Monday, 25 November 2024

**(10.00 am)**

**LADY JUSTICE THIRLWALL:** Good morning.

Mr De La Poer.

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

MS ALISON KELLY (sworn)

Questions by MR DE LA POER

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

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

**A.** Alison Kelly.

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

**A.** I did.

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

**A.** It is.

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

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



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

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

**A.** I was.

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

**A.** Yes.

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

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

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

**A.** Yes.

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

**A.** Yes.



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

**A.** Yes.

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

**A.** Yes, I was.

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

**A.** Yes.

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

**A.** Yes.

**Q.** So let's look at the Countess of Chester. You joined as Director of Nursing and Quality in 2013; is that right?

**A.** That's correct.

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

**A.** It was.

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



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

**A.** Yes.

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

**A.** Yes.

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

**A.** Yes.

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

**A.** Yes.

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

**A.** I did.

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

**A.** I did.

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

**A.** I did.

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

2018. Was there any connection between the two of you at Northern Care Alliance?

**A.** No, none at all.

**Q.** The first topic we are going to deal with, Ms Kelly, is safeguarding. As you have just told us, you were the Executive Lead for Safeguarding; is that right?

**A.** I was.

**Q.** What you say in your witness statement, you don't need to turn it up but I can take you to it, but I will just quote:

"The increase in mortality was never viewed as a safeguarding matter."

That is the assertion you make in your statement; is that correct?

**A.** That's correct, at the time, yes.

**Q.** Does that cover the full period that the Inquiry will be looking at all the way through to when the police were notified?

**A.** Yes.

**Q.** As you might imagine, we are going to look at the detail of particular meetings in due course. At this stage I would just like to establish some fairly high level propositions.

You had a meeting on 11 May of 2016 which included



Dr Brearey; is that right?

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

**Q.** He attended that meeting in his capacity as a Consultant paediatrician and the lead for the neonatal unit; is that right?

**A.** That's correct.

**Q.** He was concerned about the increase in neonatal mortality; is that right?

**A.** That's correct.

**Q.** Among the things said by Dr Brearey at that meeting was that he had a concern that Letby may be the cause of that increase; is that correct?

**A.** We discussed at length the detail of the Thematic Review that he had undertaken with a number of colleagues including external stakeholders in addition to Eirian Powell's points that she had brought to that meeting.

He never at that meeting talked about deliberate harm but he was worried about the increase in mortality.

**Q.** So we are just going to focus upon my question which didn't include the phrase "deliberate harm". It was that he was concerned that the increase in neonatal mortality may be due to Letby?

**A.** May be due to Letby, yes.

**Q.** If it is due to her, there are only two



possibilities, do you agree? One, that she is doing so inadvertently, potentially through incompetence; or two, she is doing so deliberately?

**A.** Yes.

**Q.** So although -- and we can come to the detail -- it may not have been said out loud, Dr Brearey was raising with you the possibility that Letby may be deliberately harming babies; is that fair?

**A.** I would push back on that and say there was never any clarity in him articulating his true concerns at that time.

**Q.** No. But we have established that he -- what he has articulated to you is he is concerned Letby may be the cause and you have accepted that that can only be in one of two ways?

**A.** Yes.

**Q.** So it must be the case, surely, that what he was saying is that Letby may -- he was raising the possibility that Letby may be deliberately harming babies?

**A.** May be, yes.

**Q.** Of course as to the issue of inadvertent or incompetent harm, you had very strong reassurance, didn't you, in that meeting from Eirian Powell and Anne Murphy that incompetence was unlikely?



**A.** Yes.

**Q.** Because they were telling you what a good nurse she was?

**A.** Yes.

**Q.** So on that basis if Dr Brearey was correct in his concern, or may be, if anything, does that not increase the fact the possibility that it is deliberate?

**A.** From his perspective there was a possibility that that was deliberate. But as we were talking through the information that we had to hand at that meeting, including detailed analysis of cases which pointed to some clinical issues, we were open at that meeting to what the causes could be. From a perspective -- from a nursing perspective, that could have been a competency issue.

**Q.** You were in a unique position that day in that meeting, weren't you, because you were the Executive Lead for Safeguarding?

**A.** Yes.

**Q.** The only safeguarding role person in the meeting?

**A.** Yes.

**Q.** Was that an extremely important duty that you had that day?

**A.** Yes.

**Q.** Did that duty trump or should be treated as a priority over any duty that you had to the staff?
**A.** At that time, it -- it wasn't clear to me that this was a safeguarding issue.
**Q.** My question is: was your duty to safeguarding your primary duty?
**A.** At that time as the lead, yes.
**Q.** You have told us it didn't even occur to you to treat it as a safeguarding issue; is that right?
**A.** That's correct.
**Q.** Do you accept that you should have thought about it in those terms on 11 May?
**A.** I have reflected a lot about my safeguarding role in all of this case and reflecting back, maybe I should have done, yes.
**Q.** Now, within safeguarding, where there is a concern that somebody may be causing harm, in this case to babies, is it ever appropriate as an action plan just to wait and see if the harm is caused again from a safeguarding perspective?
**A.** From a safeguarding perspective, no, that wouldn't be appropriate. However, I had assurance at that meeting from my senior nursing team that there were no concerns with that individual at that time.
**Q.** They had no concerns that she might



incompetently be causing harm, that is what they were telling you?
**A.** Yes.
**Q.** Now, we are talking about safeguarding, which is about deliberate harm. Your strategy from that meeting was to wait and see if harm was caused again, wasn't it?
**A.** I think we all agreed at that meeting that there was nothing clear -- clearly articulated at that meeting because there were clinical concerns in terms of outcomes and practice versus what I was hearing from my senior team, which was we had no competency issues.
So we all felt by the end of that meeting that we could review the situation in a number of weeks' time. And everybody -- as far as I'm aware, everybody left that meeting feeling happy with those actions.
**Q.** Had you thought about what was being said to you as a safeguarding concern, would you have viewed it as appropriate just to wait to see if harm was caused again?
**A.** If it was being viewed and we had had a collaborative conversation at that time about safeguarding, then actions may have been different.
But we didn't have a safeguarding conversation because it was more about clinical outcomes and practice



and potential competency issues.
**Q.** So if you had thought to raise it as a safeguarding issue to say this may be a safeguarding concern, if you had said that at the meeting, you would have expected there to have been a discussion based upon that?
**A.** Yes.
**Q.** If in those circumstances you had said to Dr Brearey: do you think she might be causing harm deliberately and he had said yes, what would you have done?
**A.** We -- I probably would have took different action but that conversation never took place.
**Q.** Now, had you treated it as a safeguarding issue, would you have spoken to the named doctor, Dr Isaac, immediately following that meeting?
**A.** I would have probably gone to my safeguarding team, as in the nursing team first, Dr Isaac was based on the unit. So I probably would have gone to my corporate nursing team first.
**Q.** Isn't this a matter for the named doctor?
**A.** It -- it is but the first place I would have gone would have been my team, which are the safeguarding team.
**Q.** At that stage, would there have been



a discussion about whether Letby should be placed under formal supervision or even suspended or moved to deal with less sick babies? Is that the sort of discussion that would have happened had you treated it as a safeguarding concern?
**A.** Potentially. Potentially if it had been discussed as a safeguarding issue at that time.
**Q.** And a referral to the LADO so that they knew what was going on would have happened?
**A.** Yes, that would have been part of the process.
**Q.** Through that, the police would have been notified as part of the multi-agency response, wouldn't they?
**A.** Potentially, yes.
**Q.** Well, is there any potential about it?
**A.** Part of the process is the police, yes.
**Q.** Yes. Now, do you accept that it was your responsibility as lead for safeguarding to ensure that proper consideration was given in that meeting to safeguarding?
**A.** Looking back, and reflecting on that meeting, there should have been a safeguarding conversation. But it never came up and I never approached it as a safeguarding issue. We talked about in detail the clinical reviews that had been undertaken as part of the

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

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

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

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

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

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

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

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

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



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

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

**Q.** Can I just --

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

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

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

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

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

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

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



not complicated, is it?

**A.** No.

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

**Q.** Yes, so that's -- that's them giving you an expert opinion, isn't it?

**A.** Yes.

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

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

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

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

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

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

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



whether there is a basis for concern and that is something to add into the mix, isn't it?
**A.** Yes.
**Q.** You were told that the babies, some of them, had not responded to resuscitation as had been expected?
**A.** Yes.
**Q.** That is another expert opinion?
**A.** Yes.
**Q.** Were you told about the unexplained rashes?
**A.** No.
**Q.** So you have there, we have just been through, four expressions of expert opinion plus a fact which is consistent with the concerns that you are being told about?
**A.** Yes.
**Q.** That is an adequate basis for action, isn't it?
**A.** Yes. But we were balancing that with the nursing view of her practice and of how highly she was thought of on the unit as well.
**Q.** Which is irrelevant, is it not, to the issue of whether she is doing this deliberately?
**A.** Well, we needed to get -- we needed to get more facts, we needed to pull things together to see what the fuller picture was at the time.



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



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

**A.** No.
**Q.** Well, how can you rely upon the fact that they haven't come to you if you don't even know if they know?
**A.** Because -- well, they were, they were on the unit at the time, so I would expect the clinicians to talk to each other there were designated doctors that were holding a role for safeguarding.
**Q.** Did they ever say they had spoken to the designated or named doctor?
**A.** The clinicians didn't, no, not to my knowledge.
**Q.** So wasn't the obligation on you to flush that issue out by saying: have you spoken to the named doctor or even going to speak to the named doctor yourself, isn't that your obligation?
**A.** At the time if we would have been discussing it as a safeguarding role, yes, that would have been my role. But I was also relying on others within the structures beneath me to also raise those concerns.
**Q.** Do you accept you should have been discussing it as part of your safeguarding role?
**A.** On reflection, yes, because but at the time we were talking about clinical outcomes for babies and it was more around a rise in mortality as opposed to an actual safeguarding case. I know that sounds



difficult to -- to comprehend because we now know much more about what happened compared to what we were dealing with at the time.
**Q.** You knew at the time that the Consultants thought she was murdering babies; that's -- that was their central message to you, wasn't it?
**A.** In June they talked about deliberate harm, yes.
**Q.** Yes. And -- and deliberate harm to a human being who is now dead is murder, isn't it?
**A.** Yes.
**Q.** So you knew that that was their central concern and therefore you don't need hindsight or what we know now, do you; that is a safeguarding issue to be confronted, do you agree?
**A.** Yes, at the time. But it wasn't -- it wasn't at the time.
**Q.** Now, at no stage during 2016 or 2017 did you speak to the named doctor for safeguarding, is that right, about this issue?
**A.** About this issue, no, not that I can recall.
**Q.** At no stage during 2016 and 2017 did you raise this matter with the hospital Safeguarding Strategy Board, did you?
**A.** I recall -- I think on one of the agendas



there was a discussion about the cluster of three deaths that happened in 2015 --
**Q.** Yes?
**A.** -- I think it was.
It wouldn't be a forum where we would talk about an individual member of staff, so it wasn't discussed at the safeguarding meeting.
**Q.** You wouldn't say "there is a major safeguarding concern which is currently being dealt with", you wouldn't even tell the board that that was happening?
**A.** We -- we would talk about that but as I say, we were not considering it as a safeguarding issue at that time.
**Q.** Now, the Local Children's Safeguarding Board, we are just going to bring up three documents here, 7 July, if we bring up INQ0004320, and we are going to go to page -- we are just going to bring that up, please. This is one of your notes, Ms Kelly, it is 7 July. Just take a moment to look at it.
If we look a third of the way down on the right-hand side we can see "safeguarding referral" in your handwriting; is that right?
**A.** That's correct.
**Q.** So it does appear that on 7 July 2016 you had



in mind to make a referral to the LADO?
**A.** I can't recall the actual conversation about that. That was with CCG and specialist commissioning colleagues.
I have written it there. I don't know whether it was consideration that we talked about in the meeting, I don't recall myself being given an action to leave that meeting and go and do that referral.
**Q.** It's not for them to give you an action; it is for you to decide as safeguarding lead whether you need to make a referral, isn't it?
**A.** Yes, but some of the people that were in that meeting were also leads for safeguarding as well so I'm not sure what the conversation was entirely.
**Q.** Was this you telling NHS England that you were going to make a safeguarding referral?
**A.** I don't recall.
**Q.** Do you agree that's what it looks like?
**A.** I have written notes, yes, bullet points of things that were discussed in that meeting but the context, I'm not sure of.
**Q.** Were you seeking to reassure NHS England that you were responding to this appropriately?
**A.** We were really clear about the concerns that we had in raised mortality and I have written there

"Thematic Review". I honestly can't remember the safeguarding conversation.

**Q.** Well, you say that you were really clear. Did you tell NHS England that in the two weeks before the Consultants had come to you and said that they believed that a member of staff may be deliberately harming babies?

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

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

**A.** No.

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

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

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

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

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



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

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

**A.** -- the conversation.

I don't know.

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

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

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

**A.** It is.

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

**A.** Yes.

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

**A.** Yes.

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

**A.** No.



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

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

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

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

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

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

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

Again, we were trying to balance what we were



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

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

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

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

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

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

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

**A.** It was part --

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

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

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

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

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

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

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

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

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

**A.** No.

**Q.** -- Ms Frame?

**A.** No.

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



didn't tell her?

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

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

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

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

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

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

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



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

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

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

**A.** Yes.

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

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

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

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

**A.** Yes.

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

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

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



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

**A.** Yes.

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

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

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

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

**A.** Yes.

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

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



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



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



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

**Q.** Now, you had by March 2018 seen the document that the Consultants had prepared for the police, hadn't you?
**A.** No, I never saw that.
**Q.** You never saw that?
**A.** No.
**Q.** Were you aware that they had sent one?
**A.** Yes, I was, but it was never shared as far as mine were to the Executive Team.
**Q.** So as you were preparing this referral, did it occur to you to think to say: well, I wonder if I should go and have a look at that document that the Consultants have prepared so that I can put forward the concerns that they have in the most persuasive way that I can?
**A.** That -- at the time, that would have been a good idea. But I didn't do that.
**Q.** Well, is that because at this time you had a feeling of hostility towards the Consultants and that you did not think the police investigation was going anywhere?
**A.** That's not true.
**Q.** Because this is a safeguarding referral, it's important, isn't it, to state their concerns at their highest?
**A.** Yes.



**Q.** This isn't determinative of whether there are any consequences to anyone; it's just important that everybody understands the worst case scenario?
**A.** Yes.
**Q.** Let's have a look and see what you say about the College review --
**A.** Could I --
**Q.** The 29 June:
"External review commissioned. No definitive conclusions could be drawn from the Royal College review."
Do you think that that was a misleading statement for you to make?
**A.** I think the external review came out with a number of different recommendations that were very wide, varying at the time.
I don't -- I don't see that as being misleading.
**Q.** Well, we will consider it from this perspective: you were told in terms by the Royal College at the end of their review that they had not investigated whether Letby had done it; isn't that correct?
**A.** I can't recall that but I think that might have been said, yes.
**Q.** So telling the safeguarders that a report that



did not investigate Letby was inconclusive is misleading, isn't it?
**A.** I think it's just language that was used by me in that -- in that referral. It wasn't miss, I didn't feel at the time it was misleading.
**Q.** Well, it might be read by a reader, do you agree, as suggesting, well, somebody has looked into it and they couldn't find anything?
**A.** I think when the College review was undertaken they chose to interview Letby.
**Q.** I am here talking about what the reader of this --
**A.** Oh, the reader of this, sorry.
**Q.** The reader of this, that what you said may be read as suggesting that the Royal College had investigated it and had not reached any definitive conclusion on the point?
**A.** You -- you could read that from there but I would have assumed if it wasn't clear, the LADO could have called me and to clarify.
**Q.** Well, is the problem --
**A.** I suppose I have just done that in a bullet point list, it may have needed more detail.
**Q.** The problem is that it may be perfectly clear to what -- to the LADO what you are saying it is exactly



what I have suggested that you have commissioned the Royal College to investigate the concerns about Letby, that they had done so and their conclusions were not conclusive?
**A.** You could deduce that from that, yes, but maybe I should have put more detail into that --
**Q.** Well --
**A.** -- section.
**Q.** In fact, the Royal College recommended that Dr Hawdon, as it turned out to be, conduct a Casenote Review?
**A.** Yes.
**Q.** By this stage you knew that Dr Hawdon had recommended a local forensic review in relation to four babies?
**A.** Yes.
**Q.** Because she was concerned about each of those four babies?
**A.** That a further review was required, yes.
**Q.** Yes, because she was concerned about those four babies?
**A.** Yes.
**Q.** You don't mention that here?
**A.** No. And -- and looking at that referral it -- it obviously did need more detail.

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

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

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

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

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

**Q.** Now, if we go over the page, we will see that you say that she hasn't undertaken any clinical duties or be permitted to go on to the neonatal unit. Presumably that's to reassure the safeguarders that nobody has been exposed to risk of harm?

**A.** Yes.

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

**A.** I was not aware of that.

**Q.** -- by March 2018?

**A.** There was something that was brought to my attention about Alder Hey and myself and Sue Hodkinson the HR Director found out about it and it was stopped.

**Q.** That was in the summer of 2017.



**A.** I don't recall the date.

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

**A.** Okay.

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

**A.** (Nods)

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

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

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

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

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

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

**A.** Yes.



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

**A.** Knowing what we know now compared to what we knew then, I don't think I did fulfil that role. However, as I mentioned before myself and others did not look at this as a safeguarding issue. It was about clinical outcomes, a raise in mortality and concerns raised by clinicians about an individual and we needed to get more information.

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

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

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

**A.** I did.

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

**A.** That's correct.

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



**A.** That's correct.

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

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

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

**A.** Yes.

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

**A.** Yes.

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

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

to a child; or behaved towards a child or children in the way it indicates she/he is unsuitable to work with children, then the process outlined below should be followed."

We can see that that process includes liaison with the LADO, do you see?

**A.** Yes.

**Q.** Now, that is exactly what the Consultants said to you in late June of 2016, wasn't it? That they were concerned that she may have behaved in a way that harmed a child, possibly committed a criminal offence, may be unsuitable to work with children?

**A.** Yes.

**Q.** And that should have triggered an immediate contact with the LADO, shouldn't it?

**A.** Yes.

**Q.** You didn't do that. Why did you not follow this policy?

**A.** I -- I don't know why I didn't follow this policy. It -- it was under the safeguarding banner for me and I have explained why I didn't consider it to be safeguarding at the time.

**Q.** But this is a separate responsibility that you have for safeguarding?

**A.** But this was part of -- I was one of many



others in the organisation that held this role. We did talk about the neonatal unit concerns at meetings. I don't know why the LADO element was never discussed.

**Q.** Was that because you just weren't taking these concerns seriously?

**A.** That's not true. We absolutely were taking the concerns seriously.

**Q.** Was it -- was it because you thought you would lose control if an external body was notified?

**A.** No.

**Q.** So you have mentioned that it was discussed at meetings. We are going to just whip through some of them now. INQ0015537, page 4.

Bottom right-hand corner, third bullet from the bottom:

"Consider SOS process re: meeting."

Do you see that?

**A.** Yes.

**Q.** Speak Out Safely process. So it would appear that consideration was being given at a meeting which I think is recorded as having you, Ian Harvey and Eirian Powell at; is that right?

**A.** Yes, notes at the top.

**Q.** Neither Ian Harvey nor Eirian Powell, were they Speak Out Safely designated officers?



**A.** No.

**Q.** So you were the one who had that knowledge and information in this meeting?

**A.** Yes.

**Q.** This was an action for you to go and look at the Speak Out Safely process?

**A.** Yes, I think we did talk about consideration of that.

**Q.** Well, you have talked about it but this is an action, isn't it --

**A.** Yes.

**Q.** -- for you to go and have a look at the policy?

**A.** It doesn't actually say "policy" there but I think it was about more of a conversation with the other designated leads for Speak Out Safely at the time.

**Q.** If you had gone away and given serious thought to the Speak Out Safely process, wouldn't that have led you to realising that the LADO needs to be contacted?

**A.** I think at the time Speak Out Safely, the processes around that weren't fully embedded in the organisation. But I do recognise that that note there is about consideration of that process at that time --

**Q.** It --

**A.** -- and that the LADO was never a consideration



in those meetings.

**Q.** Is there any note that you have seen between there and September 2016, so in other words the next two or three months, where you actually sat down and considered the Speak Out Safely process?

**A.** We had Speak Out Safely meetings with various members and I do recall that neonatal unit was discussed. I can't recall -- do you have the meeting note?

**Q.** We are going to look at it.

**A.** Okay.

**Q.** You can take it from me not at any point during 2016?

**A.** 16, okay.

**Q.** So this is a note for yourself to sit down and work something out. You are, if I may say so, a good maker of notes, you write reflections for yourself and so on, don't you?

**A.** (Nods)

**Q.** Is that just something that got forgotten?

**A.** Possibly. Yes. There was lots going on at that time. You can see by those notes there were lots of things to consider.

**Q.** Well, that's an important one, isn't it, in terms of priorities, do you agree?

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



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



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



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

it hasn't been talked about, because two days later you are still not certain what's going on but we can bring it up.

So we just move through this and we are really looking for what isn't there but that's the first page, that is the second page, third page, fourth page.

Now, I am sure everyone's got the reference and people can go away and check it and make sure I haven't missed anything, but perhaps you will take it from me for now that it's just not mentioned in that meeting?

**A.** No, I do see that I wasn't at that meeting either.

**Q.** Even so, it hasn't even been put on the agenda. So we can take that down.

So let's move forward to 22 November, staying with Speak Out Safely. INQ0002879, page 222. What you are going to see now is the investigation report from Dr Green. This is the final version of that report and it has this addition, among others, after it had been sent to Lucy Sementa and then sent back, so that is the evidence we have. So this is something that wasn't in the first draft, it is in the second and final draft.

"In response to how the Trust have dealt with this I conclude that the Trust have considered the concerns of the Consultants in line with both the disciplinary



and Speak Out Safely policies."

That is a finding of fact that Dr Green makes.

In fact, I am sure we won't need to go to it, you hadn't talked to him about the Speak Out Safely policy?

**A.** No, not that I recall.

**Q.** If you had, you would have said to him: we haven't dealt with it under the Speak Out Safely policy, that is what you would have said to him?

**A.** I -- I am unsure as to what Sue Hodkinson would have said to him because she also took a key part in that process.

**Q.** You knew for a fact it hadn't been dealt with under the Speak Out Safely policy, didn't you?

**A.** If the timings of those meetings -- are you referring to the meeting we have just looked through?

**Q.** Yes, it is not registered on the spreadsheet that was kept as a running spreadsheet, it does not appear in the minutes of any meeting and we can see in September there was a discussion about whether, how it was going to be treated so that --

**A.** Yes, I -- I don't, I don't know why Dr Green wrote that if he was not aware of the process.

**Q.** Well, presumably you read it at some point after the grievance process?

**A.** Who, myself?



**Q.** Yes, Dr Green's report.

**A.** It was quite some time after that we received the report from what I can recollect.

**Q.** Well, did you ever correct that fact?

**A.** No.

**Q.** Well, should you have corrected it bearing in mind that it is false?

**A.** At the time yes, but I don't recall seeing the report until much, much later on.

**Q.** I mean, it's false in a way that makes the Executives look better than in fact is true, isn't it?

**A.** Can you rephrase that sorry?

**Q.** I am so sorry, could you just repeat that answer?

**A.** I said can you repeat your question, sorry.

**Q.** I beg your pardon, that was entirely my fault. May I apologise?

**A.** It's okay.

**Q.** It was false in a way that made the Executives look better than was in fact true; do you agree?

**A.** No, no, I don't agree.

**Q.** It makes it look like the policy has been applied as it should have been when in fact the policy wasn't applied?

**A.** I don't understand why Dr Green put that in.



He was a very credible manager, so I can't understand why he would have put something in there if it hadn't actually happened.

**Q.** So my question, wherever it's come from, is it is false in a way that makes the Executives look better than was in fact the case; do you agree?

**A.** You could say that, but that was not the intention.

**Q.** INQ0003158, page 3. This is the grievance determination. Presumably that was something you saw very shortly after it was published?

**A.** I can't remember the actual time, but I do recall seeing it. Yes.

**Q.** Second paragraph:

"In response to how the Trust have dealt with this I conclude that the Trust have considered the concerns the Consultants in line with both the disciplinary and Speak Out Safely policies."

Practically a copy and paste, I think one or two words are slightly reordered.

So this is what Annette Weatherley is saying in her formal resolution of the grievance, it is the same false statement. Did you ever correct it?

**A.** Me personally, no. But I don't know what conversations Annette Weatherley and Chris Green will

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

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

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

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

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

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

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

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

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

**A.** I think because it had been talked about so



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

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

**Q.** I am sure --

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

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

**A.** No.

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

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

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

**A.** In terms of what we didn't talk about at the



meeting, yes.

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

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

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

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

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

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

**Q.** Well --

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

**Q.** Let's move to where it was first discussed INQ0098375, page 3. This is a meeting on 20 February 2017. We can see here that you say:

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

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



**A.** I do agree. I think we talked about it a lot but actually didn't pin it down to actually documenting it.

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

**A.** Yes.

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

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

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

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

**A.** Yes.

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

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

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

**A.** Yes.

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

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

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

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

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



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

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

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

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

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

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

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

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

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



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

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

**Q.** Well --

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

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

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

**Q.** Absolutely, because --

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

**Q.** INQ0003344, this is a meeting on 16 March. Again we are just looking at what's happening to the Consultants around the time that the Speak Out Safely committee decided not to record their concerns. Now, you are recorded as being present at the top. Do you see your initials?



**A.** Yes.

**Q.** Go to page 3. And we are looking for a reference to Speak Out -- forgive me, it says:

"Sue meeting Ravi."

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

**Q.** You can't see.

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

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

"Part of me says ring police and GMC."

Do you see that that right in the centre?

**A.** Okay, yes.

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

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

**Q.** 16 March 2017.

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

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

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

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

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

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

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

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



NNU."

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

It goes on to say:

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

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

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

"How could it be logged as nothing?"

Now, the --

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

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

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

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

**A.** (Nods)



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

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

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

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

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

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

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



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

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

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

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

**A.** Yes.

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

**A.** Yes.

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

**A.** (Nods)

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

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

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

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

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

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

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



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

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

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

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

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



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

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

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

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

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

**(11.34 am)**

**(A short break)**

**(11.50 am)**

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

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

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



the Thematic Review; is that correct?

**A.** That's correct.

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

**A.** Yes.

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

**A.** Yes.

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

**A.** Yes.

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

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

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

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

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

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

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

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

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

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

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

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

**A.** Yes.

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

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



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

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

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

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

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

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

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

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

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



an increase?

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

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

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

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

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

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

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

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

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

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

**A.** No.



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

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

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

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

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

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

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

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

**A.** Absolutely not.

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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



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

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

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

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

**A.** No.

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

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

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

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

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

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

**A.** No.



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

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

**A.** Yes.

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

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

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

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

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

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

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

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

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

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

**A.** Sorry, could you repeat that?

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



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

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

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

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

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

**A.** Yes.

**Q.** "High level reasons expressed."

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

**A.** Sorry, repeat that?



**Q.** "High level reasons expressed."

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

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

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

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

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

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

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



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

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

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

**A.** Yes.

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

**A.** Yes.

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

**A.** Yes.

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

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

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

**A.** No.

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

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

**Q.** Can I just --

**A.** At that time --

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

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

**A.** In which respect?

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

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

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

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

But in fact you have not fully articulated the



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

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

**Q.** Please just focus on what I am asking you. You give a list of events or pieces of information, the increase in deaths, in-depth review, didn't identify cause, theme for this increase and then you say "for this reason ..."

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

Isn't that the true picture?

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

**Q.** Is --

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

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



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

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

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

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

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

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

**A.** No.

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

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

**A.** Yes, I --

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



**A.** Sorry.

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

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

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

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

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

**A.** No.

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

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

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

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

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

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

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

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

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

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

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

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

INQ0014405.

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

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



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

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

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

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

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

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



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

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

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

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

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

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

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

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



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

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

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

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

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

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

**Q.** Well --

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

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

you see the word "firmer position"?
**A.** Whereabouts are you looking, sorry?
**Q.** It is highlighted on your screen.
**A.** Oh.
**Q.** So this is a record of the fact that the Consultants were saying --
**A.** Sorry, can I just read a little bit above that email?
**Q.** Of course you can.
**A.** Note, sorry. (Pause)
Okay.
**Q.** So at this meeting what was being discussed by the Executives was the Consultants were -- had adopted a firmer position in light of all the reports that had been done to that date and they were asserting "not natural causes", that is the natural reading of this note, do you agree?
**A.** Yes.
**Q.** So that's what you are talking about three days before going into the CQC and there is not a hint of that given to the CQC, is there?
**A.** I think at that time we -- it was becoming more and more apparent that there were significant care issues and I know at the time the paediatricians challenged the recommendations of the Royal College



report.
**Q.** Significant --
**A.** And the fact that all those -- all those babies -- well, the majority of those babies had postmortems as well, so it was -- it was becoming clearer that there was more care issues than there were deliberate harm issues.
I'm not sure the terminology "firmer position" -- I'm not sure what that is actually alluding to.
**Q.** Well, it would be to suggest that they have moved from a position of saying: this may not be natural causes, to: this is not natural causes. So in other words, their position is firmer that would be?
**A.** But that wasn't reflected in the reports that we were receiving --
**Q.** But that --
**A.** -- at the time.
**Q.** But that is what the expert Consultant body are telling you their position is.
Now, you have said that it's becoming clearer that it's care issues. We are going to come to have a look at the Royal College report in due course, but whether it's care issues or deliberate harm you needed to tell the CQC, didn't you, what was going on in your Trust? And that didn't happen, did it?



**A.** We, we did tell the CQC but we didn't give them that level of detail because we didn't know ourselves at that time. We needed to pull all of those elements together to be able to articulate what was actually going on and it was a complex picture and in reflection, perhaps more information should have been shared at that time, there was an opportunity in that engagement meeting.
But we didn't fully understand or we needed further review by from the recommendations of -- of Dr Hawdon, we needed to understand what the outcomes of that were going to be so that we could have fuller details to share in the CQC.
**Q.** I mean, do you agree in terms of an overview here because we are seeing this emerging time and time again that consistently what other external bodies are being told is everything but the Consultants' concerns, do you think that's a fair characterisation of the period up until the end of May -- end of April 2017?
**A.** I think we were really clear in the communication plan in July 16 that we told all of our regulators about an increase in mortality.
**Q.** Can I just ask you to focus upon my question.
Do you agree that what is happening to all of these external bodies is you are telling them everything apart



from the Consultant concerns; that that is the one piece of information that is consistently missing from all of these communications?
**A.** I think looking back then we should have perhaps mentioned that as well at the time.
However, we were really keen to fully understand what was going on. But perhaps those Consultant concerns should have been mentioned in the beginning.
**Q.** Being really keen to fully understand what is going on is the absolute opposite of the correct approach to a safeguarding issue; do you agree?
**A.** Excuse me, say that again, sorry?
**Q.** Finding out absolutely everything that is going on is the opposite of the approach you should take in a safeguarding situation, do you agree?
**A.** Yes. But as I mentioned earlier, we -- I -- were not considering this as a safeguarding concern. We were thinking of it as a mortality issue that we needed to get to the bottom of and to the information that was coming to light it was more about clinical outcomes as opposed to an individual.
**Q.** The information coming to light -- and this is my last question on this topic -- just before the CQC meeting was your Consultant body were asserting, it would seem in terms, that they did not think these

deaths were natural.
That was information coming to light three days before the CQC meeting, wasn't it?
**A.** In that note that's what that implies. However, despite all the work that we were doing around trying to get to the bottom of the increasing mortality, our clinician colleagues were not accepting that some of those were -- some of those deaths had been the outcome of sub optimal care.
**Q.** Well, they were right about that, weren't they?
**A.** Yes, but we didn't have any proof at that time but that was about unnatural causes.
**Q.** You don't --
**A.** My understanding at the time was that there were no babies that were expected to die and it's not until we had experts from outside the organisation to do a more thorough investigation that we started to find out some of the clinical issues that were happening on the unit.
**Q.** Number 1 in the Thematic Review which we are turning to now as published on 2 March was that there were sudden and unexpected deteriorations in babies who died?
**A.** Yes, that is in the report.



**Q.** Well, let's have a look at that topic 4, March to May 2016. On 17 March, you were sent a copy of the Thematic Review; is that right?
**A.** Yes, am I able to see the email?
**Q.** Yes. In fact, we will go to the email first, INQ0003089. In fact it is the 21st but it is -- the first information is the 17th, that is my mistake.
So if we go to page 2. We can see that 17 March, Ms Powell is saying she wants to arrange a meeting to discuss how to move forward, she tells you in terms that there has been an increase in mortality. Although they are small numbers, it is quite a big increase, isn't it?
**A.** Yes.
**Q.** And that a commonality was that a particular nurse was on duty either leading up to or during this and a reference to when Letby started and a doctor was also identified as a common theme, however not as many as the nurse, and she goes on to say that nothing obvious has been identified and therefore they want some input from you.
You respond four days later to say: could you see the report.
**A.** (Nods)
**Q.** With the plan being for a meeting to follow.
**A.** Yes.



**Q.** Within less than an hour, as we go over the page, Ms Powell sends you the Thematic Review?
**A.** Yes.
**Q.** Now, did you consider that Thematic Review when you were sent it?
**A.** I think I did at the time, yes.
**Q.** Because I mean you specifically asked to see it.
**A.** Yes.
**Q.** And so did you then go and have a look at the appendix 1 to look at what was being said about Letby?
**A.** I think when I received that, I recognised that Ian Harvey and I needed to discuss that at our next one to one.
**Q.** I am so sorry, can I just ask you to focus on my question.
When you received it, did you go to appendix 1?
**A.** No, I don't recall doing that, no, at the time.
**Q.** Well, you had been told by Eirian Powell on the 17th that there was a commonality and there attached to the report set out exactly what that commonality was. Why didn't you look at it?
**A.** I think in the overarching email even though there had been quite a bit of work undertaken there was



nothing in that email that was drawing my attention to something really serious or urgent.
So in terms of --
**Q.** Can I just ask you to pause there. You have just been told that eight babies have died against an expectation of two or three; is that not in and of itself extremely serious?
**A.** It is serious but the tone of the email from Eirian to meet and understand her report didn't give me a sense of urgency.
**Q.** Well, do you think bearing in mind her next fact was to draw attention to the fact that discussed at a local level was the association of a member of staff that that was immediately something that you should pay close attention to?
**A.** Yes, at the time, because she drew my attention to it in that email.
**Q.** You should have paid close attention to it from the very start, shouldn't you?
**A.** Yes, and I am not -- I am not making excuses, but this will have been one email in amongst hundreds of emails that I would have received and I would not be able to open every attachment for every email that I would have received.
**Q.** This is -- this is your job, isn't it?

**A.** It is my job, yes.
**Q.** It's a very important and serious job, do you agree?
**A.** My job as a Director of Nursing?
**Q.** Yes.
**A.** Yes.
**Q.** It's a well-paid job?
**A.** Yes.
**Q.** You had enough information in that email of the 17th to see that there was something serious to be investigated, do you agree?
**A.** Yes.
**Q.** You then went to the trouble of asking for the report so that you could get some more information but do we understand that from your reference to the fact you get a lot of emails and can't open every attachment that you didn't actually open it, is that why you told us that?
**A.** I am just putting context into --
**Q.** Well --
**A.** -- workload at the time.
**Q.** Well, did you open the email -- the attachment?
**A.** I did, but I can't recall when I did.
**Q.** Does that rather tend to suggest that you did



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



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



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

a meeting for 4 May?
**A.** Yes.
**Q.** So that is 14 days after you received this where you have been chased as you said you would expect if it was urgent, and nothing appears to happen to bring this to a head; is that a fair summary of those 14 days?
**A.** There had been a time delay and I don't know with not having access to my diary why that took so long to start having a meeting.
**Q.** Well, would anything other than ordinary hospital business be what you would discern from that diary?
**A.** Yes.
**Q.** There would be other things potentially?
**A.** There would be lots of things going on across the hospital.
**Q.** That weren't ordinary hospital business?
**A.** I don't understand, sorry.
**Q.** Well, you have got a job to do and it's a busy job?
**A.** Yes.
**Q.** I am just trying to understand what you think your diary, how that would shed light on why, over a 14-day period it would appear that there hasn't been a response to a chasing email sending you a document



with somebody's name in red and it's really what you are anticipating that diary might have revealed that would be capable of explaining that 14 days?
**A.** I have not had access to my diary for this Inquiry so I am not able to comment on that. However, I think you will -- I am sure you will be coming to subsequent emails. What I hadn't appreciated at the time, because I didn't have time to open the appendix for the staffing, was the text that was in red because the previous reports that were being sent to Ian Harvey and I had no red text in it at all and were not raising any concerns about any issues.
**Q.** This one that was sent to you on 14 April did have red text?
**A.** It did, yes.
**Q.** Yes, and nothing happened for 14 days, it would appear?
**A.** No, and from that perspective I can only imagine that I didn't have time to open the appendix for the staffing.
**Q.** So just the whole thread starts with Eirian Powell saying she wants your help, that the context is too many dead babies and that a member of staff has been identified.
She then sends you the report, 24 days go by, she



then sends you another document with Letby's name in red and your position is you didn't click on the attachment on 14 April just to see what it was all about?
**A.** I think there was the report and then there was a staffing document and embedded in the report, I think if I have got the right version because there were a number of versions, I think there were 16 embedded documents. I would not have had time to look at all of those.
**Q.** On 14 April there was one document, as we understand it, it was this one. It requires five seconds to click on it, on an issue that had gone cold since March.
**A.** And I believe there was doctors highlighted in red in that report as well.
**Q.** But you wouldn't have known that, you tell us, because you didn't click on it?
**A.** No, probably not at the time no, I don't recall that.
**Q.** Was it an unacceptable failing on your part bearing in mind what you had been told in the thread which you just had to scroll down to see the context that you did not open this document at the time?
**A.** I can't recall when I opened the document. But if it was something so urgent, knowing the busy



portfolio that a Director of Nursing has, I'm not sure why others did not approach me directly or Ian Harvey to say: we absolutely need a meeting, like this afternoon.
People have done that before, they have come to stand at my office and say: we have got a serious concern, I need to speak to you.
So having this buried in an inbox, it is not a good excuse but I can honestly say I can't remember at what point I opened that document.
**Q.** 4 May, Dr Brearey emails you when it appears the meeting can't go ahead at its scheduled time INQ0003138. Scroll down, please.
He tells you in terms:
"There is a nurse on the unit who has been present for quite a few deaths and other arrests. Eirian has sensibly put her on day shifts at the moment but can't do this indefinitely. It would be very helpful to meet before she is due to go back on night shifts. there is some pressure regarding staffing levels with this at the moment."
So Dr Brearey is telling you, in terms, that there is a particular nurse who is associated for quite a few deaths; is that right?
**A.** That's -- yes, that's what he is saying to me.
**Q.** That is exactly you were told by Eirian Powell

in March?
**A.** That email though does not strike me as having an urgent issue. In fact, it refers to staffing and it feels like there is a staffing issue as opposed to any issue with that individual's practice.
**Q.** Ms Kelly, it's very important that you just focus upon my question. My question was: that was the same information that you had been given in March by Eirian Powell, I didn't ask you anything about the tone of this email, so just please focus.
We have got a lot to get through. Can you answer my question, please?
**A.** That, yes, that was a topic that was in that report in March.
**Q.** Let's go over the page. Your reply, not to Dr Brearey, but this is forwarding it would appear it on to Karen Rees, copying in Sian Williams.
"Aah!! Please can you look at this with Anne M/Eirian -- if there is a staff trend here and we have already changed her shift patterns because of this, then this is potentially very serious!! I will check the report they sent through. I did not notice there was a staff trend!!"
Now, firstly, you had been told about the trend by Eirian Powell, hadn't you, in March?



**A.** Yes, as part of that original report.
**Q.** And if you had clicked upon the report, you would have seen it was sent to you in April, the trend was there marked in red, wouldn't you?
**A.** Yes, and I don't recall seeing that report in red.
**Q.** So when you say "I did not notice", was that you concealing the fact that you had not looked?
**A.** Absolutely -- I don't recall seeing the version with the red text at that -- I don't know what time I opened that document, but I hadn't obviously taken that in because I wouldn't have written that email and when I did, I was quite concerned.
**Q.** Yes, but I'm just asking you to focus on the language. "I did not notice" suggests that you opened it and didn't see it?
**A.** The staffing attachment?
**Q.** Yes.
**A.** Yes.
**Q.** But in fact you tell us you don't think you opened it.
**A.** I don't recall. I don't recall seeing that.
**Q.** So a truthful way of expressing that was: I hadn't looked at the attachment until now?
**A.** I can't be certain when I looked at that.



**Q.** And we can see here that you then do open that attachment:
"Please see attached ... Lucy Letby highlighted in red!! I have not noticed this when I first reviewed."
But if what you are telling us is right, you hadn't in fact reviewed it?
**A.** I can't be certain.
**Q.** Well, in which case that would be a lie, wouldn't it? If you hadn't -- I mean, if you hadn't reviewed it and you were writing, "I have not noticed this when I first reviewed", you would be lying, wouldn't you?
**A.** I don't lie.
**Q.** Okay. Well --
**A.** There's the report and there's an attachment to the report. I have probably looked at the report and not fully appreciated the elements in red which were in the staffing element.
**Q.** Well, we have already established that if you had clicked on the staffing trend, which has the red name in, you would immediately see the name in red. You can't miss it.
**A.** No.
**Q.** So I am just trying to understand why it is that you are telling your subordinates that you had



reviewed that document but not noticed it.
**A.** Probably the first part of the Thematic Review.
**Q.** But you are talking here about the document where Letby's name is in red.
**A.** I just -- I don't recall. I just don't recall.
**Q.** Is it possible that you were seeking to conceal the fact that you had not paid adequate attention to this by claiming to have reviewed a document that you had not reviewed?
**A.** I wasn't -- I wasn't concealing anything.
I think, and again it's not an excuse, but the workload of an Executive Director in a 600-bedded hospital is huge and there will be documents that I will have opened and not fully taken consideration of.
**Q.** Can we just be clear --
**A.** I did not, I did not realise the text in red.
**Q.** You have spoken in general terms. This document, which you have agreed anybody opening it could immediately see that Letby's name in red, that doesn't fall into the category that you are talking about, does it, when you make that generalised assertion; that some documents you may have opened and not looked at in detail?

**A.** I -- I don't recall.
**Q.** And you then sent a message to Mr Harvey, INQ0003087.
We can see that at the top unfortunately the date doesn't appear reproduced on it, but we can say it's some time after 4 May:
"Please see Steve's comments below which alarmed me!! Since receiving this I have asked Karen Rees to liaise with Eirian regarding this particular nurse (Eirian's further review is attached for info), I am currently reassured that there are no issues but I think it's worthy of wider review hence our planned meeting."
Now, wasn't it a little premature to reach the conclusion that there were no issues?
**A.** I'm unsure as to what Eirian and Karen had fed back to me.
**Q.** Well, you hadn't heard from Dr Brearey about -- and he was the person who had the concerns?
**A.** Again, you know, I would expect Dr Brearey to have come to see me personally if he had had a significant issue with a nurse on the unit.
**Q.** And does the fact that a person has not come to see you personally mean that there are no issues?
**A.** No, not necessarily. But an email trail being used as a way of escalation isn't sometimes effective as



it can be just because of the volume that you receive. And also the way in which it's articulated in the email, this didn't raise any concerns to me at that time.
**Q.** So let's go back to where I started about this email. Was it premature for you to be saying that you were reassured that there are no concerns -- or no issues, forgive me?
**A.** There will have been a reason why I wrote that. So I'm assuming that I was already told that there were no issues with that particular individual.
**Q.** But that was before you had even heard what Dr Brearey had to say about it and he was the one who had pushed for the meeting in the email below. Shouldn't you have heard from Dr Brearey before you reached that conclusion?
**A.** Possibly, yes.
**Q.** And really what it comes to is do you think there's a possibility that you went into the meeting on 11 May close-minded?
**A.** No.
**Q.** Let's have a look, INQ0015537, page 3. We have already covered this meeting of 11 May.
I just want to ask you a question about one of the notes that you made, bottom left-hand corner:
"No hard evidence."



I'm just wondering whether even at this stage things had become a little adversarial, do you have any comment upon that?
**A.** No, not adversarial. I think we felt at the time there was still a view that nobody had seen anything, there had been no results provided to us, there was nothing that suggested that there was anything sinister going on and when --
**Q.** Can I just pause you there. We've been through it. Nothing that suggested nothing sinister was going on. More babies had died was something that may indicate that something sinister was going on, do you agree?
**A.** I would push back on that because on the Thematic Review what is really clear on there is that there were significant care issues, there were competency issues.
So that was starting to build a picture of, of what we were trying to understand around the reasons for our increased mortality.
No -- so when I mean "no hard evidence" there was no physical evidence or anything that anybody could show us that was a problem.
**Q.** I'm just wondering if you are setting the bar too high at that point if you are requiring hard



evidence at this stage to respond to a risk?
**A.** I think that was done in, in -- also in the context of babies had had postmortems, there were outcomes that were -- that the Coroner was satisfied with.
There were a number of different things that were going on, but still the clinicians were finding it very difficult to -- to give us examples of what was actually being done to harm babies as opposed to an association with one individual.
**Q.** If there really was a murderer on your unit, why would the clinicians necessarily have seen or heard anything because such a person is going to act in a covert way, aren't they?
**A.** Yes, but, when you have things reported to you as in "we have a gut feeling", "I have a drawer of doom" information that can't be shared, it -- it doesn't give you confidence that we are getting the information that we need.
**Q.** You have mentioned the drawer of doom. You were the -- an Executive Director. If that was troubling you, did you ever say to Dr Brearey: I need to see in your drawer of doom?
**A.** Not personally, no.
**Q.** No, and you had the authority to do that,

didn't you?
**A.** I could have done, yes, in conjunction with the Medical Director.
**Q.** So I am just wondering how troubled at the time you were about this drawer of doom because if you were taking it seriously presumably you would have said, "I want to see what's in that drawer."
**A.** Yes, at the time. But again I was relying at that time with Karen Rees who was our -- my Head of Nursing who had had detailed conversations with Dr Brearey about that.
**Q.** But she didn't have the authority to do what you as an Executive had the authority to do?
**A.** No, but I discharged my duty through my -- through my leadership team. So I would have expected her to have done that as well.
I could have done it, but I can't do all actions.
**Q.** Well, if, if a nurse manager says to a doctor, "I want to see the material you have got" and the doctor says no, all that that nurse manager can do is come up to the very top of the hospital, the Executives and say, "I can't get access to it."
At that point, isn't it over to the Executives and in particular you as her line manager to say, "Well, if there's a drawer which has all this evidence in I want



to see it."
**A.** Yes, and, and I had a conversation with Ian Harvey on that, on the Monday afterwards, and I believe that the clinicians on that Friday evening went home and that's when Karen raised her concerns with me.
**Q.** Did you say to Dr Brearey, "I need to see what's in that evidence drawer."
**A.** No, not directly.
**Q.** Why didn't you do that?
**A.** It was a very random thing to have shared and I am not quite sure what I thought at the time because I didn't know whether that was a figure of speech or whether it actually was a drawer with documents in it that wasn't being shared. So that's why I needed to speak to Mr Harvey, which we did on the Monday, and I was satisfied with Karen's response to me about her discussion with Dr Brearey at that time.
**Q.** You see, the drawer of doom is used as a way of discrediting the doctors, isn't it, that they are talking in this ridiculous language that they won't share. That's where this sits in this piece, isn't it?
**A.** I just thought it was a very odd thing to say. It's nothing you would think a Consultant would say and when they were challenged they wouldn't share any



information which, which again troubled me a bit.
**Q.** Why didn't you say, if they weren't being forthcoming, "I understand you have paperwork that supports this. Bring it to me."
**A.** Yes, I should have done that the week after.
**Q.** Well, and is that -- the reason that you didn't because you just weren't taking this seriously enough?
**A.** I absolutely was taking it seriously.
**Q.** What other explanation do you have for why you did not request written evidence which you understood was being said existed?
**A.** On that Friday, I think we were all a little bit bewildered really in terms of trying to get our heads round what had actually been said.
There were actions put in place by Karen Rees that were fed back to me and felt that was proportionate and appropriate at the time and that I would discuss that with Ian Harvey on the Monday morning.
**Q.** Well, did Ian Harvey tell you that you shouldn't ask for the contents of --
**A.** I don't recall the detail because we needed to then go to the meeting where we spoke to Dr Jayaram and Dr Brearey later on that day. I can't recall having a conversation about shall we speak to Dr Brearey about



it. But he was made aware.
**Q.** Did you think he was lying, Dr Brearey, when he said that he had evidence in his drawer?
**A.** I -- I didn't know what to think. I didn't know what to think. It just seemed a very unusual thing to say.
**Q.** And he having said that he had written evidence, was it an unusual thing that you never asked to see it?
**A.** I -- I don't know. I -- like I say, at the time I didn't know whether it was actually a physical drawer or whether it was a figure of speech and Karen Rees I know had had detailed conversations about that and he refused to give any detail over. So it -- it was a very odd situation and a very odd set of circumstances that we needed to reflect on over the weekend and then have a conversation on the Monday.
**MR DE LA POER:** My Lady, I am about to change topic. I wonder if we could break at this stage and could I ask for a shorter than normal lunch break so as to ensure that we make the maximum use of today, please.
**LADY JUSTICE THIRLWALL:** Yes. Will 40 minutes be sufficient?
**MR DE LA POER:** Yes, I hope so.
**LADY JUSTICE THIRLWALL:** So that means coming back

at 25 to 2. So we will take a break now.
**(12.55 pm)**
**(The luncheon adjournment)**
**(1.35 pm)**
**LADY JUSTICE THIRLWALL:** Yes.
**MR DE LA POER:** Ms Kelly, we are going to resume by looking at the period immediately following the deaths of Child O and Child P. Now, we know that Child P died at 4 o'clock on 24 June of 2016.
You were spoken to about the neonatal unit at some point on 24 June; is that right?
**A.** That's correct.
**Q.** It's your position as you set out in your statement that you believe that was after the death of Child P?
**A.** I think so, yes.
**Q.** We don't need to go into the reasons but how confident are you that it was after 4 o'clock?
**A.** I am not that confident. I know it was late on a Friday afternoon, but I can't be certain of the time.
**Q.** Whenever it was, the first you knew about problems on the 24th was from Karen Rees; is that right?
**A.** That's correct.
**Q.** She told you that two Consultants suggested to



her that Letby was intentionally harming babies?
**A.** Yes.
**Q.** And that allegation was being made in the context of at least one very recent death that you were told about; is that right?
**A.** Yes.
**Q.** Because you were at least told about the death of Child O, whether or not you were told about the death of Child P at that stage?
**A.** I think so, yes.
**Q.** So the context here is that you had left things on 11 May with a "watch and wait" approach and that you needed to be notified if there were any sudden unexpected deteriorations. You are then told a death has occurred and that two Consultants, the clinical lead for the paediatric department and the neonatal unit lead were both saying, in terms, that Letby may be responsible for that death; is that right?
**A.** Yes.
**Q.** So this required immediate action, did it, from you?
**A.** Which period of time are we talking about?
**Q.** When Karen Rees told you?
**A.** Oh, Karen Rees spoke to me.
**Q.** That is what we are focused on, we have



explained what the context was?
**A.** Friday evening.
**Q.** Here at that moment, at the very least Child O may have been murdered by Letby is what you were being told?
**A.** I am not certain when I was told about Baby O in terms of the time of death but what I do know is on that Friday afternoon, Karen Rees did come to speak to me very concerned about what she had been told from the doctors.
**Q.** Which was that they were concerned that Letby was intentionally harming babies?
**A.** Yes.
**Q.** That was in the context, the trigger for them saying that was a death the day before?
**A.** Yes.
**Q.** So again just focusing on my question, what was being said to you was that two Consultants were concerned that Letby may have murdered Child O, isn't that what you were being told?
**A.** Yes. But not in those terms. Not directly. That was the problem. There was no clear articulation of the facts and how that was -- how they were coming to that conclusion.
**Q.** But that was the conclusion you were being



told that they had reached?
**A.** From their perspective, yes.
**Q.** Yes, and so that requires immediate action from you, do you agree?
**A.** Yes.
**Q.** What immediate action, which is to say what you did immediately being told that information, did you take?
**A.** Karen Rees and I had a conversation, I can't remember the sequencing but I think she -- she had been back to the unit to find out what the plan was for the weekend in terms of staffing.
**Q.** Just pause there. You finished your conversation with Karen Rees. Who, if anybody, did you pick up the phone to speak to, or did you go out of your office to speak to, to action, to act upon this concern?
**A.** Personally I didn't do anything after I spoke to Karen because as I mentioned before my duties are discharged to my team, I -- I have Karen Rees held in very high regard. She was going to do a set of actions and I was happy with that.
**Q.** This is a concern of the highest degree of magnitude, isn't it?
**A.** It will -- there were concerns being raised, yes.

**Q.** No, listen to my question please.
This is a concern of the highest degree of magnitude, wasn't it?
**A.** It was a serious concern, yes.
**Q.** You don't accept the characterisation "highest degree of magnitude"; very, very serious?
**A.** It -- it was very serious but Karen having spoken to me I felt we were doing the right things that evening.
**Q.** Well, and did you discover that Letby was due to work?
**A.** No, I was unaware of that.
**Q.** Did you ask Karen Rees to find out if Letby was due to work?
**A.** No, I didn't at the time.
**Q.** You have just been told that Letby may be responsible for a murder the previous day and that was the sincere view of two very senior Consultants.
Why was your first step not to find out if she was working the next day?
**A.** Because I know that Karen had had a conversation with the unit and I had made an assumption that everything was okay, I had some assurance from Karen that there was no issues with the team over the weekend. She put some additional resource



in place. So I was satisfied with the actions that she had taken that evening.
**Q.** What additional resource could be put in place if Letby had been determined to murder over the weekend?
**A.** There was additional supervision provided for the whole of the neonatal unit, but there had already been some assurances from -- it wasn't Eirian, actually, it was Yvonne Griffiths I think that was on duty, that they didn't have any concerns about staff over the weekend.
**LADY JUSTICE THIRLWALL:** Did that include Letby?
**A.** Yes, collectively.
**MR DE LA POER:** So the nursing staff saying they are not worried about Letby working over the weekend, the doctors saying they are because they think she may have just killed a baby.
**A.** But.
**Q.** Should you have taken further steps at that time?
**A.** I have reflected a lot about that and it was just a very, very difficult time.
**Q.** Well --
**A.** But at the time I felt I had taken appropriate action with Karen Rees, because we were still not getting any information from the Consultants about how



they thought Letby was a risk.
**Q.** I think we have established that you made no effort yourself to go and find out why these two senior doctors thought that a member of staff may have murdered a baby in the previous 24 hours?
**A.** Not at that time, no.
**Q.** Well, you don't take any step to ensure that Letby can't harm any more babies; you don't take any step yourself to speak to anybody about it; and you don't take any step to get to the bottom from the horse's mouth, from the Consultants themselves, why they thought what they thought.
Doesn't that just indicate that you just didn't take this seriously enough?
**A.** I was taking it seriously, but as a director you do not do every single action that's required of you. You have a team to do that. I was satisfied with Karen Rees' approach, we had a conversation, we had a further conversation later that evening because that's when Dr Brearey and Karen Rees had a conversation on the telephone and I was satisfied by the actions that were being taken over the weekend, I recognise I didn't ask the specific question: is Letby working tomorrow? I had that assurance from Karen that staffing had been reviewed and everyone was satisfied.



Yes, on reflection, I -- I -- I could have done something differently and maybe that was a missed opportunity.
**Q.** Everybody being satisfied: did every single person who was satisfied know exactly what it was that Dr Brearey and Dr Jayaram were concerned about?
**A.** When I say that, I'm talking about Karen Rees and her conversation, which I don't know the detail of, with Yvonne Griffiths on the unit that evening.
**Q.** This is exactly the sort of situation, isn't it, that calls for an Executive Director to be involved directly and personally, isn't it?
**A.** What we know now compared to what we knew then you could say that, yes. But we don't have capacity as Executives to do every single action and I -- I relied on one my most senior nurses to understand what was going on.
**Q.** What was more pressing than the suggestion by two Consultants that a member of staff may just have committed murder?
**A.** I just felt I needed some concrete evidence because it just felt like when Karen came to speak to me, it just felt like they were being quite blasé about the statements that they made.
And, you know, it was a very difficult thing to

hear. So maybe I didn't, I didn't process it as -- as I should have done at the time.

**Q.** Is it as simple as the fact you just didn't believe them?

**A.** I didn't not believe them; I wanted some evidence.

**Q.** Well, why did you need -- why did you need evidence to become directly and personally involved yourself, wouldn't that allow you to gather evidence there and then and find out if there really was a risk to those babies the next day?

**A.** But when -- when clinicians say: I need you to take that nurse off the unit and they don't give you any rationale or any -- any concrete evidence, I have said that before, about why, then it's quite -- that's quite difficult to manage and I know we have had a conversation earlier on about evidence. But I think it was just really, really difficult and, you know, looking back I perhaps could have done something differently but at that time myself and Karen Rees I felt we were taking the right action.

**Q.** But that action did not include taking steps to protect babies if Letby posed a risk; do you accept that?

**A.** What I didn't ask or didn't clarify was



whether she was on duty the day after and I should have done.

**Q.** So my question again, just focusing on my question is: your actions did not include keeping babies safe from Letby if she posed a risk?

**A.** That -- that is difficult to hear. But I -- maybe I should have done something differently at that time, yes.

**Q.** You then received another call from Karen Rees at home?

**A.** Yes.

**Q.** Telling you that Dr Brearey had repeated his request for Letby to be suspended?

**A.** Yes.

**Q.** Do you agree that was an opportunity for you to contact Dr Brearey directly to find out what was going on instead of operating through an intermediary?

**A.** I believe in Karen Rees' evidence that Dr Brearey didn't believe that Karen had contacted me, so when she spoke to me she said: don't be surprised if Dr Brearey gives you a call and that call didn't materialise.

**Q.** Didn't there come a point in the evening where you should have called him?

**A.** Again, I think the assurances that Karen gave



me, it felt like a number of actions were being put in place. Again, persistently asking what, what evidence have you got? What is the rationale for this? Have you seen her doing anything? A number of questions I think and there was -- there was no -- it felt one way there was no information coming back.

**Q.** But the person you are asking is not the person with the answers. The person with the answers is Dr Jayaram or Dr Brearey.

Just for the final time on this topic, why not just pick up the phone to them and say: this is your Executive Director, the safeguarding lead, phoning you. You want somebody off the ward, you think that she may have committed murder, tell me about it?

**A.** Yes, on reflection I -- I perhaps should have done something differently.

**Q.** On the 26 June, which was a Sunday, Dr Brearey invited to you a meeting with the senior paediatricians where all of these matters could be told to you directly; that's right, isn't it?

**A.** It is, yes.

**Q.** You didn't go to that meeting, did you?

**A.** No. Neither Ian Harvey or I attended that meeting and I don't know why because we have not had access to our diaries as part of this Inquiry.



**Q.** Can you conceive of anything more significant that was going on in the hospital at that time to prevent you from going to a meeting where the Consultants would have explained to you why they thought Letby was murdering babies?

**A.** I can't comment on what else was going on in the hospital at that time and I can't comment on what was in my diary at that time. However, I do know that we knew that we would gain feedback from that meeting and myself and Ian Harvey were due to meet Dr Jayaram after that meeting in the charity Babygrow meeting which is what took place.

**Q.** I think that took place at 10 am, in fact it was before that meeting?

**A.** Right.

**Q.** In which Dr Jayaram said was it was very worrying and you say in your statement you felt a significant shift in gravity. That is all before the Consultant meeting at midday. But you just didn't go to that meeting?

**A.** And I don't know --

**Q.** For some reason you can't give us?

**A.** I don't know why, I haven't got access to that information.

**Q.** I mean, would you agree it would have to be

a pretty extraordinary thing that you would have to go to not to prioritise going to that meeting to hear what they had to say?

**A.** I can't comment. I honestly can't comment because I don't know what else was in my diary. There was lots of competing priorities across the organisation and I understand what you are saying, but I am not able to articulate the detail any longer any more.

**Q.** Again, if we just track back, what we have understood that you didn't do anything immediately being told Karen Rees, other than to send her back into find out more. You didn't phone Dr Brearey later that day. You didn't turn up to the meeting on Monday the 27th. I mean one potential explanation for all of that is you just weren't taking this seriously enough?

**A.** That's not true. I take every part of my role very seriously but, I can't -- I can't comment on the context that was happening at the time.

**Q.** There was then a meeting on the evening of 27 June, which you and Ian Harvey went to, together with some nursing managers. Do you recall the meeting that I am talking about?

**A.** Are we able to get that up? Is there any notes?

**Q.** Yes, INQ0015537, this is the action plan



meeting, I am sure you recall it?

**A.** Okay.

**Q.** Do you remember the one I am referring to?

**A.** Yes, I do.

**Q.** Well. we can bring up the action plan and page 4 is the notes that you made of it. Nobody at that meeting held a concern themselves, did they?

**A.** No, not directly no.

**Q.** Nobody who held a concern was invited to that meeting, were they?

**A.** I think what was quite tricky at the time was trying to get everybody in the room at the same time with knowing that Consultants have clinical commitments. So that was an immediate meeting that myself, Ian and Eirian Powell had and I think with the intention that myself and Ian Harvey followed up with the Consultants afterwards, I just think we couldn't get everybody in the same meeting.

**Q.** Were any Consultants actually invited to that meeting?

**A.** I'm not sure, but I think we were due to meet them afterwards.

**Q.** Because the Inquiry hasn't seen any evidence I don't believe?

**A.** I haven't seen any.



**Q.** No, I am sure you haven't and yet without having anybody present at that meeting who actually held a concern or could articulate what their concern, an action plan was created. Do you accept now that formulating an action plan without either you or Ian Harvey having heard from the Consultants yourselves was not an appropriate approach?

**A.** It -- it would have been beneficial to have them there but I'm not sure why they weren't there, I can't comment on the diary request.

**Q.** Were they being excluded from this so that the plan could be developed without reference to them?

**A.** No.

**Q.** When we look at the action plan, did any of these actions that were identified address the risk in the short term, in the immediate term, that the Consultants had identified?

**A.** No. But I think there were a number of actions that we could have which we did take forward --

**Q.** Well, Letby was still --

**A.** -- to support the Consultants' concerns.

**Q.** Well, the one action that could be taken to address the Consultants' concerns that just a few days earlier Letby had committed murder would have been to stop Letby from working that week. You see this is the



27th which is the Monday and she was rostered to work that week before she went on holiday?

**A.** Right. I was under the impression that she wasn't in work but I have since found out by information for this Inquiry that she actually was at work.

**Q.** Well, had anybody told you in terms: she is not at work?

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

**Q.** Well, isn't the most important step you need to take before do you a list of things -- a list for things some time in the future is to find out what does the shift pattern say so that we can see if she is going to pose a risk this week.

**A.** Yes, and -- and Eirian should have shared that information at the time.

**Q.** I'm sorry, who should have shared that information?

**A.** Eirian Powell knowing the shift, knowing the shift rota.

**Q.** Well, shouldn't you have asked?

**A.** Yes, I should have asked but I made an assumption that she -- she wasn't in work as a run-up to annual leave.

**Q.** What did you base that assumption on?

**A.** I'm not sure. I didn't ask the question.

**Q.** Do you think that as at this meeting you had lost sight of the importance of maintaining patient safety that week?

**A.** No, because there's a whole host of actions there --

**Q.** But --

**A.** -- that we are trying to glean what was going on.

**Q.** But none of those actions are addressing the risk that the Consultants have identified for you, which is that she might have killed and might kill again.

**A.** I suppose we found it quite -- we found it quite difficult to kind of comprehend, really. You know, as a Director of Nursing, in that organisation I was over nearly 1,000 nurses and midwives. The last thing on my mind is that one of my nurses is -- is deliberately harming children or babies or adults.

**Q.** It's not unheard of, is it?

**A.** It's not unheard of but I have to say that was not in the forefront of my mind.

**Q.** No, but you certainly weren't sitting there on 27 June thinking: that has never ever happened before?

**A.** No.

**Q.** Here you have extremely credible, knowledgeable expert people telling you that that is



what they think the risk is and you don't even appear to be talking about how you might address that risk?

**A.** I think at the time I was relying on my senior nursing team to give me assurances on Letby, particularly Eirian Powell, who knew her the best. I -- I would not know individual nurses on an individual basis.

So I -- I made an assumption that everything was okay on the unit and I didn't ask those questions.

**Q.** Well, how would Eirian Powell know if Letby was murdering anybody?

**A.** She wouldn't have known. But she would have raised concerns should she have had any concerns about her as an individual and her practice. The practice bit is really important because you automatically go to competency, not murder.

**Q.** But that is not what we are dealing with, is it? At this stage, if we focus on 27 June you were dealing with murder, that's what was being suggested, and Ms Powell couldn't give you any reassurance about that, could she?

**A.** But when you say suggestions of murder, suggestions from clinicians who could still not articulate why they thought that. And that was -- that was quite frustrating and maybe it's because I wanted



clear answers as to why they were so concerned.

**Q.** Is this meeting an example of where the situation had degenerated into doctors versus nurses?

**A.** Sorry, say that again?

**Q.** Is this meeting an example of where the situation has degenerated into doctors versus nurses?

**A.** No, not at all and throughout this process we were really keen to hear a nurse's perspective and a doctor's perspective and actually patient safety was absolutely paramount. This was a team that before all of this worked really well together and it's unfortunate that because of the events that we are now talking about it, it -- it became divisive between the nurses and the doctors and that's -- that's not conducive to good working.

**Q.** It is important that you understand that if you are going to say that patient safety is paramount that I am going to need to ask you for how patient safety was paramount bearing in mind that this meeting did not address the risk that had been communicated to you?

**A.** I -- yes, I made an assumption that Eirian Powell was -- was managing the risk at a unit level.

**Q.** I am going to move to my sixth topic which is



the involvement of the police. INQ0047571.

This is, as we will see, a series of emails on 29 June. So we are going two days forward and here you say that you discussed in that first sentence at the bottom with Sian Williams, your deputy, the police.

Now, we are going to come back to Ms Williams in due course, so this is at an earlier stage, before her involvement with the review.

So there is a discussion about the police and what Mr Harvey says is:

"My own feeling the police have been raised, I think we will have to."

The context for all of this is Dr Saladi's email, which you will remember, in which he says: I think we need to report ourselves to the police?

**A.** Yes.

**Q.** So you have discussed it with Ms Williams, Mr Harvey has said in terms I think we will have to, and you have replied:

"Thanks, yes, I would agree re the police."

So the position seems to be although that time is plainly wrong, 7.31 in the morning, for reasons I can't explain to you, out of sequence, but it would seem that early in the morning on the 29th, your position is the police need to be involved; is that right?

**A.** It is but I -- I don't recall the specific conversation which Sian Williams, my deputy, at the time.

**Q.** Well, we will not trouble ourselves about that. So that's where we start on the morning of the 29th. We can then see that there was a meeting with the paediatricians and the Executives, INQ0003371, also on the same day. We will go, please, to page 3.

I am just going to draw your attention to two parts, firstly, of these minutes and then of minutes the following day.

We can see a note towards the top. There is a discussion about Commission review, then police, or police and consequences, balance needed.

So that appears to be a discussion that's going on at that time about the police. We can also see, just diverting for a moment as it's on screen, "Nurse cannot be excluded".

Do you know why it was being said on the 29th that Letby couldn't be excluded?

**A.** No, I can't recall that.

**Q.** I mean, of all the people present in the room as her line manager whether ultimately she was excluded would sit with you; is that right?

**A.** It would, yes.



**Q.** Does it seem likely that you are saying to this meeting "nurse cannot be excluded"?

**A.** I may have done but I can't recall it doesn't say who -- who actually said that in those notes.

**Q.** No, but it's unlikely that others at the meeting would be asserting in terms she couldn't be excluded?

**A.** Not necessarily because as an Executive Team we work really cohesively and so we -- we freely spoke about each other's portfolios so, I mean, you would directly think that would be attributed to me, but I'm not sure.

**Q.** We will go over to the meeting the following day. We are staying with this idea of the police, so just we can see there INQ0003362, this is a meeting on 30 June. Sir Duncan Nichol attends this meeting and we will just track through what's said at that meeting.

Page 4, and what Mr Chambers says right in the middle:

"TC [I'm not sure what the symbol indicates but] nurse removed, would death stop?"

**LADY JUSTICE THIRLWALL:** It says "if".

**MR DE LA POER:** "If nurse removed would death stop", and Dr Brearey replies "risk would be reduced".

Then we will go over the page. Just to see, we can



see and it's not the only time but this is our example that at one point in this meeting Mr Cross at the top "outline of police action".

Then just finally to complete these notes before I ask you about what was said across these two meetings:

"Test hypothesis: yes, no, police."

So firstly I -- just if we can take that down -- want to ask you about what you recall Mr Cross said at the time of these two meetings about the police?

**A.** I think we had a general discussion about, about the police. I think throughout it all we were trying to be open-minded. We did refer to Stephen Cross because he had knowledge of the police from his previous roles and I think there was a conversation around -- although I can't be absolutely accurate, I think there was a conversation around what we would need to consider if we phoned the police. But the level of detail I can't recall.

**Q.** Well, other witnesses have told us about him saying things like "blue and white tape", "neonatal unit a crime scene", that sort of thing. Do you have any recollection of him saying anything like that?

**A.** I'm not sure about the words "crime scene". I think it was more around how would we manage a police investigation in terms of messaging to families,



messaging to the local community and in particular also around families that were going to be using the neonatal unit in the future.

So I think there was a wider -- from what I recall, a broader conversation around -- you know, we would need to be really sure about phoning the police because we need to consider our patients, our staff, a number of different elements. I can't remember those terms that you have shared though.

**Q.** Why, if you call the police, would it necessarily need to be the case that your patients would ever find out about it if you are just contacting the police to ask them: can you give us some advice in this situation?

**A.** In terms of advice?

**Q.** Yes.

**A.** That could have -- that could have happened. I thought you meant a wider investigation which obviously comms would need to be involved.

**Q.** At this stage you are discussing calling the police?

**A.** Yes.

**Q.** The criteria that you have identified about concerns that might arise in the mind of current patients or future patients, that will only happen if

the investigation reaches a stage where it needs to be made public?
**A.** Yes.
**Q.** If it reaches that stage, it's pretty serious, isn't it?
**A.** Yes.
**Q.** Presumably if it had reached that stage everybody would be entitled to know about the fact that there was an active police investigation?
**A.** Yes.
**Q.** So do any of those factors really bear on the decision about whether you should be picking up the phone and speaking to a suitable police officer to say: this is what's happening here?
**A.** I think at the time we felt that we needed to get much more information internally so that we knew how we would articulate these concerns to the police. You know, on reflection maybe we could have gone to the police then but it actually didn't feel -- it didn't feel the right thing to do at that time because we felt we needed more information so that we could articulate clearly to the police what the problem was and at that time we weren't clear, it was complex.
**Q.** You say it didn't feel like the right thing to do. That may be because it wasn't the right thing to do



or it may be your sense of what was right was miscalibrated, do you think that your --
**A.** No, I think we had a general conversation about the fact that we needed to know we all personally needed to understand what was actually going on in our organisation so that we could then clearly articulate to the police what the problem was because at that time we didn't really have a sense of what was going on.
So it was a collective decision, it wasn't any one of us made a decision not to go to the police at that time. It was a general discussion at the Executive meeting around we needed to find more information out first before we considered the police.
**Q.** So by 5 July, Ms Appleton-Cairns was speaking to Mr Ian Pace of DAC Beachcroft and she is recorded as saying that there were no malicious issues and what Ms Appleton-Cairns has said when asked about that is that she had assurances from you and Ian Harvey that there was nothing malicious and that she had been told that you had been through every case.
Were you saying around the 5 July that there were no malicious issues?
**A.** I don't recall that because we hadn't gathered all our information.
**Q.** Quite, it would be quite -- I mean, if that is



what you said --
**A.** I don't recall.
**Q.** -- it would not -- it would not represent a sound statement of the position, would it?
**A.** No, no.
**Q.** Now, Ms Williams, your deputy, was commissioned as part of the review process that was taken out specially to conduct a staffing analysis?
**A.** Yes.
**Q.** She has told us that she and Ms Fogarty, who did it together, reached the conclusion that the police should be called because of the association that they had identified of Letby. That's what Ms Williams' evidence was and Ms Fogarty gave evidence supportive of that. What Ms Williams said is that she spoke to you among other people about the fact that she thought the police should be called after she had done her review so not on 29 June as we have seen there, but after she had done her review.
Did she tell you that the police should be called?
**A.** I can't recall the detail of that conversation. I know that they did a detailed analysis, her and Julie Fogarty. I'm not sure of when that was escalated in terms of the concerns.
**Q.** What was the conclusion of that analysis?



**A.** That piece of work was part of a wider internal investigation and I believe that that did show that Letby was present but not directly caring for babies at that time.
**Q.** So it confirmed that the information you had before that was accurate?
**A.** But I think also just to add to that, there were also doctors named in that analysis as well.
**Q.** Well, you were -- the name of Letby raised before, Ms Williams has conducted that piece of work and confirmed independently of Ms Powell and Dr Brearey that their information is sound in terms of the basic facts and she herself is concerned, she tells us, about it.
Is it your position that you just didn't realise that she thought the police needed to be called or that she may have said that to you and you have forgotten?
**A.** I really can't remember that conversation. But I think again that staffing analysis was about an association of individuals with incidents which formed part of a bigger piece of work which we needed to get, we needed to collate so that we were able to articulate to the police when we went to the police.
I can't recall the details of Sian Williams's conversation with me about that, I have to be honest.
**Q.** It would be a strange state of affairs, do you

agree that if she told you that she thinks the police should be called, if you had forgotten her saying that?

**A.** Yes, I mean, in -- there was so much going on at that time. Lots of people were doing different sets of actions, this was when we had our internal incident review process. She -- she may have raised that concern about the police but I think we were looking at information in the round but I don't recall the detail of that conversation.

**Q.** That staffing analysis never gets referred to again, does it?

**A.** Sorry?

**Q.** That staffing analysis which demonstrated the association with Letby and led to Ms Williams being concerned, it never gets referred to again once it's carried out, does it?

**A.** I am not certain about that.

**Q.** Well, let's just cast your mind back. Did you tell anyone in all of the organisations and all the conversations that you had with external bodies, did you ever say one of the things we did was a staffing analysis and that staffing analysis demonstrated that Letby did have a strong association with a number of these babies?

**A.** I don't think that level of detail was shared



at the time, no, but in the CQC list I think I wrote we were doing a staffing analysis.

**Q.** That you were doing or had done? I mean, on 30 June you said you were going to do it. But you never told the CQC after you had done it what the outcome of it was?

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

**Q.** Well, we have looked at the 17 February when you are telling them about what the position is then, you didn't say at any point: we did a staffing analysis as part of our internal review and it demonstrated the association of Letby?

**A.** I think, yes, association with Letby but I think that was just one part of a bigger jigsaw, if you like, that there was lots of other things going on at the same time, so we needed to get a full picture.

It was complex, it was unclear, the staffing element was one -- just one part of it and we needed to pull all that together to get an idea of what was going on.

**Q.** Why was it complex?

**A.** We had different reviews that were going to be commissioned, we had to downgrade the unit which operationally was challenging because that wasn't just about the Countess, that was about our partners across



the system. The clinical criterias being drawn up. There were a number of different things that were happening in that time and the staffing analysis and the association with Letby was one part of that.

So that's -- that's a reason why we didn't communicate fully with our regulators at the time because we needed to understand what was actually going on, in the absence of any clear evidence, again, from our clinicians.

**Q.** I would like to just ask to you consider this explanation so that you can comment upon it: you commissioned a staffing analysis, it demonstrated the very thing that Dr Brearey had told you he had found when he and Ms Powell had gone through it, you didn't like the fact that that was a piece of evidence which supported the allegation and so you just didn't refer to it again?

**A.** That is absolutely untrue. I did not feel that at the time. I think the word "association" is a really interesting one because there was association with doctors, there was association with some care issues which were already articulated in the Thematic Review, competency issues on the unit.

So we couldn't just hone in on one element. It needed to have a multi-factorial approach.



**Q.** We are going to come back to what you say about doctors being indicated by that analysis. We are going to move to my seventh topic, which is the NMC, which will give us an opportunity to do that.

Now, you sent an email to the NMC on 4 June asking for some -- an opportunity to speak to their ELS service, that led to a conversation which led to an email being sent following the conversation, summarising what happened, and you went through that email and just marked up any changes?

**A.** Yes.

**Q.** We don't need to go through it all again but I can bring it up on screen, if you need me to, but I am sure you will be able to take it from me that among the things that you said to the NMC was that there was no evidence?

**A.** At that time there was no evidence.

**Q.** Well, we are not going to go through all of that again. We will move through to the email of 31 August, INQ0002964. This is an email that you have been chased for an update, we can see was sent on 23 August by Mr Newman and seven days later you provide that update.

It's just one part of this:

"As previously mentioned, we undertook a thorough

internal review [in that first paragraph]. Nothing significant was identified within this."

So far as this is concerned, that's misleading, isn't it, that nothing of significance was identified with your internal review?

**A.** At that time that was my perception, was nothing significant was identified that would lead me to think that further action was required. I was asking Tony Newman for further advice, giving an update on what we were doing, which we had agreed in the previous communication. I don't -- I wasn't meaning to mislead anybody.

**Q.** Well, let me invite you to consider this. Within that internal review, there had been the staffing analysis done that had confirmed the Letby association, that's one thing. We have been over that. But also Dr Gibbs together with Ms Martyn had conducted a review of the cases referred out and had identified six cases which they were concerned about.

Now, both of those are relevant to the development of the potential concerns about Letby, but you are not reporting those to the NMC, instead you are suggesting that nothing of significance came out of it. Why is that?

**A.** Again I think it's terminology in the email



concern. Just -- that's something of significance, isn't it?

**A.** But we were still unsure as to what was going on. So it was -- you could say it was a holding position.

**Q.** It is a holding position that isn't accurate?

**A.** But we have removed LL so we have removed the risk, so I was informing them she was on non-clinical duties.

**Q.** This is an example of information that the Executives had that is being withheld from the external bodies that tends to suggest that the concerns may be credible, isn't it?

**A.** No. We were not holding anything from anybody. What we needed to do was be really clear, again, as I mentioned earlier about understanding our organisation and what was actually going on in our organisation before we could share that with our regulators.

On reflection, we probably should have shared more with our regulators because we might have got some support to be able to manage this perhaps in a different way, but at the time I think the actions were numerous and we were dealing with the detail on a day-to-day basis.



because below that is:

"Following discussions with the board and on receiving views from our clinicians, a step ... taken to take LL on non-clinical duties".

So again, removing the risk but still in a fact-finding position. So at that time, it felt that was the right thing to say but I -- you know, it wasn't purposely misleading.

**Q.** But it isn't accurate, is it?

**A.** It's probably ambiguous.

**Q.** Well, "nothing" -- the word "nothing" is not capable of ambiguity, is it?

**A.** Significant. Depends how you define "significant".

**Q.** Well, you had commissioned Dr Gibbs as part of the Executives to look at cases. If he had found none of concern to him, that would be nothing of significance. If he has found six which are of concern to him, is that not something of significance?

**A.** From a clinical perspective but we were still unclear as to what was going on. So further information needed to be gleaned from those further cases from Dr Gibbs and Anne Martyn's review.

**Q.** But you are talking here about the output of the internal review they identified six cases of



**Q.** But --

**A.** On reflection, like I say, we -- we probably should have shared more at key stages with our regulators.

**Q.** Now, from 27 April, you knew that the police were going to be involved, 2017, didn't you?

You can take that down.

**A.** Okay, sorry.

**Q.** From 27 April 2017 you knew the police were going to be involved?

**A.** Okay.

**Q.** Do you agree with that?

**A.** Yes.

**Q.** You did not contact the NMC to tell them that, did you?

**A.** I can't recall. Maybe I didn't do that in a timely way. I can't recall.

**Q.** Well, 18 May 2017, the NMC had found out about police involvement from a press release and so they called you. Does that sound right?

**A.** I think we communicated with everybody, unless the NMC were inadvertently left off that list. I thought when we were commissioning the police investigation that there was a separate communication plan sharing with our external bodies what we were

doing.
**Q.** Well, at all events, let's have a look and see what was sent, INQ0002449, page 1. So this is the record of what was discussed. If we look in the centre of the page:
"AK advised me as she had explained to TN previously there was a view held by several medical colleagues that a registrant may be the common denominator and are quite strong in their view that she may be the cause. This is largely based on an identification of her having been present on most but not all of the occasions when infants collapsed and died."
Well, that isn't a fair or accurate characterisation of the Consultants' views, was it?
**A.** I think that is quite clearly articulated as the Consultants' views.
**Q.** Well, their views were, starting point: an unexpected number of babies have died, there were sudden and unexpected deteriorations, the babies had failed to respond to resuscitation as we expected them to, we have investigated and we cannot identify any other common cause for this, but we can identify one person in common for all of these, and that is Lucy Letby.
That in a summary position was where they were by



the time the police came to be contacted and you are not advancing any of that on their behalf, are you?
**A.** As I mentioned earlier, aside to an association with Letby, there were significant clinical concerns that were borne out of the Royal College report, the Hawdon Review and McPartland Reviews and that constituted sub optimal care across the board in varying degrees across those -- those poor babies that died or had deteriorated.
**Q.** Not a single one of those causes -- sub optimal care was said to have caused death, though, was it?
**A.** But there were also postmortems as well, that had outcomes, so there were a number of different elements.
**Q.** You have mentioned the postmortems, the postmortems did not suggest that the sub optimal care, if there was some, had caused death, did they?
**A.** No, but if you put all of those elements together it doesn't show a particularly positive image of how that unit was being managed and there were a number of -- and the other element is that the words "unexpected" and "unexplained" were never discussed before June '16.
**Q.** Well --



**A.** So --
**Q.** Again I am just going to make an assertion about that. In the Thematic Review of neonatal mortality it describes those sudden unexpected deteriorations, doesn't it?
**A.** Sudden deteriorations, yes, but when you look at those cases that did actually find their way to a Datix report, and that is not all of the cases --
**Q.** Well, but the Consultants were saying that, that is what they were telling you, that we have notes from June of 2016 of Dr Saladi saying: these were not the babies we were expecting to collapse?
**A.** But when you look at the Mortality Reviews that were actually led by Dr Brearey, there were no concerns being raised at all up to that point. So if you take all of that in the context of sub optimal care, there were lots of reasons why poor babies were dying and this was an -- in line with an association with one member of staff.
**Q.** You have just said it again, there were lots of reasons why these babies were dying. That's not correct though, is it, Ms Kelly: none of the care issues were the reason why the babies were dying.
The fact that the unit wasn't well led was never identified as a reason that babies were dying.



They couldn't work out what the increase in -- was the cause of increase in mortality from a medical perspective?
**A.** But when you spoke to the clinicians, they still couldn't articulate the reasons why babies were dying. They -- they associated it with one individual and there were lots of things, lots of elements that came out of those reviews that were quite concerning, competency issues, delays in care, delays in intubation, numerous things that will have contributed to poor outcomes for babies.
So -- and I know that's not referred to in the postmortems -- postmortem, but if you put that picture together, it's not -- it's not a good picture. So what I was trying to articulate here was we were doing lots of reviews, lots of analysis and we had reviewed, removed Letby from practice, which was the right thing to do at that time, so it wasn't clear, it wasn't clear, it was a complex picture.
**Q.** So do we take from all of that that your position as at 18 March was that the likely explanation for all of these deaths was poor care?
**A.** Potentially, yes.
**Q.** And what medical opinion had been offered that reached the same conclusion that you had?

**A.** It -- it wasn't just my conclusion. It was the outputs of the reviews that we had done.

**Q.** No, no, did any doctor say that poor care was the explanation?

**A.** Dr Hawdon's report, the outputs of her report talk about sub optimal care in varying degrees across all the cases that were reviewed.

**Q.** Did she say that that sub optimal care caused death?

**A.** I don't think she used those words, but there was -- they were contributing factors.

**Q.** Well, Dr Subhedar had been part of the Thematic Review?

**A.** Yes.

**Q.** He had reviewed Dr Hawdon's report and by this time, as you will have known, was saying that there were seven babies that he was concerned about, this is a wholly independent view on behalf of the network from a Consultant neonatologist who had involvement at the start and had involvement just before this?

**A.** Yes.

**Q.** He was not suggesting that the deaths were explained by sub optimal care, was he? And he knew everything you did?

**A.** It was -- I'm not sure about that and I ...



**Q.** Well, can I help you with it because he says he thinks seven babies need further review, so he had not reached that conclusion in relation to those seven babies?

**A.** No, but he did provide helpful guidance for the Thematic Review which I know some of those babies did get discussed in the Neonatal Network Meetings and no concerns were raised at that time. I recognise later on he wanted further reviews of additional babies.

**Q.** But that was the position going in to this referral. You see, let me try and cut through this.

You have a clinical background in adult nursing?

**A.** Yes.

**Q.** You were provided with a number of expert opinions by Consultant paediatricians and a Consultant, two Consultant neonatologists, and in particular the network was giving some oversight to this and not a single one of them said in terms to you, or in writing: sub optimal care is the explanation for this.

Yet you seem to have reached that conclusion for yourself despite that body of evidence. Why is that?

**A.** The body of evidence came from Dr Hawdon's review, which does mention sub optimal care.

**Q.** She doesn't -- well, let's take Dr Hawdon?

**A.** I think -- I think she does. But it is



a combination of a number of things because we were looking at so many different elements and the outputs of the Royal College, the outputs of the Hawdon Review, the McPartland Review, didn't point to somebody intentionally harming babies.

**Q.** Let's just think about that for a moment. Dr Hawdon concluded that four babies' deaths were unexplained and unascertained, didn't she?

**A.** There was further review required on those, yes.

**Q.** Yes, because she had reached that conclusion.

So that is potentially four babies who were murdered; you couldn't exclude that?

**A.** Potentially yes, there was further review required.

**Q.** Dr Subhedar increased the category of potentially murdered babies to seven, didn't he?

**A.** I think he increased that, yes.

**Q.** Yes. You didn't have any basis or sufficient expertise yourself to say that Dr Subhedar was wrong to be worried that seven babies may fall into that category?

**A.** No, not personally. But -- and we welcomed Dr Subhedar's input to -- and again conversations with probably with Dr -- with Mr Harvey around more babies



being added to that list of further review for further review. But as I mentioned before, all the work that was being done, whether that internally or externally was leading down a path that suggested care was not of a good standard on that unit.

**Q.** Well, I would only be repeating myself to point out that none of it said that it was causative so we will move on and we will look at your referral to the NMC, which is up on our screen.

One other sentence to ask you about:

"Other staff were present on a similar number of relevant occasions"?

**A.** Sorry, on this same document?

**Q.** Same paragraph, final sentence of that paragraph.

**A.** I believe some of the doctors were on duty at similar times, but not as many as Letby.

**Q.** No, no, no. In fact, Letby was associated with nine of the ten deaths on the Thematic Review plus two more in the form of the deaths of Child O and Child P, so at that time her association was 11. The next highest association was Dr Harkness with six but Dr Harkness had left the Trust in March and so there could be no question that Dr Harkness had caused the deaths of O and P because he wasn't even working at the

hospital.
So just help us with why you are suggesting that other staff were present on a similar number of relevant occasions?
**A.** I think that was just going over generally what the outputs of that Thematic Review were, there was a staffing analysis attached.
I haven't gone into specifics in that sentence so it's kind of a high level sentence, really. But I was aware that some doctors were present but not as many times as Letby.
**Q.** Well, doesn't it rather exaggerate the position?
**A.** Sorry?
**Q.** Doesn't it rather exaggerate the position to say other staff were present on a similar number of occasions?
**A.** That was not written intentionally to mislead people. But doctors were highlighted in the staffing analysis.
**Q.** So that's the update post arrest.
In fact, when it comes to a referral to the NMC, the NMC found out about the arrest on 3 July and they tell us they contacted you and you made a referral on 4 July 2018. We don't need to bring it up unless you



want to, but the text that is in that 4 July is an almost perfect but not quite lift from your LADO referral from March of 2018; does that sound right?
**A.** Similar, yes.
**Q.** Yes. Similarly, when you are referring Letby to the Fitness To Practise Directorate, do you think that you were putting the concerns against her at their highest?
**A.** At the time I thought I was articulating exactly what had been going on and I had had regular communication with NMC and it took a while for that to filter through the NMC, I believe.
**Q.** Part 8, we are going to look at the involvement of the RCPCH and Dr Hawdon and we start with the amendment to the Terms of Reference. Were you involved in that process?
**A.** Very briefly. Mr Harvey took the lead on that.
**Q.** The word "apparent" was inserted into the Terms of Reference so it didn't just talk about the increase in mortality but the apparent increase in mortality. Was that a word that you suggested should be included?
**A.** I can't recall that. No, I had very little, very little involvement in that Terms of Reference



development.
**Q.** Well, it's just --
**A.** I can't recall.
**Q.** Sorry?
**LADY JUSTICE THIRLWALL:** Can't recall.
**MR DE LA POER:** Can't recall, thank you.
You see the word "apparent" was also included on 11 July in the Risk Register entry, do you remember?
**A.** Okay, from the division?
**Q.** Yes.
**A.** Yes.
**Q.** We understand from Ms Townsend that that was scripted following a meeting with the Executive Team. Is her recollection correct about that?
**A.** Yes, I have absolutely no recollection of that because a risk articulated at divisional level would have been discussed at divisional level.
**Q.** Well, it might have been brought to the divisional level, having already been written?
**A.** Sorry?
**Q.** It might have been brought to the divisional level having already been written?
**A.** Potentially, but I -- that would -- we would not have a role as an Executive Team to draft risks that were held on a Divisional Risk Register; that would be



the responsibility of those clinical teams.
**Q.** Were you the Executive lead for risk?
**A.** I was, yes.
**Q.** Then of course in July 2016, so this is all happening in July 2016, we had the paper written by you and Ruth Millward, certainly there is both your names at the bottom, called "Position paper", which uses the phrase "apparent increase in the number of neonatal deaths".
So again did you have a participation in the writing of that position paper?
**A.** I commissioned that piece of work and Ruth and some of her operational team pulled all of that information together.
**Q.** Do you agree now that using the word "apparent" in July was entirely unnecessary? In other words, by July of 2016, it was well-established that there had been an increase in the mortality rate?
**A.** Yes, if you look at the data that was being provided.
**Q.** Yes.
**A.** But again, terminology. It wasn't intentionally put there to mislead people.
**Q.** Somebody has decided to stick the word "apparent" into the Terms of Reference but you say you

can't recall if that was you?
**A.** I don't recall having much input at all in that report -- the Terms of Reference.
**Q.** You had a meeting on 1 September 2016 with the RCPCH and what Ms Eardley told us was that you were particularly supportive of Letby and quite dismissive of the allegation. Is that a description of your behaviour in that meeting that you recognise?
**A.** No, I was not, I have never been dismissive. We took this very, very seriously, I felt that we had an open conversation with the Royal College team and with Sue Eardley on her first day in the organisation. That was myself and Ian Harvey.
I certainly wouldn't say that I was dismissive at all.
**Q.** On 2 September there was a meeting where, as we understand it from those who attended, you and Ian Harvey and Tony Chambers were told that a case-by-case review of the deaths needed to take place?
**A.** From who, sorry?
**Q.** From the RCPCH?
**A.** Oh, right, okay.
**Q.** Do you recollect that?
**A.** I do recollect that, yes.



**Q.** They also told you as is recorded in the notes HR process for Lucy?
**A.** Yes.
**Q.** And so does it follow that as at 2 September, you knew that the RCPCH was not able to answer your concerns about Letby or the concerns about Letby?
**A.** Not fully about Letby, no. Because there was -- we -- they focused on the clinical and operational and management of the unit.
**Q.** But did you think they could answer anything about whether Letby had killed babies? As at 2nd --
**A.** Probably unclear at the time but it was just again keeping an open mind and also gathering as much information as possible.
**Q.** It's important to be clear though, isn't it, Ms Kelly, because if at subsequent meetings as we have seen you are telling people that the RCPCH is either inconclusive about the allegation or hasn't found anything to support the allegation it's quite important to know that the RCPCH weren't actually investigating that?
**A.** I think it was important to get a rounded picture of what was going on through the Royal College review and I think that was just again one part of the jigsaw to see if there was any intentional harm.



**Q.** Well, let's just nail it down. Did you think as at the time of the RCPCH reviewers left the site that the RCPCH had investigated whether Letby had murdered babies?
**A.** Not, not directly, no.
**Q.** Well, or indirectly?
**A.** We didn't know at the time. And actually I think it was the Royal College that offered to meet with Letby while they were on side -- on site. but I think the outcomes of their report was just another piece of information that we were trying to glean around the high mortality.
**Q.** They mentioned the HR process. We can see a little more detail in their letter of 5 September, INQ0003120 and over the page, this is addressed of course to Ian Harvey but presumably you would have seen this letter?
**A.** I think Ian would have shared that with us, yes.
**Q.** "HR Investigation. Our understanding is an allegation has been made and therefore a process of investigation needs to be put in place which sets out nature of the allegation and the process you will follow to investigate it."
So that is a disciplinary investigation?



**A.** (Nods)
**Q.** The Trust never instituted a disciplinary investigation into Letby, did they?
**A.** No, we took external legal HR advice and we were struggling to articulate what policy would be applied to do an HR investigation of that type.
**Q.** The RCP --
**A.** Notwithstanding that, this morning we talked about safeguarding and I recognise that there was probably a missed opportunity from a safeguarding perspective, but from an HR, we -- it's not that we ignored that recommendation from the Royal College, we sought external advice to support our decision-making.
**Q.** And who -- was this DAC Beachcroft that you are saying --
**A.** Through Sue Hodkinson, the HR Director, yes.
**Q.** Are you satisfied that what was communicated was that the Royal College had said a disciplinary procedure needs to be instituted to address an allegation of harm by a member of staff?
**A.** We knew that we needed to look at whether an HR investigation was required and that's why we -- we struggled internally to understand how we would do that. That's why we took the legal advice externally.
**Q.** Did you back to the RCPCH to ask for more

information about what they meant?
**A.** I didn't personally, no.
**Q.** You see, because do you agree at later meetings it is suggested by members of the Executive that the RCPCH had made recommendations which the Trust had followed?
**A.** Yes.
**Q.** But of course that was a recommendation made by the RCPCH which the Trust didn't follow?
**A.** We did follow it to an extent because we had -- we had further conversations about that particular action --
**Q.** That's --
**A.** -- and guidance given to us externally.
**Q.** They recommended you do a disciplinary process. You didn't do a disciplinary process, therefore surely you didn't follow the recommendation?
**A.** We didn't ignore it. We sought external advice.
**Q.** But you didn't follow it, did you?
**A.** We didn't follow it to the letter, no.
**Q.** Dr Hawdon's report recommended a local forensic review in four cases. What steps were taken to institute that local forensic review?
We can take that down --



**A.** Sorry, where --
**Q.** Dr Hawdon did a report, I'm sorry, we had covered all of this already. I just wanted to ask a follow-up question about it.
In that report she identified five cases, initially four, after the postmortem review --
**A.** (Nods)
**Q.** -- that required local forensic review. That was her conclusion. What was done about that?
**A.** That action sat with the Medical Director and my understanding is that further communication was made with forensic pathologist from Alder Hey is my understanding, to do a further review of those cases.
**Q.** Firstly not a forensic pathologist but if you are referring to Dr McPartland.
**A.** McPartland.
**Q.** But that was always part of the original requirement that a pathologist look at the cases?
**A.** Yes.
**Q.** So that was baked in. Once that review had taken place, a local forensic review was required according to Dr Hawdon. The Inquiry has seen no evidence that anything was done so far as that's concerned, just giving you the opportunity to indicate whether anything was done?



**A.** I am unsure of that. I wasn't close enough to the detail. That would have been Mr Harvey that would have instigated that. I'm not sure whether that actually took place or not.
**Q.** The Trust received the RCPCH report on 28 November of 2016. Included in the email to Mr Harvey was a suggestion it should be for wider dissemination amongst those who contributed.
We can bring up the detail but you may be able to take it from me that within the RCPCH report there were recommendations to CDOP and to the transportation and Neonatal Network, weren't there?
**A.** Yes.
**Q.** We can see from the report and we can look at it, but you may be able to take it from me that they don't provide an explanation for the increase in mortality rate, do they?
**A.** From the -- sorry, from which report?
**Q.** The RCPCH report?
**A.** Yes, the Royal College, no.
**Q.** No. And they make a number of what are termed immediate recommendations?
**A.** Yes.
**Q.** So that's on 28 November. On 21 December, you wrote to NHS England, INQ0008077. Just familiarise



yourself with this letter. We can see you mention Dr Hawdon's work, the neonatologist from London. And you say that:
"Obviously the safety of our unit is paramount. From the day the Review Team left the Trust they assured us there were no immediate actions or concerns."
I mean, in fact they had recommended a number of immediate steps, hadn't they?
**A.** Yes. But also we have since learnt from this Inquiry that the Royal College had concerns whilst they were on our hospital site and didn't raise anything with us.
**Q.** We just need to focus on this. the report says in terms it lists A to F immediate recommendations. That is an immediate action. You had received that report 21 days before this and yet you appear to be telling NHS England that there were no immediate actions from the report. Why are you saying that?
**A.** I think I am probably looking at that as if it were a CQC inspection, so meaning whilst they were on site there were no immediate actions, although that will have been listed in the recommendations as to what we needed to do first.
So potentially that was misleading, but not intentionally.

**Q.** Just consider this. I mean, that report could have been sent to NHS England at this stage, couldn't it? It was all finished and finalised, there had been some recommendations about Dr Hawdon but that report itself was a finished article as at 28 November, do you agree?

**A.** It was a finished article but I think because there was further deep dives required we wanted to make sure that we had a fuller picture. So that was discussed, that wasn't -- I wrote this letter but that wasn't my decision, it was a collective decision from the Executives.

**Q.** If you had written to the NHS England and said there are a number of immediate actions for us from this report, that would have immediately provoked them to say we need to see the report, don't we?

**A.** Potentially, yes.

**Q.** Yes, and so by telling them that there were no immediate actions you were effectively able to delay when you had to give them the report?

**A.** That was not done intentionally. I think I meant there as in when they were on site there was nothing that they brought to our attention that we needed to immediately address but I recognise the way that that is written it probably -- it looks like it's



referring to the actual report recommendations.

**Q.** Now, the report was published on 7 February 2017. Here we are talking about the dissemination, not the confidential version.

That means that it had been held and withheld from CDOP who had a recommendation that the Neonatal Network and indeed the Consultants on the unit in terms of their opportunity to consider how they might improve their practice; is that fair?

**A.** Yes, I think it's, I think it's recognised from the Executives' perspective that the delay in sharing it with the paediatricians wasn't good enough at the time. We should have done that in a more timely way.

**Q.** One explanation which I would like you to consider and comment on is that it was deliberately withheld to the last possible moment so that the paediatricians didn't have an earlier opportunity to point out that it didn't address their concerns?

**A.** No, not at all.

**Q.** Well --

**A.** We recognised that the communication of the actual report could have been better but that was not done intentionally from a Consultant perspective.

**Q.** Could have been better?



**A.** Could have been better, yes.

**Q.** It put patient safety at risk by withholding it, didn't you?

**A.** In -- in not sharing actions, you mean?

**Q.** Yes.

**A.** Potentially, but that wasn't -- that wasn't the intention at the time.

**Q.** Again, a straightforward question: it put patient safety at risk not sharing that report as soon as it was available, didn't it?

**A.** You could say that, yes.

**MR DE LA POER:** My Lady, I have a little further to go but I wonder given the time we have been going about an hour and a quarter whether we could take a break?

**LADY JUSTICE THIRLWALL:** Yes, certainly. We will take 15 minutes. So we will come back just before 10 past 3.

**(2.53 pm)**

**(A short break)**

**(3.10 pm)**

**LADY JUSTICE THIRLWALL:** Sorry to keep you all waiting. Mr De La Poer.

**MR DE LA POER:** Ms Kelly, my penultimate topic is the grievance procedure.

We will start with Dr Green. You tell us in your



witness statement that you recognise it would have been better if the investigator had been entirely independent from the hospital; is that right?

**A.** On reflection, yes.

**Q.** Is that because this involved an assessment of the personalities of people who Dr Green would know?

**A.** Yes.

**Q.** We turn to Ms Weatherley.

Are we correct to understand that you were responsible for selecting Ms Weatherley?

**A.** Not directly. I contacted a chief nurse who I used to work with and asked her for advice of somebody that could help with an external investigation.

**Q.** What Sir Duncan Nichol has said the fact that you chose a nurse from somewhere you had worked might create the perception of not being entirely fair, that is his perspective?

**A.** At the time --

**Q.** Do you have a comment upon that?

**A.** At the time I thought it was an appropriate move. I didn't know Annette Wetherby -- Weatherley so it was somebody completely independent so I just went to a previous employer just to get access to get somebody to do it quickly so that we wouldn't be having long delays.

**Q.** Bearing in mind that there was by this stage, September, some tension between the doctors and the nurses --

**A.** Yes.

**Q.** -- should it have been somebody who was neither a doctor nor a nurse who was adjudicating on this?

**A.** In, yes -- looking back in hindsight, that might have been a good idea.

**Q.** Because whether or not this happened there is at the very least a risk that a nurse would side with -- that there would be a perception that a nurse would side with somebody from her profession?

**A.** Potentially but it's not unusual in a grievance process that you would have somebody from the same profession hearing a case.

**Q.** Now, you were interviewed as a witness in the grievance, weren't you?

**A.** Yes.

**Q.** The 20 October 2016, we will just bring up some of the things that you said to Dr Green, INQ0002879 and we will go to page 21.

So we begin towards the bottom with you saying that SB had pinpointed an individual nurse. In fact, it was Eirian Powell who had first identified the nurse to you,



hadn't she?

**A.** I think it was a combination of the -- the two of them working together at the time, yes.

**Q.** It was Eirian Powell who had first identified the nurse to you, wasn't it?

**A.** In the email trail that we have previously looked at.

**Q.** Yes.

**A.** Yes, but I know it was a piece of work that Steve, Stephen Brearey was also part of.

**Q.** And you go on to say that:

"There was a discussion involving Karen Rees to find out if there were any issues ..."

Then this:

"In the meantime, SB conducted his own mini review of the cases and analysis of staff on duty at the time of deaths."

Is the mini review a reference to the Thematic Review?

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

**Q.** So the first thing is that wasn't --

**A.** I'm not sure, to be honest.

**Q.** Well, Dr Brearey didn't conduct the Thematic Review on his own, did he?

**A.** No.



**Q.** No. In fact there was another Consultant from the Trust, someone from the network, a number of nursing staff and someone from the Risk Department?

**A.** I suppose what I meant by that was he was actually leading it because he instigated it, so --

**Q.** You see, one way of --

**A.** It was collective, it was collective, but it reads that he did it on his own.

**Q.** Yes, one of the ways of reading both of those things is that Dr Brearey is out on a frolic of his own here?

**A.** Is what, sorry?

**Q.** He is out on a frolic of his own, that he is acting on his own making these assertions, that is one interpretation. Can you see how that might be understood in that way?

**A.** Yes.

**Q.** It's -- rather than saying that it was the joint conclusion of the nurse manager and Dr Brearey that Letby was identified as having an association, rather than saying that a number of others were conducted in the Thematic Review and the analysis of staff on duty at the time of deaths, you are putting this all on Dr Brearey?

**A.** I think because he was the clinical lead he



was leading on a number of pieces of work, so that's probably where I was coming from in terms of he was the clinical lead, he was expected to oversee and lead some of those pieces of work.

**Q.** Page 22, top:

"LL was on duty but not always allocated to the particular baby. There were lots of indirect links being made to one individual but there was no other rationale for it."

There was a rationale, wasn't there, as you knew, which is that she was identified as being associated and after all of the investigations that were done, no clinical cause could be identified, so there was a rationale?

**A.** There wasn't a clear rationale. There was an association with Letby and as I mentioned earlier there was an association with issues with care as well.

**Q.** Well --

**A.** And also other members of staff.

**Q.** Why were you not, when describing what the Consultants' position was, stating it as they had stated it to you?

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

**Q.** Yes, the Consultants -- we will start at the beginning.

The Consultants had told you, and we have been through all of this, that there was an increase, unexpected, that babies who were collapsing who shouldn't have, that there was a pattern that had been noticed in terms of association. Of course by this stage we had the fact that that pattern was at night and that she was then moved on to days and the pattern stopped. Those were all the things that had been said before this meeting to you by the Consultants and yet you appear to be characterising their position as a lot of indirect links being made to one individual but no other rationale.

I suppose one way of saying it is do you agree that is not a fair characterisation of their position?

**A.** I suppose it could have been -- I could have articulated in a little bit more detail to give context.

**Q.** Well, it is quite dismissive of their position, isn't it?

**A.** Not intentionally, I think throughout this process we were listening to both sides all of the time there were numerous discussions with the clinicians. But the wording of how it's articulated there probably doesn't give the full picture.

**Q.** Well, it's suggesting that there is no rationale for it when in fact they had given you



a rationale. So it is a mischaracterisation of their position, isn't it?

**A.** I think when you are going back to what we talked about before the break, which was the numerous reviews that had been undertaken, there were lots of things to consider.

**Q.** So just focus. This is you summarising for Dr Green what the Consultants' position is?

**A.** Yes, and that could have been done in a bit more detail.

**Q.** Well, it is a mischaracterisation of their position, isn't it?

**A.** I wouldn't put it in those terms. But I could have given more detail.

**Q.** And you have said there are no significant concerns about her, no red flags, no themes, or trends.

Well, some themes had been identified, hadn't they, in particular as far as she was concerned the fact that the collapses were at nights then she was moved off nights and the pattern stopped.

So it is factually inaccurate to say no theme or trend had been identified, isn't it?

**A.** A few more elements of detail would have been helpful there.

**Q.** That is -- that is a false statement, isn't



it, to say no themes or trends?

**A.** I think that was -- that was -- I was responding in the context of -- well, I should have I should have done more -- I should have articulated more detail around that. It is misleading.

**Q.** And false?

**A.** You could say potentially false. Yes.

**Q.** Then we have what you say about the RCPCH, so we need to move to one-third of the way down. Did anything come out of the report:

"Confirm nothing significant as far as Lucy"?

**A.** Sorry, what paragraph are you at?

**Q.** It's one-third of the way down?

**A.** Oh, yes.

**Q.** "Did anything come out from the report?"

"Confirm nothing significant as regards Lucy. The report is only just in. It is a draft report and we are awaiting forensic investigation of the medical notes of the cases involved."

So that is a reference to the RCPCH and Dr Hawdon.

But you knew, didn't you, when you uttered those words, that the RCPCH had not investigated whether Letby was responsible?

**A.** My understanding was not directly, no. But part of the Royal College review was to look at anything



clinical or management-wise that was untoward.

**Q.** That is a misleading statement from you, is it not, "confirm nothing significant as regards Lucy", in circumstances where the full picture is that it was not investigating Lucy?

**A.** I think we are just trying to keep an open mind at the time with the Royal College review --

**Q.** Is it a misleading statement?

**A.** Pardon?

**Q.** Is it a misleading statement?

**A.** It is misleading, yes.

**Q.** Then if we look further down, about two-thirds of the way down:

"The original plan was supervision but due to staffing levels, this wouldn't be possible, so the decision was made to redeploy Letby to another department, a non-clinical area, while the review was undertaken. AK and SW did this to protect LL."

Now, in fact, moving Letby was not solely for the reason of protecting her, was it?

**A.** In circumstances where we need to take a member of staff out of clinical practice, because of an incident or a situation, it's not good to keep that individual in that environment should anything else happen.

**Q.** Ms Kelly, just please focus upon my question. Letby was not moved solely to protect her, was she? There was more to it than that?

**A.** Yes, because as time went on we realised that there was -- we needed to investigate more about what was going on so we needed to remove her from clinical practice and the Consultants were concerned about that.

**Q.** So why aren't you telling Dr Green that Letby was moved both for her own protection and also the protection of patients?

**A.** That was a given. That was a given. And that's --

**Q.** But you say it's a given. It all starts to look like the Consultants' concerns don't have any real basis to them. You have only moved her to protect her from them, you have only -- the Royal College hasn't found anything. There's no rationale for their position. I mean, these are cumulative points in your interview that I would just like to give you the opportunity to comment upon whether or not that is in fact the impression that you are setting out to create here?

**A.** That wasn't the impression at the time. Again, lots of things going on. We were listening to the Consultants. In fact, they were pleased I think



that we had taken Letby out of the clinical area.

**Q.** Well, they were pleased because they thought patients would be safer?

**A.** Yes.

**Q.** But you are not articulating that here?

**A.** I suppose I would say that that's a given for me taking her out because of patient safety but I haven't articulated it there in my interview.

**Q.** Now, at the bottom we can see that there were no immediate actions by the external review. In fact, one of them was to start a disciplinary process, wasn't it; that was one of their actions?

**A.** Yes.

**Q.** You don't tell Dr Green that, do you?

**A.** No, not there. Although I'm not sure whether Dr Green had sight of the Royal College report, I am unsure of that.

**Q.** You are here talking about it, you are on the one hand saying that there were no immediate actions but in fact there was an immediate action and that was to start a disciplinary process.

So that just isn't a true statement, is it?

**A.** I think going back to what I said before when I said "no immediate actions" I kept referring to when they were on site there were no immediate actions as



opposed to the list of actions that were contained in the back of the report and I recognise that's misleading.

**Q.** Well, it's --

**A.** But the HR -- the HR element we did seek advice because that was a conversation with myself and Sue Hodkinson, the director of HR at the time, and we were given advice externally.

**Q.** What you should have said to Dr Green was there was a recommendation that we commence disciplinary proceedings but we have decided not to do that.

That is the true position as opposed to "no immediate actions"?

**A.** That isn't a true reflection of what you have just articulated so it could have been more detailed, yes, I -- I accept that.

**Q.** Right at the bottom, you say the Terms of Reference For external review panel were not about an individual but they were informed of the concerns raised about an individual by Ian Harvey.

That's a partial picture, isn't it, because while it is true that they were informed about it, they in fact said that they couldn't deal with it?

**A.** I'm not sure of the detailed conversation between the lead for the Royal College and Mr Harvey.



**Q.** Well, they told you that on 2 September, that they could not investigate your concerns?

**A.** We felt we needed -- we felt we were being transparent with them and said there was an issue that had been raised by the Consultants about an individual, just to give them some context of them starting their review in our organisation.

**Q.** So again one impression for your comment is that Dr Brearey is off on a frolic of his own. You brought in the RCPCH. They know all about Letby. They haven't found anything. We only had to move her because it was for her own protection from allegations. I mean, that's -- and the Consultants don't have a rationale for their position. That is what we have looked at, each one of these points.

Just looking at what you were actually saying there and the choices that you were making about what you did and didn't say, were you trying to undermine the Consultants when you were speaking to Dr Green?

**A.** No.

**Q.** Can you offer --

**A.** But what I do recognise is that I could have clearly -- more clearly articulated the position.

**Q.** Well, you could have said things that weren't misleading, do you mean?

**A.** They were not intentionally misleading.
**Q.** You could have avoided saying false things, is that what you mean by "providing more detail"?
**A.** I think what I said and what I didn't say, you know, I have reflected on that and I probably could have said more, but again none of that was done intentionally.
**Q.** Page 24. Let's just have a look at how you characterise the Consultants, where that asterisk is.
Yes:
"We will need lots of support. From AK professional perspective sees no issues. There is an issue around Consultants fuelling the situation."
Now, do you think that the word "fuelling" is and I don't intend a pun here, inflammatory?
**A.** It's probably not a good choice of words. But at the time which is why a grievance was raised in the first place, some of the Consultants were exhibiting poor behaviours. And I don't think that helped the situation. Also recognise having a grievance process in the middle of all the other reviews that we were undertaking with their support probably didn't help the relationships with the Consultants.
**Q.** We can see, finally, that it was confirmed with you that there is no investigation into Letby



herself, which again was factually correct but omitted the fact that such an investigation had been recommended; do you agree?
**A.** It -- it was recommended and we didn't ignore it and as I mentioned before, we sought legal advice --
**Q.** Dr Green --
**A.** -- to guide us what we could or couldn't do at that time.
**Q.** Dr Green wouldn't know any of that, would he?
**A.** No.
**Q.** On its face, it simply looks as if you don't think there's an allegation into Letby worth investigating?
**A.** You could read it like that, yes.
**Q.** Is that the way you intended it to be understood?
**A.** No.
**Q.** Of course, what we can see from the earlier entries is:
"The case will be closed when we get LL back on the unit".
What you were telling Dr Green across this interview was that you expected that Letby would return to the unit?
**A.** After this process, and doing an assessment



after all of the information that was gathered around all of the reviews we needed to make an assessment of whether she was going back on the unit.
**Q.** Well, do you think it was a bit premature to be saying that when you still hadn't had the outcome of all of your --
**A.** It probably was a little bit premature. We needed to get the full picture but it was complex, it was complicated, and there was an individual in the middle of this as well as a group of Consultants who were upset by this process.
**Q.** You see how telling Dr Green that Letby would be going back on the ward again is communicating that you don't think there is anything in the concerns that are being investigated?
**A.** I think that was on the back of all the other elements that had come out of the reviews and was leading down a clinical route as opposed --
**Q.** Can you just focus on my question, please.
Do you agree that that is what the impression you are giving is; that you don't think there's anything in the concerns because you are simply saying regardless of the fact there is ongoing investigation, she is going back on the ward?
**A.** It was probably premature for me to say that.



But the view that I had at that time was that it was more of a clinical issue than an individual with her.
**Q.** Now, saying it to --
**A.** Individual issue.
**Q.** Saying it to Dr Green is one thing. Telling the person concerned that they are going back on the unit would be quite another, wouldn't it?
**A.** Yes.
**Q.** INQ0014313. Now, this is whilst the grievance procedure is ongoing and this is a summary of a discussion you have had with Letby.
The letter is dated 15 November 2016 and we can go straight to the top of page 2. We can see here:
"Alison explained that further to our previous discussions it was important that we made you aware of a change that had been agreed in regards to the decision-making process for your reinstatement back in to your role in the neonatal unit.
"As we had previously discussed, the decision had been previously agreed to sitting at board level. However, it has been agreed that it should be delegated to Alison as your Professional Nursing Lead. Alison explained she had no concerns in returning you back to the neonatal unit and that we were going to plan for this with Karen over the coming weeks."

We can also see that at the time it was acknowledged that the grievance process still provided an opportunity to share concerns.

Now, the grievance process was about how you and the other Executives had treated Letby; is that right?

**A.** I think there's two parts that's how -- how she was aggrieved as to how she was removed from the unit, but also linked with that she also was very unhappy with the behaviours of the Consultants.

**Q.** So the grievance process was about how the Executives had removed her from the unit?

**A.** It's in the way that she was removed, yes.

**Q.** Here is you, a witness in the grievance, whilst the grievance is going on, having a meeting with her telling her that she is going to go back on the unit; do you see that that?

**A.** I recognise that as a conflict yes.

**Q.** Yes, and inappropriate?

**A.** Yes. I have reflected a lot on the involvement of myself and the direct conversations I had with Letby and again if -- if I knew then what I know now, that would not be my normal practice.

**Q.** You are also --

**A.** Sorry --

**Q.** Please --



**A.** I think what the problem was at that time was the way in which concerns were raised as in from -- from the clinical unit directly to Executives caused us a problem because it didn't go through the usual governance routes. So by the time it got to us or when it got to us we kind of as an Executive Team took on the actions ourselves and in hindsight I think that was probably inappropriate in some cases and this is probably one of those examples.

**Q.** So your concern appears to be that the Consultants, having raised their issue with among others the Executive Lead for Safeguarding, and one of the designated officers for Speak Out Safely, that that was the problem?

**A.** No, not the problem, but they should have gone through -- I'm not sure why they didn't go through the usual route which is through their divisional structure, up through the appropriate committees up to Executives.

Anyone can come straight to an Executive, that's absolutely fine. But I think what we recognise is because it came to us directly what we should have done is -- is push it back down the organisation and there's a tier of individuals that sit beneath the Executives that probably felt left out of the loop.

**Q.** The final point about this is self-evident.



You were telling Letby before all of the investigations had been concluded, Dr McPartland hadn't even been instructed by this stage that she was going back on the unit.

**A.** That was premature.

**Q.** Well, was that because you had closed your mind to what those reports might reveal and you were just operating on the basis you had a single objective which was to get her back on the unit?

**A.** It wasn't a single objective. It was probably premature me having that conversation with her at that time when I knew that all of the other pieces of information hadn't been concluded.

But again, going back to what I said before, we were keeping an open mind and tried to not have the doctors versus nurses scenario which ultimately did end up feeling like that.

**Q.** But telling Letby that she was going back on the unit before the investigation was complete is the very opposite of having an open mind, isn't it?

**A.** I think it was premature of me to have said that directly to Letby, yes.

**Q.** Is it the very opposite of having an open mind?

**A.** I think I disagree with that. I think there



was a lot going on and I suppose the conflict for me was I was the Professional Lead for Nursing as well which probably wasn't helpful in that conversation that we were having there.

But yes, I have reflected on that and it could have -- it could have been done differently in light of the other investigations that were going on.

**Q.** Now, you, as you have told us, were a witness in the grievance. You were sent a copy of the draft outcome letter, weren't you?

**A.** I think I recall that, yes.

**Q.** And you went through it and you made comments upon it, didn't you?

**A.** I'm not sure. I don't know if that's in my statement if I made comments on it or not.

**Q.** INQ --

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

**Q.** -- 0056172. So if we can see on this first page there are some strike-throughs, this is the version, as we understand it, that you sent back, having received a copy.

**A.** Okay.

**Q.** If we scroll to page 2, we will see section 7, where, as we understand it, you have written:

"I conclude I fully ..."

Sorry, the original text said:
"I conclude I fully support the conclusions that Chris Green came to and uphold this part of the grievance."
You added:
"Are we adding in Chris' conclusions?"
Do you have any recollection of having done so?
**A.** I don't understand the context of what that was. No.
**Q.** Well, as we understand it and you must have a proper opportunity to consider this, but now is not the time but let me tell you what we understand the position to be: it was sent to you by HR?
**A.** Okay.
**Q.** That you made comments upon it and sent it back before the final version was published?
**A.** Okay.
**Q.** Following those comments, a section was added here. Now, in fairness so I acknowledge the full picture, the evidence of Ms Appleton-Cairns was that Mr Green -- Dr Green's conclusions were always going to be added in there, but nevertheless it would appear that you, if we have understood it correctly, were making the suggestion that Dr Green's investigation report conclusions were added to this report.



Do you have any recollection of having done this at all?
**A.** No, I would not normally be very involved in grievances, that would sit with HR so I really don't recall that.
**Q.** If it turns out to be the case -- and we will send the references over to you --
**A.** Please, yes.
**Q.** If it turns out to be the case that you have commented upon the draft outcome, would you agree now that that would be inappropriate --
**A.** Yes, I would.
**Q.** -- given that you were one of the people about whom the grievance was made and you were a witness in it?
**A.** Yes, I would agree with that.
**Q.** Now, one of the conclusions of Dr Green that is added in, it is the first part of what is added in and I am sure you can recall this, is a comment upon the fact that the doctors had not acted honestly by reference to good medical practice. Do you remember that passage in the outcome letter?
**A.** No, just repeat that, please?
**Q.** Well, it may just be easier if I show you, INQ0003158, page 2. This is the final version and we



can see that section 7 has now been populated. The conclusion about the Trust's Speak Out Safely appears there and we can then see:
"However, I do not find the Consultants' concerns when reiterated to the Executive Team were clear, honest and objective. GMC guidance."
That is how the final version after, as we understand it, it has been sent to you, you have made comments upon it and it's come back.
**A.** Okay. I don't recall. What question are you asking, sorry?
**Q.** Well, the question is:
"Can you see how that passage there criticising the Consultants by reference to their regulator is greatly increasing the temperature of this process?"
**A.** I acknowledge it probably wasn't helpful to use that terminology.
**Q.** Was it your intention that that found its way into the final report?
**A.** No, I absolutely don't recall making amendments to that document.
**Q.** Well, as I say, we will send the references and we will be transparent about your response?
**A.** Yes.
**Q.** My final part, Dr Jayaram.



On 16 March 2017 there was a directors' meeting and I will bring up the notes, INQ0003344. So this is -- firstly, just familiarise with it, we can see your initials at the top. In fact, we have looked at this meeting previously but we are going to focus upon another part of it.
At this time, so that everybody is anchored, this was the time at which there was discussion about whether Dr Jayaram would engage in mediation with Letby --
**A.** Okay.
**Q.** -- where the Consultants had been required to write their letter of apology, that happened a few weeks earlier and we know that shortly before this the letter was written or the email was written by Mr Harvey that we have looked at already mentioning the GMC so that is all the context to this.
If we go to the bottom of page 2, we can see that there is discussion about something that Dr Jayaram had said to Sue Hodkinson the day before, and we can see a comment that she makes, we are going to come to the substance of it in a moment but "Ravi cannot see perceived gap between doctors and nurses". Do you see that entry, about two-thirds of the way down?
**A.** Thank you.
Yes, I have seen that.

**Q.** So that is part of what Ms Hodkinson -- the meeting comes back and forth from what Dr Jayaram has said the previous day but that is one of the things that Ms Hodkinson is reporting to the group, effectively that he perceives some sort of gap between the way doctors and nurses are being treated is one interpretation of that. So this is just a repetition by Ms Hodkinson about what's been told by Dr Jayaram and we can see that further down, Mr Chambers is recorded as suggesting that you, AK and Sue, to have conversation with Ravi.

So it appears that there's been some discussion in the meeting about some disquiet expressed by Dr Jayaram and a proposal being made by Mr Chambers is that you and Ms Hodkinson have a conversation with Dr Jayaram. So far, a fair interpretation of these notes?

**A.** Yes, except, I didn't -- I didn't -- I wasn't involved in conversations with Dr Jayaram.

**Q.** Well, that's the suggestion made --

**A.** The suggestion there, yes, but I think it might have been Sue Hodkinson and Tony Chambers, potentially.

**Q.** Well, we are just working our way through, that is the suggestion made.

If we go over the page to page 3, we can have a look a third of the way down. And we can see -- in



fact it is a quarter of the way down:

"Sue, three deaths. Lucy at cot. Real concerns. Lucy moved valves aka why not before serious allegations."

Then just to complete this:

"Sue to check with Ravi re these comments."

Then just we have Mr Chambers saying:

"Lucy cannot go back to the unit. They want us to throw Lucy under a bus."

And then your challenge "She should go back".

So that's that part of the discussion?

**A.** (Nods)

**Q.** So let's break it down. Is it right that Ms Hodkinson was reporting to the Executives that Dr Jayaram had raised three specific cases in relation to Letby's behaviour?

**A.** I believe so at the time, yes.

**Q.** We don't have a full transcript of what he said but it appears that he is referring to Letby being beside a cot at one point?

**A.** (Nods)

**Q.** And that Letby moved valves?

**A.** Yes.

**Q.** That is what's captured here?

**A.** Yes.



**Q.** He's here, among other things, talking about his experience of Child K, isn't he?

**A.** Yes.

**Q.** As you say, these are serious allegations.

Your first reaction when Mr Chambers suggests how you should respond is that Letby can go back to the unit, despite the fact that you have just had reported to you three specific cases, is that what these notes mean?

**A.** No, I think what I meant there by "the challenge" is I will be challenged if she goes back on the unit.

**Q.** Let's have a look --

**A.** We had significant pressure from the Royal College of Nursing at that time with all the grievance, et cetera, that were supporting Lucy.

**Q.** Well, Mr Chambers responds:

"Okay, she goes back and something happens."

So that would be exactly what you would expect him to say if you had said she should go back, do you see?

**A.** Yes, I can understand why you say that but I did not refer to it like that and I think at that time we were really shocked that Dr Jayaram hadn't brought any of these concerns to us before and then all of a sudden he was saying the detail around Baby K. So we



were quite shocked and horrified and that is when Sue Hodkinson and Tony Chambers went to see Dr Jayaram; it wasn't me.

**Q.** Well, there was an explanation, wasn't there, being offered within the meeting for why Dr Jayaram had not said it before; do you remember?

**A.** Sorry, I don't follow?

**Q.** Just look up towards the top:

"They feel like battered wives. Execs is abuser."

So that's what you were being told just before that piece of information was imparted. So you have had the shock of the fact that: why now? At that point, doesn't this require action?

**A.** It does and there was action taken after that. I think that terminology at the top is -- is not the best. Like I said before, there were numerous conversations with the clinicians in trying to support them and in reflection we probably could have done more to support them because they were feeling very upset on the back of the grievance, et cetera. So it wasn't the best situation at that time.

**Q.** It's essential to get a full account from Dr Jayaram, isn't it, if you are to understand exactly what he's saying?

**A.** Yes, and I believe that's where Sue and Tony

went to speak to him afterwards.
**Q.** And who is it you say went to speak to him?
**A.** Sue Hodkinson and Tony Chambers, I believe, it wasn't me.
**Q.** What did you understand to be what he was saying to them after that meeting?
**A.** I'm not sure of the detail. But we were quite shocked at what Sue had shared with us at that meeting.
**Q.** That's then.
Having got over your shock, realised this is a serious allegation, wasn't it absolutely imperative for you as the Executive Lead for Safeguarding to have a full understanding of what Dr Jayaram was saying?
**A.** I think we discussed that as a team and it was felt that Sue and Tony go and speak to him.
**Q.** So when they went to speak to him after that had happened, did you say to them: okay, what did Dr Jayaram tell you? I want to know as much detail as possible?
**A.** I am unsure as to the level of detail that they discussed with Sue and Tony.
**Q.** Given how significant this is, and you spent some time in your witness statement remarking upon the significance of it, don't you?
**A.** (Nods).



**Q.** How is it that sitting there now you don't actually know what happened to follow this up?
**A.** Again at the time I -- I don't think any of us were considering -- and I mentioned this earlier this morning, as a safeguarding concern what we were concerned about at that time as well is why Dr Jayaram was suddenly telling us about what he saw or he didn't see that was really significant that he didn't bring to our attention before.
**Q.** You have got an explanation for why he may have delayed but whatever the reason for his delay, don't you need to completely understand what it is that he is saying so that you can act upon it?
**A.** Yes, should have got the information but I can't recall what information came back after the meeting.
**Q.** Because what you tell us is in your witness statement is if you had been told that back in February 2016 that somebody was interfering -- a nurse was interfering with valves, is you would have immediately taken steps to have them suspended?
**A.** Yes, yes, action I would have taken. But she was off the unit at this point so that risk had been removed.
**Q.** Yes, but your reaction when you are told



appears to involve absolutely no further progressing of this concern?
**A.** I think we discussed -- as those notes suggest we discussed it as an Executive Team and it was agreed that Sue and Tony go and speak to Dr Jayaram.
**Q.** Was it also agreed that once they had spoken to him that was the end of the matter?
**A.** I don't think so, but I don't recall what the feedback mechanism was at the time.
**Q.** Well, you have had a chance to look through all the notes. It never comes up again at any future Exec meeting, does it?
**A.** I don't recall, no.
**Q.** Why would you not be at the next Exec meeting saying: so what happened with that very serious allegation that Dr Jayaram has made? Why don't we see that?
**A.** I don't know. I can't answer that.
**Q.** Is that because you just weren't taking it seriously?
**A.** We were absolutely taking things seriously.
**Q.** Where is the evidence that it was taken seriously?
**A.** I -- I am unsure at that time what we did with that information.



**Q.** You see, there were plenty of opportunities to tell people about this event, weren't there? Let me give you some examples so you don't answer in a vacuum. We know that Mr Harvey prepared a summary document on 3 April for, it would seem, Mr Medland, the barrister?
**A.** Okay, yes.
**Q.** Mr Cross prepared a document called "Rationale". We know both of those were sent to Mr Medland.
Neither of those documents contain any reference to Dr Jayaram's concerns which were articulated at this meeting only two weeks earlier.
Now, obviously they are the authors of that but it would appear that you never said "we really need to include this eye witness evidence that we have from Dr Jayaram about valves being adjusted"; why didn't you do that?
**A.** I -- I wasn't involved in any of the -- of pulling together that document for Mr Medland.
**Q.** When you spoke to the NMC on 18 May, a conversation we have already gone over, you could have said "we have eye witness evidence from one of our Consultants of valves being adjusted", but you didn't do that. Why not?
**A.** I don't know.

**Q.** When you refer the matter to the LADO, on 27 March, and you are summarising what you think the concerns are, you don't say: a Consultant has some eye witness evidence about valves being interfered with, do you?

**A.** No and I don't recall the feedback mechanism from that meeting about what further information he shared.

**Q.** So is it the position you just forgot about it?

**A.** I -- I can't recall. Honestly, I can't recall.

**Q.** Well, is there any other credible explanation for why -- and we will just headline them -- we have got the NMC, LADO, the NMC again when you make the referral on 18 July, your police statement of 15 February 2019, your Facere Melius interview on 23 July 2020, you don't mention this incident in any of those when characterising what the Consultants have said to you?

Can you offer any explanation for that?

**A.** I haven't got an explanation, I don't know, I don't recall what further follow-up action we took as an Executive Team at that time once that information had been shared.

**Q.** Is that because you all just ignored it?



**A.** No, we didn't ignore it, Sue and Tony went to see Dr Jayaram straight away and I'm not sure what the outcome of that meeting was.

**Q.** Are you even able to say that they spoke to him about it?

**A.** I believe they did but that would be for Sue and Tony to articulate.

**Q.** Well, you can tell us what you know. What makes you think that they did speak to Dr Jayaram about it?

**A.** I have made an assumption that they did and that was the action from that Executive meeting.

**Q.** Does it follow from that that you never asked them: what did Dr Jayaram say?

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

**Q.** Is there any record of you anywhere asking: what did Dr Jayaram say?

**A.** I -- I cannot find any record of that, no.

**MR DE LA POER:** Ms Kelly, thank you for answering my questions. Those are all that I have.

My Lady, I wonder if now would be an appropriate moment to turn over to Mr Baker, who I think is the first.

**LADY JUSTICE THIRLWALL:** Yes, Mr Baker.

Questions by MR BAKER



**MR BAKER:** Ms Kelly, I ask questions on behalf of the Families of 12 babies and children. I am going to ask you first of all about the Thematic Review, some questions about that.

**A.** Yes.

**Q.** But I want to go back to something that you said to Mr De La Poer when he was questioning you. You said in evidence, he asked you about postmortems and postmortems not suggesting sub optimal care if there was a cause of death and you said:

> **"Answer:** No, but if you put all of those elements together it doesn't show a particularly positive image of how that unit was being managed and there were a number of -- and the other element is that the words 'unexpected' and 'unexplained' were never discussed before June '16."

Do you remember giving that evidence?

**A.** I do, yes.

**Q.** Could we go, please, to INQ0003251 and to page 7 of that, please.

**A.** Maybe it's my referral to the Thematic Review that I meant, not June '16.

**Q.** Well, let's go to that and see what it says. This is, as you say, the Thematic Review. It's a final version of it from March 2016 and we can -- can you see



the heading "Sudden Deterioration"?

**A.** Yes.

**Q.** It says:

"Some of the babies suddenly and unexpectedly deteriorated and there was no clear cause for the deterioration/death identified at PM."

So how does that square with your evidence to the Inquiry that the words "unexpected" and "unexplained" were never used before 2016?

**A.** Yes, it was meant to be from the Thematic Review, apologies, not the June '16 timescale.

**Q.** Sorry, I didn't hear that clearly; could you just say that again?

**A.** I should have referred to the Thematic Review as opposed to just saying the June '16 timescale.

**Q.** Well, you should have said that of course "sudden", "unexpected", "unexplained" were words that were being used throughout the early part of 2016 and to suggest they weren't used before June 2016 which was a -- I would say an attempt to denigrate the accounts that were being given to you by the Consultants, was misleading, wasn't it?

**A.** I made a mistake, it would have been the Thematic Review that I would have been referring to.

**Q.** Well, I'm sorry, it can't be, because

that's March 2016 and you have said in clear terms that those words were never used before June 2016?

**A.** Yes, it was my mistake.

**Q.** Well, was it carelessness as to whether you were giving accurate evidence or was it a deliberate attempt to mislead?

**A.** No, it wasn't deliberate attempt. It was careless of my timescales.

**Q.** Okay when did you become aware that the Thematic Review process was under way?

**A.** I think there was a meeting -- a Serious Incident meeting in January, where it was a suggestion that the clinical team were going to do a review and that's when the first draft appeared in February but needed further work as time went on.

**Q.** So what you say in your witness statement, paragraph 232 is:

"I was already aware of the Thematic Review because of the emails on 15 February 2016 with Ian Harvey and the brief mention of it at a Serious Incident Panel meeting in January 2016."

**A.** Yes. Sorry, what paragraph are you at in my statement?

**Q.** 232. It accords with what you have just said in evidence a moment ago.



**A.** Yes.

**Q.** Is that right, that is the first you had heard that a Thematic Review was under way was when it was mentioned briefly in a Serious Incident Panel meeting in January 2016?

**A.** From what I can recall, yes.

**Q.** Eirian Powell was part of the Thematic Review process. Given the usual chain of command, wouldn't you have expected her to notify you that she was taking part in a Thematic Review of neonatal deaths in the latter part of 2015?

**A.** Not necessarily as a chief nurse. So she may have mentioned that to her line manager so not necessarily.

**Q.** Did you have conversations directly with Eirian Powell or was everything done through --

**A.** A lot of it was done through the nursing hierarchy which is the team below me.

**Q.** Yes. But did you have conversations with Eirian Powell?

**A.** During this process yes, I did yes, I did sometimes.

**Q.** Were those conversations always documented?

**A.** No. Unless they were in action planning meetings which we have already covered today.



**Q.** Yes. If we could look please at INQ0003220, please. So this is an email from you to Julie Fogarty dated 2 December 2015, a quarter to 5 and you say:

"Sorry if I haven't been clear. I mean the Thematic Review of neonatal deaths recently undertaken. In the spirit of transparency [I think that should be 'I would like'] the report to go to the next QSPEC."

The originating email at the bottom asks:

"Hi, where are things up to re the Thematic Review? I am keen to get a paper to December QSPEC."

Julie Fogarty has responded saying:

"The updated midwifery element was received in November at QSPEC. It was the paediatric update that was missing."

Now, the Thematic Review was the nomenclature used by Dr Brearey and Eirian Powell in their study which was being undertaken during the latter part of 2015?

**A.** I think this was, as you can see at the top, my handwritten note is it was quite confusing that this was called a Thematic Review, this was actually the obstetric review that was completed by Sara Brigham at the end of 2015.

**Q.** Yes. We can see the handwritten bit at the top. When was that added?

**A.** A similar time because at the time that was an



obstetric review and as far as I was aware, there was no neonatal review undertaken until we had had the conversation in January is my understanding.

**Q.** Sorry when you say at the same time, you are not seriously suggesting this email was printed out that you annotated it and put it in a file somewhere in December 2015?

**A.** No, no.

**Q.** When did you write:

"NB. Despite terminology below this was an obstetric maternity review"?

**A.** I can't recall when I wrote that but that would have been on the back of the conversation with Julie Fogarty to discuss the -- the terminology around what that review was actually going to be.

**Q.** So to clarify though, did you write that after issues relating to Lucy Letby became known?

**A.** I can't answer that question. I have got no recollection of the timing of it.

**Q.** You gave evidence about how busy you are with emails and how many you have to deal with. Would you really have had time to go back through all of your emails apropos of nothing at some time prior to Lucy Letby's crimes becoming apparent, print it out and annotate it?

**A.** No.
**Q.** No. So is it likely then that this occurred -- this annotation was put in after the point where Lucy Letby's crimes became known?
**A.** I can't comment on that. I have no recollection of the timing of that.
**Q.** Well, isn't it rather a self-serving annotation to move away from the obvious that's in the body of the original email, namely that in December 2015 you were aware of a Thematic Review of the neonatal unit and in particular deaths occurring there?
**A.** No. That was confusing terminology about the obstetric review that --
**Q.** Well, as the annotation accepts:
"... despite terminology below, this was an obstetric maternity review."
**A.** Yes.
**Q.** Well, the obstetric maternity reviews was the Brigham review and you can take it from me nowhere within the Brigham review does it refer to itself as a Thematic Review of neonatal deaths?
**A.** I think it is just semantics of the terminology. My understanding at that time was that there was confusion around what kind of review was going on and it appeared that it ended up being an obstetric



review, not a neonatal review.
**Q.** Okay.
Well, in that case can we move on, please, to INQ0003089, it's an email I think you will have seen before. Okay, so these are the emails where Eirian Powell attaches or notifies you about the findings of the Thematic Review. So if we go, please, to the bottom at page 2.
Now, would you agree:
"Hi Alison, I was hoping we could arrange a meeting with you to discuss how to move forwards with regards to our findings."
That suggests that Eirian Powell knew that you were already aware of the Thematic Review, it's not language which suggests she has to introduce the concept to you?
**A.** It -- you could assume that but I wasn't aware of the work that Eirian Powell was doing, there was a lot -- it's now come to light that she was doing a lot of reviews herself on the unit which wouldn't involve me or me even having knowledge of that.
**Q.** Okay. So one interpretation of the language she is using, though, is that it assumes some level of knowledge on your part, ie she doesn't begin it with:
"Dear Alison, you may not have known but Dr Brearey and I and others carried out a Thematic Review last year



and I would like to notify you about the findings."
Would it not follow if that were the interpretation that it's likely that you and Eirian Powell had had some discussion prior to 17 March regarding the Thematic Review?
**A.** I think that's highly unlikely. I would not be directly involved with some work being undertaken on a clinical unit. That would not be my role. But she would have had conversations with her line managers and wider clinical team.
**Q.** Yes, but if there was -- if there was a concern about a high mortality rate and a commonality between a particular nurse and that mortality rate, isn't that exactly the sort of thing you would expect to be elevated up through to you? Wouldn't you expect to know about it?
**A.** If what, sorry?
**Q.** Wouldn't you expect to know about it?
**A.** Yes, but I would also expect it to go through the usual channels instead of it coming directly to me. But as I mentioned before, if somebody had such a concern that I would hope that they wouldn't rely on emails for me to see it in my inbox, I would expect them to come and see me personally.
**Q.** There you go. You would expect them to come



to see you personally?
**A.** Yes.
**Q.** Yes, and isn't it likely therefore if that was your expectation that is exactly what Eirian Powell had done?
**A.** No, I don't recall her coming to my office.
**Q.** Well, presumably there's lots of things you don't recall. You don't recall receiving this email, do you?
**A.** I do remember seeing this email.
**Q.** Isn't it plausible that Eirian Powell did come and see you in your office some time prior to 17 March and discussed the Thematic Review with you?
**A.** I think it's highly unlikely. I'm not sure what was in her evidence but there was obviously the email trail about wanting to share the information that she had been doing at a unit level and requesting a meeting as we discussed earlier.
**Q.** Okay. Let's assume then if you did receive this email from a standing start and had no prior knowledge of it, the Thematic Review, looking at Eirian Powell's email to you, can you see within that anything that might cause you alarm or concern?
**A.** I think as we talked earlier you could work your way through each of those points, points 1 to 3,

but then that is qualified by despite reviewing these cases, there's nothing obvious that we are able to identify.

So for me, there wasn't significant concerns being raised and they were the experts, Eirian and Stephen Brearey were doing that themselves.

**Q.** Is that what they are saying? I mean, despite reviewing these cases there was nothing obvious that we were able to identify, therefore your input would be valued.

In the context of high mortality, a commonality was that a particular nurse was on duty either leading up to or during, "this particular nurse commenced working on in the unit in January 2012 without incident". What do you think they are getting at with a commonality with a particular nurse?

**A.** They had obviously done some workaround staffing but again that wasn't giving me a full picture so I think what I was focusing on was the qualified statement at the bottom which was: Eirian was raising this and as far as they were concerned there was no obvious issues going on and that's why they needed our further review, further input.

So there was nothing for me that significantly raised concerns at that time.



**Q.** So that was -- I mean, you didn't pick the phone up to Eirian and say: hang on a moment what's all this about, high mortality commonality of a member of staff; no?

**A.** No, I wouldn't go directly to a ward manager.

**Q.** Okay.

**A.** Usually it would go through my nursing team.

**Q.** So instead you take four days to get back saying:

"Can you send Ian and I the report in the first instance."

Had you discussed this with Ian Harvey in the interim?

**A.** I don't recall. I think we had our catch-up in April around the review that was more finalised at that point.

**Q.** This is still March. I mean, if you discussed it with Ian, how did you know that Ian didn't already have a copy?

**A.** I think he had a draft copy which he sent to me in February.

**Q.** Yes, but how did you know that, for example, Stephen Brearey hadn't sent Ian Harvey a copy?

**A.** Sorry, can you repeat that?

**Q.** Yes. So you are asking Eirian Powell to send



you and Ian a copy of the report. Unless you had spoken to Ian Harvey, how would you know that he hadn't already got one from Stephen Brearey?

**A.** I didn't. I would just assume that if she was sending it to me it would be helpful to send it to him as well.

**Q.** So if we go up the page you can see that Eirian Powell sends you the report, just go on to the next page, sorry, page 1. 11.02, so she sends you a copy of the report, 11.02 on 21 March, an hour or so after you emailed her.

That is a report that we saw earlier that talked about sudden, unexpected and unexplained deaths?

**A.** Yes.

**Q.** Yes. You had so little curiosity in Eirian Powell's emails and attachments that you can't recall reading them, the attachments?

**A.** I am -- I'm not sure, no.

**Q.** Is that an honest answer, that you didn't open the attachment?

**A.** Yes, it's quite possibly that I read the email and at that time, the same time, didn't open the attachment.

**Q.** So an email that commences: high mortality, commonality of a particular nurse and you are sent



a report in response to your request for that report, and you don't even open the attachment?

**A.** I can't recall when I did.

**Q.** Isn't Eirian Powell's email ringing obvious alarm bells to you about what this might all be about?

**A.** I think what I focused on at the time was the qualifying statement underneath which was almost reassuring, so it wasn't saying: we need a meeting tomorrow, this is very, very urgent. It was almost done in a passive way, as in: we have done this piece of work, we are just going to ask -- it would be good if we could have a conversation with you and Ian about any further actions that we might need to take.

So for me reading it, and it's great in the cold light of day to look at it now, but at the time it didn't raise significant concerns with me.

**Q.** Right. So you would blame Eirian Powell for not being explicit enough in her emails to you?

**A.** I am just talking about the way that sometimes messages get lost in emails and it's not a great form of communication.

**Q.** Can we go to INQ0107095, please. Now Eirian Powell had sent you a further email on 14 April, which enclosed an updated copy of the report, of the Thematic Review, okay? But if we can go please first of

all to INQ0107095 and page 148 of that, please.
It can take a little time to catch up, I think. There we go.
So at the top of that page it is 11 April, so this is before Eirian Powell sends you the updated Thematic Review, but after she had sent you the 2 March version okay.
So NNU -- it is your discussion. It is your one-to-one with Ian Harvey:
"NNU Thematic Review paeds/NNU poor ..."
And then "maternity" or "with maternity".
So if you are having a conversation with somebody, Ian Harvey, on 11 April 2016, referring to the Thematic Review, isn't it axiomatic that you have read it before that?
**A.** Potentially, or we just had that as an agenda item to talk about generally in terms of needing to meet. I think there is a further one-to-one I had with Ian after that.
**Q.** Well, we are going on to the next page, if we can, then. So we have got zoomed in here but this will do.
"Follow-up feedback from external Consultant ..."
What's the squiggle before "Steve Brearey"?
**A.** "Re".



**A.** We would have just been talking generally about where's it up to? What we are doing with it? What meeting does it need to go to? As we put there it goes to the quality meeting for noting, Steve Brearey to attend. So more about logistics than the actual content at the time is my recollection.
**Q.** Yes, but your evidence -- let's be clear about this -- is on 2 March Eirian Powell emails you and says: I want to talk about the Thematic Review, high mortality/commonality. You ask for a copy of that, you are sent it on 21 March, your evidence is, as I understand it before the Inquiry, you probably didn't read it.
Now, here we have a meeting on one-to-one with Ian Harvey, Medical Director, on 11 April 2016. Are you honestly saying you hadn't read the Thematic Review by this point?
**A.** I probably did. I can't remember the timing of that.
**Q.** Yes, so by this point, you would have been aware, not only of the commonality and the increased mortality, but also that deaths were sudden, unexpected, and unexplained, wouldn't you, if you had read it?
**A.** Yes, but the first line at the top of the report says "no common -- common themes".



**Q.** "... re Steve Brearey/Ian Harvey. NNU mortality QSPEC for noting. SB [Steve Brearey] to attend."
What is the "external Consultant Re Steve Brearey"?
**A.** I don't recall unless that was some communication from the network in terms of Nim.
**Q.** Well, what feedback would you be expecting from an external Consultant regarding Steve Brearey in the context of the NNU mortality?
**A.** I have no idea what that refers to. Possibly a network --
**Q.** But again --
**A.** -- reference.
**Q.** You are here again discussing or noting discussions regarding NNU mortality on 11 April so it's before you have received the updated version on 21 April. Again, isn't it -- or 14 April, sorry.
Isn't it inevitable that you have read the Thematic Review by that point?
**A.** Potentially, but not necessarily.
**Q.** Would you have attended a meeting and discussed a Thematic Review that you hadn't read?
**A.** Are we talking about the May meeting now or this?
**Q.** No, no, we are talking about the April?



**Q.** If we go on then to the next one to one with Ian Harvey, now this is the INQ0003385, and we are now on 18 April 2016. We by this point you have had a copy from Eirian Powell on 14 April of the updated Thematic Review which has Lucy Letby's name highlighted in red within it?
**A.** (Nods)
**Q.** Now, if you look at -- it's just under -- is it week commencing 20 April, can you see that there? CQC discussion.
**A.** Sorry, whereabouts on the page?
**Q.** It is the second entry down?
**A.** Right, yes.
**Q.** "CQC discussion re interview leads for ..."
**A.** Dashboard.
**Q.** "... dashboard re QSPEC."
**A.** "EOL" is end of life.
**Q.** Thank you.
Then it says:
"NNU Mortality Review, document including staff."
Now, doesn't "document including staff" indicate that you are now aware that there is a document, a Thematic Review which includes reference to individual staff members?
**A.** Potentially, yes.

**Q.** Can you think of any other explanation as to why you would have written "document including staff" under Mortality Review in April 2016 unless you were referring to the document sent to you by Eirian Powell on 14 April 2016?

**A.** Yes, that will have been just a conversation with Ian and I will about the fuller report including the staff.

**Q.** Yes, so again by 18 April, because this is your planning ahead, isn't it, for the week commencing the 20th but the note is written on 18 April, you were aware that there was a Mortality Review, a Thematic Review which highlighted Lucy Letby's name in red?

**A.** We probably talked about that in that meeting, yes. I can't recall at what point we discussed that report because there were a number of iterations but the final one, you are correct, had Lucy Letby's name in red.

**Q.** Yes, so that was actually the version that was sent to you on 14 April by Eirian Powell. So it's the name highlighted in red.

So it would follow, wouldn't it, a few days later here you are discussing "document including staff" must be referencing that document?

**A.** Possibly, yes, in the catch-up.



**Q.** Possibly or probably?

**A.** I can't -- I can't recall the detail of the conversation. But we have obviously had it on our agenda to talk about.

**Q.** It goes on to say:

"[Query] review by Hill Dicks."

Now Hill Dicks are a firm of solicitors, they are not the ones who do the employment cases; we heard that is DAC Beachcroft?

**A.** Yes.

**Q.** Hill Dickinson are the firm who represent the Trust in relation to negligence matters?

**A.** Yes, they did and I have reflected on that comment and I don't know why that is written underneath the NNU Mortality Review because that's not something we would ordinarily do and I didn't even have any contact with Hill Dickinson. That came through the legal team.

So I am -- I'm not sure of the context of why I wrote that there.

**Q.** Yes. Isn't it obvious, we can piece it together: there is a conversation going on with Ian Harvey in April 2016, referencing the Mortality Review, noting that there is now a document that includes staff members on it and asking the question: do we need to have this reviewed by our solicitors?



Now, that seems to be a fairly logical construction of what's written there?

**A.** It does feel that that would be logical but I have absolutely no recollection as to what -- what that was on there for. It -- I don't think it was linked at all to the NNU.

**Q.** Well, it's written directly. It's written as part of the NNU Mortality Review section, isn't it?

**A.** It would be highly unusual for me to instruct Hill Dickinson to do any legal work. It wasn't part of my portfolio so I can't really explain why that is written there or what indeed the action was.

**Q.** But suspicions about a member of staff being associated with a rise in mortality is quite an unusual situation, isn't it?

**A.** It is, but like I said, I have no idea why the Hill Dickinson reference is there.

**Q.** Now, in fact if we go on then please to your emails of INQ --

**LADY JUSTICE THIRLWALL:** Mr Baker, just before you do that, I wonder if we might just check the date of that highlighted entry?

**MR BAKER:** Of course.

**LADY JUSTICE THIRLWALL:** I think I heard you say 20 April I wonder if it was the 25th?



**MR BAKER:** I think it could be 25 April. It says "week commencing 25th", I think.

**LADY JUSTICE THIRLWALL:** It's your writing, Ms Kelly.

**A.** It would be WC, week commencing, the 25th.

**LADY JUSTICE THIRLWALL:** Yes, thank you.

**MR BAKER:** The 25th. If you are writing "week commencing 25 April", is that a note you are making on 18 April or on 25 April?

**A.** I'm not sure it looks like a separate entry.

**Q.** I think in your witness statement you describe it as part of a note you made during your one-to-one with Ian Harvey on 18 April?

**A.** It does look like that because we would go through a list of topics we needed to discuss and I would write some notes on each of those.

**Q.** But in any event it's before you speak to the Consultants formally? Before you speak --

**A.** Yes, yes.

**Q.** And if we could go on then please to INQ0003138, again you have seen this before, if you look at the email at the bottom 4 May 2016:

"Ah, can you please look at this with Anne and Eirian. If there is a staff trend here and we have already changed her shift patterns because of this and

this is potentially very serious."
What do you mean by "potentially very serious"?
**A.** That we could have a competency problem --
**Q.** Yes.
**A.** -- is what my first reaction was to that.
**Q.** Yes. The next one you can see here Lucy Letby highlighted in red.
"I had not noticed this when I first reviewed. Can you look at this per my previous email?"
If we go on to emails that you were sending to Ian Harvey at around the same time, so that is INQ0003087, you can see you are sending on an email here from Stephen Brearey, who's upset that you haven't been able to have a meeting so far:
"There is a nurse on the unit who has been present for quite a few of the deaths and other arrests and she he has sensibly been put on day shifts, only at the moment."
So again that is the same comments that you were making in your previous emails about the shift to day shifts.
You say:
"Hi Ian, please see Steve's comments below which alarmed me."
Now, why did you find them alarming? Was that



because of the same reason?
**A.** Yes, I thought we had a competency issues and that was being called out.
**Q.** Is it right to say then certainly by 4 May 2016, if not before, there's an obvious safeguarding issue, isn't there?
**A.** Yes, and we talked about safeguarding earlier on.
**Q.** Yes.
**A.** But it was more around -- again I'll repeat what I said earlier, at the time we were looking at concerns through a mortality lens, not a safeguarding one and it wasn't clear. But this particular -- about the particular nurse in terms of Letby, the first place I went to was competency.
**Q.** Well, it may be the first place you go to, but competency, a nurse causing a rise in mortality, it still is a safeguarding issue, isn't it?
**A.** Sorry, say that again?
**Q.** A nurse causing a rise in mortality due to incompetence is a safeguarding issue, isn't it?
**A.** Potentially, yes, but at the time we needed to find more information out.
**Q.** Can I be explicit about this: between March, April, May we have got I would suggest a number of red



flags here that require action and seemingly on the face of it, you and/or Ian Harvey aren't taking any action, and I represent the Families of two of the Triplets O and P who died in June and they would suggest that delays at this time allowed Lucy Letby to go on and murder their children.
Now, on reflection, do you think that things could have been done more expeditiously through March, April and May to bring forward a meeting to seriously discuss these issues?
**A.** I think I mentioned before and, you know, reflected on this that there were delays and I don't know why there were delays, I haven't got access to my diary, in meeting with the team to discuss this in more detail.
I think that the sense as I mentioned before of there was lack -- for me there was a sense of lack of urgency to meet and so it did kind of tick along longer than it should have -- should have done.
**Q.** Well, there seems to be reasonable expedition on the part of Eirian Powell when it comes to answering your request to send you things.
**A.** Yes.
**Q.** It was open to you to pick the phone up or indeed to email people faster and say "let's set



a meeting up". Are you seriously blaming the people who were bringing this to your door --
**A.** No, but what I am saying is when you are in charge of a whole hospital there are challenges with the timeliness that you get to actions and I recognise that some of these actions should have been taken more timely. And it's, you know, people could have come and spoke to me or picked up the phone. My PA would invariably take urgent messages from teams to come and speak to me. So again going back to what I said before, communication via email is not that good in terms of raising significant concerns.
**Q.** Were you too busy to do your job?
**A.** Sorry?
**Q.** Were you too busy to do your job properly; is that your evidence?
**A.** I was -- I am not saying I was too busy not to do my job, I was a very busy person. My portfolio was very large, so getting to emails in a timely way was difficult. You will see some of the emails are either very first thing in the morning -- excuse me.
**Q.** Was it the case that -- I mean, if you can't see your emails and people are emailing you about potential safeguarding issues and you can't manage your emails because you can't get to them or there's too many

of them, that's an obvious safety issue. Why didn't you raise it with the hospital?

**A.** I think I sit here as a chief nurse and I would say that everybody else in my position would be in exactly the same position in terms of workload. The other thing to mention, though, is everybody in the organisation was responsible for safeguarding, there was specific safeguarding doctors, specific safeguarding nurses, nobody raised any concerns with any of those individuals and -- and the clinicians on the unit didn't raise a safeguarding concern.

**Q.** But --

**A.** So there could have been some action taken before it had got to me.

**Q.** If everybody says it is somebody else's responsibility then nobody does it; that is the risk, isn't it?

**A.** I recognise that, but the safeguarding policy actually says safeguarding is everybody's responsibility, which is good when that works in practice but I recognise what you are say in terms of everybody thinks everybody else is doing something.

**Q.** The Speak Up Safely policy says that you are to raise your safeguarding issues as quickly as possible because delay can cause for continuation of harm,



doesn't it?

**A.** Yes.

**Q.** If you raise those concerns and nobody can act on them, or does anything about it --

**A.** Sorry?

**Q.** If you raise your concerns, if you elevate your whistleblowing concerns and nobody acts upon it, because they are too busy or don't read their emails or for whatever reason, that is a serious safety issue, isn't it?

**A.** You could look at it like that, yes. But the reality is that does happen in practice and I rely on the rest of my team to flag concerns to me directly if I cannot get to everything that happens to be in my inbox.

**Q.** I am going to move on just to events following the deaths of Child O and Child P. You have been asked questions about the meeting on 29 June. I would like to ask you questions about the 6 July 2016. But first of all can we go to INQ0014261 and to page 3 of that document, please.

So this is an exchange between you and Tony Newman, the regulation adviser for the NMC. You can see that here is an email, 6 July 2016, it has been amended by you to correct his note. Does that make sense to you?



**A.** That's right.

**Q.** So he's provided you with a summary of the discussion and you have changed it so it fits with your recollection of the meeting or the discussion?

**A.** Yes.

**Q.** It's the final item amongst the list of question marks. It says:

"The Executive Team are due to meet today 6 July to decide if this registrant will be reported to the police to investigate."

So you have obviously had a conversation with Tony Newman at the NMC where you have advised him that the Executive Team -- he has written "Trust board" but you have changed that, the Executive Team were due to meet on 6 July 2016 to decide if there would be a report to the police regarding Lucy Letby; do you see that?

**A.** Yes.

**Q.** Now, was that actually discussed on 6 July 2016, because I can't see?

**A.** I'm not sure. I think we were talking generally around because all the concerns that had been raised at the end of June '16, we then had a rapid series of actions that we took as an Executive Team. We were talking more broadly around will this require police investigation, but as I mentioned earlier we



decided that we needed to find more information out internally before we went to the police.

**Q.** Yes, but I mean don't --

**A.** So I'm not sure of that reference there.

**Q.** Yes, but you have obviously checked it because you have changed "Trust board" to "Executive Team"?

**A.** Yes.

**Q.** Now, it's fairly explicit, isn't it, it is not a vague record, it is a record of an Executive Team due to meet today, 6 July, to decide if this registrant will be reported to the police to investigate.

Do you agree that the obvious inference from that is that that is what you told Tony Newman during your conversation?

**A.** Yes, that was my understanding at the time.

**Q.** Yes.

**A.** But I think once we had got together as an Executive Team there was further discussions going forward around what we needed to do internally before the police.

**Q.** So other people of course will look at the 6 July meeting and what happened there. We can actually look at your account of it because you have it in your witness statement from paragraph 403 onwards. You give an account of the meeting here.

So page 120 of your witness statement. Do you agree that that account of the meeting does not record any discussions about calling the police? Take your time to read it. (Pause)

**A.** No, I think that's because when we got together as a team we felt we needed to do the internal work before going to the police.

**Q.** Yes, but you have to get there, don't you, there has to be a conversation about: are we going to call the police or not? That meeting on 6 July doesn't record any conversations at all about the question of whether we are going to call the police or not.

**A.** No, I don't, I have not written anything down I don't recall.

**Q.** Now, were you misleading Tony Newman when you reassured him that there was going to be an Executive Team discussion on 6 July to decide if the police should be called?

**A.** I don't think I was at that time because I think that's what genuinely we were going to talk about as an Executive Team, but then that went into lots of other actions.

So I think at the time I was being absolutely honest with Tony Newman.

**Q.** You weren't absolutely honest with him or were



you, sorry?

**A.** I was.

**Q.** You were?

**A.** Yes.

**Q.** So you believed that that was going to be discussed at the 6 July. You went into the meeting, you must have been astounded when nobody mentioned it. Did you not think to raise it?

**A.** If it's not documented I'm not sure what we discussed about the police. I think we kind of went into action mode around what we needed to do and I am not certain whether we actually talked about the police or not, if it's not documented.

**Q.** It's not documented. Okay so I am going to --

**A.** But I think the intention was when I spoke to Tony that that's what we were going to do.

**Q.** But somewhere between the cup and the mouth that just vanished?

**A.** Sorry?

**Q.** Somewhere between that conversation and the meeting starting, the any suggestion the police might be discussed was just forgotten about?

**A.** Well, not forgotten, maybe not documented. I'm not sure, I can't comment.

**Q.** Finally, you attended a meeting with Mother C



in July 2016 which was also attended by Sian Williams.

Now, by July 2016, you were aware that serious concerns had been raised regarding the conduct of Lucy Letby, you were aware that discussions regarding calling the police had been floated around because that's what you said to Tony Newman. You were aware that the RCPCH report was being commissioned or being undertaken to investigate some issues on the face of it perhaps surrounding Lucy Letby and you had a meeting with Mother C in July after she became aware through an article in the Chester Chronicle that there was an investigation under way.

Now, do you recall meeting with Mother C?

**A.** So I have reflected on this and I had no -- as far as I am aware -- I am not saying that the meeting didn't take place, as far as I am aware I didn't meet with any Family members. My deputy, Sian Williams, and Ian Harvey kind of coordinated the family communication. So I don't recollect having a conversation with Mother C.

**Q.** Okay, she came into the hospital I think apropos of nothing and having read the article or become aware of the article --

**A.** I believe so, yes.

**Q.** -- in the Chester Chronicle and waited



a little while and you and Sian Williams came down and met with her in a room to discuss the Royal College report?

**A.** Right. I really don't recollect that.

**Q.** Okay. Well, she recalls that conversation very clearly. It's plausible you have forgotten about it. You are not disagreeing that that took place?

**A.** I am not disagreeing it didn't happen. I don't recall having any conversations with any Family members of any babies at that time.

**Q.** What you said to her, and I am going to just read from her evidence before the Inquiry:

> **"Answer:** So this lady went and got Sian Williams and Alison Kelly who came down and spoke to me. It was a fairly short meeting to my recollection where I was told by them that there was an investigation being done by the Royal College that was more of a formality because there had been a very small increase in the number of deaths, but it was looking at various sort of logistical things like staffing levels and that sort of thing and that they weren't really expecting anything to come from it and that they tried to contact me because that was -- that was challenging."

Now, given what you knew at the time that was completely misleading, wasn't it, if you said that?

**A.** If I said that, if I was at that meeting I absolutely don't recall meeting any Families like I said. But I think one of the things that one of the key elements and it's in my reflections of -- of this case is that we didn't get the communication right with Families and we didn't get the balance right and I think that is an example of where we didn't get it right.

**Q.** Yes. Mother C was pregnant at the time, her previous child had died, as it turns out murdered by Lucy Letby, and it's not about communications.

I suggest, based upon what you knew, you lied to her?

**A.** I don't recall. Honestly, I don't recall that meeting. But what we did talk about as an Executive Team is the fact that we could have done much, much more to support Families. And it was clear that each Family potentially wanted to be communicated with in a different way, so to meet the needs and expectations of those Families we -- we should have done more to do, to meet those expectations and we didn't.

**Q.** I can't imagine any of the Families wanted to be lied to.

**A.** I'm not saying that they were lied to.

**MR BAKER:** Thank you, my Lady. I have no more questions.



**LADY JUSTICE THIRLWALL:** Thank you, Mr Baker.

We will take a 15-minute break before we continue.

How much has everyone else got, Mr Skelton?

**MR SKELTON:** 10 minutes.

**LADY JUSTICE THIRLWALL:** Thank you.

**MS BLACKWELL:** 20 minutes.

**MR KENNEDY:** About five.

**LADY JUSTICE THIRLWALL:** Thank you. So we will start again at 5 o'clock.

**(4.45 pm)**

**(A short break)**

(5.00 pm)

Questions by MR SKELTON

**LADY JUSTICE THIRLWALL:** Mr Skelton.

**MR SKELTON:** Ms Kelly, I ask questions on behalf of the [indistinct]

I am just going to deal with two discrete issues, if I may. One is about the meeting you attended on 2 July 2015 which was the Serious Incident meeting.

**A.** Yes.

**Q.** Do you recall that?

**A.** I do.

**Q.** So this was after the three children had died in June: Baby A, Baby C, Baby D. How usual was it for you to attend a Serious Incident meeting?



**A.** Very usual, I would normally chair it and if it's not me, it would be the Medical Director, Ian Harvey.

**Q.** How usual was it for there to be an incident meeting about three deaths?

**A.** We could have spikes across the hospital, infrequently but not usually.

**Q.** Had you attended a Neonatal Mortality Meeting of this kind before with three babies having died within two weeks?

**A.** I didn't attend any Mortality Meetings as a Director of Nursing. Are you talking about the --

**Q.** I am using, sorry, I used the wrong shorthand?

**A.** -- extraordinary meeting that we had afterwards?

**Q.** Yes. You had attended one before?

**A.** Sorry, say that again?

**Q.** My question was: had you attended a meeting before where there had been a group of three neonates who died within a two-week period?

**A.** No, not at that time.

**Q.** The purpose was, was it, to look for common factors between the children and their deaths?

**A.** Yes, potentially, but also to understand each of the cases individually.



**Q.** Dr Brearey in his evidence to the Inquiry, both in writing and orally, described the process of going through the children's deaths at the meeting and then at the end he said that Eirian Powell raised the observation that Lucy Letby had been on the unit on the three occasions when the three babies had collapsed and his reaction, which he described in detail to this hearing was "oh no, not nice Lucy". And you were at that meeting and he recalls you having heard that as well; do you remember that?

**A.** That wasn't said at that meeting, Eirian Powell wasn't at that meeting, so my notes reflect that and I have said in my witness statement that Lucy Letby's name was not mentioned at that meeting at all.

**Q.** In his evidence he says that your response to that information that Letby was the connecting factor because I think Eirian Powell had in fact identified her quite early on as being the connecting factor, was that was something you needed to keep an eye on. You said that: we'll keep an eye on it. Do you remember that?

**A.** No, I don't because Lucy Letby's name wasn't mentioned at that meeting and Eirian Powell wasn't at that meeting.

**Q.** Did she ever mention she had spotted the

connection between that member of staff quite early on?
**A.** No.
**Q.** So even after the issue came up a year or so later, did she ever say: well, in fact, I spotted this back in June 2015?
**A.** No, not to my knowledge.
**Q.** That's the case even after three more children died and Lucy Letby was connected to those three deaths as well?
**A.** Can you repeat that, sorry?
**Q.** And she never mentioned it even after three further children died, all of whom were connected to Lucy Letby as well? That is Baby E, Baby I, Baby K?
**A.** No, until she started to do the internal reviews that she was doing with Steve Brearey on the unit and then that escalated as we have already talked about today to doing the Thematic Review.
**Q.** You have been asked in detail about your evolving knowledge about the Thematic Review that occurred and I am not going to go through that in detail but there is just one email from Dr Brearey that I want today ask you about, it is INQ0107818, this is from 4 May. If you could go to -- there should be a second page there, please.
So just the email you can just see on 4 May at



16:10.
"There is a nurse on the unit who has been present for quite a few of the deaths and other arrests."
I wondered if you picked up that second phrase "and other arrests", that Steve Brearey was mentioning for the first time it seems not just the fact that children had died but that children had collapsed, arrested in fact, which is the most serious form of collapse, and Letby had also been present for those collapses or arrests. Did you pick that up?
**A.** Not at the time because to me that the context of that email was more about staffing concerns as opposed to what he was saying about that particular nurse. The arrest bit is a good point because none of those were actually reported on the Datix system so throughout my Rule 9 request for my statement, I was repeatedly asked: did you know about X baby that deteriorated? No, we never got to know about those until this Inquiry and further reviews that we did because they weren't actually reported at the time.
So in terms of that particular email I didn't pick up on other arrests because I didn't understand the context at the time. To me, that was more of a concern about: we have got some staffing issues and they were just flagging it to me, but also had some concerns about



a nurse potential competency issue. That is how I read that.
**Q.** You had been involved with the original -- the SI I mentioned?
**A.** Yes, I did, yes.
**Q.** The mortality continued, which you were aware of, whether you were aware of the details you know that babies carried on dying. And you knew that there was a connection between a member of staff because you have already accepted that you had in fact seen the table by this point in May and he's also mentioning that children had arrested. So this is more information. It's significant, isn't it?
**A.** It is more information but again we needed to understand the detail of that which is why it was important that Dr Brearey shared that with us.
**Q.** Did you ask him to?
**A.** Not at that point, no.
**Q.** At any point?
**A.** The Thematic Review had additional sections added after discussion with the network which did talk about deteriorating babies which hadn't been in the original report, so that kind of started to build up the picture of what was going on.
**Q.** Did you check to see if Letby was associated,



as he was suggesting, with the arrests as well as the deaths?
**A.** Not personally. Not personally, no.
**Q.** Again without going into the detail, it appears that what happens over the next couple of days is that Karen Rees takes charge of the issue and liaises with Eirian Powell and others and there is a meeting that takes place which I don't think you attended; is that right?
**A.** I don't think I was at that, no.
**Q.** Is that the meeting that is with Karen Rees Yvonne Griffiths, Anne Murphy, Eirian Powell?
**A.** Okay, so the senior nursing team.
**Q.** Indeed.
**A.** Yes.
**Q.** It appears at that meeting that they discuss Lucy Letby's potential involvement and there is a document, the neonatal mortality document, which Eirian Powell has produced which is one of the attachments that you were sent which you asked to be printed off, which makes clear at the start -- you will be familiar with the document -- that there is no evidence in her opinion against Lucy Letby, do you remember that document?
**A.** I do remember the document, is it the one with

the clinical almost like a clinical case review on the furthermost column to the right?

**Q.** Just briefly in the interests of time, I will put it on screen, 0003243. It's this one.

**A.** Okay, right. Yes.

**Q.** So this I think is the subject of that meeting that you are discussing --

**A.** Yes.

**Q.** -- with the three sort of nursing team managers, you are not attending the meeting but they clearly discuss Lucy Letby directly, including the question of whether or not there is sufficient evidence, as they put it -- or she puts it -- against her and they reject that possibility.

Now, is it the case then that after this meeting Karen Rees speaks to you and gives you reassurance that Letby is not involved?

**A.** I can't recall Karen coming to speak to me directly but I do recall Eirian referring to this document in the meeting of 11 May where Steve Brearey also provided the Thematic Review analysis.

**Q.** In the email that you sent to Ian Harvey on 6 May, which I won't call up because it's been on the screen many times, the one in which you say you are alarmed, you say: I am currently reassured there are no



issues". Who reassured you there are no issues?

**A.** I'm not sure it might have been Karen because Eirian would have escalated any concerns up through her nursing structure to Karen, so it may have been Karen that provided that reassurance to me. I felt at the time that there was nothing to be concerned about and I would have got some assurance from my team to make that decision.

**Q.** Can I test that, please.

The senior nurses have met and they have decided that there is no evidence to connect Lucy Letby to the deaths. They weren't qualified it make that assumption, were they?

**A.** Not, not on their own, no.

**Q.** And you were reliant on a reassurance therefore which didn't have a proper medical basis?

**A.** I think this document I believe once they collated it was shared with Dr Brearey prior to the 11 May meeting because it does talk about other issues aside to potential competencies of -- of Letby.

So my understanding was that Eirian Powell and Dr Brearey were doing this as a joint piece of work but recognised this was about what you are talking about, was a nursing meeting without doctors there. So it was just one part of a bigger picture which needed to be



investigated further.

**Q.** Well, it looks from the big picture as if positions get entrenched around this period of time. There's a meeting of the senior nursing staff who report up to you in which they take the position that Letby is not involved, you rely on that reassurance but it is completely at odds with the Consultants' view which you are aware of, Steve Brearey's view, because he tells you that on the 11th, and in fact that position never changed, did it: you and Karen Rees and Eirian Powell never changed your mind from that point onwards, did you?

**A.** I would disagree with that. I think we heard both sides and it's evident from the 11 May meeting we, Ian Harvey and myself, listened to both sides, the clinical and the staffing challenges as well as some of the strategic and operational issues that Eirian Powell articulates in his paper.

And as I said before, Dr Brearey had this document but I don't think he had a chance to look at it before the 11 May meeting. But as time went on, yes, I would agree, the relationships did become strained between doctors and nurses and that -- that was, that caused us some difficulty.

**Q.** Well --



**A.** But at this time, from my perspective as the Director of Nursing, I was keeping an open mind. It wasn't just about an individual, she hasn't done anything, we needed to understand more fully what was going on in terms of the raised mortality.

**Q.** Well, "open mind" meant that you had to recognise, as you accepted with Mr De La Poer this morning, the possibility of deliberate harm which is what Dr Brearey suspected, number one.

**A.** Yes.

**Q.** Number two was if that possibility is on the table and it has some basis, as it did from the clinical staff, it was a patient safety issue because you could not exclude that risk safely?

**A.** I agree.

**Q.** The only option in those circumstances is to trigger the safeguarding process or call the police?

**A.** Yes, and as I mentioned earlier on because the focus to start with was around increased mortality, it wasn't just about my -- my view. Everybody looked at this through a mortality lens and not a safeguarding one and I have done a lot of reflection as the Executive Lead for Safeguarding and I accept there would have been some opportunities to have gone down a safeguarding route but it didn't feel obvious at the time.

**Q.** Well, you are putting it in soft and euphemistic terms, if I may say so. You said at the start of your evidence today when you apologised to the Families, or you acknowledged their loss, that there were things you didn't get right?

**A.** Yes.

**Q.** Can I put it to you this is the thing you got wrong: when you were presented with concerns that raised the issue of potential deliberate harm you did not take the appropriate steps and trigger the safeguarding process?

**A.** Yes, and I mentioned that earlier on. That is one of the things that I have spent a lot of time reflecting on. But at that time it -- it didn't feel obvious. There was lots of things going on and now I know so much more information, it seems obvious to me that that should have happened.

But at that time, it wasn't something that was considered by anybody.

**Q.** To be clear, the likely eventuality that would have occurred had you triggered that process is within 24 hours the designated officer would have been alerted, the police would have been alerted and Letby, in all likelihood, would have been suspended pending an investigation to check safety of the unit.



**A.** That -- that would have been the process, yes.

**MR SKELTON:** Thank you.

Thank you, my Lady.

**LADY JUSTICE THIRLWALL:** Thank you very much, Mr Skelton. Mr Kennedy.

Questions by MR KENNEDY

**MR KENNEDY:** Ms Kelly, my name is Andrew Kennedy. I ask questions on behalf of the Countess of Chester Trust.

I want to deal with two discrete issues.

The first is something you mentioned -- well, both relate to issues you mentioned in answer to Mr De La Poer's questions earlier.

Firstly, my understanding of your evidence was that at the time of the CQC inspection in February of 2016, you were not aware of an increase in mortality on the neonatal unit; is my understanding correct?

**A.** We had just received the draft report of the Thematic Review but up to that point, deaths had been reviewed where they had been reported, had been reviewed on an individual basis but what hadn't become apparent was that there was a trend over time. So at the time we were not fully aware of the picture.

**Q.** So my understanding is that as at the time you spoke to the CQC, you hadn't had an opportunity to



digest the Thematic Review?

**A.** That is my recollection, yes.

**Q.** All right. Can we just test that piece of evidence. If we go back to the 2 July, so the special -- SI Panel meeting which considered the three neonatal deaths, so A, C and D, in answer to Mr Skelton's questions you told him it would be -- it was unusual for you to be considering three deaths in one meeting?

**A.** Yes.

**Q.** All right. Three neonatal deaths in one meeting?

**A.** Yes.

**Q.** Would one question for you have been -- and bearing in mind these were three deaths in 14 days, would one question for you have been: how does that compare to the unit's normal performance?

**A.** Yes, that could have been a question that could have been asked, but Dr Brearey did a presentation to that meeting and had articulated quite clearly his Mortality Reviews of each of those cases and in light of his expertise in doing those reviews, there was nothing that he was raising as a concern at that meeting that I should have been concerned about albeit there was a cluster of deaths which I now believe can happen but



that's only with the information I have had for this Inquiry.

**Q.** Do you think you asked the question: how does this compare to last year or the year before or the year before that?

**A.** I don't think I did ask that question. But I was assured by the clinician who was in charge of the care of those babies that there was no concerns and he also didn't raise, to my recollection, that this was unusual.

**Q.** You referred in answer to Mr Skelton's questions to you said your note and I have checked back to your witness statement and you refer to a document perhaps we can just pull it up, so it's INQ000 -- I am going to say 3350. I am immediately wrong, then 3530. Forgive me, I ... 3530.

So is this note that you are talking about, this is the one you refer to, we can look at it in your statement if you want to.

**A.** Yes, what page is that, please?

**Q.** It's page 46 of your statement you start on 45 at paragraph 144. You will see in a couple of places you refer to documents and so 147, you see second line in the handwritten note, 3530, which is this document.

**A.** So this document in front of us is -- it's not

my note, it's a note of Julie Fogarty, the Director of Midwifery at the time and it is only the top part of that note that refers to that SI meeting, the bottom is -- is other business.

**Q.** I think where there is I think the horizontal line across the middle of the page just above the words "Janet Beech", everything above that relates to this meeting?

**A.** Yes.

**Q.** So we can ignore everything below that. This perhaps consistent with Ms Fogarty's designation as the Head of Midwifery, this appears to be deal with midwifery issues?

**A.** Yes, she specifically make notes for that as she is Director of Midwifery.

**Q.** All right. There is nothing in here about neonatal matters?

**A.** It -- it was linked -- she was at that meeting so it was linked to the neonatal cases that Dr Brearey was sharing. He brought a document that went through each of the cases, very detailed.

**Q.** All right. Did you see a copy of that document?

**A.** Not beforehand, no, we went through it in the meeting.



**Q.** All right. Can we just see whether we can just establish what the document was. Can I ask for another document, INQ0003191, and perhaps if we can just --

**A.** That is the document I was thinking of.

**Q.** That is the document, all right.

**A.** Yes.

**Q.** Can we just scroll down through that to one page more, please. So we can see there that the document gives you comparable neonatal mortality?

**A.** (Nods)

**Q.** So that we can see that three deaths in 14 days in 2015 is as many deaths as there had been on the unit in the previous four of five years over a year.

**A.** Yes.

**Q.** All right. It would follow from that that you must have been alert at least to a rise in neonatal mortality, whether explained or otherwise?

**A.** Yes.

**Q.** Okay.

**A.** But at the time Dr Brearey, who clearly went through those cases, didn't articulate that there was a problem.

**Q.** I am not now concerned with whether there was a problem, I just want to establish whether or not you



knew about a rise in neonatal mortality and I think we are agreed that you would have done looking just at this crude data?

**A.** Yes.

**Q.** Okay. If we wind the clock on, towards the end of that year, 2015, there was a review conducted by Dr Brigham?

**A.** Yes.

**Q.** I don't know if you remember from that, that looked at those three -- it looked at two things, one was stillbirths and one was neonatal deaths?

**A.** (Nods)

**Q.** In terms of neonatal deaths, it looked at -- we can again look at the data if you want to it -- five deaths of which four are what we are referring to as indictment babies, does that ring a bell with you?

**A.** It -- it does, yes.

**Q.** Okay. The conclusion of that, certainly, and that was looking -- that was looking at those aspects from an obstetric perspective and I think your understanding was that there was to be a paediatric or a neonatal equivalent review?

**A.** Yes. That's where the confusion was at the end of 15 and it ended up being two separate reports, as we know.



**Q.** Okay, but as at 2015 at least on Dr Brigham's data, we now had five neonatal deaths?

**A.** Yes.

**Q.** Correct. So if you had cast your mind back to the document we just looked at, you were now higher -- it was now higher than the previous high point which I think was 2008 when there had been four deaths; correct?

**A.** Yes.

**Q.** Okay. So there was a rise in neonatal mortality.

When the Thematic Review came along, and can we look at INQ0003217, and I take it while this is being pulled up, that you would have been -- you would have been keen to keep this under review the question of neonatal mortality after your meeting with Dr Brearey in July 2015 or keep -- sorry, perhaps keep an eye on it?

**A.** Yes.

**Q.** Okay.

**A.** I suppose the problem being that mortality as -- as a topic, if you like, came under the Medical Director and there was a lot of focus at that time on adult mortality to the point where that was mandated to be reported to the board.

Neonatal mortality did not have that level of

scrutiny or focus nationally. So even though there were reviews being undertaken in the Trust, I don't think we fully appreciated until we had the Thematic Review that there was an increase in neonatal deaths.

The document that Sara Brigham collated and then presented to the Quality Committee I recall didn't get any challenge and there was lots of actions reported to support practice going forward but there was nothing that was being flagged as a concern at that time.

**Q.** We can look at Dr Brigham's review if we need to but it was looking at matters from an obstetric perspective. So in terms of action going forward, those were obstetrically focused actions?

**A.** Yes, in the main but the -- the -- they kind of crossed -- crossed over with what was coming out of the Thematic Review the following year.

**Q.** All right. Well, maybe another time we have to test that piece -- test how right that is?

**A.** I think the other thing just to add, sorry, is there was an email trail between myself and Ian Harvey to say there had been these two reviews and actually we need the two teams to work much more collaboratively together and I think in a view to having a more collaborative approach to reports in the future.

**Q.** I understand that. As I say, I am just



testing the hypothesis of what you knew when it came to the CQC inspection later in February and my -- my proposition is that you had had -- you knew of three deaths in July, you knew how that compared to previous annual mortality. By November you knew there had been at least two more, so we are now five for the year; correct?

**A.** Yes.

**Q.** I suppose it might beg this question: when it came to speaking to CQC was there an imperative in fact to be -- to look to see what it was the Thematic Review had revealed?

**A.** Yes. That's not an unreasonable suggestion.

**Q.** Okay.

**A.** And I don't think from myself and Ian Harvey's perspective we probably hadn't joined all the dots together at that time, so we didn't raise anything with the CQC because we needed to look at it ourselves internally.

**Q.** But if you had done, you would have seen that it wasn't five, it was ten on the Thematic Review?

**A.** In -- in the document, yes.

**Q.** Yes. Okay. And so whether in fact CQC were told when you saw them in February or later, did they not need to be told about a rise in mortality?



**A.** I -- I think yes, on reflection we, we could have mentioned that but I think Ian and I -- Ian Harvey and I needed to understand fully the Thematic Review and then pull all of that together. I don't think we felt that we had all the information at that time because it hadn't all been pulled together but recognised we could have told the CQC more at that time.

**Q.** And certainly by March, when you got the final Thematic Review; correct?

**A.** Yes.

**Q.** All right. I just want to deal with one other matter and it's this and it relates to the Thematic Review.

You have said in answer to Mr De La Poer's questions that the Thematic Review had raised concerns in relation to clinical care and you used that -- you used that as a way of explaining perhaps your understanding of mortality later on in 2016, is that -- is -- am I correct in that's what your --

**A.** I -- I deduced from the report that there were a number of actions to be taken forward to improve practice, as well as other things that were in that report.

**Q.** Can we -- if we can just look through the Thematic Review and just flag one or two points from it.



So if we go on to -- forgive me, just go back one page. It's just worth observing under the purpose of the meeting the second sentence:

"An obstetric Thematic Review did not identify any common themes or identifiers that might be responsible for the rise in mortality in 2015."

So that was speaking of -- in from a neonatal perspective the obstetric review hadn't provided any assistance; correct?

**A.** Yes, but there were a number of actions attached to that report as well from an obstetric perspective.

**Q.** Again perhaps that is something I need perhaps to come back to on another day. If we then go on to -- I have got -- if we go on to the next page, we can just see in relation to -- just pick up three cases. I am just going to pick up A, C and D, which are the ones you considered in July.

So there was a comment in relation to the umbilical venous catheter, UVC, and we can see three lines president bottom:

"No PM evidence of line or UVC related complication."

There's a reference to a congenital abnormality. Then it says this:

"Agreed agreement today that the related complication very unlikely to have caused arrest."

So whether that is the complication of the UVC or the congenital complication?

**LADY JUSTICE THIRLWALL:** It says "line related".

**MR KENNEDY:** Forgive me.

**A.** I think that to do with line insertion and they pulled the line out.

**MR KENNEDY:** Forgive me, I am sorry, so that is the UVC. I am reading from a different version so I am skipping between the two. So the line related complication.

So there is no postmortem or apparently clinical review correlation in relation to the UVC; correct?

**A.** Correct.

**Q.** Then if we look at Child C, final sentence in the main box:

"Agreed PM report but no cause for deterioration identified."

Again there's reference further up to a displacement of the UVC.

Then in relation to Child D, so next one down, you will see that there's an entry about halfway down:

"Group felt initial delay in starting antibiotics very unlikely to have been contributory to death."



**A.** Can I interject there, please, because on the far column on the right-hand side it then talks about some of the clinical deficiencies that needed to be picked up in training, ie delayed cord clamping, staff to be aware of the policy, continued to emphasise trainee doctors' awareness of sepsis guidelines.

These are actually quite key clinical elements.

**Q.** I appreciate that but in the case of Child D, that was specific, the delay in starting antibiotics which is the importance of following sepsis guidelines?

**A.** Yes, and we did a Level 2 Investigation on Child D.

**Q.** Forgive me?

**A.** We did a Level 2 Serious Incident Investigation on Child D because of those issues around sepsis.

**Q.** Indeed, but the conclusion of the Thematic Review was a delay in starting antibiotics was very unlikely to be contributory to death. We can see that here.

**A.** Yes, in the middle.

**Q.** Yes. If we -- if we go on then, please, to page 7, we can see the themes -- I'm sorry, I am working from a different version. Perhaps if we just quickly bring up 0003251 which is the final version. This is



the February version, and page 7 of that, so 0007.

We have looked at this document a number of times. You looked at it with Mr Baker in relation to sudden and unexpected deteriorations and no clear cause of death identified at postmortem. There's a comment in relation to timing of arrests and then in relation to delayed cord clamping, which is one the clinical issues, we can see, not reading through the whole thing, the last sentence where it says:

"However there were no cases of severe hypothermia and only one case of mild hypothermia in the cases reviewed, that being relevant to the impact of delayed cord clamping."

So that didn't give a clinical concern relevant to understanding cause of death, did it?

**A.** No, but further on, just above in that paragraph it does talk about "teams had not yet been able to ensure adequate temperature control for all preterm babies close to mum during delayed cord clamping".

So I understand what you are saying but -- but if you read that report in its entirety, to me, as a clinician, there were deficiencies in care, albeit the report and some of the postmortems may have said it didn't contribute to death.



**Q.** Well, that's the point. In terms of understanding the reason for death, or the cause of death, the clinical concerns that you mentioned in relation to the Thematic Review in the same way as I think you agreed with Mr De La Poer in relation to the RCPCH, those clinical concerns didn't provide an adequate explanation as to cause of death, did they?

**A.** Not on their own, no.

**MR KENNEDY:** No, all right. Ms Kelly, thank you. Those are my questions, my Lady.

**LADY JUSTICE THIRLWALL:** Thank you very much, Mr Kennedy.

Ms Blackwell.

QUESTIONS BY MS BLACKWELL

**MS BLACKWELL:** Mrs Kelly, you have been asked some questions at the beginning of your evidence session this morning now about your background in nursing but I just want to expand upon that for a couple of moments if I may and talk about your full role as an Executive at the time of the events with which this Inquiry is concerned.

You were professionally responsible for around about 1,000 nurses and midwives; is that right?

**A.** That's correct.

**Q.** Yes. We have heard that there were 600 beds

in the hospital at which you worked and is it right that there are about 20 cots in the NNU?
**A.** Yes.
**Q.** And there were about 14 nurses working on that unit; is that right?
**A.** Yes.
**Q.** You have made reference to the nursing structure that lay beneath you and is it right that as well as working in lengthy office hours within the hospital, you worked in the evenings and at weekends?
**A.** Yes, that was quite usual.
**Q.** We can see from some of the emails at which we have looked the times at which you were corresponding with your colleagues. Would you be in back-to-back meetings for most of your working days?
**A.** Yes.
**Q.** And would some of those meetings take you out of the hospital and to other places in the locality?
**A.** Yes. As we mentioned this morning, I had a key role in working with the local university.
**Q.** Yes.
**A.** And also a profile across Cheshire and merse as a region, in terms of leadership and nurse development, so there was number of times where I was out of the organisation.



**Q.** You have expressed already the number of emails that you would receive on a daily basis?
**A.** Yes.
**Q.** What did you wear to work?
**A.** I was really keen to demonstrate to my teams, ie the 1,000 nurses and midwives, that I was a nurse and I was the nurse on the board. So I did have a uniform and I did work clinically and that would be on a regular basis. And actually that gave me a full appreciation of challenges on the shop floor that I would be able to articulate at the board.
**Q.** Was wearing a uniform obligatory in your position?
**A.** No.
**Q.** Was working clinically obligatory in your position?
**A.** No.
**Q.** But you chose to do both of those things?
**A.** Yes.
**Q.** Thank you.
You have been asked more recently about the Serious Incident Panel meeting on 2 July of 2015 --
**A.** Yes.
**Q.** -- by both Mr Skelton and also Mr Kennedy.
Are you in any doubt as to whether or not



Eirian Powell was present at that meeting?
**A.** No. She wasn't at that meeting.
**Q.** And are you in any doubt about whether or not Lucy Letby's name was mentioned during that meeting?
**A.** No, she wasn't mentioned at that meeting.
**Q.** We know because I took Mr Brearey to it, Dr Brearey to it when I asked him questions that immediately following that meeting you sent him an email.
**A.** Yes.
**Q.** Do you remember?
**A.** Yes, I do.
**Q.** I'm not going to ask that we put it up, but I will read out to you some of what you said in that email to him:
"It was reassuring to know that each case had been looked at in such detail and that we recognised that some areas required further review ..."
And that you offered to speak to Dr Brearey if he wanted to talk through anything in Ian's absence because I think that Mr Harvey was away from work at that time?
**A.** That's correct.
**Q.** Yes. Did Dr Brearey ever respond to that offer to talk through with you anything that he wanted to?



**A.** No.
**Q.** Did he ever come to see you or speak to you to raise any concerns following that meeting?
**A.** No.
**Q.** Was the next that you heard from Dr Brearey his email to you in May of the following year?
**A.** Yes.
**Q.** All right. Well, in between those times we know that you received several copies of the Thematic Review, first of all in February, and then later on in March, and you have been asked questions about a lack of urgency --
**A.** Yes.
**Q.** -- in your actions or reactions to being provided with those reports. Now, I would like to put up an email which we have seen before, but to take you through different aspects of it. It's at INQ0003138 and please may we look at page 2.
This is the email which you received from Dr Brearey on 4 May when the meeting that was originally arranged for that day had to be cancelled and you were looking for a new date and if we look at the top, please, this email is the one that we've seen before.
This is his response after the meeting had been cancelled:

"Thanks, Alison,
"There is a nurse on the unit who has been present for quite a few of the deaths and other arrests."
Mr Skelton asked you about the raising of the prospect of other arrests. It's this I want to ask you about:
"Eirian has sensibly put her on day shifts."
What did you take from Dr Brearey telling you that he thought that moving Nurse Letby to day shifts was a sensible move?
**A.** Yes, and the impression I got from that email was it was to provide support and welfare for Letby, as we would with any other nurse who was struggling. We would sensibly move them from nights to days.
**Q.** Did he, around about this time, ever suggest that she should be either supervised or taken off the ward?
**A.** No.
**Q.** "But can't do this indefinitely."
He goes on to say:
"It would be very helpful to meet before she's due to go back on to night shifts."
So did that suggest to you that he was contemplating that a time would come when she would go back on to night shifts?



**A.** Yes.
**Q.** Yes:
"There is some pressure regarding staffing numbers with this at the moment."
What did you take him to mean by that?
**A.** I think it felt to me that there was some staffing challenges and that they were lacking on the night shifts. So, therefore, we needed to have a conversation to make sure that the unit was sensibly staffed.
**Q.** He gave evidence to this Inquiry that: Several weeks before this, in fact once the Thematic Review was in the process of being completed back in February of 2016, he had requested an urgent meeting with Ian Harvey. Did you know anything about that?
**A.** No.
**Q.** Did he ever seek an urgent meeting with you to discuss these matters?
**A.** No.
**Q.** Did he ever email you in those terms?
**A.** No.
**Q.** I would like now to go to INQ0003089, please, and to look at the manner in which you were being addressed by Eirian Powell about these matters at around this time.



Now, if we can go to page 2, please. We have looked at the email at the bottom of this page on several occasions today and you have given evidence that you took some comfort, that's my word, not yours, from the way in which Eirian Powell signed off this email when she said:
"Despite reviewing these cases there was nothing obvious that we were able to identify. Therefore your input would be valued."
Did you see any sense of urgency --
**A.** No.
**Q.** -- in what Eirian Powell was suggesting to you there?
**A.** No, not at that time.
**Q.** Thank you. We see your response above on 21 March and please could we go back to page 1 now to see the terms in which Eirian Powell was addressing you the following month on 14 April:
"Hi Alison, I was wondering what your thoughts were after going through the Thematic Review. I notice that the Thematic Review did not include the medical team that were involved. I have therefore attached the document that includes this."
Did you take anything in that email as a note of urgency or warning that this matter had to be addressed



and soon?
**A.** No. It just felt like a general we need a general catch up just to talk some things through. There was no sense of urgency from my respect.
**Q.** Thank you. Moving now to the 11th -- that can come down, thank you very much -- the 11 May meeting.
You have not really been asked very much about what went on at that meeting. The Inquiry already knows that it was at that meeting that Dr Brearey went through the results of the Thematic Review which, by that time, had been completed. And the Inquiry has also heard that Eirian Powell and Anne Murphy went through the document that Eirian Powell had prepared in preparation for that meeting?
**A.** Yes.
**Q.** Dr Brearey has told this Inquiry that in doing so Eirian Powell was acting in an emotional state. Do you agree with that evidence?
**A.** That is not my recollection of the meeting, no.
**Q.** How would you describe the way in which Eirian Powell and Anne Murphy conducted themselves?
**A.** They were very professional, but they were very assertive and they were very passionate about articulating the assurance provided for their member of

staff. But in addition to that, they were also equally as assertive about some of the clinical challenges that they were having on the unit at that time, for instance transport issues.

**Q.** What was Dr Brearey's reaction to their assertiveness and the issues that they were bringing up during the course of the meeting?

**A.** He, he didn't really react to what was being said. He was very focused on going through the Thematic Review in terms of the clinical care and the clinical cases.

**Q.** Can I ask you this, please. Did he ever mention deliberate harm?

**A.** No.

**Q.** Did he challenge Eirian Powell and Anne Murphy about what they were saying?

**A.** No.

**Q.** And when you received his follow up email, which I took him to, I am not going to ask that we look at it now, in which he said that he was, and I'm paraphrasing again, content with the outcome of the meeting, what did you take that as being?

**A.** That we all left that meeting on 11 May agreeing with the actions to be taken and that he was happy that we were taking the appropriate action and



then he cascaded that to his colleagues.

**Q.** Did he, like you, express that he thought it was a helpful meeting?

**A.** It was a helpful meeting, yes.

**Q.** Yes. And did he at any stage following the meeting concluding on 11 May and between 23 June ever approach you or as far as you know any of the other Executives to bring any further concerns to your attention?

**A.** No.

**Q.** Now, it was put to you this morning that by this time doctors believed that Lucy Letby was murdering babies.

Had that ever been suggested to you in those terms?

**A.** No.

**Q.** The Inquiry has heard that on 24 June, following the death of Child O the previous day, Dr Jayaram met Karen Townsend in the cafe at the hospital and raised as the third item on an agenda with her the concerns that the Consultants had and in particular in relation to Child K, I think, which was mentioned -- or, rather, sorry, not in relation to Child K but in relation to the Consultants' concerns?

**A.** Yes.

**Q.** How did that come to your attention?



**A.** That was raised up through Karen Rees because Karen Townsend had asked her earlier in the day following that meeting to go and find out what was going on and then that sort of escalated as time went on to the actions that we then took following the deaths of Baby O and Baby P.

**Q.** All right. Now, I have mentioned Child K there. Of course by 24 June, Child K had collapsed and died and that had happened back in February of 2016, the day before the CQC meeting.

When was that brought to your attention?

**A.** Not until the following year when Dr Jayaram had that conversation with Sue Hodkinson.

**Q.** Well, I'm going --

**A.** So there was nothing raised at that time of the incident with us.

**Q.** Do you know whether or not the Consultants were being pressed for evidence of the association with Letby and how that was connected to the deaths or collapses?

**A.** We were constantly asking questions of the clinicians of evidence and more information and it's only further down the line, in 2017, that we were told about Baby K, which was extraordinary because that could have been raised the year before.



**Q.** All right. We know that on 6 July of 2016 you contacted the NMC?

**A.** Yes.

**Q.** And you had a conversation with Tony Newman after which he sent the email which we have looked at this afternoon setting out the seven points which you then corrected in part, and do you agree that that accurately reflects the conversation that you had had with him on that day?

**A.** On that day, yes, I do.

**Q.** All right. It's been suggested to you that had you activated the safeguarding policy at this time that Lucy Letby would have undoubtedly been suspended and that the police would have been informed and that matters would have taken their natural course.

We know that the police were told about the concerns in April of 2017 and that Lucy Letby wasn't arrested until July of 2018.

Do you know whether the police took any action to ensure that she was suspended or somehow supervised in whatever role she had at the hospital between those dates and during the course of their investigation?

**A.** There are some email evidence from the police asking whether she was part of a nurse bank, which means you can work anywhere, not just in the hospital but

elsewhere, and that was a follow-up action that Dee Appleton-Cairns took.

**Q.** Yes.

**A.** However, other than that, nothing as far as I'm aware was undertaken and indeed further conversations with the NMC it became apparent that there was little concern about putting restrictions on her practice until significant time down the investigation, which I thought was quite inappropriate because it was almost at the end of the investigation that action was going to be taken about restricting her practice.

**Q.** Thank you. Moving on to the RCPCH report and the questions that you have answered today about the fact that one of the considerations and recommendations was that action was required in terms of an HR investigation, which I think has been described as a disciplinary investigation.

Did you consider any difficulties in carrying out that recommendation and if you did, what advice did you take about that?

**A.** So I think as I mentioned earlier, we were struggling at the time looking at our HR policies internally to actually truly understand what we would be -- what policy we would be using to discipline Letby on and that's when myself and Sue Hodkinson in



particular sought external HR legal advice, which was really supportive at the time.

So it wasn't that we ignored that recommendation; it's just that we took a different tact based on external advice.

**Q.** All right. Next topic, Dr Hawdon's report, please. You have given evidence today that your understanding of that report was that there were a number of examples of sub optimal care raised and you have explained your understanding about the extent of the effect of such sub optimal care.

Now, I would like, just very briefly please, to look at INQ0003172 and please could we go to page 44. Thank you. This is the page that deals with the summary of cases where we can see they are divided into two groups: the first group is where the death or collapse is explained but may have been prevented with different care and learning may improve the outcome for other babies.

So what did you understand that to mean?

**A.** To me that demonstrated that care wasn't being delivered in the standards that we would expect for neonatal care and there was obviously some areas of improvement required.

**Q.** And that the deaths or collapses may have been



prevented with different care?

**A.** Yes.

**Q.** And we can see that within Group 1 are Child H, Child Q, Child E, Child C and a series of other children and then we can see in the second group the death or collapse is unexplained and it's the investigation of these cases which would potentially benefit from, we know, the local forensic review as to the circumstances and we know that that took place.

**A.** Yes.

**Q.** Yes. Thank you. We can take that down, please.

Two further matters if I may. The first is in relation to the meeting with Mother C. It's been put to you that Mother C's recollection is that you were present, you were one of two female clinicians present at that meeting and it's already been remarked upon by Counsel to the Inquiry this morning that you are a person who almost religiously takes a note --

**A.** Yes.

**Q.** -- in the meetings that you are present in and a good note.

Have you looked in the notebooks which have been provided to you, copies of the notebooks by the Inquiry, as to whether or not you have any note at any time of



meeting any of the mothers of any of the indictment children?

**A.** There was no record in my meeting notes -- in my notebook I should say. As part of my role, I would very often meet with families on the back of complaints or if they had any concerns. I would religiously take notes of those meetings and if there was anything that was of concern that needed follow up I would usually reflect that back in a letter.

I have no evidence of any of those notes that may have been taken at that meeting with Mother C. So I can only assume, I'm not saying it didn't happen, but I can assume that I wasn't there.

**Q.** Right. And is there any record at all that you can find of a follow-up letter?

**A.** No.

**Q.** Thank you. Finally this, I said I would come back to it. It's the meeting on 16 March of 2017 when you say it was first brought to your attention that Dr Jayaram had witnessed an incident at the cot of Child K that he concluded was her inflicting deliberate harm.

Now, during the course of that meeting, we have looked at note already, you are recorded as having said, "Why not before"?

**A.** Yes.
**Q.** And that was you have told the Inquiry your reaction to, well, to what?
**A.** Shock that we had not been told about that before.
**Q.** And by way of an example of an explanation as to why that hadn't come out before, Counsel to the Inquiry took you to the note that records it being reported during the course of that meeting that the Consultants felt like battered wives and that the Executives were the abusers.
As an Executive, how did you feel about the fact that the sensitivity of the two Consultant leads on the neonatal unit and of children's services felt so bruised that they compared themselves to battered wives?
**A.** Yes, shocked. Shocked and an inappropriate comment to make.
**Q.** And did you find this excuse for Dr Jayaram keeping the eye witness evidence about Child K to himself for a full 13 months, during the continuing collapses and deaths of the neonates, and you, as you have told the Inquiry, repeatedly asking for evidence of Letby's involvement --
**A.** No.
**Q.** -- ample justification for his silence?



**A.** No.
**MS BLACKWELL:** Thank you. My Lady, that concludes my questions.
**LADY JUSTICE THIRLWALL:** Thank you very much, Ms Blackwell.
Questions by LADY JUSTICE THIRLWALL
**LADY JUSTICE THIRLWALL:** One of the things you said a bit earlier -- we are nearly finished.
**A.** That's okay.
**LADY JUSTICE THIRLWALL:** -- a little bit earlier was that you think that you should have been more supportive of the Consultants --
**A.** Yes.
**LADY JUSTICE THIRLWALL:** -- you said that earlier in your evidence.
This is really just for my understanding. In what way were you at all supportive of the Consultants?
**A.** I think what I was meaning by that was more on a pastoral perspective.
**LADY JUSTICE THIRLWALL:** Yes.
**A.** So I know that my colleague Sue Hodkinson was conscious that there was a lot of stress in the team with everything that was going on at the time and she may refer to some of that in her, her evidence.
But I think what we could have done better on



reflection is provide more formal support for that team. I made sure --
**LADY JUSTICE THIRLWALL:** When you say "that team", you mean the Consultants' team.
**A.** The Consultant team, sorry, yes.
From a nursing perspective, there were quite good structures in place to get that organised; probably not so much with the Consultant body.
So -- but I do, on reflection, I think we could have put more support in to -- to get them through the very tricky time that we had.
**LADY JUSTICE THIRLWALL:** Yes. In fact, was there any support put in?
**A.** I think from -- I think Occupational Health support was offered to a couple of people, but more of a -- as a collective really and I don't think we asked the question at that time what: What extra support do you need? Particularly at the time of the grievance which was quite tricky in terms of relationships and I think they were feeling quite upset by the whole process.
So I think, on reflection, we could have put some formal mechanisms in place to support them at that time.
**LADY JUSTICE THIRLWALL:** Thank you. Then just one last matter if I may.



You have been asked repeatedly by different people whether you took the Consultants' concerns seriously and what I would just like to ask you about a little bit is what were you being told were the views of the senior nurses about what the Consultants were telling you?
We have seen what's said in the meetings --
**A.** Yes.
**LADY JUSTICE THIRLWALL:** -- but presumably there would have been conversations between you and Karen Rees, for example. What was her view of it?
**A.** Yes, and Karen Rees in particular was very passionate about her profession and she was very upset by what she was hearing from the Consultant body.
But we all recognised at the time that we needed to get lots of information together to get a true picture of what at the time was a very complicated story.
So I think some of the comments that were being made by the Consultants did affect some of my team to the point where I needed also to provide additional support for my team and that included the Risk Management Team as well, not just the nursing component.
**LADY JUSTICE THIRLWALL:** Yes. Ms Rees gave some evidence about being asked to take Lucy Letby off the ward and you will be aware of that exchange --
**A.** Yes.

**LADY JUSTICE THIRLWALL:** -- with Dr Brearey.
**A.** Yes.
**LADY JUSTICE THIRLWALL:** I don't need to take you back over that. But she told us that she had had experience in an earlier job of some cardiologists wanting a nurse removed from their unit or something like that.
**A.** Yes.
**LADY JUSTICE THIRLWALL:** I haven't got the precise wording, and she was incensed by that and having dug into it discussed there was an ulterior motive for that.
And in this case she told us, and I am sure you're aware of this, that she wondered whether there was some sort of relationship between Lucy Letby and Dr Brearey.
Did she talk to you about that?
**A.** She mentioned that on the -- not in those detailed terms.
**LADY JUSTICE THIRLWALL:** No.
**A.** But felt there was a personal issue, was how she phrased it when she spoke to me on that Friday evening around the death of Baby P.
So when she came to see me she -- she was very, very upset and she got the impression there was something personal, she said "something personal". We didn't go into any detail of what she thought that was.



**LADY JUSTICE THIRLWALL:** No and we know because she told us --
**A.** And she --
**LADY JUSTICE THIRLWALL:** I'm so sorry. I didn't mean to cut across you.
**A.** -- potentially she -- but she was quite exercised by that.
**LADY JUSTICE THIRLWALL:** Yes, she was quite angry about it, wasn't she?
**A.** Yes. Yes.
**LADY JUSTICE THIRLWALL:** And she told us that she went and asked Lucy Letby about it and she said there was nothing, nothing to it.
**A.** I believe she did, yes.
**LADY JUSTICE THIRLWALL:** But we know, don't we, that that information became sort of currency within the hospital, don't we. So does that give us any clue or did it give you any clue about whether or not the nurses perhaps thought that doctors were just making this up?
**A.** They may have done. I think -- you're absolutely right, I think one comment was made and before you knew it there were lots of rumours going round --
**LADY JUSTICE THIRLWALL:** Yes.
**A.** -- and some inappropriate comments made



corridor conversations --
**LADY JUSTICE THIRLWALL:** Don't worry, don't worry. I mean I know there's been a lot of that and we've heard evidence about it.
**A.** Corridor conversations, et cetera.
**LADY JUSTICE THIRLWALL:** Yes.
**A.** So it got very -- it became very insensitive to everybody involved and what was fact and what wasn't fact was not clear.
**LADY JUSTICE THIRLWALL:** No. All right.
**A.** Yes.
**LADY JUSTICE THIRLWALL:** Thank you very much indeed. Does anybody want to ask anything arising out of what I have just asked? No.
In that case, Mrs Kelly, thank you for coming. You are free to go.
**A.** Thank you.
**LADY JUSTICE THIRLWALL:** Now, tomorrow I think we have got Ms Hodkinson coming.
**MR DE LA POER:** We have and Dr Rackham.
**LADY JUSTICE THIRLWALL:** Yes. I would like to avoid everyone, particularly the shorthand writer, having to sit for another long day.
Can we just have some discussion before everyone disperses to make sure that we have got enough time if



we start at 10 o'clock to finish within a reasonable time, namely by 4.30? So if I can just leave that to those who are involved. On the face of it, it looks fine but I would just like people to have a proper look and think about how long it actually takes to ask questions and of course receive the answers.
So I will otherwise see you tomorrow at 10 o'clock.
**(6.05 pm)**
**(The Inquiry adjourned until 10.00 am, on Tuesday, 26 November 2024)**

**I N D E X**