

Tuesday, 26 November 2024

(10.00 am)

LADY JUSTICE THIRLWALL: Good morning.
Ms Langdale.

MS LANGDALE: May I call Ms Hodgkinson, please.

LADY JUSTICE THIRLWALL: Swear in the witness,
please.

MS SUSAN HODKINSON (sworn)

Questions by MS LANGDALE

LADY JUSTICE THIRLWALL: Thank you very much. Yes.

MS LANGDALE: Ms Hodgkinson, you prepared
a statement dated 14 August 2024 for the Inquiry. Can
you confirm that the contents are true and accurate as
far as you are concerned?

A. Yes, I can.

Q. You tell us in paragraph 1 that you are making
the statement in your capacity as the former Executive
Director of People and Organisational Development at the
Countess of Chester Hospital.

Can you just tell us what that role entailed,
please?

A. If it's possible first before going through
that, may I say a few words?

Q. Yes.

A. Thank you. I firstly would like to say, to

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and every organisation within the NHS doing the
incredibly hard job that they do today and will continue
to do in the future.

Thank you.

Q. Your role at the time Director of People, what
did that entail?

A. It was a very extensive role. So the key --
I suppose my key take on it was to support all members
of staff within the Countess. We had roughly around
about 4,400 members of staff and key responsibilities
was that I was the Exec Lead for the Trust People
Strategy which comprised of elements in relation to
equality, diversity, inclusion.

It comprised around the education, the leadership,
the competence of staff.

I also was the Executive Lead for a shared service
which supported around about 19,000 staff across
five organisations which was comprised of both
recruitment, flexible staff, payroll, pensions and
Occupational Health. In addition, the learning
development of the teams, providing the opportunity for
people to raise concerns through the Freedom to Speak
Up -- or Speak Out Safely process as it was -- I was
initially -- and I was also, I think, very active within
by the Cheshire and Merseyside region and also within

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pass on to particularly the Families and to all members
of the Inquiry my deepest sorrow and my condolences on
the loss of your loved ones. I can really not imagine
how this -- this is for you all and there isn't a day
that doesn't go by that you are in my thoughts.

The Countess when I worked there was my local Trust
and it is still my local Trust. I have been treated
there, members of my family have been treated there,
members of my family have been born there and also
members of my family have received the services from the
neonatal team as well in the past.

So for this to happen not only whilst I worked
there but also being a member of the local community was
something that I would never, ever have envisaged and
I would not wish on any other person to go through this.

I am very grateful to the Inquiry for having the
opportunity to tell the Families and also all of the
Inquiry members the reasons why I took the decisions and
the actions that I did at that time, eight years ago.

I am also grateful to the Inquiry for the chance to
have some time to reflect and also to support
potentially some of the recommendations that may come
out in the Inquiry report that may support not only my
former colleagues at the Countess, and many of them who
I still know now, but also every single member of staff

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the Northwest HR Directors Forum as well.

So not only did I have my responsibilities within
the Countess, I had responsibilities within the local
region and the wider region as well.

Q. How do you think your role had the potential
to affect the wider culture in the hospital; the
Director of People in the wider culture?

A. Sorry?

Q. How did your role affect that wider culture in
the hospital?

A. I think how I set the tone around how our
staff felt, were led by their managers, managers or
leaders, how they were educated, how they were supported
when they joined the Trust, you know, those first couple
of weeks and things, which are really important but also
how they developed throughout their career and I think
I took a particular, I suppose, point around this: to
understand how it was to be a member of staff at the
Countess.

I did many -- and this was my own decision to do
this, I did many back to the floor exercises which was
really insightful seeing how people treated me in
different ways. For example, when I was a domestic
assistant in A&E in the domestic assistant uniform, not
being seen by certain people, which was really

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1 interesting.

2 I think also as a porter, cleaning the beds, you
3 know, doing, doing the downgrading -- you know, the --
4 apologies, the servicing of the beds, shadowing
5 Consultants and anaesthetists in surgery. Various
6 different elements. You know, and that continued
7 throughout my time at the Countess. I wanted to get
8 a real sense of how it was to be a member of staff
9 there.

10 **Q.** Your experience before you came to the
11 Countess, you say to us you started your career in 1995
12 as an assistant manager at WHSmith?

13 **A.** Yes.

14 **Q.** In 1998 became a store manager at Iceland
15 Foods which involved the management of two stores with
16 teams ranging between 20 and 30 employees.

17 January 2002, you became a support centre
18 human resources manager, responsible for providing HR
19 advice, guidance and support to the buying and marketing
20 departments.

21 Your first role within the NHS was as an electronic
22 staff record benefits realisation manager and ESR
23 account manager. That was in 2005 to 2008.

24 You became strategic ESR account manager lead for
25 the North West in June 2010.

5

1 **Q.** What did that require of you in terms of
2 obligations to patients or to baby safety, safeguarding?

3 **A.** At which point?

4 **Q.** At any point in your career and the time that
5 you are Executive at the Trust, did you feel responsible
6 or accountable to a professional body for the way in
7 which you made decisions around baby safety or patients?

8 **A.** I think it goes without saying that every --
9 every member of staff has that professional -- has that
10 professional accountability. I think unlike the NMC,
11 the GMC, the HCPC, all of the other regulatory bodies
12 that exist, from a non-clinical perspective there isn't
13 a professional body there at the moment.

14 However, as a people professional, I would see that
15 I am obligated to the Chartered Institute of Personnel
16 Development but alongside that I think it goes without
17 saying, especially because it's my local Trust, that
18 patient safety was absolutely paramount and the
19 well-being of all members of the Trust was paramount to
20 me.

21 **Q.** Shall we have a look at the policies? You
22 refer to various policies in place at the time in your
23 statement and if we can go, please, to INQ0003012,
24 page 1. This is the 2013 Speak Out Safely policy that
25 was in place.

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1 In any of those roles, were you subject yourself to
2 regulation, professional regulation of any kind?

3 **A.** So there is a point as well that you have
4 missed there. Apologies, Ms Langdale. I also was
5 an area human resource manager as well, so where I was
6 essentially looking after -- I was the HR lead for
7 a region when I worked for Iceland as well.

8 So, you know, my actual HR career as such started
9 in around about February 2000. So, you know, from then
10 to now that's what, 24 years of being a people
11 professional as such.

12 So I think in relation to your point about
13 regulation, I started very early on undertaking the
14 I suppose the route into professional qualification
15 around from the Chartered Institute of Personnel
16 Development.

17 Obviously in those days remote learning wasn't what
18 it is now and I had to -- for my role when I was working
19 with Iceland I had to move up to Newcastle so I tried to
20 remote learn for a period but it was very difficult to
21 do that at that time.

22 So essentially I still, even though I wasn't fully
23 qualified at that stage, I classified myself as under
24 the regulation of, I suppose, our professional body, the
25 CIPD.

6

1 We see the purpose set out there:

2 "This policy supports staff by ensuring their
3 concerns are fully investigated and that there is
4 someone independent outside of their team to speak to.
5 For the purposes of this policy the term
6 'whistleblowing' refers to the disclosure by workers of
7 malpractice as well as illegal acts, miscarriage of
8 justice, dangers to health and safety [et cetera].

9 "The Countess of Chester is committed to openness,
10 transparency and candour so that staff feel able to
11 raise concerns and/or debate issues of concern about
12 healthcare matters in a responsible way without fear of
13 victimisation."

14 If we go to page 3, we see under "Process to be
15 followed to express a concern":

16 "When staff wish to express their concern about
17 patient care, they should normally do so to their line
18 manager."

19 At page 6, we also see there are designated
20 officers, as you have said already including Mr Harvey,
21 Ms Kelly and yourself. Just to be clear, the policy
22 doesn't require that those concerns need to be said in
23 a formal environment, do they? They could be said in
24 a car park, a corridor wherever someone has a chance to
25 raise a concern and it feels right to raise one. It is

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1 not important where you are physically sited to raise
2 a concern?

3 **A.** No, but it typically was either -- I don't
4 think necessarily concerns would be raised in the car
5 park as such but they were typically either brought --
6 there was multiple different concerns throughout my time
7 within being an Exec Director of People at the Countess
8 where either members of staff emailed me, put in time in
9 through my secretary or, you know, rang me to raise
10 a concern.

11 So there was multiple different mechanisms to do
12 that.

13 **Q.** Of course. If we go to page 7, at the top:
14 "The person making the disclosure will be asked
15 whether or not he/she wishes to make either a written or
16 verbal statement. In either case, the designated
17 officer will write a summary of the interview which will
18 be agreed by both parties."

19 If we go to page 8. In certain cases, three
20 paragraphs up from the bottom:

21 "... such as allegations of ill treatment of
22 patients, exclusion from work on full pay may have to be
23 considered immediately."

24 That's made clear at the bottom as well.

25 "If the Chief Executive, as a result of the
9

1 wasn't as clear-cut as how things may be seen now. And
2 certainly that was -- that was the key point where there
3 would be no hesitation for me or for any other member of
4 the Executive Team at that time in contacting the police
5 but I --

6 **Q.** Do you agree that there was nobody who
7 suggested to Dr Brearey or Dr Jayaram that they sat down
8 with an interview with you as a designated officer or
9 Mr Harvey or Ms Kelly, write down their concerns so that
10 the Chief Executive could make a decision as to whether
11 there was a case to answer, and an investigation was
12 required?

13 **A.** I think there was a meeting on 30 June 2016 of
14 which I was party of which was only a number of days
15 after I first knew about the specific details and the
16 concerns where the Consultants did state they were
17 extremely concerned around potential of one member of
18 staff being involved.

19 However, it was also clear to me in that meeting
20 that there were also concerns that the care that was
21 provided was not ideal. Dr Brearey did say that --

22 **Q.** We are going to go to the minutes of those?

23 **A.** Sorry.

24 **Q.** We will go to 30 June, there is a lot of
25 meetings on that day.

11

1 investigation, decides there is a case to be answered by
2 the person against who the disclosure has been made ..."
3 So simply a case to be answered.

4 "... the Trust disciplinary procedure will be
5 invoked. If there appears to be evidence of a criminal
6 act, the Chief Executive will consult the police before
7 invoking the disciplinary procedure."

8 So standing back, it was perfectly plausible,
9 wasn't it, that where these concerns had been raised at
10 the very early stage by Dr Brearey in the Thematic
11 Review highlighting patterns and concerns of events at
12 night for babies that the Chief Executive might have
13 responded to those concerns in -- in the context of this
14 policy and removed Lucy Letby and referred the matter to
15 the police?

16 **A.** Mm-hm. Yes, so is there a question or --

17 **Q.** Yes. Do you accept that that would have been
18 an appropriate use of the policy, and given the Thematic
19 Review and the concerns about Sudden and Unexpected
20 Deaths and them happening at night, that in 2015 this
21 policy could, and if it had been employed, have made
22 a real difference?

23 **A.** I accept that the policy states that. I think
24 at that time eight years ago there were multiple
25 different factors at play and I -- I believe that it
10

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1 **A.** Okay.

2 **Q.** But in principle you agree that this policy
3 was a route through where there was concerns of
4 a criminal act and suspicion?

5 **A.** This policy was. There were a numerous other
6 policies that could have been used as well and I think
7 it's important that the Inquiry is aware that this
8 policy was considered right at the outset as well.

9 **Q.** And was rejected, so it was never going to be
10 used?

11 **A.** Sorry -- sorry?

12 **Q.** And rejected as a tool because there were
13 never written interviews taken in the way I described or
14 a decision made by the Chief Executive, was there?

15 **A.** Sorry, I was just trying to explain as well.
16 It was not rejected. I can see how that could be seen
17 now but I can honestly say it was not rejected. It was
18 considered right at the outset. You know, I know
19 from -- the Inquiry probably has seen the copious
20 amounts of notes I have taken and I remember on 27 June
21 it was also raised under a Speak Out Safely element that
22 we should consider it.

23 And because of all of the various different
24 conversations that were taking place with Dr Brearey,
25 with -- with Dr Jayaram, with others, some of the
12

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1 obstetricians as well, it was being captured already as
2 part -- and that was all being considered.

3 So whilst it -- the Inquiry may believe that it was
4 rejected, it certainly was not.

5 **LADY JUSTICE THIRLWALL:** Was it used -- I'm sorry
6 Ms Langdale.

7 Did you use this policy?

8 **A.** It was -- it was considered under this policy
9 as well and --

10 **LADY JUSTICE THIRLWALL:** Sorry, so you did use this
11 policy?

12 **A.** Absolutely. So --

13 **LADY JUSTICE THIRLWALL:** Let me make a note of
14 that.

15 **A.** -- in 2017 I know we formally recorded it as
16 well but it was absolutely badged under this policy.

17 **MS LANGDALE:** Ms Appleton-Cairns gave evidence to
18 the Inquiry to say that yourself and Mr Harvey chose not
19 to follow the policy, that the meetings you say were
20 happening and concerns may have been being documented in
21 meetings but you chose not to follow the policy formally
22 in the way I have described, where you set out concerns
23 in an interview, they are then considered whether there
24 is a case to answer, whether there's something that
25 needs scrutinising.

13

1 **A.** I don't recall specifically but I do have some
2 reflections around the mediation process. I don't know
3 whether it's worth me going through those now.

4 **Q.** Not now. We have a lot to go through so we
5 will get to all the topics --

6 **A.** I understand.

7 **Q.** -- rest assured.

8 Did you know that it was voluntary at the time of
9 events --

10 **A.** Yes.

11 **Q.** -- unfurling?

12 **A.** Yes.

13 **Q.** Did you yourself ever make clear to Dr Jayaram
14 or Dr Brearey that it was voluntary and they did not
15 have to mediate with Letby if they didn't want to?

16 **A.** I believe I did on 15 March 2017. I am --
17 I am sure I did with Steve -- sorry, with Dr Brearey.
18 But I definitely did with Dr Jayaram on 15 March.

19 **Q.** In terms of grievances generally within the
20 Trust, was it the case that the HR team supported those
21 hearing the decision, so in this case it was

22 Annette Weatherley, we will come to the detail later,
23 but we know Dee Appleton-Cairns was supporting her.

24 What was your understanding that HR would do,
25 produce written materials for the hearing manager?

15

1 **A.** I think if you look at all of the
2 conversations, the meetings that were had, everything
3 was documented, everything was detailed within going
4 through to the Executive Team. So I can see why it,
5 it's perceived that we didn't choose to use this policy.
6 But that was not the case, it was considered under this
7 policy.

8 **Q.** To follow --

9 **A.** Absolutely.

10 **Q.** To follow the policy?

11 **A.** It was considered under this policy and
12 without doubt.

13 **Q.** The grievance policy, if we can go to that
14 please, INQ0002879, page 99. The purpose is set out on
15 that page:

16 "The Trust acknowledges from time to time a member
17 of staff may feel aggrieved by an incident."

18 If we go over the page, "Mediation", to page 2.
19 Mediation set out there is a voluntary process, isn't
20 it?

21 **A.** Mm-hm.

22 **Q.** At any time, did Mr Harvey or Mr Chambers ask
23 you to confirm whether it was a voluntary process or
24 not; in other words you couldn't compel a member of
25 staff to undertake mediation?

14

1 **A.** So I think if -- correct me if I am wrong, are
2 there two questions there as well? So what's typically
3 the process from a HR perspective and then what, what
4 they would actually do. So I think if both within my
5 time at the Countess and at Liverpool Heart and Chest,
6 the HR team were there to support and I suppose make
7 sure that the process happened in as ACAS guidelines are
8 in a full and fair way.

9 **Q.** In a fair way?

10 **A.** In a full and fair way.

11 **Q.** Right.

12 **A.** That is the guidance from ACAS as well. And
13 I think as a large employer as the Countess was, and as
14 the NHS is, we always have to comply with ACAS
15 guidelines as well, or should always try to do.

16 So I think the role of the -- my team, as it was
17 then, would firstly be to be supporting the
18 investigating lead, the investigating officer, and
19 ensure that those -- those meetings took place
20 appropriately and that members of the staff who were
21 involved in any grievance were also supported as part of
22 that. And then there would be, as is the same for
23 a disciplinary process, you know, HR members of the team
24 are supporting the person who is the grievance hearing
25 manager as well to ensure that the process is followed

16

1 as per policy and if there are any queries that need to
2 be taken forward there is access to legal advice as
3 well.

4 **Q.** So full and fair. What does that look like
5 for a grievance process, a full and fair process?

6 **A.** That the process is responded to in a timely
7 manner, that there's an opportunity for informal and
8 formal proceedings to take place if necessary and that
9 there is a way in which all parties' thoughts can be
10 considered.

11 **Q.** Should people attending for an interview know
12 what it is that they are supposed to have said or done
13 before they attend a grievance interview or not?

14 **A.** Not necessarily. Not necessarily. You know
15 there -- they potentially would be given some insight
16 but there will be other aspects that come up as part of
17 that interview that they may not be aware of. But
18 I think it's important to remember that every member of
19 staff that goes into that kind of situation is afforded
20 the opportunity to have either an employed
21 representative from the Trust supporting them or
22 a Union-based representative as well.

23 **Q.** The Inquiry has obtained expert evidence on
24 the subject of grievances, have you seen that --

25 **A.** I have yes.

17

1 to consider the approach to it and it's, you know,
2 I have reflected around the grievance process an awful
3 lot, particularly because I think, you know, there
4 are -- there are elements where it impacted on so many
5 people.

6 I think, you know, if -- if there was
7 an opportunity to have not undertaken the grievance
8 process, then I would have sought that.

9 **Q.** I am not asking about that yet, I was asking
10 you generally.

11 So you have had experience in the NHS as a Director
12 of People and you are familiar with that. It was your
13 practical experience within the Trust, you know people
14 sometimes do that; raise a grievance because concerns
15 have been raised about their ability or what? In what
16 kind of circumstances? You don't need to give me
17 specific cases but in response to what?

18 **A.** Yes, I have seen that, I have seen that.

19 But I think, you know, the key part is that there
20 were concerns that Letby raised which were not about the
21 care; they were about a number of other different
22 aspects.

23 **Q.** We will come to that.

24 I appreciate they were about the Execs's
25 decision-making actually, weren't they?

19

1 **Q.** -- from Professor Bowers?

2 Do you recognise or have any experiences of
3 grievances being used as a defensive manoeuvre? Did you
4 understand what was being described there as a defensive
5 manoeuvre?

6 **A.** Is it possible to bring up the -- is that
7 stated in the report as well, the Bowers report, that
8 point or ...

9 **Q.** Yes, this is the second statement you may have
10 not seen that but it is --

11 **A.** No, I haven't seen that. Is that possible to
12 bring up at all.

13 **Q.** No, it's not possible.

14 **A.** No.

15 **Q.** I am asking you about defensive manoeuvres.
16 Have you ever known about a grievance being used where
17 somebody's being criticised or concerns have been raised
18 about them and in consequence they raise a grievance,
19 it's a defence really, it is taking the focus off the
20 concerns made about them and raise a grievance. Have
21 you come across that in your HR experience in the NHS?

22 **A.** I have sadly, yes.

23 **Q.** So it's something you would recognise or --

24 **A.** Yes, I would, but I think, you know, the
25 difficulty is that when you receive a grievance you have

18

1 **A.** Without doubt, yes.

2 **Q.** Let's deal with that later and focus now on
3 your knowledge -- the policy can come down, thank you --
4 before 30 June of events because it's not clear when,
5 for example, you first saw the Thematic Review by
6 Dr Brearey which you will have seen later where there's
7 attached to it --

8 **A.** Yes.

9 **Q.** -- staff rotas and Lucy Letby highlighted
10 around various events that the doctors couldn't
11 medically explain.

12 When did you see that? Can you remember now
13 roughly?

14 **A.** I think it was after the 30 June meeting.

15 Definitely. You know, the -- the key points that I --
16 I suppose started to get and, you know, I recall about
17 this now because of the documentation, the key points
18 where this was raised was first was QSPEC, I think it
19 was on 15 December 2015, where Julie Fogarty brought --

20 **Q.** The Bringham review about obstetric deaths and
21 neonatal deaths?

22 **A.** Yes. I don't recall it being the Bringham
23 review, but if that is what it was called, that's
24 helpful to know.

25 And, you know, going back to that particular QSPEC

20

1 meeting, it -- it didn't raise any red flags with me.
 2 There were other elements on that agenda where I --
 3 I raised different things. But there was nothing in
 4 there that raised any red flags, you know, that -- there
 5 was I think reference to further review, there was
 6 reference to external review of or external panel member
 7 as well, looking at it.

8 But myself and no one else, and there was clinical
 9 representatives in the QSPEC meeting there,
 10 David Semple, Martin Sedgwick and others who are
 11 clinically qualified, I am not, no one raised any
 12 concerns at that stage.

13 I think the next point was a point around about May
 14 I think it may have been about 5 May 2016 within an Exec
 15 meeting where there was reference to STEIS being raised
 16 which is obviously -- again, apologies, because I am
 17 not -- this didn't come under my remit, but it would be
 18 around that raising of that -- that risk.

19 So did I triangulate those points at that time?
 20 No. But then certainly I think it was on 27 June 2016
 21 where there was a note in my book which was after -- it
 22 was during a series of meetings that I had had on that
 23 day, where some of those concerns came to light and then
 24 particularly the point I recall is 30 June meeting.

25 **Q.** So let's go to the 30 June meeting because you
 21

1 **A.** Mm-hm.

2 **Q.** -- and in the afternoon, which we are going to
 3 go to in a moment, and before we do, do you think it
 4 would have been helpful to retain a medical input from
 5 one of those Consultants in the other meetings when they
 6 weren't there?

7 **A.** I think that Dr Harvey, Mr Harvey, though, was
 8 representing those views to the Executive Team. He was
 9 the -- you know, he was the Medical Director leading the
 10 medical portfolio really as well. So ...

11 **Q.** So his presence would have reassured you that
 12 you had medical input?

13 **A.** Yes.

14 **Q.** Can we go then, please, to INQ0015639,
 15 page 51.

16 These are your notes so you will be able to read
 17 them more quickly than the rest of us and this is
 18 a meeting at 10.05 am. It looks as though there was
 19 a clinical meeting this morning, you refer to that.

20 Can you tell us on the right-hand side where the
 21 brackets are what your notes say and refresh your memory
 22 of what was being said?

23 **A.** It's difficult to read it like this because
 24 it's not as clear as it is on relativity as well, even
 25 though it is my own handwriting.

23

1 have many meetings that day, don't you, it is about
 2 five, I am not going to take you to all of them.
 3 Sometimes the Execs meet early in the day, 9 until 10 --

4 **A.** Yes.

5 **Q.** -- then 1 until 2 and sometimes you are
 6 meeting with the Consultants as well.

7 Looking back, do you think it would have been more
 8 helpful if the Execs had continued to have at least one
 9 Consultant in all their meetings that they were
 10 discussing these matters?

11 **A.** I think that is a really good question,
 12 actually. No, I don't think it should have been one
 13 Consultant. I think it -- you know, there were
 14 different views coming from others, obviously Dr Brearey
 15 was the clinical lead, Dr Jayaram was involved.

16 Apologies whether it was Mr McCormack or
 17 Dr McCormack I can't remember but --

18 **Q.** I don't mean at the one meeting when they were
 19 all present but I mean the other ones in the day where
 20 you might not have been able to get everyone together
 21 but just to retain a medical perspective in all of the
 22 other meetings?

23 **A.** Sorry, if you could clarify the question that
 24 you are asking me?

25 **Q.** You had meetings in the morning --
 22

1 **Q.** It says:

2 "Agree review, don't go to police. Conditions on
 3 this review within two weeks."

4 So it looks like they are discussing doing another
 5 review within two weeks, that is a condition?

6 **A.** Yes.

7 **Q.** "Significant condition. Nurse removed from
 8 unit. Excluded from Trust. Non-patient contact area or
 9 call police. Nurse is aware, nurse is under OH."

10 Is that Occupational Health?

11 **A.** Occupational Health, yes.

12 **Q.** "Not aware of suspicions ... IH concerned
 13 around safety of unit, not able to function a separate
 14 level."

15 **A.** And then SCBU unit I think that stands for as
 16 well.

17 **Q.** And then if we go to the next page:
 18 "Nurse -- leave and pull evidence together."
 19 What have you said there?

20 **A.** I think the -- I don't know what the "leave"
 21 stands for. "Pull evidence together" would have been
 22 information around the nurse particularly I would
 23 imagine in terms of her personnel file, looking at
 24 the -- the aspects of any -- any information that we had
 25 around her particularly.

24

1 Q. So you didn't know much and then you are
 2 coming into these meetings on this day, when you are
 3 hearing all of this, what are you making of all of that?
 4 A. As you can imagine, very concerned. Yes, very
 5 concerned. I can't recall, apologies.
 6 Q. What --
 7 A. I can't recall if this was before the meeting
 8 that I was involved with the Consultants or afterwards
 9 on that day. But yes, very concerned.
 10 Q. If we go to page 53, over the page, this is
 11 your notebook. This was an earlier meeting on that day.
 12 Can you see where it says halfway down with an
 13 asterisk:
 14 "Eirian under significant pressure, very
 15 emotional."
 16 A. Apologies, I can't.
 17 Q. There we are, it's been highlighted for you.
 18 A. Thank you. Yes, okay.
 19 Q. "Feels spoken to today."
 20 So Eirian was in a meeting with you and you record
 21 that. What was she very emotional about?
 22 A. I don't know whether she was actually at that
 23 meeting. If I look at the representatives at the top,
 24 Alison, Ian, Dee, Sian, Gill Galt, Julie Fogarty,
 25 Karen Rees.

25

1 comment.
 2 Q. So it looks as though she is in the hospital
 3 on the 30th and then as you were expecting by the
 4 meeting notes for her to go on to annual leave.
 5 If we go on to the next page, Mr Chambers:
 6 "Can we decide what we are doing?"
 7 "Demands" is put there; do we know what that means,
 8 demands?
 9 A. No, I don't -- I don't know what that means.
 10 Q. You refer to conditions that the review is
 11 done in two weeks. It looks like the Consultants have
 12 said if you are going to do a review, two weeks, and the
 13 action is for Mr Harvey to get a review done in
 14 two weeks.
 15 Then the action "staff member" next to you:
 16 "Clear articulation of Consultants' concerns to AK
 17 to formalise."
 18 The action "closure of unit" --
 19 **LADY JUSTICE THIRLWALL:** It looks as though closure
 20 of unit is the next action.
 21 **MS LANGDALE:** Yes, for Mr Harvey and Ms Kelly.
 22 So the action for you Ms Hodgkinson appears to be:
 23 "Clear articulation of Consultants' concerns to AK
 24 to formalise."
 25 A. Mm-hm.

27

1 So I would imagine that either Sian or Karen has
 2 described that but I couldn't confirm who had described
 3 that.
 4 Q. So somebody's described that to you and you
 5 have written that down?
 6 A. Yes.
 7 Q. That can go down and if we can just have
 8 please, INQ0003361, page 1. This is Mr Cross's note of
 9 the same meeting on 30 June, the one with
 10 Sir Duncan Nichol and the one that we have just gone
 11 through your notes for.
 12 If we look at "Sue", your contribution further down
 13 the page.
 14 A. Mm-hm.
 15 Q. You say:
 16 "Is this the last day?"
 17 So you are referring there to the day the last day
 18 the nurse is working, Letby being on shift on 30 June,
 19 do you remember that? You were querying?
 20 A. I don't specifically remember saying that, but
 21 if Stephen's recorded it, I can see it's there.
 22 Q. She was going on annual leave but as at the
 23 30th you are saying "is this the last day?", ie before
 24 she goes on annual leave presumably?
 25 A. I -- I presume, I can't recall that specific

26

1 Q. Do you remember that was your task at the end
 2 of that meeting?
 3 A. I don't specifically remember, no, but however
 4 -- and again I can't remember the exact sequencing on
 5 the day but I know that in the meeting that I was in
 6 where the Consultants were present, I felt then that was
 7 a clear articulation of their -- of their concerns.
 8 Q. So we can go to that meeting which did follow,
 9 it is meeting 4 of that day for you.
 10 If we go to INQ0015639, page 54. Indeed you say at
 11 paragraph 62 of your statement "this meeting was
 12 an opportunity for the Consultants to raise concerns".
 13 If we go, please, to page 55. The right-hand side.
 14 0055, at the bottom. We will find it.
 15 Can you have a look, please, next to JM on the
 16 right-hand side, Jim McCormack, and read what he has
 17 said there? If you can help us with your notes at the
 18 beginning.
 19 A. Is it the point at the bottom, apologies?
 20 Q. It's all the way down, you see "JM" on the
 21 right, all the way down?
 22 A. Thank you.
 23 Q. So starts "last thought", can you read that
 24 out for us, they are your notes?
 25 A. So the last thought in minds member of staff

28

1 responsible for deaths. External review, went through
2 stillbirth separate -- something -- death review.
3 **Q.** Non death review, is that?
4 **A.** It could be, it could be. Apologies, I was
5 writing fast.

6 Separate non-death review through the great lengths
7 what the situations were, was, first time about member
8 of staff. Last three days only going on what hearing
9 from paediatrician, nights/days change.

10 **Q.** Nights/days change, so she's changed from
11 nights to days, is that what was being said? That's
12 what happened, that makes sense, doesn't it? She's been
13 moved from nights to days and deaths have followed?

14 **A.** Yes.
15 Wholeheartedly agree with the review, take
16 two months, hasn't been raised, member of staff, not
17 sure what review will do. Service concerns, member of
18 staff, fantastic unit but concerned
19 Beverley Allitt/Shipman being raised.

20 **Q.** So Mr McCormack, Beverley Allitt/Shipman being
21 raised. What was he saying there?

22 **A.** That there were concerns that potentially
23 a member of staff was causing deliberate harm.

24 **Q.** Is killing babies. I mean, Shipman and Allitt
25 murdered, didn't they?

29

1 perfect.

2 **Q.** Let's focus on page 58 and what Dr Jayaram
3 said as well in your notes. At the bottom would you
4 like to read out what you have noted around "air
5 embolism"?

6 **A.** Is it the paragraph right at the bottom on
7 the --

8 **Q.** Yes.

9 **A.** Thank you.

10 Air embolism, what concern member of staff having
11 babies, nothing to explain. Entirely -- I think that's
12 entirely -- resuscitated, reasons happened 1, 2, not
13 this many times. All collapses identify early, core
14 suspicion seems to be receiving there and what happens.
15 This is the concern.

16 Apologies.

17 **Q.** So he is setting out his concern, very
18 clearly, that the babies have collapsed, the
19 resuscitation measures we know he frequently points out
20 aren't as you would expect in a naturally collapsing
21 baby; is that what he was saying there?

22 **A.** I -- I from a non-clinical perspective,
23 he's -- he's raising elements of concern there.

24 **Q.** Air embolism. What did you understand from
25 that, what he said about air embolism?

31

1 **A.** Yes, they did.

2 **Q.** He has put it right there that this is
3 a fantastic unit but there are serious concerns about
4 Beverley Allitt/Shipman being raised?

5 **A.** He did say that, I have recorded it in my
6 notes.

7 **Q.** What impact did that have on you when he said
8 that?

9 **A.** Again, you know, knowing -- knowing the Trust
10 from a personal perspective and also a professional
11 basis as well, yes, it really worried me.

12 **Q.** Well, two babies had just died, one after the
13 other in circumstances where a nurse had been moved from
14 nights -- because deaths were happening, medically
15 unexplained deaths -- to the day?

16 **A.** Mm-hm.

17 **Q.** That's just happened. Where did your first
18 thoughts go?

19 **A.** At that point in the meeting, obviously to --
20 to potentially, you know, there was deliberate harm
21 being caused here. However, as you go through the
22 meeting there were other aspects that were raised
23 that -- that put a different -- put a different view
24 particularly -- I can't remember which page it is on,
25 but, as I say, Dr Brearey saying that the care wasn't

30

1 **A.** I don't know what that actually -- I didn't
2 know at the time what that means.

3 **Q.** You didn't ask, you didn't say: what do you
4 mean, air embolism?

5 **A.** Not within the meeting, no, because it was
6 happening so fast and it was --

7 **Q.** When did you ask about that?

8 **A.** I can't recall specifically but if there are
9 any things that I was concerned about, I would ask one
10 of my clinical colleagues so -- around it and they would
11 know what that means.

12 **Q.** Who did you ask?

13 **A.** I -- I think we had a general discussion
14 afterwards, whether it's noted or not but I -- I would
15 have definitely asked about it.

16 **Q.** And did someone tell you that is a method of
17 attack he is referring to air embolism as a deliberate
18 way --

19 **A.** Not that I recall.

20 **Q.** -- of killing babies?

21 **A.** Not that I recall, no. No, not that I recall.

22 **Q.** But you knew without clinical training what
23 the reference to Shipman and Allitt meant: murderers?

24 **A.** Yes. However, I think it's clear from the
25 notes in that meeting that there were different elements

32

1 that were coming up. In addition, whilst I know that
2 this was very much a Consultant meeting, there were
3 other aspects of information that were presented in
4 separate discussions which was a view from the nursing
5 side as well or nursing staff as well, should I say.

6 **Q.** Let's go through this meeting, 54. We will
7 scroll gently through it and don't feel rushed,
8 Ms Hodgkinson, you were having a meeting with the
9 Consultants and do stop us where we hit a suggestion
10 that there was care or concerns that something else was
11 causing death, unexpected deaths of babies. So take
12 your time. It's your writing, so it's probably a bit
13 easier for you than others but we will go slowly?

14 **A.** Yes.
15 (Pause) Apologies I was still reading through.

16 (Pause)
17 I mean, I think it's very evident in the -- the
18 notes that it was a very open meeting.

19 I do --

20 **Q.** When you say "open" do you mean they were able
21 to express --

22 **A.** Yes.

23 **Q.** -- they thought there was a murderer?

24 **A.** Not just that but other aspects as well. You
25 know, I think it's not on that page that I can see.

33

1 was also being provided.

2 **Q.** I have asked you to look at these meeting
3 notes to identify in this very meeting --

4 **A.** Yes.

5 **Q.** -- who -- was Dr Brearey?

6 **A.** Yes, apologies, Dr Brearey did say that. I am
7 just trying find where that is because it is definitely
8 in there.

9 **Q.** What, that the concern was that the care was
10 not perfect?

11 **A.** Yes.

12 **Q.** That doesn't mean that unexplained, unexpected
13 deaths were explained by that, did it, if he said that?

14 **A.** No, but it does mean that there are other
15 factors that we need to consider.

16 **Q.** How were you going to consider other factors?
17 Somebody says "I think there's a murderer and I can't
18 explain these deaths", how were you possibly going to
19 understand what the medical factors were?

20 **A.** I am -- I am reliant on other members of -- of
21 the teams to explain those clinical factors to me.

22 Obviously this was, you know, a very experienced,
23 very talented and very well-respected group of
24 individuals who were raising these concerns. But I --

25 I am dependent on others from a clinical perspective to

35

1 **LADY JUSTICE THIRLWALL:** Do you want to go back to
2 the previous page?

3 **A.** If you wouldn't mind.

4 **LADY JUSTICE THIRLWALL:** 59, please.

5 **MS LANGDALE:** The previous one, 59, begins at the
6 top with Mr Harvey saying "suspect", what does that say,
7 something aware?

8 **A.** "Suspect RC aware".

9 **Q.** "Beverley Allitt"

10 Who is RC?

11 **A.** I can't recall now.

12 **Q.** "Raised area of concern broadly."?

13 **LADY JUSTICE THIRLWALL:** It could be the
14 Royal College.

15 **A.** I don't think, yes, maybe not at that stage
16 because we hadn't -- I'm not sure. I mean, no I think
17 there was an open dialogue in the conversation, I think
18 it's fair to say, and these -- you know, there was no --
19 I certainly didn't feel at that stage there was no
20 downplaying of the concerns, no dismissing of the
21 concerns.

22 **MS LANGDALE:** There is no medical alternative for
23 the deaths provided, is there?

24 **A.** But there was an element of -- there was an
25 element of concern in terms of the level of care that

34

1 consider what steps I suppose need to be thought through
2 around explaining this.

3 **Q.** Did you think Mr McCormack was a sensible man?

4 **A.** I -- yes. I hadn't had much interaction with
5 Jim, but yes, I did.

6 **Q.** Let's see what he says at the bottom the page
7 we have stopped on, 59. He says:

8 "Expertise forensic investigation. Decision to
9 involve police. Difficult decision to make."

10 He's the person who says the RCPCH review can't
11 deal with the forensic review, they are not able to do
12 that. We see here Mr Cross, is "SPC" Mr Cross?

13 **A.** Yes.

14 **Q.** What's he saying there? What have you
15 recorded there?

16 **A.** This, as I recall, was Mr Cross's explanation
17 of what would happen if the police were to come in

18 **Q.** And what was that?

19 **A.** That there would -- the unit would be closed
20 and it would be classed as a crime scene, there would be
21 blue and white tape everywhere. The unit would be --
22 the unit would be sealed and I think it's -- you can see
23 the other points that I have captured there as well,
24 I specifically remember him saying that.

25 **Q.** And what does Mr Chambers say in response to

36

1 that?
 2 **A.** Proportionate response embarking on all agree
 3 problem, can't answer difficult question.
 4 I don't know what I have put there.
 5 Concern about member of staff. Test on hypotheses.
 6 Three options. Nul, substance, police called,
 7 hypothesis simply and joint view. Heading, creates
 8 witch hunt, not suggesting not up for this. Make safe
 9 for babies, consequence of member of staff.
 10 **Q.** Let's look at these three options.
 11 Are his three options nul, ie nothing in the issue,
 12 or substance in the concerns and the police called or
 13 hypothesis and joint view creates a witch hunt.
 14 What -- is he creating different options there?
 15 **A.** Apologies, could you ask the question again?
 16 **Q.** What's he saying -- what does "nul substance
 17 or hypothesis" mean? What are his three options?
 18 **A.** Nul, do nothing, it's always an option in any
 19 situation, never mind the situation.
 20 **Q.** Because you don't believe it and you're not
 21 worried about it?
 22 **A.** No --
 23 **Q.** How could you do nothing when someone is
 24 saying "I think there's a murderer", unless you didn't
 25 believe it was true.

37

1 **Q.** And you had senior and respected Consultants
 2 there, didn't you?
 3 **A.** Yes.
 4 **Q.** Dr Jayaram and Dr Brearey?
 5 **A.** Yes.
 6 **Q.** Just to be clear, at no time did you doubt
 7 their expertise or motives for raising concerns, did
 8 you?
 9 **A.** No.
 10 **Q.** You say that very clearly in your statement.
 11 Perhaps you would like to express it in your own
 12 words what do you think motivated them to raise these
 13 concerns?
 14 **A.** That they couldn't answer what was happening.
 15 **Q.** They genuinely were concerned that she was
 16 causing deliberate harm?
 17 **A.** That she was present on a number of the shifts
 18 and they -- they couldn't answer what was happening.
 19 **Q.** That is not my question. You know that is not
 20 my question.
 21 Did you accept that their concern, she was
 22 genuinely murdering babies?
 23 **A.** They had genuine concerns that Letby had --
 24 may not have provided the care -- you know, that's --
 25 I think there is so much more that we know now but at

39

1 **A.** I know but in -- in any situation in life
 2 there's always a do nothing option. So I think Tony
 3 meant it like that. You would have to ask Tony
 4 specifically but I think Tony meant it like that, not to
 5 dismiss it.
 6 The substance being that the police are called or
 7 that there's, you know, a hypothesis, a range of -- of
 8 other, other considerations.
 9 **Q.** Right. What are the range of other
 10 considerations, where is he going there now he's
 11 speaking about a witch hunt?
 12 **A.** Again, I can't remember specifically what he
 13 what he's referring to there or what was said. I have
 14 captured the notes as you know as he described it to the
 15 best of my ability. I can only imagine it's -- you know
 16 are there other elements which are causing these deaths
 17 to happen.
 18 The -- it's important the Inquiry, and I am sure
 19 you know this as well from all of the different
 20 reference points and I am not clinical, but I know that
 21 in a neonatal babies are the most vulnerable patients
 22 that a hospital can have and also the most complex type
 23 of care and there are -- it's really difficult as well
 24 to provide that care and I think many hospitals struggle
 25 as well.

38

1 that time, there was genuine concerns around the care.
 2 **Q.** Please answer this yes or no. Do you accept
 3 that Dr Brearey and Dr Jayaram were genuinely concerned
 4 that Letby was murdering, deliberate harming babies?
 5 Yes or no?
 6 **A.** They were genuinely concerned.
 7 **Q.** So it's a yes, you accept that was their level
 8 of concern?
 9 **A.** They were genuinely concerned. They -- I can
 10 see that the way that this is written, you know, and the
 11 conversation but there were many other factors playing
 12 into this as well.
 13 **Q.** This meeting, you tell us you didn't know very
 14 much about what was going on on the unit?
 15 **A.** Mm-hm.
 16 **Q.** And that the meeting notes referring to
 17 Dr Fogarty were quite obtuse on the point of neonatal
 18 deaths. Accepting that point for a moment, you come
 19 into this and you are being told by these Consultants
 20 what they are worried about and what they think is
 21 happening or may be happening.
 22 **A.** Mmm.
 23 **Q.** What's difficult from your perspective in
 24 terms of what you do next when you hear serious minded,
 25 experienced paediatricians saying that? Why was this

40

1 difficult?

2 **A.** Why was which point difficult?

3 **Q.** Why was it difficult for you to see what they
4 were saying and to know what to do next as an HR person?

5 **A.** Well, it was difficult as a mum hearing some
6 of that as well, without doubt.

7 **Q.** What, because you worried very much for the
8 babies who had died because you have got one and you
9 worry about those that might die continually?

10 **A.** You know, and for anyone who goes through
11 a situation like that.

12 So I suppose there's that personal aspect and
13 I can't apologise for that, that's me.

14 **Q.** So are you saying that took you to baby safety
15 because you felt like that; that took you to protecting
16 babies quickly?

17 **A.** Apologies, can I just go back because I will
18 lose my train of thought, if that's okay.

19 I think, you know, it goes without saying that
20 really concerned me and I think the first thing
21 I thought was: where is -- we need to look at which this
22 member of staff is on the unit and is she continuing
23 providing patient care?

24 **Q.** As the meeting was happening, she was on the
25 unit and you had flagged that up, hadn't you?

41

1 But I had to go on the assurance that I was being
2 given from the nursing team as well.

3 **Q.** Let's go to page 60. Halfway down on the
4 left-hand side:

5 "Mr Chambers feels personal. Need to be safe, kind
6 and effective."

7 What was that about? See above, you have put.

8 "Dr Brearey made feeling clear. Mr Chambers feels
9 personal. Need to be safe, kind and effective"?

10 **A.** I mean the phrase "safe, kind and effective"
11 was in the relation to the Trust values. I don't know
12 what the point "feels personal" relates to.

13 **Q.** Well, there is reference to a witch hunt,
14 isn't there, and now "feels personal".

15 What do you think that was about, who was being
16 thought about in those comments?

17 **A.** I -- I don't know whether that's related to
18 Letby or -- I don't know.

19 **Q.** Seems like it, doesn't it?

20 **A.** I -- I can see how that's read and how that
21 comes across but I don't -- I don't know in terms of,
22 you know, how he actually meant that.

23 **Q.** We know when Mrs Appleton-Cairns met with
24 Ms Weatherley before she was conducting the grievance
25 they both spoke of a witch hunt and Mrs Appleton-Cairns

43

1 **A.** I -- I see that now. I think everything was
2 happening so quickly on that day. If -- but she was
3 I had had assurance from the nursing team that they were
4 satisfied at that point that that was, that was the case
5 and then she was going -- she was going to be going on
6 leave and she never returned back to the unit after that
7 stage.

8 **Q.** You are head of HR and the nurses we know were
9 very friendly, lacking in objectivity when they were
10 dealing with Letby. You come to this meeting, you don't
11 know anything about the situation, you tell us, and you
12 just tell us your first thoughts are as a mum and
13 thinking about the babies.

14 Did you not want to go out of the room and say:
15 where is she, should we make sure she is not in this
16 hospital at this moment, on the unit?

17 **A.** I can see that now.

18 **Q.** Didn't you see it then, from what you have
19 told us? It is not about what you say retrospectively.

20 **A.** I can see it now. However, I think there was
21 you are trying to have a balance, a view of all of the
22 different information and taking all of that information
23 into account and I -- you know, I didn't know then that
24 there was, there was, you know, the support around the
25 nurses and -- and the view of Letby as it was.

42

1 said: yes, we think it's a witch hunt, it's sad, or
2 something similar. So a witch hunt was something as you
3 know which was used by your deputy certainly moving
4 through events, wasn't it?

5 **A.** (Nods)

6 **Q.** So it's very likely that's what this referred
7 to here, isn't it?

8 **A.** It -- it could be but, I can't, I can't be
9 certain.

10 **Q.** Do you not remember now that the view of your
11 deputy was that there was a witch hunt in respect of
12 Letby?

13 **A.** So again there's two different things, what we
14 are talking about in this meeting and -- and
15 Dee Appleton-Cairns as well.

16 **Q.** It is the same thing, isn't it, it is witch
17 hunt so we are talking about that?

18 **A.** I can see how you -- you are saying it is the
19 same thing.

20 **Q.** Yes.

21 **A.** I think in terms of this meeting I don't know
22 how -- what Tony was specifically referring to, I can
23 definitely see that he's referring to our Trust values.
24 In terms of Dee saying that, I can see that from -- from
25 the statement and obviously her transcript as well.

44

1 Q. Did you share her view?
 2 A. At times, possibly. But at other times, no.
 3 Q. Can we go to page 62. This is a follow-up
 4 meeting at 4.35 on the 30th and you are all being
 5 allocated -- the Execs meet again, you allocate various
 6 tasks. It looks as though security is something that
 7 you are looking at. If we look on the left-hand side,
 8 bottom:
 9 "Internal only security"?
 10 A. Mm-hm.
 11 Q. We know if we can have, please, on the screen
 12 INQ0004888, page 1, you in fact liaise with Tim Lister?
 13 A. Yes.
 14 Q. You conduct a security review sending it to
 15 colleagues on this list --
 16 A. Yes.
 17 Q. -- with a view to enhancing the security of
 18 the unit, making recommendations. If we go to page 8 of
 19 a different document, actually INQ0014135, page 8.
 20 A. Excuse me.
 21 Q. We see at bullet point 9:
 22 "CCTV to cover patient intensive care rooms."
 23 A. Yes, I see that, thank you.
 24 Q. Mr Lister has sent you that quote earlier.
 25 So you are at the point -- we can take that down,
 45

1 we were taking the concerns really seriously, but also
 2 we wanted to make sure that we were looking at
 3 everything from all sides, all angles.
 4 Q. What was the reason for cameras in the
 5 intensive care unit at the NNU?
 6 A. I think to provide that extra level of
 7 assurance.
 8 Q. Against what?
 9 A. I suppose whether it be from a competence
 10 perspective, whether it be from a general care
 11 perspective or whether it be from a deliberate harm for
 12 anyone perspective. So I think it was that extra level
 13 of assurance.
 14 Q. Did you intend to tell people they were being
 15 filmed?
 16 A. Absolutely we would have done, yes.
 17 Q. You say "we would have done" --
 18 A. Apologies -- it is a duty for us to do that as
 19 well.
 20 Q. Your communication generally as HR wasn't the
 21 most transparent throughout these events, was it, with
 22 Lucy Letby herself first of all?
 23 A. I think that's -- that's seen from the
 24 grievance outcome as well.
 25 Q. So when you say we would have done, did you do
 47

1 thank you -- where the intention was to have CCTV and
 2 access control systems installed on the NNU to improve
 3 security?
 4 A. Mmm mm.
 5 Q. Did that happen?
 6 A. I think first thing to note is that this
 7 didn't come under my portfolio at all.
 8 Q. No.
 9 A. So I am not -- that's not an excuse. I think
 10 it was just that I was taking an action to -- to look at
 11 it at that time. I recall that it didn't happen.
 12 I think there was something in relation to funding,
 13 unfortunately. But it was then -- I can't remember
 14 whether it was Mark Brandreth whether it came under
 15 because I think he was the Chief Operating Officer at
 16 the time, but I know that the CCTV wasn't installed.
 17 Q. Did you feel that was an investigative task?
 18 Putting CCTV up to see what was going on, given the
 19 meeting you had just had, what did you make of the
 20 request that you should even look for this?
 21 A. I don't -- it -- I think at that time you --
 22 we were just working through and trying to put in as
 23 many measures as possible really as well and --
 24 Q. Many measures for what?
 25 A. Just to assure the teams. Obviously you know,
 46

1 that you are talking to Mr Lister, just go and have an
 2 open consultation with people and say we need to film
 3 what's going on in here, in the NNU; did you say
 4 anything to him?
 5 A. Again this was not under my portfolio, so
 6 I was looking at something which was, you know, it was
 7 an action that we had agreed at the time but not to --
 8 this is not an excuse. It's -- it's -- this was an area
 9 where I think it was Mark Brandreth who was the Chief
 10 Operating Officer would then take forward with and
 11 I recall that the quote came in, that definitely went to
 12 Debbie O'Neill as the Chief Finance Officer.
 13 But I don't know what necessarily happened with it
 14 then but I know that the CCTV was not put in.
 15 Q. A different topic. You are asked by Ms Kelly
 16 I think to listen to a conversation she has with
 17 a Tony Newman, if we can go to your note INQ0015639,
 18 page 72. This is Ms Kelly's professional body, so it is
 19 the NMC.
 20 While we are finding that, what did Ms Kelly ask
 21 you to be on the call for, do you know?
 22 A. I think just to hear the advice from an NMC
 23 perspective as well. I was taking a back -- almost like
 24 a back seat on the call, you know, I didn't really
 25 contribute as such. That's Alison's professional body.
 48

1 But it was also, you know, if there were any,
2 subsequent actions that I may need to put in place from
3 that discussion as well.

4 **Q.** What did you understand she was seeking advice
5 about?

6 **A.** I think whether there needed to be a potential
7 referral. Obviously explaining the situation in
8 relation to Letby and I think seeking external advice
9 from the nurse professional body as well.

10 **Q.** What do your bullet points at the end say?

11 **A.** The three bullet points at the end?

12 **Q.** Yes, what's the conclusion of the meeting?

13 **A.** Okay, thank you.

14 Make notes and advise to refer; full investigation
15 interim order; police don't proceed criminal charges,
16 still work on organisational basis.

17 So I think those are, you know, the potential three
18 options.

19 **Q.** What did you understand by the last one:
20 police don't proceed with criminal charges, still work
21 on organisation?

22 **A.** So if, if ... if there was no potential
23 criminal charges she could continue working on an
24 organisational basis. It's difficult to recall exactly
25 the discussion from eight years ago.

49

1 Consultants think this is an Allitt/Shipman situation,
2 as had been expressed on 30 June?

3 **A.** I don't recall that specific phrase being used
4 but I did -- I do believe that we did say that
5 Consultants had significant concerns.

6 **Q.** He emails Ms Kelly cc'ing you, if that comes
7 down please. INQ0003607, page 2, and while we are
8 finding it, Ms Hodgkinson, it has amends on it, yellow
9 boxes and amends and it looks from the email chain that
10 Ms Kelly has made some corrections or amendments to
11 confirm the note?

12 **A.** (Nods)

13 **Q.** We see this is the agreed note which he's
14 happy to accept of a summary of the conversation. Can
15 you just have a read of that, please.

16 The first point: Trust has seen a rise in mortality
17 of babies. Was it expressed to Mr Newman that these
18 were babies that were stable and were not expected to
19 collapse and did not respond on resuscitation as you
20 would expect them to?

21 **A.** I -- I can't say for definite whether that was
22 explained. Again you would have to raise that with
23 Ms Kelly.

24 **Q.** Each death has been the subject of a clinical
25 team case review.

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1 **Q.** Would you like to go to your statement it
2 might help. It is paragraphs 73, 74, 75. You say as
3 you just said now at paragraph 75 --

4 **A.** Thank you.

5 **Q.** "... cannot specifically recall this aspect of
6 the discussion but think it could be interpreted as
7 Tony Newman advising that in the event Letby were to be
8 investigated by the Police and that investigation did
9 not lead to any criminal charges then she could continue
10 to work at the Trust"?

11 **A.** Mm-hm yes.

12 **Q.** And you say at paragraph 73:

13 "... we discussed the potential referral of Letby
14 to the NMC and what would likely happen in the event of
15 a referral, including the likely imposition of an
16 interim order during any investigation [and] we
17 discussed the various options on NMC referral and Tony
18 Newman requested [her] PIN number which I have noted
19 down as an action to follow up ..."

20 **A.** Mm-hm.

21 **Q.** What was the information Mr Newman was given
22 during this call about the suspicions or concerns?

23 **A.** What was what, sorry?

24 **Q.** What information was Mr Newman given about
25 suspicions and concerns? Did you, for example, say: the

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1 What did you understand that was?

2 **A.** I -- knowing, knowing obviously more from the
3 27 June onwards the Thematic Review, the elements around
4 the Thematic Review.

5 **Q.** Was he sent the Thematic Review with the table
6 with Letby's name highlighted?

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

8 **Q.** You say:

9 "The review has produced no evidence as to lack of
10 confidence by individuals or the team."

11 Did in the conversation you point out to Mr Newman
12 that was the point; there wasn't a lack of competency
13 this was deliberate harm being caused?

14 **A.** I -- I would love to say I can definitely say.
15 I can't say whether that was raised or not.

16 **Q.** And you say:

17 "The Registrant has received occupational support.
18 Some clinicians are concerned that the Registrant may
19 present a serious risk to public safety, although no
20 evidence is available at this time."

21 No evidence is available at this time. Was that
22 a fair summary of what he had been told?

23 **A.** I think when you look at it now, with
24 everything that we know, no.

25 However, I think with -- with all of the different

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1 information points coming in at that time, it was a fair
2 summary.

3 **Q.** There was an omission, wasn't there, of
4 important information you had heard at the meeting on
5 30 June and it would have been much easier just to say
6 what you heard on 30 June rather than try and filter it
7 in any way from your perspective, wouldn't it? Just to
8 go and say: this is what they think, they didn't expect
9 these deaths, they are unexpected, they can't medically
10 explain them. They think there is an Allitt/Shipman
11 situation?

12 **A.** I don't think there was a filtering, I really
13 don't, I don't think Alison was trying to filter or
14 myself, at all. I think, you know, this -- this kind of
15 situation is something that you never ever, ever plan to
16 experience, hope to experience and there's not really,
17 you know, a huge amount -- whilst there is policies and
18 things, there's not a great deal of guidance there. And
19 I can categorically say there was no, there was no
20 filtering. There was no misleading or anything like
21 that in this conversation.

22 **Q.** If you go to, please, the next document,
23 INQ0002964, page 1, this is a follow-up letter from
24 Ms Kelly which you are cc'd into on 31 August:

25 "As previously mentioned we undertook a thorough
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1 police", it is the second paragraph of that letter?

2 **A.** Yes.

3 **Q.** Did you think that was correct?

4 **A.** At that time, there were -- there were
5 collective discussions, not only with myself and the
6 rest of the Executive Team, also other, the Chair, the
7 Non-Executive Directors as well and that, that was the
8 position at that time.

9 **Q.** Why didn't you say the Consultants think
10 there's an Allitt/Shipman situation, what was the
11 problem with just repeating that? You say there was no
12 intention to filter. But it's a serious omission, isn't
13 it, and it seems the most obvious thing to say if you
14 are imparting their concerns?

15 **A.** That would be -- I was taking more of
16 a back -- back seat role in this conversation because it
17 isn't my professional body, so it would be a question to
18 ask Ms Kelly that one.

19 **Q.** But it would be for you, wouldn't it, when she
20 got off the phone to say something to her, as head of HR
21 and a fellow Exec: look, Alison, I think you have
22 understated that, this is what they said in the meeting,
23 it's really serious?

24 **A.** I think it goes without saying that Alison and
25 I -- and it's very clear from my notes, from my

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1 internal review."

2 You understand that to be the Thematic Review; yes?

3 **A.** (Nods)

4 **Q.** "Nothing of significance was identified within
5 this. Following discussions with our board and on
6 receiving views from our clinicians, the step was taken
7 to place Letby on non-clinical duties. She agreed to
8 this. There has been no indication to discuss this
9 matter with the police at this time."

10 Were you comfortable, again, with the expression:
11 there's been no indication to discuss this matter with
12 the police?

13 **A.** So I think -- I think -- if I may just before
14 I answer that question, I think the "thorough internal
15 review" also refers to the aspects around the Silver
16 Control, Silver Command aspect. Also Ian Harvey did
17 a further review as well around the cases.

18 **Q.** Sian Williams, when she did her bit of work
19 around that, said she concluded as soon as she had done
20 her bit they should go to the police and that she shared
21 that view. Did she share it with you?

22 **A.** I don't recall her saying that to me, no,
23 I don't. Apologies, what was the other question as
24 well?

25 **Q.** "No indication to discuss this matter with the
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1 statement, there was multiple times we would sense-check
2 around how we were both interpreting the situation and
3 whether we needed to do things differently as well.

4 **Q.** She didn't believe the concerns could be true,
5 did she, Ms Kelly, she didn't believe them?

6 **A.** She -- she was trying to take everything into
7 account.

8 **Q.** Is the answer yes or no? Did she believe that
9 Letby could have done these things and the concerns were
10 true?

11 **A.** I think -- I think she as the professional
12 lead for all of the nurses and midwives across the
13 organisation -- I think it would be a really difficult
14 thing to take in.

15 **Q.** Eirian Powell and Karen Rees have both been
16 very clear at the time that they couldn't believe that,
17 unthinkable to them, both accept they lacked objectivity
18 and particularly for Karen Rees and we will come to the
19 weekly meetings she was required to have, she got far
20 too close to Letby?

21 **A.** Mmm.

22 **Q.** So that's their position. What's yours --
23 Ms Kelly's dealt with hers yesterday but what's yours?
24 You weren't a fellow nurse, you weren't close to her.
25 What was your reason for not accepting the concerns the
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1 paediatricians had on their face and saying: these need
2 to be investigated, and for talking about witch hunts?

3 **A.** No, it -- it is a very good question and
4 consideration as well.

5 I think I was reliant on taking into account all of
6 the other information that was being shared with me
7 from -- you know, from Mr Harvey, from other aspects in
8 relation to the Silver Control -- Silver Command piece.

9 I call it control, it's command.

10 But then I think because so much had been looked
11 into at that stage, and whilst it's not decrying the
12 Consultants concerns, there still wasn't a clear answer
13 and we had to, you know, I suppose I was trying to take
14 an objective view.

15 I think the thing that I was really, that I was
16 assured around at that stage was that the nurse was not
17 on the unit.

18 **Q.** This Silver Command stuff, it's like you were
19 doing a police investigation in the hospital without the
20 ability, talents and resources to do that, wasn't it?

21 **A.** I just --

22 **Q.** Sending people off when they should be looking
23 after patients in the day job to look at things,
24 scrutinise, you looking at CCTV, Sian Williams looking
25 at rotas that Eirian Powell has already looked at but

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1 This communication internally wasn't transparent
2 and open at all about the position, was it, the big
3 picture? What you were actually dealing with?

4 **A.** I think there is a balance around also
5 maintaining confidentiality. You just, I know you
6 described us as a small hospital, I think we like to
7 call a medium district general hospital, with those --

8 **Q.** Fair enough.

9 **A.** Yes, with those members of staff.

10 So yes, we would like to be transparent. But you
11 also have to consider confidentiality not only of first
12 and foremost patients but also staff as well.

13 **Q.** We know, the Inquiry is aware, and so were the
14 Execs, one of the Consultants was saying: I wouldn't
15 want my own baby here?

16 **A.** I know.

17 **Q.** A Consultant on the unit. So this internal
18 communication is providing false reassurance, isn't it,
19 in a number of ways and you know as Execs a Consultant
20 thinks that?

21 **A.** I can see how you see that. We -- we tried to
22 do the best, we -- this communication, we tried to do
23 the best that we felt we could at that time.

24 **Q.** There's another letter to a solicitor -- if we
25 can take those down, please -- INQ0004597. And a bit

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1 doesn't particularly like the answer?

2 **A.** I described it in my statement as a hybrid
3 exercise. I think those -- that's the phrase I have
4 used. When there's a -- you know, an incident within
5 the hospital, you would -- you know, whether it's around
6 capacity, patient capacity, flow of beds or other
7 things, potentially you would instigate, that -- that
8 kind of Silver Control/Command kind of exercise, I have
9 done it myself, to manage that and then people do
10 undertake various different roles, there is guidance
11 around that. Many organisations will be the same.

12 This was a hybrid exercise.

13 **Q.** Communications internally. There is two
14 documents I would like us to have a look at, please,
15 INQ0002677, page 1. Have a read of that one first.
16 These are messages to staff.

17 It's paragraph 3:

18 "We have seen in some of our most poorly babies
19 an increase in neonatal mortality rates."

20 If we can then look, please INQ0002822, page 1,
21 identified change in what our internal mortality data
22 information is telling us.

23 You are a small hospital, you have said you felt
24 very much a part of that hospital and you are head of
25 HR.

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1 after then, 18 July, and you have had a conversation
2 with Corinne Slingo about going to the police or not.

3 When you do get external legal advice, are you
4 asked to do that by Mr Chambers or Mr Harvey or another
5 Exec or can you independently decide to go and get that
6 advice?

7 **A.** I can independently decide.

8 **Q.** Okay.

9 **A.** Apologies. I managed the budget for that
10 particularly. There was different advice that Mr Cross
11 had from a legal perspective which was more around, say,
12 patient cases, which was in I think we had commissioned
13 a contract as such with Hill Dickinson around that but
14 from a people perspective our legal advice was
15 DAC Beachcroft and if there was any conflict of interest
16 I could always seek additional advice from there as
17 well.

18 **Q.** So Ms Slingo, if we go to the next page, has
19 given her advice and she bases it on what she sets out
20 in the bullet points at paragraph 1:

21 "The only current evidence of any clinical concern
22 is the potentially circumstantial fact that one
23 particular nurse was on shift on more occasions than
24 others at the point when neonatal deaths arose"

25 Nothing about them being unexpected and unexplained

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1 and not the ones the doctors wanted, was there?

2 **A.** I think I went into quite a lot of detail with
3 Corinne.

4 **Q.** Did you send her the Thematic Review? She
5 said she had asked for documents, she didn't get
6 documents. Any reason for not sending her the charts
7 with the association with Letby?

8 **A.** Yes. No, I know -- I know that that wasn't
9 sent. I think if I recall that I spoke to Mr Cross
10 about whether to send that or not. You know, this kind
11 of advice that I was receiving was not employment advice
12 as such. This was regulatory advice.

13 So if I recall Ian Pace, he advised me that there
14 was regulatory support within DACB Beachcroft and
15 recommended me to have a conversation with Corinne which
16 was obviously this first conversation.

17 That -- you know, that would normally I guess be
18 under the kind of remit from Mr Cross's perspective, but
19 because the offer was there from Beachcroft I took that
20 offer and --

21 **Q.** If we look at the penultimate bullet point:
22 "Currently no cause of death or thematic clinical
23 basis to suggest the deaths are connected to each other
24 or connected by common intervention".

25 That was the point of Dr Brearey's review, wasn't

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1 **A.** I must have got that from one of the Executive
2 Team, I can't say whether that was through Stephen or
3 Ian specifically but I must have received that
4 information.

5 **Q.** What was the point you were making there and
6 there were no concerns or there wasn't any issue?

7 **A.** No. It was that obviously when there is any
8 patient death of concerning circumstances there needs --
9 it needs to go to the Coroner and the Coroner would --
10 is obviously external to the Trust as well and so
11 that's -- it's important to get that additional set of
12 insight, external insight, around what was happening and
13 I think at that stage there was obviously information
14 from the Coroner, there was information from the
15 Thematic Review, there was information previously which
16 I referred to earlier from the QSPEC conversation which
17 included external, you know, panel member as part of
18 that.

19 Then there was also the information from the
20 Consultants. So there was multiple at this stage
21 aspects being presented at that time.

22 **Q.** When Ms Slingo gave evidence to the Inquiry
23 Chair, she said:

24 "If I wasn't told everything that was known then
25 that would be disappointing to find out and it appears

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1 it, the common theme was the pattern of deaths and the
2 presence of a nurse?

3 **A.** (Nods)

4 **Q.** So the bullet point at 5 is not accurate, is
5 it; far from it?

6 **A.** I can imagine the phrase "thematic" if --
7 I must have raised with her the Thematic Review.

8 **Q.** Did you phrase the fact there was a pattern
9 identified of deaths in the night and a common link of
10 a nurse?

11 **A.** I certainly said about the common link of the
12 nurse. I don't -- I cannot be certain whether I said
13 about the pattern of deaths at the night because
14 I suppose was I looking for that specific detail when
15 I was going through things? I was trying to -- I was
16 receiving I suppose that, that information from clinical
17 colleagues.

18 I knew there was problem, I had heard that directly
19 from the Consultants as I said earlier, I have described
20 that to Ms Slingo as well, I described the position in
21 terms of the Coronial system and it was a really mixed
22 picture.

23 **Q.** "Approximately 75% of the deaths have also
24 been through the Coronial system." Where did you get
25 that figure from?

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1 to be the case."

2 Let me ask you this question arising from that.
3 You were asking Ms Slingo about whether you should be
4 going to the police. Why didn't you say to her: the
5 Consultants have said this is a Beverley Allitt/Shipman
6 situation. What you had heard with your own ears
7 Mr McCormack saying in that meeting of 30 June as soon
8 as you said that to her you would have got an answer
9 wouldn't you: go to the police?

10 It's a really important point.

11 **A.** Mm-hm. I think there's two aspects to this.
12 I think I described -- and it's clear from the notes
13 that Corinne has, has helpfully provided back,
14 I described a range -- you know, the situation. Did
15 I use that phrase? I don't recall. Potentially maybe
16 I should have done but I -- it wasn't around
17 a misleading point or any aspect there.

18 In addition, you know Ms Slingo is the head of
19 healthcare regulatory, she is the most senior person
20 within DACB to advise on those matters. I had gone to
21 I had been recommended to speak with her, and I would
22 suggest potentially she should have asked me more
23 questions. But I felt that I was giving a clear and
24 honest and truthful overview at that time.

25 **Q.** Do you remember her asking for documents. You

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1 said before you asked Mr Cross if you could send it to
2 her. Might she have said: can you send me documents and
3 did you check with him if you could?

4 **A.** I -- I believe I did check with him if I could
5 and I was trying to, I was trying to pass this over to
6 Stephen and obviously later that happened in I think
7 2017. I can't remember the exact date. But
8 unfortunately those documents weren't sent to her.

9 **Q.** Can we have please another document
10 INQ0007197, page 138. And this is a note, Mr Cross's
11 note of an Exec meeting on 3 August 2016. And there's
12 an action relating to Inquest:

13 "Child A Inquest action. Statements need to be
14 reviewed by IH and AK. Coroner pushing for statement."

15 Can you remember now -- it looks as though the
16 statements are to be reviewed by Mr Harvey and Ms Kelly.
17 Can you remember a discussion about Child A's Inquest
18 and the need for review of their statements?

19 **A.** Apologies, I can't remember that specific
20 conversation.

21 **Q.** I think early on in the NNU action plans you
22 were put next to Coroner but also Mr Cross. Did he take
23 over that?

24 **A.** He took over that action yes.

25 **Q.** So did you ever deal with the Coroner?

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1 colleagues at this stage. It is noted that Nurse Letby
2 was aware that the report had been received by the Trust
3 ... noticed that the chairman and the board needed to be
4 updating. Agreed once Executive colleagues have had
5 a chance to read the report. A decision would be made
6 on further distribution. Action: [Mr Harvey]."

7 **A.** Mm-hm.

8 **Q.** When you heard that said, did you think it was
9 reasonable that the Consultants shouldn't see the report
10 at the same time as the Executives given that they had
11 been pushing for it to be done in two weeks in that
12 first meeting you were at and they were still waiting?

13 **A.** I think -- I think as a -- particularly in
14 members of the -- Executive members who were clinical
15 needed to consider that first.

16 The -- I think it was reasonable at that stage but
17 I think the information was provided not long after that
18 as well.

19 **Q.** Why wouldn't they consider it at the same
20 time? Would they have had a different approach to the
21 same information? Why wouldn't you see it with another
22 medical colleague?

23 **A.** It was requested by the board and I think it
24 was -- you know, it was relevant, similar to other
25 reports that the Executive Team review it first.

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1 **A.** No.

2 **Q.** If we go over the page since we are on that
3 meeting note, there is a reference to something that we
4 know halfway down Eirian Powell states in an email:
5 "Nurse started 2012, why now? Occupational Health
6 referral."

7 At the bottom:

8 "What about nurse, more support."

9 So there's discussion there, isn't there, about
10 more support for her?

11 **A.** Yes.

12 **Q.** We will come to that later.

13 **A.** Apologies, I think that may also be more
14 support in general as well but it certainly would be
15 around her.

16 **Q.** And the final document before we break if we
17 can, INQ0004348, page 1. This is another Executive
18 Directors Group, it is a typed note, Ms Hodgkinson, on
19 Wednesday 19 October in Tony's office.

20 It appears, if we look at the bottom of the
21 neonatal review, that a document, the RCPCH document:

22 "... has now been received by the Trust, a copy of
23 which Ian Harvey has shared with Alison Kelly.

24 Ian Harvey highlighted aspects of the review. It was
25 agreed that a copy would only be shared with Executive

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1 **MS LANGDALE:** Thank you. This is a good time to
2 take a break, my Lady.

3 **LADY JUSTICE THIRLWALL:** Thank you very much. So
4 we will take a break now and we will start again at 10
5 to 12.

6 **A.** Okay, thank you.

7 (11.33 am)

(A short break)

9 (is 11.49 am)

10 **MS LANGDALE:** Ms Hodgkinson, we move now to
11 15 March, INQ0003219, page 3.

12 This is the conversation you have with Dr Jayaram.
13 You tell us in your statement at paragraph 285:

14 "[The] conversation with Ravi marked a real turning
15 point in my mind and hearing those concerns made it
16 clear to me that more needed to be done."

17 If we go to page 4, overleaf, you have documented
18 here, and unlike your handwritten notes you have typed
19 up this meeting, haven't you?

20 **A.** (Nods)

21 **Q.** So why did you do that?

22 **A.** So that I had a clear record, it was literally
23 the conversation that I had with Ravi I was trying to
24 capture as much as possible in my mind, it was
25 a free-flowing conversation and --

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1 Q. Had he come to see you about the mediation
2 point or something else?

3 A. Sorry, what was that?

4 Q. What had he come to see you about, did you
5 think?

6 A. He reached out to me in relation to the
7 mediation, the process, what would happen around that as
8 well and then we -- it was in his office, the meeting,
9 I recall it being around about an hour and a half or so,
10 maybe slightly longer, and it was a, you know, very
11 open, open discussion.

12 I had interacted with Ravi before all of this. He
13 was an excellent host of the Trust awards so that's how
14 sometimes I had interacted with him. He was also an
15 education lead from a clinical perspective so those were
16 the elements that I had interacted with him around.

17 But it was -- specifically the conversation was
18 around the mediation to start with.

19 Q. Did you trust him?

20 A. Sorry?

21 Q. Did you trust him as a colleague and as
22 a medical doctor?

23 A. I had no reason not to.

24 Q. So that is a yes?

25 A. Yes.

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1 Further down into the next answer, you say:

2 "... and the kind of things -- it would be in the
3 notes, but the kind of things, the way he was saying,
4 you know, there was an incident with the baby. Perhaps
5 the baby didn't die, but there was mottling on the skin,
6 there was something on the skin that couldn't be
7 explained. That he felt that was, because he knew that
8 Lucy again was there, but he couldn't be definitely
9 certain it was Lucy but there was something not right.
10 It was a really worrying meeting but he was very, very
11 open with me, really open, and it was a good meeting and
12 I agreed at the end of it and I said: right, Ravi, I am
13 going to have to take these concerns seriously. And
14 I think on that day I spoke to Tony straight away and
15 said: I think we need to do something, we need to -- we
16 need to have a conversation with Ravi."

17 If we go to page 44. Continuing in that vein:

18 "I think Tony -- Tony came as Chief Exec to Ravi
19 and Steve's relationship, there was more to it at that
20 point. And Tony really wasn't having many discussions
21 -- I mean, he wouldn't, you know. He wouldn't.

22 "So I remember speaking to Tony. I said: look, you
23 know, I feel really, really uncomfortable about this.
24 We need to hear Ravi's concerns. I have asked Tony to
25 go and meet with him. He said that we were free. So

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1 Q. He told you what?

2 A. He was obviously going through around, you
3 know, his concerns in relation to the mediation and we
4 talked that through extensively but I think the key
5 point is the top paragraph.

6 Q. Mmm.

7 A. Where he recalled to me three occasions where
8 he had concerns, one, as it says, a baby deteriorated;
9 another where a valve was at a different setting; and
10 a third and I don't think -- I don't know whether as the
11 conversation went he told me what the third incident was
12 but I don't remember and I don't think I -- I think
13 I was probably -- in fact I know I was stunned at
14 hearing that.

15 Q. You tell the police, if it helps, nearer to
16 events as well, INQ0012175, page 43, it begins slightly
17 the page before. You were trying to reassure in terms
18 of mediation process but, over the page:

19 "It was at that point that I suppose made me feel
20 really, really uncomfortable. I didn't think we had
21 really looked into some of the aspects enough clinically
22 and I have to take his concerns seriously.

23 "One of the things I was, as well as being Director
24 of People, I was one of what's classed as a Freedom to
25 Speak Up Guardian."

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1 Tony and I went to go and see Ravi and Steve and, you
2 know, they just explained some of the issues and
3 concerns further and we talked about: well, what do you
4 think we should do and it felt quite positive."

5 Do you remember now having those discussions with
6 Tony and Ravi as you described them there?

7 A. Yes, I do remember having them.

8 Q. Did Ravi Jayaram, we see him continually
9 saying through the documents, repeat what he had said to
10 you and generally about sudden and unexpected, not the
11 babies expected to die, raise his concerns in a frank
12 way with them?

13 A. Mm-hm.

14 Q. You were seriously concerned after that
15 conversation with him?

16 A. (Nods)

17 Q. You describe to the police he had made you
18 reflect perhaps that you hadn't been looking into some
19 of the aspects enough clinically before then. Do you
20 remember saying that? Is that what you thought,
21 actually we haven't taken these seriously enough, this
22 is really serious?

23 A. Yes, yes. I think the other -- the other
24 thought was why is Ravi telling me this now? So I think
25 why I didn't call the police straight away was because

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1 I needed to triangulate, I needed to check, had anyone
2 else heard of this? Had anyone else heard those
3 specific phrases that Ravi was telling me then? You
4 know, because for me to hear that as a non-clinical
5 person I remember going home at night and I was -- I was
6 in tears about it.

7 **Q.** So pausing there. What's the relevance of the
8 fact that he told you and when he told you to how
9 serious the concerns were?

10 **A.** Sorry, what's the --

11 **Q.** Well, you say you were wondering why had he
12 told you that now, what's the importance of that
13 compared with the importance of what he was saying?

14 **A.** I suppose I couldn't understand why that
15 information was only coming to light then.

16 **Q.** What were the options for that? When you say
17 you couldn't understand it, what did you think it might
18 be, the reason for him taking that time?

19 **A.** I don't -- I don't know. I think because it
20 was an open and hopefully a trusting conversation.

21 **Q.** So you had made it easier for him to say it?

22 **A.** I hope so, I hope so.

23 **Q.** So that didn't discredit anything he was
24 saying, was it; if anything, it reflected on the fact
25 that no one had been as receptive as you had before

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1 **A.** I did believe him but I think my reflection
2 point is, and I know we may come to this as well, but
3 I think it's important I say this at this time:

4 "I should have said to Ravi and because we spoke
5 a number of times the days afterwards, apologies,
6 I should have said at that stage: "Ravi, I don't want
7 you to go through with the mediation".

8 You know, from knowing that and now knowing the
9 distress that mediation meeting caused him as well,
10 I can only say I am very sorry, Ravi, because
11 I shouldn't have continued with that. I cannot tell you
12 why I did. I think it was just, you know, the flow, but
13 I -- I should have paused.

14 **Q.** You did though go to Mr Chambers and you did
15 at the next meeting, let's go to a meeting on 16 March,
16 which is INQ0003344, page 1, and this is a meeting with
17 the Execs, it is the day after his comments to you and
18 let's see what you do tell your fellow Execs then.

19 Halfway down, you speak about still unexplained
20 deaths. On behalf of all bullied and intimidated, being
21 victimised like other whistleblowers?

22 **A.** Mm-hm.

23 **Q.** That's of course -- I didn't take you to the
24 full note of 15 March, but that is what Dr Jayaram is
25 saying to you, that he feels victimised?

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1 then, is that fair?

2 **A.** You could see it that way, but --

3 **Q.** Isn't that the only way to see it. Help me
4 with it another way, it is a genuine question: how on
5 earth can you look at that differently?

6 **A.** No, I see what you are saying, Ms Langdale, as
7 well and --

8 **Q.** He is talking --

9 **A.** I suppose I am pleased -- apologies, I am
10 pleased that he had that conversation with me because
11 I think it changed our direction.

12 **Q.** It appears to have been used against him that
13 he only raised these concerns at this point.

14 **A.** I don't, I think I have reflected a lot around
15 this particular aspect because I think to have that
16 conversation as a member of the Executive Team and to be
17 told in those terms I think one, I was very privileged
18 that he told me in those terms in that way. You know,
19 I don't know why he told me but I am glad that I enabled
20 him to tell me in those terms.

21 **Q.** And you believed him --

22 **A.** Yes, and I did believe him.

23 **Q.** -- without a doubt?

24 **A.** Sorry?

25 **Q.** You had no doubt?

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1 **A.** Yes.

2 **Q.** You are very clearly sharing that at the
3 meeting, aren't you, with Ms Kelly and Mr Chambers?

4 **A.** (Nods)

5 **Q.** Want conversation with Tony/Ian. They do not
6 feel assured.

7 What did they not feel assured about?

8 **A.** I think the way that Tony and Ian were
9 managing, managing the process, maybe the -- you know,
10 their kind of relationship as well. Yes.

11 **Q.** And you say, or somebody says:

12 "Needed more support as clinicians."

13 I am assuming that's you because you seem to relay
14 or hear what happened in the meeting. Would it be you
15 saying: they need more support

16 **A.** Yes.

17 **Q.** Over the page:

18 "TC had conversation with the CEO of Great Ormond
19 Street, help me understand mindset of neonates, Peter
20 will meet them, favour, he could then advise on process
21 to get through this."

22 You refer later they want a neonatologist. Can you
23 remember what that's about, what's Mr Chambers saying
24 about "help me understand mindset of neonates", do you
25 know?

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1 A. Yes, I think -- I think it was around almost
2 like a bringing together of the Executive Team and the
3 Consultants as well to try and I suppose rectify the
4 relationship that had broken down at that stage as well.

5 Q. And get a mindset, a collective mindset.
6 There was a very different mindset, wasn't there, with
7 the Consultants having, you trusted them, genuine
8 concerns that a nurse was murdering babies --

9 A. Mm-hm.

10 Q. -- and them looking for other ways to
11 investigate events internally within the hospital?

12 A. I -- I think, you know, there was multiple
13 different factors that probably led us to that situation
14 as well. I don't think -- you know, I am sure we will
15 talk about the grievance again but I don't think that
16 helped. I think, you know, you have got to remember
17 that the Consultants had raised these concerns, we then
18 had multiple reviews which were also, you could argue,
19 criticising the care that was happening on the unit as
20 well.

21 Then they had the elements -- particularly Ravi and
22 Steve had the elements related to the grievance, that is
23 further criticisms. Then, you know, the elements
24 around, well, we are then getting Dr Hawdon in.

25 Q. We will deal with those separately.

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1 a leader, as a manager to me and I think to the other
2 Executive Team.

3 But he got emotional and I think sometimes those
4 emotions meant that he said things that came across in
5 a way that --

6 Q. Aggressive and intimidating?

7 A. Some people may see it like that.

8 Q. So the answer is yes, you liked him, but yes?

9 A. No, I can see why people could see it like
10 that but I don't think he meant to come across as
11 intimidating.

12 Q. Page 3, you set out at the top what's been
13 said about three deaths?

14 A. Yes.

15 Q. Alison Kelly says: why not before serious
16 allegations?

17 Was that the first time Ms Kelly had been told by
18 you --

19 A. Yes.

20 Q. -- what Dr Jayaram said. Her response is "why
21 not before?"

22 A. Yes.

23 Q. Mr Chambers says:

24 "Lucy cannot go back to unit.

25 "[Ms Kelly] challenges: she should go back."

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1 A. No, I know, I am just trying to describe

2 I suppose all of those aspects plus --

3 Q. You thought that you were doing things and
4 it's in retrospect they weren't right --

5 A. No, no, what I am describing is that the --

6 I suppose that appreciation, the breakdown of the
7 relationship was due to a number of factors. I think

8 all of those different points that I have just

9 described, plus then, you know, how they perceived Tony
10 or Ian in some of the meetings as well, and I think all

11 of that came together to break down --

12 Q. How did you perceive Tony Chambers in some of
13 the meetings? Did you witness him to be intimidating
14 and bullying in his tone and manner?

15 A. Not -- knowing Tony, no.

16 Q. What does that mean; that sounds like
17 a caveat?

18 A. I can see what you are saying, but knowing
19 Tony, he's --

20 Q. For those of us who didn't, what would we make
21 of him if we went into a meeting.

22 A. If may just describe Tony as I knew him, you
23 know, he was a fantastic Chief Exec. He couldn't have
24 cared any more about making a difference within the
25 Countess. He was passionate, he was supportive as

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1 A. Mm-hm.

2 Q. So you have just told her a description of
3 events that you say was a turning point for you:

4 "Took you home, afterwards upset"?

5 A. (Nods)

6 Q. Ms Kelly's first reaction is diametrically
7 opposed on its face because she says "she should go
8 back".

9 What did you make of that? Why do you think she
10 was saying that?

11 A. I think she was -- she was shocked around why
12 this was the first time it had been said in these terms.

13 Q. Therefore it couldn't be true?

14 A. Sorry?

15 Q. Therefore it couldn't be true because she is
16 suggesting here, isn't she, "she should go back"; if she
17 thought she was murdering babies, would she say that?

18 A. No, I don't think it was because she was
19 suggesting it wasn't true. I think she was, she was

20 genuinely concerned why -- why had -- why had this
21 information not been shared in these terms before?

22 Q. Why is that relevant to whether she should go
23 back?

24 A. I -- I don't know. I don't know.

25 Q. It isn't relevant, is it?

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1 A. I think possibly because Alison and I were
2 having those regular conversations with Letby and that
3 was -- that was the position that obviously we had -- we
4 were continuing to inform Letby about.

5 I think with that, there was -- I know it's hard to
6 say it now, but there was almost a point of where we
7 were just trying to maintain the status quo with Letby,
8 knowing that certainly from my perspective it was highly
9 unlikely she was going to go back even though I may have
10 said it -- it was highly unlikely she was ever going to
11 go back into that unit.

12 Q. Mr Chambers:

13 "Okay she goes back and something happens. Deal
14 with the Speak Out Safely. Part of me says ring police
15 and GMC."

16 A. (Nods)

17 Q. What's the purpose of the GMC?

18 A. I don't know. I don't know.

19 Q. But he's suggesting there GMC?

20 A. Yes, I don't know. I think if you can imagine
21 in the meeting obviously I am relaying what --
22 information which shocked me hugely. It was a very
23 emotional meeting, it was a very difficult meeting.

24 Q. Ms Kelly doesn't seem shocked or emotional
25 about the safety of babies on the unit, does she,

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1 describing that.

2 Q. Let's deal with the management of Letby now,
3 because it is complicated in terms of what she has been
4 told. I appreciate that. Let's go to INQ0012175,
5 page 9.

6 This is what you tell the police.

7 A. Sorry, what was the page number again?

8 Q. It is INQ0012175, page 9. It's going to come
9 up.

10 We see here you tell the police:

11 "Lucy was informed, it was her first day back from
12 annual leave, because as I said" --

13 **LADY JUSTICE THIRLWALL:** Are you using a hard copy?

14 A. I have got the hard copy here as well.

15 **LADY JUSTICE THIRLWALL:** I didn't appreciate that.

16 A. Yes.

17 **LADY JUSTICE THIRLWALL:** Will you also look at it
18 on the screen, so we are all looking from the same copy?

19 A. Thank you.

20 **MS LANGDALE:** You said:

21 "Deep dive review took place while she was on
22 annual leave. This was the first day back and she was
23 advised that obviously there were some concerns around
24 the increase in neonatal mortality and a potential
25 connection with her being on duty. You know, a concern

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1 because she says "she should go back"?

2 A. She --

3 Q. So what was she shocked by?

4 A. I think she was shocked about these -- the --
5 the information that I was relaying back. She was
6 absolutely shocked. Ms Kelly, you know, again I have
7 as, as a nurse and as a Director of Nursing she -- she
8 was an excellent nurse to work with.

9 Q. Let's go, please, to INQ -- that document can
10 come down -- 0014281, page 1 and a meeting on 28 March.
11 Sir Duncan is here?

12 A. Yes.

13 Q. Ian Harvey, yourself, Alison Kelly. Sue and
14 Alison Kelly.

15 "Lucy being returned to unit week commencing
16 Monday, 3 April 17 for one hour a day."

17 Mr Cross says:

18 "This can't happen in the view of police
19 investigation. To be discussed further."

20 But at 28 March 2017 that was your and Ms Kelly's
21 view; that she was on her way back to the unit and due
22 to start the following week?

23 A. So that -- that goes back to my point earlier
24 that in terms of trying to maintain the status quo, that
25 was the position we were saying to Letby, so that was

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1 that obviously on that basis potentially we needed to
2 refresh her competencies and we would redeploy her from
3 the unit but she was not advised that she was going
4 under an investigation. She was not advised she was
5 being suspended. We went for a different employment
6 process. A different, yes, I suppose than what we would
7 normally do but that was because we still weren't saying
8 that was all due to Lucy at the time."

9 A. Mm-hm.

10 Q. Then over the page, you comment, so page 25
11 actually, not over the page, page 25, you comment this:

12 "So, you know, I think that -- I suppose alongside
13 all of that the Royal College review and the draft
14 report had happened but Ian and Alison to some extent
15 were kind of managing that part but we started those
16 series of meetings with Lucy. Did I believe she had
17 done anything or did that come across or did she know
18 nothing of that came across? When I have thought about
19 this for a long time and I never -- I did not believe at
20 that stage she had done anything. She was a quiet
21 person, very reserved, but could get angry at other
22 points. In those meetings she was very emotional, but,
23 you know, I suppose when you have got a member of staff
24 and you know they are being led by a very strong Union,
25 you don't know whether they are being like that because

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1 of the Union or, you know, that's generally how they
2 are."

3 So when you say to the police you were following
4 a different employment process, you tell them that's not
5 what you would normally do because you weren't saying
6 that this was due to Lucy at the time.

7 Is that your thinking about why you are not telling
8 Letby the concerns you have? What employment process
9 were you following?

10 **A.** I -- I think the reason that we didn't explain
11 all of the concerns was in case we had to take further
12 action further down the line. You know, redeployment is
13 -- is in people professional terms and in employment law
14 terms, it is a neutral act. It's supporting both -- and
15 we did it to support both the unit and to run
16 functionally and also to support that member of staff as
17 well because we still needed to make sure that the unit
18 continued to run.

19 **Q.** Before you redeployed her to the Risk Team,
20 can we have on screen, please, INQ0002839, so it is not
21 before then, this is when the review has been
22 undertaken, the RCPCH review.

23 This is the letter that Sian Williams sends to
24 Letby and she told the Inquiry that you drafted this
25 letter for her and she didn't think it was transparent:

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1 practice during that time.

2 **Q.** You had a complaint from her Union, didn't
3 you, about the process? If we go to INQ0002960, page 2.
4 You are cc'd to this email to Clare Edwards. We see at
5 the first paragraph:

6 "It has been alleged our member has been involved
7 with more of the deceased patients than any other member
8 of staff. According to our member she is going to be
9 informed at the meeting on Monday she will have to work
10 under direct supervision and an action plan will have to
11 be followed."

12 Next but one paragraph:

13 "My concerns are more to do with processes, what
14 process has been followed and how has the organisation
15 come to the conclusion it has? I would like to see
16 evidence of an investigation into these allegations and
17 the subsequent outcome. Who was the investigation
18 officer? What evidence is there to suggest that our
19 member may be linked to these unexplained mortality
20 rates?"

21 If we go back to page 2, we will see further emails
22 between yourselves. You email Alison Kelly. If we go
23 to page 1. Concerned about the situation, and at the
24 top, everyone is very stressed, Sian mentioned her
25 email, you managed to have a chat with her and the

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1 "...and with the benefit of hindsight I should have
2 stood up to this more than this."

3 So if you read this letter, it's one of a number.
4 Do you think you were being clear with Letby at all?

5 **A.** I think the grievance found that we weren't as
6 well.

7 **Q.** If we look at INQ0002879, page 91, this is
8 drafted by -- sent from Eirian Lloyd-Powell, I think
9 Yvonne Griffiths may have had a hand in drafting it but
10 you presumably saw it and would have approved at the
11 time of what was being said at this stage?

12 **A.** I don't think I approved this, no.

13 **Q.** But it was being suggested, did you know it
14 was being suggested Lucy was agreeing to the supervision
15 first and others would have to follow and there was no
16 plan for everyone to have supervision, was there; it was
17 just her that you were concerned about?

18 **A.** It was just, yes, and that's -- that's --
19 apologies, Ms Langdale, I thought you were going to ask
20 something else then as well. That -- the process around
21 supervision was a normal process that we would use and
22 any organisation would use within the NHS.

23 But it was potentially around was there a concern
24 with her competence, her education and ensuring that
25 there was a relevant professional supervising her

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1 Unions. I will chat with you tomorrow.

2 So this appears to have created some stress for
3 you, for Sian Williams, for Alison Kelly. Would you
4 like to expand upon that for us?

5 **A.** Yes, I think one managing -- understanding the
6 concerns from the Consultants, you know, was -- was --
7 again I said it in my first words at the start, being in
8 this situation knowing those concerns from the
9 Consultants at the start, knowing the difference of
10 opinion of the nursing team, knowing that there was
11 a whole set of other initial reviews that had been
12 undertaken, you know, this, this was something that
13 I had never envisaged having to go through.

14 And I don't think any of the team, and that added
15 to the stress around this as well, trying to find the
16 right set of actions to undertake, yes, it was -- it was
17 an incredibly stressful situation.

18 **Q.** The next day we know you seek some advice from
19 Mr Ian Pace. That is INQ0102205, page 1. So this is on
20 18 July. You are setting it all out on page 1. If we
21 go to page 2. He sets out paragraph 2:

22 "We may also want to refer to the fact this action
23 has been taken only in the interests of patient safety
24 but also to protect her position going forwards."

25 Further down the page, the penultimate paragraph,

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1 we see you say:

2 "Sue believes that they are going to need to call
3 in the police and she also mentioned there was potential
4 press interest in the story."

5 So your view following the emails from the Union
6 reps and talking to him was that you would need to go to
7 the police?

8 **A.** I think you -- it was very helpful this
9 morning, actually, because you raised the point around
10 Dee Appleton-Cairns' first conversation with Ian.
11 I think it was roughly around 5 July and Dee had used
12 the phrase around Beverley Allitt at that stage with --
13 with Ian.

14 So he knew and then obviously then I had the
15 conversation as well so he knew the gravity of the
16 situation that we were dealing with.

17 **Q.** Did you think you should go to the police?
18 You seem to be saying you are going to need to. Was it
19 your view --

20 **A.** I think that was one of the options,
21 definitely. It was always an option that we were
22 looking at as a team, it was -- absolutely all the way
23 through it was an option we were looking at.

24 **Q.** When did it become the option you thought that
25 was the right one?

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1 concerns about him and said that more issues are being
2 raised about him regarding behavioural issues. Seems to
3 be a suggestion he's bullying and harassing employees on
4 the ward. I accept this is likely to be an issue which,
5 depending on the issues, whether it is bullying or
6 whether it is a breakdown in relations may need to be
7 managed. My concern was that there was a risk now that
8 he has raised these concerns that he could allege this
9 was a protected disclosure and if we start managing
10 these concerns at this stage she may say she has been
11 subject to a detriment as a consequence."

12 What did you make of the advice you were being
13 given around this?

14 **A.** Apologies, in respect of what?

15 **Q.** What did you think he was telling you there?
16 You have said you have raised concerns about behavioural
17 issues --

18 **A.** Mm-hm.

19 **Q.** -- being raised about him regarding
20 behavioural issues.

21 What were those concerns, what were you
22 understanding they were?

23 **A.** So I think the concerns were the impact this
24 was having on Dr Brearey and how then he was coming
25 across with others as well. So, you know, I think it

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1 **A.** For definite 15 March 2017.

2 **Q.** That can come down, thank you. On 8 September
3 you have another consultation with Mr Pace, that is
4 INQ0102274, page 1. You explain to him that Letby had
5 now been removed from the unit and placed in the Risk
6 Management Team.

7 You refer there to:

8 "The barrister who is on the review particularly
9 commented in relation to the treatment of Letby and
10 raised concerns regarding her treatment and exclusion
11 from the ward."

12 We know there was a non-practising barrister on the
13 RCPCH review. When you refer to the person as
14 a barrister, what was your understanding about that
15 person's qualifications or role?

16 **A.** I -- I didn't know initially that there was
17 a barrister on the -- on the review group at all. And
18 to be honest, I wasn't really managing that whole
19 process. That was from Mr Harvey.

20 **Q.** So had Mr Harvey told you there was
21 a barrister on it? Who had told you, do you know?

22 **A.** I can't recall exactly who had --

23 **Q.** So someone had said it to you and then you say
24 that to him. And then over the page at page 2, you say:

25 "In respect of the Consultant Dee and Sue both have

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1 was the stress of the situation was impacting on his
2 behaviour, whether knowingly or unknowingly, I don't
3 know. But it was impacting on his behaviour.

4 And I think the point that Ian was saying was that
5 because Dr Brearey had raised those clinical concerns at
6 the -- obviously with -- with other members of the
7 Executive Team before I was involved, that was
8 a protected disclosure from a whistleblowing
9 perspective.

10 **Q.** That can come down, please. The 8 September
11 there is a meeting again between Execs and if we go to
12 an options document first, if we can, INQ0004660,
13 page 1.

14 **A.** Excuse me.

15 **Q.** This appears to be the document you presented
16 in the Executive meeting with the options around what
17 could be done with Letby. Do you recollect that this is
18 your document?

19 **A.** Yes, I pulled this together.

20 **Q.** You put it together. So we see there's four
21 options on the front, other options on the next page.

22 In the meeting, it suggests you went for option
23 number 4. Do you know which option were you going for?

24 **A.** What I think we went with -- actually 4.

25 It -- we -- you know, there was the intention to

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1 reintegrate back at some stage but the redeployment
 2 continued within the Risk and Patient Safety team.
 3 **Q.** So:
 4 "Reintegrate that with NNU without ITU/HDU duties
 5 whilst competencies review in three months."
 6 That looks like that's option four, doesn't it?
 7 **A.** It could -- yes, I don't know who took the
 8 notes of the meeting, obviously when you are presenting
 9 it it's -- you know, I wasn't capturing all of the
 10 details but we -- we retained her in that redeployed
 11 role at that time.
 12 **Q.** If we go back to the meeting notes,
 13 INQ0006265, page 1. This is Mr Cross, Mr Harvey,
 14 Ms Kelly, Ms Rees, part of the meeting, yourself,
 15 Tony Chambers:
 16 "Position re Lucy Letby. Options paper.
 17 "Constructive dismissal discussed, other risks, no
 18 further work for nurse. Paediatricians not happy on
 19 return. SH options, recommended option 4."
 20 Which appeared to be the one we have just spoken
 21 about?
 22 **A.** Mm-hm.
 23 **Q.** Competencies being assessed, et cetera.
 24 Then it says: potential deal with Steve.
 25 Was this about managing a move or getting him away

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1 was speaking to people within the unit.
 2 **Q.** Who did you think -- who told you that and who
 3 was it?
 4 **A.** I can't recall specifically but it was
 5 definitely, it was -- it was raised?
 6 **Q.** If it had foundation, no doubt you would have
 7 been interested to know so who, what? You have had
 8 a long time to think about this.
 9 **A.** I think -- I think it was from a nursing
 10 perspective.
 11 **Q.** A nursing perspective?
 12 **A.** Yes.
 13 **Q.** So one of the nurses may have said that to
 14 you. Who?
 15 **A.** It may have come through from Alison Kelly or
 16 from Karen Rees but, I -- I can't recall specifically.
 17 I think it was, it was valid to be concerned about
 18 Steve's behaviour because of the pressure that he was
 19 under as well. He was the clinical lead for that unit.
 20 **Q.** The pressure he was under because he wasn't
 21 being heard with the complaints he was making?
 22 **A.** No, I don't, I don't think it was just that.
 23 I think it was all the different aspects as well, you
 24 know, it's clear I didn't have much interaction with
 25 Dr Brearey but it's still clear he took this very

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1 from the unit, potential deal with Steve?
 2 **A.** No, I think -- I think it goes back to my
 3 point earlier as well in that there were concerns around
 4 Dr Brearey's behaviour at that stage which, you know,
 5 now on reflection I can see why because of the way in
 6 which the Consultants were having to deal with so many
 7 matters.
 8 But I think it's important to note that right at
 9 the outset, and I think it's on my notes from around
 10 about 27 June 2016, that we were considering
 11 occupational health support for Dr Brearey at that point
 12 as well.
 13 **Q.** We will go to that later. When you say "his
 14 behaviour", there's one email he sent Ruth Millward
 15 which the Inquiry has examined and subsequent to that he
 16 was asked to attend mediation with Ms Millward as
 17 a consequence of that email. Is that the behaviour you
 18 are referring to, because there is nothing else in his
 19 behaviour or communication with staff that the Inquiry
 20 has seen that would reflect what you have just said?
 21 **A.** So, I don't -- I don't think the mediation
 22 actually happened with Ms Millward, apologies.
 23 I think that was -- she raised a concern, we saw it
 24 on one of the earlier emails as well. But I understood
 25 that there was other concerns being raised around how he

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1 personally as well.
 2 **Q.** If we go to INQ0015640, page 40, the next day,
 3 it's Dr Jayaram's behaviour looking at this meeting that
 4 appears to be being raised. Is this your note? Is this
 5 one of your notes, Ms Hodgkinson?
 6 **A.** It is, yes, apologies.
 7 **Q.** Behaviour is not appropriate now we have got
 8 it for Ravi Jayaram, can you see, number 2?
 9 **A.** (Nods)
 10 **Q.** The obstetrician's behaviour. That is
 11 Mr McCormack, is it?
 12 **A.** Yes.
 13 **Q.** So suddenly we are talking about their
 14 behaviours as well.
 15 **A.** (Nods)
 16 **Q.** Why was that?
 17 **A.** I think it was because the -- again, I --
 18 I don't remember the full specifics around it but
 19 I think there was a particular incident or -- or
 20 a number of people were concerned around some of the
 21 language that was being used and how things were being
 22 talked about, which weren't necessarily in keeping with
 23 the Trust's values and behaviours.
 24 **Q.** We will go to the evidence for that later,
 25 thank you, but if we look, please, at INQ0002860,

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1 page 1, on the same day you are getting this letter from
 2 Karen Rees. We see in the second paragraph she says:
 3 "In my opinion, this decision is wrong and
 4 immoral."

5 This is about the position for Letby not going back
 6 on the ward. She says at paragraph 4:

7 "I am led to believe two of the clinicians do not
 8 want LL back on the NNU. Why is the senior clinician
 9 allowed to destroy someone's career without any clear
 10 evidence?"

11 When you received that, you knew, because you had
 12 spoken to Dr Jayaram, that he had genuine concerns and
 13 you believed those concerns. You had been in a meeting
 14 on 30 June with Mr McCormack, Dr Brearey. This wasn't
 15 about one or two Consultants; it was a respected medical
 16 body of people, wasn't it?

17 **A.** (Nods)

18 **Q.** When you read Karen Rees' letter, did you go
 19 and disabuse her of some of this?

20 **A.** Sorry, I missed that?

21 **Q.** Did you go and tell her: you have got that
 22 wrong, that is not what Dr Brearey's saying or what he
 23 was trying to destroy someone's career? There is no
 24 motive there is nothing I am worried about; that's not
 25 the position?

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1 they did?

2 **A.** Again I have reflected on this an awful lot,
 3 you know, I have also had multiple different meetings
 4 with Letby, as you will see from the various letters,
 5 the various notes in my notebook and yes, it's -- it's
 6 something -- I think we were all we were almost acting
 7 like almost business partners as such managing the
 8 situation and I think all of that now has meant that my
 9 trust and judgment in people has really changed.

10 **Q.** If you look at one of those letters,
 11 INQ0008964, page 83, you find yourself in the situation
 12 where you are reassuring Letby from an early stage and
 13 before there's been any question of investigating the
 14 Consultants' concerns, at paragraph 5 here you say:

15 "Alison and I advise the best outcome would be to
 16 get you back working on the neonatal unit. Karen
 17 reiterated not to worry about how this would happen.
 18 She reassured you that a robust supportive plan would be
 19 put in place to facilitate this."

20 **A.** (Nods)

21 **Q.** And we go over the page, page 84. You repeat:
 22 "Whilst you know you have support already available
 23 from Occupational Health, please be aware the service
 24 can be accessed at any time."

25 So not only does she have support, she can access

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1 **A.** I think -- I think Karen was a very passionate
 2 individual but she was a very strong nurse as well. And
 3 she would challenge -- there was many situations --
 4 excuse me -- outside of this that I saw her challenge
 5 things.

6 So the question that you are asking me is: did
 7 I challenge her back?

8 **Q.** Yes, did you say to her: that's not an immoral
 9 decision, these were genuine concerns raised by the
 10 medical body?

11 **A.** Yes, we had.

12 **Q.** You had those conversations?

13 **A.** We did go through that and the reasons why.

14 I think it's also important to know that at roughly
 15 the same point I was also having similar concerns raised
 16 by Kathryn de Berger, who was one of my direct reports
 17 but she was the Occupational Health and Wellbeing Lead
 18 supporting Letby as well and raising why were we not
 19 letting her back on the unit.

20 **Q.** Both Karen Rees and Kathryn de Berger we know
 21 were having weekly meetings, weren't they, with Letby?
 22 Karen Rees says she was asked to do that by you and
 23 looking back, that may have compromised her objectivity.
 24 She got close to Letby. Do you agree that it was not
 25 a good idea those meetings should happen in the format

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1 direct line for service help?

2 **A.** (Nods)

3 **Q.** If we look at another letter, 26 October,
 4 INQ0008964, page 81. This is October. And you say at
 5 paragraph 4:

6 "We explained we would represent your concerns
 7 within the board conversations and would continue to
 8 keep you updated on how this was progressing."

9 **A.** (Nods)

10 **Q.** If we go over the page. Paragraph 2:

11 "I explained you are not under investigation but
 12 that we are temporarily redeployed you as a supportive
 13 measure as it was a vulnerable environment with some of
 14 the comments we have been made aware of."

15 So suddenly she is not being told of the genuine
 16 concerns which you believed and felt were a patient
 17 safety concern. She's being told she needs to be
 18 protected from a vulnerable environment because of some
 19 of the comments that are being made by others about her,
 20 what did you mean by that?

21 **A.** I think, now looking back at this, I could
 22 have worded that differently.

23 **Q.** Because it wasn't true?

24 **A.** No, no, no. No, but I just think that I could
 25 have perhaps again been more transparent with this.

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1 Q. What should you have said then? Let's not
2 worry what's there, what would have been the right thing
3 to say to Letby then?

4 A. That, you know, there were these the concerns
5 around her providing care.

6 Q. And that they needed investigating?

7 A. But I -- apologies.

8 Q. No, go on?

9 A. I was just going to say I think you asked me
10 at the start as part of my role as the Exec Director of
11 People as well within the Trust and I think any Chief
12 People Officer, as they are now, or Executive Director
13 of People, also has to -- when you have an employment
14 case such as this, not only are you considering the
15 patient safety implications, the workforce implications,
16 you are also considering the potential legal risk, the
17 employment legal risk around a situation. I had been
18 advised obviously by Mr Pace that we were at risk of
19 a potential constructive unfair dismissal claim and
20 while that was a claim that I was prepared to -- if it
21 came out from Ms Letby, that I was prepared to manage.
22 As a steward of the organisation and managing taxpayers'
23 money obviously, you are trying to ensure that you
24 balance your decision-making.

25 And so I think that that was, you know, a factor.

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1 representatives, Colm Byrne and others who -- who
2 supported the RCN and I think when going through the
3 documentation from the RCN I have had probably 10 or
4 more different types of emails expressing concern around
5 the way in which we were treating Letby.

6 When the mediation process took place, and
7 Dr Brearey did not attend, their view around how we
8 should be managing that, there was also other aspects
9 around the multiple different conversations that I had
10 with Hayley Griffiths I think it was at the time. So
11 there was a significant amount of pressure from the RCN.

12 Q. You write a further letter to Letby,
13 INQ0008964, page 79. This relates to a review that's
14 been conducted, the RCPCH review. And you say at
15 paragraph 5:

16 "Alison reassured both yourself and Hayley
17 Mr Harvey was very clear around the confidentiality of
18 information contained within the draft report ...
19 doesn't want to cause you or any member of staff more
20 distress. The process of factual accuracy review would
21 be strictly managed by him."

22 By Mr Harvey.

23 A. Mmm.

24 Q. "... and I added that if either yourself or
25 Hayley become aware of anything untoward then you need

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1 It was obviously advice had given by our external legal
2 team and it was an element where I was trying to make
3 sure that we were mitigating any other risk as well.

4 Q. You get letters from Tony Millea, from Kathryn
5 de Berger, I won't take you to them all but expressing
6 concerns about Letby's health and well-being and you
7 come yourself to write a letter, INQ0002982, page 1,
8 back to Tony Millea.

9 You say:

10 "Both Alison and I are very much aware of the
11 impact on Lucy's health and well-being ... we know
12 Karen, Hayley and our occupational health manager are
13 providing significant support around. We did discuss
14 any further support she may require and we agreed to
15 follow it up with clinical contact with the NNU team
16 which had not taken place whilst Eirian was on leave."

17 What pressure were you feeling at this point in
18 respect of Letby herself?

19 A. I think particularly throughout all of this
20 process the Royal College of Nursing put myself and
21 Alison Kelly under significant pressure. I don't know
22 whether that was right or not but that's certainly how
23 it felt, so that was not only the local representative
24 who I did work with really well who was the Staff-Side
25 Chair as well, but also Tony Millea, and other

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1 to advise Karen, Alison or myself immediately."

2 What was the instruction you had had there from
3 Mr Harvey, if any?

4 A. I think there was a concern that information
5 was going to be disclosed around any member of staff but
6 particularly Letby, given the volume of -- or not
7 necessarily volume, the concerns that the Consultants
8 had raised. And I think as well, you know, within the
9 grievance there was the point around her
10 confidentiality.

11 Q. Over the page, you also explain that you
12 thought Mr Millea's availability was key to the
13 grievance hearing alongside the chair of the hearing and
14 would ensure he was available. Why was that?

15 A. It was important that -- again this is
16 standard practice I suppose within any grievance, that
17 if -- I think I mentioned it before as well, that anyone
18 who raises a grievance -- apologies -- particularly when
19 it goes through a formal basis, they are afforded the
20 right to have either an employed member of staff to
21 support them or their Union representative.

22 So obviously Letby was keen to have an experienced
23 Union representative there, which was Mr Millea.

24 Q. That can go down, thank you, and a totally
25 different document from the Risk Register, INQ0004657.

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1 This is an entry, Ms Hodkinson, on the Risk
 2 Register placed by Karen Townsend and it says:
 3 "Potential damage to reputation of neonatal service
 4 and wider Trust due to apparent increased mortality
 5 within the neonatal unit."
 6 The risk was added 11 July 2016.
 7 In Karen Townsend's evidence, she said Ms Kelly and
 8 Ms Hodkinson scripted this for her. Do you remember
 9 scripting anything or putting anything together for the
 10 Risk Register that reflected what was going on in the
 11 neonatal unit?
 12 **A.** I-- I don't specifically remember scripting
 13 that for Karen, no, I don't. I can see that it -- you
 14 know, the damage to the reputation point.
 15 **Q.** What was the damage to the reputation point
 16 about the neonatal unit?
 17 **A.** I -- I -- how -- how would those requiring the
 18 services from the neonatal unit feel by having their
 19 babies there?
 20 **Q.** When there were suspicions of a nurse
 21 murdering babies there?
 22 **A.** Or that, you know, the unit was being
 23 downgraded, you know, some of the public communication
 24 that we had to do, how would --
 25 **Q.** It would depend why it was being downgraded,
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1 predominantly around that openness and transparency in
 2 managing the issues.
 3 **Q.** She wanted to know what the allegations were
 4 and how the Trust were dealing with them and informed of
 5 any evidence the Trust may have in regards to the above.
 6 She was never, through this process, given the
 7 Consultants' or the Thematic Review or anything like
 8 that, which was the evidence of the concerns against
 9 her, was she?
 10 **A.** No, no.
 11 **Q.** So why was that?
 12 **A.** I think it didn't feel appropriate because it
 13 goes back to the point I said before in that potentially
 14 if there was an investigation that was required further
 15 down the line, you know, we were balancing that -- that
 16 position all the time and you can see from various
 17 different notes the options appraisal, as I said before,
 18 the advice from Corinne Slings, various different
 19 aspects, you know, going to the police was a potential.
 20 So to give that information we felt was not
 21 appropriate.
 22 **Q.** INQ0005279, page 2. This is your deputy
 23 summarising the key questions needing answering and she
 24 says:
 25 "We do not have a modicum of defence for this ...
 107

1 wouldn't it, that might --
 2 **A.** Sorry?
 3 **Q.** It would depend why it was being downgraded;
 4 that might influence most of us as users of a hospital?
 5 **A.** Yes, yes. I mean, ultimately as I know from
 6 friends and family I mentioned earlier who had to access
 7 the service, to have that facility on your doorstep was
 8 fantastic and to have you know those -- those clinicians
 9 on your doorstep was amazing.
 10 But to then not -- take that away or reduce that
 11 level of service, you know, for a -- for a local Trust,
 12 that's -- that's significant in terms of the reputation.
 13 **Q.** That can go down now, please. Can we have
 14 INQ0008964, page 95. I am sure we can take this quite
 15 swiftly in the light of your earlier evidence,
 16 Ms Hodkinson.
 17 I am going to put on the screen the grievance and
 18 I think you agree with me that the grievance was
 19 actually against how the Execs, yourself, as head of HR,
 20 Sian Williams, Alison Kelly, how you had been
 21 communicating and the processes you had been using to
 22 inform Letby about what was actually taking place?
 23 **A.** Yes, I think there was a further element as
 24 well, if I may, which was around the concern in terms of
 25 how Letby had been spoken about but it, but it was
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1 propose we appoint an investigating officer, I suggest
 2 Sandra Flynn. However, the investigating officer will
 3 have to ask very difficult questions of the Consultants.
 4 I understand you were considering asking Ian Harvey to
 5 speak to Stephen Brearey and other Consultants have
 6 asked him to explain their concerns in writing and Speak
 7 Out Safely."
 8 **A.** Yes.
 9 **Q.** Because then they wouldn't have to have been
 10 shared.
 11 Did you actively consider following the process at
 12 this point and avoiding what was going on with the
 13 grievance?
 14 **A.** I did speak to Ian -- excuse me, I did speak
 15 to Ian Harvey at that stage. I don't know what Ian did
 16 with that but I suppose it goes without saying and
 17 I think I mentioned this earlier as well, apologies,
 18 that Speak Out Safely was always around this set of
 19 issues as well.
 20 **Q.** You were then interviewed yourself in the
 21 grievance INQ0002879, page 25. And you are asked about
 22 the redeployment decision. Second box:
 23 "The point I am concerned with is how open we were
 24 with Lucy. The reason we weren't was there being such
 25 vehement feeling without substantiation."
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1 Vehement feeling without substantiation. It's not
2 what you have told us you thought, certainly from
3 March 2017, is it?

4 **A.** No, I know, I -- I -- I realise how that now
5 looks and feels but it was from in terms of March 2017,
6 did you say, as well, apologies?

7 **Q.** Yes.

8 **A.** Yes. If I had -- if I known that information
9 at the point of this meeting, on 21 October 2016,
10 I would not have been -- I would not have said that in
11 that way.

12 **Q.** You had had by the meeting, the June 2016
13 meeting when the doctors had said what they were
14 concerned about and why. Did you still see that as
15 without substantiation? Are you saying even then what
16 we know was said on 30 June from your perspective was
17 without substantiation?

18 **A.** I -- that was potentially a poor choice of
19 words at that stage.

20 I think what I was trying to get at, and didn't
21 articulate it well, I see, was that there was this range
22 of factors that, that were we were having to unpick.
23 You know, many different people had looked at this, the
24 clinicians were raising those concerns around, around
25 Letby. You know, at that stage, multiple different

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1 referencing the concerns from the medical perspective as
2 well. I don't, I don't recall exactly when it was but
3 Kathryn did raise to me particularly the health concerns
4 around Letby and that was picked up in, from one of the
5 meetings that I had with her with, with Kathryn and also
6 with Letby as well.

7 I think, on reflection, the medical side of the
8 support that we offered we could have done more, we
9 could have done more.

10 I think whilst it goes without saying the
11 Occupational Health support was there, did we -- Ian was
12 managing multiple different aspects -- I've done it
13 again -- multiple different aspects and did he have the
14 capacity to pick all of that up? I don't know.

15 Could we have put someone in place to support the
16 team? Yes. Could I have asked one of my business
17 partners to support the team more regularly? Yes. And
18 I think those are some of the reflections that I would
19 like the Inquiry to be aware of as well.

20 **Q.** The hearing manager's findings. If we go
21 please to INQ0003611, page 2 and while we do, the
22 appointment Annette Weatherley, do you think she was an
23 appropriate choice as a nurse? Would it have been
24 better to have a neonatologist, for example, who
25 understood the medical concerns?

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1 reviews, multiple different people outside of the
2 organisation telling us different things.

3 **Q.** The only people we have seen you describe
4 before this meeting as either being emotional or
5 over-involved are senior nurses. You don't describe the
6 doctors as being vehement in terms of tone or emotional
7 involvement, do you?

8 **A.** No and that's why I say I apologise.
9 That's -- it's, it's -- I think that it was the emotion
10 myself at that time and that was probably inappropriate.

11 **Q.** Over the page, you say, in answer to
12 Dr Green's question:

13 "The aim is to get Letby back on the unit, that is
14 the intention to get her back, how she wants it to
15 happen. She needs some control."

16 And then in the last, on the last page, page 27, at
17 the top:

18 "Difficult conversations for the board.

19 Kathryn de Berger has concerns over Letby's short and
20 long-term health as a result of it. IH is following up
21 on the medical side."

22 So you express in this meeting concerns for Letby,
23 don't you? They are filtering through even at this
24 point?

25 **A.** Yes, without doubt. But I think I'm also

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1 **A.** I think when you go back to what the grievance
2 was about: this was about the transparency of the
3 information we had provided to Letby and how she
4 believed she was being referred to by clinicians. This
5 wasn't about clinical care. This was about the
6 transparency and openness of the Trust and this was
7 about how she was being treated.

8 So on the basis of that, we felt it was important
9 to have someone independently hear the investigation and
10 all the findings that Dr Green had, had undertaken and
11 it was important that that person was aware of what
12 potential nursing support could be put in place because
13 Letby was a nurse.

14 **Q.** Should she have been aware, when
15 Dee Appleton-Cairns was putting material together, for
16 example of the Thematic Review, conversations, like the
17 one you had on 30 June? Should she have been aware of
18 the bigger picture, Annette Weatherley?

19 **A.** You could look at it now and say that
20 absolutely, yes. But at the time, those weren't the
21 points that she was raising her grievance about. So it
22 wasn't relevant for the points that she needed the
23 answers on.

24 **Q.** So you stayed in the lanes of the grievance
25 process?

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1 A. Sorry?

2 Q. You stayed in the lanes of the grievance
3 process, the points she had raised and dealing with
4 those?

5 A. She was dealing with those, yes.

6 Q. Looking at these findings now, at paragraph 7.
7 When you read this, what did you make of this
8 conclusion at paragraph 7, particularly her finding
9 herself able or appearing to be able to acknowledge
10 concerns were raised through appropriate channels in
11 line with both the Trust's Speak Out Safely policy and
12 guidance proffered by the GMC?

13 Did you think that was the case when you read that?

14 A. Obviously this, this was shared with me.
15 I didn't make any changes. It wasn't for me to make any
16 changes to this. I -- I participated as one of the --

17 Q. Interviewees.

18 A. -- witnesses essentially as well. But it's
19 not for me to change what the Chair of a grievance
20 hearing finds.

21 Q. Did you think that was wrong, just inaccurate?
22 I see you couldn't change it, but did you read that and
23 think that's wrong?

24 A. Now? Now?

25 Q. Did you then? I mean, you knew what had
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1 A. I don't -- I don't believe I did. But as
2 I say, would it be -- I don't -- at the time I did not
3 think it was appropriate to change the -- the
4 information that was included from an independent Chair
5 of a grievance hearing.

6 **LADY JUSTICE THIRLWALL:** Just to be clear. This is
7 the Chair incorporating what Christopher Green says.

8 A. Yes.

9 **LADY JUSTICE THIRLWALL:** A direct quote from his.
10 That's just really for the record.

11 A. Yes.

12 **MS LANGDALE:** So you didn't challenge it at the
13 time, but you knew that that had been said; that's the
14 position?

15 A. I didn't challenge it at the time, no.

16 Q. That can come down, thank you.
17 You send another letter to Lucy Letby,
18 January 2017, INQ0008964, page 49, and you say at
19 page 50:
20 "We went on to discuss how we all needed to agree
21 a communication plan for your transition back to the
22 unit."
23 You explained how you wanted to be open and honest
24 in the communication that was issued regarding your
25 return. You recognise that as a Trust we may not want
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1 happened in terms of him talking to you, Dr Jayaram,
2 what had happened at meetings.

3 A. I -- I think it could have been worded
4 differently, but it wasn't -- it would be completely
5 inappropriate for me to change that wording that
6 a independent Chair has added into their findings from
7 a grievance.

8 Q. And here we see the next finding:
9 "I do not find the Consultants' concerns when
10 reiterated to the Executive Team were clear, honest and
11 objective."
12 What did you make of that? I mean, Dr Jayaram had
13 spoken to you as and Exec. Did you think he wasn't
14 clear, honest and objective?

15 A. These were the findings of the, the Chair of
16 the grievance hearing.

17 Q. But you knew that one was wrong, didn't you?
18 You were an Exec and you knew that it wasn't the
19 case that any Consultant hadn't been clear, honest and
20 objective with you?

21 A. I can see that now, how you are saying that,
22 yes.

23 Q. So when you read that did you say: Well,
24 which Exec are they supposed to have not been clear,
25 honest and objective with you?
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1 to communicate certain things.
2 And then four paragraphs down:
3 "Alison and I advise you that one of the key
4 actions stated within the letter was to arrange
5 a meeting with your parents and yourself."
6 This is the grievance letter.

7 A. Mmm.

8 Q. What did you make of that recommendation, that
9 there should be a meeting? As head of HR, what did you
10 think about that?

11 A. Very unusual. Very unusual to meet with the
12 parents and I -- I'm sure the Inquiry has seen from my
13 statement that I had already had a quite difficult set
14 of interactions with Mr Letby as well. So it was an
15 unusual step. But as far as possible whenever
16 a grievance hearing is undertaken, you -- an
17 organisation will try and deliver each of those points
18 of that grievance.

19 Q. We know in a meeting, the meeting held on
20 22 December 2016, at the Chief Executive's office, if we
21 go to INQ0002912, page 3. We see Mr Letby at the
22 penultimate entry says:
23 "Look at the highlighted section of the grievance.
24 At the summing up of the hearing Dr Chris Green advised
25 everyone that they showed everyone empathy. Only RJ
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1 [that is Ravi Jayaram] SB [Stephen Brearey] lacking.
 2 The behaviour of those two people, they should be
 3 instantly dismissed."

4 If we go over the page to page 5, Mr Harvey at the
 5 bottom:

6 "It's not appropriate behaviour nor had it been
 7 reported to me subsequently. SH and I met with SB.
 8 Will be followed up with documentation to all of them."

9 Mr Letby:

10 "What severity of action?"

11 And you say:

12 "It depends on the issue. If it's helpful we can
 13 share the disciplinary policy with you so you are aware.
 14 Hayley will be able to advise you from her
 15 understandings."

16 Mr Harvey, over the page:

17 "We need to support you. We need to ensure we pick
 18 up with medical staff and also the requirement for
 19 mediation."

20 So he is saying they should be dismissed.
 21 Mr Harvey is saying it's not appropriate behaviour and
 22 you're saying, "I can share the disciplinary policy and
 23 Hayley will be able to help you."

24 Why did you want to share with him the disciplinary
 25 policy or why would that be helpful?

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1 nature or spoken to a staff member's parents. These
 2 were however exceptional circumstances and I felt
 3 I needed to step in and support other members of staff
 4 who were struggling with the amount of pressure being
 5 exerted."

6 When Kathryn de Berger was asked if she felt she
 7 was being pressured by Mr Letby in phone calls she said
 8 she couldn't recall that. Can you tell us from your
 9 perspective how it was that you saw that staff were
 10 responding to the situation of being contacted by
 11 Mr Letby?

12 **A.** Sorry, it went in and out slightly then.
 13 Apologies, could you say that again?

14 **Q.** Yes. What was your understanding of how your
 15 staff, Kathryn de Berger in particular, was responding
 16 and/or Hayley Griffiths if she had said anything to you
 17 about the level of calls from Mr Letby?

18 **A.** So I think I do recall the conversation with
 19 Kathryn and again for the benefit of the Inquiry
 20 Kathryn, extremely experienced Occupational Health
 21 nurse, been at the Trust for a good number of years,
 22 been at other organisations as well, and I had no reason
 23 to doubt her telling me this as well.

24 She, she described to me how Mr Letby was getting
 25 quite agitated on the phone with her, that it was

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1 **A.** I think just trying to be, I -- I think just
 2 trying to be helpful in the meeting. Sometimes that's
 3 my downfall.

4 **Q.** So you are trying to please him, "We have our
 5 disciplinary policy."

6 But you know why he's asking for that, or you think
 7 you know why he's interested in that. Because he thinks
 8 they should be instantly dismissed, doesn't he?

9 **A.** I think it's very clear that the parents
 10 wanted -- they wanted to take action against the
 11 Consultants.

12 **Q.** If you take that down. At paragraph 375 of
 13 your statement.

14 **A.** Which paragraph, apologies?

15 **Q.** 375.

16 **A.** Thank you.

17 **Q.** It is your calls with John Letby and you
 18 documented calls on 16 and 17 January. You say:

19 "In my view he wanted to express his anger towards
 20 the ongoing situation with Letby. He had previously
 21 contacted Kathryn de Berger who was providing
 22 Occupational Health support to Letby. John was placing
 23 Kathryn under significant pressure to have the calls
 24 escalated to a more senior level. In normal
 25 circumstances I would not have dealt with a call of this

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1 becoming increasingly difficult for her to manage. She
 2 felt very uncomfortable.

3 And, you know, I didn't -- I felt that it was --
 4 I needed to try and support her through this situation
 5 as well. It was very unusual for me to have that; in
 6 fact, I don't think I have ever spoken to a member of
 7 a family in relation to an employment issue. That was
 8 the only time.

9 And then having the conversation with Mr Letby, it
 10 was very clear it was a very difficult set of
 11 conversations.

12 **Q.** You found yourself at the board meeting,
 13 I will call it up, INQ0003237, page 4. It is a board
 14 meeting on 10 January 2017 and it's you who finds
 15 yourself reading out a statement from the individual,
 16 it's reported that it was in the individual's own words.
 17 Was that the statement from Letby herself, the one that
 18 Karen Rees then read to the Consultants in the
 19 Consultants' meeting? See page 4, paragraph 6.

20 **A.** Yes. Yes. Sorry, what is the question as
 21 well?

22 **Q.** You read it out, we have seen the statement,
 23 I don't need to take you to you it, is three or four
 24 pages long. How come you were reading that out at the
 25 board, had anyone asked to you do that? Did you think

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1 that was a good idea?

2 **A.** I can't recall exactly why I read it out.
3 Maybe because I -- I was representing members of staff,
4 only for those purposes or perhaps because I was -- you
5 know, I had, I had met with Letby on a regular basis.
6 I can't recall the reason why I read that out.

7 **Q.** That can come down, please and very briefly
8 before we stop for another break, INQ0057275, page 1.

9 There is now an issue for communications, wasn't
10 there, it is just the top of the email we need from
11 Mrs Appleton-Cairns. You see at the top, we don't need
12 the A&E stuff.

13 "Met with Lucy and her family prior to Xmas. Comms
14 being worded with Gill. Lucy wants to draft her own
15 comms. Work to be done with SH."

16 So this is comms around what obviously people are
17 going to be told and if we see -- if that can come down
18 INQ0102217, page 1, you look like you sought advice on
19 this?

20 **A.** (Nods)

21 **Q.** Can we get a draft from Mr Pace --

22 **A.** Yes.

23 **Q.** -- on INQ0102217. That's his suggestion. Let
24 people read it. (Pause)

25 But then we see what is sent at INQ0058663, page 1.
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1 that time?

2 **A.** At that -- at that stage because she was she
3 had been redeployed, I see -- if she wasn't due to leave
4 at that point so at that point in time that was -- that
5 was factual.

6 **Q.** You thought she was coming back at that point
7 in time in April as far as you --

8 **A.** (Nods)

9 **Q.** Is that option 4 she was getting back?

10 **A.** That was -- that was the direction of travel
11 at that stage, yes.

12 **MS LANGDALE:** The meetings you have or the weekly
13 meetings there are a number. Perhaps it is a good time
14 to break and we will only go to a few of those and a few
15 comments.

16 **LADY JUSTICE THIRLWALL:** Okay. Ms Langdale, how
17 long for the lunch?

18 **MS LANGDALE:** Would 2 o'clock be suitable?

19 **LADY JUSTICE THIRLWALL:** Yes, certainly. That's
20 five minutes longer than I was thinking, so that's good.
21 We will take a break now and start again at 2 o'clock.

22 (1.08 pm)

23 (The luncheon adjournment)

24 (1.58 pm)

25 **MS LANGDALE:** My Lady, Ms Hodgkinson, we will pick
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1 We see there:

2 "After a thorough investigation established all the
3 allegations to be unfounded and untrue and I have
4 therefore been fully exonerated and I have received
5 a full apology from the Trust."

6 That goes to all of the staff in the NNU.

7 What did you think about the accuracy of that as
8 a communication as far as you were concerned?

9 **A.** Very disappointed in it, if I am honest. We
10 had provided the guidance to Letby and her Union
11 colleague and this was the information that was then
12 distributed.

13 **Q.** You then have a meeting on 6 February again
14 with Mr and Mrs Letby and Lucy Letby, INQ0008964. It
15 starts at page 29. INQ00089640029, there we are.

16 If we go to page 33 in this meeting, this is
17 a regroup to discuss everything:

18 "SL: We want something on record. What if
19 I leave?"

20 And you say:

21 "There will be nothing on your record. It will not
22 affect your reference or any other matters."

23 So she's asking in February 2017 what is going to
24 happen hereon in, and you say not affect your reference
25 or any other matters. Was that your understanding at
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1 up with the meetings that were happening on a weekly
2 basis with Letby and they are at INQ0005340, beginning
3 from page 2.

4 I am not going to highlight many passages as we
5 scroll through but just a few, if you can, for
6 amplification.

7 This first meeting on 10 January, second paragraph.
8 Reassurance is given by Mr Chambers that there was
9 nothing in the report about you. This is the RCPCH
10 report, because he is talking about governance,
11 communication, doctor/nurse relationships.

12 Did you ever see yourself the RCPCH report. It can
13 be highlighted in paragraph 2 at the top?

14 **A.** Sorry, again?

15 **Q.** Did you ever see the RCPCH report yourself?

16 **A.** I -- I do recall, yes, but it was really for
17 Mr Harvey to kind of manage that report.

18 **Q.** There was a whole section about Letby, of the
19 nurse, wasn't there and the HR process that needed to be
20 followed and recommendations for forensic review of
21 a number of babies that had died and we see here
22 reassurance given there was nothing in the report about
23 you.

24 When Mr Chambers said that, were you uncomfortable
25 or ...

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1 A. I think there was.
 2 Q. Actually, my apologies, you may not have been
 3 -- were you at this meeting?
 4 A. I don't think I was, no, no. In fact if you
 5 look at the details above, no. Tony, Alison, Letby,
 6 Karen Rees and Hayley.
 7 Q. Would you have thought that's not right if you
 8 had been?
 9 A. I think I seem to recall there were two
 10 different -- there was a confidential report and there
 11 was a more public facing report as well or not
 12 necessarily public facing but there was a different type
 13 of report.
 14 Q. So there was something where stuff had been
 15 taken out and if it was talking about the bit that had
 16 been taken out, that was justifiable?
 17 A. I -- I -- having not been in the meeting
 18 I couldn't necessarily comment.
 19 Q. Okay. Let's go to page 3, please. You are
 20 advised in the top meeting: spoken with Karen Rees about
 21 taking those calls that you said about in the evening
 22 with Mr Letby.
 23 A. (Nods)
 24 Q. Made it clear you are a trusted member of
 25 staff. The onus is to have correspondence with you

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1 any arrangements around where she was going?
 2 A. Yes.
 3 Q. You were aware of the Alder Hey visits,
 4 weren't you, that was something that was discussed?
 5 A. Well, not at the time when they had actually
 6 happened. We were aware but she was supposed to be
 7 advising us.
 8 Q. So did you find out later than you would have
 9 expected?
 10 A. Those that she had been but at that point we
 11 stopped it straight away, because it was clear that she
 12 was supposed to be advising us.
 13 Q. There was also a course, I think, that she
 14 attended, there was a discussion and you followed up
 15 whether there was any clinical involvement or something
 16 similar?
 17 A. Yes, there was no clinical involvement.
 18 Q. And then the Trust funded that?
 19 A. Yes, that was at I think Glan Clwyd, if
 20 I recall.
 21 Q. That's right. If we go to page 7, this time
 22 14 February, the third paragraph in that middle meeting,
 23 you are saying:
 24 "It would be helpful if you [that is Letby] could
 25 start thinking about what you wanted out of the

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1 first and not your parents.
 2 A. Mm-hm.
 3 Q. So that was discussed at the time. In
 4 paragraph 3, there's reference to "further support was
 5 needed at the time for your mum", and "that you would
 6 follow it up with Kathryn de Berger, Occupational Health
 7 and Wellbeing Manager, as necessary."
 8 Was that an invitation for her mother to take
 9 Occupational Health support?
 10 A. No, no, it wasn't. I think I may have
 11 described this in the statement with the police as well.
 12 Mrs Letby came across is quite timid but also very, very
 13 upset and -- and it was a concern about her own
 14 well-being and potentially I wanted to check with
 15 Kathryn whether there was something that she needed to
 16 do in terms of liaising with her -- with Ms Letby's GP,
 17 nothing more from a Trust provision to be provided.
 18 Q. Page 5. A meeting on 31 January in the second
 19 to last paragraph. You had advised -- this is Letby
 20 presumably:
 21 "... have been liaising with a colleague based at
 22 Alder Hey to view theatre lists and to have an
 23 observational contract. We agreed you would work with
 24 Karen to come back with a plan around this next week."
 25 Were you expecting Letby to keep you informed of

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1 mediation and what success looks like as part of this as
 2 the mediator may ask you to describe this as part of the
 3 process."
 4 Did you have that conversation with Letby about
 5 what she wanted out of it or not?
 6 A. Yes, because I recall that we had clarified
 7 with -- I think Kathryn had clarified with the Cheshire
 8 and Wirral Partnership Mediation Team as to how the
 9 mediation would go and what they would be looking to
 10 speak to Letby about as well. So that was one of those
 11 points.
 12 Q. Page 9, please. A meeting on 1 May at the
 13 top:
 14 "We concluded the meeting [sorry, 1 March] by
 15 discussing your plans for transition back to the NNU.
 16 You had been working with Karen on dates 3 April and
 17 10 April."
 18 That's your understanding of the dates that were
 19 being aimed for at that time?
 20 A. That's correct.
 21 Q. We see overleaf at page 10, the penultimate
 22 paragraph:
 23 "We agreed we would continue working through the
 24 plan for you to return and you would continue with your
 25 planning meeting with Yvonne, which was taking place on

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1 3 April."

2 Those can come down now, thank you, and if we go to
3 INQ0004402, page 1, this is an Executive Team note.
4 I don't think that date's correct, Ms Hodgkinson,
5 Wednesday, 22 March, because the action notes from
6 29 March have already happened, do you see that,
7 accepted?

8 **A.** (Nods)

9 **Q.** Your meetings are on Wednesdays so it looks
10 like this may be 5 April, the following one. But look
11 at the box at 2:

12 "LL was due on the unit today, has chest infection,
13 leave next week so defer until post Easter. [She]
14 doesn't want to go back to be pulled off unit again."

15 Can you remember her having a chest infection or
16 something that delayed that 3 April start, it seems to
17 be being referred to there?

18 **A.** I -- I can't specifically remember the chest
19 infection. I think it -- you know, at this stage maybe
20 it isn't explicit in the notes there, but I think as
21 I mentioned before it was almost like a maintaining
22 a status quo with Letby and, yes, we weren't transparent
23 at that stage but it was because of the information that
24 Dr Jayaram had disclosed to me on 15 March.

25 **Q.** Indeed it looks 5 April 2017, there is
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1 **A.** Yes, only afterwards.

2 **Q.** So no one spoke to you about that at the time?

3 **A.** No.

4 **Q.** Then we see another letter of 27 April,
5 INQ0008964, page 7, we see paragraph 4:

6 "You asked if you can return to the unit and both
7 Alison and I explained that this time the Trust decision
8 was your return to the unit has been paused."

9 Then over the page, penultimate paragraph:

10 "Alison explained that as your professional lead
11 she did want you to return to the unit. However, she
12 acknowledged again that this position is very difficult
13 for you and that we will get there. She reiterated that
14 Mr Harvey is facilitating the discussion in relation to
15 the clinical case review and requesting an urgent
16 meeting with the Consultants".

17 So as late as 27 April 2017, Ms Kelly explaining
18 she did want her to return to the unit?

19 **A.** (Nods)

20 **Q.** Was that your understanding that that's what
21 Ms Kelly thought at 27 April?

22 **A.** At that stage, it wasn't, that -- I think --
23 it's fair to say we weren't transparent with Letby at
24 that stage.

25 **Q.** Can we go, please, to INQ0002797, page 4.
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1 a letter --

2 **A.** Yes.

3 **Q.** -- sent from you, INQ0003477, page 1.

4 "Alison provided an update ... She advised that
5 work has been ongoing regarding clinical concerns
6 raised. She had met with Karen earlier today ... after
7 further discussions it was felt we should pause your
8 return to the neonatal unit at this time and to review
9 the position after the Easter break."

10 We see at the bottom, Letby asked if it was
11 guidance that she shouldn't return, or a management
12 instruction. Over the page:

13 "... asked if [she] could continue to visit the
14 unit and we advised we would consider whether this was
15 possible. After reflecting on this further and to
16 support your successful transition back to the unit, we
17 would recommend that we again pause with these visits at
18 this time."

19 The Inquiry received some evidence about a tea
20 party or an occasion in anticipation of her coming back
21 on to the ward having a cup of tea with some colleagues
22 on the ward and one of them saying it was very awkward
23 because she seemed very angry and didn't talk to them.

24 Do you remember that being set up, a kind of
25 facilitation visit or something to set the tone?
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1 Paragraph 5. Meeting between yourself,
2 Kathryn de Berger, Hayley Cooper, Karen Rees, Ms Letby
3 and Alison Kelly. Paragraph 5:

4 "Hayley then added how you had both been informed
5 by two different sources that Dr Brearey was leaving the
6 Trust. Alison and I explained we were not aware ... In
7 addition, Kathryn explained she had some concerns in
8 relation to the completion of the mediation with
9 Dr Jayaram. She advised that as part of mediation the
10 second part of the process required both parties to sign
11 an agreement on agreed ways of working and this was
12 returned to Jane, the mediator."

13 So pressure around them mediating. I think you
14 conceded at the outset you should have made it clear to
15 them and everyone they didn't have to do that?

16 **A.** Yes.

17 **Q.** They clearly thought they did, didn't they,
18 and Dr Jayaram did and didn't want to?

19 In terms of Dr Brearey was leaving the Trust,
20 that's what Hayley Griffiths said to you. What did you
21 know about that at that time?

22 **A.** I didn't know anything about that, that was
23 news to me.

24 **Q.** So 4 May, if people were talking about that in
25 the hospital, that was of news to you?
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1 A. At that -- at that stage, yes. I mean,
2 I think -- I think it also links back, though,
3 potentially to the pressure I mentioned before that he
4 was feeling, you know on various different bases.
5 Q. At a meeting INQ0002797, page 9, so
6 3 June 2017 this is. Three paragraphs up from the
7 bottom:

8 "You asked what was the reason [so Letby asked what
9 the reason was] behind the decision that you could no
10 longer go to Alder Hey. Alison explained she had
11 instructed Karen to also pull every member of staff from
12 their shadowing sessions at Arrowse Park Hospital and it
13 was not about singling you out."

14 Again was that transparent?

15 A. No. It wasn't. With Letby, no. And I think,
16 you know, that is that's a recognition that potentially
17 we could have been more transparent with her.

18 Q. Then over the page, page 10:

19 "Hayley also asked if you could visit the unit but
20 we collectively agreed this may be a police decision as
21 they may want this to take place in a controlled way."

22 A. Apologies, which paragraph is that?

23 Q. The penultimate paragraph on page 10.

24 A. Thank you very much.

25 Q. You see:

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1 that a Consultant, SB, is going around the NNU and
2 informing staff he has seen the external report ..."

3 That's the RCPCH report:

4 "... and, I quote, 'appears to be bragging about
5 it', stating 'the report has cleared all the medical
6 team as expected' and he also informed the staff that
7 had been given the funding for a new Consultant post
8 because of it."

9 When you received that, as head of HR --

10 A. Mm-hm.

11 Q. -- what did you do with that? Did you find
12 out who was supposed to have said it or did you just let
13 that sit as a hearsay complaint?

14 A. No, I think it's -- I can't remember exact
15 sequencing but I don't know whether this was linked to
16 one of the conversations that I had with Ian and whether
17 we spoke to Dr Brearey at the time. I can't remember
18 the exact sequencing around it. So it may have been
19 before that, but I -- yes, I -- I can't remember it
20 exactly what else happened then.

21 Q. This is 23 November and then we know from
22 Dr Brearey's evidence he receives and has a meeting with
23 Ian Harvey. If we call that up before we look at your
24 note of the meeting INQ0003094, page 1.

25 This is a letter that Mr Harvey sends Dr Brearey

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1 "Hayley also asked if you could visit the unit but
2 we collectively agreed this may be a police decision as
3 they may want this to take place in a controlled way."

4 It was very important that it was understood where
5 she was working --

6 A. Yes.

7 Q. -- or not, right?

8 A. Yes.

9 Q. Throughout the time in 2017 there was no
10 restriction, there was no interim order preventing her
11 from doing so?

12 A. I am trying to remember whether we had,
13 I don't think at that stage we had a system called
14 TeleTracking in place. We had that at some other point.
15 However, she was being closely monitored within the Risk
16 and Patient Safety team as well and if there were any
17 areas that she -- she was not given any aspect around
18 the neonatal, midwifery, obstetrics areas at all and
19 I recall that they were more pharmacy based.

20 Q. I am going to move finally now to the
21 Consultants' position and the support they by comparison
22 did or did not get. If we look, please, at INQ0002884,
23 page 1. This is a letter to Ms Kelly and you and others
24 from Hayley Cooper.

25 "Yesterday, some of her colleagues informed her

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1 having had you in the room when he met with Dr Brearey.
2 And so you know, if you don't already, Ms Hodgkinson,
3 Dr Brearey's evidence on this is:

4 "The only discussion I had with one nurse in
5 respect of the RCPCH report was to mention one aspect
6 that was not contentious, that two new Consultants had
7 to be appointed before the unit went back to the LNU
8 designation."

9 That is what he said; he was talking about the
10 designation and what was required?

11 A. Okay.

12 Q. We see in this meeting and from this letter
13 that Dr Brearey is being told that he can't share the
14 final report, but only in a controlled way, by which he
15 means Mr Harvey there should be an order of priority and
16 sharing the information whilst ensuring appropriate
17 support for those with whom it's been shared and he
18 expects a factual response.

19 Do you think that's quite a controlling letter in
20 terms of the issue it was addressing, how a professional
21 Consultant should deal with a report into concerns he
22 has about babies dying?

23 A. I don't know whether controlling -- I would
24 agree with the phrase controlling, but I can see where
25 it says "in a controlled way".

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1 I think -- and again this would be from, for
 2 Mr Harvey, for Ian, to -- to reference really as well,
 3 but I think he was making clear that the information
 4 that came through from the RCPCH report was shared
 5 sensitively and obviously there are -- you know, there
 6 are parents and there are babies at the heart of the
 7 report as well and making sure that that information was
 8 carefully managed and -- and communicated in the right
 9 way.
 10 **Q.** So what did you think they knew about that
 11 report in December 2016, the parents?
 12 **A.** What did I what, sorry?
 13 **Q.** What did you think the parents knew about that
 14 report in December 2016?
 15 **A.** I wasn't involved in any of the parent
 16 communications, so I couldn't be clear in terms of what
 17 happened then.
 18 **Q.** So do you know if Mr Harvey was --
 19 **A.** I know he was responsible for -- for that.
 20 But I don't know which parents he spoke to and when.
 21 **Q.** Shall we look at your notes of the meeting
 22 because you were there and you can perhaps tell us how
 23 the meeting unfolded?
 24 **A.** I was.
 25 **Q.** INQ0015641, page 26. It goes over to page 27.

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1 "... said no issue with Medical Consultant because
 2 of review getting ninth Consultant. Everyone hearing
 3 all sorts of things. Be very careful at this stage what
 4 you say and report concerns nurses and medical staff.
 5 Problem is they are getting head of steam."
 6 **LADY JUSTICE THIRLWALL:** Gather.
 7 **A.** "Gather head of steam", apologies.
 8 **MS LANGDALE:** The next bit?
 9 **A.** "Stephen Brearey, if cross line not my
 10 intention but not explicit in what discussed two weeks
 11 ago."
 12 Would you like me to continue?
 13 **Q.** Please.
 14 **A.** Okay.
 15 "Not completely quiet", possibly.
 16 **MS LANGDALE:** Not kept.
 17 **LADY JUSTICE THIRLWALL:** Keep.
 18 **A.** Yes:
 19 "... but this was a draft. I am sure I made clear
 20 at outset when final versions not received but need to
 21 be very careful, a lot of sensitivities, what say and no
 22 say it."
 23 **Q.** And over the page?
 24 **A.** "Misrepresentation, hopeful find two reports,
 25 next two weeks. Conversation with you. This is a note

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1 If we look at -- sorry I will wait until it comes
 2 on screen.
 3 **A.** No problem.
 4 **Q.** If we look at your third paragraph about SB.
 5 Sorry, second paragraph: SB wasn't entirely explicit?
 6 **A.** Mm-hm.
 7 **Q.** Hasn't spoken about any sensitive details,
 8 discuss with Ruth, is that Ruth Millward?
 9 **A.** I think it is Ruth Millward yes.
 10 **Q.** So Ruth Millward, so the Head of Risk and
 11 Patient Safety this conversation is being had with?
 12 **A.** (Nods)
 13 **Q.** So discuss with Ruth re draft discussed with
 14 Ravi Jayaram, a fellow Consultant.
 15 Mentioned to some nursing staff about the ninth
 16 Consultant before Level 2 designation.
 17 So as he told the Inquiry then that is what he said
 18 he had spoken about?
 19 **A.** Mm-hm.
 20 **Q.** What does the next -- can you decipher your
 21 writing? I am sure it is clear, it's my eyesight
 22 probably, tell us what it says --
 23 **A.** No, no it's my writing as well --
 24 **Q.** -- the next paragraph?
 25 **A.** -- I will be honest.

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1 of conversation re concerns I have."
 2 **Q.** What did you think the concerns he did have,
 3 he doesn't mention parents and patients, by the way,
 4 does he, he says members of staff in terms of concerns?
 5 So from being there rather than trying to anticipate it
 6 from being there, what were his concerns?
 7 **A.** I think it was, I think Steve was the clinical
 8 lead for the unit and I think whether Ian was explicit
 9 or not he was wanting Steve to make sure he was leading
 10 the messaging around the unit and leading them in the --
 11 in the appropriate way.
 12 **Q.** What was the appropriate way to lead that
 13 messaging?
 14 **A.** I think it's, you know, trying -- trying to
 15 keep to the facts.
 16 **Q.** What facts?
 17 **A.** The -- the facts that Ian had described as
 18 such. I think, you know, on reflection whenever I join
 19 or whenever a member of HR joins a meeting it always can
 20 be perceived in potentially the wrong way which is more
 21 of a management conversation and -- and to some extent
 22 this was -- but I think I was also there to also offer
 23 that additional support to Dr Brearey as well and also,
 24 you know, to ensure that the points that were, there was
 25 no other points that Ian made that were not needed.

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1 Q. It appears, though, with the timings, doesn't
2 it, that all this arose from the letter I have taken you
3 to from Hayley Griffiths, the complaint effectively at
4 the end of November. She makes a complaint, he's been
5 heard to speak, when in fact it's Ruth Millward who is
6 spoken to, and this is the response?

7 A. (Nods)

8 Q. Where Mr Harvey, you are there noting it, all
9 formal, isn't it?

10 A. Mmm.

11 Q. We are having to respond to this complaint
12 made by Hayley Griffiths, you don't go and speak to
13 Ruth Millward to see what was said?

14 A. Mm-hm.

15 Q. He's hung out to dry, isn't he, here, in your
16 letter telling him in a matter that he's really
17 concerned about as the neonatal lead who he can't
18 discuss and when?

19 A. Mm-hm.

20 Q. The contents of a report that they were
21 promised was going to be obtained in two weeks, that was
22 the condition: remember, we will get a report in two
23 weeks?

24 A. (Nods)

25 Q. Comes much later, they need to scrutinise it,
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1 the unredacted version?

2 A. Mm-hm.

3 Q. So he wants to see the whole report, to see
4 what's been said by the RCPCH?

5 A. (Nods)

6 Q. And is the answer he gets to that --

7 A. I think likely, yes.

8 Q. -- magnet for all gossip?

9 A. Yes so, "give heads up, something
10 circulating".

11 Q. So what did you understand from that, that
12 they couldn't see the unredacted version or could or
13 what?

14 A. I -- I believe at some stage they were going
15 to see it, yes.

16 Q. But not at that point because of concerns of
17 gossip, is that what that reads like?

18 A. I -- I couldn't -- couldn't say exactly why
19 Ian said that. Or what was, you know, the exact meaning
20 around it but I think there was a general concern from
21 Mr Harvey that things were being said in the unit that
22 were starting to gather, as he said in his words on the
23 first page, a head of steam.

24 Q. So that can go down now.

25 So we know from the doctors' point of view they
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1 but Letby's complaint precipitates this, doesn't it,
2 this meeting, this formality?

3 A. I think -- I think there were other elements
4 that played in and I think there was other information
5 that was coming through. I know that there may not be
6 the documentation associated with it but I seem to
7 recall there were other elements coming through, so it
8 wasn't just about Letby's complaint.

9 Q. Let's look at the rest of your note here, it
10 is still on the screen. Is there anything else in there
11 that deals with anything other than his discussion of
12 a draft report with Ruth Millward and mentioning a ninth
13 Consultant?

14 A. Sorry?

15 Q. Look at this meeting, so the meeting that you
16 have had, you have been asked by Mr Harvey to note this
17 meeting?

18 A. Yes.

19 Q. So is there anything else in these two pages
20 of notes before we take them off the screen that refers
21 to anything else bubbling up?

22 A. I think there is a point around further down
23 the page, the third from bottom: IH, a magnet for all
24 gossip.

25 Q. Yes because Dr Brearey says are we able to see
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1 think a review is going to be done within two weeks
2 although at the meeting we saw Mr McCormack pointed out
3 they wouldn't be able to do a review looking at the
4 suspicion of a nurse or an Allitt/Shipman situation.

5 When the report comes, it is redacted, they have
6 not seen it. You know the Executives are shown it
7 first?

8 A. Mm-hm.

9 Q. When you sit there now, thinking from an HR
10 perspective, that was not how the Consultants should
11 have been treated, was it?

12 A. I think I said before there were different
13 elements -- there are -- there are reflections around
14 how we could have supported the Consultants differently.

15 Q. Then if we look at INQ0005795, page 1,
16 Ian Harvey asks you in preparation for a meeting, he's
17 trying to get the Consultants to do mediation, isn't he,
18 and he wants information from you?

19 A. Mm-hm.

20 Q. You set out what's required from the grievance
21 process and you set out there Annette Weatherley's
22 findings.

23 A. Yes.

24 Q. "Clearly evident within the witness statements
25 that your movement from the unit was orchestrated by the
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1 Consultants with no hard evidence to support this
2 action."

3 This was 25 January 2017.

4 **A.** (Nods).

5 **Q.** "... behaviours and comments, as witnessed by
6 a number of senior managers and Executive staff, fall
7 far short of what is expected by the Trust and
8 professional standards."

9 Had you read the grievance report and tried to see
10 what the evidence was for any of those comments or
11 behaviours that were suggested?

12 **A.** Yes, I had, I did read the grievance report
13 afterwards of course.

14 **Q.** There was hearsay and no hard evidence from
15 anyone, was there? There was Eirian Powell's written
16 document sent by Mrs Appleton-Cairns, to Dr Green. But
17 no first hand account from someone saying: I heard them
18 say this ...

19 **A.** I -- I -- I can't recall specifically but
20 I know that definitely in my notes I have reference to
21 in various different meetings this person had said this
22 or this person had said that.

23 **Q.** What names -- the Inquiry has heard from a lot
24 of people and asked questions about it --

25 **A.** No, I appreciate -- I appreciate.
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1 the meeting.

2 **A.** Apologies, which note is it, Ms Langdale?

3 **Q.** 1 March.

4 **A.** Okay, thank you.

5 **Q.** So at the top you say:
6 "Response from Coroner more optimistic."
7 What do you mean, more optimistic?

8 **A.** I am, I am not clear on whether that was
9 around point 1 or in relation to something else,
10 apologies, I'm not clear.

11 **Q.** It says:

12 "Allow them to distance from allegations,
13 collectively raise concerns conflating the two together.
14 Not helpful moving forwards. Doesn't mean don't follow
15 through on the grievance. Ian Harvey: separate
16 grievance and concerns. Processes in parallel,
17 grievance and mediation".

18 So did Mr Harvey -- indeed did you -- see them as
19 separate issues, investigation of the concerns about
20 whether she was harming babies, from the grievance
21 process, and whether the Execs had failed to be honest
22 with her?

23 **A.** They were absolutely two separate things and
24 I think -- I don't know whether this also refers to that
25 the Consultants could raise a grievance as well, should
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1 **Q.** Just doing the best you can, what names of
2 a person do you say heard either of the Consultants
3 Drs Brearey or Jayaram speak in a derogatory way about
4 anyone?

5 **A.** Certainly I think Eirian Powell described that
6 Dr Brearey had said that or Eirian was concerned about
7 Letby's well-being and Dr Brearey had said: I am not
8 concerned about that. And Eirian had said something
9 along the lines of: what if she goes and takes her own
10 life? And he said: I am not bothered, or words to that
11 effect.

12 **Q.** Mm-hm.

13 **A.** That is one of those instances.

14 **Q.** So she told you that, did she, or did you see
15 that in writing?

16 **A.** I either was told that through one of the
17 nursing team -- I can't remember seeing it in writing
18 but I was definitely told that.

19 **Q.** That can go down now, thank you. Another
20 document, please, just to see what you understood about
21 the Coroner at this point. INQ0015641, it's another of
22 your notes, 1 March. Sorry INQ0015641, page 111.
23 Page 0111.

24 I don't think it's that, 0111. Read the note by
25 all means to anchor yourself into the position it was at
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1 they feel that that was appropriate.

2 **Q.** Well, the Consultants, Dr Jayaram wanted to
3 find out what had been said at the grievance, didn't he?

4 **A.** He did.

5 **Q.** So if we can just trace a series of emails to
6 see what happened there. In fact, before we do, can we
7 just pick up with your email to Mr Harvey in relation to
8 Jim McCormack. INQ0006219, page 2.

9 **A.** Excuse me.

10 **Q.** We see there he's asking for your assistance
11 because Jim McCormack doesn't know what he is supposed
12 to be apologising for so he's finding what that's about
13 and sending an email back and you set out what
14 Eirian Powell's statement had said in the grievance
15 investigation.

16 So it was her written statement of what was said?

17 **A.** Mm-hm.

18 **Q.** Can you see at the bottom?

19 **A.** Yes, I do.

20 **Q.** Again, did it concern you sending that to
21 Mr Harvey for which Mr McCormack was required to
22 apologise, did it concern you whether he had ever been
23 asked if he said that, Mr McCormack, in other words, if
24 he had done that?

25 **A.** I think in one of the meetings he had said he
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1 had done that as well, Mr McCormack.

2 **Q.** Was that your understanding?

3 **A.** Yes.

4 **Q.** Had he ever said that to you?

5 **A.** No. He hadn't specifically called her
6 a murderer to me.

7 **Q.** He had never been interviewed for the
8 grievance, you see. So it was Ms Powell's comments in
9 her written document that formed the evidence for that
10 but you didn't trace that back, you relied on Ms Powell,
11 did you?

12 **A.** It wasn't for me to rely on Ms Powell, it was
13 for the grievance obviously to -- that highlighted the
14 issue and in addition I think Ms Letby had already heard
15 that prior to Ms Powell raising it.

16 **Q.** Just to make the position clear for all, at
17 INQ0006432, page 1, Dr Brearey writes to you to make it
18 clear he thinks it's inappropriate to be undertaking the
19 grievance process. And then we know and we will come to
20 the meeting in a moment, Dr Jayaram discusses going to
21 it as well but he also emails at INQ0011870, page 1.

22 It's when he appreciates we see at paragraph 2 that
23 the mediator told him it was an entirely voluntary
24 process and he hadn't appreciated that.

25 If we can go please to INQ0003219, page 1, this is
149

1 Talk about Trust values and behaviours, [Chambers]
2 didn't display those then.

3 "Feel the board want us all to leave. If
4 [Tony Chambers] really wanted this to work, would be
5 thinking about STP and pushing as hard as he can to get
6 the unit back to Level 2. We feel we are not wanted ...
7 Raised he's written his resignation, three of us all
8 actively looking.

9 "Feel I can offer more outside of the organisation
10 to patient safety as not wanted here."

11 It is very troubling, is it not, that Dr Brearey
12 and Dr Jayaram thought they could keep patients in your
13 hospital safe when they weren't working there; safer
14 than when they were working there?

15 **A.** Mm-hm.

16 **Q.** When you read this, what did you think about
17 how the hospital had failed to treat the Consultants
18 with respect and concern that they had for the babies?

19 **A.** Obviously this -- this was the first part of
20 the meeting and it really disappointed me that Ravi was
21 feeling like this and I think, you know, I expressed
22 that to him as well.

23 I did state that to the Executive Team the next day
24 in terms of the level of feeling and --

25 **Q.** It is not feeling, is it?
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1 a meeting with you on 15 March to discuss mediation and
2 follow-up and you explain the process at page 1?

3 **A.** Mm-hm.

4 **Q.** If we go to page 2, Ravi Jayaram, so looking
5 at the treatment of the Consultants, he:

6 "advised he's read about whistleblowers in other
7 organisations and those who raise concerns and they feel
8 they are being treated by the board like this. The
9 board going down a path and set on a path, making
10 decisions around a member of staff returning and think
11 they may have been misled. [You] advised Ravi Jayaram
12 that Speak Out Safely incorporates whistleblowing and
13 patient safety concerns encouraged for everyone.
14 Concerns treated under the policy.

15 "Dr Jayaram raised concerns regarding losing
16 confidence in Tony Chambers, Ian Harvey and the board.
17 Feel bullied and intimidated to just accept it, the
18 plan. Feel being pushed back on to the Consultants as
19 our fault."

20 **A.** Mm-hm.

21 **Q.** "Alison Kelly praised her nurses and offered
22 support. Medics had nothing from Tony Chambers and
23 Ian Harvey. All started with Tony Chambers meeting in
24 September re the ninth Consultant. Poor communication.
25 Could have made a complaint then about his behaviour.
150

1 **A.** No, it is --

2 **Q.** It is reality.

3 **A.** Yes.

4 **Q.** Because there is plenty about they had gut
5 feelings about, suspicions, how they felt, not loved.
6 It is belittling, isn't it, Ms Hodkinson? They had
7 medical concerns, wanted to protect babies at the
8 hospital, and this is how they were treated?

9 **A.** I know it -- and it's, you know, it's
10 disappointing to read this now and I'm glad that Ravi
11 felt that he could raise that with me. And I think
12 I said earlier and I stand by this as well, I think now
13 on reflection, we should have put more in place for the
14 Consultants.

15 I think if there is an opportunity for me to add on
16 this as well, I think when trying to run a hospital, you
17 know, in a busy medium-sized district general hospital
18 alongside managing this type of case was extremely
19 difficult. I think not only for Tony, but for
20 Mr Harvey, for all of us, and I think potentially we
21 should have put additional support in place for the
22 medics particularly.

23 **Q.** Support from you, from the behaviour --

24 **A.** Not necessarily.

25 **Q.** From the behaviour you were all exhibiting
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1 towards them, they needed protection from the way the
2 Execs were treating their concerns and suspicions and
3 them?

4 **A.** Apologies, are you meaning me personally or --

5 **Q.** All of you as Execs, collectively, as Execs:
6 Mr Chambers, Mr Harvey, you, Ms Kelly; they needed
7 protection from you?

8 **A.** I don't think necessarily they needed
9 protection from us but I think we should have put more
10 -- an additional level of support in place to make sure
11 that they felt they were listened to, they were
12 supported and whether that was one of the Divisional
13 Medical Directors who specifically undertook that level
14 of support, whether it was designated occupational
15 health leads, there are multiple ways we could have done
16 it and I think with everything that we were managed,
17 managing, we overlooked that.

18 **Q.** This is why they needed protection,
19 Ms Hodgkinson.

20 Can we have a look, please, at INQ0015642, page 48.
21 11.45 am. 12 May 2017:

22 "RJ/SB plan re management.

23 "GMC [number 1] actions from grievance, mitigation
24 from whistleblowing.

25 "4. Action plan to manage out."

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1 **A.** (Nods)

2 **Q.** You were then dealing with your fellow Execs
3 but you weren't able to do what should have been done
4 with those concerns or even before then, were you? Was
5 that because you liked to please those around you or you
6 were an active participant in the conversations around
7 how do we shut this down, stop the Consultants on their
8 witch hunt and make sure Letby gets back on the unit?

9 **A.** Okay. Could you just clarify what you are
10 asking me, sorry?

11 **Q.** How actively were you involved in the
12 decision-making around she should stay on unit and come
13 back and there is a witch hunt here with the
14 Consultants' concerns? How active were you in that
15 story?

16 **A.** I think from that point onwards, I was
17 absolutely not active in anything in relation to that.
18 However, as I said earlier, I think the messaging to
19 Letby was almost like a stalling tactic as such to
20 ensure that we were not, I suppose, raising concerns
21 around us bringing the police in. I think one of the
22 difficulties, it took some time for that -- for
23 a follow-up meeting to happen with Dr Jayaram and
24 Dr Brearey.

25 Obviously Tony and I went to see Ravi and Steve the

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1 To manage out?

2 **A.** (Nods)

3 **Q.** That is what Mr Chambers was discussing,
4 wasn't he, managing them out?

5 **A.** (Nods). Yes. Nothing happened with that
6 though.

7 **Q.** Well --

8 **A.** Nothing happened with that at all.

9 **Q.** Very difficult to find that note as well, not
10 a criticism of you, you at least noted it. But in all
11 of the material we have, that was clearly a discussion,
12 wasn't it, from him?

13 **A.** It was a discussion in our one-to-one and
14 nothing happened with that at all. I think in addition
15 as well just -- apologies, I forgot to mention, in that
16 conversation with Dr Jayaram on 15 March he said to me
17 it was the first time he felt he had been listened to.
18 And I can absolutely say I did not take anything forward
19 around Deborah Healey and follow-up call. I expressed
20 to Tony my concern around this, this advice, but nothing
21 happened around this.

22 **Q.** And it's clearly the case you did hear his
23 concerns when he first raised them --

24 **A.** (Nods)

25 **Q.** -- back in March 2017?

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1 next day on 16 March. As you will see in my police
2 statement, there is various different elements where
3 I have then spoken to Ravi a number of times. But the
4 key part that we had agreed at that stage was to then
5 have a meeting with -- apologies, I can't remember the
6 name, I know it's Nim and Julie Maddocks, I can't
7 remember the -- is it the Neonatal Network?

8 **Q.** Mm-hm.

9 **A.** And that was one of the actions that they
10 wanted. So that took some time to -- to be arranged
11 I think that took place on 27 March and obviously that
12 was the one where there was collective agreement around
13 going to the police and I think, you know, I was
14 concerned that it was taking some time then to go to the
15 police.

16 **Q.** If we just finally, Dr Jayaram's complaints
17 about the grievance. If we go to INQ0068497, page 1,
18 there are a series of INQ numbers here, Mrs Killingback,
19 so I apologise in advance for that, but the first one is
20 the first two emails.

21 You have emailed to say:

22 "I just want to advise you that I have received
23 feedback that the joint meeting has gone well ... very
24 much appreciated."

25 He responds:

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1 "Cognitive dissonance once more. No, it did not go
2 well. I have never felt as threatened, vulnerable,
3 disappointed and angry in my life."

4 We then see another email chain, INQ0011817,
5 page 4. Pausing before we begin that. Dr Jayaram said
6 in evidence that he felt he was under duress to engage
7 in the mediation, do you appreciate that's how he must
8 felt?

9 **A.** Sorry, what was that?

10 **Q.** That he felt under duress to engage in
11 mediation?

12 **A.** As I said earlier, I have reflected a lot
13 around this and obviously I have heard Dr Jayaram's
14 evidence, I can see this in the emails now and I regret
15 putting him through the mediation process, I should have
16 stalled it at that stage on 15 March as soon as he
17 disclosed that information to -- to me.

18 I apologise if he felt under duress and for the --
19 for the experience he went through.

20 **Q.** Page 5 -- we are looking at page 4. Page 5 of
21 the letter he says:

22 "I felt as if I had been hung out to dry."

23 "Two things that I found disturbing [paragraph 3]
24 were that she has been led to believe (I am unsure
25 whether from the grievance statements or from her

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1 in due course which will include more detail around your
2 request to access relevant documentation."

3 And higher on 10 April, "any progress," he's having
4 to follow it, saying:

5 "None of my colleagues have any recollection of an
6 ultimatum being given to the Trust by myself and Steve,
7 nor do they feel we orchestrated a campaign."

8 If we go to page 2. You say on 11 April:

9 "Apologies, I am just on leave for a few days

10 I will be back in later this week and be pulling
11 together relevant extracts of the grievance."

12 Email above. He's saying it is over:

13 "... three weeks since I have asked for the
14 documents discussed in my original email. Am I to
15 assume the relevant extracts are still being pulled
16 together, you are completing a fuller response and that
17 Stephen Cross is still looking?"

18 If we go back to page 1, so 11817, page 1, he says:

19 "I am still keen ..."

20 What was the delay, had you spoken to Mr Cross
21 about it?

22 **A.** Yes.

23 **LADY JUSTICE THIRLWALL:** We have not seen that last
24 document, I don't think.

25 **MS LANGDALE:** If we go to your response, the

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1 discussions with board members) that I and a colleague
2 orchestrated a campaign to have her removed and
3 a colleague gave an ultimatum to the Trust that if she
4 was not suspended we would call the police, which as we
5 know is clearly not true."

6 At the bottom of the page, he says:

7 "In the light of my concerns, please could you
8 arrange for me to be provided with access to copies of
9 the minutes from board meetings attended by the
10 paediatricians, board meetings where the neonatal issues
11 were discussed by the board and relevant copies of the
12 grievance documentation."

13 **A.** Yes.

14 **Q.** If we go back to page 4, you respond:

15 "Thank you for your email. As you may be aware,
16 I have spoken with Ian about your email. I understand
17 he has spoken with you. I would be happy to meet with
18 you."

19 Above he says:

20 "I think the concerns I have made were explicit,
21 what's the process for me to be allowed to see the
22 documentation referred to previously?"

23 If we go back to page 3. You say:

24 "Thank you for your email. I will provide a more
25 comprehensive response to your email and your concerns

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1 response email, 5 May. INQ0002931, page 1. Take your
2 time. Everyone can read the response.

3 **A.** Thank you. (Pause)

4 **Q.** We know the Trust subsequently took legal
5 advice on this. You weren't at that meeting with
6 Corinne Slingo, it is Dee Appleton-Cairns, so I don't
7 went to trouble you with that. But you respond with the
8 extracts of interview notes on page 2 and that was it.

9 Dr Jayaram made a Freedom of Information Request,
10 didn't he, and got sent little sections but he gave
11 evidence it was only with the Public Inquiry he saw the
12 whole grievance investigation and how it was put
13 together, both Dr Green's findings and also
14 Annette Weatherley's decision-making?

15 **A.** Mm-hm.

16 **Q.** When you look at that now, and the way
17 Dr Jayaram and Brearey were criticised within that
18 process and subsequently, do you accept that was
19 entirely wrong?

20 **A.** The criticism of them?

21 **Q.** Yes, the criticism and the process, it was
22 entirely wrong?

23 **A.** I think it goes -- I think it goes back to
24 what the grievance was about though. The grievance was
25 not about the care within the unit. The grievance was

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1 about how Letby felt that she had not been openly and
2 transparently communicated with by the Trust and also
3 reference to inappropriate comments being made about
4 her. So I think it's slightly different.

5 **Q.** The grievance finding by Ms Weatherley was
6 that the doctors, the Consultants, had not been clear,
7 honest and objective dealing with you, the Executives.
8 That was wrong?

9 **A.** Mmm (Nods)

10 **Q.** The way they were treated by you as
11 an employer was totally wrong?

12 **A.** (Nods) Sorry, the question is?

13 **Q.** Do you agree that it's totally wrong?

14 **A.** I have already said I think we should have put
15 more -- more support in place and as I mentioned
16 earlier, you know, I regret taking Mr -- Dr Jayaram
17 going through the mediation process once I knew on
18 15 March.

19 **Q.** The Speak Out Safely policy was never followed
20 as it should have been at the beginning, never followed?

21 **A.** I -- I think I -- because of there being so
22 many reviews the view was that all of those reviews were
23 still being captured under the Speak Out Safely policy
24 and I think I recall at some point early 2017 the formal
25 recording of this was captured within the, as it

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1 **LADY JUSTICE THIRLWALL:** -- when we get to it. So
2 if you look at the bottom left-hand corner.

3 **A.** Yes.

4 **LADY JUSTICE THIRLWALL:** Is that the bit you were
5 thinking of?

6 **A.** There was -- there was another point as well.

7 **LADY JUSTICE THIRLWALL:** I haven't found that but
8 do you want to read out this bit, if it's one of them,
9 if you read it out?

10 **A.** In relation to Dr Brearey's point?

11 **LADY JUSTICE THIRLWALL:** Yes, I thought that is
12 what we were looking for, yes.

13 **A.** Of course:

14 "Something nagging me, open about care on the unit.
15 Observations before meeting, Datix incidents,
16 inconsistencies, problems governance."

17 I don't know whether that is "facilitates" or
18 "facilitators: "

19 "First one wonderful and left. Second replaced,
20 less than adequate, replaced by someone, fish out of
21 water."

22 **MS LANGDALE:** My Lady I think at page 57 there is
23 also a reference that you may have been referring to
24 before, Ms Hodkinson.

25 **LADY JUSTICE THIRLWALL:** Thank you, Ms Langdale.

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1 probably was called then, the Freedom to Speak Up Group
2 as well.

3 **MS LANGDALE:** Those are my questions, Ms Hodkinson.

4 **A.** Okay, thank you.

5 Questions by LADY JUSTICE THIRLWALL

6 **LADY JUSTICE THIRLWALL:** Thank you, Ms Langdale.

7 Just before you start, Mr Baker, I will just ask
8 a question because I meant to ask it earlier and I don't
9 want it to come out of anybody else's time but mine.

10 Early on in your evidence, you were referring to --
11 you were referred to one of the meetings at which you
12 thought Dr Brearey had said something and you couldn't
13 find it and then we moved on?

14 **A.** Yes.

15 **LADY JUSTICE THIRLWALL:** I think I have found the
16 passage.

17 **A.** Thank you.

18 **LADY JUSTICE THIRLWALL:** So the document is
19 00015639 and it is at page 60.

20 **A.** Thank you.

21 **LADY JUSTICE THIRLWALL:** Now, I know you have had
22 a hard copy made of a set of notes but I don't know if
23 it's this meeting but let's have a look and see if you
24 can read what's on the screen first --

25 **A.** Certainly.

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1 **MS LANGDALE:** Bottom right of page 57. That's 58.

2 **A.** Yes, that is the point.

3 **LADY JUSTICE THIRLWALL:** That is the bit you were
4 looking for.

5 **A.** Yes.

6 **LADY JUSTICE THIRLWALL:** Do you want read that?

7 **A.** I can indeed:

8 "Reviewed every case more than once. Care never
9 perfect. Learnt concern, theme to this individual. All
10 clinicians come back, not going to reassure us that
11 issue comes back but Dr Brearey was saying that the care
12 was never perfect."

13 **LADY JUSTICE THIRLWALL:** Thank you very much. Now
14 Mr Baker, it's your turn.

15 Questions by MR BAKER

16 **MR BAKER:** Thank you, Mrs Hodkinson. I ask
17 questions on behalf of the Families of 12 children.

18 You referred to whistleblowing as being a protected
19 disclosure, what do you mean by "protected disclosure"?

20 **A.** In a sense that if a member of staff raises
21 concerns around patient safety that they will be
22 protected around ramifications of any action taken by
23 the Trust.

24 **Q.** Why do whistleblowers need to be protected?

25 **A.** So that they can raise concerns openly, fairly

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1 and on a timely basis.

2 **Q.** It's because there is a problem, isn't there,
3 when it comes to whistleblowing, that whistleblowers are
4 often victimised, bullied, managed out of Trusts?

5 **A.** There has been -- there has been, it's I think
6 -- you know, certainly from the education I had around
7 it through Henrietta Hughes, who was the National
8 Freedom to Speak Up Guardian at the time through the
9 team. There was various different cases, unfortunately
10 were there were some -- some deaths of former members of
11 staff who have, you know, been whistleblowers,
12 absolutely. So a critical, a critical element.

13 **Q.** So whistleblowers are vulnerable first of all?

14 **A.** (Nods)

15 **Q.** That is why they need the protection to make
16 their disclosures. They are vulnerable to victimisation
17 bullying, managing out of their jobs?

18 **A.** (Nods)

19 **Q.** What they do is incredibly important?

20 **A.** (Nods)

21 **Q.** Because they are the eyes and ears of the
22 organisation --

23 **A.** Mmm.

24 **Q.** -- when it comes to patient safety?

25 **A.** Mm-hm.

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1 feel to their colleagues?

2 **A.** Yes.

3 **Q.** Being a whistleblower is a brave and difficult
4 thing, isn't it?

5 **A.** Extremely.

6 **Q.** What it says at the bottom, the final
7 paragraph:

8 "If staff are uncertain about whether or not to
9 express a concern it is normally better for them to
10 voice this rather than to remain silent. Often
11 discussing an issue, normally with the immediate
12 manager, will provide an opportunity to view the matter
13 from a different perspective. From there it can go
14 forward be and be dealt with if necessary. Delay in
15 expressing concern could lead to recurrence and/or make
16 investigations more difficult."

17 **A.** Mmm.

18 **Q.** So what you are telling your staff or the
19 hospital staff there is: if you have a concern, voice
20 it?

21 **A.** Mm-hm.

22 **Q.** We will listen to you, we will protect you but
23 if you delay voicing this concern, then you risk harm to
24 the patients, so that's what's written on paper for the
25 staff.

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1 **Q.** So they have to be protected because a culture
2 has to be created whereby whistleblowers feel safe to
3 disclose patient safety issues?

4 **A.** Yes.

5 **Q.** There is an expectation when it comes to
6 whistleblowing, provided that the whistleblower acts in
7 good faith --

8 **A.** Mm-hm.

9 **Q.** -- then they will be protected?

10 **A.** Yes.

11 **Q.** And their concerns will be listened to?

12 **A.** (Nods)

13 **Q.** And effectively what's said within the Speak
14 Out Safely policy, and if we go to INQ0003014, and to
15 page 2, now towards the bottom of the page, it says:

16 "By implication this policy is concerned with the
17 possibility that a member or members of staff are not
18 delivering the standard of patient care expected of
19 them. Making a complaint about the way in which
20 a patient or patient group has been treated may
21 therefore place an individual member of staff in the
22 difficult position of choosing between loyalty to
23 a colleague and the patient's best interests."

24 So we can see this dichotomy between the need to
25 protect patient safety and the loyalties that people may

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1 If we go back to a snapshot of early 2017. History
2 tells us that the Consultants were right, Lucy Letby is
3 a serial killer?

4 **A.** Mm-hm.

5 **Q.** Now, a receptive whistleblowing culture, one
6 that is properly embedded and has proper leadership
7 behind it, would encourage people to come forward with
8 their concerns as soon as possible?

9 **A.** Yes.

10 **Q.** Potentially if it existed it could have
11 actually saved lives?

12 **A.** Mm-hm.

13 **Q.** If we go to INQ0015642, and to page 48, there
14 we go, you have seen this note before. Now, you were
15 taken to this note and you said nothing happened around
16 this?

17 **A.** Mm-hm.

18 **Q.** Well, can I tell you the reason why nothing
19 happened around this. Because on 12 May, there was
20 a meeting between the Executives and the police, so the
21 involvement of the police on 12 May stopped this, it
22 didn't happen because people changed their minds about
23 it.

24 **A.** May -- may I just raise a point there, though,
25 if that is possible?

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1 Q. Yes.
 2 A. Apologies, please continue if you were going
 3 to.
 4 Q. You can raise a point, that's fine?
 5 A. Thank you. I think -- again I have thought
 6 long and hard about why Tony said this, I think it was
 7 linked back to what I described before, you know,
 8 Tony -- he was -- he was -- he is or was then a great
 9 person to -- to work around, but I think sometimes his
 10 frustrations came through and this was one of those
 11 moments. But it was in a place to me, I made a note of
 12 it, you can all see that there, but nothing did happen
 13 with it and I challenged it in the meeting and if it had
 14 continued, I would have challenged it then as well.
 15 Q. Yes. So let's look at what's being discussed.
 16 So plan re management item 1 GMC, so refers the
 17 Consultants to the GMC?
 18 A. Mm-hm.
 19 Q. Item 2, actions from grievance.
 20 Now, in February 2017, at a meeting
 21 Ian Chambers(sic) Had said to Lucy Letby and her
 22 parents that he supported the nurses and that Lucy Letby
 23 would be back on the ward, he gave that assurance didn't
 24 he?
 25 A. (Nods) Mmm mm.

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1 whistleblowers, we were doing the brave thing that the
 2 policy told us to do, and now you are managing us out?
 3 A. I -- it -- as I say, nothing further happened
 4 around this.
 5 Q. Well, something may have interrupted it. But
 6 this was certainly Tony Chambers's plan on the 12 May,
 7 wasn't it, because you are writing it down?
 8 A. It's what we talked about in our one-to-one.
 9 Q. Yes, and this is your note and nowhere within
 10 this note does it say that you challenged him about it?
 11 A. But I wouldn't necessarily write my own note
 12 about what I discussed. If you check any of the notes
 13 that I have taken, I don't -- if I do say something it's
 14 very quick, if, say, for example, going back to that
 15 30 June meeting, I think I say one point there around
 16 Occupational Health, so I quickly make a note of it
 17 myself.
 18 Q. Okay.
 19 A. But we definitely did discuss.
 20 Q. So when you have meetings and you make file
 21 notes you don't write your own words down. We will come
 22 back to that in a moment. Are you saying that you
 23 challenged him about this or were you part of this?
 24 A. I believe I did, but I -- but again you would
 25 need to verify that with Tony. I think I was very

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1 Q. Now, item 3, what does this mean:
 2 "Mitigation from SOS/whistleblowing"?
 3 A. I can't -- I can't recall the specifics around
 4 that at the moment as to what -- what exactly, you know,
 5 he said or meant by it. I --
 6 Q. Does that stand for Speak Out Safely?
 7 A. "SOS" is Speak Out Safely, yes.
 8 Q. So why would you need to mitigate the Speak
 9 Out Safely/whistleblowing policy? Why would that need
 10 to be mitigated in this situation?
 11 A. I -- I don't know.
 12 Q. Well, can you guess?
 13 A. Potentially "how do you manage around that",
 14 but as I say I -- I think I just took a note of this at
 15 that stage and I know that I would have gone back to
 16 Tony about it because it really concerned me.
 17 Q. So given what's written next:
 18 "Action plan: to manage out the two Consultants."
 19 A. Yes.
 20 Q. Presumably you would have to do that by
 21 working around the SOS whistleblowing policy which
 22 protects them?
 23 A. Potentially.
 24 Q. Well, not potentially; you would have to,
 25 wouldn't you? Because they would say: we were

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1 surprised that that was --
 2 Q. Yes. Because it's reprehensible, isn't it, if
 3 that was the plan, utterly reprehensible?
 4 A. It's disappointing.
 5 Q. No, no, it's reprehensible. Because these are
 6 whistleblowers and a plan is being created to refer them
 7 to the GMC and manage them out which is completely the
 8 opposite of what should happen to whistleblowers, isn't
 9 it?
 10 A. (Nods) It, it's -- if those are the words that
 11 you choose to use, I suppose from my perspective, it was
 12 disappointing.
 13 Q. Well, let's look at what you write when you
 14 write notes then, please. Can we go to INQ0003219. So
 15 this is a note of your meeting with Ravi Jayaram on
 16 15 March 2017. We can see it's effectively a script
 17 that has "RJ" for Ravi Jayaram and "SH" for you.
 18 So it does actually include your words as well?
 19 A. But I think that's very -- this type of
 20 meeting is very different to a one-to-one with
 21 a manager. This is a meeting where Ravi has at the end
 22 of the meeting disclosed very serious concerns to me
 23 that I had never heard in those terms before.
 24 So and in addition his concerns around the
 25 mediation. So I think it's appropriate that I wrote it

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1 like this, but for a one-to-one with my line manager,
2 I wouldn't be -- I think if you checked in any of my
3 notes, I wouldn't be saying "I said this, he said that".

4 **Q.** So a one-to-one with your line manager where
5 your line manager tells you to mitigate the
6 whistleblowing policy and manage two Consultants out of
7 the Trust, that must be a fairly extraordinary meeting
8 to have?

9 **A.** And I think as you will see from one of the
10 actions that I -- I typically -- what I do when I take
11 an action is I write an A and circle it. And so one of
12 the actions was to get external advice about this which,
13 whilst I can't remember all of the detail of that
14 meeting, because it was eight years ago, or seven years
15 ago, I think that one was now, you know, I -- I felt
16 uncomfortable to give advice on that myself and needed
17 to take external advice on it.

18 Deborah Healey is a partner at DACB and so was the
19 most experienced person I could go to there from
20 an employment perspective.

21 **Q.** Can I suggest to you that the note is written
22 in the way that it is, the note on 12 May, because you
23 were a willing participant in that conversation; you
24 were there supporting Tony Chambers in that
25 conversation?

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1 **A.** No.

2 **Q.** -- had they not taken this step and called the
3 police?

4 **A.** No, I said earlier that we were maintaining
5 almost like a stalling position, a status quo position
6 with Letby because of the growing likelihood at that
7 stage that the police were going to get involved and
8 I think because of the pressure from the RCN throughout,
9 you know, that year and a bit, they were very clear
10 around how they wanted the doctors to be managed as
11 well.

12 So it was not to add anything further to make this
13 an even more difficult position than it was.

14 **Q.** Can I take you then finally to INQ0005810
15 which is a note between -- of the meeting between
16 a number of Executives and Lucy Letby's parents and
17 Lucy Letby.

18 If we turn, please, to page 3.

19 Tony Chambers:

20 "I met with the neonatal nurses. Hayley was there.
21 What you say in the email are two different things. We
22 have made it clear we support the nursing medical team.
23 All support your transition back. We are in a good
24 place. The unit needs time to reflect what the report
25 says. Leadership, trust, professional honour, intact

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1 **A.** No, not at all. Not at all, categorically not
2 supporting that position.

3 **Q.** Finally, can I tell you something else that
4 almost happened. You see this process, the defensive
5 grievance, the victimisation of the doctors, delayed
6 Lucy Letby being brought to justice?

7 **A.** Mmm mm.

8 **Q.** Do you agree?

9 **A.** I said earlier that, you know, I was
10 disappointed that they took so long for the police to be
11 instigated from that 15 March meeting.

12 **Q.** But the diversion into the grievance, into
13 meetings reassuring Letby and her parents that apologies
14 would be given, the victimisation of the doctors all
15 delayed Lucy Letby being brought to justice, didn't it?

16 **A.** I don't think the grievance did. I think that
17 happened in parallel to the external reviews. All of
18 the external reviews were still taking place while the
19 grievance process happened.

20 So I would -- I would disagree with that point.

21 **Q.** What Dr Brearey and Dr Jayaram said in -- one
22 of them said in their evidence was that at the time the
23 police were contacted they believed that Lucy Letby was
24 about five days away from coming back to the ward.
25 That's what would have happened, isn't it --

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1 for yourself. I want it to continue."

2 What Tony Chambers is saying there to Lucy Letby
3 and her parents is that he backs the nurses, we are
4 supporting you coming back, your honour is intact and
5 I want that to continue.

6 Now, that's a reassurance, an assurance to
7 Lucy Letby that she's coming back, isn't it?

8 **A.** I think he says we made it clear we support
9 the nursing medical team, so both staff groups there.
10 I think some of the wording that Tony said could have
11 been worded differently and I think this is where Tony
12 perhaps tried too hard on some occasions, not just this,
13 other occasions I recall outside of this case where he
14 tried to do the right thing and sometimes it just didn't
15 come out in the right way.

16 **Q.** I mean his attitude, do you agree, was that
17 Lucy Letby was coming back and if the doctors didn't
18 like it, they would be gone?

19 **A.** I don't think that was -- I think also in that
20 particular meeting and in the conversations I had had
21 with Mr Letby he was adamant about the feeling for the
22 doctors. He was wanting to refer them to the GMC.
23 I think Tony was trying to manage that in the meeting as
24 well.

25 **MR BAKER:** Thank you, my Lady, I have no more

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1 questions.

2 **LADY JUSTICE THIRLWALL:** Thank you, Mr Baker.
3 Mr Sharghy.

4 Questions by MR SHARGHY

5 **MR SHARGHY:** Mrs Hodgkinson, I ask questions on
6 behalf of the remaining Families of the babies that
7 Lucy Letby harmed.

8 Can I start off by asking you that during the
9 period from 2015 to 2017, did you believe that a nurse
10 could deliberately harm babies in their care?

11 **A.** No, not until that point on 15 March. But you
12 always have to have an open mind that not just a nurse
13 could harm babies, but that any member of staff could do
14 something which either knowingly or unknowingly could
15 affect patients within the Trust and that's --
16 apologies, that's -- you know, there are other cases
17 that I was dealing with during that time where that
18 happened as well.

19 **Q.** You were asked by Ms Langdale previously in
20 terms of your knowledge regarding the actions of
21 Beverley Allitt and the fact that she did harm babies in
22 her care. Was that not even within your contemplation
23 during that period of 2015 to 2017?

24 **A.** It absolutely was, it absolutely was, and
25 I think it goes back to a point I made earlier as well

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1 **Q.** Of course, but at the time --

2 **A.** Yes.

3 **Q.** -- the level of evidence that's required
4 before action is taken doesn't need to be substantive,
5 does it?

6 **A.** It -- it -- I think at that time eight years
7 ago it -- there was various, the Thematic Review had
8 happened, certainly from my perspective I was hearing
9 those other elements on 30 June, not consistent around
10 how the care was in the unit, there was multiple
11 different factors playing in. And whilst now I know
12 that we all -- you know, we all know the terrible acts
13 that Letby did, it wasn't clear at the time.

14 **Q.** Do you agree or disagree with the proposition
15 that at that stage, in 2015 to 2017, the evidence
16 concerning deliberate harm did not have to be
17 substantive before action was taken?

18 **A.** I can only say from the point I was involved,
19 if that's -- because I wasn't involved prior to.

20 **Q.** Which is why I have taken the period 2015 to
21 2017?

22 **A.** Yes, yes. The concerns can be raised as --
23 absolutely.

24 **Q.** Is it also right to say that there was no
25 policy at the time between that period that specifically

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1 in terms of my deputy Dee Appleton-Cairns who actually
2 raised this with our external legal time DACB on 5 --
3 gosh, I have forgot my dates now. Is it 5 July 2016?

4 **Q.** July.

5 **A.** So absolutely, the point was well known at
6 that stage.

7 **Q.** So even though you didn't quite believe that
8 a nurse could deliberately harm babies within that
9 period, you would have known, wouldn't you, in your role
10 that if there were concerns raised about the very thing,
11 that that is quite a serious matter?

12 **A.** Absolutely.

13 **Q.** In terms of the threshold for action that
14 needs to be pretty low, doesn't it?

15 **A.** It does, it does.

16 **Q.** Insofar as evidence is concerned, that goes
17 with the threshold, if there is a low threshold you
18 don't need a huge amount of evidence; is that your
19 understanding at the time?

20 **A.** It was at the time. However, I think it's
21 important to note that having reviewed the Bowers report
22 particularly I think there's an excellent recommendation
23 in there that if I and the rest of my Executive
24 colleagues had had at the time would have been extremely
25 helpful for to have.

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1 required a certain threshold or type of evidence to
2 substantiate action to be taken to protect patients?

3 **A.** Safeguarding policy.

4 **Q.** Yes, but it didn't require things such as
5 substantive evidence to be provided?

6 **A.** No, no, but the safeguarding policy I suppose
7 was one -- was an element you could link in to there.

8 **Q.** In your witness statement to this Inquiry, you
9 have used the phrase "no substantive evidence" 13
10 times --

11 **A.** Right, okay.

12 **Q.** -- to indicate and justify why no action was
13 taken. Can you help explain why that does appear
14 multiple times in your witness statement when in fact
15 that was not the threshold?

16 **A.** I hadn't counted how many times I have, I have
17 written it. So, but it -- this was an extremely complex
18 set of circumstances, set of information, the
19 Consultants' concerns, absolutely, I have said, you
20 know, that I heard them and I specifically acted on them
21 when Dr Jayaram spoke to me on 15 March 2017, but
22 I think it was incredibly, incredibly complex.

23 **Q.** Let's go to the discussion and I won't
24 necessarily turn up the notes, unless you wish me to do
25 so, about the discussion you had with Dr Jayaram on

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1 15 March 2017?
 2 **A.** Yes.
 3 **Q.** I understood your evidence to the questions
 4 that Ms Langdale asked you that you were stunned?
 5 **A.** Mm-hm.
 6 **Q.** You were drawn to tears on your way home and
 7 you said two further important things which was: it
 8 changed our direction, and I understood that to mean the
 9 direction of the Executives?
 10 **A.** Mm-hm.
 11 **Q.** You also said that at that meeting and the
 12 information you were provided regarding these three
 13 babies was what made you sure, "definite" I think is the
 14 word you used, that this was the time that the police
 15 should be brought in, so those are your words?
 16 **A.** (Nods)
 17 **Q.** Insofar as actually what happened only 15 days
 18 later, and I think it is important to bring this
 19 document up, INQ0005340, page 10, this is a meeting that
 20 you were present at with Lucy Letby, Karen Rees,
 21 Kathryn de Berger and Alison Kelly on 30 March 2017. So
 22 15 days after this shocking revelation is made to you
 23 and you are of the clear view the police need to be
 24 called?
 25 **A.** Yes.

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1 concerns and the potential for a police referral, there
 2 continued to be no substantive evidence."
 3 That is simply not true, is it?
 4 **A.** I accept that now and -- yes, but --
 5 **Q.** What?
 6 **A.** I think, sorry.
 7 **Q.** I was going to say: this is a witness
 8 statement you made to this Inquiry this year?
 9 **A.** Mm-hm.
 10 **Q.** Earlier on this year. Why are you making such
 11 statements when you must clearly understand and know
 12 that it isn't correct?
 13 **A.** I -- I apologise for that.
 14 **Q.** You were also taken by both Ms Langdale and
 15 Mr Baker to the discussions about managing out the
 16 Consultants. Again I'm not going to take you to the
 17 note. What I would like you to do, please, is go in
 18 your witness statement to pages 116-117,
 19 paragraphs 348-349. Thank you, that document can come
 20 down.
 21 Mr Baker has taken you through in some detail the
 22 action plan, that is not what I am going to focus on.
 23 I am going to focus on what you say in paragraph 349.
 24 You indicate that you didn't agree with the position of
 25 managing out the Consultants but what you do go on to

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1 **Q.** Can you explain why, therefore, on the
 2 penultimate paragraph up, it says:
 3 "We [that must include you] agreed that we would
 4 continue working through the plan for your return to the
 5 unit and that you would continue with your planning
 6 meeting with Yvonne ..."
 7 Which would take place a few days later?
 8 **A.** Yes, yes. So the reason -- reason from that
 9 as I stated earlier as well is that we were maintaining
 10 a status quo with Letby. There -- there was not a plan
 11 at that stage for her to go back but I think in terms of
 12 communication with her we were stating that there was
 13 still that plan to happen. But internally from an Exec
 14 perspective that was not going to proceed.
 15 **Q.** Can I please take you to your own witness
 16 statement, which I hope you have a hard copy of?
 17 **A.** Yes.
 18 **Q.** It is on page 131, paragraph 390, where you
 19 discuss this very meeting.
 20 **A.** Sorry, 131?
 21 **Q.** Page 131, paragraph 390. You say just
 22 two-thirds of the way down:
 23 "It remained a collective decision [that again must
 24 include your part] to work towards Letby's return to the
 25 NNU on 3 April 2017. Whilst there were ongoing clinical

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1 say is that:
 2 "There was a growing consensus at the time that the
 3 Consultants, namely Dr Brearey and Dr Jayaram, were not
 4 acting professionally or working in the best interests
 5 of the Trust."
 6 Do you agree that all of the concerns, all of the
 7 matters that these two doctors raised, were solely in
 8 the best interests of their patients, the babies?
 9 **A.** I think they were in -- in the best interests
 10 of the patients and babies, yes.
 11 **Q.** So who was part of this consensus that was
 12 suggesting that they should not have their patients'
 13 best interests at heart, but the Trust's best interests?
 14 **A.** I think that --
 15 **Q.** By who, I should indicate names, please, if
 16 you can?
 17 **A.** Sorry?
 18 **Q.** Names --
 19 **A.** Names.
 20 **Q.** -- of people within the Executive Team who
 21 were part of this growing consensus.
 22 **A.** I think potentially Tony, Ian, Stephen.
 23 **Q.** Alison Kelly?
 24 **A.** No, not specifically, no.
 25 **Q.** So were they the driving force behind

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1 effectively the shutting down of the Consultants and the
2 concerns they were raising?

3 **A.** They -- there was aspects which they were
4 concerned around how they were.

5 **Q.** Okay. You also go on to say that as far as
6 you were aware there appeared to be resistance to accept
7 and work to implement the recommendations as a result of
8 the RCPCH, again Dr Jayaram and Dr Brearey have given
9 evidence and the Inquiry has heard more evidence around
10 what recommendations were being made.

11 But what evidence were you being told was present
12 that indicated that these two Consultants were not
13 supportive of what the RCPCH had in fact recommended?

14 **A.** May I have a moment to think about that as
15 well?

16 **Q.** Of course.

17 **A.** Thank you.

18 (Pause)

19 I think -- and again it's probably best to pick this
20 up with Mr Harvey as well, but I think it was some of
21 the points that were coming through from the
22 recommendations and whether they were appropriate or
23 not. Or -- or that needed to be seen through.

24 I think having, I didn't manage the RCPCH process,
25 I didn't manage the communication with the -- with the

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1 12 May and Tony's points there, that no further action
2 took around that and I would -- as I have said in my
3 statement and I challenged it in the meeting, granted
4 I accept I didn't record it, what I said, but I did
5 challenge it and I would have continued to have
6 challenged that view if that was Tony's view on
7 a long-term basis.

8 I think -- you know, on reflection now it's as
9 I said before in terms of the process that -- the
10 feeling that Ravi has had particularly. You know, I was
11 closer to Ravi because of that conversation. For him to
12 have felt like that I accept, you know, is really
13 difficult and that is something that we should have
14 acknowledged.

15 **Q.** Finally, would you accept it was a spectacular
16 failure on the part of the Executive Team to take
17 patient safety seriously and to put it primarily in
18 their thoughts?

19 **A.** No. I would not accept that at all.

20 I think at the outset of this we took patient
21 safety extremely seriously I mentioned right at the
22 beginning, this is my local hospital, I still go there
23 now for various different things. Members of my family
24 still go there now. I am really passionate about the
25 care that is provided at the Countess of Chester and

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1 Consultants as part of that but I think there was some
2 reticence around what some of the findings were from the
3 RCPCH review, the Hawdon review, all of those different
4 factors and I think it also goes back to what I said
5 earlier: when you look at it now, the Consultants were
6 being criticised from all angles and we didn't see that,
7 we didn't think -- we didn't think of it in their terms
8 and we should have done.

9 **Q.** Standing back for a moment and looking at the
10 totality of your involvement, your knowledge and your
11 actions at the time, it's hard to steer away from the
12 narrative which was an individual nurse who serious
13 concerns were raised in relation to of deliberate harm,
14 was assisted and being worked back into her position on
15 this unit, despite the serious concerns.

16 Those Consultants who were raising the concerns and
17 should have had the protection under the Speak Out
18 policy and other policies, no doubt, that the Trust had
19 were effectively being ostracised and in the process of
20 being managed out.

21 How did you allow that narrative to arise, to
22 develop, and to continue until the police effectively
23 became involved?

24 **A.** So I think they weren't effectively being
25 managed out. If you go back to that point around the

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1 I was extremely passionate about it then. We didn't get
2 everything right. But we certainly tried to get
3 everything right.

4 **MR SHARGHY:** Thank you, my Lady, thank you.

5 **LADY JUSTICE THIRLWALL:** Thank you very much,
6 Mr Sharghy. Mr Kennedy.

7 Questions by MR KENNEDY

8 **MR KENNEDY:** Ms Hodkinson, I have one or two
9 questions on behalf of the Countess of Chester Trust.

10 You have been asked a lot of questions about
11 managing out and I am not going to -- I do not know want
12 to take more time over that, I just want to address two
13 points with you, if I may.

14 We can put back up your note if you need it. But
15 the second part of the note refers to a call with
16 a solicitor at DAC Beachcroft?

17 **A.** Mm-hm.

18 **Q.** Just so that we are clear, was that the plan
19 at the end of your meeting with Mr Chambers, that you
20 would speak to DAC Beachcroft about the issues that you
21 had addressed, including managing out?

22 **A.** Yes, it was the plan, I didn't -- I didn't
23 instigate that.

24 **Q.** Understood.

25 Just in terms of the chronological context, so this

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1 is 12 May. Were you aware on 12 May when you were
2 having this conversation with Mr Chambers that 10 days
3 before, so 2 May, he had written to Cheshire Police
4 seeking an investigation?

5 **A.** I -- I can't remember specifically the dates
6 around --

7 **Q.** All right.

8 **A.** -- that, but I think because particularly
9 Mr Cross and Tony were dealing with most of those -- in
10 fact, all of those aspects.

11 **Q.** All right. Ignoring the date -- sorry, the
12 number of days, were you aware in general terms that at
13 the time of this meeting, there had been a request to
14 Cheshire Police that they investigate --

15 **A.** I knew that we were going to be speaking to
16 the police, yes, at some stage -- apologies. I knew
17 that we were going to be speaking to the police at some
18 stage and as I said earlier from that meeting on
19 15 March, it seemed to take a lot of time.

20 **Q.** Indeed. My question to you was whether you
21 were aware that that conversation with the police had
22 taken place before this meeting with Mr Chambers?

23 **A.** It's difficult to specifically remember now
24 eight years ago but I -- I -- so I couldn't speculate.

25 **Q.** You were a member of the Executive Team, there
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1 "The Trust should explain that it was prepared to
2 listen to any concerns raised in respect of patient
3 safety and Sue [so that is you] agreed that she would be
4 able to support this by the fact that the three
5 investigations [sorry, that doesn't read very well] have
6 been raised and considered and each have concluded that
7 LL [so Letby] has played no part"?

8 **A.** Mm-hm.

9 **Q.** So that is just one part.

10 Can I just ask you also to comment on a second,
11 which is -- or just take you to a second, which is
12 five lines down that same paragraph, starting on the
13 right-hand side of the page -- sorry, four lines down.

14 If we need to read in for context, please say.

15 Mr Pace records they, so I take that to be the
16 Trust or the Executive Team:

17 "... consider this to be a failure to follow
18 reasonable management instructions, specifically the
19 continued comments they make."

20 Do you see that?

21 **A.** Yes, I found that now, thank you.

22 **Q.** Okay. I want to deal with, if it can stay up
23 on the screen for a moment, the first of those that we
24 looked at, so the conclusion that Letby had played no
25 part.

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1 had been a lot of toing and froing, hadn't there, about
2 whether or not it was appropriate to refer the case to
3 the police?

4 **A.** Mm-hm, there was --

5 **Q.** Do you --

6 **A.** Sorry.

7 **Q.** Do you think that you were aware that that had
8 happened by 12 May?

9 **A.** I -- I think I probably was.

10 **Q.** Okay.

11 **A.** And obviously I think Mr Cross was also taking
12 advice from Mr Medland as well at that stage.

13 **Q.** I am not concerned about that. I just want to
14 understand your state of knowledge.

15 I am going to ask you just to look at one, to start
16 by looking at one document, if I may. It's INQ0102280,
17 and just for you to sort out where we are in time, what
18 we are about to look at, this is a note of a meeting
19 that you had with Ian Pace -- sorry, note of a telephone
20 call you had with Ian Pace. We can see it was
21 25 January.

22 **A.** Yes.

23 **Q.** I want just to ask you about two passages in
24 it. So the first is at the foot of the second

25 paragraph. So there's a comment, last sentence I think:
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1 Firstly, do you think that is an accurate record of
2 the conversation or that part of the conversation?

3 **A.** I think on reflection now eight years ago

4 I could have worded it differently -- I could have

5 worded it differently, but I think what I am referring

6 to is that there was multiple different reviews, there

7 was multiple different aspects and each of them were

8 still really unclear.

9 **Q.** Each of them was ...

10 **A.** Still very unclear, apologies.

11 **Q.** Well, that is how you might word it now. But
12 Mr Pace has recorded you as wording it on the basis that
13 each have concluded that Letby had played no part?

14 **A.** Yes.

15 **Q.** My question to you is: do you think that is an
16 accurate record of what you told him?

17 **A.** If that is what he's documented in terms of
18 the telephone note out -- you know, Ian is a very
19 experienced lawyer, that must have been what I said.

20 **Q.** All right. The three investigations, are
21 those the Thematic Review, the RCPCH Review and the
22 Hawdon Review?

23 **A.** Yes.

24 **Q.** Okay. Just so that we understand the basis
25 for that assertion that they played no part, had you

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1 read each of those yourself or were you relying upon
2 a report from somebody else as to the contents of those
3 reports?

4 **A.** I would have certainly reviewed them but
5 I wouldn't necessarily understand all of the clinical
6 aspects around them, so I would be dependent on clinical
7 colleagues to advise me.

8 **Q.** Okay. So the assertion that Letby played no
9 part, would that have been a conclusion you reached
10 yourself or that you required assistance?

11 **A.** There was always a collective decision with
12 this.

13 **Q.** All right.

14 **A.** Always a collective decision.

15 **Q.** So that was the collective decision of the
16 Execs that Letby had played no part derived from those
17 three investigations?

18 **A.** At that point yes, and I think it's not only
19 the collective decision of the Execs, it was the
20 collective decision of the board because the board were
21 also being advised about all of this information as
22 well.

23 **Q.** Very well. We might just look at that latter
24 question. So in terms of -- in terms of timing, we know
25 that the following day, 26 January, there was a meeting
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1 meeting; do you recall that?

2 **A.** I -- I do, yes. It's difficult because
3 obviously it was specifically eight years ago so I don't
4 remember every single meeting in detail.

5 **Q.** No, but this was quite a significant meeting
6 because --

7 **A.** No, I appreciate that. I remember --
8 I remember elements of the meeting but I am -- I can
9 only assume you are correct.

10 **Q.** All right.

11 Do you remember whether Dr Hawdon's report was
12 presented to the meeting at all?

13 **A.** I don't specifically remember now.

14 **Q.** All right. Do you recall that the board
15 received a presentation from Mr Harvey?

16 **A.** Yes.

17 **Q.** All right. That presentation, if we look
18 through that presentation, was consistent with what we
19 have just looked at with Ian Pace --

20 **A.** Mm-hm.

21 **Q.** -- that these reviews indicated that Letby
22 played no part?

23 **A.** Yes.

24 **Q.** Okay. If it is right that the board didn't
25 receive a copy of the RCPCH report aside from to read at
195

1 with the paediatricians at which they were told that the
2 board's conclusion was that Letby should be allowed to
3 return to work?

4 **A.** Mm-hm.

5 **Q.** Yes?

6 **A.** Mm-hm.

7 **Q.** That conclusion we trace back to the
8 10 January, you recall that, that was the meeting at
9 which the outcome of the RCPCH and Dr Hawdon's report
10 was presented to the board by the Exec team?

11 **A.** Mm-hm.

12 **Q.** Does that ring a bell?

13 **A.** I believe so, yes.

14 **Q.** Okay. Well, if I help you further. It was
15 the meeting at which you read Letby's statement to the
16 board?

17 **A.** (Nods)

18 **Q.** It may be helpful just to -- we can anchor it
19 in terms of INQ number, it's 0003237. Do you remember
20 this just while it comes up: the RCPCH report was
21 provided to the board at the beginning of the meeting.
22 I don't think we can derive that from -- particularly
23 from the note but we can see that object that Part 2 is
24 to look at this very issue. Do you remember that the
25 RCPCH report was presented to the board to read at the
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1 the meeting and if it is right that they didn't receive
2 a copy of the Hawdon report from an HR perspective, so
3 your skill, is that an appropriate way of assisting
4 people to make decisions?

5 **A.** No, I mean ideally you want to take in the
6 information particularly, you know, as an Executive
7 Director you are going from meeting to meeting, you
8 know, and it's with that nature of information you need
9 time to digest it.

10 **Q.** From the board's perspective, which is being
11 asked to sign off the recommendation from Mr Harvey, it
12 needs to do so on an informed basis, doesn't it?

13 **A.** I would imagine so, yes.

14 **Q.** You imagine so, or do you know so?

15 **A.** Yes, apologies.

16 **Q.** To do so on an informed basis it would need to
17 have the material to read at least in advance?

18 **A.** Yes.

19 **Q.** Okay. And if we look at the same -- similar
20 question in relation to the meeting on 26 January, with
21 the paediatricians, same question. If the
22 paediatricians were being asked to sign up to now
23 a board decision to allow Letby back on to the unit
24 again for them to make an informed decision they would
25 need to see both the RCPCH report and the Hawdon report,
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1 wouldn't they?

2 **A.** I -- I believe so, you would need to
3 double-check with Mr Harvey as to what he -- whether the
4 sequencing of when he shared both elements with them,
5 particularly obviously the RCPCH report because that was
6 earlier.

7 **Q.** Indeed. Well, we have looked at some material
8 in relation to whether Dr Brearey had seen a draft of it
9 earlier, haven't we?

10 **A.** (Nods)

11 **Q.** Okay. But just in terms of -- in terms of
12 good HR management, for that a decision of that level of
13 importance, it would need to be taken on an informed
14 basis and therefore with people having had sight of the
15 material which is said to ground the decision; correct?

16 **A.** I would agree, yes.

17 **Q.** Okay. Another matter, just see if we can
18 agree on. The board -- sorry, the Exec team did not
19 have the benefit of subject matter expertise, so they
20 didn't have the benefit of a neonatologist or
21 a paediatrician advising them?

22 **A.** Correct.

23 **Q.** That was a point that was made to you by
24 Dr Jayaram when you saw him -- excuse me, Jayaram?

25 **A.** Yes.

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1 Letby, that they could have benefitted from some
2 independent interpretation of the reports. Do you have
3 any thoughts on that?

4 **A.** I think as a reflection, without -- yes,
5 I think that is a good recommendation really as well --

6 **Q.** All right.

7 **A.** -- and I think there are some other aspects
8 that if I do get the opportunity to, I would like to
9 reflect on some other points as well.

10 **Q.** So subject matter expertise is crucial,
11 particularly in matters of this importance?

12 **A.** Absolutely.

13 **Q.** Okay. I just want to ask you briefly about
14 behaviours. Do you think -- I am trying to, we have had
15 a lot of questions, so I am trying to just steer a way
16 through this.

17 Do you think that the net effect of the way that
18 the grievance was managed was to turn the focus from
19 concerns about how the Exec team had managed Letby to
20 what it was that the paediatricians were alleged to have
21 said about her? Do you think that was a failing of the
22 grievance process?

23 **A.** I think it was -- it's a complication of the
24 grievance process happening.

25 **Q.** All right.

199

1 **Q.** On 15 March?

2 **A.** And that --

3 **Q.** Sorry, forgive me?

4 **A.** No, I was just going to say and hence why
5 I think, you know, Ian Harvey was -- I hope I get this
6 right -- an orthopaedic surgeon.

7 **Q.** He was an orthopaedic surgeon?

8 **A.** So that's another reason why that external
9 advice was sought; to ensure that that additional and
10 appropriate and knowledgeable clinicians who were based
11 in that particular specialty were involved in reviewing
12 the cases.

13 **Q.** Very well.

14 That external support and advice being a reference
15 to the RCPCH --

16 **A.** RCPCH, Dr Hawdon.

17 **Q.** -- and Dr Hawdon?

18 **A.** Yes.

19 **Q.** All right, because of course the Thematic
20 Review was in-house?

21 **A.** Yes, with an element of an external
22 representative, I believe, as well.

23 **Q.** All right.

24 It might be observed that if the conclusion of the
25 Execs was that both reports effectively exonerated

198

1 **A.** But I think the two elements, the reviews of
2 which, as we all know, there were multiple different
3 reviews, plus the grievance process both happened in
4 parallel. I think it goes back to my point that I have
5 made several times, I don't think we considered things
6 fully from the Consultants' perspective, that they were
7 getting information and criticism from all different
8 angles from the grievance, from the reports, how they
9 felt that as an Executive Team they were being heard or
10 listened to by us.

11 I think all of that alongside probably the -- real
12 feeling of angst they had around these patient safety
13 issues, you know, and what that meant to them --
14 apologies, I will finish in a moment as well -- I think
15 that all impacted on how they were feeling.

16 **Q.** My question was a slightly different one which
17 was whether you think the focus moved from the way that
18 Letby had been managed by the Executive Team to
19 criticisms of the behaviour of the Consultant
20 paediatricians; do you think that happened?

21 **A.** Mm-hm.

22 **Q.** That was a change of focus?

23 **A.** Looking at it now, you could say that but
24 I think at the time we tried to deal with both aspects
25 independently.

200

1 Q. Well, they were both part of the grievance,
2 weren't they?

3 A. Well the -- the way in which the Consultants
4 had spoken about Letby was part of the grievance and
5 then how the openness and transparency from the Trust
6 was part of the grievance.

7 Q. Okay. So they were both party to the
8 grievance.

9 My question is whether the focus moved from the
10 former so that is how things had been managed by the
11 Trust towards or the Executive Team towards how, what
12 the paediatricians had said?

13 A. Sorry, I'm not sure quite -- apologies.

14 Q. All right, I am not going -- I can deal with
15 this in due course, I will leave this and move on.

16 I want to -- I just want to ask you one question if
17 I can or one or two questions about the meeting that you
18 had with Dr Brearey and if we could bring up INQ0003094,
19 which is the letter that Mr Harvey wrote to Dr Brearey
20 at the conclusion of or after your meeting?

21 A. Yes.

22 Q. So this is the 24 November meeting. You were
23 asked questions about this letter by Ms Langdale.

24 The proposition that I was going to put to you, and
25 she put something similar, was that this letter was

201

1 being a -- you say in paragraph 443, this is a real
2 turning point. So this is page 149?

3 A. Yes.

4 Q. You make various points but you say it is
5 a real turning point. You describe it as a crucial
6 meeting, you mentioned in your oral evidence about it
7 bringing you to tears?

8 A. Mm-hm.

9 Q. The serious concern we can see over the page
10 in 444. It resulted in a meeting I think the following
11 day or that day between you and Tony Chambers --

12 A. The following day.

13 Q. -- and Dr Jayaram?

14 A. Yes.

15 Q. That in turn led to a meeting 10 or 11 days
16 later on 27 March and if we can just bring up that
17 meeting, so that's INQ0004406.

18 So we can see that, thank you, in addition to you,
19 the three protagonists, so you, Mr Chambers, Dr Jayaram,
20 we have now -- in addition we have Ian Harvey and then
21 we have two from the Neonatal Network and we have
22 Dr Brearey.

23 A. Mm-hm.

24 Q. We don't see anything about Dr Jayaram's
25 revelations or what he had said in this document, do we?

203

1 a little heavy-handed. Would you agree with that?

2 A. Yes, I would now, yes.

3 Q. All right. Particularly just help us with the
4 final sentence of the penultimate paragraph, where
5 Mr Harvey writes: to do anything other than this is in
6 direct contravention of an instruction from myself?

7 A. Yes.

8 Q. As noted by you, by Sue, by you. So you are
9 the witness to the direct -- sorry, you are witness to
10 the instruction?

11 A. Mm-hm.

12 Q. If we understand that phrase "direct
13 contravention of an instruction from myself", so myself
14 being the Medical Director or management, we understand
15 that in employment law perspective, that would be
16 a basis for disciplinary action against an employee,
17 wouldn't it?

18 A. It would be -- you could consider it under the
19 disciplinary policy and -- but it would depend on the
20 level, the level of the -- the I suppose discretion --
21 the level of the action really as well.

22 Q. Very well. I am just going to move on
23 finally, if I may, just to your conversation with
24 Dr Jayaram on 15 March and just ask you to reflect on
25 what you have said in your witness statement about this

202

1 A. I -- I -- I don't recall, no. I mean I think
2 this meeting and I think I state it in my police
3 statement as well, this was one of the -- the core
4 outcomes that came from that, that meeting with
5 Dr Jayaram. When Tony and I then went to see Ravi and
6 Steve the next day, they wanted to have the meeting with
7 the Neonatal Network as well to go through, obviously
8 took some time to get arranged and Ravi's request for me
9 to be there. I would not normally be in that kind of
10 meeting.

11 There would be no need for me normally to be in
12 that kind of meeting because it was a clinically facing
13 meeting.

14 Q. But --

15 A. Apologies, if I just continue on this point.

16 Ravi wanted me to be there in case there was any
17 tension for me to mediate as such.

18 Q. All right. But from your perspective, the
19 conversation that you had had 12 days earlier was a game
20 changer?

21 A. Yes.

22 Q. I just wonder why there is no reference -- if
23 it was a game changer, no reference to it being brought
24 up by Dr Jayaram or by Mr Chambers or indeed by you?

25 A. I think it was a -- I believe some of the

204

1 information had already been provided to particularly
 2 I think Nim, by Dr Jayaram or Dr Brearey, they were
 3 going to have some of those conversations as well and so
 4 this was about what do we do next? If we are going to
 5 call the police what does that mean? If we are going to
 6 change further aspects round the unit, what does that
 7 mean? And ensuring that the Neonatal Network was part
 8 of that conversation as well.

9 **Q.** But there is no reference to this
 10 game-changing revelation from Dr Jayaram?

11 **A.** I think that was -- you know, it was a given
 12 as part of -- I wouldn't say there was any stage in
 13 which Dr Jayaram couldn't describe that again in that
 14 meeting should he chose to -- sorry, should he choose
 15 to.

16 **Q.** I appreciate that but there is no reference to
 17 you raising it?

18 **A.** No, but I was more on an observatory mediatory
 19 basis.

20 **Q.** Okay.

21 **A.** This was a group of people I have -- you know,
 22 that was I think Julie Maddocks, Nim. I didn't have any
 23 connection with them at all.

24 **Q.** Okay. Can we look just briefly at the second
 25 page and just see -- what are you, notetaker?

205

1 a briefing paper prepared by Ian Harvey, do you recall
 2 that?

3 **A.** Yes, I do.

4 **Q.** All right. There is a rationale document
 5 prepared by Mr Cross, the gist of both of those is that
 6 it's not thought that a crime had been committed, isn't
 7 it?

8 **A.** Yes, but I think that it was -- it was
 9 appropriate to go to the police because I think also
 10 around that time, it could have been 18 April, I think
 11 I also reached out to Corinne Slingo again, had that
 12 conversation there.

13 **Q.** But -- and there is the consequence of those
 14 two pieces, those two documents seem to have formed the
 15 basis for the instruction of the barrister?

16 **A.** Yes, but I -- Mr Cross was --

17 **Q.** If you don't know, please do say?

18 **A.** Stephen Cross was leading that piece.

19 **Q.** All right. But wherever we are from the
 20 meeting on 15 March which is -- my words -- a game
 21 changer --

22 **A.** Mm-hm.

23 **Q.** -- the contact with the Cheshire Police is
 24 still six weeks away?

25 **A.** And as I explained before that was

207

1 **A.** I took the notes on this as well, yes.

2 **Q.** So we see what amongst others observations
 3 Mr Chambers made about calling the police and it's the
 4 fourth entry from the bottom of the page where you have
 5 written that he says:

6 "If that's where we are then phone the police, you
 7 can call the police."

8 **A.** Mm-hm.

9 **Q.** Presumably directed to Dr Brearey?

10 **A.** I -- I believe so, or to Dr Jayaram, it could
 11 have been either.

12 **Q.** All right, but directed to the paediatricians?

13 **A.** Yes.

14 **Q.** That effectively: over to you if you want to
 15 call the police?

16 **A.** I think that is the nature. Obviously that
 17 was how I have noted it.

18 **Q.** Okay. We know as -- and we can -- we can go
 19 to the foot of the -- just briefly if we can, the foot
 20 of that entry -- sorry, the foot of that note, where
 21 I think it's page 7, Mr Chambers's sign-off is: you need
 22 to leave it with us?

23 **A.** Mm-hm.

24 **Q.** What we know happens thereafter is then
 25 a barrister is instructed to look at it, there is

206

1 disappointing from a personal perspective.

2 **Q.** All right.

3 Do we take it that perhaps your views of the
 4 importance of what Dr Jayaram had said to you were not
 5 shared by others on the Exec Team?

6 **A.** You would have to ask the rest of the
 7 Executive Team that -- that question.

8 **MR KENNEDY:** All right. Ms Hodgkinson, thank you
 9 very much. Those are my questions.

10 **LADY JUSTICE THIRLWALL:** Thank you, Mr Kennedy.

11 **MS LANGDALE:** I am conscious of the time. We have
 12 been going two hours.

13 **LADY JUSTICE THIRLWALL:** Yes, we had better take
 14 a break. We will start again at 10 past 4.

15 (3.55 pm)

(A short break)

17 (4.09 pm)

Questions by MS BLACKWELL

18 **LADY JUSTICE THIRLWALL:** Ms Blackwell.

19 **MS BLACKWELL:** Thank you, my Lady.

20 Mrs Hodgkinson, the questioning by Ms Langdale this
 21 morning followed themes rather than a strict
 22 chronological order and so I want to begin my
 23 questioning of you by confirming what your thinking was
 24 and when.

208

1 Is it right that up until 30 June of 2016 you did
2 not know anything about the concerns of the Consultants
3 relating to deliberate harm?

4 **A.** I think there was reference to something on
5 27 June.

6 **Q.** Yes.

7 **A.** But until that point I had not been involved
8 in any discussion of the detail at all.

9 **Q.** Now the reason that I alighted upon 30 June
10 was because you have been taken to your notes of that
11 meeting?

12 **A.** Yes.

13 **Q.** You were invited to express to the Inquiry
14 what your knowledge was during the course of and by the
15 end of that meeting as to the concerns that had been
16 raised and Ms Langdale identified a comment during that
17 meeting written in your notes by Jim McCormack that
18 there were concerns of a Shipman or an Allitt nature?

19 **A.** Yes.

20 **Q.** In answer to her you also raised the prospect
21 of there being clinical care concerns raised at the same
22 meeting and her ladyship also took you to a note from
23 Stephen Brearey --

24 **A.** Yes.

25 **Q.** -- in an attempt to assist you.

209

1 almost a collective meeting in terms of members of the
2 Executive Team and -- and the paediatric Consultants as
3 well. I think it was very -- at multiple times during
4 the meeting there was almost like checkpoints to make
5 sure that people were comfortable with the next stages,
6 what we had agreed. If felt a very open meeting.

7 **Q.** Right, well, with that in mind, let's look
8 please at the right-hand side of page 54 and we can see
9 that there is reference three lines down to what I think
10 is in-depth medical review individual ones.

11 Do you see that?

12 **A.** Sorry, which?

13 **Q.** Four lines down?

14 **A.** Four lines down. From the top -- apologies,
15 I was looking at the bottom:

16 "In-depth medical review, individual cases"

17 Do you want me to continue?

18 **Q.** Yes please.

19 **A.** "Independent review. RC Paeds and Child
20 Health. Unit close for model of care, required level of
21 care. Spoken to CQC today, agreed re the informed
22 agreed actions, fair, balanced, proportionate. Did ask
23 some questions. Clinical decision-making, practice,
24 staffing, environmental. RCPCH medical and nursing to
25 be brought in, can do review in August. Two full days.

211

1 I am going to ask you to look again at the notes,
2 please, and to invite you to identify certain comments,
3 who made them and what your understanding was about them
4 so that we can get a full reflection of what was being
5 said at that meeting?

6 **A.** Okay.

7 **Q.** My Lady, given that Mrs Hodkinson had a little
8 difficulty reading these notes --

9 **LADY JUSTICE THIRLWALL:** You have a printed
10 version, have you?

11 **MS BLACKWELL:** Well, we have a printed version for
12 her. I'm not sure it has been provided to her. I was
13 awaiting --

14 **LADY JUSTICE THIRLWALL:** It was rather last minute
15 but obviously she can have it.

16 **A.** Thank you.

17 **MS BLACKWELL:** The only annotation is the page
18 number at the bottom right-hand corner.

19 **LADY JUSTICE THIRLWALL:** Good, thank you.

20 **MS BLACKWELL:** Can we also have up, please, the
21 document itself on screen, which is INQ0015639 and if we
22 go to page 54, please. As we are putting that up on the
23 screen, what are your reflections on the tone of this
24 meeting, please, Mrs Hodkinson?

25 **A.** I think it was a certainly at the outset

210

1 Immediate feedback and immediate areas of concern.
2 Report two to three weeks. No specific date. Drafting
3 proposal and Terms of Reference. Finalised TOR concerns
4 where ..."

5 I don't know whether that is visit or?

6 **Q.** Weight?

7 **A.** "... data who interviewed, all data they
8 require."

9 **Q.** Which is a reference to the instruction to the
10 RCPCH to prepare their review and ultimately their
11 report?

12 **A.** Yes.

13 **Q.** So that was being set out at the beginning of
14 the meeting --

15 **A.** At the beginning of the meeting.

16 **Q.** -- as a potential action?

17 **A.** Yes.

18 **Q.** Yes. Over the page, please. Now we can see
19 that there is a comment three lines down from the top of
20 the left-hand page attributed to Dr Brearey. What does
21 that say?

22 **A.** "Good rep", I assume that's shortened
23 reputation, "paeds and obstetrics. Didn't matter of
24 unit. Clinical concerns member of staff. Yes,
25 downgrade to Level 1. Get ..."

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1 And I think I have said I have missed out "rid":
 2 "...of intensive cots/HDU cots but not got
 3 complete assurance to clinical team without staffing."
 4 **Q.** What did you take him to mean by that because
 5 it looks as if he's talking about two different things?
 6 **A.** I think firstly it's, you know, as clinical
 7 lead explaining about, you know, the unit had a good
 8 reputation.
 9 **Q.** Yes.
 10 **A.** But that, you know, we needed to look at the
 11 acuity of the patients --
 12 **Q.** Yes.
 13 **A.** -- that we were supporting.
 14 **Q.** And that was the downgrading of the unit?
 15 **A.** Yes.
 16 **Q.** But also there had to be a reassurance to the
 17 clinical team and that couldn't take place without
 18 a staffing review?
 19 **A.** Yes.
 20 **Q.** Right, further down the page then there is
 21 another comment attributed to Dr Brearey:
 22 "Level 1 doesn't specify gestation. Nearest is
 23 Macclesfield. 32 weeks. Recommendation we take 34
 24 weeks."
 25 Was that him involving himself again with providing

213

1 "Have to plan carefully, manage better."
 2 **A.** Yes.
 3 **Q.** Then over the page:
 4 "Can't provide clear guidelines."
 5 Now, that's Jim McCormack again?
 6 **A.** Yes.
 7 **Q.** Then at the bottom of the page again:
 8 "Doesn't change ..."
 9 What is that?
 10 **A.** "Doesn't change thinking. No less than 27
 11 weeks and six days, approximate gestation 34 weeks,
 12 difficulty is sick lady."
 13 **Q.** "Looking after lady"?
 14 **A.** Yes, "looking after lady".
 15 **Q.** Then a comment attributed to Dr Jayaram,
 16 "reducing risk"?
 17 **A.** Yes.
 18 **Q.** Was he there agreeing that lowering the level
 19 of the unit would lead to a reduction of the risk?
 20 **A.** Yes.
 21 **Q.** All right. Then on the other side of the
 22 page, we can see in the middle of the page a comment
 23 attributed to Tony Chambers:
 24 "Agreed comprehensive review, agreed timescales
 25 ..."

215

1 guidance on the unit being --
 2 **A.** Yes, I suppose on the acuity of the patients
 3 and the gestation period that we should be taking in for
 4 patients as well.
 5 **Q.** On the other side of the page we see the
 6 comment by Jim McCormack which you were taken to by
 7 Ms Langdale?
 8 **A.** Yes.
 9 **Q.** He concludes that by reference to
 10 Beverley Allitt and Shipman being raised. But just
 11 above that, in the middle of his comment he says this:
 12 "First time about member of staff his last
 13 three days"?
 14 **A.** Yes.
 15 **Q.** Do you know what that was a reference to?
 16 **A.** I think whether that was he knew about it over
 17 the last three days or this was the concern over the
 18 last three days.
 19 **Q.** Of course if we identify the timing of this
 20 meeting, 30 June?
 21 **A.** Yes.
 22 **Q.** It was almost a week after Child O had died
 23 and then Child P had died on the following day and then
 24 at the bottom of the page there is another comment from
 25 Dr V:

214

1 **A.** Yes.
 2 **Q.** "... and obstetric service."
 3 What do you take that to be?
 4 **A.** That at that stage within the meeting and
 5 I think it's also referenced later on in the meeting
 6 this was what collectively we had all agreed. So the
 7 paediatricians and the Executive Team who were in that
 8 meeting as well.
 9 **Q.** Can we turn over the page please to page 57
 10 and on the left-hand side of the page, there is
 11 a comment which we know from the previous page is
 12 attributed to Tony Chambers, four lines down:
 13 "Legitimate concerns re member of staff. Two weeks
 14 annual leave from today." Then what? "Looking at every
 15 single patient?"
 16 **A.** Yes:
 17 "Not snapshot, I have captured, will determine
 18 action we take regarding level of action to take. Know
 19 request remove from direct patient care duties, during
 20 annual leave drill down actions."
 21 **Q.** Right. On the right-hand side of the page at
 22 the top of the page, is that Stephen Cross?
 23 **A.** SPC, yes, it is.
 24 **Q.** "Could be anybody."
 25 **A.** "When heard about practices going by

216

1 clinicians reinforcing open mind."
 2 **Q.** What is that a reference to?
 3 **A.** I think that, you know, that it could actually
 4 be anyone, any level of care, any level of issues,
 5 anyone who is causing this. There was obviously, you
 6 know, multiple concerns and we had to keep an open mind,
 7 not just having one member of staff in mind.
 8 **Q.** Then a few lines down Tony Chambers again:
 9 "know unit under extreme pressure. Review will
 10 help."
 11 **A.** With help.
 12 **Q.** "... with help. Acuity of patients change."
 13 **A.** Yes.
 14 **Q.** Right. Bottom of the page, Stephen Brearey
 15 again. What does that say?
 16 **A.** So:
 17 "Reviewed every case more than once. Care never
 18 perfect. Learnt concern theme to this individual. All
 19 clinicians come back, going to reassure us that issue
 20 comes back."
 21 **Q.** And then over the page, please, to page 58.
 22 Stephen Brearey at the top of the left-hand column:
 23 "Spoken at depth in May, concerns."
 24 That was him confirming that he had raised these
 25 concerns in May?

217

1 **Q.** What then?
 2 **A.** "Removed".
 3 **Q.** Removed?
 4 **A.** "Unit safe?"
 5 **Q.** Stephen Brearey: "risk removed"?
 6 **A.** Yes.
 7 **Q.** Tony Chambers:
 8 "Need to do both ..."
 9 **A.** "... comprehensive review. Proportionate fair
 10 help."
 11 **Q.** Jim McCormack says "may help"?
 12 **A.** Yes.
 13 **Q.** If we go over the page to page 59, left-hand
 14 column, Jim McCormack:
 15 "Team from RCP don't know about ..."
 16 **A.** Member of staff.
 17 **Q.** "... member of staff.
 18 "Ian Harvey: increase in mortality, cases
 19 highlighted, member of staff."
 20 **A.** "Issues highlighted."
 21 **Q.** Thank you:
 22 "... member of staff not finalised Terms of
 23 Reference."
 24 Then Ian Harvey further down:
 25 "Opened up whole can of worms, look at everything,

219

1 **A.** Yes.
 2 **Q.** "Alison Kelly: circumstantial."
 3 Stephen Brearey?
 4 **A.** "Other than HEI (*sic*) case, present at deaths,
 5 let you know about cases this year. Three Triplets just
 6 last week. Chances of. Understand don't want to wreck
 7 careers."
 8 **Q.** What was that a reference to, whose careers?
 9 **A.** The paediatricians' careers.
 10 **Q.** By raising these concerns?
 11 **A.** Yes.
 12 **Q.** Then a comment from Khalid:
 13 "Why not do external review until now."
 14 **A.** Yes.
 15 **Q.** Jim McCormack:
 16 "Take stock of what's said. Child health expertise
 17 won't look different."
 18 **A.** Yes.
 19 **Q.** Then the reference to air embolism at the
 20 bottom the page by Dr Jayaram you have already been
 21 taken to?
 22 **A.** Yes.
 23 **Q.** Top of the next page, Tony Chambers:
 24 "Direct LL"?
 25 **A.** Yes.

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1 review at some point."
 2 Then Jim McCormack further down:
 3 "Expertise forensic investigation, decision to
 4 evidence police."
 5 **LADY JUSTICE THIRLWALL:** Involve, I think.
 6 **MS BLACKWELL:** Involve police.
 7 "Difficult decision to make."
 8 Tony Chambers:
 9 "Explain police".
 10 Do you know what that is a reference to?
 11 **A.** So that was around Tony asking Stephen to
 12 explain what would happen if the police were involved,
 13 Stephen Cross was a former member of the police and it
 14 was unusual to have that level of experience in the
 15 Executive Team but it was also a benefit during this.
 16 **Q.** Thank you.
 17 Over the page to page 60, please. Left-hand column
 18 halfway down. What are the comments, please, which have
 19 the arrows or the dashes?
 20 **A.** I don't know why I started doing that rather
 21 than having the circles there.
 22 David Semple:
 23 "After two weeks definite decision at that point.
 24 "JD: two weeks review and back off leave."
 25 Dr Brearey:

220

1 "Made feeling clear."
 2 Khalid:
 3 "Apologies for tone.
 4 "TC: feels personal ... needs to be safe, kind and
 5 effective."
 6 Q. Just pause there.
 7 A. Yes.
 8 Q. Can you remember what Tony Chambers was saying
 9 feels personal?
 10 A. That this was related to one individual and
 11 that we need to -- safe, kind and effective was our
 12 phraseology around our core values within the Trust so
 13 we need today think about things in a safe kind and
 14 effective manner.
 15 Q. Then "Jim McCormack on board with plan", is
 16 that him expressing his approval?
 17 A. Yes.
 18 Q. Bottom of the page, and you have been taken to
 19 this already, from Dr Brearey: something nagging me?
 20 A. Yes.
 21 "Open about care on unit. Observations before
 22 meeting. Datix incidents. Inconsistencies. Problems.
 23 Governance facilitators. First one wonderful and left.
 24 Second replaced less than adequate, replaced by someone
 25 [and I think I have missed 'who'] is a fish out of
 221

1 get the ventilator checked?
 2 A. Yes:
 3 "If suspicious ventilator get checked."
 4 Q. Get checked.
 5 So he was suggesting that there might be --
 6 A. An equipment issue.
 7 Q. Yes. Then Alison Kelly, nothing to add from
 8 her?
 9 A. Yes.
 10 Q. "Appreciate concerns from KR."
 11 Then:
 12 "Apologies if ..." what, from Stephen Brearey?
 13 A. "Apologies if upset you."
 14 Q. If upset you and "SH support" and that's you
 15 reference?
 16 A. Occupational Health.
 17 Q. A reference to Occupational Health.
 18 Then finally on the right-hand side of this page,
 19 the concluding comments, Tony Chambers.
 20 "Thank everybody, either collectively or smaller
 21 group, get together tomorrow. View of when ..."
 22 A. Actioned, yes, unlikely tomorrow.
 23 Q. From Mr McCormack?
 24 A. "What do we say to our own staff?"
 25 Q. Tony Chambers?
 223

1 water."
 2 Q. That was him complaining about the risk
 3 facilitator who had replaced somebody else?
 4 A. Yes.
 5 Q. Then towards the bottom of the page we are
 6 getting to the end of the meeting now, Tony Chambers
 7 says anything more?
 8 A. Yes.
 9 Q. Nothing from Stephen Brearey?
 10 A. Yes.
 11 Q. He asks Ravi?
 12 A. Yes.
 13 Q. Dr Jayaram says?
 14 A. "Not them and us, Execs versus clinicians.
 15 Feeling running high. Safety for babies. Paeds and
 16 obstetrics appreciate your support [or appreciate
 17 support]. Plan pragmatic way forward. Share discomfort
 18 about member of staff. If suspicious ..."
 19 Q. Ventilation?
 20 A. "... ventilator get checked."
 21 Q. Get checked?
 22 A. "Not easy with people. Plan going forwards,
 23 drill down."
 24 Q. Just pausing again. He says that he shares
 25 the discomfort about the member of staff and if what,
 222

1 A. That's being worked through. It was a tough
 2 meeting.
 3 Q. It was a tough meeting.
 4 A. Yes.
 5 Q. So is it your belief leaving that meeting that
 6 although deliberate harm had been raised, particularly
 7 by Mr McCormack --
 8 A. Yes.
 9 Q. -- that there were other potential problems to
 10 do with clinical care and possibly equipment on the
 11 ward?
 12 A. As I said earlier to the Inquiry, that was my
 13 impression coming out of the meeting, it was multiple
 14 different factors but of course there was that concern
 15 around an individual.
 16 Q. Yes, and is it your evidence, Mrs Hodgkinson,
 17 that by the end the meeting, the atmosphere, the mood
 18 was still collegiate?
 19 A. Without doubt.
 20 Q. Right. Do we note that there was no reference
 21 in that meeting at all by Dr Jayaram to the disclosure
 22 that he was to make to you in 2017?
 23 A. No.
 24 Q. No. Thank you.
 25 The second matter I would like to ask you about,
 224

1 please, is Letby's redeployment. You have been taken by
2 Ms Langdale to the email sent to you by Karen Rees --

3 **A.** Yes.

4 **Q.** -- on that topic and the terms in which she
5 expressed her fervent support of Letby?

6 **A.** Yes.

7 **Q.** How did you feel when you read that?

8 **A.** I think concerned. Karen -- if I -- I may
9 have mentioned it earlier, very credible nurse, very
10 experienced, had nothing, you know, she was -- yes, she
11 was meeting Letby later on on a much regular basis but
12 at that stage it was still early -- early I suppose in
13 that, you know, the considerations and it felt we needed
14 to listen to her as well.

15 **Q.** Yes.

16 You were also contacted by Kathryn de Berger in
17 similar terms?

18 **A.** Yes.

19 **Q.** I would just like to look at her email to you
20 please briefly, it's INQ0002988, and it's page 2,
21 please. Thank you very much. She writes to you in
22 these terms, we will look at the date in a moment:

23 "As you are aware I have been seeing Lucy over the
24 last few months to offer her occupational health
25 support. I have seen her this morning [19 October] and
225

1 your reflections and some of these have been touched
2 upon already. But the first is a comment by
3 Professor Bowers, King's Counsel, in his first statement
4 or report and I would just like to ask you for your
5 reflection on his suggestion that he wonders whether
6 management in this case was perhaps discouraged from
7 taking disciplinary action by the fact that the
8 grievance was brought against the quasi disciplinary
9 redeployment. What is your reflection on what
10 Professor Bowers says there?

11 **A.** I think -- so firstly I think there is lot of
12 very good points in Professor Bowers's report.

13 **Q.** Yes.

14 **A.** I think in relation to that particular point,
15 I can absolutely say I would have had no hesitation in
16 taking disciplinary action about -- for a member of
17 staff including Letby as well. Throughout my career
18 I have done that. Sadly I have had had to dismiss --
19 I have had to listen to appeals, I have had, you know,
20 huge amount of experience both on a patient safety basis
21 and otherwise as well and I would not have had any
22 hesitation in taking that approach if all of the
23 information was very clear.

24 **Q.** Thank you.

25 At paragraph 11 of Professor Bowers's statement he
227

1 she has agreed for me to communicate with you following
2 our meeting together. I do have concerns today about
3 Lucy's health and well-being. She's really struggling
4 with the length of time she has been working away from
5 the neonatal unit, the lengthy process and has yet still
6 no date to return for her substantive post. She is
7 feeling isolated from her team and the ongoing
8 uncertainty of the outcome is causing high levels of
9 anxiety. The current situation is having a detrimental
10 effect on her health and well-being and I have concerns
11 for her health, both for the short and longer term.

12 "I would appreciate your advice on how the Trust
13 can expedite an outcome and conclusion so I can help
14 Lucy plan the way forward."

15 **A.** Yes.

16 **Q.** Did you take those concerns expressed to you
17 by Ms De Berger seriously?

18 **A.** Yes, without doubt and I think -- so there
19 was -- there was -- I mentioned earlier the RCN's
20 concerns in relation to her -- you take into account
21 Karen Rees' concerns, you take into account those
22 concerns and I think later as well there were also
23 concerns I had myself around her well-being.

24 **Q.** Thank you. That can go down, please.

25 The final matter I would like to ask you about are
226

1 talks about his thoughts on a protocol for determining
2 when employers should refer matters to the police. What
3 are your reflections on that?

4 **A.** I think it's a fantastic suggestion, I really
5 do. I think you may have read in my statement that
6 I sought advice on this not only from DACB -- apologies,
7 but also I sought advice from a peer who was a Director
8 of People at Stockport who had been through a very
9 similar situation.

10 **Q.** Yes.

11 **A.** I sought advice from NHS Employers and the
12 Chief Executive of NHS Employers as well and I think
13 it's -- I think to have that guidance not just from
14 a people professional perspective but from an Executive
15 Team and board perspective is essential and it -- it's
16 really unclear. There is no rulebook for dealing with
17 a case like this.

18 **Q.** In terms of an internal investigation of the
19 sort which was undertaken at an early point in these
20 matters, what are your reflections on the running of
21 a hospital when something like this arises and whether
22 or not there is a need perhaps to consider bringing in
23 another organisation or a designated Executive from
24 another organisation to assist?

25 **A.** Yes, I think I have added this in my
228

1 reflections in my statement as well. You know, I --
 2 I recall how much pressure is put under organisations
 3 both in my time eight years ago but also now speaking to
 4 former colleagues, speaking to peers as well.

5 Particularly there is so much pressure from
 6 a regulatory perspective now around the financials that
 7 the NHS is managing and I think to manage a case of this
 8 gravity alongside managing a Trust and all of the
 9 aspects around a Trust you can't do both well. So
 10 I think there has, there should be some consideration to
 11 how whether it's NHS England, or the system, the local
 12 system, the Integrated Care Board --

13 **Q.** Yes.

14 **A.** -- or other support, an organisation going
 15 through something like this as they would do if an
 16 organisation was going through a financial challenge.
 17 That happens. People are brought in to support
 18 a situation. We would have really benefitted from that
 19 as well.

20 **Q.** Thank you. And finally, at page 467 of your
 21 witness statement you tell the Inquiry that a Freedom to
 22 Speak Up Guardian was introduced in 2019 through changes
 23 to the Trust's policy and prior to your departure from
 24 the Trust.

25 **A.** Yes.

229

1 My Lady, those are my questions.

2 Further questions by MS LANGDALE

3 **MS LANGDALE:** Just two questions arising, if I may.

4 Just going back to these documents, INQ0015639,
 5 page 58, Mrs Hodkinson. Just to check what you said
 6 a note suggested so we understand your evidence. It's
 7 Dr Brearey's comment at the top of the left of the page.

8 **LADY JUSTICE THIRLWALL:** 15639, or?

9 **MS LANGDALE:** 156390058.

10 **LADY JUSTICE THIRLWALL:** I think you inserted an
 11 extra 8 just to keep us all on our toes.

12 **MS LANGDALE:** Did I? Sorry about that.

13 We see at the top to the left:

14 "Other than the HIE case present at deaths."

15 Who's he talking about there, Dr Brearey?

16 **A.** Apologies.

17 **Q.** Look at the top:

18 "Other than HIE case present at deaths."

19 **A.** Yes.

20 **Q.** So who's he talking about, who's present at
 21 the deaths?

22 **A.** I -- I believe it was Letby.

23 **Q.** Yes, so Letby present at deaths.

24 "Let you know about cases this year."

25 You have said you weren't included in all of that

231

1 **Q.** But that you note from the third witness
 2 statement of Jane Tomkinson that the Trust now actively
 3 promotes an open-door policy?

4 **A.** Yes.

5 **Q.** What do you say about that, presumably that
 6 that is something which is an improvement and should be
 7 encouraged?

8 **A.** Yes, without doubt. I think both Alison Kelly
 9 and myself did try to get approval on a number of
 10 occasions to have an independent Freedom to Speak Up
 11 Guardian towards the end of my career at the Countess
 12 after I had been unwell. We obviously recruited one
 13 which was fantastic because the Execs are perceived as
 14 scary, we have talked about that today and to have
 15 ourselves and also a Staff-Side representative as the
 16 only people that people could go to was not the ideal
 17 situation you need that independence.

18 And I know Jane, I know the vast majority of the
 19 Executive Team at the Countess now. I have worked with
 20 Jane, I have worked with the vast majority of them as
 21 well previously and I am really pleased that they are
 22 focusing in that way around Speak Out Safely. Jane is
 23 wholeheartedly committed to patient safety and I think
 24 that is a really big important step forward.

25 **MS BLACKWELL:** Thank you, Mrs Hodkinson.

230

1 but what's he saying in terms of "let you know about
 2 cases"? That he has let people know about cases she's
 3 present at this year?

4 **A.** That's either let us know or he has already
 5 let us know or he is going to let us know after the
 6 meeting.

7 **Q.** Well, he said "let you know" about cases this
 8 year:

9 "Three Triplets just last week. Chances of."

10 What does he mean, the chances of, what's he
 11 saying?

12 **A.** I -- it's difficult to I suppose remember the
 13 specifics. I have put chances of, but potentially I am
 14 speculating here.

15 **Q.** Yes.

16 **A.** It's chances of this happening again or
 17 chances of that individual.

18 **Q.** Then says: understood don't want to wreck
 19 careers.

20 Whose career is he talking about there, raising
 21 this?

22 **A.** That I do remember. It was around -- you know
 23 the clinicians -- the paediatricians were -- were so
 24 proud of the service that they were providing.

25 **Q.** Are you suggesting he was saying that he was

232

1 worried about wrecking paediatricians' reputations?
 2 **A.** At that stage he was concerned about their own
 3 reputations because he didn't want them to be associated
 4 with a unit that was having failings of care.
 5 **Q.** You have never mentioned that before.
 6 **A.** Sorry?
 7 **Q.** You have never mentioned --
 8 **A.** Me?
 9 **Q.** Yes, you never mentioned Dr Brearey was
 10 worried about the reputation of paediatricians when he
 11 spoke at any time about these matters?
 12 **A.** But that was in those notes.
 13 **Q.** Because the logic is he is saying she was
 14 present at the deaths, I will let you know about cases
 15 this year, three Triplets just last Wednesday, chances
 16 of. In other words she is on day shifts and they
 17 happened day after each other. Understand don't want to
 18 wreck career, because the mood later on continues
 19 talking about the police and the difficulty.
 20 It is Letby he is talking about, isn't it?
 21 **A.** No.
 22 **Q.** You think he is talking about the police?
 23 **A.** I remember it was specifically around the
 24 concern of the paediatricians as well because they were
 25 so proud of the care that they were providing within the
 233

1 get equipment checked if you think it is a problem. Not
 2 easy with people, plan going forwards drill down.
 3 It is the same principle: if you think there is a
 4 problem with a piece of equipment or a person, you need
 5 to drill into it.
 6 **A.** Yes, but he's also saying that with a piece of
 7 equipment that is easy to manage you can replace it or
 8 you can get it fixed. With people, it's not easy.
 9 **Q.** So he wasn't saying there was any problem with
 10 any equipment. We shouldn't understand your earlier
 11 evidence to suggest that you thought he was raising
 12 there was faulty equipment in the department. He wasn't
 13 suggesting that. He was saying when you got faulty
 14 equipment you check it, in this case it is a person, you
 15 need to check it?
 16 **A.** But it's harder -- what he is also saying, it
 17 is harder when there are challenges around people.
 18 **Q.** Yes.
 19 **A.** With equipment, it is: is it working, is it
 20 not? Does it need to be fixed, does it not.
 21 **MS LANGDALE:** Thank you.
 22 **LADY JUSTICE THIRLWALL:** Ms Blackwell, I'm sorry,
 23 I was going to invite you to sit down then I realised
 24 you haven't got a chair, sorry about that. Please do.
 25 **MS BLACKWELL:** Thank you.
 235

1 unit.
 2 **Q.** Page 60. At the bottom of that page on the
 3 "four suspicion", do you see there is a reference there
 4 to suspicion, page 60?
 5 **A.** Yes.
 6 **Q.** He is talking about equipment, if we go over
 7 to the next page.
 8 If it is a ventilator, get checked?
 9 **A.** Yes.
 10 **Q.** "Not easy with people. Plan going forwards,
 11 drill down."
 12 He is saying if there is a problem with a piece of
 13 faulty equipment you check it to see what it is. When
 14 it is a person it is harder, you need to drill down?
 15 **A.** Yes.
 16 **Q.** You agree.
 17 So he is not complaining about any equipment, he is
 18 saying it is harder with a person, you need to get on
 19 it?
 20 **LADY JUSTICE THIRLWALL:** Are we on 61 now?
 21 **MS LANGDALE:** Look at 61.
 22 **LADY JUSTICE THIRLWALL:** We have got 60 on the
 23 screen.
 24 **MS LANGDALE:** Look at the top of 61, he is not
 25 complaining about equipment, he is saying you need to
 234

1 Further questions by LADY JUSTICE THIRLWALL
 2 **LADY JUSTICE THIRLWALL:** Just one or two matters
 3 from me and then you will be able to go.
 4 We have looked now a lot of times at 15639 and we
 5 have been through it and you have it in hard copy?
 6 **A.** Yes.
 7 **LADY JUSTICE THIRLWALL:** What you told us earlier
 8 was the first thing you thought was: is she on the unit
 9 and that we need to protect patients? So you, as
 10 I understand it, went to the unit and you had had
 11 assurance from the nursing team.
 12 So what assurances were you given and from whom, if
 13 you can remember?
 14 **A.** I think -- so I went to the unit to go and see
 15 for myself --
 16 **LADY JUSTICE THIRLWALL:** Yes.
 17 **A.** -- as well and very much assurances from the
 18 leadership team.
 19 **LADY JUSTICE THIRLWALL:** So that is Eirian Powell?
 20 **A.** Eirian, Yvonne.
 21 **LADY JUSTICE THIRLWALL:** What was the nature of
 22 their assurances, perhaps it's easier -- what did you
 23 say to them and what did they say to you?
 24 **A.** Gosh, I can't specifically remember but
 25 I think it was, you know: how is the unit running? You
 236

1 know, what are the pressures on the team? Just to try
2 and get a sense of was it effective, the way in which
3 the unit was running? Because I think at that stage
4 there was multiple different things that were coming in
5 and trying to get another view.

6 **LADY JUSTICE THIRLWALL:** Did you say to them:
7 I have just heard some very worrying information in
8 a meeting I have just been at, that is why I have come
9 over here; did you tell them that?

10 **A.** I can't specifically recall that, whether
11 I did or not, but they knew that -- they knew, certainly
12 Eirian, Yvonne knew the obviously worrying information
13 anyway from the clinicians.

14 **LADY JUSTICE THIRLWALL:** And did you ask them
15 specifically about Lucy Letby?

16 **A.** I think it was probably a more general point
17 to say: Well, how, how is the unit going to run? I'm
18 sure I did speak about Letby as well, but how was the
19 unit going to run, what did we need to do, you know, how
20 did we need to assure around patient safety being
21 maintained as well. So not only around Letby, but also
22 ongoing as well.

23 **LADY JUSTICE THIRLWALL:** Because presumably the
24 unit, insofar as they were concerned, had been running
25 safely anyway?

237

1 **A.** But I think regardless of her being away, we
2 still needed to monitor how the unit was functioning.

3 **LADY JUSTICE THIRLWALL:** No, I understand that.
4 Thank you. Can I just ask you this. Once you heard
5 what was said by the clinicians, did you believe them?

6 **A.** I had no reason not to believe them.

7 **LADY JUSTICE THIRLWALL:** So, did you believe them?

8 **A.** Yes.

9 **LADY JUSTICE THIRLWALL:** I will just go now to the
10 grievance process if I may.

11 One of the things, and I don't know if you were
12 aware of this, but one of the things Dr Green told us
13 was that when the two Consultants arrived with their
14 Union representatives he thought that they must be
15 worried about their behaviours and he seemed to have
16 a view that the presence of Union representatives
17 signified something which he then thought about.

18 **A.** Mmm.

19 **LADY JUSTICE THIRLWALL:** Was that something you
20 were aware of?

21 **A.** I think, as I mentioned earlier, within every
22 grievance or, you know, any, any matter like that
23 a person is able to bring a representative.

24 **LADY JUSTICE THIRLWALL:** They are entitled to bring
25 their representative, aren't they?

239

1 **A.** From their perspective, yes.

2 **LADY JUSTICE THIRLWALL:** Yes.

3 **A.** Although there were, there were pressures in
4 terms of the resources, the staffing.

5 **LADY JUSTICE THIRLWALL:** Yes, as one's heard quite
6 a lot about that and in other hospitals as well.

7 **A.** Yes.

8 **LADY JUSTICE THIRLWALL:** But there was nothing
9 particular about that?

10 **A.** No

11 **LADY JUSTICE THIRLWALL:** So there was no particular
12 assurance that you had about Letby or indeed about the
13 unit other than in sort of general terms?

14 **A.** Yes, there was nothing else that came.

15 **LADY JUSTICE THIRLWALL:** You were satisfied, were
16 you, having heard that, that patients were safe?

17 **A.** Yes. But I think that the key part though was
18 that we were going to daily monitor how the unit was,
19 was -- not performing, that's the wrong word -- was
20 functioning. And that was one of the aspects that was
21 brought in through the Executive Team and we --

22 **LADY JUSTICE THIRLWALL:** But she was going to be
23 away, wasn't she, for a fortnight?

24 **A.** She was.

25 **LADY JUSTICE THIRLWALL:** Yes.

238

1 **A.** Yes, they are.

2 **LADY JUSTICE THIRLWALL:** So it's a slightly odd
3 situation where the investigator thinks they must be
4 worried about the way they have been behaving if they
5 bring their representative.

6 **A.** Yes, they are entitled -- absolutely. They
7 are entitled to bring it.

8 **LADY JUSTICE THIRLWALL:** So you are not aware of
9 him having that view?

10 **A.** I don't see it as an issue that they came.

11 **LADY JUSTICE THIRLWALL:** No, no, I'm sure you
12 don't. I'm just asking about the person who was making
13 the determination.

14 **A.** Yes.

15 **LADY JUSTICE THIRLWALL:** You weren't aware of that?

16 **A.** No, no.

17 **LADY JUSTICE THIRLWALL:** Right. Then can I ask you
18 about your meeting, your interview with Chris Green.

19 It's INQ0002879-0026. So it's the sixth box down, where
20 your initials appear.

21 **A.** Yes.

22 **LADY JUSTICE THIRLWALL:** You have been asked
23 a question about whether there had been a relationship
24 and we know that Karen Rees was the source of that
25 suggestion and that that had been eliminated very early

240

1 on.

2 **A.** (Nods)

3 **LADY JUSTICE THIRLWALL:** And your answer, which you

4 give there, we can read it, what I want to ask you about

5 is the next bit:

6 "We were trying to understand why he might have

7 singled her out in this way. Nothing more"

8 What was the evidence that he was acting

9 dishonestly and singling her out to make these

10 allegations against? Her what were you working on?

11 **A.** I think that the phrase "singled out", it was

12 because all of the points that Dr Brearey kept saying

13 was that it was around one member of staff. So that

14 was -- that was how I was referencing it.

15 **LADY JUSTICE THIRLWALL:** So you were trying to

16 think of a reason other than the fact that he honestly

17 suspected her?

18 **A.** Yes.

19 **LADY JUSTICE THIRLWALL:** So some other reason why

20 he was saying this.

21 **A.** Yes. Whether it was competence, whether they

22 just had a relationship -- you know, not as in

23 a physical relationship but did they not get on or was

24 there some other reason.

25 **LADY JUSTICE THIRLWALL:** Yes, and there wasn't, was

241

1 oral evidence. Due to a serious illness he is no longer

2 fit to give oral evidence. He has been asked as far as

3 he is able to provide the Inquiry with a supplementary

4 statement. If Mr Cross is able to provide this further

5 statement we will adduce that evidence in due course.

6 **LADY JUSTICE THIRLWALL:** Thank you very much indeed

7 and that will all be on the transcript.

8 **MS LANGDALE:** It is Dr Rackham now.

9 **LADY JUSTICE THIRLWALL:** Thank you. I'm sorry,

10 Dr Rackham, I didn't see you there, you came in so

11 quietly. Would you like to be sworn.

12 **DR OLIVER RACKHAM (affirmed)**

13 Questions by MS BROWN

14 **LADY JUSTICE THIRLWALL:** Do sit down, Dr Rackham.

15 I'm sorry you have been kept waiting, but we will take

16 your evidence today and you will finish it today.

17 **MS BROWN:** Could you please give your name.

18 **A.** Oliver Rackham.

19 **Q.** Dr Rackham, you have provided a statement to

20 the Inquiry dated 22 May 2024. Is that true to the best

21 of your knowledge and belief?

22 **A.** Yes.

23 **Q.** And you are a Consultant paediatrician

24 specialising in neonatal medicine. Between 2005 and

25 2018, you were the Consultant on the neonatal intensive

243

1 there?

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

3 **LADY JUSTICE THIRLWALL:** No. I think that is all

4 I have to ask. I can see, Mrs Hodgkinson, you have had

5 a very long day and I can see you are tired. Thank you

6 very much indeed for coming and helping us. We are not

7 going to adjourn now because we have another witness, so

8 if you don't mind if you would just like to leave in

9 your own time, there is no rush.

10 **A.** Okay. Thank you. Thank you, everyone.

11 **MS LANGDALE:** My Lady, may I, while the witness is

12 changing position for the next witness --

13 **LADY JUSTICE THIRLWALL:** I think you will need to

14 be closer to the microphone because you are competing

15 with a lot of other noise now.

16 There is something that has to be said which you

17 may want to listen to.

18 **MS LANGDALE:** May I update the position for the

19 Executives remaining to give evidence, my Lady.

20 Mr Chambers is anticipated to take the day tomorrow

21 and Mr Harvey will give evidence on Thursday and likely

22 complete by Friday lunchtime, I would have thought.

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

24 **MS LANGDALE:** Mr Stephen Cross has assisted the

25 Inquiry with a witness statement and was due to give

242

1 care unit at Arrowe Park and between 2011 and 2016, you

2 were the clinical service lead at Arrowe Park?

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

4 **Q.** And you were also, during the 2015/2016

5 period, a Consultant on the neonatal transport team?

6 **A.** Yes.

7 **Q.** And it's correct, is it, that Arrowe Park

8 neonatal unit differs from the Countess of Chester in

9 that it cared for babies at all levels of prematurity,

10 whereas the Countess of Chester, at the stage before it

11 was downgraded, cared for babies 27 weeks' gestation and

12 above?

13 **A.** Yes, that's right.

14 **Q.** And that meant that babies would sometimes be

15 transferred from the Countess of Chester to Arrowe Park

16 for their care and I think Arrowe Park geographically

17 was the closest referral hospital?

18 **A.** Yes, that's true.

19 **Q.** Further as clinical lead at Arrowe Park, you

20 represented Arrowe Park on the Cheshire and Merseyside

21 Neonatal Network both at the Clinical Effectiveness

22 Group and the steering group?

23 **A.** Yes.

24 **Q.** You say in paragraph 5 of your statement that

25 that the concern over an unusually high number of deaths

244

1 in Chester was brought to one meeting by Dr Brearey.

2 Are you able to recall now what that meeting was
3 and approximately when that was?

4 **A.** I'm afraid I can't tell you when it was
5 because of the time period that's passed. But it was at
6 one of the Clinical Effectiveness Group meetings where
7 we would discuss things we would describe as clinical
8 governance, so quality and safety measures, development
9 of guidelines and matters like that. And it -- it had
10 come to include reviews of mortality cases, although the
11 cases weren't all presented formally and in full as they
12 are in -- as they have become more typically done
13 recently.

14 So the fact that there was this increased number of
15 deaths was brought up, but -- and then we were aware
16 that there was a review going on into looking into that.
17 But we didn't review all of those cases in that forum.

18 **Q.** Sorry, you were aware at that point there was
19 already a review going on?

20 **A.** The first -- at the first meeting I was just
21 aware that Dr Brearey had raised the fact that there
22 were an increased number of deaths compared to normal
23 times and was bringing it to the attention of the
24 network.

25 **Q.** When he first brought that, was there any
245

1 Was that before or after Dr Brearey had raised the
2 concern or were you not aware?

3 **A.** I wouldn't be able to answer that with any
4 certainty.

5 **Q.** You say "we" were aware. Is that something
6 that was discussed between you and your colleagues at
7 Arrowe Park?

8 **A.** I think there was -- there was an awareness
9 that there were babies coming to us with conditions that
10 we wouldn't expect, so babies who had previously been
11 well and stable who were then suffering sudden
12 deterioration and without explanation who became stable
13 as soon as they came to us.

14 **Q.** You refer -- I'm not going to go through the
15 details, but you refer in your statement to the child we
16 are referring to as Child I, that came to Arrowe Park
17 after suffering collapses in October 2015. You give the
18 details.

19 But there were other similar incidents, were there?

20 **A.** There were other similar incidences.
21 I haven't had access to any of those records for a long
22 time, so I wouldn't be able to give you details of any
23 particular babies. But we were aware that there were
24 babies coming to us who it was unexpected and
25 unexplained why they'd had these collapses.
247

1 discussion about the possible explanation or causes for
2 those deaths?

3 **A.** There was no discussion around that. It was
4 just that there was an unexpected finding. There were
5 more deaths and they hadn't -- at that point their
6 internal review hadn't found anything.

7 **Q.** So are you aware of what that internal review
8 was because that would assist us with dating the
9 conversation?

10 **A.** I mean, I wouldn't have been part of those
11 reviews. But the normal is that the team involved
12 including people usually would be people who weren't
13 directly involved heavily in the care would review the
14 case.

15 **Q.** So at the stage when Dr Brearey was sharing
16 this with the neonatal, as far as you were aware there
17 was already a review under way?

18 **A.** Internally, yes. I think it was later that
19 I became aware that there was -- there were the external
20 reviews taking place.

21 **Q.** At paragraph 7 of your statement, you say:
22 "As the closest to home receiving neonatal
23 intensive care unit we were aware in Arrowe Park of an
24 unusually high number of babies suffering unusual
25 collapse or death in Chester at this time."
246

1 **Q.** And was that something you raised beyond the
2 hospital at any time?

3 **A.** It wasn't. No, I didn't.

4 **Q.** If I can turn then to Child O and Child P.

5 In June 2016, when you became involved with these
6 two children, were you already aware at this time of the
7 number of unusual collapses coming from the Countess of
8 Chester?

9 **A.** Yes.

10 **Q.** You relate to this in paragraph 10 of your
11 statement and you say on 23 June you were contacted and
12 I believe regarding an uplift, so a move to an intensive
13 care for Child O due to unexpected collapse and you say:

14 "This was an unusual and unexpected event
15 particularly in a baby of that gestation."

16 And I think you advise, but events overtook it and
17 Child O died before a transfer occurred?

18 **A.** Yes. I mean, babies of that gestation are
19 normally relatively well.

20 Obviously it's a -- it's a very traumatic
21 experience for parents having a baby born prematurely
22 and having to stay in hospital, but those babies in
23 general we would expect to do well and survive.

24 **Q.** Then the following day, you were contacted in
25 relation to Child P and I think that was also in your
248

1 role as transport Consultant --

2 **A.** Yes.

3 **Q.** -- because again what was being discussed was
4 the transfer of the baby out?

5 **A.** Yes, that's right. I was on for the transport
6 team that day.

7 **Q.** And on this occasion, you did then travel to
8 the hospital?

9 **A.** We did travel to the hospital with the
10 intention of moving that baby.

11 **Q.** And you say in the statement there was no
12 identifiable cause. Of course we know that child --
13 that you did arrive and Child P sadly died and you say
14 in your statement:

15 "There was no identifiable cause of death at the
16 time, so I was surprised at the collapse and death and
17 unable to explain what happened."

18 **A.** Yes, that's true.

19 **Q.** There was a debrief that took place after the
20 death of Child P. I believe they are sometimes known as
21 hot debriefs. What was the intention of that debrief?

22 **A.** There are two main purposes for that: one is
23 for the well-being of the staff involved, to make sure
24 everybody is okay and that their well-being is okay, is
25 any extra support needed immediately for staff. And the
249

1 babies had been able to explain what could have
2 happened. There was nothing obvious to me why that
3 could have happened.

4 And in case there was some underlying condition in
5 that family, such that that baby was also going to have
6 a collapse, it would be more sensible for it to be in an
7 intensive care unit when that happened. So I didn't
8 know was there some other medical reason for this to be
9 happening.

10 **Q.** So given the events, out of caution Child R
11 was transferred to Liverpool Women's?

12 **A.** Yes.

13 **Q.** And you then weren't involved in the care?

14 **A.** Not after the transfer, no.

15 **Q.** And I think some time afterwards you were
16 contacted by email from the ward manager Eirian Powell,
17 who said that Dr U had mentioned that you had praised
18 a Nurse Letby at the debrief and she asked if you could
19 put that in writing. And I think your response was: you
20 were unable to recall making that comment, so you
21 weren't in a position to put it in writing or otherwise?

22 **A.** I -- I don't recall the comment. I recall
23 that we, at the end of the debrief, we reflected that
24 the team, the team had functioned effectively. But
25 I didn't recall making that statement and I have no
251

1 other is for us to quickly review and say: Did we, you
2 know, with the benefit of hindsight did we do everything
3 at that point that we could have done? Is there
4 anything different that we should be doing to make sure
5 we don't, if there had been a mistake, which we didn't
6 think there was, in the resuscitation, that we didn't
7 repeat that.

8 **Q.** So just to be clear. You were just looking at
9 the resuscitation, obviously the events that you were
10 involved in, and you weren't looking at your wider
11 concern that you felt it was an unusual collapse?

12 **A.** Not during that debrief, no.

13 **Q.** Were you involved in any later debriefs
14 regarding Child P?

15 **A.** Any?

16 **Q.** Any later debriefs --

17 **A.** No, I wasn't.

18 **Q.** -- subsequently.

19 And you agreed then to transport Child R, the third
20 of the Triplets to Liverpool Women's Hospital?

21 **A.** Yes.

22 **Q.** Why was that transfer made?

23 **A.** So the child was well but was a triplet and
24 the other two Triplets had died without any explanation
25 and none of the -- none of the team caring for those
250

1 reason to disbelieve that it happened, but I don't --
2 I didn't recall making it.

3 **Q.** But you weren't able to put it in writing at
4 that stage clearly because you had no recollection?

5 **A.** No.

6 **Q.** Did that strike you as an unusual request?

7 **A.** It was an unusual request. But having said
8 that, for nurses and doctors to revalidate, to retain
9 their licence to practise, they need to provide
10 a portfolio of evidence of good practice, reflection on
11 events, their training.

12 So it is becoming more commonplace for people to
13 ask for feedback and so it's, it's not an abnormal
14 thing, but it was slightly unusual.

15 **Q.** When was it in fact that you became aware? So
16 you have explained that you were aware of the increase
17 in mortality, but when did you become aware that there
18 were suspicions and concerns that a member of staff was
19 involved potentially in the cause of those deaths?

20 **A.** I -- I was only aware of that when the -- when
21 it became public knowledge that there was a police
22 investigation.

23 **Q.** Just one final other very brief matter. In
24 your statement, you deal with the various routes where
25 a baby collapses and dies unexpectedly and you refer to
252

1 the Sudden Unexpected Death in Childhood, this is
2 paragraph 26 of your statement, and you say that the
3 SUDIc process is there to provide a prompt investigation
4 of unexpected deaths including in the neonatal period.

5 Was it your understanding that that SUDIc process
6 occurred even when a baby died in a neonatal unit in
7 hospital?

8 **A.** In best practice that would still -- that
9 would be the -- that would be the process. I think at
10 that time that was unusual for that to happen. It did
11 happen at that time, I think it's become a more accepted
12 practice that that should happen even within the
13 hospital setting. I think when the -- when the process
14 was set up that wasn't its original intention or it
15 wasn't set up for that purpose primarily but I think it
16 was expected that it would cover deaths that occurred in
17 hospital as well.

18 **Q.** So that was your experience as a clinical lead
19 in another hospital at that time?

20 **A.** Our experience was that that policy existed
21 but that it wasn't -- it wasn't always enacted for
22 babies who die in a hospital but in certain cases it
23 would be.

24 **MS BROWN:** Yes. Thank you very much, Dr Rackham,
25 I have no further questions but there will be a few more
253

1 The 23 June 2016 was Letby's first shift back. She
2 was the assigned nurse for the Triplets. On that shift,
3 Child O suffered a series of serious and unexpected
4 collapses which ended with his arrest and his tragic
5 death. That was because Letby had attacked and murdered
6 him during the course of that day.

7 Ms Brown took you to your involvement which you
8 have encapsulated at paragraph 10 in your statement.
9 May I just repeat back to you your characterisation of
10 what you were told over the telephone on that day about
11 Child O.

12 This was an unexpected collapse of unknown cause.
13 This was an unusual and unexpected event particularly in
14 a baby of that gestation with no apparent underlying
15 abnormalities who had been stable up until that point.
16 Whilst you didn't know it, that point about no
17 underlying abnormalities was correct and was confirmed
18 at postmortem.

19 But may I just ask this question: your impression
20 that you have recorded for us there in your
21 paragraph 10, was that your independent impression as an
22 external and experienced Consultant?

23 **A.** That's my own impression of the case from the
24 information I was given.

25 **Q.** And in terms of the information that you had,
255

1 questions by another representative.

2 **LADY JUSTICE THIRLWALL:** Mr Jamieson.
3 Questions by MR JAMIESON

4 **MR JAMIESON:** My Lady, thank you. Dr Rackham, good
5 afternoon. My name is Alex Jamieson. I ask questions
6 on behalf of two Family groups but for these purposes
7 and in particular, I am asking you questions directly on
8 behalf of Family OPR.

9 It's been a long day and I anticipate you will have
10 spent a long time waiting to give evidence but this is
11 important to them so I hope you will excuse me if we do
12 just spend a couple of minutes together now.

13 For brevity what, I am going to do is put the
14 questions I have into context by giving you a short
15 chronology, okay.

16 So the Triplets we have anonymised in this Inquiry
17 as O,P and R. They were born in late June of 2016 they
18 were premature but as you have said, clinically well.
19 The medical interventions that they needed were being
20 progressively reduced across the short days of their
21 lives.

22 Letby was on holiday in Ibiza at this time. She
23 knew that the Triplets had been born. Whilst she was
24 away she had exchanged messages with Dr U and others
25 seeking information about them.
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1 all that you were aware of in addition was your own
2 impression that there had been an unusual number of
3 unexplained and unexpected collapses at the Countess.
4 I don't understand you to say that anybody had shared
5 anything about their concerns about Letby with you by
6 this time.

7 **A.** What's the question?

8 **Q.** Had anybody said anything to you about Letby?

9 **A.** No, not -- they had not.

10 **Q.** Thank you. In relation to Child P, you
11 describe also in paragraph 10 a little further down the
12 page, but again a short chronology to put the questions
13 into context.

14 He too had been clinically well and improving on
15 the evening of 23 June 2016. There had been no
16 significant issues with him on the night shift into the
17 next day. But at that point his care was then handed
18 over to Letby on the morning of 24 June '16. In her
19 police interview she said that she had asked to be his
20 designated nurse on that day.

21 During that day, Baby P suffered a series of
22 serious and unexpected collapses and it was during that
23 period that Dr V has told us that Letby said to her:

24 "He's not leaving here alive, is he?"

25 That was accurate. Letby attacked and killed
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1 Child P on that day.

2 Now, as that tragic chronology was progressing, as
3 you tell us in your statement you were contacted by the
4 Countess of Chester in your role as Transport Consultant
5 and, if I may, I am just going to summarise what you
6 tell us at your paragraph 10.

7 You ensured that space was available in Liverpool
8 Women's Hospital in the NICU and you attended the
9 Countess of Chester intending to transfer Child P to the
10 NICU and you then led the resuscitation efforts when he
11 collapsed shortly after you arrived, but tragically he
12 could not be saved.

13 Now, Father P and Mother P -- OPR, I should say --
14 both had statements read to my Lady at the start of the
15 Inquiry and what they have told us is that at that point
16 they were desperate that Child R be transferred out of
17 the Countess of Chester. Father OPR described his
18 feelings in this way: I just felt that something wasn't
19 right and I knew that if they didn't take Child R to
20 Liverpool Women's Hospital, he wouldn't survive.

21 May I just ask you a couple of questions to explore
22 the actions that you took at that time.

23 Can we take it that the Liverpool Women's Hospital
24 NICU beds were a scare and precious resource at that
25 time?

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1 May I ask you this question: do you recall Father
2 OPR telling you that he thought if Child R stayed at the
3 Countess, he would be next and that he would die?

4 **A.** I -- I have to say I don't remember that
5 conversation. I do remember having the conversation
6 with the parents about moving Child R. My -- my
7 rationale for it was the thought that there may be an
8 underlying medical condition.

9 **Q.** Yes.

10 **A.** The -- the thought of this being deliberate
11 harm was not in my mind at that time.

12 **Q.** No, no. But they were anxious, they were very
13 keen that Child R be moved?

14 **A.** Yes, I mean it's not unusual for parents who
15 are in a -- who have lost a child to not want further
16 care to happen in that -- in that institution and we see
17 that -- we see that quite regularly so that -- that
18 level of anxiety was entirely reasonable and almost
19 expected.

20 **Q.** Yes. Were you aware that Mother OPR had to
21 discharge herself against medical advice to follow you
22 and her son to Liverpool Women's?

23 **A.** I -- I can't remember if I was aware at the
24 time I don't recall that happening.

25 **Q.** Okay. To bring the chronology to

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1 **A.** Yes, we had already had to move -- we had to
2 await a movement of a baby to be able to accept Baby P.

3 **Q.** Precisely. So in order to make space for
4 Child P, your preparation that day had been to remove
5 one of the babies who was being cared for in the NICU
6 assessed no doubt as being a child of lesser clinical
7 need?

8 **A.** It would be to move a baby who could be
9 appropriately cared for that -- obviously that baby
10 wouldn't have -- wouldn't have been given any less care.

11 **Q.** Wouldn't have missed out, no, not at all, not
12 at all.

13 **A.** It was that we had to wait for that move, yes.

14 **Q.** Yes, but that's what we are talking about,
15 there is no spare capacity, you have to wait for it to
16 be safe to move one baby before another one can come in.

17 Taken in isolation, there was nothing in the
18 presentation of Child R that warranted that NICU
19 resource, was there?

20 **A.** Not for Child R alone.

21 **Q.** But you made that decision in the light of
22 what had happened to his brothers and taking it shortly
23 you made those arrangements and you secured Child R's
24 transfer away from the Countess and to Liverpool Women's
25 Hospital.

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1 a conclusion, after those events, Letby was permitted to
2 work on the NNU until 30 June 2016 and it was alleged at
3 the criminal trial that during that period she went on
4 to attack Baby Q on 25 June 2016. Family OPR firmly
5 believe that it was the combination of their persistence
6 and your efforts that saved the life of their Child R,
7 that if it hadn't been for your decision, in their
8 words, they wouldn't have him today either. In the
9 light of that chronology that we have discussed, would
10 you agree that that's an entirely reasonable belief for
11 them to hold?

12 **A.** I -- I mean I knowing in retrospect what we
13 have learned -- what we have learned from the criminal
14 trial then I can, I can fully see that point of view.

15 **Q.** Thank you, doctor.

16 Finally, may I say this to you: I have been asked
17 by the parents to say that the impact of Letby's crimes
18 and of the failure to prevent them on the lives of
19 Family OPR has been unimaginable. The parents have not
20 been able to attend this Inquiry but they have followed
21 it where they can and it is imperative to them that
22 I take this opportunity to express publicly their
23 profound gratitude to you for saving their son's life.
24 In the ashes of their catastrophe you ensured that his
25 flame could continue to burn bright. You have their

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1 eternal thanks.
 2 Thank you, doctor. Thank you, my Lady.
 3 **LADY JUSTICE THIRLWALL:** Thank you, Mr Jamieson.
 4 There are no other questions, Dr Rackham, thank you very
 5 much indeed. You are free to go.
 6 **A.** Thank you.
 7 **LADY JUSTICE THIRLWALL:** So 10 o'clock tomorrow
 8 morning.
 9 **(5.14 pm)**
 10 **(The Inquiry adjourned until 10.00 am,**
 11 **on Wednesday, 27 November 2024)**
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