is the
 21 evidence we have. So this is something that wasn't in
 22 the first draft, it is in the second and final draft.
 23 "In response to how the Trust have dealt with this
 24 I conclude that the Trust have considered the concerns
 25 of the Consultants in line with both the disciplinary

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1 **Q.** Yes, Dr Green's report.
 2 **A.** It was quite some time after that we received
 3 the report from what I can recollect.
 4 **Q.** Well, did you ever correct that fact?
 5 **A.** No.
 6 **Q.** Well, should you have corrected it bearing in
 7 mind that it is false?
 8 **A.** At the time yes, but I don't recall seeing the
 9 report until much, much later on.
 10 **Q.** I mean, it's false in a way that makes the
 11 Executives look better than in fact is true, isn't it?
 12 **A.** Can you rephrase that sorry?
 13 **Q.** I am so sorry, could you just repeat that
 14 answer?
 15 **A.** I said can you repeat your question, sorry.
 16 **Q.** I beg your pardon, that was entirely my fault.
 17 May I apologise?
 18 **A.** It's okay.
 19 **Q.** It was false in a way that made the Executives
 20 look better than was in fact true; do you agree?
 21 **A.** No, no, I don't agree.
 22 **Q.** It makes it look like the policy has been
 23 applied as it should have been when in fact the policy
 24 wasn't applied?
 25 **A.** I don't understand why Dr Green put that in.

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1 and Speak Out Safely policies."
 2 That is a finding of fact that Dr Green makes.
 3 In fact, I am sure we won't need to go to it, you
 4 hadn't talked to him about the Speak Out Safely policy?
 5 **A.** No, not that I recall.
 6 **Q.** If you had, you would have said to him: we
 7 haven't dealt with it under the Speak Out Safely policy,
 8 that is what you would have said to him?
 9 **A.** I -- I am unsure as to what Sue Hodgkinson
 10 would have said to him because she also took a key part
 11 in that process.
 12 **Q.** You knew for a fact it hadn't been dealt with
 13 under the Speak Out Safely policy, didn't you?
 14 **A.** If the timings of those meetings -- are you
 15 referring to the meeting we have just looked through?
 16 **Q.** Yes, it is not registered on the spreadsheet
 17 that was kept as a running spreadsheet, it does not
 18 appear in the minutes of any meeting and we can see in
 19 September there was a discussion about whether, how it
 20 was going to be treated so that --
 21 **A.** Yes, I -- I don't, I don't know why Dr Green
 22 wrote that if he was not aware of the process.
 23 **Q.** Well, presumably you read it at some point
 24 after the grievance process?
 25 **A.** Who, myself?

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1 He was a very credible manager, so I can't understand
 2 why he would have put something in there if it hadn't
 3 actually happened.
 4 **Q.** So my question, wherever it's come from, is it
 5 is false in a way that makes the Executives look better
 6 than was in fact the case; do you agree?
 7 **A.** You could say that, but that was not the
 8 intention.
 9 **Q.** INQ0003158, page 3. This is the grievance
 10 determination. Presumably that was something you saw
 11 very shortly after it was published?
 12 **A.** I can't remember the actual time, but I do
 13 recall seeing it. Yes.
 14 **Q.** Second paragraph:
 15 "In response to how the Trust have dealt with this
 16 I conclude that the Trust have considered the concerns
 17 the Consultants in line with both the disciplinary and
 18 Speak Out Safely policies."
 19 Practically a copy and paste, I think one or two
 20 words are slightly reordered.
 21 So this is what Annette Weatherley is saying in her
 22 formal resolution of the grievance, it is the same false
 23 statement. Did you ever correct it?
 24 **A.** Me personally, no. But I don't know what
 25 conversations Annette Weatherley and Chris Green will

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1 have had and I don't know where that's come from in
2 terms of it not being followed.

3 **Q.** You are in a position to know it's false
4 because you are on the committee, you haven't discussed
5 it and in September you weren't even sure what was being
6 done with it. Wherever it's come from, you must know at
7 that point that it's not true; isn't that right?

8 **A.** As I say, I don't recall even querying that at
9 the time.

10 **Q.** No, but at the time you would have known it
11 was untrue; is that right?

12 **A.** In terms of timescales chronology then yes,
13 because we hadn't had a conversation at the Speak Out
14 Safely meeting but I still don't understand why that was
15 actually put in there when it wasn't correct.

16 **Q.** Then we come to the meeting on 26 January with
17 the paediatricians which I think you attended; is that
18 right?

19 **A.** I think I did, yes.

20 **Q.** INQ0003523, page 2. Mr Chambers telling the
21 Consultants, at the top, "stated the Speak Out Safely
22 process has been professionally managed".

23 That was a false statement, was it not, at the time
24 it was made?

25 **A.** I think because it had been talked about so
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1 meeting, yes.

2 **Q.** So knowing at the time that it was not a true
3 statement, should you have challenged it?

4 **A.** At that meeting, yes. But I think we were all
5 under the impression it was being dealt with but
6 informally.

7 **Q.** But that is not what he is saying. He is
8 saying it is professionally managed. He is praising how
9 it's been managed, isn't he?

10 **A.** I think that is the way he was articulating it
11 at the time, yes.

12 **Q.** You knew that that wasn't true, didn't you?

13 **A.** I at the time probably didn't take that on
14 board in terms of the terminology that was used.

15 **Q.** Well --

16 **A.** There was a lot discussed at that meeting.

17 **Q.** Let's move to where it was first discussed
18 INQ0098375, page 3. This is a meeting on

19 20 February 2017. We can see here that you say:

20 "We need to consider whether the concerns raised by
21 the paediatricians in the NNU need to be formally
22 logged."

23 So going into that meeting, you must have known
24 that there was no formal record of their concerns as far
25 as Speak Out Safely; do you agree?

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1 many times, I think there was an impression that it was
2 being dealt with under the Speak Out Safely policy. But
3 what we weren't very good at doing was making sure that
4 it was discussed at the meetings and minuted and actions
5 taken.

6 It -- it wasn't something that we dismissed, it
7 just didn't seem to formalise. So -- and I think that
8 statement from Mr Chambers, he probably thought that it
9 was being dealt with.

10 **Q.** I am sure --

11 **A.** But it wasn't -- it wasn't to mislead anybody.

12 **Q.** If he read Annette Weatherley's report, that's
13 where he would have got it from. But the difference is
14 Mr Chambers didn't sit on the committee; you did?

15 **A.** No.

16 **Q.** So you will have known that that wasn't true,
17 wouldn't you?

18 **A.** I didn't challenge Mr Chambers at that meeting
19 about that comment. But other members of the Executive
20 Team were also there as well who were also Speak Out
21 Safely leads.

22 **Q.** Let's focus upon you. You will have known on
23 26 January that that was not a true statement, do you
24 agree?

25 **A.** In terms of what we didn't talk about at the
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1 **A.** I do agree. I think we talked about it a lot
2 but actually didn't pin it down to actually documenting
3 it.

4 **Q.** Well, this is the first meeting, Speak Out
5 Safely, where it is being talked about?

6 **A.** Yes.

7 **Q.** "After discussion it was agreed that unless we
8 receive any further comments we should monitor the
9 situation through normal routes; it is discussed at
10 QSPEC, and if anything arises it can be brought back
11 here."

12 So that is the committee deciding not to formally
13 record the concerns of the Consultants; is that right?

14 **A.** I think this is really difficult because there
15 were so many things going on that it didn't kind of fit
16 into a -- a box, a particular one policy. It kind of
17 span over a number of different policies. So I think
18 the feeling was at the time that there were so many
19 other actions being taken it -- it probably didn't need
20 to be discussed at this meeting as well as everywhere
21 else and in reflection I -- I think we should have just
22 put it on the list as per policy.

23 **Q.** Because that would then have given an
24 auditable protection --

25 **A.** Yes.

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1 Q. -- for the Consultants, it would have been
2 able for them to say when under pressure: my concern is
3 being dealt with formally, you need to make sure there
4 are no recriminations?

5 A. To formalise that process at that time would
6 have been helpful, yes.

7 Q. It's extremely important, isn't it?

8 A. Yes.

9 Q. Why was the committee depriving the
10 Consultants of that protection?

11 A. There was no intention at that time to be
12 targeting the paediatricians for not logging that
13 formally. I think it just got lost in the mêlée of all
14 the actions that were being taken at the time. It
15 certainly wasn't done with any poor intention or malice.
16 It was that there was so much going on and there were
17 lots of discussions with the paediatricians at that time
18 anyway.

19 Q. One of the discussions shortly before the
20 meeting, before this meeting, was 26 January where they
21 were told they were going to be expected to apologise?

22 A. That was an outcome of the grievance,
23 I believe.

24 Q. Yes. So there was pressure on them to do
25 that, wasn't there?

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1 protect you from a possible referral to the GMC from
2 other parties ... "

3 A. I was not copied into that email. I can't
4 really comment on that, so I'm not sure as to why that's
5 been written.

6 Q. Well --

7 A. Certainly my understanding is that there was
8 lots of communications between the Executives,
9 Ian Harvey and the doctors. I'm unsure as to the
10 context of a GMC referral.

11 Q. Isn't that exactly the sort of situation where
12 a Consultant needs to know that their concerns have been
13 managed formally and have been recorded as such?

14 A. For -- for anybody that -- that raises
15 concerns everybody would be treated the same and yes, to
16 formalise that process would have been helpful.

17 Q. Absolutely, because --

18 A. But I am unsure as to the context of that
19 email because I wasn't copied in.

20 Q. INQ0003344, this is a meeting on 16 March.
21 Again we are just looking at what's happening to
22 the Consultants around the time that the Speak Out
23 Safely committee decided not to record their concerns.

24 Now, you are recorded as being present at the top.
25 Do you see your initials?

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1 A. There wasn't pressure. There was just
2 a recommendation that came out of the grievance that
3 that was one of the actions that was required based on
4 an independent chair.

5 Q. When knowing whether to respond to that,
6 wasn't it important that they had all been notified that
7 the concerns they had raised were under the Speak Out
8 Safely?

9 A. It -- it would have been supportive of them if
10 it had been formalised, yes.

11 Q. Presumably it would have shown that the formal
12 committee with responsibility for that was going to
13 protect them if necessary?

14 A. They would have been treated like any other
15 member of staff in raising concerns and I am unsure as
16 to why it never got formally registered.

17 Q. Well, let's see. Just eight or so days
18 after -- we perhaps don't need to bring it up -- do you
19 recall the letter written by Ian Harvey to Dr Jayaram
20 and Dr Brearey telling them to engage in mediation as
21 a potential way to avoid a referral to the GMC?

22 A. Do you have that on the screen, sorry?

23 Q. INQ0003119. Do we need to go down a page?
24 The final large paragraph:

25 "I think that this gesture would go a long way to

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1 A. Yes.

2 Q. Go to page 3. And we are looking for
3 a reference to Speak Out -- forgive me, it says:
4 "Sue meeting Ravi."

5 A. I can't see any reference on there.

6 Q. You can't see.

7 **LADY JUSTICE THIRLWALL:** What page are we on?

8 **MR DE LA POER:** On page 3. We can see that there
9 is a reference to from Tony Chambers in the middle:

10 "Part of me says ring police and GMC."

11 Do you see that that right in the centre?

12 A. Okay, yes.

13 Q. So again there seems to be, just focusing on
14 that for a moment, that what Tony Chambers is raising at
15 this meeting in front of you is the possibility of
16 contacting the GMC.

17 A. What -- sorry, what date was this meeting
18 again?

19 Q. 16 March 2017.

20 A. I -- I don't know why that was said. I do
21 know from a GMC reference perspective it was something
22 that Letby's parents had referred to in meetings
23 previously.

24 Q. So this is the time when all that pressure is
25 coming down on the Consultants about possible referral

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1 to their regulator. I'd just like you to reflect on
2 whether there was any connection between that and the
3 decision of the committee that you sat on not to
4 formally record their concerns?

5 **A.** I -- I don't understand the context of the GMC
6 referral piece in there. I don't know whether that was
7 referring to Letby's parents because I know they were
8 very keen that they may go down that route.

9 I am not making any connection with that and the
10 lack of documentation on Speak Out Safely process,
11 I think it was -- there were so many actions being
12 undertaken at that time I just think it fell by the
13 wayside in terms of formalising their concerns.

14 It was certainly nothing to do with causing them
15 detriment or -- or additional pressure at that time.
16 There was lots of discussion and lots of communication
17 with clinicians and we were listening to what they were
18 saying.

19 **Q.** So we then come forward to 24 April.
20 INQ0098434 and these, you will recall, Ms Kelly, is
21 where the committee gets itself into a disagreement
22 about its own minutes and so if we go over the page
23 under "Review of Minutes":

24 "Members did not recall agreeing not to formally
25 log the concerns raised by the paediatricians about

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1 **Q.** Of course at this stage 6 June the police were
2 now involved.

3 So putting the question at its broadest: is this
4 the committee trying to rewrite the past now it knows
5 the police is involved?

6 **A.** No, not at all. I think there was some
7 confusion as to logging it as -- as those notes
8 articulate. And I think it was a genuine oversight that
9 we didn't remember what we had agreed and the notes had
10 been amended but there was nothing to say that anything
11 suspicious was done around those notes.

12 As I say, there was, there was lots of discussions
13 with, open conversations with clinicians around
14 listening to their concerns. I think there was just
15 some confusion in that group.

16 **Q.** Well, just for the record, we don't need to go
17 back to it, but at that April meeting it was agreed for
18 the first time to record the Consultants' concerns, we
19 don't need to look at it, but by the time of this
20 meeting that was then logged.

21 I would like to conclude my questioning about Speak
22 Out Safely by giving you an opportunity to reflect on
23 some of the evidence that the Inquiry has received.

24 You deal with it in part in your witness statement
25 because you comment upon Dr Isaac's letter to you, which

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1 NNU."

2 Somebody is querying how it could be logged as
3 nothing had been received in writing and also been
4 logged elsewhere internal/external.

5 It goes on to say:

6 "[Mr Harvey] had had a conversation with one of the
7 Consultants who had requested it to be logged."

8 So can you just help us with -- in fact I should
9 probably show you the next set of minutes because --
10 INQ0098376, which is the minutes for the same meeting
11 which does not have that sentence in.

12 Do you see that it goes straight to Ms Cooper's:

13 "How could it be logged as nothing?"

14 Now, the --

15 **A.** I don't recall, I don't recall.

16 **Q.** Well, the explanation for that is that we see
17 on the meeting on 6 June INQ0098458 and we can see that
18 there is a discussion, the reviews of minutes that
19 Mr Cross has picked up, where it states:

20 "Members did not recall agreeing not to formally
21 log the concerns".

22 That appears to hold the explanation for why the
23 committee then went back and amended its own minutes
24 from the previous meeting?

25 **A.** (Nods)

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1 was written on 7 February of 2017 but never sent and
2 everybody agrees that you never --

3 **A.** No, I didn't receive that.

4 **Q.** -- received that and she drafted that letter
5 to you as the Executive Lead for Safeguarding and she
6 didn't send it.

7 Now, do you agree that of all the people in
8 a Trust, people with safeguarding concerns must feel
9 absolutely free to raise them?

10 **A.** Yes.

11 **Q.** And that a safeguarder, somebody with a formal
12 safeguarding role, must be able to feel utterly
13 unconstrained to speak about concerns; do you agree?

14 **A.** Yes.

15 **Q.** So this is perhaps a moment at which
16 safeguarding and Speak Out Safely come together?

17 **A.** (Nods)

18 **Q.** I asked Dr Isaac why she didn't send that
19 letter and she said this:

20 "Because I was waiting for the neonatal report,
21 I was waiting. There was a culture of fear as well."

22 So what Dr Isaac appears to have been saying there
23 was -- one of the reason or part of the reason why she
24 did not send you that letter raising a safeguard concern
25 was because she was afraid.

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1 I would just like you to reflect, please, upon that
2 evidence and provide us with your comment bearing in
3 mind that you were the lead for safeguarding and you
4 were also a champion of Speak Out Safely and yet it
5 would appear certainly on Dr Isaac's evidence she did
6 not feel she could speak to you?

7 **A.** So I heard that evidence and I was really
8 upset and disappointed by that response because she was
9 a safeguarding lead that came to my safeguarding
10 meetings, who contributed to a number of pieces of work.
11 I had a very open-door policy as an Executive and
12 a safeguarding lead.

13 Nobody else has ever come to me to say they feared
14 coming to raise any concerns with me. I wish she had
15 come to see me face to face. I would not -- I would
16 have thought it highly unusual for her to come -- to
17 send a letter to me when she was part of the
18 safeguarding team who were based working closely with
19 the clinicians.

20 So I really don't understand how she got that
21 impression. And it was quite upsetting really because
22 I thought we had worked really closely together as
23 a safeguarding team and to suddenly say that she felt
24 afraid of coming to speak to me I thought was very out
25 of the blue; very, very sad to hear.

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1 could have done more to support the clinicians certainly
2 in a pastoral perspective and to understand their
3 perspective in a bit more detail.

4 But it was a really challenging time. We were
5 dealing with multiple reviews, understanding what on
6 earth was going on, listening to both sides. I can --
7 I can reassure the Inquiry I did not take sides. We
8 listened to everybody and took and -- and listened to
9 those individuals and took their perspectives.

10 So it was -- it was trying to look at everything in
11 the round and I would not say it was a culture of fear
12 at all. There was lots of engagement. It was just
13 tense at times which is why we gained advice from
14 external agencies and the police eventually.

15 **MR DE LA POER:** My Lady, would that be a convenient
16 moment?

17 **LADY JUSTICE THIRLWALL:** Yes, thank you. We will
18 take a 15-minute break and start again at 10 to 12.

19 (11.34 am)

(A short break)

21 (11.50 am)

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

23 **MR DE LA POER:** Ms Kelly, topic 3, the Care Quality
24 Commission.

25 On 15 February of 2016, you were sent the draft of

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1 **Q.** This, as I made clear, in my questions, is
2 an opportunity for your reflection, so I would just like
3 you to consider the possibility that by February 2017,
4 you had somehow created the impression that you were
5 someone to be feared and that there could be adverse
6 consequences to people if they spoke out to you. So
7 I would just like you to reflect upon that and comment
8 upon it.

9 **A.** I am just very upset by that because that is
10 not in my nature, to provide that impression to staff of
11 all levels whether they are a Consultant, whether they
12 are a healthcare assistant, and throughout my career,
13 I have been held up to be a credible leader, to listen,
14 to support, to take action.

15 So to suggest that of me, I think I would disagree,
16 and it's not something that is in me as a nurse, as
17 a senior leader, as an Executive and for somebody to
18 gain that impression of me is very upsetting.

19 **Q.** Do you think there's any possibility that
20 things had become so acrimonious, doctors v nurses with
21 you backing the nurses that a culture of fear had
22 developed?

23 **A.** I wouldn't say a culture of fear. I think
24 there were challenges with the relationships. I think
25 the trust had broken down and I think on reflection we

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1 the Thematic Review; is that correct?

2 **A.** That's correct.

3 **Q.** That draft had been requested by Mr Harvey
4 from Dr Brearey?

5 **A.** Yes.

6 **Q.** You could see that from the email chain?

7 **A.** Yes.

8 **Q.** That request was expressed to be by reference
9 to the CQC visit that was to happen in the coming days
10 of that week; is that correct?

11 **A.** Yes.

12 **Q.** Did you read the Thematic Review on
13 15 February?

14 **A.** I can't be certain I read it actually on the
15 15th, no.

16 **Q.** Did you read it in preparation for your
17 meeting with the CQC on the 17th?

18 **A.** I don't recall, no.

19 **Q.** Bearing in mind it had been requested by
20 Mr Harvey for that purpose, and forwarded on to you,
21 should you have read it in preparation for your meeting
22 with the CQC?

23 **A.** My understanding at the time was that report
24 was a draft report that Mr Harvey had requested from
25 Dr Brearey and I think from the content of the email at

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1 the time, it wasn't a completed report. I think
2 Dr Brearey had mentioned that there was further work to
3 be done in feedback from others so we took that as
4 a draft report.

5 **Q.** Should you have mentioned it to the CQC?

6 **A.** I don't think so at that time because we had
7 only just received it, we hadn't a chance to digest it
8 and in actual fact it wasn't the full report.

9 **Q.** But the one thing that is wasn't going to
10 change was the fact that there had been an increase in
11 neonatal mortality. Whatever else the report said, that
12 central fact would remain, wouldn't it?

13 **A.** When we received that report, it wasn't clear
14 that there had been an increase in mortality. There
15 were incidents that had been reviewed at the Serious
16 Incident Panel, not all cases ended up being reported.
17 So we didn't have a clear picture when the CQC landed to
18 do their inspection at that time.

19 **Q.** So the Thematic Review deals with 10 cases?

20 **A.** Yes.

21 **Q.** Why was that not sufficient for you to see
22 that there had been an increase in mortality?

23 **A.** As I say, I don't recall reading in detail
24 that report as it came through from -- as it was
25 forwarded from Mr Harvey.

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1 an increase?

2 **A.** There had been an increase but there was lots
3 of explanations for that. So I don't know why that
4 wasn't discussed with the CQC at that time, I don't
5 recall that being part of my interview.

6 **Q.** An explanation for why it wasn't discussed is
7 because you hadn't opened the report?

8 **A.** I can't recall when I opened the report.

9 **Q.** Well, is it a possibility that you hadn't
10 opened it by the 17th --

11 **A.** Potentially, yes, when you get 150 or 200
12 emails a day, I might not have opened it in time to have
13 my interview with the CQC.

14 **Q.** But this was a report that had been flagged
15 within the email chain as being specifically relevant to
16 the CQC visit, hadn't it?

17 **A.** Dr Harvey had -- had emailed Dr Brearey about
18 that, yes.

19 **Q.** Yes, so all of that will have been apparent to
20 you?

21 **A.** Yes, I think he just forwarded the report on
22 to me once he's received it from Dr Brearey.

23 **Q.** Was Mr Harvey in the habit of sending you
24 reports that he didn't want you to read?

25 **A.** No.

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1 But because we knew that there was going to be
2 a follow-up report so I didn't really digest it in
3 detail at that time.

4 **Q.** I mean, being candid, did you go into that
5 meeting with the CQC not realising there had been
6 an increase in the mortality?

7 **A.** I -- I generally had not realised at that
8 time, no.

9 **Q.** Even though, opening the Thematic Review that
10 you were sent, that would be immediately apparent from
11 having opened it?

12 **A.** I can't recall when I opened that report but
13 what I did know from the covering email was that it
14 wasn't the final report it was a draft.

15 **Q.** So I will just return to my question.

16 You seem to accept that you didn't realise there
17 was an increase in neonatal mortality. Should you have
18 realised that before the CQC came?

19 **A.** In terms of systems and processes and
20 governance, and the review that the doctors had
21 undertaken as part of the Thematic Review potentially
22 yes, but we didn't have any clear clarity at that time.

23 **Q.** But you don't need any of that, you just need
24 to open up page 1 of the Thematic Review and see that is
25 what's stated, don't you, that there had been

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1 **Q.** So you knew it was for you relevant to the
2 CQC, you knew that Mr Harvey wanted you to read it?

3 **A.** I think at the time it was just Dr Harvey
4 wanted to be prepared for the CQC visit because I think
5 that we knew earlier in the year that there had been
6 some work being undertaken by the clinicians to include
7 external stakeholders.

8 So it was a prompt from Dr Harvey to Dr Brearey to
9 say: is there anything that -- that can be shared which
10 is the draft information at that time, just in case
11 there was any conversation with the CQC.

12 **Q.** Well, did you have an increase in mortality in
13 any other area in the hospital to report to the CQC at
14 that time?

15 **A.** I wouldn't have been involved in the detail.
16 The mortality per se in terms of portfolio came under
17 Dr Harvey. So I wasn't aware of other mortality issues.

18 **Q.** So this would be the only one that you had
19 been told about?

20 **A.** From that draft report, yes.

21 **Q.** Yes. Were you deliberately concealing that
22 information from the CQC?

23 **A.** Absolutely not.

24 **Q.** We received evidence from Ms Childs, who was
25 the chair, that she would typically ask: "is there

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1 anything else that you think I should be aware of or
2 should know or that you are worried about?", and that
3 she would have asked: "what are the serious concerns or
4 risks you have around patient safety? Where are you
5 most concerned and what are you doing to mitigate it?"
6 That is what she said she would have said.

7 Do you have any reason to think that she didn't say
8 that to you in your meeting?

9 **A.** I -- I don't recollect that but she -- she may
10 have said that.

11 **Q.** I mean, if she had said that and you had read
12 the report, you did have something to tell her about,
13 didn't you?

14 **A.** I don't recall at what point I read that
15 report because it was a draft report so I think we
16 needed to understand what the bigger picture was before
17 we shared anything with the CQC so I -- I can't recall
18 that.

19 **Q.** What is wrong with telling the CQC: we have
20 had an increase in mortality and we are in the process
21 of investigating it?

22 **A.** Yes, we may have said that. I'm not sure.

23 **Q.** Well, did you say that?

24 **A.** I -- I -- I don't recall saying that, no.

25 **Q.** Bearing in mind that was something you knew,

77

1 **A.** Yes, that was in relation to the report being
2 made public.

3 **Q.** Well, just help us with the phrase "CQC
4 comms"?

5 **A.** Communication cascade as a report was being
6 finalised.

7 **Q.** Yes, so that is not a reference to what the
8 Trust is going to -- press release the Trust is going to
9 release --

10 **A.** No.

11 **Q.** -- in light of the report?

12 **A.** It was -- it was an automated cascade, when an
13 organisation's report was completed, that would
14 automatically go out through the communication channels
15 at CQC.

16 **Q.** "No issues identified by CQC."

17 Does that mean that you had some prior notice to
18 what the report was going to say?

19 **A.** Yes, we will have had a draft report that we
20 would have had to scrutinise before the final one was
21 released.

22 **Q.** Yes, and so you will have seen there from that
23 that that the CQC didn't say anything about the increase
24 in neonatal mortality?

25 **A.** No.

79

1 should you have said it or you could have known if you
2 had read the report?

3 **A.** If I would have digested the report I would
4 have said that we had a very open relationship with the
5 CQC.

6 **Q.** So does it follow that if you had digested the
7 report you would have said it, the fact you didn't say
8 it must mean that you didn't read it?

9 **A.** I -- I may have read it. I don't recall
10 because it was a number of different reports for that
11 one topic and that was a draft report.

12 **Q.** We move forward to 26 June. INQ -- 29 June,
13 my mistake. INQ0015537, we are going to page 5. We
14 will just recall as that document comes up the 29 June,
15 Child O had died on 23 June, Child P on the 24th.

16 We are going to come to all of that detail in
17 a moment but we know that Dr Brearey spoke to you before
18 the weekend and we know that by the 27th there were
19 a number of meetings that were taking place so this is
20 two days after those meetings and this appears to be
21 first thing in the morning, your notes:

22 "Call from TC [Tony Chambers] to defer CQC comms in
23 light of NNU concerns raised."

24 So is that a record of Mr Chambers calling you to
25 say that the CQC comms should be deferred?

78

1 **Q.** "Need to understand all issues but would not
2 be good timing for Trust or CQC to present 'good' in
3 light of current concerns".

4 Now, in due course, did the Trust present "good";
5 in other words did the Trust draw attention to the fact
6 that the CQC had rated them "good" in this report?

7 **A.** Yes.

8 **Q.** So Mr Chambers appears to be saying or you are
9 noting that that wouldn't be a good thing because there
10 were those concerns?

11 **A.** I think because the concerns had only just
12 been raised in terms of deliberate harm, we didn't fully
13 understand what was going on. So we needed to manage
14 the communications well in light of CQC report coming
15 out that would rate us as "good".

16 **Q.** So were you party to the approval of any
17 communication after the CQC report which drew attention
18 to the fact that the CQC had rated the Trust as "good"?

19 **A.** I don't recall being part of, it would have
20 been discussed at an Executive meeting but directly
21 I wouldn't have been part of comms.

22 **Q.** So somebody else writes it, the form of words
23 comes to the Executive, you tweak it if necessary and
24 out it goes to the public?

25 **A.** Potentially that would have happened, yes.

80

1 Q. Was that an opportunity really to say: we
2 really ought not to be talking about the fact that we
3 are "good" in circumstances in which we know that we may
4 have a problem?

5 A. We weren't fully clear at that time what the
6 problem was and the CQC had had lots of information
7 prior to their visit as well as being on site and had
8 concluded that we were "good" as an overall rating.

9 I think the timing of when the concerns were raised
10 was -- was quite tricky because we needed to make sure
11 that we weren't giving any false assurances to anybody
12 and that we needed to really understand what was going
13 on, so that's why that communication took place.

14 Q. Bearing in mind what you and the other
15 Executives knew at the time, whatever the CQC said about
16 you for the reasons that you have identified in this
17 note, you shouldn't have been encouraging people to
18 think that, should you, until you got to the bottom of
19 the issues?

20 A. Sorry, could you repeat that?

21 Q. Of course -- well, let's just have a look at
22 the note, "need to understand all issues but would not
23 be good timing for Trust", so it is not just CQC but for
24 Trust "or CQC to present 'good' in light of the
25 concerns".

81

1 Q. "High level reasons expressed."
2 Is that a euphemism for saying you did not tell her
3 about the concerns of the Consultants?

4 A. We said there was a -- there was an increase
5 in mortality at that time. But again we needed to
6 understand before we could communicate more widely what
7 we were dealing with because we didn't know.

8 Q. Well, you had known that over a number of
9 days, because this is 29 June, so the concerns first
10 reached you on 24 June, following two deaths, by that
11 time you had had a proper understanding of what the
12 concerns were, didn't you?

13 A. Again, paediatricians were not clearly
14 articulating to us what the problem was. This is where
15 on the -- on that, just before that weekend, Karen Rees
16 had raised concerns with me around her communication
17 with Dr Brearey.

18 Q. They had clearly articulated that the problem
19 was Letby, hadn't they?

20 A. Without any evidence and without any facts
21 that were brought forward.

22 Q. Well, we have been through the evidence point
23 and we are not going to repeat all of that, but I had
24 understood you to accept that in fact what you had been
25 given was evidence?

83

1 So forget what the CQC there, let's just read it
2 without:

3 "... would not be good timing for Trust to present
4 'good' in light of current concerns."

5 I think what you have told us is the Trust did go
6 on to draw attention to the fact that CQC had rated them
7 "good" despite the fact you appear to be having
8 a conversation with the Chief Executive here about the
9 fact that that wouldn't be a good idea?

10 A. I think at the time, because those concerns
11 that in terms of significant harm or deliberate harm had
12 only just been highlighted, we absolutely needed to get
13 to the bottom of what was going on in terms of actions
14 being taken, reviews being undertaken, et cetera, so
15 that we could clearly communicate outwardly after that
16 what we were doing and that's what we did in terms of
17 our communication plan which came at the beginning of
18 July.

19 Q. Call to Bridget Lees, she is somebody who
20 works at CQC?

21 A. Yes.

22 Q. "High level reasons expressed."

23 Is that a euphemism for saying you did not tell her
24 about the concerns of the Consultants?

25 A. Sorry, repeat that?

82

1 A. I think it was just really difficult at the
2 time to -- to recognise what was being -- what was being
3 accused -- what was being alleged -- alleged, sorry.

4 But what in the context of the CQC, what we needed
5 to be really clear about was a full action plan of
6 understanding what was going on. And that was taking
7 into consideration the release of the report for the
8 organisation.

9 Q. In terms of this action plan they need to
10 understand what concerns you are investigating in order
11 to be able to make sense of your action plan, don't
12 they?

13 A. Yes.

14 Q. Well, let's -- you see that effectively what's
15 being said is that the process is automated so
16 presumably the report is going to be released, come what
17 may?

18 A. Yes.

19 Q. And you go on to say you need to talk to
20 Ann Ford, which is what you did the following day; is
21 that right?

22 A. Yes.

23 Q. We can see your email as a way of looking at
24 matters in the way you discuss, INQ0017411.

25 So we don't need to go through all of the detail of

84

1 this. We can deal with it in this way: you don't in
2 that email to Ann Ford say anything about the fact the
3 Consultants are concerned about a particular member of
4 staff, do you?

5 **A.** No.

6 **Q.** That was one of the reasons for you acting as
7 you did, the fact that they had raised those concerns?

8 **A.** We just needed to make sure that we had
9 clarity of the issues in order to have a clear
10 communication plan to our regulators --

11 **Q.** Can I just --

12 **A.** At that time --

13 **Q.** Ask you to focus on my question.

14 The concerns of the Consultants was part of the
15 reason for why you acted as you did?

16 **A.** In which respect?

17 **Q.** Well, in terms of the action plan you
18 developed.

19 **A.** Yes, there were a number of actions that were
20 being taken on the back of their concerns.

21 **Q.** So if we now look at how you framed it in the
22 email, the third paragraph begins: for this reason ...

23 So you set out what the problem is and then you say
24 for this reason we are doing X, Y and Z.

25 But in fact you have not fully articulated the

85

1 **A.** Because of increased mortality, yes.

2 **Q.** Because of the concerns of the Consultants
3 about it?

4 **A.** The Consultants did raise that, yes.

5 **Q.** Yes, and you have just missed that part out
6 when you say "for this reason"?

7 **A.** I think that's because we needed -- we weren't
8 sure about what was going on. So I think I would have
9 been criticised for misleading by putting more
10 information in as opposed to leaving things out. So we
11 just needed to get absolute clarity of what was going
12 on.

13 **Q.** Were you deliberately trying to hide from the
14 CQC what was in fact driving this whole review?

15 **A.** No.

16 **Q.** Now, you assert in this email that the
17 Thematic Review had been sent to the CQC, I will just
18 draw your attention to it, it is under the context, it
19 is the last sentence:

20 "However, the reviews have failed to identify any
21 cause or common theme for this increase (these reviews
22 were submitted as part of our recent CQC inspection data
23 pack)."

24 **A.** Yes, I --

25 **Q.** Can I just ask the question?

87

1 reason, have you, in the previous paragraph because you
2 haven't explained that part of the reason why you are
3 acting as you are is because of the concerns of the
4 Consultants, do you agree?

5 **A.** Because the mortality rate had been raised as
6 a problem, we felt we needed to get a wider view of what
7 was going on as opposed to directing it through Letby.

8 **Q.** Please just focus on what I am asking you.

9 You give a list of events or pieces of information, the
10 increase in deaths, in-depth review, didn't identify
11 cause, theme for this increase and then you say "for
12 this reason ..."

13 But what you have skipped out there is the fact
14 that this whole reaction, the extent of it, is being
15 generated from the fact that the Consultants are saying:
16 "we are concerned about Letby".

17 Isn't that the true picture?

18 **A.** We -- as -- I think we just needed to
19 understand and get some factual evidence --

20 **Q.** Is --

21 **A.** -- and I know we have talked about the
22 evidence before.

23 **Q.** I am sorry to cut across you but just focus on
24 my question. Isn't that the true reason for why you did
25 all of those list of actions?

86

1 **A.** Sorry.

2 **Q.** Upon what did you base that assertion?

3 **A.** So I have reflected on that email and actually
4 the timing and the chronology is wrong. So in
5 preparation for the CQC visit, there would have been
6 a huge amount of data provided, probably from the
7 previous year to support the inspection, and what I have
8 written there is I thought that the Thematic Review
9 would have been shared but actually we didn't get it
10 until February, so it is an error.

11 **Q.** Wasn't it necessary for you to check before
12 you made an assertion that they had a document, that it
13 had in fact been sent to them?

14 **A.** I should have checked but I had an operational
15 team that was dealing with that, so I wasn't that close
16 to the detail at that time.

17 **Q.** Did they write this email?

18 **A.** No.

19 **Q.** So could you have asked them: can we just
20 check that the CQC have actually had the Thematic
21 Review?

22 **A.** I could have asked at the time, yes.

23 **Q.** Should you have asked them before you made
24 that assertion?

25 **A.** Possibly. I -- I felt that I was writing to

88

1 the CQC in the full knowledge that I thought they had it
2 and obviously they hadn't had it.

3 **Q.** That factual inaccuracy has the effect of
4 making the Trust appear more transparent than in fact it
5 was, do you agree?

6 **A.** I -- I disagree. It was an error, the
7 chronology was wrong.

8 **Q.** No. We have established it is an error. The
9 effect of the error is to make the Trust appear that it
10 has been more transparent than in fact it has been; do
11 you agree?

12 **A.** There was -- no, I don't agree. There was,
13 there was no intention to mislead the CQC at that time.

14 **Q.** I didn't say anything about intention. The
15 effect of it.

16 **A.** The effect of it may give that impression that
17 we were doing that yes, but that wasn't what was
18 happening at that time.

19 **Q.** I am going to move forward to
20 17 February 2017, the engagement meeting.

21 INQ0014405.

22 Let's just have a look what's said to the CQC.
23 This is a meeting that you attended:

24 "Key risk areas: neonatal services. [Mr Harvey]
25 explained that following publication this month ... the

89

1 that there were genuine transport issues across the
2 systems where babies were being transferred far too many
3 times and transferred to other hospitals.

4 **Q.** I am not suggesting that shouldn't be
5 mentioned. What about the fact that Dr Hawdon had
6 reported that there were four babies that required
7 further forensic investigation?

8 **A.** Again, as mentioned before, and I have
9 reflected on this, it may have been helpful to share
10 more with our regulators at the time but we -- it was
11 a really complex set of circumstances that we were
12 trying to get answers to lots of questions and certainly
13 at that time nothing was leading down a route to
14 somebody deliberately harming babies.

15 **Q.** What -- well --

16 **A.** But we perhaps should have shared a bit more
17 information at that time, but we were still gathering
18 the information internally.

19 **Q.** A Consultant neonatologist had been instructed
20 to look at a number of cases and had come back and said
21 that there were four that required further
22 investigation.

23 We don't see any hint of that being communicated to
24 the CQC, do we?

25 **A.** Not at that time, no.
91

1 parents of children that were contactable were informed
2 and the report had been shared with them and key
3 stakeholders. The Coroner has been involved and there
4 are plans to discuss the report further with the
5 paediatricians. Plans for staff include attending
6 Alder Hey to help maintain competencies."

7 So let's just have a look at that. Firstly the
8 plans for staff include attending Alder Hey, is that
9 a reference to how Letby's competency was going to be
10 maintained?

11 **A.** I -- I don't recall that was anything to do
12 with Letby, no. I think there was a conversation with
13 Eirian Powell as the unit manager about how we could
14 make sure that skills were being maintained by staff on
15 the unit as we had downgraded the unit and they were
16 worried that they were going to be deskilled. So
17 I think Eirian was -- had plans in place to make sure
18 there was ...

19 **Q.** "There are lessons to be learned around
20 transport processes and in the incident reporting
21 system."

22 Now, do you think that what the CQC were being told
23 there was a misleading characterisation of in fact what
24 was going on at the Trust at that time?

25 **A.** I don't think any of that is misleading in
90

1 **Q.** Should the CQC have been told that fact?

2 **A.** I think it's because we were again still very
3 unclear and what we know from the Royal College report
4 was that -- and further with the Hawdon report that
5 there was significant care issues but again we were
6 pulling together all the strands of the information to
7 try and get a picture ourselves before we shared that
8 with our regulators.

9 **Q.** There was nothing inappropriate about saying
10 that a Consultant neonatologist had recommended more
11 investigation for four babies, was there?

12 **A.** We could -- we could have said that but we
13 didn't have any answers at the time so ...

14 **Q.** Well, you haven't had the answer. According
15 to you, you haven't had the answer at any point in this
16 process but you are telling them what you are doing but
17 you haven't revealed that fact, have you?

18 **A.** Not in that meeting, but that wasn't done with
19 any -- any ill intention.

20 **Q.** Well --

21 **A.** It was a high level meeting.

22 **Q.** Let's have a look and see what was on the
23 Executives's minds three days earlier, INQ0003379. So
24 this is the Executive Directors Group meeting and we can
25 see right or just a couple of lines below the centre, do

92

1 you see the word "firmer position"?

2 **A.** Whereabouts are you looking, sorry?

3 **Q.** It is highlighted on your screen.

4 **A.** Oh.

5 **Q.** So this is a record of the fact that the

6 Consultants were saying --

7 **A.** Sorry, can I just read a little bit above that

8 email?

9 **Q.** Of course you can.

10 **A.** Note, sorry. (Pause)

11 Okay.

12 **Q.** So at this meeting what was being discussed by

13 the Executives was the Consultants were -- had adopted

14 a firmer position in light of all the reports that had

15 been done to that date and they were asserting "not

16 natural causes", that is the natural reading of this

17 note, do you agree?

18 **A.** Yes.

19 **Q.** So that's what you are talking about

20 three days before going into the CQC and there is not

21 a hint of that given to the CQC, is there?

22 **A.** I think at that time we -- it was becoming

23 more and more apparent that there were significant care

24 issues and I know at the time the paediatricians

25 challenged the recommendations of the Royal College

93

1 **A.** We, we did tell the CQC but we didn't give

2 them that level of detail because we didn't know

3 ourselves at that time. We needed to pull all of those

4 elements together to be able to articulate what was

5 actually going on and it was a complex picture and in

6 reflection, perhaps more information should have been

7 shared at that time, there was an opportunity in that

8 engagement meeting.

9 But we didn't fully understand or we needed further

10 review by from the recommendations of -- of Dr Hawdon,

11 we needed to understand what the outcomes of that were

12 going to be so that we could have fuller details to

13 share in the CQC.

14 **Q.** I mean, do you agree in terms of an overview

15 here because we are seeing this emerging time and time

16 again that consistently what other external bodies are

17 being told is everything but the Consultants' concerns,

18 do you think that's a fair characterisation of the

19 period up until the end of May -- end of April 2017?

20 **A.** I think we were really clear in the

21 communication plan in July 16 that we told all of our

22 regulators about an increase in mortality.

23 **Q.** Can I just ask you to focus upon my question.

24 Do you agree that what is happening to all of these

25 external bodies is you are telling them everything apart

95

1 report.

2 **Q.** Significant --

3 **A.** And the fact that all those -- all those

4 babies -- well, the majority of those babies had

5 postmortems as well, so it was -- it was becoming

6 clearer that there was more care issues than there were

7 deliberate harm issues.

8 I'm not sure the terminology "firmer position" --

9 I'm not sure what that is actually alluding to.

10 **Q.** Well, it would be to suggest that they have

11 moved from a position of saying: this may not be natural

12 causes, to: this is not natural causes. So in other

13 words, their position is firmer that would be?

14 **A.** But that wasn't reflected in the reports that

15 we were receiving --

16 **Q.** But that --

17 **A.** -- at the time.

18 **Q.** But that is what the expert Consultant body

19 are telling you their position is.

20 Now, you have said that it's becoming clearer that

21 it's care issues. We are going to come to have a look

22 at the Royal College report in due course, but whether

23 it's care issues or deliberate harm you needed to tell

24 the CQC, didn't you, what was going on in your Trust?

25 And that didn't happen, did it?

94

1 from the Consultant concerns; that that is the one piece

2 of information that is consistently missing from all of

3 these communications?

4 **A.** I think looking back then we should have

5 perhaps mentioned that as well at the time.

6 However, we were really keen to fully understand

7 what was going on. But perhaps those Consultant

8 concerns should have been mentioned in the beginning.

9 **Q.** Being really keen to fully understand what is

10 going on is the absolute opposite of the correct

11 approach to a safeguarding issue; do you agree?

12 **A.** Excuse me, say that again, sorry?

13 **Q.** Finding out absolutely everything that is

14 going on is the opposite of the approach you should take

15 in a safeguarding situation, do you agree?

16 **A.** Yes. But as I mentioned earlier, we -- I --

17 were not considering this as a safeguarding concern. We

18 were thinking of it as a mortality issue that we needed

19 to get to the bottom of and to the information that was

20 coming to light it was more about clinical outcomes as

21 opposed to an individual.

22 **Q.** The information coming to light -- and this is

23 my last question on this topic -- just before the CQC

24 meeting was your Consultant body were asserting, it

25 would seem in terms, that they did not think these

96

1 deaths were natural.

2 That was information coming to light three days
3 before the CQC meeting, wasn't it?

4 **A.** In that note that's what that implies.

5 However, despite all the work that we were doing around
6 trying to get to the bottom of the increasing mortality,
7 our clinician colleagues were not accepting that some of
8 those were -- some of those deaths had been the outcome
9 of sub optimal care.

10 **Q.** Well, they were right about that, weren't
11 they?

12 **A.** Yes, but we didn't have any proof at that time
13 but that was about unnatural causes.

14 **Q.** You don't --

15 **A.** My understanding at the time was that there
16 were no babies that were expected to die and it's not
17 until we had experts from outside the organisation to do
18 a more thorough investigation that we started to find
19 out some of the clinical issues that were happening on
20 the unit.

21 **Q.** Number 1 in the Thematic Review which we are
22 turning to now as published on 2 March was that there
23 were sudden and unexpected deteriorations in babies who
24 died?

25 **A.** Yes, that is in the report.

97

1 **Q.** Within less than an hour, as we go over the
2 page, Ms Powell sends you the Thematic Review?

3 **A.** Yes.

4 **Q.** Now, did you consider that Thematic Review
5 when you were sent it?

6 **A.** I think I did at the time, yes.

7 **Q.** Because I mean you specifically asked to see
8 it.

9 **A.** Yes.

10 **Q.** And so did you then go and have a look at the
11 appendix 1 to look at what was being said about Letby?

12 **A.** I think when I received that, I recognised
13 that Ian Harvey and I needed to discuss that at our next
14 one to one.

15 **Q.** I am so sorry, can I just ask you to focus on
16 my question.

17 When you received it, did you go to appendix 1?

18 **A.** No, I don't recall doing that, no, at the
19 time.

20 **Q.** Well, you had been told by Eirian Powell on
21 the 17th that there was a commonality and there attached
22 to the report set out exactly what that commonality was.
23 Why didn't you look at it?

24 **A.** I think in the overarching email even though
25 there had been quite a bit of work undertaken there was

99

1 **Q.** Well, let's have a look at that topic 4, March
2 to May 2016. On 17 March, you were sent a copy of the
3 Thematic Review; is that right?

4 **A.** Yes, am I able to see the email?

5 **Q.** Yes. In fact, we will go to the email first,
6 INQ0003089. In fact it is the 21st but it is -- the
7 first information is the 17th, that is my mistake.

8 So if we go to page 2. We can see that 17 March,
9 Ms Powell is saying she wants to arrange a meeting to
10 discuss how to move forward, she tells you in terms that
11 there has been an increase in mortality. Although they
12 are small numbers, it is quite a big increase, isn't it?

13 **A.** Yes.

14 **Q.** And that a commonality was that a particular
15 nurse was on duty either leading up to or during this
16 and a reference to when Letby started and a doctor was
17 also identified as a common theme, however not as many
18 as the nurse, and she goes on to say that nothing
19 obvious has been identified and therefore they want some
20 input from you.

21 You respond four days later to say: could you see
22 the report.

23 **A.** (Nods)

24 **Q.** With the plan being for a meeting to follow.

25 **A.** Yes.

98

1 nothing in that email that was drawing my attention to
2 something really serious or urgent.

3 So in terms of --

4 **Q.** Can I just ask you to pause there. You have
5 just been told that eight babies have died against
6 an expectation of two or three; is that not in and of
7 itself extremely serious?

8 **A.** It is serious but the tone of the email from
9 Eirian to meet and understand her report didn't give me
10 a sense of urgency.

11 **Q.** Well, do you think bearing in mind her next
12 fact was to draw attention to the fact that discussed at
13 a local level was the association of a member of staff
14 that that was immediately something that you should pay
15 close attention to?

16 **A.** Yes, at the time, because she drew my
17 attention to it in that email.

18 **Q.** You should have paid close attention to it
19 from the very start, shouldn't you?

20 **A.** Yes, and I am not -- I am not making excuses,
21 but this will have been one email in amongst hundreds of
22 emails that I would have received and I would not be
23 able to open every attachment for every email that
24 I would have received.

25 **Q.** This is -- this is your job, isn't it?

100

1 A. It is my job, yes.
 2 Q. It's a very important and serious job, do you
 3 agree?
 4 A. My job as a Director of Nursing?
 5 Q. Yes.
 6 A. Yes.
 7 Q. It's a well-paid job?
 8 A. Yes.
 9 Q. You had enough information in that email of
 10 the 17th to see that there was something serious to be
 11 investigated, do you agree?
 12 A. Yes.
 13 Q. You then went to the trouble of asking for the
 14 report so that you could get some more information but
 15 do we understand that from your reference to the fact
 16 you get a lot of emails and can't open every attachment
 17 that you didn't actually open it, is that why you told
 18 us that?
 19 A. I am just putting context into --
 20 Q. Well --
 21 A. -- workload at the time.
 22 Q. Well, did you open the email -- the
 23 attachment?
 24 A. I did, but I can't recall when I did.
 25 Q. Does that rather tend to suggest that you did

101

1 A. I don't recall why there was such a time
 2 delay. Again, lots of things going on in the
 3 organisation at the time and the context of a Director
 4 of Nursing's workload is -- is huge.
 5 Q. Was it your responsibility -- I'm sorry, I cut
 6 across you. You finish your answer please?
 7 A. So there will be many emails that would be
 8 requiring me to open attachments over that period of
 9 time.
 10 Q. Was it your responsibility to ensure that
 11 there was a faster response than in fact you gave in
 12 this situation?
 13 A. I -- I recognise there could have been
 14 a faster response.
 15 Q. To put it bluntly, were you too slow to
 16 acknowledge and act upon these concerns?
 17 A. I think at the time, and I have reflected on
 18 this, because it does feel that it's a big delay, it --
 19 it could have been looked at in a much more timely way.
 20 Q. Again just focus on my question. Were you too
 21 slow?
 22 A. I don't think I was, to be honest. I think if
 23 -- if somebody's got something so urgent they want me to
 24 see then why not come to my office or why not phone me
 25 up?

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1 not take it seriously enough?
 2 A. I did take it seriously because I needed to
 3 discuss that with Mr Harvey, which we then had
 4 a follow-up one-to-one where we I think discussed the
 5 report.
 6 Q. Whether or not you treated it seriously my
 7 question was: did you treat it seriously enough?
 8 A. I think with the overarching email as
 9 I mentioned earlier, there wasn't anything that was
 10 telling me you need to open that attachment and have
 11 a look in terms of urgent action required.
 12 Q. Because you don't from this thread appear to
 13 have even acknowledged Ms Powell having sent you the
 14 email because some 24 days later, she has to follow up.
 15 Do you see that?
 16 A. Is that the -- oh 14 April. And -- and that
 17 was obviously not a full final report because the
 18 medical team details were not included.
 19 Q. It was presented to you as the full final
 20 report, there was no indication that it wasn't.
 21 Eirian Powell chose to update it but at the time that
 22 you received it on 21 March, you had no reason to think
 23 that it was other than the final version and for 24
 24 days, it would appear nothing happened. Is that a fair
 25 description of what --

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1 Q. Well --
 2 A. So unfortunately with emails everything gets
 3 lost in hundreds of emails that everybody gets every
 4 day. However, there's a number of weeks there that that
 5 hadn't been addressed that Eirian, nor Dr Brearey, came
 6 to seek out Ian Harvey or I.
 7 Q. Rather than pointing at what other people
 8 might have done, which is for them to answer, should you
 9 have been more attentive to this than you were?
 10 A. Looking back now, maybe I should have been,
 11 yes.
 12 Q. So you get a prompt on 14 April, which
 13 includes the medical team and that's the document, as
 14 the Inquiry understands it, that has names in red?
 15 A. Yes.
 16 Q. Yes. INQ0003277. Now, do you agree that
 17 anybody who even opens the first -- that attachment and
 18 looks at the first page would immediately see that
 19 a person's name is in red?
 20 A. Yes.
 21 Q. You can't fail to notice that. It jumps out
 22 off the page, doesn't it?
 23 A. Yes.
 24 Q. Now, that was sent to you on the 14th. On the
 25 28th, so 14 days later, your secretary arranged

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1 a meeting for 4 May?

2 **A.** Yes.

3 **Q.** So that is 14 days after you received this
4 where you have been chased as you said you would expect
5 if it was urgent, and nothing appears to happen to bring
6 this to a head; is that a fair summary of those 14 days?

7 **A.** There had been a time delay and I don't know
8 with not having access to my diary why that took so long
9 to start having a meeting.

10 **Q.** Well, would anything other than ordinary
11 hospital business be what you would discern from that
12 diary?

13 **A.** Yes.

14 **Q.** There would be other things potentially?

15 **A.** There would be lots of things going on across
16 the hospital.

17 **Q.** That weren't ordinary hospital business?

18 **A.** I don't understand, sorry.

19 **Q.** Well, you have got a job to do and it's a busy
20 job?

21 **A.** Yes.

22 **Q.** I am just trying to understand what you think
23 your diary, how that would shed light on why, over
24 a 14-day period it would appear that there hasn't been
25 a response to a chasing email sending you a document

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1 then sends you another document with Letby's name in red
2 and your position is you didn't click on the attachment
3 on 14 April just to see what it was all about?

4 **A.** I think there was the report and then there
5 was a staffing document and embedded in the report,
6 I think if I have got the right version because there
7 were a number of versions, I think there were 16
8 embedded documents. I would not have had time to look
9 at all of those.

10 **Q.** On 14 April there was one document, as we
11 understand it, it was this one. It requires
12 five seconds to click on it, on an issue that had gone
13 cold since March.

14 **A.** And I believe there was doctors highlighted in
15 red in that report as well.

16 **Q.** But you wouldn't have known that, you tell us,
17 because you didn't click on it?

18 **A.** No, probably not at the time no, I don't
19 recall that.

20 **Q.** Was it an unacceptable failing on your part
21 bearing in mind what you had been told in the thread
22 which you just had to scroll down to see the context
23 that you did not open this document at the time?

24 **A.** I can't recall when I opened the document.
25 But if it was something so urgent, knowing the busy

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1 with somebody's name in red and it's really what you are
2 anticipating that diary might have revealed that would
3 be capable of explaining that 14 days?

4 **A.** I have not had access to my diary for this
5 Inquiry so I am not able to comment on that. However,
6 I think you will -- I am sure you will be coming to
7 subsequent emails. What I hadn't appreciated at the
8 time, because I didn't have time to open the appendix
9 for the staffing, was the text that was in red because
10 the previous reports that were being sent to Ian Harvey
11 and I had no red text in it at all and were not raising
12 any concerns about any issues.

13 **Q.** This one that was sent to you on 14 April did
14 have red text?

15 **A.** It did, yes.

16 **Q.** Yes, and nothing happened for 14 days, it
17 would appear?

18 **A.** No, and from that perspective I can only
19 imagine that I didn't have time to open the appendix for
20 the staffing.

21 **Q.** So just the whole thread starts with
22 Eirian Powell saying she wants your help, that the
23 context is too many dead babies and that a member of
24 staff has been identified.

25 She then sends you the report, 24 days go by, she
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1 portfolio that a Director of Nursing has, I'm not sure
2 why others did not approach me directly or Ian Harvey to
3 say: we absolutely need a meeting, like this afternoon.

4 People have done that before, they have come to
5 stand at my office and say: we have got a serious
6 concern, I need to speak to you.

7 So having this buried in an inbox, it is not a good
8 excuse but I can honestly say I can't remember at what
9 point I opened that document.

10 **Q.** 4 May, Dr Brearey emails you when it appears
11 the meeting can't go ahead at its scheduled time
12 INQ0003138. Scroll down, please.

13 He tells you in terms:

14 "There is a nurse on the unit who has been present
15 for quite a few deaths and other arrests. Eirian has
16 sensibly put her on day shifts at the moment but can't
17 do this indefinitely. It would be very helpful to meet
18 before she is due to go back on night shifts. there is
19 some pressure regarding staffing levels with this at the
20 moment."

21 So Dr Brearey is telling you, in terms, that there
22 is a particular nurse who is associated for quite a few
23 deaths; is that right?

24 **A.** That's -- yes, that's what he is saying to me.

25 **Q.** That is exactly you were told by Eirian Powell
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1 in March?

2 **A.** That email though does not strike me as having
3 an urgent issue. In fact, it refers to staffing and it
4 feels like there is a staffing issue as opposed to any
5 issue with that individual's practice.

6 **Q.** Ms Kelly, it's very important that you just
7 focus upon my question. My question was: that was the
8 same information that you had been given in March by
9 Eirian Powell, I didn't ask you anything about the tone
10 of this email, so just please focus.

11 We have got a lot to get through. Can you answer
12 my question, please?

13 **A.** That, yes, that was a topic that was in that
14 report in March.

15 **Q.** Let's go over the page. Your reply, not to
16 Dr Brearey, but this is forwarding it would appear it on
17 to Karen Rees, copying in Sian Williams.

18 "Aah!! Please can you look at this with
19 Anne M/Eirian -- if there is a staff trend here and we
20 have already changed her shift patterns because of this,
21 then this is potentially very serious!! I will check
22 the report they sent through. I did not notice there
23 was a staff trend!!"

24 Now, firstly, you had been told about the trend by
25 Eirian Powell, hadn't you, in March?

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1 **Q.** And we can see here that you then do open that
2 attachment:

3 "Please see attached ... Lucy Letby highlighted in
4 red!! I have not noticed this when I first reviewed."

5 But if what you are telling us is right, you hadn't
6 in fact reviewed it?

7 **A.** I can't be certain.

8 **Q.** Well, in which case that would be a lie,
9 wouldn't it? If you hadn't -- I mean, if you hadn't
10 reviewed it and you were writing, "I have not noticed
11 this when I first reviewed", you would be lying,
12 wouldn't you?

13 **A.** I don't lie.

14 **Q.** Okay. Well --

15 **A.** There's the report and there's an attachment
16 to the report. I have probably looked at the report and
17 not fully appreciated the elements in red which were in
18 the staffing element.

19 **Q.** Well, we have already established that if you
20 had clicked on the staffing trend, which has the red
21 name in, you would immediately see the name in red. You
22 can't miss it.

23 **A.** No.

24 **Q.** So I am just trying to understand why it is
25 that you are telling your subordinates that you had

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1 **A.** Yes, as part of that original report.

2 **Q.** And if you had clicked upon the report, you
3 would have seen it was sent to you in April, the trend
4 was there marked in red, wouldn't you?

5 **A.** Yes, and I don't recall seeing that report in
6 red.

7 **Q.** So when you say "I did not notice", was that
8 you concealing the fact that you had not looked?

9 **A.** Absolutely -- I don't recall seeing the
10 version with the red text at that -- I don't know what
11 time I opened that document, but I hadn't obviously
12 taken that in because I wouldn't have written that email
13 and when I did, I was quite concerned.

14 **Q.** Yes, but I'm just asking you to focus on the
15 language. "I did not notice" suggests that you opened
16 it and didn't see it?

17 **A.** The staffing attachment?

18 **Q.** Yes.

19 **A.** Yes.

20 **Q.** But in fact you tell us you don't think you
21 opened it.

22 **A.** I don't recall. I don't recall seeing that.

23 **Q.** So a truthful way of expressing that was:
24 I hadn't looked at the attachment until now?

25 **A.** I can't be certain when I looked at that.

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1 reviewed that document but not noticed it.

2 **A.** Probably the first part of the Thematic
3 Review.

4 **Q.** But you are talking here about the document
5 where Letby's name is in red.

6 **A.** I just -- I don't recall. I just don't
7 recall.

8 **Q.** Is it possible that you were seeking to
9 conceal the fact that you had not paid adequate
10 attention to this by claiming to have reviewed
11 a document that you had not reviewed?

12 **A.** I wasn't -- I wasn't concealing anything.

13 I think, and again it's not an excuse, but the
14 workload of an Executive Director in a 600-bedded
15 hospital is huge and there will be documents that I will
16 have opened and not fully taken consideration of.

17 **Q.** Can we just be clear --

18 **A.** I did not, I did not realise the text in red.

19 **Q.** You have spoken in general terms. This
20 document, which you have agreed anybody opening it could
21 immediately see that Letby's name in red, that doesn't
22 fall into the category that you are talking about, does
23 it, when you make that generalised assertion; that some
24 documents you may have opened and not looked at in
25 detail?

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1 A. I -- I don't recall.

2 Q. And you then sent a message to Mr Harvey,
3 INQ0003087.

4 We can see that at the top unfortunately the date
5 doesn't appear reproduced on it, but we can say it's
6 some time after 4 May:

7 "Please see Steve's comments below which alarmed
8 me!! Since receiving this I have asked Karen Rees to
9 liaise with Eirian regarding this particular nurse
10 (Eirian's further review is attached for info), I am
11 currently reassured that there are no issues but I think
12 it's worthy of wider review hence our planned meeting."

13 Now, wasn't it a little premature to reach the
14 conclusion that there were no issues?

15 A. I'm unsure as to what Eirian and Karen had fed
16 back to me.

17 Q. Well, you hadn't heard from Dr Brearey
18 about -- and he was the person who had the concerns?

19 A. Again, you know, I would expect Dr Brearey to
20 have come to see me personally if he had had
21 a significant issue with a nurse on the unit.

22 Q. And does the fact that a person has not come
23 to see you personally mean that there are no issues?

24 A. No, not necessarily. But an email trail being
25 used as a way of escalation isn't sometimes effective as

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1 I'm just wondering whether even at this stage
2 things had become a little adversarial, do you have any
3 comment upon that?

4 A. No, not adversarial. I think we felt at the
5 time there was still a view that nobody had seen
6 anything, there had been no results provided to us,
7 there was nothing that suggested that there was anything
8 sinister going on and when --

9 Q. Can I just pause you there. We've been
10 through it. Nothing that suggested nothing sinister was
11 going on. More babies had died was something that may
12 indicate that something sinister was going on, do you
13 agree?

14 A. I would push back on that because on the
15 Thematic Review what is really clear on there is that
16 there were significant care issues, there were
17 competency issues.

18 So that was starting to build a picture of, of what
19 we were trying to understand around the reasons for our
20 increased mortality.

21 No -- so when I mean "no hard evidence" there was
22 no physical evidence or anything that anybody could show
23 us that was a problem.

24 Q. I'm just wondering if you are setting the bar
25 too high at that point if you are requiring hard

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1 it can be just because of the volume that you receive.

2 And also the way in which it's articulated in the email,
3 this didn't raise any concerns to me at that time.

4 Q. So let's go back to where I started about this
5 email. Was it premature for you to be saying that you
6 were reassured that there are no concerns -- or no
7 issues, forgive me?

8 A. There will have been a reason why I wrote
9 that. So I'm assuming that I was already told that
10 there were no issues with that particular individual.

11 Q. But that was before you had even heard what
12 Dr Brearey had to say about it and he was the one who
13 had pushed for the meeting in the email below.
14 Shouldn't you have heard from Dr Brearey before you
15 reached that conclusion?

16 A. Possibly, yes.

17 Q. And really what it comes to is do you think
18 there's a possibility that you went into the meeting on
19 11 May close-minded?

20 A. No.

21 Q. Let's have a look, INQ0015537, page 3. We
22 have already covered this meeting of 11 May.

23 I just want to ask you a question about one of the
24 notes that you made, bottom left-hand corner:

25 "No hard evidence."

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1 evidence at this stage to respond to a risk?

2 A. I think that was done in, in -- also in the
3 context of babies had had postmortems, there were
4 outcomes that were -- that the Coroner was satisfied
5 with.

6 There were a number of different things that were
7 going on, but still the clinicians were finding it very
8 difficult to -- to give us examples of what was actually
9 being done to harm babies as opposed to an association
10 with one individual.

11 Q. If there really was a murderer on your unit,
12 why would the clinicians necessarily have seen or heard
13 anything because such a person is going to act in
14 a covert way, aren't they?

15 A. Yes, but, when you have things reported to you
16 as in "we have a gut feeling", "I have a drawer of doom"
17 information that can't be shared, it -- it doesn't give
18 you confidence that we are getting the information that
19 we need.

20 Q. You have mentioned the drawer of doom. You
21 were the -- an Executive Director. If that was
22 troubling you, did you ever say to Dr Brearey: I need to
23 see in your drawer of doom?

24 A. Not personally, no.

25 Q. No, and you had the authority to do that,

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1 didn't you?

2 **A.** I could have done, yes, in conjunction with
3 the Medical Director.

4 **Q.** So I am just wondering how troubled at the
5 time you were about this drawer of doom because if you
6 were taking it seriously presumably you would have said,
7 "I want to see what's in that drawer."

8 **A.** Yes, at the time. But again I was relying at
9 that time with Karen Rees who was our -- my Head of
10 Nursing who had had detailed conversations with
11 Dr Brearey about that.

12 **Q.** But she didn't have the authority to do what
13 you as an Executive had the authority to do?

14 **A.** No, but I discharged my duty through my --
15 through my leadership team. So I would have expected
16 her to have done that as well.

17 I could have done it, but I can't do all actions.

18 **Q.** Well, if, if a nurse manager says to a doctor,
19 "I want to see the material you have got" and the doctor
20 says no, all that that nurse manager can do is come up
21 to the very top of the hospital, the Executives and say,
22 "I can't get access to it."

23 At that point, isn't it over to the Executives and
24 in particular you as her line manager to say, "Well, if
25 there's a drawer which has all this evidence in I want

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1 information which, which again troubled me a bit.

2 **Q.** Why didn't you say, if they weren't being
3 forthcoming, "I understand you have paperwork that
4 supports this. Bring it to me."

5 **A.** Yes, I should have done that the week after.

6 **Q.** Well, and is that -- the reason that you
7 didn't because you just weren't taking this seriously
8 enough?

9 **A.** I absolutely was taking it seriously.

10 **Q.** What other explanation do you have for why you
11 did not request written evidence which you understood
12 was being said existed?

13 **A.** On that Friday, I think we were all a little
14 bit bewildered really in terms of trying to get our
15 heads round what had actually been said.

16 There were actions put in place by Karen Rees that
17 were fed back to me and felt that was proportionate and
18 appropriate at the time and that I would discuss that
19 with Ian Harvey on the Monday morning.

20 **Q.** Well, did Ian Harvey tell you that you
21 shouldn't ask for the contents of --

22 **A.** I don't recall the detail because we needed to
23 then go to the meeting where we spoke to Dr Jayaram and
24 Dr Brearey later on that day. I can't recall having
25 a conversation about shall we speak to Dr Brearey about

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1 to see it."

2 **A.** Yes, and, and I had a conversation with
3 Ian Harvey on that, on the Monday afterwards, and
4 I believe that the clinicians on that Friday evening
5 went home and that's when Karen raised her concerns with
6 me.

7 **Q.** Did you say to Dr Brearey, "I need to see
8 what's in that evidence drawer."

9 **A.** No, not directly.

10 **Q.** Why didn't you do that?

11 **A.** It was a very random thing to have shared and
12 I am not quite sure what I thought at the time because
13 I didn't know whether that was a figure of speech or
14 whether it actually was a drawer with documents in it
15 that wasn't being shared. So that's why I needed to
16 speak to Mr Harvey, which we did on the Monday, and
17 I was satisfied with Karen's response to me about her
18 discussion with Dr Brearey at that time.

19 **Q.** You see, the drawer of doom is used as a way
20 of discrediting the doctors, isn't it, that they are
21 talking in this ridiculous language that they won't
22 share. That's where this sits in this piece, isn't it?

23 **A.** I just thought it was a very odd thing to say.
24 It's nothing you would think a Consultant would say and
25 when they were challenged they wouldn't share any

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1 it. But he was made aware.

2 **Q.** Did you think he was lying, Dr Brearey, when
3 he said that he had evidence in his drawer?

4 **A.** I -- I didn't know what to think. I didn't
5 know what to think. It just seemed a very unusual thing
6 to say.

7 **Q.** And he having said that he had written
8 evidence, was it an unusual thing that you never asked
9 to see it?

10 **A.** I -- I don't know. I -- like I say, at the
11 time I didn't know whether it was actually a physical
12 drawer or whether it was a figure of speech and
13 Karen Rees I know had had detailed conversations about
14 that and he refused to give any detail over. So it --
15 it was a very odd situation and a very odd set of
16 circumstances that we needed to reflect on over the
17 weekend and then have a conversation on the Monday.

18 **MR DE LA POER:** My Lady, I am about to change
19 topic. I wonder if we could break at this stage and
20 could I ask for a shorter than normal lunch break so as
21 to ensure that we make the maximum use of today, please.

22 **LADY JUSTICE THIRLWALL:** Yes. Will 40 minutes be
23 sufficient?

24 **MR DE LA POER:** Yes, I hope so.

25 **LADY JUSTICE THIRLWALL:** So that means coming back
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1 at 25 to 2. So we will take a break now.

2 (12.55 pm)

3 (The luncheon adjournment)

4 (1.35 pm)

5 LADY JUSTICE THIRLWALL: Yes.

6 MR DE LA POER: Ms Kelly, we are going to resume by

7 looking at the period immediately following the deaths
8 of Child O and Child P. Now, we know that Child P died
9 at 4 o'clock on 24 June of 2016.

10 You were spoken to about the neonatal unit at some
11 point on 24 June; is that right?

12 A. That's correct.

13 Q. It's your position as you set out in your
14 statement that you believe that was after the death of
15 Child P?

16 A. I think so, yes.

17 Q. We don't need to go into the reasons but how
18 confident are you that it was after 4 o'clock?

19 A. I am not that confident. I know it was late
20 on a Friday afternoon, but I can't be certain of the
21 time.

22 Q. Whenever it was, the first you knew about
23 problems on the 24th was from Karen Rees; is that right?

24 A. That's correct.

25 Q. She told you that two Consultants suggested to
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1 explained what the context was?

2 A. Friday evening.

3 Q. Here at that moment, at the very least Child O
4 may have been murdered by Letby is what you were being
5 told?

6 A. I am not certain when I was told about Baby O
7 in terms of the time of death but what I do know is on
8 that Friday afternoon, Karen Rees did come to speak to
9 me very concerned about what she had been told from the
10 doctors.

11 Q. Which was that they were concerned that Letby
12 was intentionally harming babies?

13 A. Yes.

14 Q. That was in the context, the trigger for them
15 saying that was a death the day before?

16 A. Yes.

17 Q. So again just focusing on my question, what
18 was being said to you was that two Consultants were
19 concerned that Letby may have murdered Child O, isn't
20 that what you were being told?

21 A. Yes. But not in those terms. Not directly.

22 That was the problem. There was no clear articulation
23 of the facts and how that was -- how they were coming to
24 that conclusion.

25 Q. But that was the conclusion you were being
123

1 her that Letby was intentionally harming babies?

2 A. Yes.

3 Q. And that allegation was being made in the
4 context of at least one very recent death that you were
5 told about; is that right?

6 A. Yes.

7 Q. Because you were at least told about the death
8 of Child O, whether or not you were told about the death
9 of Child P at that stage?

10 A. I think so, yes.

11 Q. So the context here is that you had left
12 things on 11 May with a "watch and wait" approach and
13 that you needed to be notified if there were any sudden
14 unexpected deteriorations. You are then told a death
15 has occurred and that two Consultants, the clinical lead
16 for the paediatric department and the neonatal unit lead
17 were both saying, in terms, that Letby may be
18 responsible for that death; is that right?

19 A. Yes.

20 Q. So this required immediate action, did it,
21 from you?

22 A. Which period of time are we talking about?

23 Q. When Karen Rees told you?

24 A. Oh, Karen Rees spoke to me.

25 Q. That is what we are focused on, we have
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1 told that they had reached?

2 A. From their perspective, yes.

3 Q. Yes, and so that requires immediate action
4 from you, do you agree?

5 A. Yes.

6 Q. What immediate action, which is to say what
7 you did immediately being told that information, did you
8 take?

9 A. Karen Rees and I had a conversation, I can't
10 remember the sequencing but I think she -- she had been
11 back to the unit to find out what the plan was for the
12 weekend in terms of staffing.

13 Q. Just pause there. You finished your
14 conversation with Karen Rees. Who, if anybody, did you
15 pick up the phone to speak to, or did you go out of your
16 office to speak to, to action, to act upon this concern?

17 A. Personally I didn't do anything after I spoke
18 to Karen because as I mentioned before my duties are
19 discharged to my team, I -- I have Karen Rees held in
20 very high regard. She was going to do a set of actions
21 and I was happy with that.

22 Q. This is a concern of the highest degree of
23 magnitude, isn't it?

24 A. It will -- there were concerns being raised,
25 yes.

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1 Q. No, listen to my question please.
2 This is a concern of the highest degree of
3 magnitude, wasn't it?

4 A. It was a serious concern, yes.

5 Q. You don't accept the characterisation "highest
6 degree of magnitude"; very, very serious?

7 A. It -- it was very serious but Karen having
8 spoken to me I felt we were doing the right things that
9 evening.

10 Q. Well, and did you discover that Letby was due
11 to work?

12 A. No, I was unaware of that.

13 Q. Did you ask Karen Rees to find out if Letby
14 was due to work?

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

16 Q. You have just been told that Letby may be
17 responsible for a murder the previous day and that was
18 the sincere view of two very senior Consultants.

19 Why was your first step not to find out if she was
20 working the next day?

21 A. Because I know that Karen had had
22 a conversation with the unit and I had made
23 an assumption that everything was okay, I had some
24 assurance from Karen that there was no issues with the
25 team over the weekend. She put some additional resource

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1 they thought Letby was a risk.

2 Q. I think we have established that you made no
3 effort yourself to go and find out why these two senior
4 doctors thought that a member of staff may have murdered
5 a baby in the previous 24 hours?

6 A. Not at that time, no.

7 Q. Well, you don't take any step to ensure that
8 Letby can't harm any more babies; you don't take any
9 step yourself to speak to anybody about it; and you
10 don't take any step to get to the bottom from the
11 horse's mouth, from the Consultants themselves, why they
12 thought what they thought.

13 Doesn't that just indicate that you just didn't
14 take this seriously enough?

15 A. I was taking it seriously, but as a director
16 you do not do every single action that's required of
17 you. You have a team to do that. I was satisfied with
18 Karen Rees' approach, we had a conversation, we had
19 a further conversation later that evening because that's
20 when Dr Brearey and Karen Rees had a conversation on the
21 telephone and I was satisfied by the actions that were
22 being taken over the weekend, I recognise I didn't ask
23 the specific question: is Letby working tomorrow? I had
24 that assurance from Karen that staffing had been
25 reviewed and everyone was satisfied.

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1 in place. So I was satisfied with the actions that she
2 had taken that evening.

3 Q. What additional resource could be put in place
4 if Letby had been determined to murder over the weekend?

5 A. There was additional supervision provided for
6 the whole of the neonatal unit, but there had already
7 been some assurances from -- it wasn't Eirian, actually,
8 it was Yvonne Griffiths I think that was on duty, that
9 they didn't have any concerns about staff over the
10 weekend.

11 **LADY JUSTICE THIRLWALL:** Did that include Letby?

12 A. Yes, collectively.

13 **MR DE LA POER:** So the nursing staff saying they
14 are not worried about Letby working over the weekend,
15 the doctors saying they are because they think she may
16 have just killed a baby.

17 A. But.

18 Q. Should you have taken further steps at that
19 time?

20 A. I have reflected a lot about that and it was
21 just a very, very difficult time.

22 Q. Well --

23 A. But at the time I felt I had taken appropriate
24 action with Karen Rees, because we were still not
25 getting any information from the Consultants about how

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1 Yes, on reflection, I -- I -- I could have done
2 something differently and maybe that was a missed
3 opportunity.

4 Q. Everybody being satisfied: did every single
5 person who was satisfied know exactly what it was that
6 Dr Brearey and Dr Jayaram were concerned about?

7 A. When I say that, I'm talking about Karen Rees
8 and her conversation, which I don't know the detail of,
9 with Yvonne Griffiths on the unit that evening.

10 Q. This is exactly the sort of situation, isn't
11 it, that calls for an Executive Director to be involved
12 directly and personally, isn't it?

13 A. What we know now compared to what we knew then
14 you could say that, yes. But we don't have capacity as
15 Executives to do every single action and I -- I relied
16 on one my most senior nurses to understand what was
17 going on.

18 Q. What was more pressing than the suggestion by
19 two Consultants that a member of staff may just have
20 committed murder?

21 A. I just felt I needed some concrete evidence
22 because it just felt like when Karen came to speak to
23 me, it just felt like they were being quite blasé about
24 the statements that they made.

25 And, you know, it was a very difficult thing to

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1 hear. So maybe I didn't, I didn't process it as -- as
2 I should have done at the time.

3 **Q.** Is it as simple as the fact you just didn't
4 believe them?

5 **A.** I didn't not believe them; I wanted some
6 evidence.

7 **Q.** Well, why did you need -- why did you need
8 evidence to become directly and personally involved
9 yourself, wouldn't that allow you to gather evidence
10 there and then and find out if there really was a risk
11 to those babies the next day?

12 **A.** But when -- when clinicians say: I need you to
13 take that nurse off the unit and they don't give you any
14 rationale or any -- any concrete evidence, I have said
15 that before, about why, then it's quite -- that's quite
16 difficult to manage and I know we have had
17 a conversation earlier on about evidence. But I think
18 it was just really, really difficult and, you know,
19 looking back I perhaps could have done something
20 differently but at that time myself and Karen Rees
21 I felt we were taking the right action.

22 **Q.** But that action did not include taking steps
23 to protect babies if Letby posed a risk; do you accept
24 that?

25 **A.** What I didn't ask or didn't clarify was
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1 me, it felt like a number of actions were being put in
2 place. Again, persistently asking what, what evidence
3 have you got? What is the rationale for this? Have you
4 seen her doing anything? A number of questions I think
5 and there was -- there was no -- it felt one way there
6 was no information coming back.

7 **Q.** But the person you are asking is not the
8 person with the answers. The person with the answers is
9 Dr Jayaram or Dr Brearey.

10 Just for the final time on this topic, why not just
11 pick up the phone to them and say: this is your
12 Executive Director, the safeguarding lead, phoning you.
13 You want somebody off the ward, you think that she may
14 have committed murder, tell me about it?

15 **A.** Yes, on reflection I -- I perhaps should have
16 done something differently.

17 **Q.** On the 26 June, which was a Sunday, Dr Brearey
18 invited to you a meeting with the senior paediatricians
19 where all of these matters could be told to you
20 directly; that's right, isn't it?

21 **A.** It is, yes.

22 **Q.** You didn't go to that meeting, did you?

23 **A.** No. Neither Ian Harvey or I attended that
24 meeting and I don't know why because we have not had
25 access to our diaries as part of this Inquiry.
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1 whether she was on duty the day after and I should have
2 done.

3 **Q.** So my question again, just focusing on my
4 question is: your actions did not include keeping babies
5 safe from Letby if she posed a risk?

6 **A.** That -- that is difficult to hear. But I --
7 maybe I should have done something differently at that
8 time, yes.

9 **Q.** You then received another call from Karen Rees
10 at home?

11 **A.** Yes.

12 **Q.** Telling you that Dr Brearey had repeated his
13 request for Letby to be suspended?

14 **A.** Yes.

15 **Q.** Do you agree that was an opportunity for you
16 to contact Dr Brearey directly to find out what was
17 going on instead of operating through an intermediary?

18 **A.** I believe in Karen Rees' evidence that
19 Dr Brearey didn't believe that Karen had contacted me,
20 so when she spoke to me she said: don't be surprised if
21 Dr Brearey gives you a call and that call didn't
22 materialise.

23 **Q.** Didn't there come a point in the evening where
24 you should have called him?

25 **A.** Again, I think the assurances that Karen gave
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1 **Q.** Can you conceive of anything more significant
2 that was going on in the hospital at that time to
3 prevent you from going to a meeting where the
4 Consultants would have explained to you why they thought
5 Letby was murdering babies?

6 **A.** I can't comment on what else was going on in
7 the hospital at that time and I can't comment on what
8 was in my diary at that time. However, I do know that
9 we knew that we would gain feedback from that meeting
10 and myself and Ian Harvey were due to meet Dr Jayaram
11 after that meeting in the charity Babygrow meeting which
12 is what took place.

13 **Q.** I think that took place at 10 am, in fact it
14 was before that meeting?

15 **A.** Right.

16 **Q.** In which Dr Jayaram said was it was very
17 worrying and you say in your statement you felt
18 a significant shift in gravity. That is all before the
19 Consultant meeting at midday. But you just didn't go to
20 that meeting?

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

22 **Q.** For some reason you can't give us?

23 **A.** I don't know why, I haven't got access to that
24 information.

25 **Q.** I mean, would you agree it would have to be
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1 a pretty extraordinary thing that you would have to go
2 to not to prioritise going to that meeting to hear what
3 they had to say?

4 **A.** I can't comment. I honestly can't comment
5 because I don't know what else was in my diary. There
6 was lots of competing priorities across the organisation
7 and I understand what you are saying, but I am not able
8 to articulate the detail any longer any more.

9 **Q.** Again, if we just track back, what we have
10 understood that you didn't do anything immediately being
11 told Karen Rees, other than to send her back into find
12 out more. You didn't phone Dr Brearey later that day.
13 You didn't turn up to the meeting on Monday the 27th.
14 I mean one potential explanation for all of that is you
15 just weren't taking this seriously enough?

16 **A.** That's not true. I take every part of my role
17 very seriously but, I can't -- I can't comment on the
18 context that was happening at the time.

19 **Q.** There was then a meeting on the evening of
20 27 June, which you and Ian Harvey went to, together with
21 some nursing managers. Do you recall the meeting that
22 I am talking about?

23 **A.** Are we able to get that up? Is there any
24 notes?

25 **Q.** Yes, INQ0015537, this is the action plan

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1 **Q.** No, I am sure you haven't and yet without
2 having anybody present at that meeting who actually held
3 a concern or could articulate what their concern, an
4 action plan was created. Do you accept now that
5 formulating an action plan without either you or
6 Ian Harvey having heard from the Consultants yourselves
7 was not an appropriate approach?

8 **A.** It -- it would have been beneficial to have
9 them there but I'm not sure why they weren't there,
10 I can't comment on the diary request.

11 **Q.** Were they being excluded from this so that the
12 plan could be developed without reference to them?

13 **A.** No.

14 **Q.** When we look at the action plan, did any of
15 these actions that were identified address the risk in
16 the short term, in the immediate term, that the
17 Consultants had identified?

18 **A.** No. But I think there were a number of
19 actions that we could have which we did take forward --

20 **Q.** Well, Letby was still --

21 **A.** -- to support the Consultants' concerns.

22 **Q.** Well, the one action that could be taken to
23 address the Consultants' concerns that just a few days
24 earlier Letby had committed murder would have been to
25 stop Letby from working that week. You see this is the

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1 meeting, I am sure you recall it?

2 **A.** Okay.

3 **Q.** Do you remember the one I am referring to?

4 **A.** Yes, I do.

5 **Q.** Well, we can bring up the action plan and
6 page 4 is the notes that you made of it. Nobody at that
7 meeting held a concern themselves, did they?

8 **A.** No, not directly no.

9 **Q.** Nobody who held a concern was invited to that
10 meeting, were they?

11 **A.** I think what was quite tricky at the time was
12 trying to get everybody in the room at the same time
13 with knowing that Consultants have clinical commitments.
14 So that was an immediate meeting that myself, Ian and
15 Eirian Powell had and I think with the intention that
16 myself and Ian Harvey followed up with the Consultants
17 afterwards, I just think we couldn't get everybody in
18 the same meeting.

19 **Q.** Were any Consultants actually invited to that
20 meeting?

21 **A.** I'm not sure, but I think we were due to meet
22 them afterwards.

23 **Q.** Because the Inquiry hasn't seen any evidence
24 I don't believe?

25 **A.** I haven't seen any.

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1 27th which is the Monday and she was rostered to work
2 that week before she went on holiday?

3 **A.** Right. I was under the impression that she
4 wasn't in work but I have since found out by information
5 for this Inquiry that she actually was at work.

6 **Q.** Well, had anybody told you in terms: she is
7 not at work?

8 **A.** I don't recall that, no.

9 **Q.** Well, isn't the most important step you need
10 to take before do you a list of things -- a list for
11 things some time in the future is to find out what does
12 the shift pattern say so that we can see if she is going
13 to pose a risk this week.

14 **A.** Yes, and -- and Eirian should have shared that
15 information at the time.

16 **Q.** I'm sorry, who should have shared that
17 information?

18 **A.** Eirian Powell knowing the shift, knowing the
19 shift rota.

20 **Q.** Well, shouldn't you have asked?

21 **A.** Yes, I should have asked but I made
22 an assumption that she -- she wasn't in work as a run-up
23 to annual leave.

24 **Q.** What did you base that assumption on?

25 **A.** I'm not sure. I didn't ask the question.

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1 Q. Do you think that as at this meeting you had
2 lost sight of the importance of maintaining patient
3 safety that week?

4 A. No, because there's a whole host of actions
5 there --

6 Q. But --

7 A. -- that we are trying to glean what was going
8 on.

9 Q. But none of those actions are addressing the
10 risk that the Consultants have identified for you, which
11 is that she might have killed and might kill again.

12 A. I suppose we found it quite -- we found it
13 quite difficult to kind of comprehend, really. You
14 know, as a Director of Nursing, in that organisation
15 I was over nearly 1,000 nurses and midwives. The last
16 thing on my mind is that one of my nurses is -- is
17 deliberately harming children or babies or adults.

18 Q. It's not unheard of, is it?

19 A. It's not unheard of but I have to say that was
20 not in the forefront of my mind.

21 Q. No, but you certainly weren't sitting there on
22 27 June thinking: that has never ever happened before?

23 A. No.

24 Q. Here you have extremely credible,
25 knowledgeable expert people telling you that that is

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1 clear answers as to why they were so concerned.

2 Q. Is this meeting an example of where the
3 situation had degenerated into doctors versus nurses?

4 A. Sorry, say that again?

5 Q. Is this meeting an example of where the
6 situation has degenerated into doctors versus nurses?

7 A. No, not at all and throughout this process we
8 were really keen to hear a nurse's perspective and
9 a doctor's perspective and actually patient safety was
10 absolutely paramount. This was a team that before all
11 of this worked really well together and it's unfortunate
12 that because of the events that we are now talking about
13 it, it -- it became divisive between the nurses and the
14 doctors and that's -- that's not conducive to good
15 working.

16 Q. It is important that you understand that if
17 you are going to say that patient safety is paramount
18 that I am going to need to ask you for how patient
19 safety was paramount bearing in mind that this meeting
20 did not address the risk that had been communicated to
21 you?

22 A. I -- yes, I made an assumption that
23 Eirian Powell was -- was managing the risk at a unit
24 level.

25 Q. I am going to move to my sixth topic which is

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1 what they think the risk is and you don't even appear to
2 be talking about how you might address that risk?

3 A. I think at the time I was relying on my senior
4 nursing team to give me assurances on Letby,
5 particularly Eirian Powell, who knew her the best. I --
6 I would not know individual nurses on an individual
7 basis.

8 So I -- I made an assumption that everything was
9 okay on the unit and I didn't ask those questions.

10 Q. Well, how would Eirian Powell know if Letby
11 was murdering anybody?

12 A. She wouldn't have known. But she would have
13 raised concerns should she have had any concerns about
14 her as an individual and her practice. The practice bit
15 is really important because you automatically go to
16 competency, not murder.

17 Q. But that is not what we are dealing with, is
18 it? At this stage, if we focus on 27 June you were
19 dealing with murder, that's what was being suggested,
20 and Ms Powell couldn't give you any reassurance about
21 that, could she?

22 A. But when you say suggestions of murder,
23 suggestions from clinicians who could still not
24 articulate why they thought that. And that was -- that
25 was quite frustrating and maybe it's because I wanted

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1 the involvement of the police. INQ0047571.

2 This is, as we will see, a series of emails on
3 29 June. So we are going two days forward and here you
4 say that you discussed in that first sentence at the
5 bottom with Sian Williams, your deputy, the police.

6 Now, we are going to come back to Ms Williams in
7 due course, so this is at an earlier stage, before her
8 involvement with the review.

9 So there is a discussion about the police and what
10 Mr Harvey says is:

11 "My own feeling the police have been raised,
12 I think we will have to."

13 The context for all of this is Dr Saladi's email,
14 which you will remember, in which he says: I think we
15 need to report ourselves to the police?

16 A. Yes.

17 Q. So you have discussed it with Ms Williams,
18 Mr Harvey has said in terms I think we will have to, and
19 you have replied:

20 "Thanks, yes, I would agree re the police."

21 So the position seems to be although that time is
22 plainly wrong, 7.31 in the morning, for reasons I can't
23 explain to you, out of sequence, but it would seem that
24 early in the morning on the 29th, your position is the
25 police need to be involved; is that right?

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1 A. It is but I -- I don't recall the specific
2 conversation which Sian Williams, my deputy, at the
3 time.

4 Q. Well, we will not trouble ourselves about
5 that. So that's where we start on the morning of the
6 29th. We can then see that there was a meeting with the
7 paediatricians and the Executives, INQ0003371, also on
8 the same day. We will go, please, to page 3.

9 I am just going to draw your attention to two
10 parts, firstly, of these minutes and then of minutes the
11 following day.

12 We can see a note towards the top. There is
13 a discussion about Commission review, then police, or
14 police and consequences, balance needed.

15 So that appears to be a discussion that's going on
16 at that time about the police. We can also see, just
17 diverting for a moment as it's on screen, "Nurse cannot
18 be excluded".

19 Do you know why it was being said on the 29th that
20 Letby couldn't be excluded?

21 A. No, I can't recall that.

22 Q. I mean, of all the people present in the room
23 as her line manager whether ultimately she was excluded
24 would sit with you; is that right?

25 A. It would, yes.

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1 see and it's not the only time but this is our example
2 that at one point in this meeting Mr Cross at the top
3 "outline of police action".

4 Then just finally to complete these notes before
5 I ask you about what was said across these two meetings:
6 "Test hypothesis: yes, no, police."

7 So firstly I -- just if we can take that down --
8 want to ask you about what you recall Mr Cross said at
9 the time of these two meetings about the police?

10 A. I think we had a general discussion about,
11 about the police. I think throughout it all we were
12 trying to be open-minded. We did refer to Stephen Cross
13 because he had knowledge of the police from his previous
14 roles and I think there was a conversation around --
15 although I can't be absolutely accurate, I think there
16 was a conversation around what we would need to consider
17 if we phoned the police. But the level of detail
18 I can't recall.

19 Q. Well, other witnesses have told us about him
20 saying things like "blue and white tape", "neonatal unit
21 a crime scene", that sort of thing. Do you have any
22 recollection of him saying anything like that?

23 A. I'm not sure about the words "crime scene".
24 I think it was more around how would we manage a police
25 investigation in terms of messaging to families,

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1 Q. Does it seem likely that you are saying to
2 this meeting "nurse cannot be excluded"?

3 A. I may have done but I can't recall it doesn't
4 say who -- who actually said that in those notes.

5 Q. No, but it's unlikely that others at the
6 meeting would be asserting in terms she couldn't be
7 excluded?

8 A. Not necessarily because as an Executive Team
9 we work really cohesively and so we -- we freely spoke
10 about each other's portfolios so, I mean, you would
11 directly think that would be attributed to me, but I'm
12 not sure.

13 Q. We will go over to the meeting the following
14 day. We are staying with this idea of the police, so
15 just we can see there INQ0003362, this is a meeting on
16 30 June. Sir Duncan Nichol attends this meeting and we
17 will just track through what's said at that meeting.

18 Page 4, and what Mr Chambers says right in the
19 middle:

20 "TC [I'm not sure what the symbol indicates but]
21 nurse removed, would death stop?"

22 **LADY JUSTICE THIRLWALL:** It says "if".

23 **MR DE LA POER:** "If nurse removed would death
24 stop", and Dr Brearey replies "risk would be reduced".

25 Then we will go over the page. Just to see, we can
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1 messaging to the local community and in particular also
2 around families that were going to be using the neonatal
3 unit in the future.

4 So I think there was a wider -- from what I recall,
5 a broader conversation around -- you know, we would need
6 to be really sure about phoning the police because we
7 need to consider our patients, our staff, a number of
8 different elements. I can't remember those terms that
9 you have shared though.

10 Q. Why, if you call the police, would it
11 necessarily need to be the case that your patients would
12 ever find out about it if you are just contacting the
13 police to ask them: can you give us some advice in this
14 situation?

15 A. In terms of advice?

16 Q. Yes.

17 A. That could have -- that could have happened.
18 I thought you meant a wider investigation which
19 obviously comms would need to be involved.

20 Q. At this stage you are discussing calling the
21 police?

22 A. Yes.

23 Q. The criteria that you have identified about
24 concerns that might arise in the mind of current
25 patients or future patients, that will only happen if

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1 the investigation reaches a stage where it needs to be
2 made public?

3 **A.** Yes.

4 **Q.** If it reaches that stage, it's pretty serious,
5 isn't it?

6 **A.** Yes.

7 **Q.** Presumably if it had reached that stage
8 everybody would be entitled to know about the fact that
9 there was an active police investigation?

10 **A.** Yes.

11 **Q.** So do any of those factors really bear on the
12 decision about whether you should be picking up the
13 phone and speaking to a suitable police officer to say:
14 this is what's happening here?

15 **A.** I think at the time we felt that we needed to
16 get much more information internally so that we knew how
17 we would articulate these concerns to the police. You
18 know, on reflection maybe we could have gone to the
19 police then but it actually didn't feel -- it didn't
20 feel the right thing to do at that time because we felt
21 we needed more information so that we could articulate
22 clearly to the police what the problem was and at that
23 time we weren't clear, it was complex.

24 **Q.** You say it didn't feel like the right thing to
25 do. That may be because it wasn't the right thing to do

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1 what you said --

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

3 **Q.** -- it would not -- it would not represent
4 a sound statement of the position, would it?

5 **A.** No, no.

6 **Q.** Now, Ms Williams, your deputy, was
7 commissioned as part of the review process that was
8 taken out specially to conduct a staffing analysis?

9 **A.** Yes.

10 **Q.** She has told us that she and Ms Fogarty, who
11 did it together, reached the conclusion that the police
12 should be called because of the association that they
13 had identified of Letby. That's what Ms Williams'
14 evidence was and Ms Fogarty gave evidence supportive of
15 that. What Ms Williams said is that she spoke to you
16 among other people about the fact that she thought the
17 police should be called after she had done her review so
18 not on 29 June as we have seen there, but after she had
19 done her review.

20 Did she tell you that the police should be called?

21 **A.** I can't recall the detail of that
22 conversation. I know that they did a detailed analysis,
23 her and Julie Fogarty. I'm not sure of when that was
24 escalated in terms of the concerns.

25 **Q.** What was the conclusion of that analysis?

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1 or it may be your sense of what was right was

2 miscalibrated, do you think that your --

3 **A.** No, I think we had a general conversation
4 about the fact that we needed to know we all personally
5 needed to understand what was actually going on in our
6 organisation so that we could then clearly articulate to
7 the police what the problem was because at that time we
8 didn't really have a sense of what was going on.

9 So it was a collective decision, it wasn't any one
10 of us made a decision not to go to the police at that
11 time. It was a general discussion at the Executive
12 meeting around we needed to find more information out
13 first before we considered the police.

14 **Q.** So by 5 July, Ms Appleton-Cairns was speaking
15 to Mr Ian Pace of DAC Beachcroft and she is recorded as
16 saying that there were no malicious issues and what
17 Ms Appleton-Cairns has said when asked about that is
18 that she had assurances from you and Ian Harvey that
19 there was nothing malicious and that she had been told
20 that you had been through every case.

21 Were you saying around the 5 July that there were
22 no malicious issues?

23 **A.** I don't recall that because we hadn't gathered
24 all our information.

25 **Q.** Quite, it would be quite -- I mean, if that is
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1 **A.** That piece of work was part of a wider
2 internal investigation and I believe that that did show
3 that Letby was present but not directly caring for
4 babies at that time.

5 **Q.** So it confirmed that the information you had
6 before that was accurate?

7 **A.** But I think also just to add to that, there
8 were also doctors named in that analysis as well.

9 **Q.** Well, you were -- the name of Letby raised
10 before, Ms Williams has conducted that piece of work and
11 confirmed independently of Ms Powell and Dr Brearey that
12 their information is sound in terms of the basic facts
13 and she herself is concerned, she tells us, about it.

14 Is it your position that you just didn't realise
15 that she thought the police needed to be called or that
16 she may have said that to you and you have forgotten?

17 **A.** I really can't remember that conversation.
18 But I think again that staffing analysis was about an
19 association of individuals with incidents which formed
20 part of a bigger piece of work which we needed to get,
21 we needed to collate so that we were able to articulate
22 to the police when we went to the police.

23 I can't recall the details of Sian Williams's
24 conversation with me about that, I have to be honest.

25 **Q.** It would be a strange state of affairs, do you
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1 agree that if she told you that she thinks the police
2 should be called, if you had forgotten her saying that?
3 **A.** Yes, I mean, in -- there was so much going on
4 at that time. Lots of people were doing different sets
5 of actions, this was when we had our internal incident
6 review process. She -- she may have raised that concern
7 about the police but I think we were looking at
8 information in the round but I don't recall the detail
9 of that conversation.

10 **Q.** That staffing analysis never gets referred to
11 again, does it?

12 **A.** Sorry?

13 **Q.** That staffing analysis which demonstrated the
14 association with Letby and led to Ms Williams being
15 concerned, it never gets referred to again once it's
16 carried out, does it?

17 **A.** I am not certain about that.

18 **Q.** Well, let's just cast your mind back. Did you
19 tell anyone in all of the organisations and all the
20 conversations that you had with external bodies, did you
21 ever say one of the things we did was a staffing
22 analysis and that staffing analysis demonstrated that
23 Letby did have a strong association with a number of
24 these babies?

25 **A.** I don't think that level of detail was shared
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1 the system. The clinical criterias being drawn up.
2 There were a number of different things that were
3 happening in that time and the staffing analysis and the
4 association with Letby was one part of that.

5 So that's -- that's a reason why we didn't
6 communicate fully with our regulators at the time
7 because we needed to understand what was actually going
8 on, in the absence of any clear evidence, again, from
9 our clinicians.

10 **Q.** I would like to just ask to you consider this
11 explanation so that you can comment upon it: you
12 commissioned a staffing analysis, it demonstrated the
13 very thing that Dr Brearey had told you he had found
14 when he and Ms Powell had gone through it, you didn't
15 like the fact that that was a piece of evidence which
16 supported the allegation and so you just didn't refer to
17 it again?

18 **A.** That is absolutely untrue. I did not feel
19 that at the time. I think the word "association" is
20 a really interesting one because there was association
21 with doctors, there was association with some care
22 issues which were already articulated in the Thematic
23 Review, competency issues on the unit.

24 So we couldn't just hone in on one element. It
25 needed to have a multi-factorial approach.
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1 at the time, no, but in the CQC list I think I wrote we
2 were doing a staffing analysis.

3 **Q.** That you were doing or had done? I mean, on
4 30 June you said you were going to do it. But you never
5 told the CQC after you had done it what the outcome of
6 it was?

7 **A.** I don't recall that.

8 **Q.** Well, we have looked at the 17 February when
9 you are telling them about what the position is then,
10 you didn't say at any point: we did a staffing analysis
11 as part of our internal review and it demonstrated the
12 association of Letby?

13 **A.** I think, yes, association with Letby but
14 I think that was just one part of a bigger jigsaw, if
15 you like, that there was lots of other things going on
16 at the same time, so we needed to get a full picture.

17 It was complex, it was unclear, the staffing
18 element was one -- just one part of it and we needed to
19 pull all that together to get an idea of what was going
20 on.

21 **Q.** Why was it complex?

22 **A.** We had different reviews that were going to be
23 commissioned, we had to downgrade the unit which
24 operationally was challenging because that wasn't just
25 about the Countess, that was about our partners across
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1 **Q.** We are going to come back to what you say
2 about doctors being indicated by that analysis. We are
3 going to move to my seventh topic, which is the NMC,
4 which will give us an opportunity to do that.

5 Now, you sent an email to the NMC on 4 June asking
6 for some -- an opportunity to speak to their ELS
7 service, that led to a conversation which led to
8 an email being sent following the conversation,
9 summarising what happened, and you went through that
10 email and just marked up any changes?

11 **A.** Yes.

12 **Q.** We don't need to go through it all again but
13 I can bring it up on screen, if you need me to, but I am
14 sure you will be able to take it from me that among the
15 things that you said to the NMC was that there was no
16 evidence?

17 **A.** At that time there was no evidence.

18 **Q.** Well, we are not going to go through all of
19 that again. We will move through to the email of
20 31 August, INQ0002964. This is an email that you have
21 been chased for an update, we can see was sent on
22 23 August by Mr Newman and seven days later you provide
23 that update.

24 It's just one part of this:

25 "As previously mentioned, we undertook a thorough
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1 internal review [in that first paragraph]. Nothing
2 significant was identified within this."

3 So far as this is concerned, that's misleading,
4 isn't it, that nothing of significance was identified
5 with your internal review?

6 **A.** At that time that was my perception, was
7 nothing significant was identified that would lead me to
8 think that further action was required. I was asking
9 Tony Newman for further advice, giving an update on what
10 we were doing, which we had agreed in the previous
11 communication. I don't -- I wasn't meaning to mislead
12 anybody.

13 **Q.** Well, let me invite you to consider this.
14 Within that internal review, there had been the staffing
15 analysis done that had confirmed the Letby association,
16 that's one thing. We have been over that. But also
17 Dr Gibbs together with Ms Martyn had conducted a review
18 of the cases referred out and had identified six cases
19 which they were concerned about.

20 Now, both of those are relevant to the development
21 of the potential concerns about Letby, but you are not
22 reporting those to the NMC, instead you are suggesting
23 that nothing of significance came out of it. Why is
24 that?

25 **A.** Again I think it's terminology in the email
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1 concern. Just -- that's something of significance,
2 isn't it?

3 **A.** But we were still unsure as to what was going
4 on. So it was -- you could say it was a holding
5 position.

6 **Q.** It is a holding position that isn't accurate?

7 **A.** But we have removed LL so we have removed the
8 risk, so I was informing them she was on non-clinical
9 duties.

10 **Q.** This is an example of information that the
11 Executives had that is being withheld from the external
12 bodies that tends to suggest that the concerns may be
13 credible, isn't it?

14 **A.** No. We were not holding anything from
15 anybody. What we needed to do was be really clear,
16 again, as I mentioned earlier about understanding our
17 organisation and what was actually going on in our
18 organisation before we could share that with our
19 regulators.

20 On reflection, we probably should have shared more
21 with our regulators because we might have got some
22 support to be able to manage this perhaps in a different
23 way, but at the time I think the actions were numerous
24 and we were dealing with the detail on a day-to-day
25 basis.

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1 because below that is:

2 "Following discussions with the board and on
3 receiving views from our clinicians, a step ... taken to
4 take LL on non-clinical duties".

5 So again, removing the risk but still in
6 a fact-finding position. So at that time, it felt that
7 was the right thing to say but I -- you know, it wasn't
8 purposely misleading.

9 **Q.** But it isn't accurate, is it?

10 **A.** It's probably ambiguous.

11 **Q.** Well, "nothing" -- the word "nothing" is not
12 capable of ambiguity, is it?

13 **A.** Significant. Depends how you define
14 "significant".

15 **Q.** Well, you had commissioned Dr Gibbs as part of
16 the Executives to look at cases. If he had found none
17 of concern to him, that would be nothing of
18 significance. If he has found six which are of concern
19 to him, is that not something of significance?

20 **A.** From a clinical perspective but we were still
21 unclear as to what was going on. So further information
22 needed to be gleaned from those further cases from
23 Dr Gibbs and Anne Martyn's review.

24 **Q.** But you are talking here about the output of
25 the internal review they identified six cases of
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1 **Q.** But --

2 **A.** On reflection, like I say, we -- we probably
3 should have shared more at key stages with our
4 regulators.

5 **Q.** Now, from 27 April, you knew that the police
6 were going to be involved, 2017, didn't you?

7 You can take that down.

8 **A.** Okay, sorry.

9 **Q.** From 27 April 2017 you knew the police were
10 going to be involved?

11 **A.** Okay.

12 **Q.** Do you agree with that?

13 **A.** Yes.

14 **Q.** You did not contact the NMC to tell them that,
15 did you?

16 **A.** I can't recall. Maybe I didn't do that in
17 a timely way. I can't recall.

18 **Q.** Well, 18 May 2017, the NMC had found out about
19 police involvement from a press release and so they
20 called you. Does that sound right?

21 **A.** I think we communicated with everybody, unless
22 the NMC were inadvertently left off that list.

23 I thought when we were commissioning the police
24 investigation that there was a separate communication
25 plan sharing with our external bodies what we were

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1 doing.

2 **Q.** Well, at all events, let's have a look and see
3 what was sent, INQ0002449, page 1. So this is the
4 record of what was discussed. If we look in the centre
5 of the page:

6 "AK advised me as she had explained to TN
7 previously there was a view held by several medical
8 colleagues that a registrant may be the common
9 denominator and are quite strong in their view that she
10 may be the cause. This is largely based on an
11 identification of her having been present on most but
12 not all of the occasions when infants collapsed and
13 died."

14 Well, that isn't a fair or accurate
15 characterisation of the Consultants' views, was it?

16 **A.** I think that is quite clearly articulated as
17 the Consultants' views.

18 **Q.** Well, their views were, starting point: an
19 unexpected number of babies have died, there were sudden
20 and unexpected deteriorations, the babies had failed to
21 respond to resuscitation as we expected them to, we have
22 investigated and we cannot identify any other common
23 cause for this, but we can identify one person in common
24 for all of these, and that is Lucy Letby.

25 That in a summary position was where they were by
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1 **A.** So --

2 **Q.** Again I am just going to make an assertion
3 about that. In the Thematic Review of neonatal
4 mortality it describes those sudden unexpected
5 deteriorations, doesn't it?

6 **A.** Sudden deteriorations, yes, but when you look
7 at those cases that did actually find their way to
8 a Datix report, and that is not all of the cases --

9 **Q.** Well, but the Consultants were saying that,
10 that is what they were telling you, that we have notes
11 from June of 2016 of Dr Saladi saying: these were not
12 the babies we were expecting to collapse?

13 **A.** But when you look at the Mortality Reviews
14 that were actually led by Dr Brearey, there were no
15 concerns being raised at all up to that point. So if
16 you take all of that in the context of sub optimal care,
17 there were lots of reasons why poor babies were dying
18 and this was an -- in line with an association with one
19 member of staff.

20 **Q.** You have just said it again, there were lots
21 of reasons why these babies were dying. That's not
22 correct though, is it, Ms Kelly: none of the care issues
23 were the reason why the babies were dying.

24 The fact that the unit wasn't well led was never
25 identified as a reason that babies were dying.
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1 the time the police came to be contacted and you are not
2 advancing any of that on their behalf, are you?

3 **A.** As I mentioned earlier, aside to an
4 association with Letby, there were significant clinical
5 concerns that were borne out of the Royal College
6 report, the Hawdon Review and McPartland Reviews and
7 that constituted sub optimal care across the board in
8 varying degrees across those -- those poor babies that
9 died or had deteriorated.

10 **Q.** Not a single one of those causes --
11 sub optimal care was said to have caused death, though,
12 was it?

13 **A.** But there were also postmortems as well, that
14 had outcomes, so there were a number of different
15 elements.

16 **Q.** You have mentioned the postmortems, the
17 postmortems did not suggest that the sub optimal care,
18 if there was some, had caused death, did they?

19 **A.** No, but if you put all of those elements
20 together it doesn't show a particularly positive image
21 of how that unit was being managed and there were
22 a number of -- and the other element is that the words
23 "unexpected" and "unexplained" were never discussed
24 before June '16.

25 **Q.** Well --
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1 They couldn't work out what the increase in -- was
2 the cause of increase in mortality from a medical
3 perspective?

4 **A.** But when you spoke to the clinicians, they
5 still couldn't articulate the reasons why babies were
6 dying. They -- they associated it with one individual
7 and there were lots of things, lots of elements that
8 came out of those reviews that were quite concerning,
9 competency issues, delays in care, delays in intubation,
10 numerous things that will have contributed to poor
11 outcomes for babies.

12 So -- and I know that's not referred to in the
13 postmortems -- postmortem, but if you put that picture
14 together, it's not -- it's not a good picture. So what
15 I was trying to articulate here was we were doing lots
16 of reviews, lots of analysis and we had reviewed,
17 removed Letby from practice, which was the right thing
18 to do at that time, so it wasn't clear, it wasn't clear,
19 it was a complex picture.

20 **Q.** So do we take from all of that that your
21 position as at 18 March was that the likely explanation
22 for all of these deaths was poor care?

23 **A.** Potentially, yes.

24 **Q.** And what medical opinion had been offered that
25 reached the same conclusion that you had?
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1 A. It -- it wasn't just my conclusion. It was
2 the outputs of the reviews that we had done.

3 Q. No, no, did any doctor say that poor care was
4 the explanation?

5 A. Dr Hawdon's report, the outputs of her report
6 talk about sub optimal care in varying degrees across
7 all the cases that were reviewed.

8 Q. Did she say that that sub optimal care caused
9 death?

10 A. I don't think she used those words, but there
11 was -- they were contributing factors.

12 Q. Well, Dr Subhedar had been part of the
13 Thematic Review?

14 A. Yes.

15 Q. He had reviewed Dr Hawdon's report and by this
16 time, as you will have known, was saying that there were
17 seven babies that he was concerned about, this is
18 a wholly independent view on behalf of the network from
19 a Consultant neonatologist who had involvement at the
20 start and had involvement just before this?

21 A. Yes.

22 Q. He was not suggesting that the deaths were
23 explained by sub optimal care, was he? And he knew
24 everything you did?

25 A. It was -- I'm not sure about that and I ...

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1 a combination of a number of things because we were
2 looking at so many different elements and the outputs of
3 the Royal College, the outputs of the Hawdon Review, the
4 McPartland Review, didn't point to somebody
5 intentionally harming babies.

6 Q. Let's just think about that for a moment.
7 Dr Hawdon concluded that four babies' deaths were
8 unexplained and unascertained, didn't she?

9 A. There was further review required on those,
10 yes.

11 Q. Yes, because she had reached that conclusion.
12 So that is potentially four babies who were
13 murdered; you couldn't exclude that?

14 A. Potentially yes, there was further review
15 required.

16 Q. Dr Subhedar increased the category of
17 potentially murdered babies to seven, didn't he?

18 A. I think he increased that, yes.

19 Q. Yes. You didn't have any basis or sufficient
20 expertise yourself to say that Dr Subhedar was wrong to
21 be worried that seven babies may fall into that
22 category?

23 A. No, not personally. But -- and we welcomed
24 Dr Subhedar's input to -- and again conversations with
25 probably with Dr -- with Mr Harvey around more babies

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1 Q. Well, can I help you with it because he says
2 he thinks seven babies need further review, so he had
3 not reached that conclusion in relation to those seven
4 babies?

5 A. No, but he did provide helpful guidance for
6 the Thematic Review which I know some of those babies
7 did get discussed in the Neonatal Network Meetings and
8 no concerns were raised at that time. I recognise later
9 on he wanted further reviews of additional babies.

10 Q. But that was the position going in to this
11 referral. You see, let me try and cut through this.
12 You have a clinical background in adult nursing?

13 A. Yes.

14 Q. You were provided with a number of expert
15 opinions by Consultant paediatricians and a Consultant,
16 two Consultant neonatologists, and in particular the
17 network was giving some oversight to this and not
18 a single one of them said in terms to you, or in
19 writing: sub optimal care is the explanation for this.
20 Yet you seem to have reached that conclusion for
21 yourself despite that body of evidence. Why is that?

22 A. The body of evidence came from Dr Hawdon's
23 review, which does mention sub optimal care.

24 Q. She doesn't -- well, let's take Dr Hawdon?

25 A. I think -- I think she does. But it is

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1 being added to that list of further review for further
2 review. But as I mentioned before, all the work that
3 was being done, whether that internally or externally
4 was leading down a path that suggested care was not of
5 a good standard on that unit.

6 Q. Well, I would only be repeating myself to
7 point out that none of it said that it was causative so
8 we will move on and we will look at your referral to the
9 NMC, which is up on our screen.

10 One other sentence to ask you about:
11 "Other staff were present on a similar number of
12 relevant occasions"?

13 A. Sorry, on this same document?

14 Q. Same paragraph, final sentence of that
15 paragraph.

16 A. I believe some of the doctors were on duty at
17 similar times, but not as many as Letby.

18 Q. No, no, no. In fact, Letby was associated
19 with nine of the ten deaths on the Thematic Review plus
20 two more in the form of the deaths of Child O and
21 Child P, so at that time her association was 11. The
22 next highest association was Dr Harkness with six but
23 Dr Harkness had left the Trust in March and so there
24 could be no question that Dr Harkness had caused the
25 deaths of O and P because he wasn't even working at the

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1 hospital.

2 So just help us with why you are suggesting that
3 other staff were present on a similar number of relevant
4 occasions?

5 **A.** I think that was just going over generally
6 what the outputs of that Thematic Review were, there was
7 a staffing analysis attached.

8 I haven't gone into specifics in that sentence so
9 it's kind of a high level sentence, really. But I was
10 aware that some doctors were present but not as many
11 times as Letby.

12 **Q.** Well, doesn't it rather exaggerate the
13 position?

14 **A.** Sorry?

15 **Q.** Doesn't it rather exaggerate the position to
16 say other staff were present on a similar number of
17 occasions?

18 **A.** That was not written intentionally to mislead
19 people. But doctors were highlighted in the staffing
20 analysis.

21 **Q.** So that's the update post arrest.

22 In fact, when it comes to a referral to the NMC,
23 the NMC found out about the arrest on 3 July and they
24 tell us they contacted you and you made a referral on
25 4 July 2018. We don't need to bring it up unless you

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1 development.

2 **Q.** Well, it's just --

3 **A.** I can't recall.

4 **Q.** Sorry?

5 **LADY JUSTICE THIRLWALL:** Can't recall.

6 **MR DE LA POER:** Can't recall, thank you.

7 You see the word "apparent" was also included on
8 11 July in the Risk Register entry, do you remember?

9 **A.** Okay, from the division?

10 **Q.** Yes.

11 **A.** Yes.

12 **Q.** We understand from Ms Townsend that that was
13 scripted following a meeting with the Executive Team.

14 Is her recollection correct about that?

15 **A.** Yes, I have absolutely no recollection of that
16 because a risk articulated at divisional level would
17 have been discussed at divisional level.

18 **Q.** Well, it might have been brought to the
19 divisional level, having already been written?

20 **A.** Sorry?

21 **Q.** It might have been brought to the divisional
22 level having already been written?

23 **A.** Potentially, but I -- that would -- we would
24 not have a role as an Executive Team to draft risks that
25 were held on a Divisional Risk Register; that would be

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1 want to, but the text that is in that 4 July is

2 an almost perfect but not quite lift from your LADO
3 referral from March of 2018; does that sound right?

4 **A.** Similar, yes.

5 **Q.** Yes. Similarly, when you are referring Letby
6 to the Fitness To Practise Directorate, do you think
7 that you were putting the concerns against her at their
8 highest?

9 **A.** At the time I thought I was articulating
10 exactly what had been going on and I had had regular
11 communication with NMC and it took a while for that to
12 filter through the NMC, I believe.

13 **Q.** Part 8, we are going to look at the
14 involvement of the RCPCH and Dr Hawdon and we start with
15 the amendment to the Terms of Reference. Were you
16 involved in that process?

17 **A.** Very briefly. Mr Harvey took the lead on
18 that.

19 **Q.** The word "apparent" was inserted into the
20 Terms of Reference so it didn't just talk about the
21 increase in mortality but the apparent increase in
22 mortality. Was that a word that you suggested should be
23 included?

24 **A.** I can't recall that. No, I had very little,
25 very little involvement in that Terms of Reference

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1 the responsibility of those clinical teams.

2 **Q.** Were you the Executive lead for risk?

3 **A.** I was, yes.

4 **Q.** Then of course in July 2016, so this is all
5 happening in July 2016, we had the paper written by you
6 and Ruth Millward, certainly there is both your names at
7 the bottom, called "Position paper", which uses the
8 phrase "apparent increase in the number of neonatal
9 deaths".

10 So again did you have a participation in the
11 writing of that position paper?

12 **A.** I commissioned that piece of work and Ruth and
13 some of her operational team pulled all of that
14 information together.

15 **Q.** Do you agree now that using the word
16 "apparent" in July was entirely unnecessary? In other
17 words, by July of 2016, it was well-established that
18 there had been an increase in the mortality rate?

19 **A.** Yes, if you look at the data that was being
20 provided.

21 **Q.** Yes.

22 **A.** But again, terminology. It wasn't
23 intentionally put there to mislead people.

24 **Q.** Somebody has decided to stick the word
25 "apparent" into the Terms of Reference but you say you

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1 can't recall if that was you?

2 **A.** I don't recall having much input at all in
3 that report -- the Terms of Reference.

4 **Q.** You had a meeting on 1 September 2016 with the
5 RCPCH and what Ms Eardley told us was that you were
6 particularly supportive of Letby and quite dismissive of
7 the allegation. Is that a description of your behaviour
8 in that meeting that you recognise?

9 **A.** No, I was not, I have never been dismissive.
10 We took this very, very seriously, I felt that we had an
11 open conversation with the Royal College team and with
12 Sue Eardley on her first day in the organisation. That
13 was myself and Ian Harvey.

14 I certainly wouldn't say that I was dismissive at
15 all.

16 **Q.** On 2 September there was a meeting where, as
17 we understand it from those who attended, you and
18 Ian Harvey and Tony Chambers were told that
19 a case-by-case review of the deaths needed to take
20 place?

21 **A.** From who, sorry?

22 **Q.** From the RCPCH?

23 **A.** Oh, right, okay.

24 **Q.** Do you recollect that?

25 **A.** I do recollect that, yes.

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1 **Q.** Well, let's just nail it down. Did you think
2 as at the time of the RCPCH reviewers left the site that
3 the RCPCH had investigated whether Letby had murdered
4 babies?

5 **A.** Not, not directly, no.

6 **Q.** Well, or indirectly?

7 **A.** We didn't know at the time. And actually
8 I think it was the Royal College that offered to meet
9 with Letby while they were on site -- on site. but
10 I think the outcomes of their report was just another
11 piece of information that we were trying to glean around
12 the high mortality.

13 **Q.** They mentioned the HR process. We can see
14 a little more detail in their letter of 5 September,
15 INQ0003120 and over the page, this is addressed of
16 course to Ian Harvey but presumably you would have seen
17 this letter?

18 **A.** I think Ian would have shared that with us,
19 yes.

20 **Q.** "HR Investigation. Our understanding is
21 an allegation has been made and therefore a process of
22 investigation needs to be put in place which sets out
23 nature of the allegation and the process you will follow
24 to investigate it."

25 So that is a disciplinary investigation?

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1 **Q.** They also told you as is recorded in the notes
2 HR process for Lucy?

3 **A.** Yes.

4 **Q.** And so does it follow that as at 2 September,
5 you knew that the RCPCH was not able to answer your
6 concerns about Letby or the concerns about Letby?

7 **A.** Not fully about Letby, no. Because there
8 was -- we -- they focused on the clinical and
9 operational and management of the unit.

10 **Q.** But did you think they could answer anything
11 about whether Letby had killed babies? As at 2nd --

12 **A.** Probably unclear at the time but it was just
13 again keeping an open mind and also gathering as much
14 information as possible.

15 **Q.** It's important to be clear though, isn't it,
16 Ms Kelly, because if at subsequent meetings as we have
17 seen you are telling people that the RCPCH is either
18 inconclusive about the allegation or hasn't found
19 anything to support the allegation it's quite important
20 to know that the RCPCH weren't actually investigating
21 that?

22 **A.** I think it was important to get a rounded
23 picture of what was going on through the Royal College
24 review and I think that was just again one part of the
25 jigsaw to see if there was any intentional harm.

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1 **A.** (Nods)

2 **Q.** The Trust never instituted a disciplinary
3 investigation into Letby, did they?

4 **A.** No, we took external legal HR advice and we
5 were struggling to articulate what policy would be
6 applied to do an HR investigation of that type.

7 **Q.** The RCP --

8 **A.** Notwithstanding that, this morning we talked
9 about safeguarding and I recognise that there was
10 probably a missed opportunity from a safeguarding
11 perspective, but from an HR, we -- it's not that we
12 ignored that recommendation from the Royal College, we
13 sought external advice to support our decision-making.

14 **Q.** And who -- was this DAC Beachcroft that you
15 are saying --

16 **A.** Through Sue Hodgkinson, the HR Director, yes.

17 **Q.** Are you satisfied that what was communicated
18 was that the Royal College had said a disciplinary
19 procedure needs to be instituted to address
20 an allegation of harm by a member of staff?

21 **A.** We knew that we needed to look at whether an
22 HR investigation was required and that's why we -- we
23 struggled internally to understand how we would do that.
24 That's why we took the legal advice externally.

25 **Q.** Did you back to the RCPCH to ask for more

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1 information about what they meant?
 2 **A.** I didn't personally, no.
 3 **Q.** You see, because do you agree at later
 4 meetings it is suggested by members of the Executive
 5 that the RCPCH had made recommendations which the Trust
 6 had followed?
 7 **A.** Yes.
 8 **Q.** But of course that was a recommendation made
 9 by the RCPCH which the Trust didn't follow?
 10 **A.** We did follow it to an extent because we
 11 had -- we had further conversations about that
 12 particular action --
 13 **Q.** That's --
 14 **A.** -- and guidance given to us externally.
 15 **Q.** They recommended you do a disciplinary
 16 process. You didn't do a disciplinary process,
 17 therefore surely you didn't follow the recommendation?
 18 **A.** We didn't ignore it. We sought external
 19 advice.
 20 **Q.** But you didn't follow it, did you?
 21 **A.** We didn't follow it to the letter, no.
 22 **Q.** Dr Hawdon's report recommended a local
 23 forensic review in four cases. What steps were taken to
 24 institute that local forensic review?
 25 We can take that down --
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1 **A.** I am unsure of that. I wasn't close enough to
 2 the detail. That would have been Mr Harvey that would
 3 have instigated that. I'm not sure whether that
 4 actually took place or not.
 5 **Q.** The Trust received the RCPCH report on
 6 28 November of 2016. Included in the email to Mr Harvey
 7 was a suggestion it should be for wider dissemination
 8 amongst those who contributed.
 9 We can bring up the detail but you may be able to
 10 take it from me that within the RCPCH report there were
 11 recommendations to CDOP and to the transportation and
 12 Neonatal Network, weren't there?
 13 **A.** Yes.
 14 **Q.** We can see from the report and we can look at
 15 it, but you may be able to take it from me that they
 16 don't provide an explanation for the increase in
 17 mortality rate, do they?
 18 **A.** From the -- sorry, from which report?
 19 **Q.** The RCPCH report?
 20 **A.** Yes, the Royal College, no.
 21 **Q.** No. And they make a number of what are termed
 22 immediate recommendations?
 23 **A.** Yes.
 24 **Q.** So that's on 28 November. On 21 December, you
 25 wrote to NHS England, INQ0008077. Just familiarise
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1 **A.** Sorry, where --
 2 **Q.** Dr Hawdon did a report, I'm sorry, we had
 3 covered all of this already. I just wanted to ask
 4 a follow-up question about it.
 5 In that report she identified five cases, initially
 6 four, after the postmortem review --
 7 **A.** (Nods)
 8 **Q.** -- that required local forensic review. That
 9 was her conclusion. What was done about that?
 10 **A.** That action sat with the Medical Director and
 11 my understanding is that further communication was made
 12 with forensic pathologist from Alder Hey is my
 13 understanding, to do a further review of those cases.
 14 **Q.** Firstly not a forensic pathologist but if you
 15 are referring to Dr McPartland.
 16 **A.** McPartland.
 17 **Q.** But that was always part of the original
 18 requirement that a pathologist look at the cases?
 19 **A.** Yes.
 20 **Q.** So that was baked in. Once that review had
 21 taken place, a local forensic review was required
 22 according to Dr Hawdon. The Inquiry has seen no
 23 evidence that anything was done so far as that's
 24 concerned, just giving you the opportunity to indicate
 25 whether anything was done?
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1 yourself with this letter. We can see you mention
 2 Dr Hawdon's work, the neonatologist from London. And
 3 you say that:
 4 "Obviously the safety of our unit is paramount.
 5 From the day the Review Team left the Trust they assured
 6 us there were no immediate actions or concerns."
 7 I mean, in fact they had recommended a number of
 8 immediate steps, hadn't they?
 9 **A.** Yes. But also we have since learnt from this
 10 Inquiry that the Royal College had concerns whilst they
 11 were on our hospital site and didn't raise anything with
 12 us.
 13 **Q.** We just need to focus on this. the report says
 14 in terms it lists A to F immediate recommendations.
 15 That is an immediate action. You had received that
 16 report 21 days before this and yet you appear to be
 17 telling NHS England that there were no immediate actions
 18 from the report. Why are you saying that?
 19 **A.** I think I am probably looking at that as if it
 20 were a CQC inspection, so meaning whilst they were on
 21 site there were no immediate actions, although that will
 22 have been listed in the recommendations as to what we
 23 needed to do first.
 24 So potentially that was misleading, but not
 25 intentionally.
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1 Q. Just consider this. I mean, that report could
2 have been sent to NHS England at this stage, couldn't
3 it? It was all finished and finalised, there had been
4 some recommendations about Dr Hawdon but that report
5 itself was a finished article as at 28 November, do you
6 agree?

7 A. It was a finished article but I think because
8 there was further deep dives required we wanted to make
9 sure that we had a fuller picture. So that was
10 discussed, that wasn't -- I wrote this letter but that
11 wasn't my decision, it was a collective decision from
12 the Executives.

13 Q. If you had written to the NHS England and said
14 there are a number of immediate actions for us from this
15 report, that would have immediately provoked them to say
16 we need to see the report, don't we?

17 A. Potentially, yes.

18 Q. Yes, and so by telling them that there were no
19 immediate actions you were effectively able to delay
20 when you had to give them the report?

21 A. That was not done intentionally. I think
22 I meant there as in when they were on site there was
23 nothing that they brought to our attention that we
24 needed to immediately address but I recognise the way
25 that that is written it probably -- it looks like it's

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1 A. Could have been better, yes.

2 Q. It put patient safety at risk by withholding
3 it, didn't you?

4 A. In -- in not sharing actions, you mean?

5 Q. Yes.

6 A. Potentially, but that wasn't -- that wasn't
7 the intention at the time.

8 Q. Again, a straightforward question: it put
9 patient safety at risk not sharing that report as soon
10 as it was available, didn't it?

11 A. You could say that, yes.

12 **MR DE LA POER:** My Lady, I have a little further to
13 go but I wonder given the time we have been going about
14 an hour and a quarter whether we could take a break?

15 **LADY JUSTICE THIRLWALL:** Yes, certainly. We will
16 take 15 minutes. So we will come back just before
17 10 past 3.

18 (2.53 pm)

(A short break)

20 (3.10 pm)

21 **LADY JUSTICE THIRLWALL:** Sorry to keep you all
22 waiting. Mr De La Poer.

23 **MR DE LA POER:** Ms Kelly, my penultimate topic is
24 the grievance procedure.

25 We will start with Dr Green. You tell us in your

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1 referring to the actual report recommendations.

2 Q. Now, the report was published on
3 7 February 2017. Here we are talking about the
4 dissemination, not the confidential version.

5 That means that it had been held and withheld from
6 CDOP who had a recommendation that the Neonatal Network
7 and indeed the Consultants on the unit in terms of their
8 opportunity to consider how they might improve their
9 practice; is that fair?

10 A. Yes, I think it's, I think it's recognised
11 from the Executives' perspective that the delay in
12 sharing it with the paediatricians wasn't good enough at
13 the time. We should have done that in a more timely
14 way.

15 Q. One explanation which I would like you to
16 consider and comment on is that it was deliberately
17 withheld to the last possible moment so that the
18 paediatricians didn't have an earlier opportunity to
19 point out that it didn't address their concerns?

20 A. No, not at all.

21 Q. Well --

22 A. We recognised that the communication of the
23 actual report could have been better but that was not
24 done intentionally from a Consultant perspective.

25 Q. Could have been better?

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1 witness statement that you recognise it would have been
2 better if the investigator had been entirely independent
3 from the hospital; is that right?

4 A. On reflection, yes.

5 Q. Is that because this involved an assessment of
6 the personalities of people who Dr Green would know?

7 A. Yes.

8 Q. We turn to Ms Weatherley.

9 Are we correct to understand that you were
10 responsible for selecting Ms Weatherley?

11 A. Not directly. I contacted a chief nurse who
12 I used to work with and asked her for advice of somebody
13 that could help with an external investigation.

14 Q. What Sir Duncan Nichol has said the fact that
15 you chose a nurse from somewhere you had worked might
16 create the perception of not being entirely fair, that
17 is his perspective?

18 A. At the time --

19 Q. Do you have a comment upon that?

20 A. At the time I thought it was an appropriate
21 move. I didn't know Annette Wetherby -- Weatherley so
22 it was somebody completely independent so I just went to
23 a previous employer just to get access to get somebody
24 to do it quickly so that we wouldn't be having long
25 delays.

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1 Q. Bearing in mind that there was by this stage,
2 September, some tension between the doctors and the
3 nurses --
4 A. Yes.
5 Q. -- should it have been somebody who was
6 neither a doctor nor a nurse who was adjudicating on
7 this?
8 A. In, yes -- looking back in hindsight, that
9 might have been a good idea.
10 Q. Because whether or not this happened there is
11 at the very least a risk that a nurse would side with --
12 that there would be a perception that a nurse would side
13 with somebody from her profession?
14 A. Potentially but it's not unusual in
15 a grievance process that you would have somebody from
16 the same profession hearing a case.
17 Q. Now, you were interviewed as a witness in the
18 grievance, weren't you?
19 A. Yes.
20 Q. The 20 October 2016, we will just bring up
21 some of the things that you said to Dr Green, INQ0002879
22 and we will go to page 21.
23 So we begin towards the bottom with you saying that
24 SB had pinpointed an individual nurse. In fact, it was
25 Eirian Powell who had first identified the nurse to you,

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1 Q. No. In fact there was another Consultant from
2 the Trust, someone from the network, a number of nursing
3 staff and someone from the Risk Department?
4 A. I suppose what I meant by that was he was
5 actually leading it because he instigated it, so --
6 Q. You see, one way of --
7 A. It was collective, it was collective, but it
8 reads that he did it on his own.
9 Q. Yes, one of the ways of reading both of those
10 things is that Dr Brearey is out on a frolic of his own
11 here?
12 A. Is what, sorry?
13 Q. He is out on a frolic of his own, that he is
14 acting on his own making these assertions, that is one
15 interpretation. Can you see how that might be
16 understood in that way?
17 A. Yes.
18 Q. It's -- rather than saying that it was the
19 joint conclusion of the nurse manager and Dr Brearey
20 that Letby was identified as having an association,
21 rather than saying that a number of others were
22 conducted in the Thematic Review and the analysis of
23 staff on duty at the time of deaths, you are putting
24 this all on Dr Brearey?
25 A. I think because he was the clinical lead he

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1 hadn't she?
2 A. I think it was a combination of the -- the two
3 of them working together at the time, yes.
4 Q. It was Eirian Powell who had first identified
5 the nurse to you, wasn't it?
6 A. In the email trail that we have previously
7 looked at.
8 Q. Yes.
9 A. Yes, but I know it was a piece of work that
10 Steve, Stephen Brearey was also part of.
11 Q. And you go on to say that:
12 "There was a discussion involving Karen Rees to
13 find out if there were any issues ..."
14 Then this:
15 "In the meantime, SB conducted his own mini review
16 of the cases and analysis of staff on duty at the time
17 of deaths."
18 Is the mini review a reference to the Thematic
19 Review?
20 A. I think so, yes.
21 Q. So the first thing is that wasn't --
22 A. I'm not sure, to be honest.
23 Q. Well, Dr Brearey didn't conduct the Thematic
24 Review on his own, did he?
25 A. No.

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1 was leading on a number of pieces of work, so that's
2 probably where I was coming from in terms of he was the
3 clinical lead, he was expected to oversee and lead some
4 of those pieces of work.
5 Q. Page 22, top:
6 "LL was on duty but not always allocated to the
7 particular baby. There were lots of indirect links
8 being made to one individual but there was no other
9 rationale for it."
10 There was a rationale, wasn't there, as you knew,
11 which is that she was identified as being associated and
12 after all of the investigations that were done, no
13 clinical cause could be identified, so there was
14 a rationale?
15 A. There wasn't a clear rationale. There was an
16 association with Letby and as I mentioned earlier there
17 was an association with issues with care as well.
18 Q. Well --
19 A. And also other members of staff.
20 Q. Why were you not, when describing what the
21 Consultants' position was, stating it as they had stated
22 it to you?
23 A. Can you repeat that, sorry?
24 Q. Yes, the Consultants -- we will start at the
25 beginning.

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1 The Consultants had told you, and we have been
2 through all of this, that there was an increase,
3 unexpected, that babies who were collapsing who
4 shouldn't have, that there was a pattern that had been
5 noticed in terms of association. Of course by this
6 stage we had the fact that that pattern was at night and
7 that she was then moved on to days and the pattern
8 stopped. Those were all the things that had been said
9 before this meeting to you by the Consultants and yet
10 you appear to be characterising their position as a lot
11 of indirect links being made to one individual but no
12 other rationale.

13 I suppose one way of saying it is do you agree that
14 is not a fair characterisation of their position?

15 **A.** I suppose it could have been -- I could have
16 articulated in a little bit more detail to give context.

17 **Q.** Well, it is quite dismissive of their
18 position, isn't it?

19 **A.** Not intentionally, I think throughout this
20 process we were listening to both sides all of the time
21 there were numerous discussions with the clinicians.
22 But the wording of how it's articulated there probably
23 doesn't give the full picture.

24 **Q.** Well, it's suggesting that there is no
25 rationale for it when in fact they had given you

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1 it, to say no themes or trends?

2 **A.** I think that was -- that was -- I was
3 responding in the context of -- well, I should have
4 I should have done more -- I should have articulated
5 more detail around that. It is misleading.

6 **Q.** And false?

7 **A.** You could say potentially false. Yes.

8 **Q.** Then we have what you say about the RCPCH, so
9 we need to move to one-third of the way down. Did
10 anything come out of the report:

11 "Confirm nothing significant as far as Lucy"?

12 **A.** Sorry, what paragraph are you at?

13 **Q.** It's one-third of the way down?

14 **A.** Oh, yes.

15 **Q.** "Did anything come out from the report?"

16 "Confirm nothing significant as regards Lucy. The
17 report is only just in. It is a draft report and we are
18 awaiting forensic investigation of the medical notes of
19 the cases involved."

20 So that is a reference to the RCPCH and Dr Hawdon.

21 But you knew, didn't you, when you uttered those
22 words, that the RCPCH had not investigated whether Letby
23 was responsible?

24 **A.** My understanding was not directly, no. But
25 part of the Royal College review was to look at anything

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1 a rationale. So it is a mischaracterisation of their
2 position, isn't it?

3 **A.** I think when you are going back to what we
4 talked about before the break, which was the numerous
5 reviews that had been undertaken, there were lots of
6 things to consider.

7 **Q.** So just focus. This is you summarising for
8 Dr Green what the Consultants' position is?

9 **A.** Yes, and that could have been done in a bit
10 more detail.

11 **Q.** Well, it is a mischaracterisation of their
12 position, isn't it?

13 **A.** I wouldn't put it in those terms. But I could
14 have given more detail.

15 **Q.** And you have said there are no significant
16 concerns about her, no red flags, no themes, or trends.

17 Well, some themes had been identified, hadn't they,
18 in particular as far as she was concerned the fact that
19 the collapses were at nights then she was moved off
20 nights and the pattern stopped.

21 So it is factually inaccurate to say no theme or
22 trend had been identified, isn't it?

23 **A.** A few more elements of detail would have been
24 helpful there.

25 **Q.** That is -- that is a false statement, isn't

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1 clinical or management-wise that was untoward.

2 **Q.** That is a misleading statement from you, is it
3 not, "confirm nothing significant as regards Lucy", in
4 circumstances where the full picture is that it was not
5 investigating Lucy?

6 **A.** I think we are just trying to keep an open
7 mind at the time with the Royal College review --

8 **Q.** Is it a misleading statement?

9 **A.** Pardon?

10 **Q.** Is it a misleading statement?

11 **A.** It is misleading, yes.

12 **Q.** Then if we look further down, about two-thirds
13 of the way down:

14 "The original plan was supervision but due to
15 staffing levels, this wouldn't be possible, so the
16 decision was made to redeploy Letby to another
17 department, a non-clinical area, while the review was
18 undertaken. AK and SW did this to protect LL."

19 Now, in fact, moving Letby was not solely for the
20 reason of protecting her, was it?

21 **A.** In circumstances where we need to take
22 a member of staff out of clinical practice, because of
23 an incident or a situation, it's not good to keep that
24 individual in that environment should anything else
25 happen.

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1 Q. Ms Kelly, just please focus upon my question.
2 Letby was not moved solely to protect her, was she?
3 There was more to it than that?

4 A. Yes, because as time went on we realised that
5 there was -- we needed to investigate more about what
6 was going on so we needed to remove her from clinical
7 practice and the Consultants were concerned about that.

8 Q. So why aren't you telling Dr Green that Letby
9 was moved both for her own protection and also the
10 protection of patients?

11 A. That was a given. That was a given. And
12 that's --

13 Q. But you say it's a given. It all starts to
14 look like the Consultants' concerns don't have any real
15 basis to them. You have only moved her to protect her
16 from them, you have only -- the Royal College hasn't
17 found anything. There's no rationale for their
18 position. I mean, these are cumulative points in your
19 interview that I would just like to give you the
20 opportunity to comment upon whether or not that is in
21 fact the impression that you are setting out to create
22 here?

23 A. That wasn't the impression at the time.

24 Again, lots of things going on. We were listening
25 to the Consultants. In fact, they were pleased I think

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1 opposed to the list of actions that were contained in
2 the back of the report and I recognise that's
3 misleading.

4 Q. Well, it's --

5 A. But the HR -- the HR element we did seek
6 advice because that was a conversation with myself and
7 Sue Hodgkinson, the director of HR at the time, and we
8 were given advice externally.

9 Q. What you should have said to Dr Green was
10 there was a recommendation that we commence disciplinary
11 proceedings but we have decided not to do that.

12 That is the true position as opposed to "no
13 immediate actions"?

14 A. That isn't a true reflection of what you have
15 just articulated so it could have been more detailed,
16 yes, I -- I accept that.

17 Q. Right at the bottom, you say the Terms of
18 Reference For external review panel were not about an
19 individual but they were informed of the concerns raised
20 about an individual by Ian Harvey.

21 That's a partial picture, isn't it, because while
22 it is true that they were informed about it, they in
23 fact said that they couldn't deal with it?

24 A. I'm not sure of the detailed conversation
25 between the lead for the Royal College and Mr Harvey.

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1 that we had taken Letby out of the clinical area.

2 Q. Well, they were pleased because they thought
3 patients would be safer?

4 A. Yes.

5 Q. But you are not articulating that here?

6 A. I suppose I would say that that's a given for
7 me taking her out because of patient safety but
8 I haven't articulated it there in my interview.

9 Q. Now, at the bottom we can see that there were
10 no immediate actions by the external review. In fact,
11 one of them was to start a disciplinary process, wasn't
12 it; that was one of their actions?

13 A. Yes.

14 Q. You don't tell Dr Green that, do you?

15 A. No, not there. Although I'm not sure whether
16 Dr Green had sight of the Royal College report, I am
17 unsure of that.

18 Q. You are here talking about it, you are on the
19 one hand saying that there were no immediate actions but
20 in fact there was an immediate action and that was to
21 start a disciplinary process.

22 So that just isn't a true statement, is it?

23 A. I think going back to what I said before when

24 I said "no immediate actions" I kept referring to when
25 they were on site there were no immediate actions as

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1 Q. Well, they told you that on 2 September, that
2 they could not investigate your concerns?

3 A. We felt we needed -- we felt we were being
4 transparent with them and said there was an issue that
5 had been raised by the Consultants about an individual,
6 just to give them some context of them starting their
7 review in our organisation.

8 Q. So again one impression for your comment is
9 that Dr Brearey is off on a frolic of his own. You
10 brought in the RCPCH. They know all about Letby. They
11 haven't found anything. We only had to move her because
12 it was for her own protection from allegations. I mean,
13 that's -- and the Consultants don't have a rationale for
14 their position. That is what we have looked at, each
15 one of these points.

16 Just looking at what you were actually saying there
17 and the choices that you were making about what you did
18 and didn't say, were you trying to undermine the
19 Consultants when you were speaking to Dr Green?

20 A. No.

21 Q. Can you offer --

22 A. But what I do recognise is that I could have
23 clearly -- more clearly articulated the position.

24 Q. Well, you could have said things that weren't
25 misleading, do you mean?

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1 A. They were not intentionally misleading.
 2 Q. You could have avoided saying false things, is
 3 that what you mean by "providing more detail"?
 4 A. I think what I said and what I didn't say, you
 5 know, I have reflected on that and I probably could have
 6 said more, but again none of that was done
 7 intentionally.
 8 Q. Page 24. Let's just have a look at how you
 9 characterise the Consultants, where that asterisk is.
 10 Yes:
 11 "We will need lots of support. From AK
 12 professional perspective sees no issues. There is
 13 an issue around Consultants fuelling the situation."
 14 Now, do you think that the word "fuelling" is and
 15 I don't intend a pun here, inflammatory?
 16 A. It's probably not a good choice of words. But
 17 at the time which is why a grievance was raised in the
 18 first place, some of the Consultants were exhibiting
 19 poor behaviours. And I don't think that helped the
 20 situation. Also recognise having a grievance process in
 21 the middle of all the other reviews that we were
 22 undertaking with their support probably didn't help the
 23 relationships with the Consultants.
 24 Q. We can see, finally, that it was confirmed
 25 with you that there is no investigation into Letby

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1 after all of the information that was gathered around
 2 all of the reviews we needed to make an assessment of
 3 whether she was going back on the unit.
 4 Q. Well, do you think it was a bit premature to
 5 be saying that when you still hadn't had the outcome of
 6 all of your --
 7 A. It probably was a little bit premature. We
 8 needed to get the full picture but it was complex, it
 9 was complicated, and there was an individual in the
 10 middle of this as well as a group of Consultants who
 11 were upset by this process.
 12 Q. You see how telling Dr Green that Letby would
 13 be going back on the ward again is communicating that
 14 you don't think there is anything in the concerns that
 15 are being investigated?
 16 A. I think that was on the back of all the other
 17 elements that had come out of the reviews and was
 18 leading down a clinical route as opposed --
 19 Q. Can you just focus on my question, please.
 20 Do you agree that that is what the impression you
 21 are giving is; that you don't think there's anything in
 22 the concerns because you are simply saying regardless of
 23 the fact there is ongoing investigation, she is going
 24 back on the ward?
 25 A. It was probably premature for me to say that.

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1 herself, which again was factually correct but omitted
 2 the fact that such an investigation had been
 3 recommended; do you agree?
 4 A. It -- it was recommended and we didn't ignore
 5 it and as I mentioned before, we sought legal advice --
 6 Q. Dr Green --
 7 A. -- to guide us what we could or couldn't do at
 8 that time.
 9 Q. Dr Green wouldn't know any of that, would he?
 10 A. No.
 11 Q. On its face, it simply looks as if you don't
 12 think there's an allegation into Letby worth
 13 investigating?
 14 A. You could read it like that, yes.
 15 Q. Is that the way you intended it to be
 16 understood?
 17 A. No.
 18 Q. Of course, what we can see from the earlier
 19 entries is:
 20 "The case will be closed when we get LL back on the
 21 unit".
 22 What you were telling Dr Green across this
 23 interview was that you expected that Letby would return
 24 to the unit?
 25 A. After this process, and doing an assessment

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1 But the view that I had at that time was that it was
 2 more of a clinical issue than an individual with her.
 3 Q. Now, saying it to --
 4 A. Individual issue.
 5 Q. Saying it to Dr Green is one thing. Telling
 6 the person concerned that they are going back on the
 7 unit would be quite another, wouldn't it?
 8 A. Yes.
 9 Q. INQ0014313. Now, this is whilst the grievance
 10 procedure is ongoing and this is a summary of
 11 a discussion you have had with Letby.
 12 The letter is dated 15 November 2016 and we can go
 13 straight to the top of page 2. We can see here:
 14 "Alison explained that further to our previous
 15 discussions it was important that we made you aware of
 16 a change that had been agreed in regards to the
 17 decision-making process for your reinstatement back in
 18 to your role in the neonatal unit.
 19 "As we had previously discussed, the decision had
 20 been previously agreed to sitting at board level.
 21 However, it has been agreed that it should be delegated
 22 to Alison as your Professional Nursing Lead. Alison
 23 explained she had no concerns in returning you back to
 24 the neonatal unit and that we were going to plan for
 25 this with Karen over the coming weeks."

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1 We can also see that at the time it was
 2 acknowledged that the grievance process still provided
 3 an opportunity to share concerns.
 4 Now, the grievance process was about how you and
 5 the other Executives had treated Letby; is that right?
 6 **A.** I think there's two parts that's how -- how
 7 she was aggrieved as to how she was removed from the
 8 unit, but also linked with that she also was very
 9 unhappy with the behaviours of the Consultants.
 10 **Q.** So the grievance process was about how the
 11 Executives had removed her from the unit?
 12 **A.** It's in the way that she was removed, yes.
 13 **Q.** Here is you, a witness in the grievance,
 14 whilst the grievance is going on, having a meeting with
 15 her telling her that she is going to go back on the
 16 unit; do you see that that?
 17 **A.** I recognise that as a conflict yes.
 18 **Q.** Yes, and inappropriate?
 19 **A.** Yes. I have reflected a lot on the
 20 involvement of myself and the direct conversations I had
 21 with Letby and again if -- if I knew then what I know
 22 now, that would not be my normal practice.
 23 **Q.** You are also --
 24 **A.** Sorry --
 25 **Q.** Please --

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1 You were telling Letby before all of the investigations
 2 had been concluded, Dr McPartland hadn't even been
 3 instructed by this stage that she was going back on the
 4 unit.
 5 **A.** That was premature.
 6 **Q.** Well, was that because you had closed your
 7 mind to what those reports might reveal and you were
 8 just operating on the basis you had a single objective
 9 which was to get her back on the unit?
 10 **A.** It wasn't a single objective. It was probably
 11 premature me having that conversation with her at that
 12 time when I knew that all of the other pieces of
 13 information hadn't been concluded.
 14 But again, going back to what I said before, we
 15 were keeping an open mind and tried to not have the
 16 doctors versus nurses scenario which ultimately did end
 17 up feeling like that.
 18 **Q.** But telling Letby that she was going back on
 19 the unit before the investigation was complete is the
 20 very opposite of having an open mind, isn't it?
 21 **A.** I think it was premature of me to have said
 22 that directly to Letby, yes.
 23 **Q.** Is it the very opposite of having an open
 24 mind?
 25 **A.** I think I disagree with that. I think there

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1 **A.** I think what the problem was at that time was
 2 the way in which concerns were raised as in from -- from
 3 the clinical unit directly to Executives caused us
 4 a problem because it didn't go through the usual
 5 governance routes. So by the time it got to us or when
 6 it got to us we kind of as an Executive Team took on the
 7 actions ourselves and in hindsight I think that was
 8 probably inappropriate in some cases and this is
 9 probably one of those examples.
 10 **Q.** So your concern appears to be that the
 11 Consultants, having raised their issue with among others
 12 the Executive Lead for Safeguarding, and one of the
 13 designated officers for Speak Out Safely, that that was
 14 the problem?
 15 **A.** No, not the problem, but they should have gone
 16 through -- I'm not sure why they didn't go through the
 17 usual route which is through their divisional structure,
 18 up through the appropriate committees up to Executives.
 19 Anyone can come straight to an Executive, that's
 20 absolutely fine. But I think what we recognise is
 21 because it came to us directly what we should have done
 22 is -- is push it back down the organisation and there's
 23 a tier of individuals that sit beneath the Executives
 24 that probably felt left out of the loop.
 25 **Q.** The final point about this is self-evident.

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1 was a lot going on and I suppose the conflict for me was
 2 I was the Professional Lead for Nursing as well which
 3 probably wasn't helpful in that conversation that we
 4 were having there.
 5 But yes, I have reflected on that and it could
 6 have -- it could have been done differently in light of
 7 the other investigations that were going on.
 8 **Q.** Now, you, as you have told us, were a witness
 9 in the grievance. You were sent a copy of the draft
 10 outcome letter, weren't you?
 11 **A.** I think I recall that, yes.
 12 **Q.** And you went through it and you made comments
 13 upon it, didn't you?
 14 **A.** I'm not sure. I don't know if that's in my
 15 statement if I made comments on it or not.
 16 **Q.** INQ --
 17 **A.** I don't recall.
 18 **Q.** -- 0056172. So if we can see on this first
 19 page there are some strike-throughs, this is the
 20 version, as we understand it, that you sent back, having
 21 received a copy.
 22 **A.** Okay.
 23 **Q.** If we scroll to page 2, we will see section 7,
 24 where, as we understand it, you have written:
 25 "I conclude I fully ..."

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1 Sorry, the original text said:
 2 "I conclude I fully support the conclusions that
 3 Chris Green came to and uphold this part of the
 4 grievance."
 5 You added:
 6 "Are we adding in Chris' conclusions?"
 7 Do you have any recollection of having done so?
 8 **A.** I don't understand the context of what that
 9 was. No.
 10 **Q.** Well, as we understand it and you must have
 11 a proper opportunity to consider this, but now is not
 12 the time but let me tell you what we understand the
 13 position to be: it was sent to you by HR?
 14 **A.** Okay.
 15 **Q.** That you made comments upon it and sent it
 16 back before the final version was published?
 17 **A.** Okay.
 18 **Q.** Following those comments, a section was added
 19 here. Now, in fairness so I acknowledge the full
 20 picture, the evidence of Ms Appleton-Cairns was that
 21 Mr Green -- Dr Green's conclusions were always going to
 22 be added in there, but nevertheless it would appear that
 23 you, if we have understood it correctly, were making the
 24 suggestion that Dr Green's investigation report
 25 conclusions were added to this report.

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1 can see that section 7 has now been populated. The
 2 conclusion about the Trust's Speak Out Safely appears
 3 there and we can then see:
 4 "However, I do not find the Consultants' concerns
 5 when reiterated to the Executive Team were clear, honest
 6 and objective. GMC guidance."
 7 That is how the final version after, as we
 8 understand it, it has been sent to you, you have made
 9 comments upon it and it's come back.
 10 **A.** Okay. I don't recall. What question are you
 11 asking, sorry?
 12 **Q.** Well, the question is:
 13 "Can you see how that passage there criticising the
 14 Consultants by reference to their regulator is greatly
 15 increasing the temperature of this process?"
 16 **A.** I acknowledge it probably wasn't helpful to
 17 use that terminology.
 18 **Q.** Was it your intention that that found its way
 19 into the final report?
 20 **A.** No, I absolutely don't recall making
 21 amendments to that document.
 22 **Q.** Well, as I say, we will send the references
 23 and we will be transparent about your response?
 24 **A.** Yes.
 25 **Q.** My final part, Dr Jayaram.

203

1 Do you have any recollection of having done this at
 2 all?
 3 **A.** No, I would not normally be very involved in
 4 grievances, that would sit with HR so I really don't
 5 recall that.
 6 **Q.** If it turns out to be the case -- and we will
 7 send the references over to you --
 8 **A.** Please, yes.
 9 **Q.** If it turns out to be the case that you have
 10 commented upon the draft outcome, would you agree now
 11 that that would be inappropriate --
 12 **A.** Yes, I would.
 13 **Q.** -- given that you were one of the people about
 14 whom the grievance was made and you were a witness in
 15 it?
 16 **A.** Yes, I would agree with that.
 17 **Q.** Now, one of the conclusions of Dr Green that
 18 is added in, it is the first part of what is added in
 19 and I am sure you can recall this, is a comment upon the
 20 fact that the doctors had not acted honestly by
 21 reference to good medical practice. Do you remember
 22 that passage in the outcome letter?
 23 **A.** No, just repeat that, please?
 24 **Q.** Well, it may just be easier if I show you,
 25 INQ0003158, page 2. This is the final version and we

202

1 On 16 March 2017 there was a directors' meeting and
 2 I will bring up the notes, INQ0003344. So this is --
 3 firstly, just familiarise with it, we can see your
 4 initials at the top. In fact, we have looked at this
 5 meeting previously but we are going to focus upon
 6 another part of it.
 7 At this time, so that everybody is anchored, this
 8 was the time at which there was discussion about whether
 9 Dr Jayaram would engage in mediation with Letby --
 10 **A.** Okay.
 11 **Q.** -- where the Consultants had been required to
 12 write their letter of apology, that happened a few weeks
 13 earlier and we know that shortly before this the letter
 14 was written or the email was written by Mr Harvey that
 15 we have looked at already mentioning the GMC so that is
 16 all the context to this.
 17 If we go to the bottom of page 2, we can see that
 18 there is discussion about something that Dr Jayaram had
 19 said to Sue Hodgkinson the day before, and we can see
 20 a comment that she makes, we are going to come to the
 21 substance of it in a moment but "Ravi cannot see
 22 perceived gap between doctors and nurses". Do you see
 23 that entry, about two-thirds of the way down?
 24 **A.** Thank you.
 25 Yes, I have seen that.

204

1 Q. So that is part of what Ms Hodkinson -- the
2 meeting comes back and forth from what Dr Jayaram has
3 said the previous day but that is one of the things that
4 Ms Hodkinson is reporting to the group, effectively that
5 he perceives some sort of gap between the way doctors
6 and nurses are being treated is one interpretation of
7 that. So this is just a repetition by Ms Hodkinson
8 about what's been told by Dr Jayaram and we can see that
9 further down, Mr Chambers is recorded as suggesting that
10 you, AK and Sue, to have conversation with Ravi.

11 So it appears that there's been some discussion in
12 the meeting about some disquiet expressed by Dr Jayaram
13 and a proposal being made by Mr Chambers is that you and
14 Ms Hodkinson have a conversation with Dr Jayaram. So
15 far, a fair interpretation of these notes?

16 A. Yes, except, I didn't -- I didn't -- I wasn't
17 involved in conversations with Dr Jayaram.

18 Q. Well, that's the suggestion made --

19 A. The suggestion there, yes, but I think it
20 might have been Sue Hodkinson and Tony Chambers,
21 potentially.

22 Q. Well, we are just working our way through,
23 that is the suggestion made.

24 If we go over the page to page 3, we can have
25 a look a third of the way down. And we can see -- in

205

1 Q. He's here, among other things, talking about
2 his experience of Child K, isn't he?

3 A. Yes.

4 Q. As you say, these are serious allegations.

5 Your first reaction when Mr Chambers suggests how
6 you should respond is that Letby can go back to the
7 unit, despite the fact that you have just had reported
8 to you three specific cases, is that what these notes
9 mean?

10 A. No, I think what I meant there by "the
11 challenge" is I will be challenged if she goes back on
12 the unit.

13 Q. Let's have a look --

14 A. We had significant pressure from the
15 Royal College of Nursing at that time with all the
16 grievance, et cetera, that were supporting Lucy.

17 Q. Well, Mr Chambers responds:

18 "Okay, she goes back and something happens."

19 So that would be exactly what you would expect him
20 to say if you had said she should go back, do you see?

21 A. Yes, I can understand why you say that but
22 I did not refer to it like that and I think at that time
23 we were really shocked that Dr Jayaram hadn't brought
24 any of these concerns to us before and then all of
25 a sudden he was saying the detail around Baby K. So we

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1 fact it is a quarter of the way down:

2 "Sue, three deaths. Lucy at cot. Real concerns.
3 Lucy moved valves aka why not before serious
4 allegations."

5 Then just to complete this:

6 "Sue to check with Ravi re these comments."

7 Then just we have Mr Chambers saying:

8 "Lucy cannot go back to the unit. They want us to
9 throw Lucy under a bus."

10 And then your challenge "She should go back".

11 So that's that part of the discussion?

12 A. (Nods)

13 Q. So let's break it down. Is it right that
14 Ms Hodkinson was reporting to the Executives that
15 Dr Jayaram had raised three specific cases in relation
16 to Letby's behaviour?

17 A. I believe so at the time, yes.

18 Q. We don't have a full transcript of what he
19 said but it appears that he is referring to Letby being
20 beside a cot at one point?

21 A. (Nods)

22 Q. And that Letby moved valves?

23 A. Yes.

24 Q. That is what's captured here?

25 A. Yes.

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1 were quite shocked and horrified and that is when
2 Sue Hodkinson and Tony Chambers went to see Dr Jayaram;
3 it wasn't me.

4 Q. Well, there was an explanation, wasn't there,
5 being offered within the meeting for why Dr Jayaram had
6 not said it before; do you remember?

7 A. Sorry, I don't follow?

8 Q. Just look up towards the top:

9 "They feel like battered wives. Execs is abuser."

10 So that's what you were being told just before that
11 piece of information was imparted. So you have had the
12 shock of the fact that: why now? At that point, doesn't
13 this require action?

14 A. It does and there was action taken after that.

15 I think that terminology at the top is -- is not the
16 best. Like I said before, there were numerous
17 conversations with the clinicians in trying to support
18 them and in reflection we probably could have done more
19 to support them because they were feeling very upset on
20 the back of the grievance, et cetera. So it wasn't the
21 best situation at that time.

22 Q. It's essential to get a full account from
23 Dr Jayaram, isn't it, if you are to understand exactly
24 what he's saying?

25 A. Yes, and I believe that's where Sue and Tony

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1 went to speak to him afterwards.

2 **Q.** And who is it you say went to speak to him?

3 **A.** Sue Hodgkinson and Tony Chambers, I believe, it
4 wasn't me.

5 **Q.** What did you understand to be what he was
6 saying to them after that meeting?

7 **A.** I'm not sure of the detail. But we were quite
8 shocked at what Sue had shared with us at that meeting.

9 **Q.** That's then.

10 Having got over your shock, realised this is
11 a serious allegation, wasn't it absolutely imperative
12 for you as the Executive Lead for Safeguarding to have
13 a full understanding of what Dr Jayaram was saying?

14 **A.** I think we discussed that as a team and it was
15 felt that Sue and Tony go and speak to him.

16 **Q.** So when they went to speak to him after that
17 had happened, did you say to them: okay, what did
18 Dr Jayaram tell you? I want to know as much detail as
19 possible?

20 **A.** I am unsure as to the level of detail that
21 they discussed with Sue and Tony.

22 **Q.** Given how significant this is, and you spent
23 some time in your witness statement remarking upon the
24 significance of it, don't you?

25 **A.** (Nods).

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1 appears to involve absolutely no further progressing of
2 this concern?

3 **A.** I think we discussed -- as those notes suggest
4 we discussed it as an Executive Team and it was agreed
5 that Sue and Tony go and speak to Dr Jayaram.

6 **Q.** Was it also agreed that once they had spoken
7 to him that was the end of the matter?

8 **A.** I don't think so, but I don't recall what the
9 feedback mechanism was at the time.

10 **Q.** Well, you have had a chance to look through
11 all the notes. It never comes up again at any future
12 Exec meeting, does it?

13 **A.** I don't recall, no.

14 **Q.** Why would you not be at the next Exec meeting
15 saying: so what happened with that very serious
16 allegation that Dr Jayaram has made? Why don't we see
17 that?

18 **A.** I don't know. I can't answer that.

19 **Q.** Is that because you just weren't taking it
20 seriously?

21 **A.** We were absolutely taking things seriously.

22 **Q.** Where is the evidence that it was taken
23 seriously?

24 **A.** I -- I am unsure at that time what we did with
25 that information.

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1 **Q.** How is it that sitting there now you don't
2 actually know what happened to follow this up?

3 **A.** Again at the time I -- I don't think any of us
4 were considering -- and I mentioned this earlier this
5 morning, as a safeguarding concern what we were
6 concerned about at that time as well is why Dr Jayaram
7 was suddenly telling us about what he saw or he didn't
8 see that was really significant that he didn't bring to
9 our attention before.

10 **Q.** You have got an explanation for why he may
11 have delayed but whatever the reason for his delay,
12 don't you need to completely understand what it is that
13 he is saying so that you can act upon it?

14 **A.** Yes, should have got the information but
15 I can't recall what information came back after the
16 meeting.

17 **Q.** Because what you tell us is in your witness
18 statement is if you had been told that back in
19 February 2016 that somebody was interfering -- a nurse
20 was interfering with valves, is you would have
21 immediately taken steps to have them suspended?

22 **A.** Yes, yes, action I would have taken. But she
23 was off the unit at this point so that risk had been
24 removed.

25 **Q.** Yes, but your reaction when you are told

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1 **Q.** You see, there were plenty of opportunities to
2 tell people about this event, weren't there? Let me
3 give you some examples so you don't answer in a vacuum.
4 We know that Mr Harvey prepared a summary document on
5 3 April for, it would seem, Mr Medland, the barrister?

6 **A.** Okay, yes.

7 **Q.** Mr Cross prepared a document called
8 "Rationale". We know both of those were sent to
9 Mr Medland.

10 Neither of those documents contain any reference to
11 Dr Jayaram's concerns which were articulated at this
12 meeting only two weeks earlier.

13 Now, obviously they are the authors of that but it
14 would appear that you never said "we really need to
15 include this eye witness evidence that we have from
16 Dr Jayaram about valves being adjusted"; why didn't you
17 do that?

18 **A.** I -- I wasn't involved in any of the -- of
19 pulling together that document for Mr Medland.

20 **Q.** When you spoke to the NMC on 18 May,
21 a conversation we have already gone over, you could have
22 said "we have eye witness evidence from one of our
23 Consultants of valves being adjusted", but you didn't do
24 that. Why not?

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

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1 **Q.** When you refer the matter to the LADO, on
2 27 March, and you are summarising what you think the
3 concerns are, you don't say: a Consultant has some eye
4 witness evidence about valves being interfered with, do
5 you?

6 **A.** No and I don't recall the feedback mechanism
7 from that meeting about what further information he
8 shared.

9 **Q.** So is it the position you just forgot about
10 it?

11 **A.** I -- I can't recall. Honestly, I can't
12 recall.

13 **Q.** Well, is there any other credible explanation
14 for why -- and we will just headline them -- we have got
15 the NMC, LADO, the NMC again when you make the referral
16 on 18 July, your police statement of 15 February 2019,
17 your Facere Melius interview on 23 July 2020, you don't
18 mention this incident in any of those when
19 characterising what the Consultants have said to you?

20 Can you offer any explanation for that?

21 **A.** I haven't got an explanation, I don't know,
22 I don't recall what further follow-up action we took as
23 an Executive Team at that time once that information had
24 been shared.

25 **Q.** Is that because you all just ignored it?
213

1 **MR BAKER:** Ms Kelly, I ask questions on behalf of
2 the Families of 12 babies and children. I am going to
3 ask you first of all about the Thematic Review, some
4 questions about that.

5 **A.** Yes.

6 **Q.** But I want to go back to something that you
7 said to Mr De La Poer when he was questioning you. You
8 said in evidence, he asked you about postmortems and
9 postmortems not suggesting sub optimal care if there was
10 a cause of death and you said:

11 **"Answer:** No, but if you put all of those elements
12 together it doesn't show a particularly positive image
13 of how that unit was being managed and there were
14 a number of -- and the other element is that the words
15 'unexpected' and 'unexplained' were never discussed
16 before June '16."

17 Do you remember giving that evidence?

18 **A.** I do, yes.

19 **Q.** Could we go, please, to INQ0003251 and to
20 page 7 of that, please.

21 **A.** Maybe it's my referral to the Thematic Review
22 that I meant, not June '16.

23 **Q.** Well, let's go to that and see what it says.
24 This is, as you say, the Thematic Review. It's a final
25 version of it from March 2016 and we can -- can you see
215

1 **A.** No, we didn't ignore it, Sue and Tony went to
2 see Dr Jayaram straight away and I'm not sure what the
3 outcome of that meeting was.

4 **Q.** Are you even able to say that they spoke to
5 him about it?

6 **A.** I believe they did but that would be for Sue
7 and Tony to articulate.

8 **Q.** Well, you can tell us what you know. What
9 makes you think that they did speak to Dr Jayaram about
10 it?

11 **A.** I have made an assumption that they did and
12 that was the action from that Executive meeting.

13 **Q.** Does it follow from that that you never asked
14 them: what did Dr Jayaram say?

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

16 **Q.** Is there any record of you anywhere asking:
17 what did Dr Jayaram say?

18 **A.** I -- I cannot find any record of that, no.

19 **MR DE LA POER:** Ms Kelly, thank you for answering
20 my questions. Those are all that I have.

21 My Lady, I wonder if now would be an appropriate
22 moment to turn over to Mr Baker, who I think is the
23 first.

24 **LADY JUSTICE THIRLWALL:** Yes, Mr Baker.

25 Questions by MR BAKER
214

1 the heading "Sudden Deterioration"?

2 **A.** Yes.

3 **Q.** It says:

4 "Some of the babies suddenly and unexpectedly
5 deteriorated and there was no clear cause for the
6 deterioration/death identified at PM."

7 So how does that square with your evidence to the
8 Inquiry that the words "unexpected" and "unexplained"
9 were never used before 2016?

10 **A.** Yes, it was meant to be from the Thematic
11 Review, apologies, not the June '16 timescale.

12 **Q.** Sorry, I didn't hear that clearly; could you
13 just say that again?

14 **A.** I should have referred to the Thematic Review
15 as opposed to just saying the June '16 timescale.

16 **Q.** Well, you should have said that of course
17 "sudden", "unexpected", "unexplained" were words that
18 were being used throughout the early part of 2016 and to
19 suggest they weren't used before June 2016 which was
20 a -- I would say an attempt to denigrate the accounts
21 that were being given to you by the Consultants, was
22 misleading, wasn't it?

23 **A.** I made a mistake, it would have been the
24 Thematic Review that I would have been referring to.

25 **Q.** Well, I'm sorry, it can't be, because
216

1 that's March 2016 and you have said in clear terms that
2 those words were never used before June 2016?

3 **A.** Yes, it was my mistake.

4 **Q.** Well, was it carelessness as to whether you
5 were giving accurate evidence or was it a deliberate
6 attempt to mislead?

7 **A.** No, it wasn't deliberate attempt. It was
8 careless of my timescales.

9 **Q.** Okay when did you become aware that the
10 Thematic Review process was under way?

11 **A.** I think there was a meeting -- a Serious
12 Incident meeting in January, where it was a suggestion
13 that the clinical team were going to do a review and
14 that's when the first draft appeared in February but
15 needed further work as time went on.

16 **Q.** So what you say in your witness statement,
17 paragraph 232 is:

18 "I was already aware of the Thematic Review because
19 of the emails on 15 February 2016 with Ian Harvey and
20 the brief mention of it at a Serious Incident Panel
21 meeting in January 2016."

22 **A.** Yes. Sorry, what paragraph are you at in my
23 statement?

24 **Q.** 232. It accords with what you have just said
25 in evidence a moment ago.

217

1 **Q.** Yes. If we could look please at INQ0003220,
2 please. So this is an email from you to Julie Fogarty
3 dated 2 December 2015, a quarter to 5 and you say:

4 "Sorry if I haven't been clear. I mean the
5 Thematic Review of neonatal deaths recently undertaken.
6 In the spirit of transparency [I think that should be
7 'I would like'] the report to go to the next QSPEC."

8 The originating email at the bottom asks:

9 "Hi, where are things up to re the Thematic Review?
10 I am keen to get a paper to December QSPEC."

11 Julie Fogarty has responded saying:

12 "The updated midwifery element was received in
13 November at QSPEC. It was the paediatric update that
14 was missing."

15 Now, the Thematic Review was the nomenclature used
16 by Dr Brearey and Eirian Powell in their study which was
17 being undertaken during the latter part of 2015?

18 **A.** I think this was, as you can see at the top,
19 my handwritten note is it was quite confusing that this
20 was called a Thematic Review, this was actually the
21 obstetric review that was completed by Sara Brigham at
22 the end of 2015.

23 **Q.** Yes. We can see the handwritten bit at the
24 top. When was that added?

25 **A.** A similar time because at the time that was an

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1 **A.** Yes.

2 **Q.** Is that right, that is the first you had heard
3 that a Thematic Review was under way was when it was
4 mentioned briefly in a Serious Incident Panel meeting in
5 January 2016?

6 **A.** From what I can recall, yes.

7 **Q.** Eirian Powell was part of the Thematic Review
8 process. Given the usual chain of command, wouldn't you
9 have expected her to notify you that she was taking part
10 in a Thematic Review of neonatal deaths in the latter
11 part of 2015?

12 **A.** Not necessarily as a chief nurse. So she may
13 have mentioned that to her line manager so not
14 necessarily.

15 **Q.** Did you have conversations directly with
16 Eirian Powell or was everything done through --

17 **A.** A lot of it was done through the nursing
18 hierarchy which is the team below me.

19 **Q.** Yes. But did you have conversations with
20 Eirian Powell?

21 **A.** During this process yes, I did yes, I did
22 sometimes.

23 **Q.** Were those conversations always documented?

24 **A.** No. Unless they were in action planning
25 meetings which we have already covered today.

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1 obstetric review and as far as I was aware, there was no
2 neonatal review undertaken until we had had the
3 conversation in January is my understanding.

4 **Q.** Sorry when you say at the same time, you are
5 not seriously suggesting this email was printed out that
6 you annotated it and put it in a file somewhere in
7 December 2015?

8 **A.** No, no.

9 **Q.** When did you write:

10 "NB. Despite terminology below this was an
11 obstetric maternity review"?

12 **A.** I can't recall when I wrote that but that
13 would have been on the back of the conversation with
14 Julie Fogarty to discuss the -- the terminology around
15 what that review was actually going to be.

16 **Q.** So to clarify though, did you write that after
17 issues relating to Lucy Letby became known?

18 **A.** I can't answer that question. I have got no
19 recollection of the timing of it.

20 **Q.** You gave evidence about how busy you are with
21 emails and how many you have to deal with. Would you
22 really have had time to go back through all of your
23 emails apropos of nothing at some time prior to
24 Lucy Letby's crimes becoming apparent, print it out and
25 annotate it?

220

1 A. No.

2 Q. No. So is it likely then that this
3 occurred -- this annotation was put in after the point
4 where Lucy Letby's crimes became known?

5 A. I can't comment on that. I have no
6 recollection of the timing of that.

7 Q. Well, isn't it rather a self-serving
8 annotation to move away from the obvious that's in the
9 body of the original email, namely that in December 2015
10 you were aware of a Thematic Review of the neonatal unit
11 and in particular deaths occurring there?

12 A. No. That was confusing terminology about the
13 obstetric review that --

14 Q. Well, as the annotation accepts:
15 "... despite terminology below, this was an
16 obstetric maternity review."

17 A. Yes.

18 Q. Well, the obstetric maternity reviews was the
19 Brigham review and you can take it from me nowhere
20 within the Brigham review does it refer to itself as
21 a Thematic Review of neonatal deaths?

22 A. I think it is just semantics of the
23 terminology. My understanding at that time was that
24 there was confusion around what kind of review was going
25 on and it appeared that it ended up being an obstetric

221

1 and I would like to notify you about the findings."

2 Would it not follow if that were the interpretation
3 that it's likely that you and Eirian Powell had had some
4 discussion prior to 17 March regarding the Thematic
5 Review?

6 A. I think that's highly unlikely. I would not
7 be directly involved with some work being undertaken on
8 a clinical unit. That would not be my role. But she
9 would have had conversations with her line managers and
10 wider clinical team.

11 Q. Yes, but if there was -- if there was
12 a concern about a high mortality rate and a commonality
13 between a particular nurse and that mortality rate,
14 isn't that exactly the sort of thing you would expect to
15 be elevated up through to you? Wouldn't you expect to
16 know about it?

17 A. If what, sorry?

18 Q. Wouldn't you expect to know about it?

19 A. Yes, but I would also expect it to go through
20 the usual channels instead of it coming directly to me.
21 But as I mentioned before, if somebody had such
22 a concern that I would hope that they wouldn't rely on
23 emails for me to see it in my inbox, I would expect them
24 to come and see me personally.

25 Q. There you go. You would expect them to come

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1 review, not a neonatal review.

2 Q. Okay.

3 Well, in that case can we move on, please, to
4 INQ0003089, it's an email I think you will have seen
5 before. Okay, so these are the emails where
6 Eirian Powell attaches or notifies you about the
7 findings of the Thematic Review. So if we go, please,
8 to the bottom at page 2.

9 Now, would you agree:

10 "Hi Alison, I was hoping we could arrange a meeting
11 with you to discuss how to move forwards with regards to
12 our findings."

13 That suggests that Eirian Powell knew that you were
14 already aware of the Thematic Review, it's not language
15 which suggests she has to introduce the concept to you?

16 A. It -- you could assume that but I wasn't aware
17 of the work that Eirian Powell was doing, there was
18 a lot -- it's now come to light that she was doing a lot
19 of reviews herself on the unit which wouldn't involve me
20 or me even having knowledge of that.

21 Q. Okay. So one interpretation of the language
22 she is using, though, is that it assumes some level of
23 knowledge on your part, ie she doesn't begin it with:
24 "Dear Alison, you may not have known but Dr Brearey
25 and I and others carried out a Thematic Review last year

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1 to see you personally?

2 A. Yes.

3 Q. Yes, and isn't it likely therefore if that was
4 your expectation that is exactly what Eirian Powell had
5 done?

6 A. No, I don't recall her coming to my office.

7 Q. Well, presumably there's lots of things you
8 don't recall. You don't recall receiving this email, do
9 you?

10 A. I do remember seeing this email.

11 Q. Isn't it plausible that Eirian Powell did come
12 and see you in your office some time prior to 17 March
13 and discussed the Thematic Review with you?

14 A. I think it's highly unlikely. I'm not sure
15 what was in her evidence but there was obviously the
16 email trail about wanting to share the information that
17 she had been doing at a unit level and requesting
18 a meeting as we discussed earlier.

19 Q. Okay. Let's assume then if you did receive
20 this email from a standing start and had no prior
21 knowledge of it, the Thematic Review, looking at
22 Eirian Powell's email to you, can you see within that
23 anything that might cause you alarm or concern?

24 A. I think as we talked earlier you could work
25 your way through each of those points, points 1 to 3,

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1 but then that is qualified by despite reviewing these
2 cases, there's nothing obvious that we are able to
3 identify.

4 So for me, there wasn't significant concerns being
5 raised and they were the experts, Eirian and
6 Stephen Brearey were doing that themselves.

7 **Q.** Is that what they are saying? I mean, despite
8 reviewing these cases there was nothing obvious that we
9 were able to identify, therefore your input would be
10 valued.

11 In the context of high mortality, a commonality was
12 that a particular nurse was on duty either leading up
13 to or during, "this particular nurse commenced working
14 on in the unit in January 2012 without incident". What
15 do you think they are getting at with a commonality with
16 a particular nurse?

17 **A.** They had obviously done some workaround
18 staffing but again that wasn't giving me a full picture
19 so I think what I was focusing on was the qualified
20 statement at the bottom which was: Eirian was raising
21 this and as far as they were concerned there was no
22 obvious issues going on and that's why they needed our
23 further review, further input.

24 So there was nothing for me that significantly
25 raised concerns at that time.

225

1 you and Ian a copy of the report. Unless you had spoken
2 to Ian Harvey, how would you know that he hadn't already
3 got one from Stephen Brearey?

4 **A.** I didn't. I would just assume that if she was
5 sending it to me it would be helpful to send it to him
6 as well.

7 **Q.** So if we go up the page you can see that
8 Eirian Powell sends you the report, just go on to the
9 next page, sorry, page 1. 11.02, so she sends you
10 a copy of the report, 11.02 on 21 March, an hour or so
11 after you emailed her.

12 That is a report that we saw earlier that talked
13 about sudden, unexpected and unexplained deaths?

14 **A.** Yes.

15 **Q.** Yes. You had so little curiosity in
16 Eirian Powell's emails and attachments that you can't
17 recall reading them, the attachments?

18 **A.** I am -- I'm not sure, no.

19 **Q.** Is that an honest answer, that you didn't open
20 the attachment?

21 **A.** Yes, it's quite possibly that I read the email
22 and at that time, the same time, didn't open the
23 attachment.

24 **Q.** So an email that commences: high mortality,
25 commonality of a particular nurse and you are sent

227

1 **Q.** So that was -- I mean, you didn't pick the
2 phone up to Eirian and say: hang on a moment what's all
3 this about, high mortality commonality of a member of
4 staff; no?

5 **A.** No, I wouldn't go directly to a ward manager.

6 **Q.** Okay.

7 **A.** Usually it would go through my nursing team.

8 **Q.** So instead you take four days to get back
9 saying:

10 "Can you send Ian and I the report in the first
11 instance."

12 Had you discussed this with Ian Harvey in the
13 interim?

14 **A.** I don't recall. I think we had our catch-up
15 in April around the review that was more finalised at
16 that point.

17 **Q.** This is still March. I mean, if you discussed
18 it with Ian, how did you know that Ian didn't already
19 have a copy?

20 **A.** I think he had a draft copy which he sent to
21 me in February.

22 **Q.** Yes, but how did you know that, for example,
23 Stephen Brearey hadn't sent Ian Harvey a copy?

24 **A.** Sorry, can you repeat that?

25 **Q.** Yes. So you are asking Eirian Powell to send
226

1 a report in response to your request for that report,
2 and you don't even open the attachment?

3 **A.** I can't recall when I did.

4 **Q.** Isn't Eirian Powell's email ringing obvious
5 alarm bells to you about what this might all be about?

6 **A.** I think what I focused on at the time was the
7 qualifying statement underneath which was almost
8 reassuring, so it wasn't saying: we need a meeting
9 tomorrow, this is very, very urgent. It was almost done
10 in a passive way, as in: we have done this piece of
11 work, we are just going to ask -- it would be good if we
12 could have a conversation with you and Ian about any
13 further actions that we might need to take.

14 So for me reading it, and it's great in the cold
15 light of day to look at it now, but at the time it
16 didn't raise significant concerns with me.

17 **Q.** Right. So you would blame Eirian Powell for
18 not being explicit enough in her emails to you?

19 **A.** I am just talking about the way that sometimes
20 messages get lost in emails and it's not a great form of
21 communication.

22 **Q.** Can we go to INQ0107095, please. Now
23 Eirian Powell had sent you a further email on 14 April,
24 which enclosed an updated copy of the report, of the
25 Thematic Review, okay? But if we can go please first of

228

1 all to INQ0107095 and page 148 of that, please.
 2 It can take a little time to catch up, I think.
 3 There we go.
 4 So at the top of that page it is 11 April, so this
 5 is before Eirian Powell sends you the updated Thematic
 6 Review, but after she had sent you the 2 March version
 7 okay.
 8 So NNU -- it is your discussion. It is your
 9 one-to-one with Ian Harvey:
 10 "NNU Thematic Review paed/NNU poor ..."
 11 And then "maternity" or "with maternity".
 12 So if you are having a conversation with somebody,
 13 Ian Harvey, on 11 April 2016, referring to the Thematic
 14 Review, isn't it axiomatic that you have read it before
 15 that?
 16 **A.** Potentially, or we just had that as an agenda
 17 item to talk about generally in terms of needing to
 18 meet. I think there is a further one-to-one I had with
 19 Ian after that.
 20 **Q.** Well, we are going on to the next page, if we
 21 can, then. So we have got zoomed in here but this will
 22 do.
 23 "Follow-up feedback from external Consultant ..."
 24 What's the squiggle before "Steve Brearey"?
 25 **A.** "Re".

229

1 **A.** We would have just been talking generally
 2 about where's it up to? What we are doing with it?
 3 What meeting does it need to go to? As we put there it
 4 goes to the quality meeting for noting, Steve Brearey to
 5 attend. So more about logistics than the actual content
 6 at the time is my recollection.
 7 **Q.** Yes, but your evidence -- let's be clear about
 8 this -- is on 2 March Eirian Powell emails you and says:
 9 I want to talk about the Thematic Review, high
 10 mortality/commonality. You ask for a copy of that, you
 11 are sent it on 21 March, your evidence is, as
 12 I understand it before the Inquiry, you probably didn't
 13 read it.
 14 Now, here we have a meeting on one-to-one with
 15 Ian Harvey, Medical Director, on 11 April 2016. Are you
 16 honestly saying you hadn't read the Thematic Review by
 17 this point?
 18 **A.** I probably did. I can't remember the timing
 19 of that.
 20 **Q.** Yes, so by this point, you would have been
 21 aware, not only of the commonality and the increased
 22 mortality, but also that deaths were sudden, unexpected,
 23 and unexplained, wouldn't you, if you had read it?
 24 **A.** Yes, but the first line at the top of the
 25 report says "no common -- common themes".

231

1 **Q.** "... re Steve Brearey/Ian Harvey. NNU
 2 mortality QSPEC for noting. SB [Steve Brearey] to
 3 attend."
 4 What is the "external Consultant Re Steve Brearey"?
 5 **A.** I don't recall unless that was some
 6 communication from the network in terms of Nim.
 7 **Q.** Well, what feedback would you be expecting
 8 from an external Consultant regarding Steve Brearey in
 9 the context of the NNU mortality?
 10 **A.** I have no idea what that refers to. Possibly
 11 a network --
 12 **Q.** But again --
 13 **A.** -- reference.
 14 **Q.** You are here again discussing or noting
 15 discussions regarding NNU mortality on 11 April so it's
 16 before you have received the updated version on
 17 21 April. Again, isn't it -- or 14 April, sorry.
 18 Isn't it inevitable that you have read the Thematic
 19 Review by that point?
 20 **A.** Potentially, but not necessarily.
 21 **Q.** Would you have attended a meeting and
 22 discussed a Thematic Review that you hadn't read?
 23 **A.** Are we talking about the May meeting now or
 24 this?
 25 **Q.** No, no, we are talking about the April?

230

1 **Q.** If we go on then to the next one to one with
 2 Ian Harvey, now this is the INQ0003385, and we are now
 3 on 18 April 2016. We by this point you have had a copy
 4 from Eirian Powell on 14 April of the updated Thematic
 5 Review which has Lucy Letby's name highlighted in red
 6 within it?
 7 **A.** (Nods)
 8 **Q.** Now, if you look at -- it's just under -- is
 9 it week commencing 20 April, can you see that there?
 10 CQC discussion.
 11 **A.** Sorry, whereabouts on the page?
 12 **Q.** It is the second entry down?
 13 **A.** Right, yes.
 14 **Q.** "CQC discussion re interview leads for ..."
 15 **A.** Dashboard.
 16 **Q.** "... dashboard re QSPEC."
 17 **A.** "EOL" is end of life.
 18 **Q.** Thank you.
 19 Then it says:
 20 "NNU Mortality Review, document including staff."
 21 Now, doesn't "document including staff" indicate
 22 that you are now aware that there is a document,
 23 a Thematic Review which includes reference to individual
 24 staff members?
 25 **A.** Potentially, yes.

232

1 Q. Can you think of any other explanation as to
2 why you would have written "document including staff"
3 under Mortality Review in April 2016 unless you were
4 referring to the document sent to you by Eirian Powell
5 on 14 April 2016?

6 A. Yes, that will have been just a conversation
7 with Ian and I will about the fuller report including
8 the staff.

9 Q. Yes, so again by 18 April, because this is
10 your planning ahead, isn't it, for the week commencing
11 the 20th but the note is written on 18 April, you were
12 aware that there was a Mortality Review, a Thematic
13 Review which highlighted Lucy Letby's name in red?

14 A. We probably talked about that in that meeting,
15 yes. I can't recall at what point we discussed that
16 report because there were a number of iterations but the
17 final one, you are correct, had Lucy Letby's name in
18 red.

19 Q. Yes, so that was actually the version that was
20 sent to you on 14 April by Eirian Powell. So it's the
21 name highlighted in red.

22 So it would follow, wouldn't it, a few days later
23 here you are discussing "document including staff" must
24 be referencing that document?

25 A. Possibly, yes, in the catch-up.
233

1 Now, that seems to be a fairly logical construction
2 of what's written there?

3 A. It does feel that that would be logical but
4 I have absolutely no recollection as to what -- what
5 that was on there for. It -- I don't think it was
6 linked at all to the NNU.

7 Q. Well, it's written directly. It's written as
8 part of the NNU Mortality Review section, isn't it?

9 A. It would be highly unusual for me to instruct
10 Hill Dickinson to do any legal work. It wasn't part of
11 my portfolio so I can't really explain why that is
12 written there or what indeed the action was.

13 Q. But suspicions about a member of staff being
14 associated with a rise in mortality is quite an unusual
15 situation, isn't it?

16 A. It is, but like I said, I have no idea why the
17 Hill Dickinson reference is there.

18 Q. Now, in fact if we go on then please to your
19 emails of INQ --

20 **LADY JUSTICE THIRLWALL:** Mr Baker, just before you
21 do that, I wonder if we might just check the date of
22 that highlighted entry?

23 **MR BAKER:** Of course.

24 **LADY JUSTICE THIRLWALL:** I think I heard you say
25 20 April I wonder if it was the 25th?
235

1 Q. Possibly or probably?

2 A. I can't -- I can't recall the detail of the
3 conversation. But we have obviously had it on our
4 agenda to talk about.

5 Q. It goes on to say:
6 "[Query] review by Hill Dicks."

7 Now Hill Dicks are a firm of solicitors, they are
8 not the ones who do the employment cases; we heard that
9 is DAC Beachcroft?

10 A. Yes.

11 Q. Hill Dickinson are the firm who represent the
12 Trust in relation to negligence matters?

13 A. Yes, they did and I have reflected on that
14 comment and I don't know why that is written underneath
15 the NNU Mortality Review because that's not something we
16 would ordinarily do and I didn't even have any contact
17 with Hill Dickinson. That came through the legal team.

18 So I am -- I'm not sure of the context of why
19 I wrote that there.

20 Q. Yes. Isn't it obvious, we can piece it
21 together: there is a conversation going on with
22 Ian Harvey in April 2016, referencing the Mortality
23 Review, noting that there is now a document that
24 includes staff members on it and asking the question: do
25 we need to have this reviewed by our solicitors?
234

1 **MR BAKER:** I think it could be 25 April. It says
2 "week commencing 25th", I think.

3 **LADY JUSTICE THIRLWALL:** It's your writing,
4 Ms Kelly.

5 A. It would be WC, week commencing, the 25th.

6 **LADY JUSTICE THIRLWALL:** Yes, thank you.

7 **MR BAKER:** The 25th. If you are writing "week
8 commencing 25 April", is that a note you are making on
9 18 April or on 25 April?

10 A. I'm not sure it looks like a separate entry.

11 Q. I think in your witness statement you describe
12 it as part of a note you made during your one-to-one
13 with Ian Harvey on 18 April?

14 A. It does look like that because we would go
15 through a list of topics we needed to discuss and
16 I would write some notes on each of those.

17 Q. But in any event it's before you speak to the
18 Consultants formally? Before you speak --

19 A. Yes, yes.

20 Q. And if we could go on then please to
21 INQ0003138, again you have seen this before, if you look
22 at the email at the bottom 4 May 2016:

23 "Ah, can you please look at this with Anne and
24 Eirian. If there is a staff trend here and we have
25 already changed her shift patterns because of this and
236

1 this is potentially very serious."

2 What do you mean by "potentially very serious"?

3 **A.** That we could have a competency problem --

4 **Q.** Yes.

5 **A.** -- is what my first reaction was to that.

6 **Q.** Yes. The next one you can see here Lucy Letby
7 highlighted in red.

8 "I had not noticed this when I first reviewed. Can
9 you look at this per my previous email?"

10 If we go on to emails that you were sending to
11 Ian Harvey at around the same time, so that is
12 INQ0003087, you can see you are sending on an email here
13 from Stephen Brearey, who's upset that you haven't been
14 able to have a meeting so far:

15 "There is a nurse on the unit who has been present
16 for quite a few of the deaths and other arrests and she
17 he has sensibly been put on day shifts, only at the
18 moment."

19 So again that is the same comments that you were
20 making in your previous emails about the shift to day
21 shifts.

22 You say:

23 "Hi Ian, please see Steve's comments below which
24 alarmed me."

25 Now, why did you find them alarming? Was that
237

1 flags here that require action and seemingly on the face
2 of it, you and/or Ian Harvey aren't taking any action,
3 and I represent the Families of two of the Triplets
4 O and P who died in June and they would suggest that
5 delays at this time allowed Lucy Letby to go on and
6 murder their children.

7 Now, on reflection, do you think that things could
8 have been done more expeditiously through March, April
9 and May to bring forward a meeting to seriously discuss
10 these issues?

11 **A.** I think I mentioned before and, you know,
12 reflected on this that there were delays and I don't
13 know why there were delays, I haven't got access to my
14 diary, in meeting with the team to discuss this in more
15 detail.

16 I think that the sense as I mentioned before of
17 there was lack -- for me there was a sense of lack of
18 urgency to meet and so it did kind of tick along longer
19 than it should have -- should have done.

20 **Q.** Well, there seems to be reasonable expedition
21 on the part of Eirian Powell when it comes to answering
22 your request to send you things.

23 **A.** Yes.

24 **Q.** It was open to you to pick the phone up or
25 indeed to email people faster and say "let's set
239

1 because of the same reason?

2 **A.** Yes, I thought we had a competency issues and
3 that was being called out.

4 **Q.** Is it right to say then certainly by

5 4 May 2016, if not before, there's an obvious
6 safeguarding issue, isn't there?

7 **A.** Yes, and we talked about safeguarding earlier
8 on.

9 **Q.** Yes.

10 **A.** But it was more around -- again I'll repeat
11 what I said earlier, at the time we were looking at
12 concerns through a mortality lens, not a safeguarding
13 one and it wasn't clear. But this particular -- about
14 the particular nurse in terms of Letby, the first place
15 I went to was competency.

16 **Q.** Well, it may be the first place you go to, but
17 competency, a nurse causing a rise in mortality, it
18 still is a safeguarding issue, isn't it?

19 **A.** Sorry, say that again?

20 **Q.** A nurse causing a rise in mortality due to
21 incompetence is a safeguarding issue, isn't it?

22 **A.** Potentially, yes, but at the time we needed to
23 find more information out.

24 **Q.** Can I be explicit about this: between March,
25 April, May we have got I would suggest a number of red
238

1 a meeting up". Are you seriously blaming the people who
2 were bringing this to your door --

3 **A.** No, but what I am saying is when you are in
4 charge of a whole hospital there are challenges with the
5 timeliness that you get to actions and I recognise that
6 some of these actions should have been taken more
7 timely. And it's, you know, people could have come and
8 spoke to me or picked up the phone. My PA would
9 invariably take urgent messages from teams to come and
10 speak to me. So again going back to what I said before,
11 communication via email is not that good in terms of
12 raising significant concerns.

13 **Q.** Were you too busy to do your job?

14 **A.** Sorry?

15 **Q.** Were you too busy to do your job properly; is
16 that your evidence?

17 **A.** I was -- I am not saying I was too busy not to
18 do my job, I was a very busy person. My portfolio was
19 very large, so getting to emails in a timely way was
20 difficult. You will see some of the emails are either
21 very first thing in the morning -- excuse me.

22 **Q.** Was it the case that -- I mean, if you can't
23 see your emails and people are emailing you about
24 potential safeguarding issues and you can't manage your
25 emails because you can't get to them or there's too many
240

1 of them, that's an obvious safety issue. Why didn't you
 2 raise it with the hospital?
 3 **A.** I think I sit here as a chief nurse and
 4 I would say that everybody else in my position would be
 5 in exactly the same position in terms of workload. The
 6 other thing to mention, though, is everybody in the
 7 organisation was responsible for safeguarding, there was
 8 specific safeguarding doctors, specific safeguarding
 9 nurses, nobody raised any concerns with any of those
 10 individuals and -- and the clinicians on the unit didn't
 11 raise a safeguarding concern.

12 **Q.** But --

13 **A.** So there could have been some action taken
 14 before it had got to me.

15 **Q.** If everybody says it is somebody else's
 16 responsibility then nobody does it; that is the risk,
 17 isn't it?

18 **A.** I recognise that, but the safeguarding policy
 19 actually says safeguarding is everybody's
 20 responsibility, which is good when that works in
 21 practice but I recognise what you are say in terms of
 22 everybody thinks everybody else is doing something.

23 **Q.** The Speak Up Safely policy says that you are
 24 to raise your safeguarding issues as quickly as possible
 25 because delay can cause for continuation of harm,

241

1 **A.** That's right.

2 **Q.** So he's provided you with a summary of the
 3 discussion and you have changed it so it fits with your
 4 recollection of the meeting or the discussion?

5 **A.** Yes.

6 **Q.** It's the final item amongst the list of
 7 question marks. It says:

8 "The Executive Team are due to meet today 6 July to
 9 decide if this registrant will be reported to the police
 10 to investigate."

11 So you have obviously had a conversation with
 12 Tony Newman at the NMC where you have advised him that
 13 the Executive Team -- he has written "Trust board" but
 14 you have changed that, the Executive Team were due to
 15 meet on 6 July 2016 to decide if there would be a report
 16 to the police regarding Lucy Letby; do you see that?

17 **A.** Yes.

18 **Q.** Now, was that actually discussed on
 19 6 July 2016, because I can't see?

20 **A.** I'm not sure. I think we were talking
 21 generally around because all the concerns that had been
 22 raised at the end of June '16, we then had a rapid
 23 series of actions that we took as an Executive Team. We
 24 were talking more broadly around will this require
 25 police investigation, but as I mentioned earlier we

243

1 doesn't it?

2 **A.** Yes.

3 **Q.** If you raise those concerns and nobody can act
 4 on them, or does anything about it --

5 **A.** Sorry?

6 **Q.** If you raise your concerns, if you elevate
 7 your whistleblowing concerns and nobody acts upon it,
 8 because they are too busy or don't read their emails or
 9 for whatever reason, that is a serious safety issue,
 10 isn't it?

11 **A.** You could look at it like that, yes. But the
 12 reality is that does happen in practice and I rely on
 13 the rest of my team to flag concerns to me directly if
 14 I cannot get to everything that happens to be in my
 15 inbox.

16 **Q.** I am going to move on just to events following
 17 the deaths of Child O and Child P. You have been asked
 18 questions about the meeting on 29 June. I would like to
 19 ask you questions about the 6 July 2016. But first of
 20 all can we go to INQ0014261 and to page 3 of that
 21 document, please.

22 So this is an exchange between you and Tony Newman,
 23 the regulation adviser for the NMC. You can see that
 24 here is an email, 6 July 2016, it has been amended by
 25 you to correct his note. Does that make sense to you?

242

1 decided that we needed to find more information out
 2 internally before we went to the police.

3 **Q.** Yes, but I mean don't --

4 **A.** So I'm not sure of that reference there.

5 **Q.** Yes, but you have obviously checked it because
 6 you have changed "Trust board" to "Executive Team"?

7 **A.** Yes.

8 **Q.** Now, it's fairly explicit, isn't it, it is not
 9 a vague record, it is a record of an Executive Team due
 10 to meet today, 6 July, to decide if this registrant will
 11 be reported to the police to investigate.

12 Do you agree that the obvious inference from that
 13 is that that is what you told Tony Newman during your
 14 conversation?

15 **A.** Yes, that was my understanding at the time.

16 **Q.** Yes.

17 **A.** But I think once we had got together as an
 18 Executive Team there was further discussions going
 19 forward around what we needed to do internally before
 20 the police.

21 **Q.** So other people of course will look at the
 22 6 July meeting and what happened there. We can actually
 23 look at your account of it because you have it in your
 24 witness statement from paragraph 403 onwards. You give
 25 an account of the meeting here.

244

1 So page 120 of your witness statement. Do you
 2 agree that that account of the meeting does not record
 3 any discussions about calling the police? Take your
 4 time to read it. (Pause)
 5 **A.** No, I think that's because when we got
 6 together as a team we felt we needed to do the internal
 7 work before going to the police.
 8 **Q.** Yes, but you have to get there, don't you,
 9 there has to be a conversation about: are we going to
 10 call the police or not? That meeting on 6 July doesn't
 11 record any conversations at all about the question of
 12 whether we are going to call the police or not.
 13 **A.** No, I don't, I have not written anything down
 14 I don't recall.
 15 **Q.** Now, were you misleading Tony Newman when you
 16 reassured him that there was going to be an Executive
 17 Team discussion on 6 July to decide if the police should
 18 be called?
 19 **A.** I don't think I was at that time because
 20 I think that's what genuinely we were going to talk
 21 about as an Executive Team, but then that went into lots
 22 of other actions.
 23 So I think at the time I was being absolutely
 24 honest with Tony Newman.
 25 **Q.** You weren't absolutely honest with him or were
 245

1 in July 2016 which was also attended by Sian Williams.
 2 Now, by July 2016, you were aware that serious
 3 concerns had been raised regarding the conduct of
 4 Lucy Letby, you were aware that discussions regarding
 5 calling the police had been floated around because
 6 that's what you said to Tony Newman. You were aware
 7 that the RCPCH report was being commissioned or being
 8 undertaken to investigate some issues on the face of it
 9 perhaps surrounding Lucy Letby and you had a meeting
 10 with Mother C in July after she became aware through an
 11 article in the Chester Chronicle that there was an
 12 investigation under way.
 13 Now, do you recall meeting with Mother C?
 14 **A.** So I have reflected on this and I had no -- as
 15 far as I am aware -- I am not saying that the meeting
 16 didn't take place, as far as I am aware I didn't meet
 17 with any Family members. My deputy, Sian Williams, and
 18 Ian Harvey kind of coordinated the family communication.
 19 So I don't recollect having a conversation with
 20 Mother C.
 21 **Q.** Okay, she came into the hospital I think
 22 apropos of nothing and having read the article or become
 23 aware of the article --
 24 **A.** I believe so, yes.
 25 **Q.** -- in the Chester Chronicle and waited
 247

1 you, sorry?
 2 **A.** I was.
 3 **Q.** You were?
 4 **A.** Yes.
 5 **Q.** So you believed that that was going to be
 6 discussed at the 6 July. You went into the meeting, you
 7 must have been astounded when nobody mentioned it. Did
 8 you not think to raise it?
 9 **A.** If it's not documented I'm not sure what we
 10 discussed about the police. I think we kind of went
 11 into action mode around what we needed to do and I am
 12 not certain whether we actually talked about the police
 13 or not, if it's not documented.
 14 **Q.** It's not documented. Okay so I am going to --
 15 **A.** But I think the intention was when I spoke to
 16 Tony that that's what we were going to do.
 17 **Q.** But somewhere between the cup and the mouth
 18 that just vanished?
 19 **A.** Sorry?
 20 **Q.** Somewhere between that conversation and the
 21 meeting starting, the any suggestion the police might be
 22 discussed was just forgotten about?
 23 **A.** Well, not forgotten, maybe not documented.
 24 I'm not sure, I can't comment.
 25 **Q.** Finally, you attended a meeting with Mother C
 246

1 a little while and you and Sian Williams came down and
 2 met with her in a room to discuss the Royal College
 3 report?
 4 **A.** Right. I really don't recollect that.
 5 **Q.** Okay. Well, she recalls that conversation
 6 very clearly. It's plausible you have forgotten about
 7 it. You are not disagreeing that that took place?
 8 **A.** I am not disagreeing it didn't happen.
 9 I don't recall having any conversations with any Family
 10 members of any babies at that time.
 11 **Q.** What you said to her, and I am going to just
 12 read from her evidence before the Inquiry:
 13 **"Answer:** So this lady went and got Sian Williams
 14 and Alison Kelly who came down and spoke to me. It was
 15 a fairly short meeting to my recollection where I was
 16 told by them that there was an investigation being done
 17 by the Royal College that was more of a formality
 18 because there had been a very small increase in the
 19 number of deaths, but it was looking at various sort of
 20 logistical things like staffing levels and that sort of
 21 thing and that they weren't really expecting anything to
 22 come from it and that they tried to contact me because
 23 that was -- that was challenging."
 24 Now, given what you knew at the time that was
 25 completely misleading, wasn't it, if you said that?
 248

1 **A.** If I said that, if I was at that meeting
 2 I absolutely don't recall meeting any Families like
 3 I said. But I think one of the things that one of the
 4 key elements and it's in my reflections of -- of this
 5 case is that we didn't get the communication right with
 6 Families and we didn't get the balance right and I think
 7 that is an example of where we didn't get it right.
 8 **Q.** Yes. Mother C was pregnant at the time, her
 9 previous child had died, as it turns out murdered by
 10 Lucy Letby, and it's not about communications.
 11 I suggest, based upon what you knew, you lied to
 12 her?
 13 **A.** I don't recall. Honestly, I don't recall that
 14 meeting. But what we did talk about as an Executive
 15 Team is the fact that we could have done much, much more
 16 to support Families. And it was clear that each Family
 17 potentially wanted to be communicated with in
 18 a different way, so to meet the needs and expectations
 19 of those Families we -- we should have done more to do,
 20 to meet those expectations and we didn't.
 21 **Q.** I can't imagine any of the Families wanted to
 22 be lied to.
 23 **A.** I'm not saying that they were lied to.
 24 **MR BAKER:** Thank you, my Lady. I have no more
 25 questions.

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1 **A.** Very usual, I would normally chair it and if
 2 it's not me, it would be the Medical Director,
 3 Ian Harvey.
 4 **Q.** How usual was it for there to be an incident
 5 meeting about three deaths?
 6 **A.** We could have spikes across the hospital,
 7 infrequently but not usually.
 8 **Q.** Had you attended a Neonatal Mortality Meeting
 9 of this kind before with three babies having died within
 10 two weeks?
 11 **A.** I didn't attend any Mortality Meetings as
 12 a Director of Nursing. Are you talking about the --
 13 **Q.** I am using, sorry, I used the wrong shorthand?
 14 **A.** -- extraordinary meeting that we had
 15 afterwards?
 16 **Q.** Yes. You had attended one before?
 17 **A.** Sorry, say that again?
 18 **Q.** My question was: had you attended a meeting
 19 before where there had been a group of three neonates
 20 who died within a two-week period?
 21 **A.** No, not at that time.
 22 **Q.** The purpose was, was it, to look for common
 23 factors between the children and their deaths?
 24 **A.** Yes, potentially, but also to understand each
 25 of the cases individually.

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1 **LADY JUSTICE THIRLWALL:** Thank you, Mr Baker.
 2 We will take a 15-minute break before we continue.
 3 How much has everyone else got, Mr Skelton?
 4 **MR SKELTON:** 10 minutes.
 5 **LADY JUSTICE THIRLWALL:** Thank you.
 6 **MS BLACKWELL:** 20 minutes.
 7 **MR KENNEDY:** About five.
 8 **LADY JUSTICE THIRLWALL:** Thank you. So we will
 9 start again at 5 o'clock.
 10 **(4.45 pm)**
 11 **(A short break)**
 12 **(5.00 pm)**
 13 Questions by MR SKELTON
 14 **LADY JUSTICE THIRLWALL:** Mr Skelton.
 15 **MR SKELTON:** Ms Kelly, I ask questions on behalf of
 16 the [indistinct]
 17 I am just going to deal with two discrete issues,
 18 if I may. One is about the meeting you attended on
 19 2 July 2015 which was the Serious Incident meeting.
 20 **A.** Yes.
 21 **Q.** Do you recall that?
 22 **A.** I do.
 23 **Q.** So this was after the three children had died
 24 in June: Baby A, Baby C, Baby D. How usual was it for
 25 you to attend a Serious Incident meeting?

250

1 **Q.** Dr Brearey in his evidence to the Inquiry,
 2 both in writing and orally, described the process of
 3 going through the children's deaths at the meeting and
 4 then at the end he said that Eirian Powell raised the
 5 observation that Lucy Letby had been on the unit on the
 6 three occasions when the three babies had collapsed and
 7 his reaction, which he described in detail to this
 8 hearing was "oh no, not nice Lucy". And you were at
 9 that meeting and he recalls you having heard that as
 10 well; do you remember that?
 11 **A.** That wasn't said at that meeting,
 12 Eirian Powell wasn't at that meeting, so my notes
 13 reflect that and I have said in my witness statement
 14 that Lucy Letby's name was not mentioned at that meeting
 15 at all.
 16 **Q.** In his evidence he says that your response to
 17 that information that Letby was the connecting factor
 18 because I think Eirian Powell had in fact identified her
 19 quite early on as being the connecting factor, was that
 20 was something you needed to keep an eye on. You said
 21 that: we'll keep an eye on it. Do you remember that?
 22 **A.** No, I don't because Lucy Letby's name wasn't
 23 mentioned at that meeting and Eirian Powell wasn't at
 24 that meeting.
 25 **Q.** Did she ever mention she had spotted the

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1 connection between that member of staff quite early on?

2 **A.** No.

3 **Q.** So even after the issue came up a year or so
4 later, did she ever say: well, in fact, I spotted this
5 back in June 2015?

6 **A.** No, not to my knowledge.

7 **Q.** That's the case even after three more children
8 died and Lucy Letby was connected to those three deaths
9 as well?

10 **A.** Can you repeat that, sorry?

11 **Q.** And she never mentioned it even after three
12 further children died, all of whom were connected to
13 Lucy Letby as well? That is Baby E, Baby I, Baby K?

14 **A.** No, until she started to do the internal
15 reviews that she was doing with Steve Brearey on the
16 unit and then that escalated as we have already talked
17 about today to doing the Thematic Review.

18 **Q.** You have been asked in detail about your
19 evolving knowledge about the Thematic Review that
20 occurred and I am not going to go through that in detail
21 but there is just one email from Dr Brearey that I want
22 today ask you about, it is INQ0107818, this is from
23 4 May. If you could go to -- there should be a second
24 page there, please.

25 So just the email you can just see on 4 May at
253

1 a nurse potential competency issue. That is how I read
2 that.

3 **Q.** You had been involved with the original -- the
4 SI I mentioned?

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

6 **Q.** The mortality continued, which you were aware
7 of, whether you were aware of the details you know that
8 babies carried on dying. And you knew that there was
9 a connection between a member of staff because you have
10 already accepted that you had in fact seen the table by
11 this point in May and he's also mentioning that children
12 had arrested. So this is more information. It's
13 significant, isn't it?

14 **A.** It is more information but again we needed to
15 understand the detail of that which is why it was
16 important that Dr Brearey shared that with us.

17 **Q.** Did you ask him to?

18 **A.** Not at that point, no.

19 **Q.** At any point?

20 **A.** The Thematic Review had additional sections
21 added after discussion with the network which did talk
22 about deteriorating babies which hadn't been in the
23 original report, so that kind of started to build up the
24 picture of what was going on.

25 **Q.** Did you check to see if Letby was associated,
255

1 16:10.

2 "There is a nurse on the unit who has been present
3 for quite a few of the deaths and other arrests."

4 I wondered if you picked up that second phrase "and
5 other arrests", that Steve Brearey was mentioning for
6 the first time it seems not just the fact that children
7 had died but that children had collapsed, arrested in
8 fact, which is the most serious form of collapse, and
9 Letby had also been present for those collapses or
10 arrests. Did you pick that up?

11 **A.** Not at the time because to me that the context
12 of that email was more about staffing concerns as
13 opposed to what he was saying about that particular
14 nurse. The arrest bit is a good point because none of
15 those were actually reported on the Datix system so
16 throughout my Rule 9 request for my statement, I was
17 repeatedly asked: did you know about X baby that
18 deteriorated? No, we never got to know about those
19 until this Inquiry and further reviews that we did
20 because they weren't actually reported at the time.

21 So in terms of that particular email I didn't pick
22 up on other arrests because I didn't understand the
23 context at the time. To me, that was more of a concern
24 about: we have got some staffing issues and they were
25 just flagging it to me, but also had some concerns about
254

1 as he was suggesting, with the arrests as well as the
2 deaths?

3 **A.** Not personally. Not personally, no.

4 **Q.** Again without going into the detail, it
5 appears that what happens over the next couple of days
6 is that Karen Rees takes charge of the issue and liaises
7 with Eirian Powell and others and there is a meeting
8 that takes place which I don't think you attended; is
9 that right?

10 **A.** I don't think I was at that, no.

11 **Q.** Is that the meeting that is with Karen Rees
12 Yvonne Griffiths, Anne Murphy, Eirian Powell?

13 **A.** Okay, so the senior nursing team.

14 **Q.** Indeed.

15 **A.** Yes.

16 **Q.** It appears at that meeting that they discuss
17 Lucy Letby's potential involvement and there is
18 a document, the neonatal mortality document, which
19 Eirian Powell has produced which is one of the
20 attachments that you were sent which you asked to be
21 printed off, which makes clear at the start -- you will
22 be familiar with the document -- that there is no
23 evidence in her opinion against Lucy Letby, do you
24 remember that document?

25 **A.** I do remember the document, is it the one with
256

1 the clinical almost like a clinical case review on the
2 furthestmost column to the right?

3 **Q.** Just briefly in the interests of time, I will
4 put it on screen, 0003243. It's this one.

5 **A.** Okay, right. Yes.

6 **Q.** So this I think is the subject of that meeting
7 that you are discussing --

8 **A.** Yes.

9 **Q.** -- with the three sort of nursing team
10 managers, you are not attending the meeting but they
11 clearly discuss Lucy Letby directly, including the
12 question of whether or not there is sufficient evidence,
13 as they put it -- or she puts it -- against her and they
14 reject that possibility.

15 Now, is it the case then that after this meeting
16 Karen Rees speaks to you and gives you reassurance that
17 Letby is not involved?

18 **A.** I can't recall Karen coming to speak to me
19 directly but I do recall Eirian referring to this
20 document in the meeting of 11 May where Steve Brearey
21 also provided the Thematic Review analysis.

22 **Q.** In the email that you sent to Ian Harvey on
23 6 May, which I won't call up because it's been on the
24 screen many times, the one in which you say you are
25 alarmed, you say: I am currently reassured there are no
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1 investigated further.

2 **Q.** Well, it looks from the big picture as if
3 positions get entrenched around this period of time.
4 There's a meeting of the senior nursing staff who report
5 up to you in which they take the position that Letby is
6 not involved, you rely on that reassurance but it is
7 completely at odds with the Consultants' view which you
8 are aware of, Steve Brearey's view, because he tells you
9 that on the 11th, and in fact that position never
10 changed, did it: you and Karen Rees and Eirian Powell
11 never changed your mind from that point onwards, did
12 you?

13 **A.** I would disagree with that. I think we heard
14 both sides and it's evident from the 11 May meeting we,
15 Ian Harvey and myself, listened to both sides, the
16 clinical and the staffing challenges as well as some of
17 the strategic and operational issues that Eirian Powell
18 articulates in his paper.

19 And as I said before, Dr Brearey had this document
20 but I don't think he had a chance to look at it before
21 the 11 May meeting. But as time went on, yes, I would
22 agree, the relationships did become strained between
23 doctors and nurses and that -- that was, that caused us
24 some difficulty.

25 **Q.** Well --

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1 issues". Who reassured you there are no issues?

2 **A.** I'm not sure it might have been Karen because
3 Eirian would have escalated any concerns up through her
4 nursing structure to Karen, so it may have been Karen
5 that provided that reassurance to me. I felt at the
6 time that there was nothing to be concerned about and
7 I would have got some assurance from my team to make
8 that decision.

9 **Q.** Can I test that, please.

10 The senior nurses have met and they have decided
11 that there is no evidence to connect Lucy Letby to the
12 deaths. They weren't qualified to make that assumption,
13 were they?

14 **A.** Not, not on their own, no.

15 **Q.** And you were reliant on a reassurance
16 therefore which didn't have a proper medical basis?

17 **A.** I think this document I believe once they
18 collated it was shared with Dr Brearey prior to the
19 11 May meeting because it does talk about other issues
20 aside to potential competencies of -- of Letby.

21 So my understanding was that Eirian Powell and
22 Dr Brearey were doing this as a joint piece of work but
23 recognised this was about what you are talking about,
24 was a nursing meeting without doctors there. So it was
25 just one part of a bigger picture which needed to be
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1 **A.** But at this time, from my perspective as the
2 Director of Nursing, I was keeping an open mind. It
3 wasn't just about an individual, she hasn't done
4 anything, we needed to understand more fully what was
5 going on in terms of the raised mortality.

6 **Q.** Well, "open mind" meant that you had to
7 recognise, as you accepted with Mr De La Poer this
8 morning, the possibility of deliberate harm which is
9 what Dr Brearey suspected, number one.

10 **A.** Yes.

11 **Q.** Number two was if that possibility is on the
12 table and it has some basis, as it did from the clinical
13 staff, it was a patient safety issue because you could
14 not exclude that risk safely?

15 **A.** I agree.

16 **Q.** The only option in those circumstances is to
17 trigger the safeguarding process or call the police?

18 **A.** Yes, and as I mentioned earlier on because the
19 focus to start with was around increased mortality, it
20 wasn't just about my -- my view. Everybody looked at
21 this through a mortality lens and not a safeguarding one
22 and I have done a lot of reflection as the Executive
23 Lead for Safeguarding and I accept there would have been
24 some opportunities to have gone down a safeguarding
25 route but it didn't feel obvious at the time.

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1 Q. Well, you are putting it in soft and
2 euphemistic terms, if I may say so. You said at the
3 start of your evidence today when you apologised to the
4 Families, or you acknowledged their loss, that there
5 were things you didn't get right?

6 A. Yes.

7 Q. Can I put it to you this is the thing you got
8 wrong: when you were presented with concerns that raised
9 the issue of potential deliberate harm you did not take
10 the appropriate steps and trigger the safeguarding
11 process?

12 A. Yes, and I mentioned that earlier on. That is
13 one of the things that I have spent a lot of time
14 reflecting on. But at that time it -- it didn't feel
15 obvious. There was lots of things going on and now
16 I know so much more information, it seems obvious to me
17 that that should have happened.

18 But at that time, it wasn't something that was
19 considered by anybody.

20 Q. To be clear, the likely eventuality that would
21 have occurred had you triggered that process is within
22 24 hours the designated officer would have been alerted,
23 the police would have been alerted and Letby, in all
24 likelihood, would have been suspended pending an
25 investigation to check safety of the unit.

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1 digest the Thematic Review?

2 A. That is my recollection, yes.

3 Q. All right. Can we just test that piece of
4 evidence. If we go back to the 2 July, so the
5 special -- SI Panel meeting which considered the three
6 neonatal deaths, so A, C and D, in answer to
7 Mr Skelton's questions you told him it would be -- it
8 was unusual for you to be considering three deaths in
9 one meeting?

10 A. Yes.

11 Q. All right. Three neonatal deaths in one
12 meeting?

13 A. Yes.

14 Q. Would one question for you have been -- and
15 bearing in mind these were three deaths in 14 days,
16 would one question for you have been: how does that
17 compare to the unit's normal performance?

18 A. Yes, that could have been a question that
19 could have been asked, but Dr Brearey did a presentation
20 to that meeting and had articulated quite clearly his
21 Mortality Reviews of each of those cases and in light of
22 his expertise in doing those reviews, there was nothing
23 that he was raising as a concern at that meeting that
24 I should have been concerned about albeit there was
25 a cluster of deaths which I now believe can happen but

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1 A. That -- that would have been the process, yes.

2 MR SKELTON: Thank you.

3 Thank you, my Lady.

4 LADY JUSTICE THIRLWALL: Thank you very much,
5 Mr Skelton. Mr Kennedy.

6 Questions by MR KENNEDY

7 MR KENNEDY: Ms Kelly, my name is Andrew Kennedy.

8 I ask questions on behalf of the Countess of Chester

9 Trust.

10 I want to deal with two discrete issues.

11 The first is something you mentioned -- well, both
12 relate to issues you mentioned in answer to
13 Mr De La Poer's questions earlier.

14 Firstly, my understanding of your evidence was that
15 at the time of the CQC inspection in February of 2016,
16 you were not aware of an increase in mortality on the
17 neonatal unit; is my understanding correct?

18 A. We had just received the draft report of the
19 Thematic Review but up to that point, deaths had been
20 reviewed where they had been reported, had been reviewed
21 on an individual basis but what hadn't become apparent
22 was that there was a trend over time. So at the time we
23 were not fully aware of the picture.

24 Q. So my understanding is that as at the time you
25 spoke to the CQC, you hadn't had an opportunity to

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1 that's only with the information I have had for this
2 Inquiry.

3 Q. Do you think you asked the question: how does
4 this compare to last year or the year before or the year
5 before that?

6 A. I don't think I did ask that question. But
7 I was assured by the clinician who was in charge of the
8 care of those babies that there was no concerns and he
9 also didn't raise, to my recollection, that this was
10 unusual.

11 Q. You referred in answer to Mr Skelton's
12 questions to you said your note and I have checked back
13 to your witness statement and you refer to a document
14 perhaps we can just pull it up, so it's INQ000 -- I am
15 going to say 3350. I am immediately wrong, then 3530.
16 Forgive me, I ... 3530.

17 So is this note that you are talking about, this is
18 the one you refer to, we can look at it in your
19 statement if you want to.

20 A. Yes, what page is that, please?

21 Q. It's page 46 of your statement you start on 45
22 at paragraph 144. You will see in a couple of places
23 you refer to documents and so 147, you see second line
24 in the handwritten note, 3530, which is this document.

25 A. So this document in front of us is -- it's not

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1 my note, it's a note of Julie Fogarty, the Director of
2 Midwifery at the time and it is only the top part of
3 that note that refers to that SI meeting, the bottom
4 is -- is other business.

5 **Q.** I think where there is I think the horizontal
6 line across the middle of the page just above the words
7 "Janet Beech", everything above that relates to this
8 meeting?

9 **A.** Yes.

10 **Q.** So we can ignore everything below that. This
11 perhaps consistent with Ms Fogarty's designation as the
12 Head of Midwifery, this appears to be deal with
13 midwifery issues?

14 **A.** Yes, she specifically make notes for that as
15 she is Director of Midwifery.

16 **Q.** All right. There is nothing in here about
17 neonatal matters?

18 **A.** It -- it was linked -- she was at that meeting
19 so it was linked to the neonatal cases that Dr Brearey
20 was sharing. He brought a document that went through
21 each of the cases, very detailed.

22 **Q.** All right. Did you see a copy of that
23 document?

24 **A.** Not beforehand, no, we went through it in the
25 meeting.

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1 knew about a rise in neonatal mortality and I think we
2 are agreed that you would have done looking just at this
3 crude data?

4 **A.** Yes.

5 **Q.** Okay. If we wind the clock on, towards the
6 end of that year, 2015, there was a review conducted by
7 Dr Brigham?

8 **A.** Yes.

9 **Q.** I don't know if you remember from that, that
10 looked at those three -- it looked at two things, one
11 was stillbirths and one was neonatal deaths?

12 **A.** (Nods)

13 **Q.** In terms of neonatal deaths, it looked at --
14 we can again look at the data if you want to it --
15 five deaths of which four are what we are referring to
16 as indictment babies, does that ring a bell with you?

17 **A.** It -- it does, yes.

18 **Q.** Okay. The conclusion of that, certainly, and
19 that was looking -- that was looking at those aspects
20 from an obstetric perspective and I think your
21 understanding was that there was to be a paediatric or
22 a neonatal equivalent review?

23 **A.** Yes. That's where the confusion was at the
24 end of 15 and it ended up being two separate reports, as
25 we know.

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1 **Q.** All right. Can we just see whether we can
2 just establish what the document was. Can I ask for
3 another document, INQ0003191, and perhaps if we can
4 just --

5 **A.** That is the document I was thinking of.

6 **Q.** That is the document, all right.

7 **A.** Yes.

8 **Q.** Can we just scroll down through that to one
9 page more, please. So we can see there that the
10 document gives you comparable neonatal mortality?

11 **A.** (Nods)

12 **Q.** So that we can see that three deaths in
13 14 days in 2015 is as many deaths as there had been on
14 the unit in the previous four of five years over a year.

15 **A.** Yes.

16 **Q.** All right. It would follow from that that you
17 must have been alert at least to a rise in neonatal
18 mortality, whether explained or otherwise?

19 **A.** Yes.

20 **Q.** Okay.

21 **A.** But at the time Dr Brearey, who clearly went
22 through those cases, didn't articulate that there was
23 a problem.

24 **Q.** I am not now concerned with whether there was
25 a problem, I just want to establish whether or not you

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1 **Q.** Okay, but as at 2015 at least on Dr Brigham's
2 data, we now had five neonatal deaths?

3 **A.** Yes.

4 **Q.** Correct. So if you had cast your mind back to
5 the document we just looked at, you were now higher --
6 it was now higher than the previous high point which
7 I think was 2008 when there had been four deaths;
8 correct?

9 **A.** Yes.

10 **Q.** Okay. So there was a rise in neonatal
11 mortality.

12 When the Thematic Review came along, and can we
13 look at INQ0003217, and I take it while this is being
14 pulled up, that you would have been -- you would have
15 been keen to keep this under review the question of
16 neonatal mortality after your meeting with Dr Brearey in
17 July 2015 or keep -- sorry, perhaps keep an eye on it?

18 **A.** Yes.

19 **Q.** Okay.

20 **A.** I suppose the problem being that mortality
21 as -- as a topic, if you like, came under the Medical
22 Director and there was a lot of focus at that time on
23 adult mortality to the point where that was mandated to
24 be reported to the board.

25 Neonatal mortality did not have that level of

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1 scrutiny or focus nationally. So even though there were
2 reviews being undertaken in the Trust, I don't think we
3 fully appreciated until we had the Thematic Review that
4 there was an increase in neonatal deaths.

5 The document that Sara Brigham collated and then
6 presented to the Quality Committee I recall didn't get
7 any challenge and there was lots of actions reported to
8 support practice going forward but there was nothing
9 that was being flagged as a concern at that time.

10 **Q.** We can look at Dr Brigham's review if we need
11 to but it was looking at matters from an obstetric
12 perspective. So in terms of action going forward, those
13 were obstetrically focused actions?

14 **A.** Yes, in the main but the -- the -- they kind
15 of crossed -- crossed over with what was coming out of
16 the Thematic Review the following year.

17 **Q.** All right. Well, maybe another time we have
18 to test that piece -- test how right that is?

19 **A.** I think the other thing just to add, sorry, is
20 there was an email trail between myself and Ian Harvey
21 to say there had been these two reviews and actually we
22 need the two teams to work much more collaboratively
23 together and I think in a view to having a more
24 collaborative approach to reports in the future.

25 **Q.** I understand that. As I say, I am just
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1 **A.** I -- I think yes, on reflection we, we could
2 have mentioned that but I think Ian and I -- Ian Harvey
3 and I needed to understand fully the Thematic Review and
4 then pull all of that together. I don't think we felt
5 that we had all the information at that time because it
6 hadn't all been pulled together but recognised we could
7 have told the CQC more at that time.

8 **Q.** And certainly by March, when you got the final
9 Thematic Review; correct?

10 **A.** Yes.

11 **Q.** All right. I just want to deal with one other
12 matter and it's this and it relates to the Thematic
13 Review.

14 You have said in answer to Mr De La Poer's
15 questions that the Thematic Review had raised concerns
16 in relation to clinical care and you used that -- you
17 used that as a way of explaining perhaps your
18 understanding of mortality later on in 2016, is that --
19 is -- am I correct in that's what your --

20 **A.** I -- I deduced from the report that there were
21 a number of actions to be taken forward to improve
22 practice, as well as other things that were in that
23 report.

24 **Q.** Can we -- if we can just look through the
25 Thematic Review and just flag one or two points from it.
271

1 testing the hypothesis of what you knew when it came to
2 the CQC inspection later in February and my -- my
3 proposition is that you had had -- you knew of three
4 deaths in July, you knew how that compared to previous
5 annual mortality. By November you knew there had been
6 at least two more, so we are now five for the year;
7 correct?

8 **A.** Yes.

9 **Q.** I suppose it might beg this question: when it
10 came to speaking to CQC was there an imperative in fact
11 to be -- to look to see what it was the Thematic Review
12 had revealed?

13 **A.** Yes. That's not an unreasonable suggestion.

14 **Q.** Okay.

15 **A.** And I don't think from myself and Ian Harvey's
16 perspective we probably hadn't joined all the dots
17 together at that time, so we didn't raise anything with
18 the CQC because we needed to look at it ourselves
19 internally.

20 **Q.** But if you had done, you would have seen that
21 it wasn't five, it was ten on the Thematic Review?

22 **A.** In -- in the document, yes.

23 **Q.** Yes. Okay. And so whether in fact CQC were
24 told when you saw them in February or later, did they
25 not need to be told about a rise in mortality?
270

1 So if we go on to -- forgive me, just go back one page.
2 It's just worth observing under the purpose of the
3 meeting the second sentence:

4 "An obstetric Thematic Review did not identify any
5 common themes or identifiers that might be responsible
6 for the rise in mortality in 2015."

7 So that was speaking of -- in from a neonatal
8 perspective the obstetric review hadn't provided any
9 assistance; correct?

10 **A.** Yes, but there were a number of actions
11 attached to that report as well from an obstetric
12 perspective.

13 **Q.** Again perhaps that is something I need perhaps
14 to come back to on another day. If we then go on to --
15 I have got -- if we go on to the next page, we can just
16 see in relation to -- just pick up three cases. I am
17 just going to pick up A, C and D, which are the ones you
18 considered in July.

19 So there was a comment in relation to the umbilical
20 venous catheter, UVC, and we can see three lines
21 president bottom:

22 "No PM evidence of line or UVC related
23 complication."

24 There's a reference to a congenital abnormality.

25 Then it says this:
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1 "Agreed agreement today that the related
 2 complication very unlikely to have caused arrest."
 3 So whether that is the complication of the UVC or
 4 the congenital complication?
 5 **LADY JUSTICE THIRLWALL:** It says "line related".
 6 **MR KENNEDY:** Forgive me.
 7 **A.** I think that to do with line insertion and
 8 they pulled the line out.
 9 **MR KENNEDY:** Forgive me, I am sorry, so that is the
 10 UVC. I am reading from a different version so I am
 11 skipping between the two. So the line related
 12 complication.
 13 So there is no postmortem or apparently clinical
 14 review correlation in relation to the UVC; correct?
 15 **A.** Correct.
 16 **Q.** Then if we look at Child C, final sentence in
 17 the main box:
 18 "Agreed PM report but no cause for deterioration
 19 identified."
 20 Again there's reference further up to
 21 a displacement of the UVC.
 22 Then in relation to Child D, so next one down, you
 23 will see that there's an entry about halfway down:
 24 "Group felt initial delay in starting antibiotics
 25 very unlikely to have been contributory to death."
 273

1 the February version, and page 7 of that, so 0007.
 2 We have looked at this document a number of times.
 3 You looked at it with Mr Baker in relation to sudden and
 4 unexpected deteriorations and no clear cause of death
 5 identified at postmortem. There's a comment in relation
 6 to timing of arrests and then in relation to delayed
 7 cord clamping, which is one the clinical issues, we can
 8 see, not reading through the whole thing, the last
 9 sentence where it says:
 10 "However there were no cases of severe hypothermia
 11 and only one case of mild hypothermia in the cases
 12 reviewed, that being relevant to the impact of delayed
 13 cord clamping."
 14 So that didn't give a clinical concern relevant to
 15 understanding cause of death, did it?
 16 **A.** No, but further on, just above in that
 17 paragraph it does talk about "teams had not yet been
 18 able to ensure adequate temperature control for all
 19 preterm babies close to mum during delayed cord
 20 clamping".
 21 So I understand what you are saying but -- but if
 22 you read that report in its entirety, to me, as
 23 a clinician, there were deficiencies in care, albeit the
 24 report and some of the postmortems may have said it
 25 didn't contribute to death.
 275

1 **A.** Can I interject there, please, because on the
 2 far column on the right-hand side it then talks about
 3 some of the clinical deficiencies that needed to be
 4 picked up in training, ie delayed cord clamping, staff
 5 to be aware of the policy, continued to emphasise
 6 trainee doctors' awareness of sepsis guidelines.
 7 These are actually quite key clinical elements.
 8 **Q.** I appreciate that but in the case of Child D,
 9 that was specific, the delay in starting antibiotics
 10 which is the importance of following sepsis guidelines?
 11 **A.** Yes, and we did a Level 2 Investigation on
 12 Child D.
 13 **Q.** Forgive me?
 14 **A.** We did a Level 2 Serious Incident
 15 Investigation on Child D because of those issues around
 16 sepsis.
 17 **Q.** Indeed, but the conclusion of the Thematic
 18 Review was a delay in starting antibiotics was very
 19 unlikely to be contributory to death. We can see that
 20 here.
 21 **A.** Yes, in the middle.
 22 **Q.** Yes. If we -- if we go on then, please, to
 23 page 7, we can see the themes -- I'm sorry, I am working
 24 from a different version. Perhaps if we just quickly
 25 bring up 0003251 which is the final version. This is
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1 **Q.** Well, that's the point. In terms of
 2 understanding the reason for death, or the cause of
 3 death, the clinical concerns that you mentioned in
 4 relation to the Thematic Review in the same way as
 5 I think you agreed with Mr De La Poer in relation to the
 6 RCPCH, those clinical concerns didn't provide an
 7 adequate explanation as to cause of death, did they?
 8 **A.** Not on their own, no.
 9 **MR KENNEDY:** No, all right. Ms Kelly, thank you.
 10 Those are my questions, my Lady.
 11 **LADY JUSTICE THIRLWALL:** Thank you very much,
 12 Mr Kennedy.
 13 Ms Blackwell.
 14 **QUESTIONS BY MS BLACKWELL**
 15 **MS BLACKWELL:** Mrs Kelly, you have been asked some
 16 questions at the beginning of your evidence session this
 17 morning now about your background in nursing but I just
 18 want to expand upon that for a couple of moments if
 19 I may and talk about your full role as an Executive at
 20 the time of the events with which this Inquiry is
 21 concerned.
 22 You were professionally responsible for around
 23 about 1,000 nurses and midwives; is that right?
 24 **A.** That's correct.
 25 **Q.** Yes. We have heard that there were 600 beds
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1 in the hospital at which you worked and is it right that
 2 there are about 20 cots in the NNU?
 3 **A.** Yes.
 4 **Q.** And there were about 14 nurses working on that
 5 unit; is that right?
 6 **A.** Yes.
 7 **Q.** You have made reference to the nursing
 8 structure that lay beneath you and is it right that as
 9 well as working in lengthy office hours within the
 10 hospital, you worked in the evenings and at weekends?
 11 **A.** Yes, that was quite usual.
 12 **Q.** We can see from some of the emails at which we
 13 have looked the times at which you were corresponding
 14 with your colleagues. Would you be in back-to-back
 15 meetings for most of your working days?
 16 **A.** Yes.
 17 **Q.** And would some of those meetings take you out
 18 of the hospital and to other places in the locality?
 19 **A.** Yes. As we mentioned this morning, I had
 20 a key role in working with the local university.
 21 **Q.** Yes.
 22 **A.** And also a profile across Cheshire and Merse
 23 as a region, in terms of leadership and nurse
 24 development, so there was number of times where I was
 25 out of the organisation.

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1 Eirian Powell was present at that meeting?
 2 **A.** No. She wasn't at that meeting.
 3 **Q.** And are you in any doubt about whether or not
 4 Lucy Letby's name was mentioned during that meeting?
 5 **A.** No, she wasn't mentioned at that meeting.
 6 **Q.** We know because I took Mr Brearey to it,
 7 Dr Brearey to it when I asked him questions that
 8 immediately following that meeting you sent him
 9 an email.
 10 **A.** Yes.
 11 **Q.** Do you remember?
 12 **A.** Yes, I do.
 13 **Q.** I'm not going to ask that we put it up, but
 14 I will read out to you some of what you said in that
 15 email to him:
 16 "It was reassuring to know that each case had been
 17 looked at in such detail and that we recognised that
 18 some areas required further review ..."
 19 And that you offered to speak to Dr Brearey if he
 20 wanted to talk through anything in Ian's absence because
 21 I think that Mr Harvey was away from work at that time?
 22 **A.** That's correct.
 23 **Q.** Yes. Did Dr Brearey ever respond to that
 24 offer to talk through with you anything that he wanted
 25 to?

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1 **Q.** You have expressed already the number of
 2 emails that you would receive on a daily basis?
 3 **A.** Yes.
 4 **Q.** What did you wear to work?
 5 **A.** I was really keen to demonstrate to my teams,
 6 ie the 1,000 nurses and midwives, that I was a nurse and
 7 I was the nurse on the board. So I did have a uniform
 8 and I did work clinically and that would be on a regular
 9 basis. And actually that gave me a full appreciation of
 10 challenges on the shop floor that I would be able to
 11 articulate at the board.
 12 **Q.** Was wearing a uniform obligatory in your
 13 position?
 14 **A.** No.
 15 **Q.** Was working clinically obligatory in your
 16 position?
 17 **A.** No.
 18 **Q.** But you chose to do both of those things?
 19 **A.** Yes.
 20 **Q.** Thank you.
 21 You have been asked more recently about the Serious
 22 Incident Panel meeting on 2 July of 2015 --
 23 **A.** Yes.
 24 **Q.** -- by both Mr Skelton and also Mr Kennedy.
 25 Are you in any doubt as to whether or not

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1 **A.** No.
 2 **Q.** Did he ever come to see you or speak to you to
 3 raise any concerns following that meeting?
 4 **A.** No.
 5 **Q.** Was the next that you heard from Dr Brearey
 6 his email to you in May of the following year?
 7 **A.** Yes.
 8 **Q.** All right. Well, in between those times we
 9 know that you received several copies of the Thematic
 10 Review, first of all in February, and then later on
 11 in March, and you have been asked questions about a lack
 12 of urgency --
 13 **A.** Yes.
 14 **Q.** -- in your actions or reactions to being
 15 provided with those reports. Now, I would like to put
 16 up an email which we have seen before, but to take you
 17 through different aspects of it. It's at INQ0003138 and
 18 please may we look at page 2.
 19 This is the email which you received from
 20 Dr Brearey on 4 May when the meeting that was originally
 21 arranged for that day had to be cancelled and you were
 22 looking for a new date and if we look at the top,
 23 please, this email is the one that we've seen before.
 24 This is his response after the meeting had been
 25 cancelled:

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1 "Thanks, Alison,
 2 "There is a nurse on the unit who has been present
 3 for quite a few of the deaths and other arrests."
 4 Mr Skelton asked you about the raising of the
 5 prospect of other arrests. It's this I want to ask you
 6 about:
 7 "Eirian has sensibly put her on day shifts."
 8 What did you take from Dr Brearey telling you that
 9 he thought that moving Nurse Letby to day shifts was
 10 a sensible move?
 11 **A.** Yes, and the impression I got from that email
 12 was it was to provide support and welfare for Letby, as
 13 we would with any other nurse who was struggling. We
 14 would sensibly move them from nights to days.
 15 **Q.** Did he, around about this time, ever suggest
 16 that she should be either supervised or taken off the
 17 ward?
 18 **A.** No.
 19 **Q.** "But can't do this indefinitely."
 20 He goes on to say:
 21 "It would be very helpful to meet before she's due
 22 to go back on to night shifts."
 23 So did that suggest to you that he was
 24 contemplating that a time would come when she would go
 25 back on to night shifts?

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1 Now, if we can go to page 2, please. We have
 2 looked at the email at the bottom of this page on
 3 several occasions today and you have given evidence that
 4 you took some comfort, that's my word, not yours, from
 5 the way in which Eirian Powell signed off this email
 6 when she said:
 7 "Despite reviewing these cases there was nothing
 8 obvious that we were able to identify. Therefore your
 9 input would be valued."
 10 Did you see any sense of urgency --
 11 **A.** No.
 12 **Q.** -- in what Eirian Powell was suggesting to you
 13 there?
 14 **A.** No, not at that time.
 15 **Q.** Thank you. We see your response above on
 16 21 March and please could we go back to page 1 now to
 17 see the terms in which Eirian Powell was addressing you
 18 the following month on 14 April:
 19 "Hi Alison, I was wondering what your thoughts were
 20 after going through the Thematic Review. I notice that
 21 the Thematic Review did not include the medical team
 22 that were involved. I have therefore attached the
 23 document that includes this."
 24 Did you take anything in that email as a note of
 25 urgency or warning that this matter had to be addressed

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1 **A.** Yes.
 2 **Q.** Yes:
 3 "There is some pressure regarding staffing numbers
 4 with this at the moment."
 5 What did you take him to mean by that?
 6 **A.** I think it felt to me that there was some
 7 staffing challenges and that they were lacking on the
 8 night shifts. So, therefore, we needed to have
 9 a conversation to make sure that the unit was sensibly
 10 staffed.
 11 **Q.** He gave evidence to this Inquiry that:
 12 Several weeks before this, in fact once the Thematic
 13 Review was in the process of being completed back
 14 in February of 2016, he had requested an urgent meeting
 15 with Ian Harvey. Did you know anything about that?
 16 **A.** No.
 17 **Q.** Did he ever seek an urgent meeting with you to
 18 discuss these matters?
 19 **A.** No.
 20 **Q.** Did he ever email you in those terms?
 21 **A.** No.
 22 **Q.** I would like now to go to INQ0003089, please,
 23 and to look at the manner in which you were being
 24 addressed by Eirian Powell about these matters at around
 25 this time.

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1 and soon?
 2 **A.** No. It just felt like a general we need
 3 a general catch up just to talk some things through.
 4 There was no sense of urgency from my respect.
 5 **Q.** Thank you. Moving now to the 11th -- that can
 6 come down, thank you very much -- the 11 May meeting.
 7 You have not really been asked very much about what
 8 went on at that meeting. The Inquiry already knows that
 9 it was at that meeting that Dr Brearey went through the
 10 results of the Thematic Review which, by that time, had
 11 been completed. And the Inquiry has also heard that
 12 Eirian Powell and Anne Murphy went through the document
 13 that Eirian Powell had prepared in preparation for that
 14 meeting?
 15 **A.** Yes.
 16 **Q.** Dr Brearey has told this Inquiry that in doing
 17 so Eirian Powell was acting in an emotional state. Do
 18 you agree with that evidence?
 19 **A.** That is not my recollection of the meeting,
 20 no.
 21 **Q.** How would you describe the way in which
 22 Eirian Powell and Anne Murphy conducted themselves?
 23 **A.** They were very professional, but they were
 24 very assertive and they were very passionate about
 25 articulating the assurance provided for their member of

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1 staff. But in addition to that, they were also equally
2 as assertive about some of the clinical challenges that
3 they were having on the unit at that time, for instance
4 transport issues.

5 **Q.** What was Dr Brearey's reaction to their
6 assertiveness and the issues that they were bringing up
7 during the course of the meeting?

8 **A.** He, he didn't really react to what was being
9 said. He was very focused on going through the Thematic
10 Review in terms of the clinical care and the clinical
11 cases.

12 **Q.** Can I ask you this, please. Did he ever
13 mention deliberate harm?

14 **A.** No.

15 **Q.** Did he challenge Eirian Powell and Anne Murphy
16 about what they were saying?

17 **A.** No.

18 **Q.** And when you received his follow up email,
19 which I took him to, I am not going to ask that we look
20 at it now, in which he said that he was, and I'm
21 paraphrasing again, content with the outcome of the
22 meeting, what did you take that as being?

23 **A.** That we all left that meeting on 11 May
24 agreeing with the actions to be taken and that he was
25 happy that we were taking the appropriate action and

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1 **A.** That was raised up through Karen Rees because
2 Karen Townsend had asked her earlier in the day
3 following that meeting to go and find out what was going
4 on and then that sort of escalated as time went on to
5 the actions that we then took following the deaths of
6 Baby O and Baby P.

7 **Q.** All right. Now, I have mentioned Child K
8 there. Of course by 24 June, Child K had collapsed and
9 died and that had happened back in February of 2016, the
10 day before the CQC meeting.

11 When was that brought to your attention?

12 **A.** Not until the following year when Dr Jayaram
13 had that conversation with Sue Hodgkinson.

14 **Q.** Well, I'm going --

15 **A.** So there was nothing raised at that time of
16 the incident with us.

17 **Q.** Do you know whether or not the Consultants
18 were being pressed for evidence of the association with
19 Letby and how that was connected to the deaths or
20 collapses?

21 **A.** We were constantly asking questions of the
22 clinicians of evidence and more information and it's
23 only further down the line, in 2017, that we were told
24 about Baby K, which was extraordinary because that could
25 have been raised the year before.

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1 then he cascaded that to his colleagues.

2 **Q.** Did he, like you, express that he thought it
3 was a helpful meeting?

4 **A.** It was a helpful meeting, yes.

5 **Q.** Yes. And did he at any stage following the
6 meeting concluding on 11 May and between 23 June ever
7 approach you or as far as you know any of the other
8 Executives to bring any further concerns to your
9 attention?

10 **A.** No.

11 **Q.** Now, it was put to you this morning that by
12 this time doctors believed that Lucy Letby was murdering
13 babies.

14 Had that ever been suggested to you in those terms?

15 **A.** No.

16 **Q.** The Inquiry has heard that on 24 June,
17 following the death of Child O the previous day,
18 Dr Jayaram met Karen Townsend in the cafe at the
19 hospital and raised as the third item on an agenda with
20 her the concerns that the Consultants had and in
21 particular in relation to Child K, I think, which was
22 mentioned -- or, rather, sorry, not in relation to
23 Child K but in relation to the Consultants' concerns?

24 **A.** Yes.

25 **Q.** How did that come to your attention?

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1 **Q.** All right. We know that on 6 July of 2016 you
2 contacted the NMC?

3 **A.** Yes.

4 **Q.** And you had a conversation with Tony Newman
5 after which he sent the email which we have looked at
6 this afternoon setting out the seven points which you
7 then corrected in part, and do you agree that that
8 accurately reflects the conversation that you had had
9 with him on that day?

10 **A.** On that day, yes, I do.

11 **Q.** All right. It's been suggested to you that
12 had you activated the safeguarding policy at this time
13 that Lucy Letby would have undoubtedly been suspended
14 and that the police would have been informed and that
15 matters would have taken their natural course.

16 We know that the police were told about the
17 concerns in April of 2017 and that Lucy Letby wasn't
18 arrested until July of 2018.

19 Do you know whether the police took any action to
20 ensure that she was suspended or somehow supervised in
21 whatever role she had at the hospital between those
22 dates and during the course of their investigation?

23 **A.** There are some email evidence from the police
24 asking whether she was part of a nurse bank, which means
25 you can work anywhere, not just in the hospital but

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1 elsewhere, and that was a follow-up action that
2 Dee Appleton-Cairns took.

3 **Q.** Yes.

4 **A.** However, other than that, nothing as far as
5 I'm aware was undertaken and indeed further
6 conversations with the NMC it became apparent that there
7 was little concern about putting restrictions on her
8 practice until significant time down the investigation,
9 which I thought was quite inappropriate because it was
10 almost at the end of the investigation that action was
11 going to be taken about restricting her practice.

12 **Q.** Thank you. Moving on to the RCPCH report and
13 the questions that you have answered today about the
14 fact that one of the considerations and recommendations
15 was that action was required in terms of an HR
16 investigation, which I think has been described as a
17 disciplinary investigation.

18 Did you consider any difficulties in carrying out
19 that recommendation and if you did, what advice did you
20 take about that?

21 **A.** So I think as I mentioned earlier, we were
22 struggling at the time looking at our HR policies
23 internally to actually truly understand what we would
24 be -- what policy we would be using to discipline Letby
25 on and that's when myself and Sue Hodgkinson in

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1 prevented with different care?

2 **A.** Yes.

3 **Q.** And we can see that within Group 1 are
4 Child H, Child Q, Child E, Child C and a series of other
5 children and then we can see in the second group the
6 death or collapse is unexplained and it's the
7 investigation of these cases which would potentially
8 benefit from, we know, the local forensic review as to
9 the circumstances and we know that that took place.

10 **A.** Yes.

11 **Q.** Yes. Thank you. We can take that down,
12 please.

13 Two further matters if I may. The first is in
14 relation to the meeting with Mother C. It's been put to
15 you that Mother C's recollection is that you were
16 present, you were one of two female clinicians present
17 at that meeting and it's already been remarked upon by
18 Counsel to the Inquiry this morning that you are
19 a person who almost religiously takes a note --

20 **A.** Yes.

21 **Q.** -- in the meetings that you are present in and
22 a good note.

23 Have you looked in the notebooks which have been
24 provided to you, copies of the notebooks by the Inquiry,
25 as to whether or not you have any note at any time of

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1 particular sought external HR legal advice, which was
2 really supportive at the time.

3 So it wasn't that we ignored that recommendation;
4 it's just that we took a different tact based on
5 external advice.

6 **Q.** All right. Next topic, Dr Hawdon's report,
7 please. You have given evidence today that your
8 understanding of that report was that there were
9 a number of examples of sub optimal care raised and you
10 have explained your understanding about the extent of
11 the effect of such sub optimal care.

12 Now, I would like, just very briefly please, to
13 look at INQ0003172 and please could we go to page 44.
14 Thank you. This is the page that deals with the summary
15 of cases where we can see they are divided into two
16 groups: the first group is where the death or collapse
17 is explained but may have been prevented with different
18 care and learning may improve the outcome for other
19 babies.

20 So what did you understand that to mean?

21 **A.** To me that demonstrated that care wasn't being
22 delivered in the standards that we would expect for
23 neonatal care and there was obviously some areas of
24 improvement required.

25 **Q.** And that the deaths or collapses may have been
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1 meeting any of the mothers of any of the indictment
2 children?

3 **A.** There was no record in my meeting notes -- in
4 my notebook I should say. As part of my role, I would
5 very often meet with families on the back of complaints
6 or if they had any concerns. I would religiously take
7 notes of those meetings and if there was anything that
8 was of concern that needed follow up I would usually
9 reflect that back in a letter.

10 I have no evidence of any of those notes that may
11 have been taken at that meeting with Mother C. So I can
12 only assume, I'm not saying it didn't happen, but I can
13 assume that I wasn't there.

14 **Q.** Right. And is there any record at all that
15 you can find of a follow-up letter?

16 **A.** No.

17 **Q.** Thank you. Finally this, I said I would come
18 back to it. It's the meeting on 16 March of 2017 when
19 you say it was first brought to your attention that
20 Dr Jayaram had witnessed an incident at the cot of
21 Child K that he concluded was her inflicting deliberate
22 harm.

23 Now, during the course of that meeting, we have
24 looked at note already, you are recorded as having said,
25 "Why not before"?

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1 A. Yes.
 2 Q. And that was you have told the Inquiry your
 3 reaction to, well, to what?
 4 A. Shock that we had not been told about that
 5 before.
 6 Q. And by way of an example of an explanation as
 7 to why that hadn't come out before, Counsel to the
 8 Inquiry took you to the note that records it being
 9 reported during the course of that meeting that the
 10 Consultants felt like battered wives and that the
 11 Executives were the abusers.
 12 As an Executive, how did you feel about the fact
 13 that the sensitivity of the two Consultant leads on the
 14 neonatal unit and of children's services felt so bruised
 15 that they compared themselves to battered wives?
 16 A. Yes, shocked. Shocked and an inappropriate
 17 comment to make.
 18 Q. And did you find this excuse for Dr Jayaram
 19 keeping the eye witness evidence about Child K to
 20 himself for a full 13 months, during the continuing
 21 collapses and deaths of the neonates, and you, as you
 22 have told the Inquiry, repeatedly asking for evidence of
 23 Letby's involvement --
 24 A. No.
 25 Q. -- ample justification for his silence?
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1 reflection is provide more formal support for that team.
 2 I made sure --
 3 **LADY JUSTICE THIRLWALL:** When you say "that team",
 4 you mean the Consultants' team.
 5 A. The Consultant team, sorry, yes.
 6 From a nursing perspective, there were quite good
 7 structures in place to get that organised; probably not
 8 so much with the Consultant body.
 9 So -- but I do, on reflection, I think we could
 10 have put more support in to -- to get them through the
 11 very tricky time that we had.
 12 **LADY JUSTICE THIRLWALL:** Yes. In fact, was there
 13 any support put in?
 14 A. I think from -- I think Occupational Health
 15 support was offered to a couple of people, but more of
 16 a -- as a collective really and I don't think we asked
 17 the question at that time what: What extra support do
 18 you need? Particularly at the time of the grievance
 19 which was quite tricky in terms of relationships and
 20 I think they were feeling quite upset by the whole
 21 process.
 22 So I think, on reflection, we could have put some
 23 formal mechanisms in place to support them at that time.
 24 **LADY JUSTICE THIRLWALL:** Thank you. Then just one
 25 last matter if I may.
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1 A. No.
 2 **MS BLACKWELL:** Thank you. My Lady, that concludes
 3 my questions.
 4 **LADY JUSTICE THIRLWALL:** Thank you very much,
 5 Ms Blackwell.
 6 Questions by LADY JUSTICE THIRLWALL
 7 **LADY JUSTICE THIRLWALL:** One of the things you said
 8 a bit earlier -- we are nearly finished.
 9 A. That's okay.
 10 **LADY JUSTICE THIRLWALL:** -- a little bit earlier
 11 was that you think that you should have been more
 12 supportive of the Consultants --
 13 A. Yes.
 14 **LADY JUSTICE THIRLWALL:** -- you said that earlier
 15 in your evidence.
 16 This is really just for my understanding. In what
 17 way were you at all supportive of the Consultants?
 18 A. I think what I was meaning by that was more on
 19 a pastoral perspective.
 20 **LADY JUSTICE THIRLWALL:** Yes.
 21 A. So I know that my colleague Sue Hodgkinson was
 22 conscious that there was a lot of stress in the team
 23 with everything that was going on at the time and she
 24 may refer to some of that in her, her evidence.
 25 But I think what we could have done better on
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1 You have been asked repeatedly by different people
 2 whether you took the Consultants' concerns seriously and
 3 what I would just like to ask you about a little bit is
 4 what were you being told were the views of the senior
 5 nurses about what the Consultants were telling you?
 6 We have seen what's said in the meetings --
 7 A. Yes.
 8 **LADY JUSTICE THIRLWALL:** -- but presumably there
 9 would have been conversations between you and
 10 Karen Rees, for example. What was her view of it?
 11 A. Yes, and Karen Rees in particular was very
 12 passionate about her profession and she was very upset
 13 by what she was hearing from the Consultant body.
 14 But we all recognised at the time that we needed to
 15 get lots of information together to get a true picture
 16 of what at the time was a very complicated story.
 17 So I think some of the comments that were being
 18 made by the Consultants did affect some of my team to
 19 the point where I needed also to provide additional
 20 support for my team and that included the Risk
 21 Management Team as well, not just the nursing component.
 22 **LADY JUSTICE THIRLWALL:** Yes. Ms Rees gave some
 23 evidence about being asked to take Lucy Letby off the
 24 ward and you will be aware of that exchange --
 25 A. Yes.
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1 **LADY JUSTICE THIRLWALL:** -- with Dr Brearey.
 2 **A.** Yes.
 3 **LADY JUSTICE THIRLWALL:** I don't need to take you
 4 back over that. But she told us that she had had
 5 experience in an earlier job of some cardiologists
 6 wanting a nurse removed from their unit or something
 7 like that.
 8 **A.** Yes.
 9 **LADY JUSTICE THIRLWALL:** I haven't got the precise
 10 wording, and she was incensed by that and having dug
 11 into it discussed there was an ulterior motive for that.
 12 And in this case she told us, and I am sure you're
 13 aware of this, that she wondered whether there was some
 14 sort of relationship between Lucy Letby and Dr Brearey.
 15 Did she talk to you about that?
 16 **A.** She mentioned that on the -- not in those
 17 detailed terms.
 18 **LADY JUSTICE THIRLWALL:** No.
 19 **A.** But felt there was a personal issue, was how
 20 she phrased it when she spoke to me on that Friday
 21 evening around the death of Baby P.
 22 So when she came to see me she -- she was very,
 23 very upset and she got the impression there was
 24 something personal, she said "something personal". We
 25 didn't go into any detail of what she thought that was.

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1 corridor conversations --
 2 **LADY JUSTICE THIRLWALL:** Don't worry, don't worry.
 3 I mean I know there's been a lot of that and we've heard
 4 evidence about it.
 5 **A.** Corridor conversations, et cetera.
 6 **LADY JUSTICE THIRLWALL:** Yes.
 7 **A.** So it got very -- it became very insensitive
 8 to everybody involved and what was fact and what wasn't
 9 fact was not clear.
 10 **LADY JUSTICE THIRLWALL:** No. All right.
 11 **A.** Yes.
 12 **LADY JUSTICE THIRLWALL:** Thank you very much
 13 indeed. Does anybody want to ask anything arising out
 14 of what I have just asked? No.
 15 In that case, Mrs Kelly, thank you for coming. You
 16 are free to go.
 17 **A.** Thank you.
 18 **LADY JUSTICE THIRLWALL:** Now, tomorrow I think we
 19 have got Ms Hodgkinson coming.
 20 **MR DE LA POER:** We have and Dr Rackham.
 21 **LADY JUSTICE THIRLWALL:** Yes. I would like to
 22 avoid everyone, particularly the shorthand writer,
 23 having to sit for another long day.
 24 Can we just have some discussion before everyone
 25 disperses to make sure that we have got enough time if

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1 **LADY JUSTICE THIRLWALL:** No and we know because she
 2 told us --
 3 **A.** And she --
 4 **LADY JUSTICE THIRLWALL:** I'm so sorry. I didn't
 5 mean to cut across you.
 6 **A.** -- potentially she -- but she was quite
 7 exercised by that.
 8 **LADY JUSTICE THIRLWALL:** Yes, she was quite angry
 9 about it, wasn't she?
 10 **A.** Yes. Yes.
 11 **LADY JUSTICE THIRLWALL:** And she told us that she
 12 went and asked Lucy Letby about it and she said there
 13 was nothing, nothing to it.
 14 **A.** I believe she did, yes.
 15 **LADY JUSTICE THIRLWALL:** But we know, don't we,
 16 that that information became sort of currency within the
 17 hospital, don't we. So does that give us any clue or
 18 did it give you any clue about whether or not the nurses
 19 perhaps thought that doctors were just making this up?
 20 **A.** They may have done. I think -- you're
 21 absolutely right, I think one comment was made and
 22 before you knew it there were lots of rumours going
 23 round --
 24 **LADY JUSTICE THIRLWALL:** Yes.
 25 **A.** -- and some inappropriate comments made

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1 we start at 10 o'clock to finish within a reasonable
 2 time, namely by 4.30? So if I can just leave that to
 3 those who are involved. On the face of it, it looks
 4 fine but I would just like people to have a proper look
 5 and think about how long it actually takes to ask
 6 questions and of course receive the answers.
 7 So I will otherwise see you tomorrow at 10 o'clock.

(6.05 pm)

9 **(The Inquiry adjourned until 10.00 am,**
 10 **on Tuesday, 26 November 2024)**

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