1 **Thursday, 7 November 2024**
2 **(9.59 am)**
3 **LADY JUSTICE THIRLWALL:** Ms Langdale.
4 **MS LANGDALE:** My Lady, may I call Ms Weatherley.
5 MS ANNETTE WEATHERLEY (sworn)
6 Questions by MS LANGDALE
7 **LADY JUSTICE THIRLWALL:** Thank you very much, do
8 sit down.
9 **A.** Thank you.
10 **MS LANGDALE:** Ms Weatherley, you provided
11 a statement to the Inquiry dated 21 June 2024. Can you
12 confirm the contents are true and accurate as far as you
13 are concerned?
14 **A.** They are, yes.
15 **Q.** You have got it in front of you if we go to
16 it, but in fact you will find documents will come up on
17 the screen in front of you. We can go back to the
18 statement where we wish to, and if at any point you are
19 not following it, do say so?
20 **A.** (Nods)
21 **Q.** If we look at your statement you tell us at
22 paragraph 2 you qualified in 1991, a Member of the Royal
23 College of Nursing, and you have a BSc in Nursing
24 Practice and an MSc in Health and Social Care Leadership
25 and Management.

1 When did you undertake the MSc?
2 **A.** 2012.
3 **Q.** Was that helpful in terms of leadership and
4 management, that course?
5 **A.** Yes.
6 **Q.** Was it a part-time course?
7 **A.** Yes.
8 **Q.** Did safeguarding crop up in that course or
9 child protection?
10 **A.** No.
11 **Q.** Not even in -- I am just asking about
12 different courses where people have done them -- the
13 context of leadership, the importance of having patient
14 safety first, particularly children and vulnerable
15 adults; anything like that?
16 **A.** No, it didn't. It was more focused
17 particularly on sort of the key aspects of leadership
18 and management. It wasn't specific to clinical care.
19 **Q.** No.
20 **A.** It was more a higher sort of broader overview
21 of leadership.
22 **Q.** So if you had to summarise management
23 priorities as a learning from that course, what would
24 they be?
25 **A.** How to build and lead effective teams.

1 **Q.** So team building, morale building?
2 **A.** Yes, to a degree. But also around aspects of
3 service delivery and sort of excellence and encouraging
4 and empowering teams to work towards that in the
5 services that they provide.
6 **Q.** Much discussion about HR and processes?
7 **A.** Not really, no.
8 **Q.** You say in autumn 2016 you were the Deputy
9 Chief Nurse at the University Hospital in
10 South Manchester. Tell us how you were asked by your
11 line manager to chair a grievance or the grievance that
12 you are here to talk about?
13 **A.** I don't recall the exact details of whether it
14 was in a specific one-to-one meeting. I imagine that it
15 was. And he just asked whether I would be prepared to
16 chair a hearing, a grievance panel hearing, in relation
17 to a nurse who had a grievance against her Executive
18 colleagues.
19 **Q.** You have explained you didn't know the nurses
20 at the Countess of Chester, you didn't know Alison Kelly
21 yourself, you didn't know --
22 **A.** No, I didn't.
23 **Q.** -- any of the people that you came across when
24 you chaired that hearing?
25 But you know that Alison Kelly had worked in your

1 role before, had she, or knew your boss; that was the
2 link?
3 **A.** She did.
4 **Q.** One of the matters that Sir Duncan Nichol
5 raised in an interview with a company called
6 Facere Melius after the events he said this:
7 "Surely Alison or Sue wouldn't have gone to the
8 Senior Nurse in South Manchester, that could have
9 created a perception of not being entirely, entirely
10 fair."
11 Do you think the fact that it was a nurse from
12 a unit or somewhere Alison Kelly had worked might create
13 a perception that it was bringing someone in where the
14 complaint was made by a nurse and there were some issues
15 between nurses and doctors, that choosing you as a nurse
16 wasn't the best choice or not, what would you comment on
17 that?
18 You wouldn't have known that background, but now
19 I am asking you, what do you think about that in terms
20 of you being independent?
21 **A.** I don't think that's something I could comment
22 on, I wasn't involved in sort of the discussions at that
23 time. Like I said, I didn't know anybody.
24 **Q.** Okay, no. But when you look back now, do you
25 think having a nurse hear that grievance in particular

1 was the best choice?
2 A. I think it's unfair to ask me to look back
3 now.
4 I think at the time I was asked a question as to
5 whether I would be prepared to listen to a grievance
6 hearing and that's something I had done many, many times
7 throughout my career.
8 Q. Of course, so you say for others to comment
9 who knew the bigger picture whether the perception of
10 that may have been fair or unfair, from your point of
11 view you didn't know that background; you have just been
12 asked to do it before?
13 A. Yes.
14 Q. You tell the police I think you have done
15 about 20 to 30 grievance -- was that grievance or
16 disciplinaries?
17 A. Probably a mixture of both but I would say
18 certainly over 20 in terms of grievances.
19 Q. Over 20. And had you always done them in the
20 same Trust?
21 A. Yes, this was the first one that had been
22 outside of the organisation I was working.
23 Q. And what was the process in the Trust you were
24 working in, when would you get the papers, when did you
25 get involved as the chair of the grievance, just talk

1 through the process as you understood it broadly to be
2 in your other Trust?
3 A. So you would ordinarily get the papers at
4 least a week in advance. Obviously the grievance from
5 a process perspective is a very limited procedure. It's
6 not -- it's almost you could describe it as a tabletop
7 exercise, so you are not investigating anything that has
8 occurred; you are sitting almost in adjudication having
9 heard representation from both the person with the
10 grievance and the person who investigated the grievance
11 to be able to come to a conclusion and a decision in
12 respect of the outcome.
13 Q. And when you do that in your other process in
14 the other Trust, do you have the person who's making the
15 grievance and their Union member present, the
16 investigator but not the people about whom the grievance
17 complaint is made, potentially?
18 A. Sorry, just say that --
19 Q. In that hearing setting you have described
20 having the person who's made the grievance and the
21 investigating officer?
22 A. Yes.
23 Q. Do you have the people who have responded to
24 the grievance?
25 A. You wouldn't, no, unless the either party had

1 specifically asked to bring witnesses to that hearing.
2 Q. Right. So the investigating officer and the
3 person raising the grievance have an input or choice
4 around who's at that hearing with you or the panel
5 overview with you?
6 A. They -- they would do.
7 Q. Right. So in this case, moving to this
8 grievance, did you have a discussion with either
9 Dr Green or Lucy Letby's representative about who was
10 going to be present at the hearing?
11 A. No, I didn't.
12 Q. So you turned up and that was sorted as far as
13 you were concerned?
14 A. Yes.
15 Q. In the same way did you have any input about
16 who was going to be interviewed or was that sorted by
17 Dr Green and supported by Lucy Sementa?
18 A. Yes, that was -- that was nothing to do with
19 me.
20 Q. Nothing to do with you?
21 A. Yes.
22 Q. So have you ever come in to any of the
23 grievances -- I don't need details -- and commented on
24 the picture that has been presented and said: well,
25 I don't know this from this person or: I haven't got

1 this, or do you just take what you are given and that is
2 the job?
3 A. You just work with the information that's
4 presented to you at the time.
5 Q. Being trained as you were to do grievances,
6 that's what your understanding is: you are just told
7 what -- deal with what's there, don't look around if you
8 think there's a bigger picture or something missing?
9 A. Yes. You would work within the confines of
10 the process of the grievance. If there was something
11 specifically that had alarmed me in any grievance, that
12 might be something you would say back to the
13 investigator there needs to be further investigative
14 work in respect of that, or you may have a question that
15 you feel has been unanswered within the investigation,
16 so you may -- you know, that that may come up during the
17 grievance.
18 Q. You were sent a grievance pack and you tell us
19 you think policies were included in that and you saw
20 those. Can I just ask if we go to INQ00028790100, which
21 is the grievance procedure from the Countess of Chester.
22 Page 0100.
23 Here at the top we see grievance is a problem or
24 concern that an employee has about their working
25 conditions et cetera and it says:

1 "If a grievance can be more appropriately dealt
2 with under a different procedure, staff will be advised
3 this is the case."
4 Then there is a list of various mechanism and
5 procedures in place.
6 My question is: you are presumably you say sent
7 this because it's a grievance but you are not presumably
8 sent all these other policies as well, are you?
9 **A.** No.
10 **Q.** Do you find, as somebody who's listened to
11 grievances, that a particular helpful description of
12 when a grievance might be more appropriately dealt with
13 under a different procedure, just a list of policies;
14 does that help you in any way as somebody who's coming
15 in to look at a grievance when you might think of using
16 a different process or not even having the grievance?
17 **A.** I don't believe that that would be something
18 that the manager hearing the grievance would be -- would
19 have an opinion about.
20 **Q.** It certainly would look complicated to find
21 out what that meant, wouldn't it, that some of these --
22 look at it -- suggest other procedures are in place for
23 example in relation to harassment and bullying, other
24 procedures.
25 Is that something you picked up on? Of course in

1 the complaint we come to deal with that is what
2 Lucy Letby does complain about, but it's not something
3 you would pick up or go and look for, is it?
4 **A.** No, sorry I am not clear on the question?
5 **Q.** So you are told in this grievance policy that
6 you did see if it can be more appropriately dealt with
7 under a different procedure, staff will be advised this
8 is the case.
9 Who would you look to check, and maybe you didn't
10 check, whether this was the right procedure for what you
11 were being asked to look at?
12 **A.** This procedure was followed because
13 a grievance had been raised, so if a grievance has been
14 raised, you follow the grievance policy.
15 **Q.** But look at this policy. It tells you there
16 are examples when it's inappropriate to follow the
17 policy, doesn't it, and one of them is complaints of
18 harassment and bullying. Did you at any time understand
19 that Lucy Letby complained that she was being bullied by
20 Dr Brearey?
21 **A.** It was mentioned by her RCN representative
22 within both his grievance to the -- or letter of
23 grievance to the Trust on Lucy's behalf and also then in
24 Lucy's actual grievance that she wanted the grievance to
25 be heard under the grievance policy as well as the

1 harassment and bullying policy.
2 But at that time, as I understood it, the
3 investigating manager, Dr Green, had said obviously that
4 was a separate policy to follow the harassment and
5 bullying and he sent that policy to Lucy and suggested
6 that that would be something she would need to look
7 through and then raise a concern in respect of that
8 thereafter.
9 **Q.** Did you look at that policy?
10 **A.** The harassment and bullying policy?
11 **Q.** Yes?
12 **A.** No, I didn't.
13 **Q.** Can we go to another policy, INQ0003012,
14 page 1.
15 This, you tell us, was also sent at the time to
16 you, the Speak Out Safely raising concerns about patient
17 care and whistleblowing policy.
18 We look at that top box and it says halfway down:
19 "Above all, the Trust encourages a culture whereby
20 staff and all levels of management fully understand that
21 it is safe and accepted to raise such matters
22 internally. Staff will be supported in these
23 circumstances at high level."
24 It continues:
25 "The policy has an aim in supporting staff in

1 fostering an open culture to raise concerns in the
2 workplace and also to provide clarity around existing
3 legal rights for staff to raise concerns about safety,
4 malpractice or other wrongdoing without suffering any
5 detriment."
6 Had you read and understood this policy?
7 **A.** Yes.
8 **Q.** Broadly what do you think the effect of this
9 is? This policy, what does it say, what does it mean?
10 **A.** This is a policy to support people who are
11 concerned to follow a process to raise those concerns.
12 **Q.** You say "follow a process". Is it also just
13 to feel able to raise concerns, to be able to articulate
14 concerns about patients?
15 **A.** Well, all staff should be able to raise
16 concerns anyway. This is the process in order to do it,
17 it just outlines a clear responsibility of the
18 organisation and also staff that would want to raise
19 concerns.
20 **Q.** We see on page 2 of that policy in the third
21 paragraph, 0002, we see:
22 "Managers have a particular responsibility to
23 protect patients, to handle concerns about their care in
24 a way that will encourage the voicing of genuine
25 misgivings whilst at the same time protecting staff

1 against unfounded allegations."
2 So to encourage people in the interests of all
3 those who use the NHS and patients, babies, vulnerable
4 adults to say when they are worried that something's not
5 right or doesn't look right?
6 **A.** That's right, yes.
7 **Q.** In the disciplinary policy finally,
8 INQ0108329, page 15, we see that includes -- you will be
9 familiar with this no doubt -- safeguarding
10 requirements, where there is a concern raised or
11 an allegation made and there's concerns that they may
12 have behaved in a way that's harmed a child or possibly
13 committed a criminal offence.
14 The level for referral is "concern and suspicion",
15 it is not concrete proof, is it? It's some concerns,
16 suspicion that children are being harmed or babies are
17 being harmed?
18 **A.** Yes.
19 **Q.** That would be something that you think would
20 be widely known or should be widely known?
21 **A.** It should be widely known. I think it's
22 certainly -- be more widely known for people that are
23 working with children certainly from a safeguarding
24 training perspective.
25 **Q.** So do you think less widely known for managers

1 or people that aren't working with children on
2 a day-to-day basis, is it something front line workers
3 with children would think about more?
4 **A.** There is different levels of safeguarding
5 training. I think the more senior you are in terms of
6 the management structure, you would -- this is covered
7 in sort of Level 2, 3, 4.
8 Level 1, which is safeguarding training for most
9 staff, for all staff, I don't think that -- well, I am
10 not sure but I'm not sure that people would know what
11 the LADO was there to do and how you would make
12 a referral.
13 **Q.** Let's -- we can take the policies down, thank
14 you.
15 When you first spoke to the police about this
16 grievance, investigation generally, you said this, if we
17 can go to INQ0017846, page 28. We see they said, the
18 second answer, they said -- this is you:
19 "He has said no party refutes that concerns were
20 raised by the Consultants, in particular [that should be
21 SB, I think] SB to the Executive Team around a perceived
22 commonality."
23 You say further down:
24 "What were your thoughts, that she should have been
25 allowed to remain on the unit supervised or was that

1 just something that could have been considered as well
2 or ..."
3 You said:
4 "Well, what I would have done at that if -- you
5 know, if I would have been any part of that Executive
6 Team would have been to say: right, well clearly that's
7 a significant concern and if you are raising that with
8 us then we do this properly.
9 "Yeah."
10 Over the page:
11 "She will be suspended for her own protection and
12 we will investigate and we will alert the police. Then
13 she would have been brought in by whoever, probably her
14 line manager, to say: have to be open and honest with
15 you in respect of the Trust policy, a concern has been
16 raised that suggests X, Y and Z. In order to protect
17 you we are going to now suspend you on full pay whilst
18 we investigate. We will assign you somebody to support
19 your psychological well-being throughout this process to
20 keep you in touch with how things are going, we will
21 take it from there. And that is what should have
22 happened."
23 You tell the police when you were first interviewed
24 that?
25 **A.** Yes.

1 **Q.** Is that what you think should have happened?
2 **A.** That should have happened in 2015, yes, when
3 the first concern was ever raised.
4 **Q.** You say very clearly on the first page that
5 commonality, just the perceived commonality, was
6 a significant concern that demanded that?
7 **A.** Sorry, I say where?
8 **Q.** If you go back to the previous page, they put
9 to you concerns were raised around a perceived
10 commonality. So you don't put it any higher than
11 a perceived commonality and you say that is
12 a significant concern.
13 **A.** That's what I remember at the time when
14 I spoke to the police around perceived commonality,
15 without having obviously any information in front of me.
16 **Q.** No, I think we will go to that. You had in
17 fact seen that table with her name next -- a perceived
18 commonality between deaths and you are saying that is
19 a concern that should have required this?
20 **A.** It, yes, but it wasn't -- the statement that
21 I gave to the police there in respect to what I would
22 have done was on the basis that the concern was not
23 about the commonality, the concern was that the
24 consultants had said that there is an allegation that
25 somebody is -- a colleague is murdering babies on the

1 unit.
2 **Q.** That's not what you say here. You don't refer
3 to the fact that a colleague has said murdering babies
4 on the unit. You just say there is a commonality
5 around, a perceived commonality.
6 We will come on to what you say the Consultants
7 said but I am giving you the opportunity to say is that
8 what you understood should have happened?
9 **A.** Perceived common -- what the Consultants were
10 saying around a perceived commonality of one particular
11 nurse on duty at the time that they felt babies were
12 being murdered.
13 **Q.** Exactly.
14 **A.** That is what I meant by "perceived
15 commonality".
16 **Q.** Yes, yes. So perceived commonality and they
17 should have gone to the police.
18 We know obviously that they didn't then and you
19 were then investigating this grievance. Was there any
20 time when you were investigating the grievance you
21 thought to suggest that or were you focused on the
22 grievance and as you said before you are just looking at
23 what's in front of you?
24 **A.** I was focused on the grievance. I didn't have
25 anything within the investigation that suggested to me

1 at that time that I would call the police in at that
2 point or suggest that the police be called in at that
3 time.
4 This is 12 months later from when I am saying
5 I would have said the right thing to do is as part of
6 that Executive Team would have been to suspend her and
7 call the police, and in that 12 months I think there had
8 been four reviews, all of which had shown no concern in
9 respect of Lucy. And therefore, that was a different
10 situation in 2016 in December when I was hearing this.
11 **Q.** Let's have a look, go back to page 12 in this
12 police interview INQ0017846, page 12. You set out when
13 we get to page 12:
14 "The Consultants were doing their own kind of
15 investigation, whatever it was that they were doing.
16 Whether they liked or disliked her, there were lots of
17 rumours around. They decided it was her. She was the
18 baby killer, they were openly talking about her as the
19 baby killer. They went to the Trust, they said 'she is
20 the baby killer we don't want her on the unit'."
21 If we go over the page to page 13, the officer
22 says:
23 "You felt that it was a witch hunt, I felt it was
24 a witch hunt."
25 Over the page:

1 "It's a rumour -- I can't remember who said it, but
2 there was rumour that she have had rebuffed I think --
3 I don't know, I think a Consultant had made it clear
4 that he had an interest in her and she had rebuffed it."
5 The officer says:
6 "What, physically?
7 "Yeah, physically."
8 Overleaf, if we go over the page to 15, officer at
9 the bottom the page:
10 "You say there was some rumour although you don't
11 know where it had come from that she had rebuffed one
12 the Consultants?
13 "Yes, it was someone told me that, I can't remember
14 who it was when I was there that there was a rumour."
15 Over the page again, page 16, and you say, page 16:
16 "When I got to the actual hearing I went a little
17 bit early and I met I think it was the head of HR or
18 deputy.
19 It was in fact the deputy HR, Mrs Dee
20 Appleton-Cairns.
21 "Yes.
22 "And she said to me 'what are your thoughts?'
23 I said 'I think it is a witch hunt'. She said 'that is
24 what we all think'."
25 When you went to -- you obviously relied on what

1 people told you at different points, you did meet with
2 her before the hearing?
3 **A.** Yes.
4 **Q.** What do you remember about that conversation
5 using that to help you, if it does?
6 **A.** It wasn't a detailed conversation, we didn't
7 have long, she asked me whether I had had the
8 opportunity to fully read the pack, cover to cover and
9 absorb it. I said I had. She asked me what my thoughts
10 were. I said it felt like a witch hunt. She said yes,
11 we all feel the same. It's very sad.
12 **Q.** When she gave evidence, she told the Inquiry
13 that it was exactly -- that meeting was exactly like
14 giving evidence at this Inquiry, she came, was shown the
15 room, meet each other, they had a chat, nothing more
16 sinister. She said she didn't recollect saying that
17 about a witch hunt.
18 You say that is wrong and she did have that
19 conversation with you?
20 **A.** She did.
21 **Q.** On the point of the Consultants, were you
22 aware that a nurse one of the ones who was interviewed
23 Karen Rees told this Inquiry and told the police she was
24 the person who asked Letby directly if she had any
25 reason to believe that the Consultants, Dr Jayaram and

1 Dr Brearey, had a personal issue with her or anything of
2 that nature and she said no and she had had good working
3 relationships, certainly with one of them?
4 **A.** (Nods)
5 **Q.** So again, were you relying on others telling
6 you that rumour when you tell the officers, as you do,
7 that you understood she might have rebuffed
8 a Consultant, where did you get that from?
9 **A.** That was said to me during the investigation
10 hearing, I think --
11 **Q.** We will go to the notes of that and of course
12 Letby was at that hearing as well so we will see but you
13 can't remember if it was a conversation out of the
14 hearing?
15 **A.** No, it was in the hearing.
16 **Q.** How many conversations did you have out of the
17 hearing, you have obviously had one with
18 Mrs Appleton-Cairns. Any others?
19 **A.** No and it wasn't so much a conversation; it
20 was a -- I had not met any of them before I hadn't met
21 her, it was having a coffee. Yes, she was right in that
22 she said: this is the venue, this is where, obviously,
23 the hearing will take place and these are the people
24 that are involved.
25 We didn't discuss the case any further beyond that

1 one sentence where I said it felt like a witch hunt and
2 she agreed.
3 **Q.** There is a line that is crossed there, though,
4 isn't it? When we meet and we meet witnesses, we don't
5 say: what did you think of this, then? There is no
6 suggestion that we would discuss anything that goes on
7 in this hearing room and you are asked questions about.
8 So there was a different line when she said: what do you
9 think? And she said "We think it is a witch hunt too,
10 that is sad". That is giving you evidence of her view
11 and what they think, isn't it, before you have even got
12 in there?
13 **A.** I would disagree with that in respect of
14 a grievance. The panel was myself and Dee. So the
15 panel would discuss what was contained within the pack,
16 if they felt they needed to, in respect to anything that
17 was about to be -- obviously before we go into the
18 hearing, anything that she might want to say, anything
19 I might want to say. We collectively were the panel.
20 **Q.** Oh, so Dee Appleton-Cairns was
21 a decision-maker as well, as far as you are concerned?
22 **A.** She is -- she is the support to -- this other
23 HR person normally in a grievance hearing is the support
24 to the hearing manager and they collectively can ask
25 questions of the representatives that are presenting the

1 grievance and those who are presenting the investigation
2 into the grievance. So therefore they make up the panel
3 who are hearing it.
4 **Q.** But that panel ceases to be anything like
5 an independent panel, doesn't it, when you have got
6 someone from HR knowing all the people, listening to
7 what they want about what they want, there is no
8 independence in that panel any more, is there?
9 **A.** The independence I suppose is when you come to
10 the decision-making in respect of outcome which was my
11 decision.
12 **Q.** But it's influenced by someone who's got close
13 access to you and is having a conversation with you that
14 goes on outside the hearing room?
15 **A.** I guess it's influenced if the hearing manager
16 is prepared to be influenced.
17 **Q.** You repeat that you think it's a witch hunt
18 when you get into the hearing room and we will come to
19 the basis for you saying that, but you saying you would
20 be able at that stand back from her telling you things
21 like that in an informed way?
22 **A.** I had said it first, that was my -- that was
23 my gut feeling when I read the initial investigation
24 report.
25 **Q.** Let's go to the pack that you were sent and we

1 know what the documents were, you say they were shredded
2 after that. Is that normal, you just shred grievance
3 process material, that is what happens in the NHS?
4 **A.** You would -- yes, you would delete the
5 information that you have.
6 **Q.** How quickly does that happen? Is that just
7 you as the hearing manager, not everybody else,
8 presumably?
9 **A.** I can't speak for anybody else but the
10 information that I have if you, if you have that
11 information you would either hand that back or you would
12 discard of that information appropriately.
13 **Q.** We have got INQ0002879, page 3. And here's
14 the grievance, that's how it came to you; is that right?
15 **A.** Yes, so the grievance was contained within the
16 pack.
17 **Q.** Yes. So these were the questions that you
18 were asked to answer?
19 **A.** No, I wasn't asked to answer them. The
20 investigating manager was asked to investigate these.
21 The role of the chair of the hearing, yes, the hearing
22 chair of the panel, is to consider whether the
23 investigation has sufficiently answered the points of
24 grievance enough that you can come to an outcome.
25 **Q.** I accept that because when we get to your

1 letters you do deal with the points and answer or
2 respond to them. So either way you agree those are the
3 questions and when we get to it, you are responding to
4 them?
5 **A.** Yes.
6 **Q.** You also have sent to you INQ0003189, page 1.
7 The Inquiry is very familiar with that document
8 now, Ms Weatherley, of course you will only have seen it
9 when it was sent to you, so just have a look at the
10 front page. We see it's this document with Letby's name
11 in red and around a number of babies, some ciphered for
12 the purposes of the Inquiry.
13 Do you remember seeing this and these links being
14 made and if you did, who did you understand had prepared
15 this?
16 **A.** I had -- I didn't see this.
17 **Q.** It was -- you refer to the mortality review
18 and you refer to common staff and it is in the pack but
19 you say you didn't see that?
20 **A.** No I hadn't seen this and there was
21 something -- and I can't remember what it was -- that
22 was in there in respect to commonality because that
23 prompted a question that I put to the investigating
24 manager in respect to there only being nurses on the
25 list. It wasn't this.

1 **Q.** Well, we know another nurse, Sian Williams,
2 who was also interviewed, and Julie Fogarty, did another
3 staffing analysis she was interviewed and she said that
4 when she completed it she thought she should have gone
5 to the police. Do you know if it was hers or you don't
6 know now, you just saw something?
7 **A.** I don't know, I can't remember what was in the
8 pack, but it was just something that had some
9 commonality on it. There was nurses on it but there was
10 no other members of staff on it.
11 **Q.** So you did see the commonality, it was either
12 this one or another one that showed Lucy Letby's name
13 linked to babies as a nurse?
14 **A.** It wasn't -- it was who was on shift at the
15 time. There weren't red crosses, it wasn't what I have
16 seen in the media.
17 **Q.** I am not interested in the media. I am
18 interested in that, the one that was prepared --
19 **A.** The only two that I have ever seen was the one
20 that was in the media and this that had red pen or any
21 red on it.
22 **Q.** Fine. So you have seen this one and the one
23 that's been produced and this is something that's been
24 put together by Eirian Powell but you didn't find out
25 who had done it. You just saw nurses only and Letby's

1 name and no doctors on it; you didn't see a list of
2 doctors?
3 **A.** No.
4 **Q.** But when you looked at that, if you looked at
5 that, what did you think?
6 **A.** I -- I don't recall looking at this.
7 **Q.** Because you do say to the police about
8 significant perceived commonality, it is a concern that
9 should go to the police. We have just been to that.
10 Was that something thought when you saw this or
11 would you say now you don't remember looking at it?
12 **A.** I didn't see this.
13 **Q.** Can we go to INQ0009618, page 9.
14 Did you see this? This is an RCPCH report and part
15 of the report?
16 **A.** No, I didn't see this.
17 **Q.** Can I just say just to refresh your memory
18 about the chart of commonality. At paragraph 12 in your
19 statement, if you have a look at it, Ms Weatherley, when
20 you tell us here what you had been sent, you say at the
21 bottom of paragraph 12:
22 "I had not seen any information at all prior to
23 receiving the pack, neither can I recall the exact
24 contents of it save the investigation and interview
25 transcripts and several appendices that are not all

1 included in the Rule 9 information ..."
2 So maybe more than we sent you from the pack here
3 but:
4 "... such as the nursing rotas and I believe the
5 chart of commonality was also included."
6 That is the chart of commonality I have just taken
7 you to.
8 So when you wrote this statement you thought you
9 had got that?
10 **A.** I had seen something that was, that had some
11 degree of commonality on it. What it looked like
12 I can't recall but it definitely wasn't that.
13 **Q.** Well, we don't have any other one that looks
14 like that.
15 **A.** I can't -- I'm sorry, I can't answer you .
16 **Q.** But you took the point that she was linked
17 with the baby deaths, the association, you took the
18 point --
19 **A.** Yes.
20 **Q.** -- the chart of commonality. So you had that
21 point?
22 **A.** Yes. But as I said with there not being
23 anybody else on that, it was just nurses, I had
24 questioned in the investigation if --
25 **Q.** You also say -- sorry, go on?

1 **A.** No go on.
2 **Q.** Paragraph 16, you say:
3 "I became aware of a completed external review by
4 the Royal College of Paediatricians looking into
5 neonatal deaths when I received the grievance pack
6 two days before the hearing. Contained within was
7 information referencing the reviewing which had
8 concluded in October 2016 and had found nothing of
9 concern but had recommended a further forensic review of
10 the case notes. That forensic review was ongoing at the
11 time of the hearing but was not investigating Letby and
12 therefore I did not feel there was a need to wait for
13 the outcome of that review."
14 So if we look at the second page of this, this is
15 the review you refer to in your statement. Look at the
16 conclusion on the next page, page 10, 0010.
17 You see there that is the recommendation you refer
18 to in your statement to the Inquiry:
19 "Conduct a thorough external independent review of
20 each neonatal death to determine any factors which could
21 have changed the outcome."
22 So it looks like this -- either you see the whole
23 report or these two pages because you refer to this in
24 your statement. Can you remember now what it was, the
25 whole report or?

1 **A.** I hadn't seen any of the report.
2 **Q.** So how did you know then about the
3 recommendation for a further forensic review of the case
4 notes?
5 **A.** Because -- sorry.
6 **Q.** Go on.
7 **A.** That was in the Executive statements that they
8 provided to Dr Green in this investigation.
9 **Q.** We have seen the interview transcripts, and we
10 will go to those, of Dr Green's interviews. But I am
11 just trying to understand what you had seen in writing
12 first and this is from the pack and these are the things
13 he had, okay? So you are saying not this?
14 **A.** No.
15 **Q.** Did you have the document from Eirian Powell,
16 a six-page document giving various concerns, a written
17 document?
18 **A.** Can you show me that?
19 **Q.** It's INQ0002879, page 63. You have been sent
20 these with your Rule 9 but let's have it on the screen
21 so you can see. This document; remember that?
22 **A.** Yes, I have seen this.
23 **Q.** So we don't need to go through all the pages
24 so you had seen that. Had you seen an email that was
25 referred to in the hearings about air embolus that was

1 forwarded to Dr Green from Eirian Powell? It was
2 an email that --
3 **A.** Yes, I have.
4 **Q.** Yes, you saw that?
5 **A.** Yes.
6 **Q.** Then there was another one from
7 Dr Ravi Jayaram to a group of people 9 September; had
8 you seen that? INQ00028790059.
9 It's the smoking gun email. This one, see:
10 "There was ... no smoking gun to explain the
11 increase in death rate identified. They did acknowledge
12 the concerns we raised over foul play."
13 **A.** I have seen this, yes.
14 **Q.** You have. So you had seen the emails, you had
15 seen something about staff commonality and you knew
16 about the review and that being recommended, the
17 forensic review by the RCPCH. Then you had interview
18 transcripts, didn't you, from a number of people. Did
19 you find them very useful in terms of answering the
20 grievance or dealing with the grievance?
21 **A.** Sorry, in what way?
22 **Q.** Did you find them very informative and useful
23 the way it had been put together if you were looking at
24 answering those questions?
25 **A.** I found that Chris or -- sorry, Dr Green, put

1 the questions, the relevant questions, the pertinent
2 questions of Lucy's grievance to each member that he
3 interviewed and they answered.
4 Some in terms of my decision-making were definitely
5 more helpful than others. Some were evasive and clearly
6 not engaging in the process.
7 **Q.** What did you think the questions were that the
8 doctors, Dr Jayaram and Dr Brearey, needed to be asked
9 to answer that grievance?
10 **A.** In respect of Dr Jayaram and Dr Brearey,
11 they -- they were unclear. They clearly didn't engage
12 with Dr Green during his investigation and the questions
13 that he put to them were very different, their responses
14 were very different than the responses as witnessed by
15 other people's testimonies.
16 They were making accusations that one nurse was
17 responsible for harming -- deliberately harming babies
18 on their unit and, yet, on the other hand in their
19 statements to Dr Green they said that it was conceivable
20 that the Royal College report could alleviate their
21 concerns. Now to me, if you are convinced that you have
22 somebody harming babies, how could anything alleviate
23 your concerns? So what they were saying in those
24 statements was confusing.
25 **Q.** Did you think to ask the Executives that or

1 think to yourself: what is that report about? The Execs
2 have commissioned it, Alison Kelly was also interviewed.
3 Was that a question that she should have been asked
4 about, what is that doing?
5 **A.** That is outside the remit of the grievance.
6 **Q.** Right, okay.
7 So let's go to Dr Jayaram interview INQ0002879,
8 page 47. What do you think he is saying in that first
9 paragraph? We can see it, take your time to read it.
10 What's the level of concern, how would you describe
11 that?
12 **A.** (Pause)
13 So what he is saying in that paragraph there is
14 that there had been an increase in the rate of babies
15 dying and they felt that that was outwith the norm.
16 They were concerned about that.
17 He had clearly been discussing it with other
18 people, there had been some review undertaken by
19 Dr Brearey. They couldn't see from that review anything
20 in terms of clinical practice or equipment or other
21 factors that could be relevant to those babies, the
22 increase in those babies who had died. But there was an
23 association with Lucy either being present at the time
24 of deaths there or thereafter. Again they discussed it
25 as a group and they were concerned and they took the

1 concerns to the Executives.
2 **Q.** He is saying there, isn't he, at the
3 beginning:
4 "The rise in mortality were not the babies you
5 would have predicted, none of them responded to any
6 resuscitation manoeuvres either."
7 In other words, these were unexpected and
8 unexplained deaths and when they were resuscitating them
9 they were doing things you wouldn't expect with
10 a naturally collapsing or dying baby?
11 **A.** He did say that, yes.
12 **Q.** So that is a significant concern, as you said
13 to the police at the beginning one that you would have
14 said "suspend her, investigate it" if you had seen that
15 early on?
16 **A.** Yes.
17 **Q.** Over the page, at page 48, Dr Green says at
18 the bottom of the page:
19 "So to clarify, was there any suggestion from any
20 of the Consultant team that Lucy had been deliberately
21 harming babies?
22 "We discussed a lot of possibilities in private, so
23 that is not a yes or no, we discussed a lot of
24 possibilities in private and took our concerns to the
25 Executive Board."

1 You had seen the emails had been forwarded to you
2 by Eirian Powell, she was on that group of emails as the
3 only nurse, as the ward manager.
4 Their concerns were being discussed in private,
5 weren't they, between them about air embolus, what was
6 the cause of these deaths, and they were discussing it,
7 they tell you there, with the Executives. There was no
8 doubt you knew that was being discussed within the
9 hospital?
10 **A.** They were discussing it in private. (Nods)
11 **Q.** Well, a group of Consultants and Eirian Powell
12 and also the Executives, within the hospital a number of
13 professionals were involved in that communication and
14 you knew that because you had seen the email that had
15 been forwarded to you?
16 **A.** Yes.
17 **Q.** Let's go to Dr Brearey's interview, if we can.
18 INQ0002879, page 51. If we go to page 52, to the top of
19 the page. He is being asked about the redeployment. He
20 says:
21 "It wasn't my decision."
22 It was clearly an HR or Executive decision, wasn't
23 it, a redeployment eventually? He said:
24 "It wasn't my decision"
25 Did you understand that the Consultants aren't

1 responsible for making the redeployment decision, are
2 they? That is an HR decision, an Executive management
3 decision?
4 **A.** The making of the decision is, yes.
5 **Q.** Then he says:
6 "We had undertaken a thematic review of deaths in
7 2015 and one that occurred in January 2016. We wanted
8 to identify common themes linking the deaths."
9 He offered to send Dr Green a copy of the report.
10 Dr Green didn't take him up on it although he had in
11 fact been cc'd into it some time before.
12 When you read that, did you think: well, I would
13 like to see what they have done or what they have got,
14 these doctors who are worried about these things, or
15 not? Did you rely on Dr Green for that?
16 **A.** Yes, yes. The -- the -- the remit of the
17 confined process, which is a grievance hearing, is based
18 on the information of the investigation that's before
19 you.
20 **Q.** Here he says:
21 "From memory there were no issues in terms of
22 clinical care. Six of nine died between midnight and
23 4 am."
24 For your information, you may know already,
25 Dr Reynolds, a GP, noticed her patients or those that

1 were looked after by Dr Shipman, there was an increased
2 pattern that elderly women at home were dying when they
3 had seen by him, didn't know what had happened when he
4 got there, didn't have any evidence to say what happened
5 when he got there. But she noticed a pattern that
6 wasn't right and she reported it to the police, there
7 wasn't an investigation or effective investigation at
8 that time, but there was later when someone else came
9 forward and had a motive in terms of a will being
10 altered and a death and that was investigated and so it
11 was Dr Shipman was brought to justice.
12 When you look at this, and he says there is
13 a pattern, did anything -- did you think anything or was
14 it just another line in a series of comments? Just
15 think what is he trying to say there, what does that
16 mean or not?
17 **A.** I think in a healthcare environment there are
18 often lots and lots of patterns, there is lots of things
19 that can contribute to illness and significant
20 deterioration. So in reading that, he has found
21 a pattern. That's what it said to me, he's found
22 a pattern, one person's view of a pattern.
23 **Q.** Then if we go to page 54, Dr Green says:
24 "Any discussions between Consultants about air
25 embolism or twisting of tubes ... no efficient

1 discussions ... privately, not my place to say."
2 Then the Union rep:
3 "You can answer specifically only for yourself, you
4 cannot comment on colleagues, only yourself."
5 Does this usually happen people come with Union
6 reps presumably to grievance procedures when they have
7 been advised?
8 **A.** Yes, that that's normal.
9 **Q.** So you would see that straight away; you have
10 got the soft skills to see that is a Union rep with
11 them, they are not supposed to be saying things about
12 other people, they are not going to say that in this
13 situation?
14 **A.** Sorry, say that again.
15 **Q.** Do you pick that up what the Union rep is
16 doing there, tell me what you think is happening there?
17 **A.** She is just clarifying for him what he can
18 answer.
19 **Q.** What is the impact on what he's saying? What
20 do you think the impact on what he's been advised on
21 what's going on is there?
22 **A.** Can we -- can we just highlight where the
23 Union rep says that --
24 **Q.** The Union person says you can answer
25 specifically?

1 **A.** Okay, it's just been highlighted, thank you.
2 **Q.** There you go, have a look at that.
3 He is talking constantly just about himself, isn't
4 he, not anybody else, not speculating about Letby, just
5 answering the questions about himself. Is that
6 something you recognised when people are in a grievance
7 procedure?
8 **A.** I'm not sure why that person said that other
9 than clarity to him. The question was any discussions
10 between Consultants and therefore the Union rep was
11 saying: you can only answer for yourself so not for the
12 Consultants, the group.
13 To me it just read that that was she was clarifying
14 for him you can only answer for yourself. This is your
15 -- this is your interview.
16 **Q.** Thank you, that can go down now.
17 You get sent the investigation report from
18 Dr Green. Do you get sent one report or two because we
19 know there is a draft and a second one, presumably you
20 just get the second final report?
21 **A.** Yes, I just had one.
22 **Q.** So if we can go, please, to INQ0002879,
23 page 221. This has been added since the draft report so
24 this is his final report.
25 "No party refutes ..."

1 Can you have a look at that paragraph:
2 "... concerns were raised by the Consultants to the
3 Executive Team around a perceived commonality between
4 LL's presence on the NNU and the collapse/deaths of
5 babies.
6 "I acknowledge that these concerns were raised
7 through the appropriate channels in line with both the
8 Trust Speak Out Safely policy and the guidance proffered
9 by the GMC. I do not find, however, that the
10 Consultants' concerns when reiterated to the Executive
11 Team were clear, honest and objective."
12 First of all, they have not been asked anything,
13 have they, about Speak Out Safely policy and how they
14 have raised concerns with Executives, that is not part
15 of the grievance, is it, you are not really looking at
16 that?
17 **A.** I think there was a question that Lucy asked
18 about it so that was in respect of one of the questions.
19 **Q.** Shall we go back to the questions and tell me
20 which one you think that was in a moment. Give me
21 a moment.
22 So you thought that was relevant. Did you think
23 that was something you needed to look at?
24 **A.** Sorry, can you just go back to the question
25 that you are asking me, so which part of that

1 highlighted paragraph?
2 **Q.** The whole paragraph. Just what do you think
3 that paragraph is saying?
4 **A.** Well, that's confirming, isn't it, that nobody
5 through the investigation was refuting that the
6 Consultants raised concerns about -- about Lucy having
7 been commonality.
8 **Q.** What about that it had been done in line with
9 the Trust Speak Out Safely policy?
10 **A.** Yes, in that they had taken those concerns to
11 their line management. But in this case they took them
12 to the Medical Director and the Executive Team.
13 **Q.** Mmm mm. But the next bit:
14 "I don't find the Consultant concerns when
15 reiterated to the Executive Team, were clear, honest and
16 objective."
17 They were never asked in the interviews, were they,
18 about whether communicating with the Executives -- about
19 that?
20 **A.** Sorry, I am not -- I am not following your
21 questions.
22 **Q.** What do you think that means, what does that
23 mean: I do not find the Consultants' concerns when
24 reiterated to the Executive Team were clear, honest and
25 objective.

1 What does that mean?
2 **A.** In that they, they didn't give them the full
3 picture of the reasons that they were concerned. So
4 through the evidence of statements that -- of other
5 people that were interviewed as part of the process
6 including the Executives, beyond the commonality and gut
7 feeling and having a drawer of doom, there was nothing
8 else that they shared and if they genuinely believed
9 that there was somebody murdering babies on their unit,
10 they had a professional duty to call in the police.
11 They didn't do that and they were putting pressure
12 on the Executive Team for Lucy to be removed off the
13 unit. That's not how you deal with somebody who's
14 murdering children and therefore their concerns when
15 raised to the Executive Team didn't go through any of
16 that. They didn't share with them what their genuine
17 concerns were.
18 **Q.** Dr Reynolds phoned the police --
19 **A.** They had a commonality.
20 **Q.** Dr Reynolds phoned the police when she was
21 concerned her patients had died and it was an unusual
22 pattern. Everybody that you interviewed knew about that
23 pattern and you said to the police you thought the
24 police should have been called -- you said they should
25 have been called in at that time.

1 So where do you get to here when you say "only gut
2 feeling and commonality, why aren't you saying they are
3 murdering babies?" How can you assert murder until
4 there has been a proper investigation of those
5 suspicious circumstances? Who could possibly have said
6 that at that time?
7 **A.** But that's what they were saying. They were
8 saying we -- we are concerned that Lucy is deliberately
9 harming babies.
10 **Q.** They hadn't said murder, though, had they?
11 And you are criticising now in your answer, you just
12 said if they thought she was murdering babies, they
13 should have said that. How could they possibly say she
14 is murdering babies at that time?
15 **A.** Harming babies, they -- they were making
16 reference to her as "the murderer".
17 **Q.** We will come on to that. We will come on to
18 why you say that. But they had very clearly, in the
19 email you saw from Dr Ravi Jayaram, saying they
20 suspected foul play, that was clear to you, that is what
21 they said: foul play. What does suspecting foul play
22 mean?
23 **A.** In Dr Jayaram's statement when he was asked
24 about foul play in respect to Lucy Letby, he said there
25 was none and that that would be speculation.

1 **Q.** He said that was speculation but you saw
2 emails that had gone between a number of senior
3 clinicians and Execs saying "suspected foul play". Did
4 you put your common sense reality hat on when he said
5 that would be speculation and think: I have seen all of
6 this, they clearly think she is doing something wrong,
7 but they are not saying it's murder. That is what was
8 happening wasn't it?
9 **A.** They -- they weren't giving any other
10 information. They didn't give it to the Trust and the
11 Trust were very clearly broadcasting that there could be
12 some personal motive to this. They didn't understand
13 because there was no material evidence that was provided
14 by any of the Consultants, but particularly Dr Brearey
15 and Dr Jayaram, that there was any link to Lucy causing
16 deliberate harm to the babies.
17 So the Trust were suggesting well, what other
18 motive could they have? And is there something personal
19 here and that was the broadcast that was coming across
20 to me in reading this.
21 **Q.** It was and you took it, you accepted it?
22 **A.** And the Consultants -- and the Consultants in
23 their own statements said that there was a possibility
24 that the outcome of the Royal College review could
25 alleviate their concerns.

1 **Q.** The Execs said that too?
2 **A.** So that was confused --
3 **Q.** The Execs said that; did you realise that?
4 **A.** Sorry?
5 **Q.** Did you realise that the Executives thought
6 that that review could alleviate concerns, they
7 commissioned it; did you realise that?
8 **A.** They did, but I am just making reference,
9 sorry, to what the Consultants said in their statements.
10 **Q.** Yes, that is my point about this paragraph
11 before we go back to the grievance.
12 This has suddenly been added to your grievance,
13 communications between doctors and Consultants and
14 whether they were clear, honest and objective and
15 whether they weren't saying she is a murderer loudly and
16 clearly to them and how she had done it.
17 That appears there. If we go back to the
18 grievance, INQ0002879, page 3, holding that paragraph in
19 mind, can you help us with which question that was
20 answering on page 3? There is the grievance.
21 **A.** I think it is in respect to I am now aware
22 some Consultants have raised issues to the Trust
23 Executive Team.
24 **Q.** "I wish to know what these allegations are and
25 how they are dealing with them."

1 Yes?
2 **A.** Yes.
3 **Q.** So what have the Consultants said and what are
4 the Trust doing and you find in the report a suggestion
5 that they have been treated properly with Speak Out
6 Safely policy by the Executives and they haven't been
7 clear, honest and objective in communicating their
8 concerns with the Executives.
9 What Letby's grievance asked for is what are the
10 concerns, what are the issues, doesn't she? So
11 paragraph 1 of Dr Jayaram's interview would tell her
12 although she knew already what the issues were?
13 **A.** Yes.
14 **Q.** So looking back at that added paragraph we
15 have gone to, you didn't know it was added, but did you
16 focus on it -- probably not as much as we are now --
17 when that came to you as a report, or did you just see
18 that as a paragraph within the investigatory report?
19 **A.** I agreed with that when I read that.
20 **Q.** You actively agreed with that?
21 **A.** In reading all of those other interviews that
22 the investigator led.
23 **Q.** Let's go to the hearing itself, please,
24 INQ0003155, page 1. How long did it last while we are
25 getting it on the screen, roughly?

1 1 December 2016, we know it's 10 o'clock start,
2 roughly do you think when did you finish it?
3 **A.** It was late after -- well, sort of maybe 3ish,
4 4ish, it was later on in the afternoon.
5 **Q.** So Dr Green, you, Deputy HR Director. We
6 should include her as a panel member from what you said
7 earlier, yes, or helping you on the panel?
8 **A.** She was with me on the panel.
9 **Q.** She was the panel as well. So the Trade Union
10 rep, Letby herself, Sementa, the HR specialist, and then
11 this notetaker.
12 Mrs Appleton-Cairns explains the meeting: we are
13 here to hear the grievance raised regarding her
14 redeployment. Annette Weatherley was there to hear the
15 grievance and that she would be supporting. So
16 Mrs Appleton-Cairns is supporting her, so providing you
17 with information, but you are the arbiter, are you, the
18 independent arbiter; would you agree with that?
19 **A.** Yes.
20 **Q.** Dr Green asks how would you like to go through
21 this. You say the conclusions to your report that
22 Lucy Letby raised you ask him if he scrutinised the
23 off-duty or looking to the word of others. What were
24 you thinking there?
25 **A.** That was the off-duty in respect to whether

1 Lucy could be supervised on the unit, the supervision of
2 her practice.
3 **Q.** To see how often she was on duty when deaths
4 occurred or something else?
5 **A.** No. The -- the decision by the Trust team was
6 that she would stay on the unit but she would be
7 supervised and she would redo her clinical competencies.
8 **Q.** Right.
9 **A.** The reason -- the reason that was suggested
10 through the investigation that that didn't happen was
11 because there was not enough staff to support
12 supervision. So my question there was: well, did you
13 scrutinise the off-duty to come to that conclusion or
14 was that what other people told you?
15 **Q.** Right and I think later on, you amend that and
16 say because you hadn't seen the evidence to see they
17 didn't have people to supervise, you would have
18 preferred to see that before you said she was
19 supervised?
20 **A.** Sorry.
21 **Q.** You would like to have known as a fact whether
22 it was the case they didn't have enough staff to have
23 done that?
24 **A.** They -- well, the nursing rota some of those
25 rotas were in the pack and when I had looked at it,

1 whilst I am not a neonatal nurse and so I am not overly
2 familiar with the neonatal nursing safe staffing
3 numbers, it appeared to me that she could have been
4 supervised on unit, it appeared to me that there were
5 sufficient staffing. But again I am not a specialist
6 neonatal nurse.
7 **Q.** Please can the questions, you say further
8 down, just be for clarity at this stage.
9 Going into it at that point did you need further
10 clarity, you had obviously read something but not --
11 **A.** So just in respect to this, this is not a full
12 chronology transcript of the -- of the event. I did say
13 that in my original statement to the Inquiry.
14 It doesn't flow. There was representation from
15 both Lucy and her representative in respect of the
16 grievance and there was also representation made by
17 Dr Green in his investigation and then thereafter there
18 were questions and the questions do not flow, so I am
19 concerned that this is not an accurate --
20 **Q.** It is not complete, is it?
21 **A.** -- record. No, it is not.
22 **Q.** Often they are not. So when we go to
23 a question you think it wasn't said, please say so.
24 Dr Green hasn't challenged anything that has been
25 written in it, but, you know, there may have been more

1 stuff that you want to tell us about as we go through
2 it.
3 The issue you are exploring is who she was told at
4 this point not to speak with. So Letby says that
5 Eirian Powell, if we go halfway down, "she was told not
6 to speak to me".
7 This is the question about whether she was told
8 there was no contact. What did you understand the
9 evidence was around whether she could contact people on
10 the unit?
11 **A.** It was within the statements. The evidence
12 was within the statements so I understand that I think
13 it was Karen Rees who said that she had advised her of
14 that, but that's not what she actually meant in that
15 from a professional perspective, she had said not to go
16 to the unit, not to speak to people, but she hadn't
17 meant that socially.
18 **Q.** Because Letby herself had said she felt
19 isolated and not supported, that was upheld, wasn't it,
20 in the grievance; that she was isolated and unsupported
21 and Karen Rees' communication had been miscommunicated
22 effectively, that she could speak to other people. That
23 is where that ended up, wasn't it?
24 **A.** I would have to go back to -- go back to the
25 grievance. So which, which --

1 **Q.** We will go to the grievance and see you upheld
2 that.
3 **A.** Okay.
4 **Q.** That's something that you accepted, that it
5 wasn't deliberate by Karen Rees?
6 **A.** Yes.
7 **Q.** But that Letby was isolated and vulnerable and
8 wasn't feeling --
9 **A.** That is how she felt, yes, that that made her
10 vulnerable.
11 **Q.** On page 5, Dr Green discusses the second
12 question:
13 "This was discussed with the exact nursing team.
14 The Trust made the decision to redeploy Letby. I agree
15 that Letby had a right to know about this and the Trust
16 had not been open and honest with their communication."
17 You agreed with that and that was right, wasn't it,
18 you told the police that when you first spoke to them
19 they should have told her what they were doing?
20 **A.** Sorry, could I just take a second to read it?
21 **Q.** Of course, yes. Page 5, have a look there.
22 **A.** So I need to go back to what the original
23 question was in the conversation.
24 **Q.** Dr Green is telling you there, isn't he, that
25 Lucy Letby --

1 **A.** Her second question of the grievance.
2 **Q.** Okay.
3 **A.** This is discussed with the Exec nursing team,
4 can you just refresh me what the second question was?
5 **Q.** The second question was:
6 "The reason for me being instructed not to have
7 contact with my NNU colleagues for an extended period of
8 time."
9 So it's not strictly limited to that question. But
10 he's making the observation to you there that she wasn't
11 told fairly about an allegation and concerns --
12 **A.** Yes.
13 **Q.** -- about harming babies?
14 **A.** Yes.
15 **Q.** Yes, and you upheld that and that was the case
16 when you listened to that evidence, wasn't it, she
17 hadn't been told that directly?
18 **A.** No, she hadn't.
19 **Q.** The Inquiry knows of course Mrs Griffiths had
20 told her, her Union member, but the point is the Trust
21 hadn't told her in letters?
22 **A.** No, they hadn't.
23 **Q.** So although she knew it, the Trust hadn't
24 communicated that.
25 If we go to page 7, please.

1 We see at box 4 Dr Green on that point says about
2 the email that went out to explain the redeployment:
3 "The Executive Team have worked hard to keep any
4 secret in hospital and they were careful to say anything
5 deliberate or confidential, however it is hard to keep
6 any secret within the hospital."
7 That was difficult, wasn't it? Mrs Griffiths told
8 us that she had moved and of course people in
9 a hospital, in a small hospital, are very interested in
10 why people are moved and what's going on, aren't they?
11 Would you agree with that?
12 **A.** I guess so.
13 **Q.** "In terms of confident [I think that must mean
14 'confidentiality'] other people [two boxes down] heard
15 the words 'baby killer' and were associating Letby with
16 these comments."
17 Yes, that is your ...
18 The Union rep says two down:
19 "The Consultant made the comment 'baby killer',
20 however provided no name."
21 So the Union rep says Letby's not been named as the
22 murderer or the baby killer but they have said a comment
23 but provided no name for who it is. Do you see that?
24 **A.** Yes.
25 **Q.** Further down, you say:

1 "[Your] investigation is clear: were the team aware
2 she deliberately set out to harm babies when the
3 Executive and Management Team have no allegations
4 towards this?"
5 Dr Green says yes, but no evidence to suggest this
6 is the case.
7 Both of you, Dr Green and yourself, at this point,
8 are saying the Consultants have no allegations towards
9 this. They have in the interview, Dr Jayaram and
10 Dr Brearey, set out the commonality of her presence with
11 sudden and unexpected deaths that they cannot medically
12 explain and the children don't respond to resuscitation
13 in some cases as you would expect.
14 They had set out their allegation, hadn't they,
15 their suspicion of foul play?
16 **A.** They hadn't made an allegation, they were
17 suggesting that there was a commonality and they both
18 say that in their interview transcript as part of the
19 investigation.
20 **Q.** So you didn't see that as an allegation or
21 suspicion?
22 **A.** I think the -- the investigation that Dr Green
23 did which is the information that I had, he had asked
24 the question were there any allegations, specific
25 allegations, and the response from both the Consultants

1 and equally from the Executive Team was there was no
2 allegations.
3 **Q.** If we go over the page, at page 9, Dr Green in
4 that first box at the top says:
5 "A very complex situation, the suggestion that
6 something could happen with the babies and the Trust
7 were not open and honest. To remove Letby, stop the
8 police would have meant an arrest which would have been
9 damaging to Letby."
10 And the Union rep says:
11 "Damage to Trust too, they were protecting
12 themselves as this would have been in the paper."
13 So at this point, the discussions around openness
14 and honesty are about the Executives being or HR being
15 honest and open with her about redeployment, aren't
16 they?
17 **A.** Yes.
18 **Q.** That is what matters here, she's been
19 redeployed and no one has told her in a letter why.
20 **A.** That that's correct.
21 **Q.** That is the issue. If we go to page 13,
22 Dr Green at the top:
23 "Unit downgraded from a 3 to a 2. Escalated to the
24 RCN. Letby well thought of, quality of her care. In my
25 chat with the Exec Team they want to see her back. The

1 Consultants will have issues with that, however the Exec
2 Team need to deal with that."
3 Pausing there. Did Dr Green or anyone ever tell
4 you about this Silver Command and 36 of them being in
5 a boardroom and being given different tasks and things
6 to look at, like commonality?
7 **A.** No, he didn't.
8 **Q.** And that he himself had been asked to take
9 some samples in relating to two of three Triplets that
10 we now know two were murdered, he had to take and store
11 TPN bags in case they could be used?
12 **A.** No, I didn't.
13 **Q.** You didn't know any of that?
14 **A.** No.
15 **Q.** So he says this to you, they want to see her
16 back and the Consultants will have issues.
17 You then say further down:
18 "The Trust are already making plans and Letby says
19 the Trust are waiting for the report before they will
20 confirm."
21 Now, that is not the RCPCH report, that is the
22 second report. We know it as Dr Hawdon's report, but
23 the forensic review. Is that what you understood or did
24 you not know which reports were? You have referred to
25 two but I don't know if you know what they were?

1 **A.** I don't know which report she was referencing
2 there but I think that she was talking about the
3 Royal College report because that's what I think she
4 understood the Trust were telling her they were waiting
5 for.
6 **Q.** And yet as you had picked up, that was never
7 going to answer the question, was it?
8 **A.** No.
9 **Q.** Whether she had murdered babies, if that was
10 going to be the question. But in fact what the doctors
11 were saying: we have got concerns, we are suspicious, we
12 can't explain it, it needs proper investigation.
13 Do you agree, did you get that sense that that's
14 what was needed?
15 **A.** I got the sense they were saying that on the
16 one hand but then on the other hand they were saying
17 that there is a possibility that the Royal College
18 report could alleviate their concerns. So it was
19 a confused message from the Consultants that I was
20 getting within this report.
21 **Q.** It is a confused picture by the time of this
22 hearing of the grievance, isn't it?
23 **A.** It is all confused.
24 **Q.** You are then moving to different -- when we
25 deal with that honesty and openness it is a totally

1 different issue that lands in the report or in
2 Dr Green's investigatory report, do you agree, it is not
3 the issue that you are discussing here?
4 **A.** Yes.
5 **Q.** At page 15, Letby says halfway down:
6 "I have gone through all of this on their word ..."
7 This is the Trust's words supporting her to go back
8 what she has been doing.
9 It's Mrs Appleton-Cairns who says "Mediation?"
10 **A.** Yes.
11 **Q.** Was that the first time that was suggested by
12 her?
13 **A.** Yes.
14 **Q.** She says, "Mediation?" and you said:
15 "Do you feel strong enough to discuss this with
16 them?"
17 She says:
18 "I want to go back to work, yes."
19 Had she mentioned to you that she was going to
20 suggest mediation before?
21 **A.** No.
22 **Q.** So it cropped up in the meeting, said to
23 Letby.
24 She says when you ask her:
25 "Well, how will you feel? The nature of the work

1 on the unit, there will be deaths. How will you feel
2 when that happens?"
3 She says:
4 "I would want assurance that this wouldn't happen
5 again."
6 What did you think that meant that she wouldn't be
7 redeployed if there were deaths or anything else
8 happened again?
9 **A.** Yes, that's what I took that to mean.
10 **Q.** So she wanted to be back on the unit. We know
11 through her member was requesting without restrictions
12 and she didn't want -- she's telling you here --
13 anything like this, assurances that if a baby died or
14 she was there when there's deaths that this would happen
15 again, that she would be redeployed?
16 **A.** Not necessarily that she would be redeployed
17 but the chaos, the mess that this was and how she had
18 been handled wouldn't happen again.
19 **Q.** Over the next page at 17, reference from you:
20 "Everyone should be culpable."
21 And the Union member says:
22 "The Trust have been held to ransom by two
23 Consultants."
24 Then he is saying -- well, actually
25 Mrs Appleton-Cairns says:

1 "I am hearing what you say but I am wanting to know
2 from Letby what comes next."
3 He says:
4 "You tell me, Dee, what will be done to the
5 Consultants?"
6 "We don't know."
7 You say:
8 "Policy gives the process for bullying and
9 harassment."
10 He says:
11 "I can't stress enough you need to deal with them."
12 Mrs Appleton-Cairns says:
13 "It's also what LL wants."
14 Letby says:
15 "It's nice to be asked as no one has."
16 Lucy Sementa:
17 "Shall I explain what will happen when there is
18 a return to the unit?"
19 Mrs Appleton-Cairns:
20 "We can agree some more wording, suggest that
21 Ruth Millward does an email to say it was positive and
22 to thank her for her hard work in the department."
23 Pausing there. You comment to the police about
24 your view about her being placed in the Risk and Safety
25 Department. What did you think about that, that that

1 was where she had been redeployed to, given the
2 circumstances?
3 **A.** In these circumstances, that was a highly
4 inappropriate place to position her, in my view.
5 **Q.** You say that, don't you, to the police of all
6 the placements. Lucy Sementa says:
7 "They were the only two that showed no empathy."
8 This is the Consultants.
9 You say:
10 "I believe the staffing issue was a red herring.
11 There is no difference between July and August and the
12 evidence supports this."
13 In this hearing, it's also the case, isn't it, that
14 at one point Dr Green says:
15 "I believe the two Consultants lied. I believe
16 they lied."
17 Do you remember?
18 **A.** He did yes, he does.
19 **Q.** He did say that, didn't he, and he said
20 yesterday if he had seen those minutes he would have --
21 or notes -- asked it to come off because it was an
22 off-the-cuff remark. But the fact is you were the
23 hearing adjudicator and the investigator says:
24 "I believe the Consultants lied."
25 **A.** Yes.

1 **Q.** When the investigator said that to you, what
2 weight did you place on that?
3 **A.** I could see why he had come to that
4 conclusion. If you -- in the statement that I provided
5 I'm not sure which section it is, but I highlight the
6 sections from everybody who was interviewed, the
7 elements that are relevant to why I considered that that
8 was perhaps a fair comment.
9 I'm not sure which section it is in the actual
10 statement.
11 **LADY JUSTICE THIRLWALL:** We will take you to that
12 and have a look.
13 **MS LANGDALE:** We can go to your statement for that.
14 It starts at paragraph 55. You say at
15 paragraph 55, this is about the honest, open and
16 objective:
17 "It was clear to me that these standards were not
18 reflected in the way the Consultants were behaving. The
19 gravity of the allegations being made by the Consultants
20 was not reflected in their interviews with Chris Green;
21 there was suggestion by managers of Consultants having
22 redacted relevant medical staffing information prior to
23 share with the Executive Team; interview transcripts
24 evidenced a lack of respect and the way in which the
25 Consultants responded to and behaved towards

1 Chris Green, the investigating officer, was neither
2 transparent, honest or respectful."
3 So in terms of the staffing information, you knew
4 that Eirian Powell had added doctors because she tells
5 you in that long list and that that list of doctors
6 didn't appear in another iteration or version that was
7 sent, so you are referring to that, something she had
8 told you about --
9 **A.** Yes.
10 **Q.** -- in that written material?
11 Did you ask Dr Brearey about that? We know you
12 didn't looking at the transcripts that wasn't put to
13 him, where are all the versions, although he offered to
14 send you the mortality review, didn't he?
15 **A.** Dr Brearey?
16 **Q.** Yes. Dr Brearey in his interview said you
17 can -- to Dr Green: why don't you have -- do you want
18 the copy of the mortality review? So you could have
19 followed up, couldn't you, the point about where doctors
20 appeared and where they didn't appear and the many
21 versions of the table if you were interested in that.
22 **A.** I don't think that -- again, my role was not
23 to do any investigating into those circumstances. It
24 was to hear the grievance.
25 **Q.** You relied on what Eirian Powell had told you

1 about that?
2 **A.** That she had the doctors on there and they had
3 been removed.
4 **Q.** And yes, and they had been removed and you say
5 that wasn't transparent?
6 **A.** It was Eirian said it and it was also
7 Ian Harvey and Alison Kelly.
8 **Q.** So Ian Harvey, Alison Kelly. You also say at
9 paragraph 56:
10 "Upon reviewing the grievance investigation pack
11 there were several interviews who stated their belief
12 that this was a witch hunt against Letby ... there was
13 no evidence to support the allegations being made by the
14 Consultants which were purely circumstantial. The
15 findings from the internal and external reviews
16 commissioned by the Trust had made no reference to any
17 matters of foul play surrounding the increase to
18 neonatal mortality at that time. Despite the Trust
19 informing the Consultants of the findings of these
20 reviews the Consultants continued to openly refer to
21 Letby as the 'angel of death', 'murderess' and 'baby
22 killer'."
23 **A.** Yes.
24 **Q.** You thought those two Consultants had done
25 that?

1 **A.** Were calling her names?
2 **Q.** Yes.
3 **A.** Did I think that?
4 **Q.** Yes.
5 **A.** According to the statements within the
6 investigation, yes.
7 **Q.** So your impression from the combination of
8 nurses who had given you information and
9 Mrs Appleton-Cairns and the others, that the two
10 Consultants had openly referred to Letby as the "angel
11 of death", "murderess" and "baby killer"?
12 **A.** Yes. In certain environments and meetings
13 I believe that that's what the people -- a number of
14 people who were interviewed have disclosed in their
15 interviews to Chris.
16 **Q.** Well, the Inquiry has heard all evidence from
17 everybody where those remarks relate, so thank you, we
18 have got the primary material for that. But "openly",
19 what did you mean "openly"?
20 **A.** In meetings and on corridors, I believe, but
21 I think that was more the junior doctors that had been
22 overheard in public areas.
23 **Q.** I think Eirian Powell had told you about
24 Nurse T and she had said that he had made some comment
25 that had worried her about coming to work and linked to

1 baby death; do you remember that?
2 **A.** Yes, it is in a statement somewhere.
3 **Q.** You of course didn't have the benefit of
4 hearing from Nurse T and what she said she did in fact
5 hear or know because you just relied on what you were
6 told by Eirian Powell for that?
7 **A.** I was relying on what Dr Green had said in his
8 investigation. It was more than Eirian Powell's, it was
9 in numerous statements, those comments.
10 **Q.** You continue in this statement to the Inquiry,
11 paragraph 57:
12 "On the face of it, these actions did present by
13 the Consultants as a witch hunt against Letby in that
14 she appeared to have been singled out by them because of
15 'commonality' and 'gut feeling'. Had they genuinely
16 believed these concerns, I would have expected them to
17 raise it immediately with the police. Instead, they
18 called Letby names in public spaces and were reluctant
19 to explain the rationale for her being singled out
20 during the interviews with Chris Green, even though
21 other individuals appeared to share commonality,
22 including medical staff."
23 Is that what you thought around the indictment
24 babies, was it your understanding that other people
25 shared commonality across the babies that were murdered?

1 **A.** Sorry, I couldn't quite hear?
2 **Q.** Did you understand --
3 **LADY JUSTICE THIRLWALL:** Sorry, just wait. Are you
4 all right?
5 Let's ask again.
6 **MS LANGDALE:** Did you understand that to be the
7 case that other medical staff had the same level of
8 commonality across the murdered and deteriorating,
9 unexpectedly babies?
10 **A.** Not the same level but there was a concerning
11 level of commonality with other members of staff as well
12 from the investigation and Dr Green.
13 **Q.** Again, did you rely on Dr Green for that?
14 **A.** That was my role, to rely on that
15 investigation.
16 **LADY JUSTICE THIRLWALL:** A concerning level of
17 commonality?
18 **A.** Sorry?
19 **LADY JUSTICE THIRLWALL:** Did I hear you correctly,
20 a concerning level of commonality?
21 **A.** There were other people whose name, whose
22 commonality flagged as being, yes, worthy of --
23 **LADY JUSTICE THIRLWALL:** Being what? Of concern.
24 **A.** Concern at that time in the -- in the
25 investigation. I think there were a number of doctors

1 who were named in some of the statements.
2 **Q.** Those are the reasons you give in your
3 statement for supporting the suggestion there wasn't
4 honesty and objectivity by the Consultants.
5 Is there anything else, have I missed anything
6 else?
7 **A.** Everything that I said in my statement was the
8 reason that, yes, I came to that --
9 **Q.** We have gone through that then. You also say
10 at paragraph 60 and 61 -- it may be helpful to have it
11 on the screen rather than me read it out -- of your
12 statement INQ01023700026, you set out what you said to
13 the police earlier, really, at 60 and 61.
14 (Pause)
15 You also -- I am just interested in the CQC and the
16 NMC there. What would you say at that time if you had
17 been presented as an Exec Team member, what are you
18 saying you would communicate with the CQC and NMC about?
19 **A.** So that would be usual practice, if you were
20 suspending somebody pending an investigation. You would
21 advise the NMC that their member, you know, a registrant
22 was being suspended and you would also advise well,
23 I would also and always have advised the CQC that there
24 was an allegation of concern that had resulted in
25 somebody being suspended pending the investigation.

1 **Q.** You also that can go down now but just for
2 your benefit, at page 27, Mrs Weatherley, you also make
3 clear in your statement:
4 "As the independent chair of a grievance hearing
5 I was in no way involved personally in any investigation
6 into either Letby or the deaths of babies on the
7 neonatal unit."
8 That's right, isn't it?
9 **A.** Yes.
10 **MS LANGDALE:** You weren't, you were coming in to
11 deal with that and weren't putting that evidence
12 together. Can we just finally go to -- we know you had
13 the final report from what you are saying, can we go to
14 the letter.
15 My Lady, I see the time, I don't know if I need to
16 stop now, I have probably about another 10 minutes but
17 I am conscious we have been going for an hour and
18 a half?
19 **LADY JUSTICE THIRLWALL:** What is more convenient,
20 would you like a break of about 15 minutes or would you
21 not? You are not bothered one way or the other.
22 **A.** I am okay if you want to continue.
23 **LADY JUSTICE THIRLWALL:** Do you want to continue or
24 shall we take the break?
25 **MS LANGDALE:** No, very happy to continue.

1 So we then come to your response to the grievance
2 and we see your first letter INQ0056139, page 1. So you
3 do this letter afterwards, this is your first draft of
4 this.
5 You set out question number 1. You say about the
6 supervision of practice "I conclude in reviewing the
7 staffing rotas these do appear to support the
8 supervision. I accept there may have been a challenge
9 with skill set. However, numbers available according to
10 the rota demonstrated that this was available, so you
11 support this part of the grievance." Were you meaning
12 there -- well tell us what did you mean there?
13 **A.** The number of staff working at that time on
14 the unit that would therefore support Lucy being
15 supervised.
16 **Q.** So you thought she could have been supervised
17 and stayed on the unit if staffing?
18 **A.** I did.
19 **Q.** So you upheld that wasn't a good enough reason
20 not having staff to supervise her, not to have her on
21 the ward if that was the decision?
22 **A.** Yes.
23 **Q.** Number 2, you set out there as we have
24 referred to earlier miscommunication and
25 misunderstanding. So Karen Rees hadn't intended to

1 exclude her but it had left her being isolated believing
2 that she couldn't speak to people and you being told by
3 her that Eirian Powell was told she couldn't speak to
4 her?
5 **A.** Yes.
6 **Q.** Question 3. We see the question and see your
7 answer. You say you believe that the Executive Team
8 could have been more open and honest and communicated
9 with her in a more regular and coordinated way; they
10 acted within the best interests.
11 Were you aware how regularly they were meeting with
12 her and her parents on some occasions and how many
13 members of staff were actually keeping in touch with
14 her?
15 **A.** Only from the emails that were contained
16 within the pack.
17 **Q.** Right. You say at number 4 "I would like the
18 Trust to outline to me how its values, such as being
19 open and honest, have been adhered to" and you say
20 "I fully support the conclusion."
21 Open and honest about what were you supporting the
22 conclusion in respect of each other, in relation to the
23 redeployment or what?
24 **A.** So can we just go to what Chris had said in
25 respect of point 4 in his investigation. That is what

1 I agreed with, but rather than reiterating all of that
2 I was just saying that I upheld that.
3 **Q.** So if we go back then to INQ00028790217.
4 We will have it in a moment. Take your time to
5 have a read of that. (Pause)
6 **A.** Was it on the next page?
7 **Q.** Yes, it is on there and the next page as well
8 at the end of page 18. We see that last, "I recognise
9 the board have found themselves in a difficult position,
10 but I conclude the Trust have not been honest and open
11 in relation to the circumstances surrounding her
12 redeployment."
13 **A.** Yes.
14 **Q.** That is what you were meaning by honest and
15 open.
16 **A.** Yes.
17 **Q.** It was about how that was communicated.
18 That can go down now, thank you.
19 Again, you support number 5: "Wish to be informed
20 of any evidence." What actually you conclude and
21 support his findings, what he has said, I can read that
22 to you because it is shorter at INQ0002879, page 218,
23 "Dr Green had said during the course of this
24 investigation I have not been made aware nor has there
25 been any allusion to any evidence relating to any

1 alleged wrongdoing by Letby. There has been repeated
2 reference to a commonality between the dates and times
3 that Letby was on duty and the collapse death of
4 a significant number of the babies, but there's nothing
5 to support that there is additional information or data
6 beyond this and that has not been shared with LL."
7 So you support that part of the grievance.
8 **A.** Yes.
9 **Q.** You support number 6, assurances from the
10 Executive Team that this has been dealt with
11 appropriately. This is Mr Harvey having said that he
12 had spoken to the Consultants or spoken to Dr Jayaram
13 about the concerns and comments that had been made. If
14 we have a look at 0219, the second paragraph. Have
15 a look at that. "Obvious concerns regarding the alleged
16 comments made but IH, Ian Harvey, stated this has been
17 addressed and there is no suggestion of any similar
18 remarks being made following this. Critically these did
19 not name Letby and were not directly heard by any of the
20 individuals interviewed as part of this process." So
21 you say you had relied on interviews, but Dr Green in
22 terms had said she was not named and not heard directly
23 by anyone interviewed.
24 And in this paragraph you say you support that
25 conclusion.

1 **A.** Yes.
2 **Q.** Indeed they are saying to you or
3 Eirian Powell's document refers to people saying but
4 nobody interviewed had heard anything openly and said
5 that they had by who?
6 **A.** I think they had. I think there was a number
7 of people that had been in a meeting where one of the
8 Consultants had said "You're harbouring a murderess" and
9 there was another meeting.
10 **Q.** That was Eirian Powell saying that?
11 **A.** In a meeting. A few of the people interviewed
12 were in that meeting and there was a couple of other
13 meetings where Stephen Brearey, I think, had referred to
14 her as the angel of death and that was heard and that
15 was somebody saying that he had said that to her. That
16 might have been Eirian.
17 I can't remember without having all those
18 statements in front of me, but it in was a number of
19 statements that people did say they had heard her.
20 **Q.** When you say statements, the interviews we
21 have read together, the transcripts?
22 **A.** Yes sorry the statements provided to the
23 investigation.
24 **Q.** So we have got all of the documents that you
25 had at the time?

1 **A.** Yes.
2 **Q.** But interestingly you see the point, he is
3 saying that, that is his conclusion, but at paragraph 6
4 you seem to be agreeing with that conclusion that I have
5 just read to you.
6 **A.** Mmm.
7 **Q.** That they didn't name Letby, were not directly
8 heard by any of the individuals interviewed as part of
9 this process and he wasn't particularly when he gave
10 evidence engaged on that topic.
11 **A.** Okay.
12 **Q.** In other words, it wasn't a big feature for
13 him when he had seen what Mr Harvey said and everybody
14 else had said, but it seems that was a big thing for
15 you, your impression of that?
16 **A.** I think the names that we used in reference to
17 Lucy by doctors in environments such as meetings with
18 other members of staff, so they had private meetings,
19 yes, and there were meetings that were not private
20 meetings where these names were referenced, when in fact
21 they were aware that she had no knowledge of any of this
22 that was going on, so that was behind her back. They
23 also had not gone to the police in respect of their
24 concerns.
25 So how seriously did they take their concerns when

1 they were also considering the Royal College report
2 might alleviate their concerns, but yet they were
3 calling her names behind her back.
4 So I considered that to be unprofessional behaviour
5 and that's why that particular aspect of the
6 investigation was of concern to me to your point.
7 **Q.** It's just that you haven't expressed that at
8 paragraph 6 the difference of opinion or set out your
9 evidence for that. In fact, you have just contradicted
10 what you have said now because you said you supported
11 what he said?
12 **A.** Sorry, paragraph 6.
13 **Q.** Yes. Your answer at 6, if we go back to your
14 determination. INQ0056139, page 2, you support what he
15 said. I have just told you what he said. There is
16 a difference between you. So that was an error, was it,
17 the way that's been communicated there? See how you say
18 you fully support his conclusion and uphold the part of
19 the grievance, whereas he had said, "I conclude the
20 Trust has not failed to protect her confidentiality with
21 regard to the circumstances regarding her redeployment."
22 So you are at complete odds there, you and the
23 investigating officer.
24 **A.** I think it was she's asking for assurance that
25 it is being dealt with appropriately. And Chris had

1 spoken to Ian Harvey who had given him the assurance
2 that he had spoken with the doctors and it would not
3 happen again. I think that's what I am referencing in
4 terms of upholding I agreed with what Chris has said
5 there.
6 **Q.** Because Mr Harvey has spoken to Dr Jayaram
7 about?
8 **A.** Who said about all of the doctors, it wasn't
9 just him specifically who had given him assurance it
10 wouldn't happen again and he agreed it was
11 unprofessional.
12 **Q.** And you still were of the impression it was
13 Dr Brearey you thought, not Dr Jayaram who had said
14 something?
15 **A.** Sorry.
16 **Q.** You were still under the impression it was
17 Dr Brearey not Dr Jayaram who had said something?
18 **A.** They both said things.
19 **Q.** You thought both, from the evidence we have
20 seen?
21 **A.** In the investigation.
22 **Q.** Okay. Number 7, "I would like to know what
23 I have been accused of." Again, you agree with
24 Dr Green. And number 8, we have got the reports, we can
25 see where the agreements are and what they both say,

1 Ms Weatherley, so I don't need to take you through them
2 all. "And how will the Trust support me" and you set
3 out here, this is what you have concluded and
4 determined:
5 "The CEO and the non-executive team as a Trust
6 board to apologise in the presence of her parents."
7 Why did you think she needed to be apologised to,
8 firstly, and, secondly, in the presence of her parents?
9 **A.** So the apology was in respect to how she had
10 been treated. The Trust hadn't followed their own
11 policies in as I had said what I would have done at the
12 beginning which would have been back in 2015 to suspend
13 and then obviously pending investigation.
14 But they hadn't communicated with her. She didn't
15 know what was going on and it was as if they were
16 managing her against the disciplinary policy but they
17 had not actually told her that.
18 So the redeployment she wasn't clear why she was
19 being redeployed. The information that she would redo
20 her competencies and be supervised but nobody else was
21 and she didn't understand why that was, so I think it
22 the whole situation was chaotic and they didn't manage
23 her very well at all and that's why I felt that they
24 needed to apologise for that.
25 **Q.** Who's "they" who did you want to apologise to

1 her?
2 **A.** So the Executive Team who her grievance was
3 against.
4 **Q.** So those --
5 **A.** That was the first -- so they needed to
6 apologise. The apology in respect of the Consultants
7 was as I described in your previous question in respect
8 of them calling her names without material evidence,
9 when they knew that she wasn't aware of what they were
10 saying or what was going on.
11 **Q.** So you wanted them to apologise for calling
12 her names?
13 **A.** That was the Consultants.
14 **Q.** Right. And yet you hadn't asked any for them
15 or either of them directly if they had called her names
16 or a murderer?
17 **A.** That was not --
18 **Q.** Just pausing there, but they had to apologise
19 for that, whether they had done that or not; is that
20 what you thought?
21 **A.** So the information contained within the
22 investigation, with the statements of interview said
23 that and that's what I had to work with as the grievance
24 manager.
25 **Q.** The allegation was Dr McCormack, an

1 obstetrician --
2 **A.** That was one of them.
3 **Q.** -- had said in a meeting, not Dr Jayaram or
4 Dr Brearey; there is no allegation in there. By all
5 means take your time.
6 **A.** Of them calling her names?
7 **Q.** Yes, those two. I am asking about those two.
8 **A.** Yes, I believe that Dr Harvey spoke with
9 Dr Jayaram about a comment that a name that he had
10 called her. Dr Jayaram agreed he had called her the
11 name and said it was inappropriate.
12 **Q.** That is what you understood Ian Harvey had
13 said?
14 **A.** Yes, in the statement.
15 **Q.** Okay let's see what Ian Harvey actually says
16 about that. If we go to INQ0002879, page 9. Go to
17 page 10 of it, so INQ0002879, page 10. If we go down to
18 that box near the bottom: "I wasn't aware of that.
19 There has been a number of behaviours on the ward that
20 do not reflect too well. I had to go -- to go and speak
21 to Dr Jayaram that some of the trainees had been making
22 reference to angel of death, but no specific person was
23 named. There was behaviour in clinic being heard
24 talking about killing babies on the unit. I had to
25 speak to Ravi about comments about killing babies. This

1 was not denied and RJ did accept that it was
2 inappropriate."
3 You took that to mean that Ravi Jayaram had been
4 talking about killing babies openly on unit, did you,
5 and that Dr Jayaram had been spoken to in those terms by
6 Mr Harvey?
7 **A.** There was that and it was also in somebody
8 else's statement. I think I reference it in the
9 statement to the Inquiry. I'm just not sure which point
10 it was in my statement.
11 **MS LANGDALE:** My Lady, it may be a good moment to
12 take a break so the witness has time to find that.
13 **LADY JUSTICE THIRLWALL:** Certainly.
14 **MS LANGDALE:** If we resume at midday.
15 **LADY JUSTICE THIRLWALL:** We will take 15 minutes
16 and start again at 12 o'clock.
17 **(11.43 am)**
18 **(A short break)**
19 **(12 noon)**
20 **MS LANGDALE:** Ms Weatherley, is there anything
21 after the break you want to specifically refers us to
22 from your statement about Dr Jayaram calling Letby
23 a baby killer in the ward?
24 **A.** Sorry, I didn't quite hear the start of the
25 question.

1 **Q.** About Dr Jayaram calling Letby a baby killer;
2 is there anything you specifically want to take us to in
3 your statement having had the break dealing with that
4 point?
5 **A.** Sorry, it wasn't my statement I was
6 referencing. It was the statements contained within the
7 investigation.
8 **Q.** Okay I can take you to those then. Let's go
9 to what they say unless you can remember one
10 specifically?
11 **A.** I -- I am -- yes you will have to bear with my
12 memory. But I seem to remember somebody had overheard
13 him, it might have been a nurse, in outpatients
14 department and had raised that I think possibly with
15 Eirian.
16 **Q.** That's right. So let's have a look what was
17 said at INQ0002879, page 38. We see there, at page 38,
18 Ravi Jayaram was heard by a nurse; is that the right
19 page?
20 **LADY JUSTICE THIRLWALL:** This is 238.
21 **MS LANGDALE:** Yes. It's 0038, 38. INQ00028790038.
22 Here we are. "Ravi Jayaram was heard by a nurse, Nurse
23 T, in outpatients when asked if anything had come from
24 the review [presumably the RCPCH review] to say
25 somebody's causing these deaths on the unit. Nurse T is

1 now anxious to return to the unit after RJ's statement.
2 EP escalated to KR."
3 So Eirian Powell says Nurse T heard Ravi Jayaram
4 say, "Somebody's causing deaths on this unit."
5 The Inquiry has heard evidence from Nurse T on what
6 she in fact heard, but let's just focus on what you read
7 there.
8 That doesn't say he said Letby is a baby killer or
9 a murderer does it; it says he has commented on a review
10 to say somebody is causing these deaths on this unit.
11 **A.** Yes, that one does.
12 **Q.** Yes. So do you put that in the category of
13 calling someone a baby killer and a murderer and
14 terrible names which is what you said?
15 **A.** Yes.
16 **Q.** Before that?
17 **A.** And again sorry that I don't have all of the
18 statements in front of me, but having read the
19 investigation and statements that were in it, there were
20 a number of statements from different people who said
21 they had been in the environment when Consultants were
22 calling her names and there was reference to
23 Ravi Jayaram having called her a name.
24 **Q.** Well the only reference to a Consultant --
25 let's go to INQ00028790030. I am going take you now

1 having read all of the interviews to what's said on this
2 topic, 0030. I will wait until it's up.
3 At the bottom the page, "Have you heard about any
4 allegations about Lucy to Sian Williams. I am aware
5 that they feel she's to blame. I was told by someone
6 else that one of the doctors had referred to in the
7 context of there is a murderer on the loose out there in
8 one of the outpatient clinics but not by name."
9 So a murderer on the loose out there, but not by
10 name. If we link that comment from Sian Williams to
11 what you are told in the pack by Eirian Powell in her
12 written document at INQ00028790064. At a meeting,
13 Eirian Powell tells you about Urgent Care meeting that
14 had been convened in May 2016, and says here:
15 "Jim McCormack directed his statement in anger in
16 a raised voice that I was harbouring a murderess on the
17 neonatal unit. I responded again there was no evidence
18 this was not a matter for us to discuss in this
19 meeting."
20 Again I am not going to ask you about whether that
21 did or did not occur, but you clearly read that from
22 Eirian Powell?
23 **A.** (Nods).
24 **Q.** About harbouring a murderess, you had heard
25 Sian Williams say someone said there is a murderer on

1 the loose out there. And you had heard about Nurse T.
2 My question, going back to your letter of
3 conclusion is: why you concluded from that evidence that
4 it was Dr Jayaram and Dr Brearey that had to apologise
5 for calling her names like baby killer? If we go back
6 to your conclusion at INQ0056139, page 2.
7 **A.** So I think I mentioned before the break about
8 Dr Brearey and angel of death.
9 **Q.** Angel of Death?
10 **A.** Angel of death, yes.
11 **Q.** Who do you say said he said angel of death?
12 **A.** Again it was in one of the statements in the
13 investigation. It may have been Eirian.
14 I'm not sure who had said that to but it was in the
15 investigation.
16 **Q.** We have all the statements in the
17 investigation I know you have had this conversation with
18 Mrs Appleton-Cairns before the meeting which we don't
19 have notes of. So I am really interested in who you
20 spoke to because you are talking with her about a witch
21 hunt and where you might have got that kind of
22 information from because I have read you what we have
23 got here and you go right into the police with baby
24 killers and what the Consultants are saying.
25 Is that just from this evidence or is there

1 a conversation that you have had?
2 **A.** No. Can I say again for the record and for my
3 integrity what I say to the Inquiry I say under oath and
4 it was true.
5 **Q.** Sorry?
6 **A.** What I said to the Inquiry and I say under
7 oath is true; that the only conversation I had with
8 Dee Appleton-Cairns on the morning of the hearing was:
9 I said it felt or it feels like a witch hunt. She said
10 "Yes, we feel that too, it's very sad."
11 That was the only conversation we had about the
12 hearing. The rest of my conclusions are based on the
13 investigation report. That is all I can make
14 conclusions on. There was no other outcome I feel
15 I could have come to with the chaos and the lack of
16 engagement and clarity from the Consultants and how they
17 behaved and also from the Executive Team in respect to
18 what they were telling me, through the investigation
19 report, in that clearly they did not believe that the
20 concerns were credible and they were looking for
21 alternative suggestions as to why the Consultants could
22 be targeting this nurse.
23 That's what I had to deal with. Anything outside
24 of that was outwith the remit of the grievance hearing.
25 **Q.** If you look at page 3, the next page of your

1 concluding findings, you say that the movement was
2 orchestrated by Consultants with no hard evidence to
3 support this action.
4 Is that what you thought even having looked at that
5 paragraph again today with Dr Jayaram's evidence to the
6 grievance panel? That there was no evidence to support
7 the action moving her from the unit?
8 **A.** Yes, Dr Jayaram's own words in his own
9 statement to the investigation was there was a link,
10 there was a commonality. Beyond that there was nothing
11 to suggest any foul play or any harm or any wrongdoing
12 on behalf of Lucy. That's in his own statement.
13 **Q.** You then say:
14 "Failure to achieve a harmonious working
15 environment should result in disciplinary action taken
16 by the Trust."
17 So if the doctors, who you require to apologise to
18 Letby, don't do that, don't get on with that, there
19 should be disciplinary action taken by the Trust?
20 **A.** No, it should be considered as
21 a recommendation.
22 **Q.** So that your --
23 **A.** It's not -- it's not in my remit to tell the
24 Trust what they need to do.
25 **Q.** Well, you say should result --

1 **A.** But my recommendation, on the basis of what
2 I had heard in the hearing, on the basis of the
3 investigation was that.
4 **Q.** So we have now got into a situation that you
5 haven't heard from those two doctors directly about
6 whether they have said those things in the terms you say
7 they have after hearing this kind of evidence. They
8 should apologise otherwise disciplinary action results.
9 Do you see that's quite absurd from their
10 perspective?
11 **A.** I believe that Dr Brearey had also in
12 a conversation with, I think it was Eirian, who had said
13 the impact of this on Lucy given their own statement
14 suggested that there was no link to Lucy other than
15 commonality and a gut feeling. She asked him about the
16 impact and she suggested, you know: What if Lucy was to
17 kill herself in respect of this or what about the damage
18 to her parents? And he said: "I really couldn't care
19 less. I don't care."
20 And then she mentioned about another nurse who was
21 also shown in the commonality and I believe his
22 reference was that that nurse was nice.
23 **Q.** Right, and you thought that was all true?
24 **A.** So there were --
25 **Q.** You thought that was all true?

1 **A.** I take what is in front of me as the truth.
2 **Q.** Let's go, please, to INQ00056151, page 1.
3 I have just taken you to the letter that you penned your
4 answers to in very brief form and then we have this
5 letter that is sent to Letby.
6 This is still a draft. No, this may be the one
7 that's actually been sent, but look at the answer to
8 number 5. It has been expanded upon since your
9 questions and answers that I have just taken you
10 through.
11 So it is INQ0056151, page 2. This is a draft so
12 it's not the one that she's ultimately sent because we
13 see more additions, but look at this at paragraph 5
14 "During the course of this investigation this has been
15 expanded upon" is this sent back to you? You have
16 clearly done your first draft with the questions and
17 answers I have gone through on 1 December.
18 Then we have this one. Do you see? Are you aware
19 whether it is Mrs Appleton-Cairns or Sue Hodkinson or
20 anyone else who do you think is adding to this?
21 **A.** As far as I was aware nobody was adding to
22 this, this was just myself and Dee.
23 **Q.** So it is Dee, it looks as though Dr Green's
24 written things in his report and they may have been
25 lifted into this letter, so as far as you are concerned

1 she's supporting you to add to your letter?
2 **A.** When the grievance had concluded, we sat and
3 wrote together what I wanted the outcome to be and where
4 I upheld parts of what Chris has said, rather than us
5 sit and write that out word for word, I just said:
6 You'll just need to cut and paste that from his report
7 into this.
8 **Q.** So we see that addition at number 5, we see
9 number 7. Then there is another version if we go to
10 INQ0056171000. This one seems to come from
11 Alison Kelly. Anyway:
12 "Please check as discussed, thanks, Alison."
13 We see next page, INQ0056173000:
14 "Hi Annette, sorry for the delay I have also added
15 in about LL's mentor."
16 So she's coming back to you this time with your
17 name spelt correctly at the bottom. And we see here at
18 number 7 look what's been here in this one been put in.
19 We need to go to INQ0056174, page 2.
20 There's all this stuff about no party refutes
21 concerns were raised. Speak Out Safely policy. Do not
22 find Consultants' concerns when reiterated to the
23 Executive Team were clear honest objective. We went
24 through all this earlier. All this appears further
25 down.

1 Over the page. Did you appreciate Alison Kelly at
2 any point was going to see your drafts before
3 finalisation?
4 **A.** No.
5 **Q.** Then it's finalised. It comes to you,
6 INQ0056175000. Just made a couple of track changes one
7 addition plus added my signature are you happy for this.
8 This is you sending it back. If we go to
9 INQ0056176, page 1, so you have had a look at the copy
10 that's come back to you from Dee, you have
11 Dee Appleton-Cairns and this is you now just finalising
12 with your own pen there at page 1. If we go to page 2,
13 we see you correct "I have not been made aware any
14 allusion to a wrongdoing" and say "I have not seen."
15 Because you had been made aware hadn't you so you
16 have bothered to correct that and seen it, you say
17 "seen." Do you see? What is the significance of your
18 change there; why have you changed that?
19 **A.** Is this my change?
20 **Q.** Yes?
21 **A.** So it doesn't have track changes on with any
22 names. I assume you have that.
23 **LADY JUSTICE THIRLWALL:** Yes, it should be in blue.
24 **A.** No, sorry it doesn't say who's made the track
25 change. How do you know that was me.

1 **Q.** Let's have a look the document before says "Hi
2 both, this is now the final document from Dee." We know
3 from the document before she says "I have accepted it
4 and it's ow the final document. You might note from the
5 most substantive page at page 3" -- let's have a look
6 at page 3 who added this?
7 **A.** Yes, it must be me because I did put that bit
8 there. I would add "however."
9 **Q.** Yes as you have explained earlier, that's why,
10 no just the emails I assumed it is yours. That is
11 correct. This is your final investigation being sent
12 after Alison Kelly had looked at it and it all seems to
13 have come from her email I will say at this stage, but
14 when you get to this point you are adding tweaks and you
15 want to say here they could have supervised her to
16 remain on the NNU with supervision, actually, because
17 you weren't satisfied they didn't have enough people to
18 do that.
19 So if they are your changes can you go please and
20 have a look at the one on the page before at page 2 and
21 explain the change there in paragraph 5.
22 **A.** I think I just felt it was a better, a more
23 grammatical sentence.
24 **Q.** Or that it would be misleading to say that you
25 had not been made aware, any allusion to any evidence

1 relating to --
2 **A.** Well, it would because I had been made aware.
3 **Q.** Yes. Yes, you had seen it.
4 **A.** Yes.
5 **Q.** So in terms of your own position you correct
6 that?
7 **A.** Yes.
8 **Q.** That can come down now, thank you.
9 We know subsequently that the Consultants were
10 required to attend mediation. Looking at the picture
11 overall, do you think the circumstances of this case,
12 this grievance, this situation, that was ever going to
13 be a practical or sensible conclusion?
14 **A.** I think in the outcome letter I was clear in
15 saying that so long as there is no reference made to
16 Lucy in the forensic review that had not yet concluded,
17 that those were the recommendations.
18 I think given that four reviews had taken place,
19 with no concern of foul play, and certainly no reference
20 to Lucy and foul play, given that the Royal College
21 review found no concern with Lucy of foul play that if
22 then a further review, a forensic deep dive of all of
23 those case notes, also found no evidence of foul play
24 that I felt that that was a fair conclusion to make in
25 the outcome of the grievance.

1 **Q.** So in terms --
2 **A.** That she should be, sorry, that she should be
3 returned to the unit.
4 **Q.** No, no so from your perspective the status of
5 that Royal College review was significant in your mind,
6 whatever it was doing was significant to this issue?
7 **A.** It was significant because it was
8 understanding a wider review of the unit in respect to
9 issues that could be resulting in a rise in neonatal
10 deaths.
11 **MS LANGDALE:** Thank you. Those are my questions,
12 Ms Weatherley. There is none from anyone else, my Lady.
13 **LADY JUSTICE THIRLWALL:** I have no questions.
14 Thank you very much, Mrs Weatherley. You are free to
15 go.
16 **A.** Thank you.
17 **MS LANGDALE:** My Lady, the next witness is
18 Ms Eardley and Mr De La Poer will be taking this next
19 witness.
20 **MR DE LA POER:** My Lady, we are going to move from
21 the grievance procedure now to consider the RCPCH and
22 our first witness in that part of your hearings is
23 Ms Sue Eardley.
24 **LADY JUSTICE THIRLWALL:** Thank you very much,
25 Mrs Eardley, would you come forward, please.

1 MS SUSAN EARDLEY (sworn)
2 Questions by MR DE LA POER
3 **LADY JUSTICE THIRLWALL:** Yes.
4 **MR DE LA POER:** Please could you give us your full
5 name.
6 **A.** Susan Joan Eardley.
7 **Q.** Ms Eardley, is it correct that you provided to
8 the Inquiry a witness statement dated 6 June of this
9 year?
10 **A.** Yes.
11 **Q.** And are the contents of that witness statement
12 true to the best of your knowledge and belief?
13 **A.** Yes.
14 **Q.** Before I begin to ask you more questions,
15 I understand that there is a statement that you wish to
16 make.
17 **A.** I would just like to talk particularly to the
18 Families of those babies about how sorry I am and
19 I cannot imagine what you must have gone through.
20 This procedure has all gone on for so long, I can
21 just hope that at the end of it there are some
22 sufficient learning that other families won't have to go
23 through what you have gone through.
24 **Q.** I begin my questions to you, Ms Eardley, by
25 dealing briefly with your background. Did you qualify

1 as a chartered electrical and electronic engineer in
2 1985?
3 **A.** Yes.
4 **Q.** And as a result of that qualification, did you
5 end up working in project management?
6 **A.** Yes.
7 **Q.** Did you come to be appointed as a part-time
8 non-executive director and subsequently board chair
9 of Mayday Healthcare NHS Trust in Croydon?
10 **A.** Yes.
11 **Q.** Have you been a member of a number of national
12 committees relating to the development of maternity
13 standards?
14 **A.** Yes.
15 **Q.** In 2005, did you join the Healthcare
16 Commission latterly the Care Quality Commission, in
17 a full time role leading on children, maternity and
18 child safeguarding policy and strategy?
19 **A.** Yes.
20 **Q.** And in that capacity, did you oversee
21 inspections?
22 **A.** Yes.
23 **Q.** Turning to the Royal College. Was it in 2010
24 that you joined the RCPCH as head of health policy?
25 **A.** Yes.

1 **Q.** Two years later, did you begin in a new post,
2 specifically to establish and run the Invited Review
3 service?
4 **A.** Yes.
5 **Q.** And in doing so, did you work closely with the
6 Royal College of obstetric paediatricians and
7 gynaecologists?
8 **A.** Yes.
9 **Q.** If we come forward in time, past the dates
10 that we are concerned with. Did you continue in that
11 role until 2019?
12 **A.** Yes.
13 **Q.** And in that role, did you oversee and/or
14 directly conduct over 100 reviews of services,
15 individuals and networks?
16 **A.** Yes.
17 **Q.** And to bring us up to date, are you currently
18 supporting the Royal College of radiologists to
19 re-establish their Invited Review service?
20 **A.** I am not doing that any longer, but I have
21 done since 2019, yes.
22 **Q.** Just so we are clear, you are not and never
23 have been a clinician; is that right?
24 **A.** Correct.
25 **Q.** You clearly have a great deal of experience

1 working in the NHS and the healthcare sector. In your
2 own words, in summary, how comfortable are you working
3 with people and in environments which are clinical?
4 **A.** I have, as you say, had a lot of experience in
5 that so yes, I am very comfortable at board level and
6 working with clinicians from all disciplines.
7 **Q.** In terms of the development of the service
8 that you were appointed to create, by 2016, how well
9 developed would you say that service was?
10 **A.** We had developed the service initially
11 building on the experience of the Royal College of
12 Obstetricians and Gynaecologists and also Royal College
13 of Surgeons, so we were developing a process not exactly
14 from scratch but using their guidance. We had conducted
15 a number of reviews and from each review there was some
16 learning and we strengthened our processes and approach
17 as we continued to do reviews.
18 **Q.** And as far as speaking in general terms the
19 circumstances of the review that you conducted at the
20 Countess of Chester Hospital was concerned would it be
21 accurate or inaccurate to describe those as unique?
22 **A.** With hindsight unique. Initially it was
23 a further development in terms of an enquiry we
24 received.
25 **Q.** We just need now between us to consider some

1 people, one person in particular, for you to introduce
2 briefly and then to look at some Policy documents.
3 Dr David Shortland you tell us had oversight of the
4 Invited Review service in his capacity as Honorary
5 Vice president for health policy; is that right?
6 **A.** Yes, that's correct.
7 **Q.** Did he also have a role as clinical lead for
8 Invited Reviews?
9 **A.** Yes.
10 **Q.** We will come to look at how the clinical lead
11 may have input and we will do so by going straight to
12 the first of the Policy documents, which is the handbook
13 for reviewers. It will come up on your screen in just
14 a moment INQ0012822 and we will go straight to page 4,
15 please.
16 Now can I just make clear at this stage we are
17 simply picking out key features of these Policy
18 documents. We will come to apply them in due course, so
19 that is coming. But I just want to invite you to
20 identify with us one or two elements.
21 Now this is described as a process flowchart and
22 was it intended to be the template by which a review
23 would begin, be conducted and conclude?
24 **A.** Yes.
25 **Q.** We can see that the first step is the request

1 for assistance. At the second step, we see the clinical
2 adviser so would that be Dr Shortland at the time?
3 **A.** It would have been at the time, yes.
4 **Q.** So the clinical adviser decides the most
5 appropriate action service design or individual
6 performance review pre-visit may be arranged.
7 Now, were you the author of this flowchart?
8 **A.** Yes.
9 **Q.** So presumably when you created it you
10 considered that that was an appropriate stage for the
11 clinical adviser to become involved?
12 **A.** Yes.
13 **Q.** Now, we can see an arrow to the right of that
14 box leading to another text.
15 "Advise to explore internal or external processes
16 eg, NCAS, GMC, BMA, MHPS, no further RCPCH action."
17 Now, this is a step away from the flow of the
18 process, isn't it?
19 **A.** Yes.
20 **Q.** Effectively it is a dead end?
21 **A.** Yes.
22 **Q.** Indicating that one would not continue with
23 the process if the advice of which examples are given is
24 tendered at that very early stage?
25 **A.** Correct.

1 **Q.** Was that designed by you as a recognition that
2 sometimes people will ask the RCPCH to provide some form
3 of help or review and it won't be appropriate for the
4 RCPCH to become involved?
5 **A.** Yes.
6 **Q.** The examples given include GMC, the
7 General Medical Council, is that a reference to the
8 possibility that some sort of regulatory action may be
9 the appropriate response?
10 **A.** Yes.
11 **Q.** If we just amplify that a little bit in terms
12 of why you might have included the GMC. If what you are
13 being asked about is effectively there is a concern that
14 a doctor may have misconducted themselves, your view
15 presumably would be, well, the GMC should be the ones
16 investigating that, not the RCPCH?
17 **A.** Yes. At the time I believe at the time the
18 GMC was developing liaison with Medical Directors around
19 the country and an enquiry about a specific individual
20 doctor, we would have suggested they talk to their
21 GMC representative, the Medical Director talk to their
22 GMC adviser about next steps rather than necessarily
23 going to the RCPCH for review.
24 **Q.** So you step off the process at that point?
25 **A.** Yes.

1 **Q.** That conversation takes place, the regulator
2 becomes involved, plainly if the regulator was to say:
3 That is nothing to do with us, then you could
4 potentially come back to this?
5 **A.** Yes.
6 **Q.** Now, you haven't listed the Nursing and
7 Midwifery Council, but they are just a list of examples.
8 By mentioning the GMC, are you intending to imply, "and
9 other regulators of a similar standing"?
10 **A.** "Eg", yes.
11 **Q.** Yes, quite so. Now, one organisation who
12 don't appear on your example list is the police.
13 **A.** Correct.
14 **Q.** Just reflecting upon it, and recognising of
15 course that this is not an exhaustive list, but as
16 a means of focusing the mind, do you think perhaps the
17 police should have been included on that list as being
18 the most extreme and clear-cut example of where the
19 RCPCH ought not to be trespassing?
20 **A.** With hindsight of course the police should be
21 there. At the time, there was such an unlikely
22 occurrence it had not crossed our mind.
23 **Q.** So highly unlikely, but potentially would you
24 agree the very worst example of a situation where the
25 RCPCH should be becoming involved, if it is in fact

1 a police matter?
2 **A.** Again, with hindsight, we would have expected
3 the Medical Director would have gone straight to the
4 police had they had suspicions.
5 **Q.** So that's the review process in a flowchart.
6 Could we go to page 8, please. We don't need to
7 look at all of this, I am sure that you will be able to
8 confirm that, the title very much tells us what this is,
9 the Handbook for Invited Reviewers, it's simply advice
10 given to reviewers about how they should conduct
11 themselves, what they should expect, that sort of thing?
12 **A.** Yes.
13 **Q.** We can see at item 6 on this page:
14 NHS policy briefing including child protection.
15 "Reviews of services will always need to be
16 considered within the local context of commissioning,
17 planning and historical configuration. One of the
18 criteria for reviewer selection is an awareness and
19 understanding of recent national and strategic changes
20 to the NHS and the opportunities and challenges these
21 present together with the ability to contextualise these
22 in relation to the service under review."
23 It goes on to speak in relatively general terms
24 referring to other policies, but my question really is,
25 is this: included in that heading is, as an example,

1 child protection. Why was that as an example
2 particularly picked out in bold as part of that title?
3 **A.** Some of the reviews that we did were relating
4 to community paediatrics and child protection was
5 an issue in some of those reviews. The RCPCH had
6 written guidance around child protection as well as
7 clinical standards. It was in there because that was
8 one of the elements that we covered.
9 **Q.** One reason to include it in the title in bold
10 is because that is a particularly important and relevant
11 policy or set of ideas that people need to be up to date
12 with; is that fair?
13 **A.** Yes. A separate set of web pages, up-to-date
14 policy guidance on child protection issues and advice,
15 yes.
16 **Q.** Now, one of the documents you didn't mention
17 just now in what was I am sure a non-exhaustive list is
18 of course Working Together?
19 **A.** Yes.
20 **Q.** Was that one of the policy documents that you
21 would expect reviewers to be aware of?
22 **A.** Yes.
23 **Q.** The Inquiry has received evidence that it
24 received periodic refreshes or updates, the version in
25 force was dated 2015 as at the time of your review?

1 **A.** Yes.
2 **Q.** Is that a document you would have expected
3 your reviewers to be aware of?
4 **A.** Yes.
5 **Q.** You have told us that you have a long-standing
6 experience in safeguarding. Was that a document that
7 you were very well versed in?
8 **A.** Indeed, yes. When I was at the
9 Health Care Commission and CQC I was involved in
10 drafting previous editions of that document.
11 **Q.** This absolutely isn't a test so that we can
12 bring it up on screen, but nor do I want to patronise
13 you as you may well know what I am talking about.
14 There is a passage in Working Together which talks
15 about what an allegation is, I will just read it out for
16 you, but we can bring it up on screen. An allegation
17 may relate to a person who works with children who has
18 behaved in a way that has harmed a child or may have
19 harmed a child, possibly committed a criminal offence
20 against or related to a child, or behaved toward a child
21 or children in a way that indicates they may pose a risk
22 of harm to children.
23 Are you familiar with that sort of language when it
24 comes to Working Together and safeguarding?
25 **A.** Yes, yes.

1 **Q.** And so was it your understanding that when
2 thinking about things from a safeguarding perspective,
3 one isn't looking for definitive proof, one merely needs
4 a suspicion before immediately everyone needs to be
5 thinking about safeguarding?
6 **A.** Yes, that is how it reads. Yes.
7 **Q.** So that is how it reads and it was a document
8 you were very familiar with, I suppose the next question
9 is: is that how you were thinking in 2016?
10 **A.** At that time, no, I was not thinking along the
11 allegation role. With hindsight I'm not sure why not
12 but at the time I was aware of the allegation.
13 **Q.** You say with hindsight you are not sure why
14 not. A possible implication of that is that you are
15 recognising you should have been thinking in those
16 terms; is that fair?
17 **A.** Yes, knowing what I know now about what
18 happened subsequently.
19 **Q.** But did you need to know that for that to be
20 the correct way to have been thinking at the time,
21 bearing in mind the language of Working Together?
22 **A.** No.
23 **Q.** In all of your experience of safeguarding, had
24 you yourself ever received or delivered any training
25 about how people should react in a healthcare setting if

1 they suspected a colleague, so another member of staff,
2 was harming or may harm a child?
3 **A.** No, that was absolutely not something on my
4 radar at all.
5 **Q.** Again, just taking the opportunity to draw on
6 somebody who has had a very long-standing experience in
7 safeguarding. Do you think that that should have been
8 part of the training back in 2016 and earlier?
9 **A.** Yes. Yes.
10 **Q.** Does it follow from that because you would
11 recognise that that is a clear example of a safeguarding
12 issue?
13 **A.** Yes.
14 **Q.** Thank you. We can take that document down.
15 We are next going to look at the Guide to Invited
16 Reviews. INQ0010214.
17 Now, whereas the previous version I think was
18 an internal RCPCH document, for the benefit of those
19 conducting a review, this was an outward-facing document
20 for the benefit of those who might want to understand
21 what the RCPCH could and couldn't do; is that right?
22 **A.** Absolutely. Both were dynamic documents and
23 we updated them as we went along as we learned new
24 things as we explored new ways of doing reviews.
25 **Q.** But you would expect that a person who might

1 be interested in involving the RCPCH would be able to
2 access this document, presumably online, in 2016, and
3 familiarise themselves with what the RCPCH could or
4 could not do?
5 **A.** Yes, it was on the website, as I understand
6 it.
7 **Q.** This, as we see, is the August 2016 iteration,
8 so it slightly postdates the first contact from the
9 Countess but represents the version in force at the time
10 of the inspection?
11 **A.** Yes.
12 **Q.** Just so we have got our dates straight.
13 **A.** Yes.
14 **Q.** If we go and have a look at page 4, we can see
15 some definitions which will help a person who is perhaps
16 not familiar with the terms the RCPCH might use to
17 understand it and the one to draw your attention to is
18 paragraph 2.2, a service review which sets out what
19 might occur, it is an invitation to visit and comment
20 upon a current service. It can be broad, the whole
21 paediatric service, or a specific element, including for
22 example safeguarding.
23 It involves meeting the clinicians and managers and
24 then this:
25 "The Terms of Reference will usually be rooted in

1 the quality, safety and efficiency of the service."
2 **A.** Yes.
3 **Q.** Just again, are these your words?
4 **A.** Yes, the document will have been through
5 a sign-off by members of the programme board, but yes.
6 **Q.** You will have proposed the original draft?
7 **A.** Yes.
8 **Q.** Does that accord with what you understood the
9 function of a service review?
10 **A.** Yes. Again, working closely with other
11 medical Royal Colleges that were providing similar
12 services.
13 **Q.** And just if we take a step back and frame the
14 situation at the Countess in a very general term. If it
15 be the case that you were asked to try and understand
16 why the number of deaths had increased, and we will look
17 at the detail of the Terms of Reference and so on, how
18 well do you think that fits with "usually rooted in the
19 quality safety and efficiency of the service"? Do the
20 two elide or are they in fact separate things?
21 **A.** We were asked to provide a review, to, as
22 I recall, see if there was any other factors that could
23 explain the increase in mortality.
24 And one of those -- the approach that I discussed
25 with Ian Harvey was that a service review would explore

1 all the possible factors, organisational factors,
2 cultural factors that may explain that increase in
3 mortality.
4 At the time of the initial conversation, I wasn't
5 aware of the other reviews that had taken place to date.
6 That was part of the whole service review.
7 **Q.** Well, we will come to the detail of your
8 conversation with Mr Harvey and I am not looking to shut
9 you down about that --
10 **A.** No, no, that's fine.
11 **Q.** -- at this stage.
12 But trying to understand why the rate of mortality
13 may have increased, may be thought, so in other words
14 what factors, may be thought to be different to looking
15 at how good is this service? How safe is this service
16 in general terms? How efficient is this service?
17 Do you see the two -- one is a specific
18 investigation into particular cases, the other is much
19 broader?
20 **A.** Yes.
21 **Q.** Do you at least see the point that I am
22 making?
23 **A.** Oh, completely. Yes.
24 **Q.** And do you agree with it or do you disagree
25 with it?

1 **A.** The -- looking at a service and eliminating
2 any factors that could be causing an increased number of
3 deaths is the purpose of a service review or one of the
4 purposes of a service review.
5 **Q.** Had you ever before this been asked, in
6 circumstances where there had been an increase in
7 deaths, to see if you could identify why that death rate
8 had increased?
9 **A.** No.
10 **Q.** And since this, have you ever been asked up
11 until 2019?
12 **A.** No.
13 **Q.** So to that degree at least, this was unique in
14 your experience?
15 **A.** Yes, there had been reviews where -- where
16 outcomes were less good, if I recall, where there had
17 been tensions on units, where there had been a feeling
18 that processes weren't as safe as they could have been.
19 I can't name specific ones at the moment but this was of
20 the nature of the kind of request that we had.
21 **Q.** Page 5, at paragraph 3.3. We can see:
22 "Each review will have its own specific Terms of
23 Reference and be uniquely designed within the scope of
24 this guidance to be both robust yet fair to all
25 concerned and to answer the questions and concerns

1 raised."
2 Now, presumably, and we will come to the caveats
3 later, you weren't meaning for people to understand when
4 they read this that whatever concern that they came to
5 you with, you would answer?
6 **A.** Yes.
7 **Q.** If we have a look at page 7, paragraph 6.1, we
8 see, "Where serious concerns are raised" and just so
9 that we check that we are on the same page, the
10 possibility that a member of staff may be murdering
11 babies presumably falls at the very extreme end of the
12 definition of serious concerns?
13 **A.** Yes.
14 **Q.** "If issues of patient safety are raised at any
15 time, the reviewers will advise the client immediately
16 and discuss what urgent action should be taken if any.
17 For concerns about an individual's practice for example
18 the client may want to consider restriction of the
19 doctor's practice as set out in the guidance [and
20 I won't rehearse that bit]. For concerns about service
21 safety beyond the scope of the review, the regulatory
22 authority should be advised with consideration as to
23 whether temporary suspicion of the service is
24 appropriate."
25 So again, just -- not looking at the detail of it

1 now but dealing with it in relatively general terms, is
2 that saying that if a doctor says in the course of the
3 review, "I think there may be a serious patient safety
4 concern", there needs to be a very strong and robust
5 reaction from the RCPCH in response?
6 **A.** This paragraph primarily referred to if on
7 a review we came across some practice which the
8 management was not aware of, which others were not aware
9 of that we thought was a concern, and that has happened
10 on some reviews where we would say -- there was one of
11 an emergency service where we said, "We really suggest
12 that you change practice immediately."
13 **Q.** Yes.
14 **A.** For this situation, we were told at the
15 beginning of the situation. So informing management
16 about it was not so pertinent because management already
17 knew.
18 **Q.** So certainly simply reflecting back what you
19 have been told and that you know they already know may
20 not have been what you needed to do. It's the advice
21 bit?
22 **A.** Yes.
23 **Q.** "The reviewers will advise the client
24 immediately."
25 **A.** Yes. Well, the client already knew. The

1 client advised us about the situation and how they were
2 managing it at the time.
3 **Q.** Does that not tend to suggest that the
4 reviewers will give advice immediately about what should
5 be done in response to the concerns?
6 **A.** Yes. This situation is if we come across
7 something that management is not aware of during
8 a review.
9 **Q.** Right.
10 **A.** For example, poor practice or for example
11 inadequate staffing, non-compliance with standards that
12 was causing a significant safety issue.
13 **Q.** So when we read it as you intended its
14 meaning --
15 **A.** Yes.
16 **Q.** -- when we read:
17 "If issues of patient safety are raised at any time
18 ..."
19 We should add in brackets, "... during the visit
20 itself."
21 **A.** Yes, that we -- that management are not
22 already aware of.
23 **Q.** So was it not the role for the RCPCH to give
24 advice about concerns that management were aware of?
25 **A.** Our role in this review was looking at issues

1 apart from the situation which management had explained
2 about the doctors' concerns. So we were looking at
3 everything else.
4 We were aware of the doctors' concerns. Our review
5 role was to look at any other factors that could be
6 there.
7 **Q.** Does that mean that you say that there was no
8 obligation on any of the reviewers, yourself included,
9 to give advice, on the basis of the information you had,
10 about how that issue that you say is outside the review
11 should be managed?
12 **A.** We did discuss it. We discussed with the
13 management how they were managing it.
14 **Q.** I understand that. But my question was about
15 whether you think there was an obligation on you and the
16 other reviewers to give advice to them about how they
17 should manage it, not just discuss, "What are you
18 doing?" but to say, "I understand what you are doing.
19 You need to do this."
20 **A.** Yes. Yes. And we did. We -- we recognised
21 the situation that the Trust was in at the time, what
22 steps they had taken and where our role was in the
23 management continuing with their investigations.
24 **Q.** Now, one of the things that you didn't advise
25 them to do is go to the police.

1 **A.** Not directly, but we did discuss it and they
2 explained why they hadn't.
3 **Q.** Well, again, you are coming at this from
4 an independent perspective. It's one thing to say, "Oh,
5 you have thought about it and you have decided not to do
6 it." It's quite another thing to say, "Well, that
7 doesn't matter. The right thing to do here is to call
8 the police."
9 The two are different. Do you agree that you
10 didn't at any time say, "You need to call the police."
11 **A.** Correct.
12 **Q.** And do you agree -- not with hindsight, but
13 based on the information you were given at the time --
14 that that was advice that should have been given at
15 least at some stage and we'll work through the
16 chronology in due course?
17 **A.** At the time we did discuss as a review team
18 whether -- and we'll come to that I suspect -- whether
19 to abort the review, whether to call the police.
20 We did consider the totality of the risks of doing
21 so and the implications of calling the police on the
22 unit as well as the situation and the safety of the unit
23 at that time, where the individual had been taken from
24 clinical duties.
25 So that was a consideration throughout.

1 **Q.** I am sure there were lots of factors to weigh
2 up --
3 **A.** Indeed.
4 **Q.** But I think the question is: ultimately, does
5 it come down to this: was the correct balance of those
6 factors at the time in fact the police should be called
7 given what you knew at the time?
8 **A.** Given what we knew at the time, we took the
9 decision at the time which I -- was right at the time.
10 **Q.** Well, we will look at the various moments in
11 time --
12 **A.** Of course, of course.
13 **Q.** -- and explore it.
14 Page 9, please, paragraph 8. 1. This really is by
15 reference to the flowchart we have already looked at:
16 "Once the clinical adviser has agreed for the
17 College to proceed with the Invited Review, an early
18 pre-review visit may be proposed to familiarise the
19 College's representatives with the relevant individual."
20 So two parts to that. The first part is that the
21 process is anticipating that it is the clinical adviser
22 who makes the decision about whether or not it would be
23 appropriate to proceed, is that correct?
24 **A.** Yes.
25 **Q.** The second is consideration of an early

1 pre-review visit. Now, you may be aware that the RCPCH
2 have said in their opening statement that they think
3 a visit to sit down and discuss with the Medical
4 Director in person, as I understand it, what it was all
5 about and what could and couldn't be done, should have
6 occurred on the basis of this case?
7 **A.** Yes.
8 **Q.** Do you agree with that or do you disagree with
9 that?
10 **A.** I agree with that, yes.
11 **Q.** Now, if we look at paragraph 9.5, which can be
12 found at page 12. We see the expectation -- this really
13 might be characterised as transparency:
14 "It is expected that the client representative will
15 share the final report amongst as many of those who
16 contributed as possible. The RCPCH will endeavour to
17 structure and phrase the report to reflect this.
18 Occasionally where there are sensitive findings or
19 concerns relating to an individual the RCPCH will write
20 separately in confidence to the Medical Director or
21 their nominee about those issues".
22 And although not writing a separate letter, did in
23 fact you produce one dissemination copy and one
24 confidential copy?
25 **A.** That's correct, yes.

1 **Q.** And was that with this paragraph in mind?
2 **A.** Yes. There were other reviews that took
3 place, where we in fact did write a separate letter or
4 have a separate appendix. For this review, we produced
5 a report and then we produced a modified report.
6 **Q.** Well, we will come to the --
7 **A.** Of course.
8 **Q.** -- the merits and demerits of that in due
9 course. But, really, if we think about the
10 dissemination copy as it's been termed --
11 **A.** Yes.
12 **Q.** -- was that produced in that way with a view
13 to it being shared with as many people who contributed
14 as possible?
15 **A.** That was always our policy; that we would
16 write the report so as many people could see it as
17 possible and we would explain at the beginning of each
18 interview that that would be the situation and that they
19 would find within the report what they had said had been
20 included, but it may be quite opaque or oblique to
21 others.
22 **Q.** And those who contributed, I'm sure this is
23 pretty obvious --
24 **A.** Yes.
25 **Q.** -- everybody who you interview?

1 **A.** Yes.
2 **Q.** We can see at 9.7:
3 "The College has no statutory authority to require
4 action following an Invited Review and can only give
5 recommendations and advice to a client. Any action
6 taken following an Invited Review is the responsibility
7 of the client. Where concerns are raised over safety or
8 staffing, the College would expect the client to notify
9 the regulatory authorities promptly of the review
10 recommendations and action plan. If during the review
11 or follow-up period the College deems that action taken
12 in response to concerns or recommendations is
13 insufficient to mitigate safety concerns the Invited
14 Review Programme Board reserves the right to authorise
15 further action, which may include reporting the findings
16 directly to the appropriate regulatory or commissioning
17 authority. The Chief Executive of the client
18 organisation would always be notified if this was being
19 considered."
20 So reserving the right, even though it's the
21 client's report, if patient safety is engaged, to ensure
22 that the right people see it if the response is
23 inadequate?
24 **A.** Yes.
25 **Q.** Now, in order for that to be practicable,

1 doesn't that require the RCPCH to apply some degree of
2 scrutiny over whether or not the recommendations that
3 it's made have been implemented?
4 **A.** Yes.
5 **Q.** Was there a recognised process for doing that,
6 or was it very much an ad hoc on the facts of the review
7 that you were doing?
8 **A.** We would usually follow up three to six months
9 after the review report was received.
10 **Q.** I think we see that at 9.8 --
11 **A.** Yes.
12 **Q.** -- which is the next line?
13 **A.** Yes. The follow -- follow up process was
14 perhaps not as strong as it could be for a number of
15 reasons which we can come to separately.
16 On this review, I was following up regularly with
17 the Medical Director about progress, but events moved on
18 at a different pace.
19 **Q.** In terms of for a patient safety issue or
20 other important issue --
21 **A.** Yes.
22 **Q.** -- for that process to be effective, does it
23 require the RCPCH to say, "We made this recommendation,
24 number 1. What have you done about it?" Or is it
25 sufficient simply to say, "How are you getting on?" and

1 for them to say, "We're doing well, thanks."
2 **A.** We would usually write to an organisation
3 three or six months later with a list of their
4 recommendations and ask them to come back to us on how
5 they had delivered against those recommendations. That
6 was the usual process.
7 **Q.** And is that -- so that's three to six months
8 after the final report.
9 **A.** Yes.
10 **Q.** So if we think about our time frame here, that
11 means that shortly after Christmas of 2017 into spring
12 of 2017, that's your window, is it, for writing?
13 **A.** The final report was the end of November. So
14 it would be February/March.
15 **Q.** February/March?
16 **A.** Yes. That would be three months; often it was
17 six months to do a formal follow up.
18 **Q.** And the expectation is three to six months.
19 Where there are very serious concerns, or potentially
20 very serious concerns, was any adjustment made to the
21 time period erring on the side of sooner rather than
22 later?
23 **A.** Well, I'd usually maintain contact with the
24 Medical Director or client anyway throughout. So the
25 formal approach would be between three or six months.

1 In this situation, the events took over.
2 **Q.** So if we --
3 **LADY JUSTICE THIRLWALL:** Mr de la Poer, just choose
4 your moment.
5 **MR DE LA POER:** Thank you very much indeed,
6 my Lady. I have got one more question about page 13.
7 **LADY JUSTICE THIRLWALL:** Yes, that's fine.
8 **MR DE LA POER:** We can see "Confidentiality".
9 **A.** Yes.
10 **Q.** Is that really for our purposes -- it's a long
11 paragraph, I'm not going to read it out -- reiterating
12 what's been said earlier, which is that you are going to
13 take a confidential approach but there are certain
14 events which the College can breach that confidentiality
15 effectively when patient safety is engaged?
16 **A.** Yes.
17 **MR DE LA POER:** Now, there is one part that we have
18 moved over, but I think, my Lady, that will be most
19 appropriately dealt with after lunch.
20 **LADY JUSTICE THIRLWALL:** Very good. Thank you very
21 much. So we will break now and start again at
22 2 o'clock.
23 **(1.01 pm)**
24 **(The luncheon adjournment)**
25 **(2.00 pm)**

1 **LADY JUSTICE THIRLWALL:** Yes, Mr De La Poer.
2 **MR DE LA POER:** My Lady, thank you. We are going
3 to look at one final part of the document that we had on
4 screen just before lunch, I wonder if that can be
5 brought back up again, and we are going to go to page 8,
6 please. Paragraph 7.5 provides list of situations which
7 the College will not take on. If we look at the third
8 bullet point down, where the expected scope includes
9 behaviour or misconduct, bullying, harassment or
10 possible mental health concerns.
11 Now, do you agree, Ms Eardley, that engaging in any
12 investigation into Lucy Letby herself was necessarily
13 taking you down the path of considering behaviour or
14 misconduct issues; is that right?
15 **A.** No, no, I don't agree with that.
16 **Q.** You don't.
17 **A.** No.
18 **Q.** Well, is the fact that a person may have acted
19 criminally not something that could be characterised as
20 behavioural or misconduct, albeit that's rather an
21 under-description?
22 **A.** All that we had heard was that she had been on
23 duty at certain times and she had been taken off
24 clinical duties.
25 **Q.** My question was about engaging in

1 investigating her?
2 **A.** We didn't do that.
3 **Q.** Well, you did add her to the list of people
4 that you were to speak to in order to get her
5 perspective?
6 **A.** We did. That was within the -- at the time
7 that was within the context of the service review.
8 **Q.** Yes, but the only reason that she was added to
9 the list, and we will come to the detail of this was --
10 **A.** Of course.
11 **Q.** -- was because of the allegations that were
12 behavioural misconduct indeed potentially criminal?
13 **A.** Yes. Yes, I accept that now. But that wasn't
14 the -- that case wasn't the situation at the time when
15 we took on the review.
16 **Q.** Well, let's have a look --
17 **A.** So that element.
18 **Q.** Sorry, I spoke across you there. Please do
19 tell me what you just said?
20 **A.** So that element, item 3, the expected scope
21 including behavioural misconduct, when we set up the
22 review that wasn't in the scope.
23 **Q.** So then let's look at page 9, paragraph 7.7:
24 "If any of the issues listed at 7.5 come to light
25 during an Invited Review, the review should be completed

1 in relation to its original remit unless advised to the
2 contrary in order to avoid prejudicing other
3 investigations by a public authority or regulator but
4 the reviewers cannot investigate or suggest solutions
5 for any of the above."
6 The first question about this is who is it that is
7 envisaged to advise to the contrary?
8 **A.** That would -- I would interpret that as being
9 in discussion with the client, but I can't --
10 **Q.** One interpretation is that this is the RCPCH
11 review?
12 **A.** Yes.
13 **Q.** The RCPCH has a duty, do you agree, to not
14 prejudice other investigations?
15 **A.** Yes.
16 **Q.** So if a senior person within the review team
17 decides that that is a risk then it might be them who
18 were advising we must stop this?
19 **A.** Yes, yes.
20 **Q.** Were you a senior person within the review
21 team?
22 **A.** Yes.
23 **Q.** Just so that we understand avoid prejudicing
24 other investigations, were these your words "as approved
25 by others"?

1 **A.** Yes.
2 **Q.** So when you wrote those words, did you have in
3 contemplation that if a situation may end up in front of
4 police, they are most unlikely to be grateful to the
5 RCPCH if all of their witnesses have already been
6 interviewed and matters that they want to investigate
7 have been discussed in that context?
8 **A.** When you put it that way, yes, I agree.
9 **Q.** Is that what you had in contemplation when you
10 wrote those words?
11 **A.** I can't say I thought about it that deeply.
12 But yes.
13 **Q.** That is the sense of it at the very least?
14 **A.** Yes, yes, the sense of it.
15 **Q.** If it is not that specific as I have
16 characterised it?
17 **A.** Yes, yes.
18 **Q.** Police perhaps are the most extreme example,
19 although the regulator is also mentioned, that it's
20 a general principle when interacting with formal and
21 serious matters like that that may interfere with
22 a person's ability to do their job in the future,
23 whether they are allowed to, or even their liberty, that
24 it is absolutely imperative that that picture is not in
25 any way muddied or confused by earlier investigations?

1 **A.** I accept that.
2 **Q.** Do you agree with that?
3 **A.** Yes, I agree with that.
4 **Q.** So we can take that down. You produced one
5 final document which is a synopsis of the role of lead
6 reviewer. I am not going to ask for it to come up but
7 just simply to acknowledge that there was guidance but
8 I am sure you can agree that there's nothing that's of
9 particular relevance to the circumstances that we are
10 dealing with within that document?
11 **A.** Correct.
12 **Q.** Now, that's the lead reviewer role. There
13 were other roles as well, a second reviewer; is that
14 right?
15 **A.** Yes.
16 **Q.** A lay reviewer?
17 **A.** Yes.
18 **Q.** A nursing and other clinical reviewer, which
19 is a broader category that may include more than one
20 person?
21 **A.** Yes, that depended on the nature of the
22 service that we were looking at. We would find somebody
23 who had the appropriate skills.
24 **Q.** So in terms of the Countess of Chester who was
25 the lead reviewer please?

1 **A.** David Milligan.
2 **Q.** Who was the second reviewer?
3 **A.** Dr Graham Stewart.
4 **Q.** Who was the lay reviewer?
5 **A.** Claire MacLaughlan.
6 **Q.** Who was the nursing reviewer?
7 **A.** Alex Mancini.
8 **Q.** So what did that leave your role as being?
9 **A.** I was head of Invited Reviews, I was
10 administering the review and being the RCPCH
11 staff representative supporting their team.
12 **Q.** Obviously on the one hand you are the head of
13 the whole department under which this review is taking
14 place, so that presumably is why you agree you were
15 a senior person present in there?
16 **A.** Yes.
17 **Q.** But on the other hand, is it right -- and I am
18 not seeking to diminish the importance of the role --
19 you are providing administrative support, liaison and
20 ensuring that all the logistics are going to work out so
21 that the clinicians can do their part?
22 **A.** Absolutely. They are clinically-led reviews,
23 peer reviews, so they are led by clinicians. My role
24 actually on the review visit was to ensure the process
25 was followed as far as possible and to provide the

1 administrative support, yes.
2 **Q.** Now we have already seen reference to the
3 Terms of Reference for a review and these govern, as the
4 name would suggest, the scope of what is undertaken, is
5 that right?
6 **A.** Yes.
7 **Q.** And we have seen also that the draft Terms of
8 Reference would usually be sent to the clinical lead,
9 that is the process flow diagram that we looked at. In
10 this case, were the draft Terms of Reference provided to
11 the clinical lead for their review?
12 **A.** I cannot recall doing that.
13 **Q.** Have you as part of your preparation uncovered
14 any email, memo or other document which suggests that
15 there was discussion or review by the clinical lead?
16 **A.** Since I left the RCPCH I haven't had access to
17 that information. It's not been provided in the
18 documents.
19 **Q.** Has anybody shown you such a document?
20 **A.** No.
21 **Q.** And acknowledging that you don't have
22 a positive memory, so this question is not an easy one
23 to answer, but is the reality in these circumstances
24 that it's likely that you did not speak to the clinical
25 lead?

1 **A.** I was speaking to the clinical lead regularly.
2 I would have mentioned the review as part of the regular
3 communications.
4 **Q.** But in terms of the formulation of the Terms
5 of Reference, is it likely that you did not speak to the
6 clinical lead about those?
7 **A.** Specifically, no, I don't think I did.
8 **Q.** So we are going to, as you would expect, look
9 at what comes next in three parts, firstly the
10 pre-visit, then the visit?
11 **A.** Yes.
12 **Q.** And then the post visit. But let's just see
13 if we can applying hindsight, and I am inviting you to
14 do that now, knowing what you know now, do you agree
15 with the suggestion that it was entirely inappropriate
16 for the RCPCH to conduct a review in the circumstances
17 that subsisted?
18 **A.** At the time it was appropriate because we were
19 excluding all other possible reasons for the high level
20 of mortality. With hindsight, no there would have been
21 other routes we should have taken.
22 **Q.** So does it follow from that that if you had
23 been fully appraised of all of the facts, as they were
24 known at the time by everybody across the piece, that
25 the review wouldn't have gone ahead?

1 **A.** Yes, that's correct.
2 **Q.** And do you agree that the fact that the review
3 did go ahead gave rise to these risks, and I am
4 stressing risks I am not suggesting that they did or
5 didn't eventuate, but these are risks from the fact that
6 your process went ahead, see if you agree:
7 Firstly, it had the potential to delay other
8 processes, do you agree?
9 **A.** Yes.
10 **Q.** Secondly, it had the potential to provide
11 false reassurance?
12 **A.** Potential, yes.
13 **Q.** And, finally, and I stress this is potential,
14 it was capable of prejudicing other investigations?
15 **A.** With hindsight, yes.
16 **Q.** Pre-visit. First contact came from Ian Harvey
17 to you on 28 June, is that right?
18 **A.** Yes.
19 **Q.** We are going to bring up the email chain we
20 are not in fact going to run through every email but
21 I would like for us to bring it up on screen please
22 INQ0009615. And we will go straight to page 5 because
23 it is a thread so the start of it is at the bottom.
24 And it begins there with Mr Harvey reaching out to
25 you?

1 **A.** Yes.
2 **Q.** And at that stage the issue is formulated in
3 the general terms: where there are concerns?
4 **A.** Yes.
5 **Q.** So that's where the conversation begins?
6 **A.** Yes.
7 **Q.** You then refer him to the website and we get
8 the URL there for I think the Invited Review document
9 that we looked at, although it would be the pre
10 August 2016 version.
11 **A.** Yes.
12 **Q.** And then if we go up the page, to page 4,
13 forgive me, that was an ambiguous statement so the
14 bottom of page 4 we can see that two days after the
15 initial contact, Mr Harvey is saying: "Further to our
16 conversation" and apologising for following up so
17 quickly.
18 And it's that conversation that I want to ask you
19 about so we have just anchored it in time it is between
20 28th and 30th. We can take the email down because you
21 have had a chance to refresh your memory from that
22 beforehand.
23 That conversation did he phone you or did you phone
24 him?
25 **A.** He will have phoned me.

1 **Q.** And in summary, what did he tell you that he
2 wanted the RCPCH to help with?
3 **A.** When I receive phone calls like that I had
4 I would quickly reach for paper to make handwritten
5 notes I did have some forms that I would fill in as
6 I went along. He will have set out the concerns they
7 had.
8 **Q.** Can I just interrupt you there. Did you do
9 that in this case?
10 **A.** I have no record of it. I will have done.
11 **Q.** Yes?
12 **A.** But my handwritten notes will have been lost
13 somewhere.
14 **Q.** I understand. I just wanted to make sure
15 there wasn't a way we could look at a contemporaneous
16 document. I'm so sorry I interrupted you, please could
17 you continue.
18 **A.** That is fine. He will have outlined, as was
19 often the case with a first contact with the Medical
20 Director, what the concerns were from his perspective
21 and seeking for the Royal College to explore whether
22 a review would be appropriate.
23 **Q.** And was that the only telephone conversation
24 you had with Ian Harvey before attending for the review
25 or were there others?

1 **A.** I haven't got records that there were others,
2 but there was certainly a lot of email correspondence.
3 There may well have been phone calls as well.
4 **Q.** The purpose of my question is to really just
5 try and understand that was the extent of what you were
6 told by Mr Harvey contained in those emails, which we
7 believe we have, and just that conversation or might
8 there have been subsequent conversations where you
9 further understood the concerns which existed?
10 **A.** There may have been other conversations but
11 I normally would have made notes of those which would
12 have come through.
13 **Q.** Well, let's deal collectively then with all of
14 the things that you were told that aren't in the emails
15 because we can all read the emails for ourselves.
16 **A.** Yes.
17 **Q.** Whether it's just in that one initial call or
18 over a number of calls, were you told about the fact
19 that there was a rise in neonatal mortality?
20 **A.** Yes.
21 **Q.** Were you told that concerns existed about the
22 association of a member of staff?
23 **A.** Yes.
24 **Q.** And was it made clear to you that those
25 concerns were simply competence or whether they were

1 sufficiently ill-defined to include the possibility of
2 deliberate harm?
3 **A.** The concerns raised were explained as simply
4 the correlation with being on shift at the same time as
5 some of those deaths had occurred.
6 **Q.** And so --
7 **A.** That was all that I was told. That there was
8 a correlation. There was no, no other evidence, nobody
9 witnessing anything. It was simply that paper
10 correlation, so it wasn't given to me as a -- of
11 significant importance.
12 **Q.** But?
13 **A.** It was a piece of context.
14 **Q.** Well, it was a piece of information?
15 **A.** Yes.
16 **Q.** -- that was shared as opposed to kept back?
17 **A.** Yes.
18 **Q.** So it was sufficiently significant to mention
19 to you, that must be inherent?
20 **A.** Yes.
21 **Q.** And association could be one of three things
22 couldn't it; either it could be pure chance, so
23 coincidence; it could be that there was a competence
24 issue and that there was a causative relationship but
25 inadvertent, or it includes, doesn't it, the possibility

1 that there is deliberate harm being caused?
2 **A.** Yes.
3 **Q.** And at the time that you were told that, do
4 you think you recognised that those three possibilities
5 existed within what you were being told?
6 **A.** Obliquely, but the focus was more on focusing
7 on the standards and the practice and finding another
8 reason.
9 **Q.** So I am going to just remind you of something
10 that you said in your witness statement I will read it
11 out, but if you want to turn it up please do. It is
12 paragraph 52, the second sentence you say: "I do not
13 recollect" -- in fact if you want to turn it up rather
14 than listening to me read it out?
15 **A.** I have it.
16 **Q.** You have it:
17 "I do not recollect clearly the context of the
18 fourth term of reference which was to identify any
19 possible common factors linking the recent neonatal
20 deaths. I had been told by Ian Harvey of the suspicions
21 raised by the doctors."
22 **A.** Yes.
23 **Q.** That is how you have framed it in your witness
24 statement.
25 **A.** Yes.

1 **Q.** So does it go a little bit further then than
2 merely the fact that there was a correlation, but that
3 it was the doctors who had identified the correlation
4 and ascribed significance to it?
5 **A.** Yes.
6 **Q.** And the words you use there is "suspicions."
7 Does it follow from that also that by whatever
8 words Mr Harvey is using, what he is communicating to
9 you is the doctors are worried that this may be
10 deliberate?
11 **A.** Yes.
12 **Q.** And so at that moment in time, whether it's
13 shortly after the initial contact or in a subsequent
14 phone call but before you get there, does it follow that
15 you knew that at least some of the doctors were worried
16 that a member of staff was deliberately killing babies?
17 **A.** That phraseology is very powerful.
18 I'm not sure it struck me with that level of depth.
19 I was aware that the doctors had suggested some
20 correlation. But nothing beyond that.
21 **Q.** But it's not a suggestion if it's a suspicion
22 is it, they are different things. One is to observe
23 a state of facts. The other is to ascribe potential
24 meaning to that state of facts and as you framed it in
25 your statement that's what's being as a possibility --

1 **A.** As a possibility.
2 **Q.** In the minds. No one is saying that there is
3 a certainty here but that's --
4 So again you draw attention to the fact I have
5 phrased it very powerfully. But in fact, is that just
6 as a matter of ordinary language based on what you were
7 told in fact what you were being told?
8 **A.** Yes. Yes.
9 **Q.** And bearing in mind that you were told that
10 more than one doctor was suspecting murder, was that not
11 an appropriate moment to say: this is not something that
12 the RCPCH should be coming involved in?
13 **A.** With hindsight that's absolutely what we
14 should have said.
15 **Q.** And did you in fact have enough information at
16 the time reasonably to reach that conclusion yourself?
17 **A.** I don't think so, no.
18 **Q.** Well, why not given what you have agreed you
19 have been told?
20 **A.** I think at the time, my view was that this was
21 being managed by the senior management and our role as
22 part of that was to see if there was another cause
23 another reason to eliminate any other reason so then the
24 management could then proceed with taking those
25 suspicions further.

1 **Q.** If we put it in another way.
2 **A.** Yes.
3 **Q.** And again you will be entitled to observe I am
4 framing it in a particularly powerful way, but if you
5 had been told that doctors were suspecting that a member
6 of staff was sexually assaulting a patient, would that
7 have been sufficient for you to say: the RCPCH shouldn't
8 be getting involved in an investigation that engages
9 with that?
10 **A.** Yes, yes.
11 **Q.** And so what is the material difference, if
12 any, between murder and sexual assault in this context?
13 **A.** I absolutely accept that point. Looking at it
14 now yes, we should not have proceeded. We should have
15 gone back and said no this is not for us, explore those
16 allegations further.
17 **Q.** You don't think that you spoke to the clinical
18 adviser about the scope of this review in terms of the
19 Terms of Reference?
20 **A.** Correct.
21 **Q.** Do you agree that if you had had such
22 a discussion that would have provided an opportunity to
23 recognise the problem with what you were being asked to
24 engage with?
25 **A.** Yes.

1 **Q.** Why do you think it was that you didn't speak
2 to the clinical adviser about the Terms of Reference and
3 how they were framed and what you were being asked to
4 do?
5 **A.** From my recollection at the time, the Invited
6 Review service was particularly busy. We were doing, we
7 were receiving a large number of requests for reviews.
8 There were two of us, plus an additional supporting
9 member of staff and trying to keep up with the numbers
10 of enquiries and deal with them effectively was
11 challenging and that may have been why some of these
12 formal procedures weren't fully followed.
13 **Q.** If I, seeking to assist you, remind you about
14 something that you said in your witness statement, in
15 relation to the discussions you had in person, with the
16 Senior Management Team?
17 **A.** Yes.
18 **Q.** We will get to those discussions in a moment
19 but what you said was that the concerns were played down
20 by the senior team?
21 **A.** Yes.
22 **Q.** That is how you framed the way in which they
23 were talking about the doctors' concerns?
24 **A.** Yes.
25 **Q.** You don't make any comment in your witness

1 statement about the way that they were presented to you
2 in the initial phone call. I want to give you the
3 opportunity, if you have a sufficiently clear
4 recollection, to comment upon whether the framing of the
5 issue may have impacted upon you?
6 **A.** Yes, it did. In my recollection at the time
7 it is difficult with the benefit of hindsight, was that
8 it was almost a passing remark that the doctors have
9 noticed that a member of staff was always there.
10 But it was not intimated to me that that was
11 a serious allegation taken seriously by the Medical
12 Director. That's my inference at the time.
13 **Q.** Yes. Well, did you ever think that the
14 Medical Director, Mr Ian Harvey, thought it was
15 a serious allegation, to use your phrase?
16 **A.** I think if he had thought it was a serious
17 allegation he would have called the police sooner.
18 **Q.** Did you ever think that Alison Kelly who you
19 also spoke to thought it was a serious allegation?
20 **A.** She was particularly supportive of Lucy Letby
21 and in my recollection quite dismissive of the
22 allegation.
23 **Q.** The third member of the senior management team
24 that you spoke to on the last day was Mr Chambers, the
25 Chief Executive?

1 **A.** (Nods)
2 **Q.** Did you ever think that in the course of that
3 conversation that Mr Chambers thought it was a serious
4 allegation?
5 **A.** My recollection of that conversation is not so
6 strong but there appeared to be consistent response from
7 the management team, that it was something the doctors
8 were raising but not something they were taking
9 particularly seriously in terms of evidence beyond that
10 correlation of the -- of the rotas.
11 **Q.** We are going to have a look at the briefing
12 and data collection sheet as it's referred, INQ0009590.
13 **A.** Yes.
14 **Q.** It's only one part that we need to turn up
15 which is the first page. It is in bold.
16 **A.** Yes.
17 **Q.** Now, it is dated 27 June 2016 but in fact
18 Mr Harvey didn't contact you until the 28th?
19 **A.** (Nods)
20 **Q.** How contemporaneous to any conversation you
21 had with him was this document?
22 **A.** So this was a template. Most of the reviews
23 were done by templates because it was a systematic way
24 to carry them out. So after the conversation with
25 Ian Harvey, I will have reached for this form online and

1 started completing it because this was the basis of my
2 preparing proposal documents and establishing the
3 review.
4 So I started the document. The way I completed it
5 was researching around the organisation to bring in as
6 much information as I could. This is a very early
7 draft. That piece in bold, the key issue, is the nub of
8 the review. The rest was information -- was either
9 guidance as to what to look for in case members of my
10 team were completing it or it was information that
11 I found from the internet.
12 **Q.** "Key issue".
13 **A.** "Key issue".
14 **Q.** "Outlier for neonatal deaths over the last 12
15 to 18 months, done a thematic review and nothing
16 highlighted -- no pattern. Neonatologists say they were
17 not expected although some might have been."
18 No pattern.
19 **A.** Mmm.
20 **Q.** If it's right that you were told in this
21 call -- and I appreciate your evidence doesn't go that
22 far, it was at some point, but it may have been this
23 call, but if it was this call that Ian Harvey told you
24 that the doctors were suspicious because of the
25 association, that those two words "no pattern" would

1 have absolutely no place in this document; do you agree?
2 **A.** So I am not quite sure I understand the
3 question.
4 **Q.** If Mr Harvey told you that an association with
5 a member of staff had been noted, before you filled this
6 inn --
7 **A.** That would have been a pattern.
8 **Q.** -- that would have been a pattern?
9 **A.** Yes.
10 **Q.** In which case saying that there is no pattern
11 would not be appropriate?
12 **A.** Correct.
13 **Q.** I'm sorry that I didn't frame that as clearly
14 as you have just helped me to.
15 So does that help at all with the question of
16 whether or not in that call Mr Harvey told you about
17 this in that first call?
18 **A.** It helps enormously. I cannot recollect when
19 I found out about the allegations, concerns from the
20 doctors. This does indicate that I wasn't told in that
21 initial call.
22 **Q.** Well, arguably it indicates that you were told
23 the contrary. Again, this is based upon --
24 **A.** (Nods)
25 **Q.** -- I accept an incomplete recollection on your

1 part and Mr Harvey will have an opportunity to give his
2 evidence about it. But a number of possibilities. If
3 he did tell you that, you have written something that
4 you shouldn't have written, do you agree?
5 **A.** Yes. If -- if he had told me, I would have
6 recorded that.
7 **Q.** So from your point of view, you would not have
8 written that if he had told you about it?
9 **A.** Correct.
10 **Q.** The proposal for the Terms of Reference was
11 sent by you on 30 June.
12 **A.** Yes.
13 **Q.** So when he sought to chase you following the
14 conversation and in that, and we will bring it up,
15 INQ0009595, page 2, you reflect back, in paragraph 3,
16 the problem.
17 **A.** Yes.
18 **Q.** "In recent months the unit management team
19 have been concerned the neonatal service appears to be
20 an adverse outlier. The individual cases have been
21 examined by the Coroner and expert from the network
22 about there appears to be neither evidence link nor
23 specific cause which could account for this level of
24 mortality."
25 Now, this is on the 30th so it follows your call?

1 **A.** (Nods)
2 **Q.** You appear to be asserting in terms that it's
3 your understanding that there is no evidence link, nor
4 specific cause.
5 **A.** Yes.
6 **Q.** Now, I appreciate that whenever it was that
7 Mr Harvey told you he did so in passing, I think was
8 your phrase, but that would render this misleading,
9 wouldn't it? To talk in those concrete terms where --
10 if you did know?
11 **A.** Yes, I cannot recall at what point I knew
12 about the allegations.
13 **Q.** If we go to pages 3 and 4, so we will start at
14 page 3, section 3, we don't need to look at the detail
15 of it. But we can see it starts with "What the RCPCH's
16 Invited Review service is"?
17 **A.** Mm-hm.
18 **Q.** Now, you can you should correct me if I am
19 wrong about this, but as we turn over the page, and we
20 are not going to read every line of it but you will be
21 familiar with it, nowhere does it say what the service
22 cannot do and shouldn't do; do you agree?
23 **A.** Yes.
24 **Q.** So those caveats that we see in that publicly
25 available document haven't made their way into this to

1 make it clear to the client, in the letter, this is what
2 we can't do?
3 **A.** Yes. I --
4 **Q.** And do you think -- I'm sorry?
5 **A.** My recollection is that I would refer to the
6 Guide to Invited Review somewhere within that proposal
7 and the Guide to Invited Review does have those caveats.
8 **Q.** But all of that is a secondary step for
9 somebody who needs to chase it down?
10 **A.** Yes.
11 **Q.** But it is a pretty important part of what you
12 do to be clear what you don't do, isn't it?
13 **A.** Yes, yes.
14 **Q.** Do you agree that that is of sufficient
15 importance to make it into a letter, so that the
16 parameters are absolutely clear in a single place that
17 you would expect the client to read carefully?
18 **A.** Yes.
19 **Q.** Again, just why do you think that those
20 caveats aren't in here?
21 **A.** We were developing -- we were continuing to
22 develop the service. We had not come across a situation
23 where those caveats had been imposed during this
24 process. Following that, they would have gone in there
25 as we learned and developed the templates.

1 **Q.** Now, you have no doubt followed that -- and
2 I am characterising it I hope fairly and accurately --
3 that the senior Executives appear to have derived some
4 reassurance -- they certainly say they provide, receive
5 reassurance -- from the RCPCH report?
6 **A.** (Nods)
7 **Q.** Knowing that now, do you agree that it's
8 essential that the client is told in writing at the
9 start what the report cannot be used for or understood
10 and what won't be investigated?
11 **A.** Yes.
12 **Q.** If we look at the bottom of the page:
13 "The concerns outlined in the client brief are not
14 uncommon and the RCPCH proposes the following approach
15 to this review ..."
16 Now, again, if you had been told by the time you
17 sent this letter about the doctors' suspicions, that
18 sentence really shouldn't have been there, do you agree?
19 **A.** That sentence was an error. The concerns
20 outlined were uncommon, that is a standard part from the
21 template which I had failed to remove.
22 **Q.** Again having sat on a board yourself and
23 understanding how these things work --
24 **A.** Yes.
25 **Q.** -- it is not beyond comprehension that

1 a letter like this will end up in front of people who
2 sit on the board and give them reassurance; is that
3 fair?
4 **A.** Yes.
5 **Q.** So when assessing the significance of that
6 error and the fact that a template was used and not
7 altered, do you agree it had the potential at least to
8 give false reassurance to anybody outside of the
9 conversation that you were having with Ian Harvey about
10 the nature of the problem?
11 **A.** Again with hindsight, yes, it did have that
12 potential.
13 **Q.** Page 5, section 5, we have the start of the
14 draft Terms of Reference and we can move through them,
15 we don't need to look at the detail of them, but bullet
16 point 1 at the very bottom of the page, is that
17 a standard Term of Reference?
18 **A.** Yes.
19 **Q.** Over the page, please. Is that second bullet
20 point a standard Terms of Reference?
21 **A.** Yes.
22 **Q.** The third bullet point, is that also
23 a standard Term of Reference?
24 **A.** In essence, yes. These Terms of Reference
25 will have been specifically designed for this review but

1 that those were the issues that we would generally cover
2 yes.
3 **Q.** I am sure it didn't formalise into a pick
4 list, which is a phrase we have heard?
5 **A.** No.
6 **Q.** But there will be certain forms of words that
7 you regularly import, bespoke to the situation, and
8 that's when I say standard is what I am meaning, these
9 are ones that if we look through all of the letters that
10 you sent out during this period, we would see those time
11 and time again?
12 **A.** Similar, yes.
13 **Q.** Yes. The final one, and we will come back to
14 the penultimate one, "Are there areas of concerns of
15 potential development?" Is that also a standard term of
16 reference?
17 **A.** The gist of it, yes, we did tend to keep the
18 Terms of Reference fairly fluid because when there were
19 concerns about a unit, sometimes the review team would
20 visit and discover things that perhaps hadn't been
21 articulated by the client at the time.
22 **Q.** Yes.
23 **A.** It gave us some scope to explore other areas
24 if we came across them.
25 **Q.** It is a catch-all to give you flexibility?

1 **A.** To some extent, yes.
2 **Q.** So then we come to the fourth one: was that
3 entirely bespoke for the situation that you were
4 presented with?
5 **A.** Yes. I think it would have been.
6 **Q.** So bearing in mind that we have gone through
7 some standard ones and nothing may turn on it, but if
8 that's the bespoke one, why isn't that one first?
9 **A.** Because the way we had approached it was as
10 a service review looking at the whole service. But the
11 trigger for that was that rise in neonatal deaths,
12 I don't know why it wasn't first.
13 **Q.** Now, when you wrote that --
14 **A.** Yes.
15 **Q.** -- made that proposal, did you know about the
16 doctors' suspicions?
17 **A.** I really cannot recall.
18 **Q.** So you might have but you might not have?
19 **A.** Yes.
20 **Q.** Let's consider the circumstances that you did
21 know. If it be right that you did know, do you agree
22 that that could be read as suggesting that that is
23 something that you are going to investigate?
24 **A.** It could be read that way, yes.
25 **Q.** Because if you did know, then if it wasn't

1 something you were going to investigate but would
2 otherwise be caught by the language, you might indicate
3 "other than" or put an exception or an asterisk or some
4 caveat to it to say: we are not investigating that?
5 **A.** Yes, because we wouldn't investigate that.
6 **Q.** Exactly so.
7 **A.** Yes.
8 **Q.** But as the Royal College, you are best placed
9 to know what you do and don't investigate?
10 **A.** Yes.
11 **Q.** When Mr Harvey, whenever it was, mentioned in
12 the way that he did the suspicions of the doctors, did
13 you say to him: "we can't look into that"?
14 **A.** No.
15 **Q.** Should you have said that to him?
16 **A.** With hindsight, yes.
17 **Q.** Well, again you have caveated "with
18 hindsight".
19 **A.** Sorry we, we -- in my view we weren't looking
20 into those particular allegations. We were looking at
21 everything else.
22 **Q.** But he's told you about the allegations. You
23 haven't said: we are not going to look into them and
24 then you have proposed a term of reference which is
25 capable of including them.

1 **A.** Yes.
2 **Q.** So does it need hindsight or does it just
3 need: actually I had enough pieces of information at the
4 time to know that I needed to make it absolutely clear
5 in writing what we were not looking into?
6 **A.** I think that is the situation. I think we
7 were in a pressured environment. Had I had the time to
8 sit back, reflect, discuss with people it may have been
9 different.
10 **Q.** Now, we can take that down, thank you very
11 much indeed. We are going to -- Mr Harvey comes back
12 with a counterproposal, 7 July. INQ0009615, page 3. If
13 we -- I do beg your pardon, bear with me a moment,
14 please. Forgive me, my mistake.
15 INQ0010256, this is the email that he sent, in
16 fact, but the actual draft Terms of Reference I think
17 should appear against the INQ I have just given. Yes.
18 Now, to all intents and purposes, the four standard
19 ones, 1, 2, 3 and 5, appear as they were; do you agree?
20 **A.** Yes.
21 **Q.** But the one bespoke one at number 4, he's come
22 back and he's said this:
23 "To consider concerns about the neonatal unit with
24 specific reference to: are there any identifiable common
25 factors or failings that might in part or in whole

1 explain the apparent increase in mortality in 2015 and
2 2016?"
3 Now, in your witness statement I think you say that
4 you didn't think this made any difference to the
5 meaning?
6 **A.** Correct.
7 **Q.** Did you wonder to yourself, if it didn't make
8 any difference to the meaning, why it was that Mr Harvey
9 had apparently gone to the trouble of redrafting it?
10 **A.** I can't say that went through my mind.
11 **Q.** Again, just thinking about it, do you think
12 that if a client adds in some more words, uses words
13 like "specifically" and so on, that that was -- at the
14 time wasn't a trigger for you to say: well, I had
15 probably better speak to the client about why he's doing
16 that and whether we both understand each other?
17 **A.** Yes, it should have been.
18 **Q.** You see because if we have a look at the
19 changes that are made, common factors or failings: now,
20 a failing is always capable of being a factor, I mean
21 that's a tautology in one way.
22 **A.** Yes.
23 **Q.** But one thing that murder will never be is
24 a failing.
25 **A.** Yes.

1 **Q.** So that appears to be directing attention at
2 things which might not be murder; do you agree?
3 **A.** I am not quite sure I follow about the -- your
4 previous comment but that --
5 **Q.** Well, we can see that he's added "in part or
6 in whole", so in other words recognising the possibility
7 that there may not be a single explanation for the
8 increase?
9 **A.** From my recollection how I may have taken that
10 would be: have the staffing levels decreased? Are they
11 accepting infants that are very early in gestation that
12 should have been at a more senior unit? Is the
13 transport service not picking them up quick enough?
14 There are many other factors that could have led to rise
15 in mortality over that period of time.
16 So whilst we know now that that was what was being
17 implied, in my mind there were a number of other things
18 that we could have been looking at.
19 As I recall, that section wasn't specifically
20 focusing on: was there a nurse involved? That wasn't in
21 my mind at the time. That was a piece of background
22 information. My understanding when this was being
23 discussed was that there may have been a whole range of
24 other factors, including practice by -- you know,
25 including clinical practice, including transport,

1 including gestation, including environment, a range of
2 things.
3 **Q.** The final addition is the insertion of the
4 word "apparent". Now --
5 **A.** Yes.
6 **Q.** -- that's capable of having an insidious
7 effect in the sense that it is capable of being read as
8 suggesting that there may not have been an increase in
9 mortality. I mean, that is how it operates in the
10 sentence?
11 **A.** Yes.
12 **Q.** Did you notice that at the time? Do you know
13 why the increase in mortality had become the "apparent"
14 increase in mortality?
15 **A.** I can't say I picked that up. No. I mean
16 there are fluctuations in mortality. Numbers are
17 usually quite small. There can be fluctuations, they
18 are whole numbers, but I didn't pick that up in the
19 sense that you are implying at the moment.
20 **Q.** We can take that down. We just pause at this
21 moment. The Terms of Reference, you adopted the revised
22 wording telling us as you do that in fact you didn't
23 think it really changed anything.
24 What the Royal College has said in their corporate
25 statement is:

1 "The time period for developing the proposal and
2 Terms of Reference for the review was unusually short as
3 it normally takes a number of weeks to draft a proposal
4 and there is often correspondence between the
5 commissioning organisation and the RCPCH to agree the
6 Terms of Reference."
7 Is that a fair observation?
8 **A.** It wasn't -- it wouldn't take that long.
9 Normally we would put a proposal together within --
10 probably within a week, 10 days. At that time that's
11 how the process was working. So it was fairly swift
12 because most of the enquiries we had for reviews were
13 quite straightforward.
14 **Q.** There is the suggestion that I would just like
15 you to consider and comment upon in light of the
16 evidence that we have just been through. If we take
17 a step back. It might be suggested that this has the
18 hallmarks of being rushed and there is insufficient care
19 and let me give you the factors for you to consider.
20 You have told us about the fact that you were under an
21 enormous amount of pressure at the time?
22 **A.** Yes.
23 **Q.** Which is a situation in which such things can
24 occur.
25 You have told us that the expected process of

1 consultation about the Terms of Reference with the
2 clinical lead as a result of that didn't occur?
3 **A.** (Nods)
4 **Q.** We have got the possibility of
5 a misunderstanding, the possibility we will see whether
6 it's right or not in due course, or a mismatch.
7 We have got no record by you in any of the
8 documents we have looked at that you have been told
9 about the suspicions and we have got standard wording
10 that shouldn't have gone in the letter that made it
11 through.
12 So those are all potential indicators that
13 insufficient care has been taken over the process.
14 I would like to give you an opportunity to comment upon
15 that, please.
16 **A.** I hear those comments. I -- with reflection
17 back, it was a very busy time. I was perhaps over
18 confident in terms of putting reviews together and
19 focusing on that. There was a gap between me saying to
20 Ian Harvey the proposal will come out and me sending it
21 to him and I will have sought agreement to that proposal
22 from it will have been from then the Director of Finance
23 to check the -- the costing put on it for sure.
24 I accept some of those comments, that it was
25 rushed. There was not the level of care that I would

1 normally have put into a proposal.
2 **Q.** You then assembled a team.
3 **A.** Yes.
4 **Q.** There was a pre-visit meeting by telephone; is
5 that right?
6 **A.** Yes.
7 **Q.** Do you have any recollection of that pre-visit
8 meeting over the telephone?
9 **A.** Normally we would try to have a pre-visit
10 meeting if we could. Back at that time, people didn't
11 do online teleconferences. We would have telephone
12 conferences which were quite difficult to manage.
13 I think we had one for that we normally had something
14 a few days before. We certainly would make sure that
15 the review team met the night before the review.
16 **Q.** We will come to that.
17 **A.** Yes.
18 **Q.** If there was a telephone meeting, do you have
19 any recollection of telling the team about the
20 suspicions of the doctors?
21 **A.** I don't have that recollection.
22 **Q.** Do you think that's because you didn't tell
23 them?
24 **A.** Yes. It could be.
25 **Q.** If it be right that at the time of that

1 conversation you knew that from Mr Harvey, is that
2 something you should have told them?
3 **A.** Yes.
4 **Q.** Do you agree that that would have been
5 an opportunity before you had made the commitment of
6 time and effort and everybody turning up and starting
7 the process, it would have been an opportunity as a team
8 to realise that this was not an appropriate course for
9 you to continue upon?
10 **A.** Yes, it would have been that opportunity.
11 **Q.** Email from Mr Milligan. 26 August, we are now
12 closing with the visit. INQ0012748, page 3. This is in
13 a chronology you have prepared. I don't think we have
14 the original email, but we have got the text of it
15 thanks to your chronology so we will just have a look at
16 that now.
17 We can see right in the middle of the page:
18 "I have had a look at most of the documentation but
19 not yet all the individual baby files and we have much
20 of the workload data I was looking for plus a more
21 in-depth analysis of what happened with the indexed
22 cases. But a number of questions arise from that, not
23 least that one individual appears to have been present
24 for all but one of them."
25 Was that an email that you received from your lead

1 reviewer?
2 **A.** Yes. That may have gone to the whole team, or
3 it may have come just to me.
4 **Q.** Now, what, by 26 August, did you know about
5 the suspicions of the doctors?
6 **A.** I think I will have done, yes.
7 **Q.** Put it another way, did Mr Harvey tell you it
8 in the days before? If not then you must have known?
9 **A.** Yes, I knew.
10 **Q.** So as far as you are concerned, do you agree
11 that email has a potentially greater significance for
12 you than anybody who didn't know?
13 **A.** Yes.
14 **Q.** One aspect of the significance is that from
15 a completely independent, cold start your lead reviewer
16 has identified the very basis of the suspicions of the
17 doctors in the hospital; is that fair?
18 **A.** Yes.
19 **Q.** Did that strike you at the time as being
20 a concerning thing?
21 **A.** I'm not sure I reflected fully on it at the
22 time as I was preparing for the review. But yes, it
23 should have done.
24 **Q.** It should have done.
25 Now, we are going to have a look at the documents

1 and I think Mr Milligan may have got early access to the
2 documents because he's sending that email on the 26th.
3 If we have a look at your email of 30 August,
4 INQ0012846. This is the email where you provide access
5 to the wider team for the documents. So --
6 **A.** They will have had access before that normally
7 about at least a week beforehand.
8 **Q.** They would have had access?
9 **A.** 12 August.
10 **Q.** I am so sorry that is my -- my mistake,
11 I don't know how I have made that, it is probably
12 because I read the top email but that is entirely my
13 error.
14 So 12 August, so before Dr Milligan's email.
15 We can see as you introduce the team to this you
16 say this: "Rather an enthusiastic set so, please don't
17 be dismayed." Is enthusiastic a euphemism for they have
18 given us quite a lot?
19 **A.** A huge amount of documents, yes.
20 **Q.** A huge amount and are you judging that huge
21 amount of documents in the context of your wider
22 experience of what you usually get from hospitals?
23 **A.** Yes. Reviewers are clinicians full time.
24 They don't have a lot of time to spend on the review.
25 I write to the client organisation with a fairly

1 detailed list of the information that we would like to
2 receive and instructions to tailor it as far as
3 possible. Many organisations just put everything on the
4 list, so it was harder to process it to make it more
5 focused for the reviewers.
6 **Q.** What you do draw out for the team is in the
7 third paragraph: "Key things to look at are probably the
8 mortality reviews and there are some concerns coming out
9 over transport service."?
10 **A.** Yes.
11 **Q.** "Please keep the Terms of Reference in mind"?
12 **A.** Yes.
13 **Q.** Now we have already looked at the Terms of
14 Reference and I have invited you to consider it from the
15 point of view of the client. Your team at this stage
16 don't know anything about Mr Harvey's concerns, I think
17 that's right?
18 **A.** Yes.
19 **Q.** The Terms of Reference don't in themselves
20 exclude the investigation of the doctors' suspicions, do
21 they? We have looked at that.
22 **A.** (Nods).
23 **Q.** And so can you see that there's also a problem
24 so far as your team is concerned about the lack of
25 clarity in what this review was and wasn't supposed to

1 be engaging in?
2 **A.** Yes. The review was to look and to see if
3 there was anything else affecting the mortality.
4 **Q.** Well, in fact, the chronology might make a bit
5 more sense now that I have got my dates right because
6 having you drawn attention to the reviews and the Terms
7 of Reference, it would appear that your colleague
8 Dr Milligan immediately looks at the mortality review
9 and spots that Letby is associated with nine out of the
10 10 deaths?
11 **A.** That was a specific document which the doctors
12 had put together.
13 **Q.** Yes?
14 **A.** And submitted, yes.
15 **Q.** But to your mind, that's not what your review
16 is there to do?
17 **A.** Yes.
18 **Q.** And yet, Mr Milligan, reading the Terms of
19 Reference, no doubt as you have encouraged him to,
20 reading the thematic review as you have encouraged him
21 to do, that is where his mind immediately goes?
22 **A.** When he saw that document prepared by the
23 doctors, yes.
24 **Q.** Yes so if we just circle back to that document
25 having set the groundwork here, quite aside from whether

1 the significance of what he said should have had
2 a greater impact upon you, do you think that was also
3 an opportunity for you to say to Dr Milligan: "We need
4 to be very clear we are not here to do that. That's the
5 one thing we are not looking at."?
6 **A.** Yes.
7 **Q.** Let's have a look at the documents briefly in
8 list form. INQ0012847. Now this is a 13-page document
9 although in fact only the first 12 are really populated
10 just one line on the 13th page, which sets out in
11 a structured way the documents that you have received
12 and there is a review process, I think it's somebody
13 providing administrative support "MA" in your unit.
14 **A.** Yes.
15 **Q.** Has had a look at them. And we can see that
16 there are a large number of staffing rotas?
17 **A.** Yes.
18 **Q.** Was it usual for clients to be sending you
19 staffing rotas to this degree?
20 **A.** That was the standard that we asked for.
21 **Q.** That was a standard thing?
22 **A.** One of the other documents in the pack is the
23 letter that we sent to Ian Harvey saying this is how to
24 prepare for the review and there is a list within that
25 of the kind of documents that we requested. So this was

1 not inappropriate to receive that.
2 **Q.** So this isn't the extra material that you were
3 talking about when describing them as enthusiastic. You
4 had asked for this and you got it?
5 **A.** We had asked for it. There was
6 a comprehensive set sent to us yes.
7 **Q.** Page 4, please. We see a document entitled
8 "Mortality review February 2016."
9 And a little bit of detail around it, "Mortality
10 review draws out themes around night cover delayed
11 clamping" and then it says this: "Six out of nine review
12 cases had arrests between midnight and 4 am and an area
13 to probe filled in blue explore night cover."
14 Now, that very amply fits the description of the
15 thematic review of neonatal mortality completed by Dr
16 Brearey in February because that is one of his
17 conclusions.
18 **A.** Yes.
19 **Q.** Was that a document that you read?
20 **A.** I'm not sure if I read that in detail because
21 Melissa was doing the reviewing. She highlighted it
22 yes, so I will have read it at some point.
23 **Q.** At the time that you read it did you have in
24 mind Dr Milligan's comments, in other words was that
25 after he had sent you the email drawing attention to the

1 commonality of a particular member of staff, or was it
2 before or can you not say?
3 **A.** I don't recollect correlating those two, no.
4 **Q.** And in terms of the "Six out of nine review
5 cases had arrests explore night cover", if we jump right
6 to the end and the report you produced, did the RCPCH
7 find any explanation for why six out of the nine deaths
8 occurred in those four hours?
9 **A.** No.
10 **Q.** So that was a question going into it?
11 **A.** (Nods).
12 **Q.** And one which was not answered at the end?
13 **A.** Correct.
14 **Q.** Now there is one other document which has
15 attracted some significance I am just going to bring it
16 up briefly, INQ0010072 and just help us to the degree
17 that you can.
18 This is not the thematic review. This is instead
19 a technology fail which I hope will be... Yes. It may
20 be there is a difficulty showing this. There we are.
21 Thank you very much indeed for that.
22 Is this a document that you believe was within the
23 pack?
24 **A.** I don't recall seeing it.
25 **Q.** No well if it helps you, Ms MacLaughlan has

1 pointed to the fact that this document doesn't appear on
2 the list so far as she can tell and so you wouldn't have
3 any reason to say positively you think that was
4 included?
5 **A.** Mmm.
6 **Q.** So we can take that down. The final event
7 before the visit begins is the night before in the
8 hotel.
9 **A.** Yes.
10 **Q.** By this stage, there can be no doubt but that
11 you knew about Mr Harvey's concerns.
12 **A.** Yes.
13 **Q.** Did you tell any of the team then?
14 **A.** I don't know from looking at previous notes.
15 Possibly not.
16 **Q.** I mean, if, if they say we were not told --
17 **A.** Then I didn't tell them.
18 **Q.** Would you have any basis to say that they are
19 wrong about that?
20 **A.** I think they would be correct then they
21 weren't told.
22 **Q.** Again do you agree that was another
23 opportunity for as a group to discuss this now in light
24 of what Dr Milligan has pointed out so you have got
25 another piece of information and say: we must stop?

1 **A.** Absolutely, it was an opportunity to discuss
2 it, yes.
3 **Q.** Yes, and did it present an opportunity to say:
4 stop?
5 **A.** It could have done. My recollection is at the
6 time perhaps it was so, so, so very unlikely that it
7 wasn't high on my radar as being an issue because it was
8 so unthinkable.
9 **Q.** But that of course is an explanation for why
10 you didn't mention it. But if you had mentioned it,
11 it's possible it would have had a greater significance
12 to one of the people that you were mentioning it to and
13 of course we know that Dr Milligan had done his own
14 analysis and it is possible, can't be known, that he
15 would have said "That is exactly what I spotted and it
16 seems like there can't be something in it." We can't
17 know?
18 **A.** I don't know why I didn't mention it. I do
19 not know.
20 **Q.** No. Now, we come to the visit. There are
21 notes about all of this and we have two other witnesses
22 coming to deal with it, so you will forgive me if
23 I don't go through every line of every one. Many of
24 them speak for themselves. The first meeting that you
25 had was with Alison Kelly and Ian Harvey?

1 **A.** Yes.
2 **Q.** That's right and Dr Milligan is recorded as
3 saying we may not be able to explore the details of the
4 deaths not doing a Casenote Review."?
5 **A.** (Nods).
6 **Q.** Was that in the context of a discussion about
7 the Consultants' suspicions?
8 **A.** I would need to see my notes but yes, I wrote
9 notes pretty much verbatim handwritten notes, probably
10 quite hard to read, but they are pretty much verbatim
11 what was said, so --
12 **Q.** We know -- sorry.
13 **A.** Depending at what point Ian Harvey mentioned
14 it would be around the Casenote Review so I suspect it
15 would be -- I haven't got it in front of me -- that it
16 was raised by Ian Harvey and then David Milligan would
17 have said we are not doing a Casenote Review because we
18 never were. That was never the situation.
19 **Q.** So far as you can remember, I appreciate there
20 are notes, but impression is important here. When
21 Dr Milligan said we may not be able to explore the
22 details of the deaths", did that strike you as being
23 a surprise to Ian Harvey or Alison Kelly? Something
24 that they were comfortable with, something that they
25 were uncomfortable with? So far as you can remember did

1 they have any appreciable reaction to being told the
2 detail of the deaths would not be explored?
3 **A.** It had always been my assumption that we
4 wouldn't be doing a detailed Casenote Review so I didn't
5 note any particular reaction. We were there to do
6 a service review not a Casenote Review.
7 **Q.** And so does it follow that what didn't happen
8 at that point is them saying well, "I thought that is
9 what you were here to give us reassurance about" -- no
10 conversation like that?
11 **A.** I don't remember it as clear as that, no.
12 **Q.** One of the notes that you made attributed to
13 Ian Harvey, is he stated he having talked about the
14 correlation of one nurse, so it's in that context,
15 wanted to think the worst but nothing else is pointing
16 to it.
17 Do you remember that phrase. It is one that you
18 specifically mention in your witness statement?
19 **A.** Yes, yes.
20 **Q.** I just wanted to try and understand just what
21 you thought he was meaning by "wanted to think the
22 worst". Who wanted to think the worst?
23 **A.** It's an unusual phrase to use. I would
24 suspect that there was that correlation of being on
25 shift. But nobody saw anything happening. It was only

1 simply that they had been on shift, which -- and without
2 any other evidence apart from being on shift and
3 everybody else thinking that she was such a good nurse
4 and always available, and very competent. He was
5 expressing his dilemma about the only correlation he had
6 was being on shift.
7 Nobody appeared to have seen anything, nobody
8 appeared to have any other suspicions about practice.
9 Things that came out later obviously.
10 **Q.** Generally speaking the idiom is that people
11 want to think the best, but?
12 **A.** Yes I don't know why.
13 **Q.** But your note is "wanted to think the worst"?
14 **A.** I know.
15 **Q.** And that is why I am just -- I mean, was he
16 saying that he wanted to think the worst or was he
17 saying that somebody else wanted to think the worst?
18 **A.** I -- I can't answer that one.
19 **Q.** You also record that Ian Harvey asserted he
20 had been through all evidence. Was it your
21 understanding that he conducted his own review of all of
22 the information?
23 **A.** I inferred from that that he had, he had
24 explored it in some detail, yes.
25 **Q.** You also record and I will just read it out

1 for you: "Ian Harvey then mentioned that he had to
2 intervene with a neonatal lead as the junior doctors had
3 been referring to Letby as nurse of death with ripples
4 through the team. He could not see how to conclude
5 without calling the police. He stated that unless there
6 is something to satisfy the medical staff from this
7 review then they will call the police."
8 The phrase "Unless there is something to satisfy",
9 could be thought to be quite a loaded one "Unless this
10 happens, this result will occur."
11 I mean is that how you took it at the time or was
12 it just an ordinary conversation?
13 **A.** I took that to mean unless the review can find
14 some other reason for the deaths, then the doctors then
15 we would call the police.
16 **Q.** Did the review find some other reason for the
17 deaths?
18 **A.** No.
19 **Q.** And, bearing in mind that you knew that that
20 was the doctors' mind that if your review didn't find
21 anything to explain it, should you not have been
22 thinking well, it's really important that we get the
23 police involved at this stage?
24 **A.** I think because of that conversation we felt
25 we were on site, it wouldn't -- we felt we can spend

1 two days to see if there's anything else and if there
2 isn't, then we had the assumption that the management
3 team would call the police because they would have the
4 information to do so.
5 **Q.** So understanding that reasoning.
6 You are envisaging one of two things happening?
7 **A.** Yes.
8 **Q.** (1) that the review will find an explanation,
9 no need for the police, or (2) the review won't find
10 an explanation, the police will become involved. Is
11 that --
12 **A.** Yes, yes, at that time that was my inference.
13 **Q.** Well bearing in mind what you have told us
14 about the risk of prejudicing police investigations, was
15 that the right way to be thinking about it?
16 **A.** We did discuss that as a review team. We were
17 on site with interviews lined up. We were aware of the
18 issues. We agreed, at that time, that we would continue
19 with the review bearing in mind that we were, we would
20 not compromise any subsequent Inquiry.
21 **Q.** Because the thing that came out of that
22 meeting was that Letby was added to the list?
23 **A.** Yes.
24 **Q.** And so you were leaning into the allegations
25 rather than staying away from them, weren't you?

1 **A.** We did discuss that in some detail as a team
2 and members of the team felt it was very important to
3 interview her and collectively as a team we agreed that
4 that would go ahead.
5 **Q.** More important than the risk of prejudicing
6 any police investigation?
7 **A.** As a team we discussed that and at the time
8 considered that proceeding with the interview in
9 a limited way would not be unhelpful. That was our view
10 of the team at the time.
11 **Q.** I will just circle back to my question where
12 we started this?
13 **A.** Yes.
14 **Q.** Was that the wrong way of thinking about it?
15 **A.** It may well have been, yes.
16 **Q.** Did in their first discussion with you,
17 Alison Kelly or Ian Harvey, tell you that the pattern of
18 deaths had changed when Letby was moved only to day
19 shifts?
20 **A.** Yes.
21 **Q.** They told you that?
22 **A.** It was very early.
23 **Q.** Yes.
24 **A.** Early days they didn't have full information
25 we knew that she had been taken from clinical duties but

1 it had only been a month or two.
2 **Q.** So we are moving now from a position, do you
3 agree, of just an association because there is
4 an additional factor which is you know the thematic
5 review has said an unusually high number of proportion,
6 that is the implication, are happening at night and you
7 know she is taken off nights and you know that the
8 pattern has changed. That is what you are telling us
9 you have been told?
10 **A.** Sorry, is this the pattern moving from nights
11 to days?
12 **Q.** Yes?
13 **A.** Oh okay. I don't think we were aware of that.
14 **Q.** You weren't aware that the pattern of sudden
15 and unexpected collapses stopped happening at night?
16 **A.** I don't recollect being aware of that. We
17 knew that she had been taken off clinical duties at
18 about the same time as the unit had been downgraded.
19 **Q.** I'm sorry I jumped ahead and it may be you
20 didn't in fact know because of my poor question what
21 I was telling you.
22 In April?
23 **A.** Yes.
24 **Q.** Letby was moved from night shifts to day
25 shifts?

1 **A.** I am aware of that now yes.
2 **Q.** You are aware of that now. In July right at
3 the beginning of July, she was moved away from clinical
4 facing role?
5 **A.** Yes.
6 **Q.** That I think was what you were answering?
7 **A.** Yes.
8 **Q.** Were you aware at the time the fact that she
9 was moved to day shifts and that the collapses at night
10 had then stopped?
11 **A.** I don't think we were aware of that detail.
12 **Q.** Now obviously you spoke to a number of people
13 including Dr Brearey and Dr Jayaram and it would follow
14 from your answer that they didn't tell you that either
15 if that's right.
16 But just thinking about it now, if you had been
17 told that by the Executive Directors in that first
18 meeting, would that have been a relevant consideration
19 for you at that stage as to whether you should continue
20 or not?
21 **A.** I think it probably would. I'm not sure that
22 came up in our conversations.
23 **Q.** The next people you spoke to were Dr Brearey
24 and Dr Jayaram and I will summarise I hope accurately
25 what they told you: that they were concerned about the

1 way in which collapses occurred and that these were
2 sudden and unexplained, that they had conducted some
3 investigations and included the network?
4 **A.** (Nods).
5 **Q.** That they could find no adequate explanation,
6 that they noted Letby's association, that they had gone
7 so far as to investigate if she might have used air
8 embolism to murder the children, and they told you that
9 they had expected the Executives to call the police?
10 **A.** Yes.
11 **Q.** So is it fair that you had an opportunity at
12 that stage for yourself to assess the level of their
13 concern?
14 **A.** Yes.
15 **Q.** Because, all new to you was that they had gone
16 so far as to conduct research into how she might have
17 done it?
18 **A.** Yes.
19 **Q.** So that isn't just a passing thought implicit
20 in that; that is a high level of concern, do you agree?
21 **A.** Yes.
22 **Q.** And did you form the view that Dr Brearey and
23 Dr Jayaram were entirely sincere in that concern?
24 **A.** Yes.
25 **Q.** And was that another opportunity to say: we

1 must stop now"?
2 **A.** It was an opportunity, yes.
3 **Q.** And should you have taken that opportunity?
4 **A.** I think so.
5 **Q.** Now, we will take a break if my Lady agrees in
6 just a moment. I just want to finish off this area.
7 What Dr Jayaram and Dr Brearey were telling you
8 was, to put it one way, they had a safeguarding concern;
9 do you agree?
10 **A.** Yes, it wasn't put like that, but yes.
11 **Q.** No, but you have got -- I appreciate you were
12 limited by the training you did or didn't receive?
13 **A.** Sure.
14 **Q.** But you have got huge experience in
15 safeguarding?
16 **A.** Yes.
17 **Q.** And that is the effect of what they are
18 saying?
19 **A.** Yes.
20 **Q.** That you have two senior clinicians sitting in
21 front of you saying, "I think that person poses a threat
22 to children."
23 **A.** Yes.
24 **Q.** In particular babies?
25 **A.** Yes.

1 **Q.** Did you ever -- and we will come to this
2 later -- that day when you spoke to Dr Mittal and
3 Dr Issac who were representatives of the safeguarding
4 unit -- did you ever ask them, "Do you know anything
5 about the concerns of these two senior Consultants?"
6 **A.** It -- we did not feel it was our place to
7 share those concerns within the organisation.
8 **Q.** One of the things you were there to
9 investigate was how robust the policies and procedures
10 were?
11 **A.** Yes.
12 **Q.** One of those procedures was the safeguarding
13 procedure?
14 **A.** Yes.
15 **Q.** A way of testing whether the safeguarding
16 procedure was robust was to find out whether
17 safeguarding concerns arrived in the safeguarding
18 department?
19 **A.** That is a very accurate point, yes.
20 **Q.** In those circumstances, should you have been
21 asking whether those serious concerns were on the radar
22 of the safeguarders?
23 **A.** What we were asking was about the unexpected
24 deaths whether they were recorded as Serious Incidents,
25 whether the procedure was being followed in terms of

1 Serious Incident Review.
2 **Q.** Yes?
3 **A.** And we concluded that not all of them were.
4 There wasn't a consistent process. If the doctors had
5 those significant concerns we couldn't see that they
6 were systematically being followed through.
7 **Q.** So undoubtedly your report ultimately
8 concludes that the SUDiC procedure as referenced in
9 Working Together --
10 **A.** Yes.
11 **Q.** -- not followed. That's a recommendation?
12 **A.** Yes.
13 **Q.** So you spoke to them about that. But we have
14 heard from Dr Garstang, who tells us that SUDiC is not
15 one and the same thing as safeguarding, it is an
16 associated process?
17 **A.** Yes.
18 **Q.** So I'll just go back to my question. Should
19 you have checked with the safeguarding department that
20 the safeguarding concerns that you were told about had
21 reached them?
22 **A.** Yes, I recollect we didn't see them as
23 safeguarding concerns in that sense at the time.
24 Obviously with clarity now, they would have been,
25 but it was so difficult to contemplate that might be

1 happening, I guess.
2 **Q.** The final thing before I ask my Lady to take
3 a break will be the lunch time discussion.
4 It was at this stage, I think, that you as a team
5 reflected upon whether you should continue or not?
6 **A.** (Nods)
7 **Q.** You had an opportunity to sit in private and
8 to discuss the things that you had been told that
9 morning.
10 **A.** Yes.
11 **Q.** Did some of your colleagues seem surprised to
12 have learned what they learned?
13 **A.** Yes.
14 **Q.** Now, you have told us already about the
15 decision-making process and what you decided to do and
16 I'm not going to go over that. But one thing that we
17 haven't touched upon in relation to that discussion is:
18 is it right that there was a discussion between those
19 present about how a person might murder babies using
20 different methodologies? I will just -- I don't want to
21 give too much away. It's a sensitive subject. But this
22 is already in the public domain. The discussion
23 included insulin injection as a possible methodology.
24 Does that -- do you remember that discussion?
25 **A.** I think so. I think that was -- that was

1 found at the Inquiry about Stepping Hill. That was --
2 **Q.** Yes.
3 **A.** -- an issue that came up in that situation.
4 **Q.** There were other methods used. I am not going
5 to say them out loud.
6 **A.** Yes.
7 **Q.** But you record them in your notes, in fact --
8 **A.** Yes, yes.
9 **Q.** -- that there were others. So the discussion
10 was insulin, that's in the public domain.
11 **A.** Yes.
12 **Q.** Air embolism, that's in the public domain?
13 **A.** Yes.
14 **Q.** And other methodologies?
15 **A.** Yes.
16 **Q.** So what we have here, is this right, that we
17 have a group of very senior and experienced people
18 actively engaging with the possibility that murder had
19 been committed in relation to the deaths that were the
20 subject of the review; is that right?
21 **A.** Yes.
22 **Q.** In and of itself, at that moment, was that not
23 a very clear moment to say, "If we are having this
24 conversation, we need to walk away, the police need to
25 come in"?

1 **A.** Yes.
2 **MR DE LA POER:** My Lady, would that be a convenient
3 moment?
4 **LADY JUSTICE THIRLWALL:** Yes, thank you very much.
5 So we will take a break now and we will come back
6 in at 20 to 4. Thank you.
7 **(3.22 pm)**
8 **(A short break)**
9 **(3.40 pm)**
10 **LADY JUSTICE THIRLWALL:** Yes.
11 **MR DE LA POER:** Ms Eardley, having spoken to
12 Dr Brearey and Dr Jayaram, the other Consultants were
13 also spoken to; is that correct?
14 **A.** Yes.
15 **Q.** Were they broadly supportive of the position
16 of Dr Brearey and Dr Jayaram?
17 **A.** As I recall, yes.
18 **Q.** So another piece of the puzzle for you was
19 that Dr Brearey and Dr Jayaram were not outliers within
20 the Consultant body, but in fact that this was a shared
21 concern?
22 **A.** Yes.
23 **Q.** Again a question I have asked you already, is
24 this another opportunity to recognise the weight of
25 reasons to stop at that point?

1 **A.** Yes.
2 **Q.** Now, so far as Letby herself was concerned, we
3 have already covered that she was not originally
4 scheduled. What you say in your witness statement is:
5 "The review team felt strongly that LL should have
6 the opportunity to give her perspective."
7 **A.** (Nods)
8 **Q.** Now, who was it within the review team who
9 first proposed speaking to Letby?
10 **A.** I think it was Claire MacLaughlan but as
11 a whole team we agreed.
12 **Q.** The phrase "Opportunity to give her
13 perspective", what was meant by that?
14 **A.** It seemed unusual that she was not included in
15 the -- in the list of people to interview. I'm not sure
16 what we meant by that beyond what it says.
17 **Q.** Why was it unusual for her not to be in the
18 list in circumstances where you were not speaking to
19 every nurse and in circumstances in which you say you
20 were not investigating her?
21 **A.** I can't recollect our thought process at the
22 time, I am sorry.
23 **Q.** Now, as the head of the Invited Review
24 service, was it within your power at that point to say:
25 we are not doing that, we are not investigating Letby.

1 **A.** It would have been, yes.
2 **Q.** You didn't do that; is that right?
3 **A.** I didn't do that. We were all equal members
4 of the review team so it was a discussion that we had
5 between us.
6 **Q.** But some are more equal than others. You are
7 the head --
8 **A.** Yes.
9 **Q.** -- of the Invited Review service?
10 **A.** Right, I acknowledge that.
11 **Q.** Is that something that you should have said at
12 that stage?
13 **A.** Yes, I think so.
14 **Q.** Why is it that you think that you didn't?
15 **A.** In that context, I recognised that Claire had
16 particular skills and competencies around nursing,
17 around the legal system. She felt it was important, so
18 I deferred to her expertise on that.
19 **Q.** What did you understand Ms MacLaughlan's
20 experience of legal process was?
21 **A.** She was a qualified barrister and she had
22 worked as a nurse in the Royal Navy.
23 **Q.** She tells us that she has never worked as
24 a barrister?
25 **A.** No.

1 **Q.** She is not practising?
2 **A.** Correct. Correct.
3 **Q.** And has never practised?
4 **A.** Correct. She had also conducted a number of
5 reviews of clinical staff when she worked in her
6 previous role.
7 **Q.** Was there any discussion at that stage about,
8 "This could all end up with regulatory or even the
9 police, we really shouldn't be going anywhere near it"?
10 **A.** I think there was some discussion amongst the
11 team, everybody had a view and we concluded that we
12 would proceed with the interview.
13 **Q.** I think you have already told us that that was
14 a wrong turn at that point.
15 **A.** Yes.
16 **Q.** Now, the interview with Letby was conducted by
17 Ms MacLaughlan, and I am sure I am pronouncing this
18 incorrectly, Mr Mancini?
19 **A.** (Nods)
20 **Q.** We understand that the decision so as not to
21 intimidate her, that two women were chosen from the
22 group of the five of you; is that right?
23 **A.** It was the particular skills that they
24 brought, the nursing skills, the nursing knowledge,
25 understanding of nursing practice.

1 **Q.** Was there any other person who you interviewed
2 who you treated in that way?
3 **A.** When we assigned people to interview sometimes
4 on a review we would have two streams of interviewing
5 and we would always -- for a doctor we would always make
6 sure there was a doctor; for nurses, we would always
7 make sure there was a nurse. So the choice of those two
8 individuals was appropriate.
9 **Q.** So it wasn't unusual that it wasn't all five
10 of you?
11 **A.** It wouldn't have been all five of us, no.
12 **Q.** Now, we can hear from Ms MacLaughlan and Mr
13 Mancini about what took place and they are our best
14 evidence for that.
15 **A.** Yes.
16 **Q.** But we understand that Letby was provided with
17 Ms MacLaughlan's mobile telephone number, were you aware
18 of that?
19 **A.** No.
20 **Q.** Would it be appropriate for a mobile telephone
21 number to be given to an interviewee?
22 **A.** It wasn't unusual. When we conducted other
23 reviews, they were very much peer reviews so we were
24 working alongside the clinicians and if they needed
25 support and advice usually we would provide

1 an opportunity to make contact. Didn't usually give
2 telephone numbers, that was unusual.
3 **Q.** Just thinking about it now. The only reason
4 Letby was chosen to be spoken to was because the
5 Consultants suspected her of murder. Looking at it
6 through that lens?
7 **A.** Yes.
8 **Q.** Might that not be even greater reason not to
9 provide your number to such a person?
10 **A.** It may well be I wasn't aware at the time.
11 That was a decision made by Claire on grounds that she
12 has given her evidence on.
13 **Q.** Well, even if there were welfare grounds,
14 would the more appropriate course not be to ensure that
15 she was properly connected with the network of support
16 that the hospital provided?
17 **A.** Yes.
18 **Q.** I mean, although it's a peer review, you are
19 people who have come in, speak briefly and then leave?
20 **A.** Yes, I wasn't aware of the -- of the
21 passing -- the sharing of the telephone number until
22 I saw the papers for this Inquiry.
23 **Q.** Now, Letby says in a message to a doctor that
24 she had been given to understand following that meeting
25 that there was going to be a recommendation by the RCPCH

1 about some sort of HR procedure. We will come to it.
2 There was in fact a recommendation about an HR, but at
3 the time, Letby appears to know that.
4 Would it have been appropriate to tell her about
5 that recommendation on what was day one of the visit?
6 **A.** I don't think it would, no.
7 **Q.** Day two. Mr Harvey and Ms Kelly, we will
8 bring this one up INQ0014605. We will go to page 6,
9 please, just so there is absolute clarity about this
10 particular issue based upon what you record.
11 We can see:
12 "Saw lots yesterday, lots of new info. Not sure if
13 the review will give you the answers you are looking
14 for. Considered aborting and starting again but ToR to
15 be important to get the background. Need independent
16 Casenote Review of all deaths by two independent people.
17 Big concerns about Lucy plus need formal process to be
18 started so she knows where she is, HR Director been
19 involved on leave, has HR advice legal to support Lucy
20 and protect as an organisation."
21 So that is what the note records.
22 **A.** These notes are ...
23 **Q.** If we scroll up, so "Reviewers all"?
24 **A.** Okay, yes.
25 **Q.** Then an arrow saying "Claire Davies" --

1 **A.** These are taken from my handwritten notes,
2 yes.
3 **Q.** So really just the takeaways here is that you
4 said in terms as a team that active consideration had
5 been given to aborting and by that were you
6 communicating that you had contemplated that the RCPCH
7 review was not appropriate? Is that inherent in what
8 you are saying? You wouldn't have considered aborting
9 unless you shouldn't have been there?
10 **A.** Can I just read it, please?
11 **Q.** Of course, by all means. (Pause)
12 **A.** Okay. So I think these will be my handwritten
13 notes from the feedback team meeting. Yes, I think we
14 knew quite early on that we needed an independent
15 Casenote Review, yes.
16 **Q.** Yes, what you appear to be saying, just
17 filling in the gaps, as a team we have thought about
18 stopping --
19 **A.** Yes.
20 **Q.** -- and starting again, but we think that it's
21 important that we continue, but you are going to need
22 another process, in fact two more processes; one --
23 **A.** Yes.
24 **Q.** -- Casenote Review, one HR process?
25 **A.** Yes, yes.

1 **Q.** So in other words the RCPCH review isn't the
2 end of the story, that is what you are saying --
3 **A.** That's right.
4 **Q.** -- on --
5 **A.** Yes.
6 **Q.** -- day two, but in particular -- and this may
7 be an issue, we will see later -- it was communicated
8 according to these notes that there had been
9 consideration of stopping?
10 **A.** Yes. That was early on. That was on day one,
11 after we had met with Ian Harvey and Alison Kelly and
12 the doctors.
13 **Q.** But here you are meeting with them at the
14 beginning of day two --
15 **A.** Yes.
16 **Q.** -- telling them what the thought process?
17 **A.** Yes.
18 **Q.** -- was?
19 **A.** Yes.
20 **Q.** You also spoke to the senior nurses later that
21 day. We can take that down, thank you very much indeed.
22 You found them, according to your witness
23 statement, to be very supportive of Letby?
24 **A.** Extremely. Yes.
25 **Q.** So, I mean, the very fact that you are talking

1 about it, about her specifically, might be thought to be
2 an indication that you are investigating whether she was
3 responsible?
4 **A.** Yes, that was certainly communicated to us by
5 the nurses.
6 **Q.** When the nurses were saying that Letby was
7 a good nurse, or whatever it was that they were saying,
8 did you say look, well, we are not here to understand
9 whether she killed these babies or not; that is not what
10 we are here to do? Or did the conversation just
11 continue in a natural way?
12 **A.** It continued in a natural way.
13 **Q.** Again, looking back on it now, shouldn't that
14 just have been shut down to show that that was not what
15 you were interested in?
16 **A.** Yes.
17 **Q.** Do you think by this stage, that lines had
18 become quite substantially blurred?
19 **A.** Yes.
20 **Q.** Now, there was a feedback session at the end
21 with Tony Chambers, Ian Harvey and Alison Kelly?
22 **A.** (Nods)
23 **Q.** You record in your witness statement that:
24 "[Mr] Chambers asked 'were the deaths expected or
25 not?'..."

1 You say you are not clear who responded but likely
2 Dr Stewart:
3 "Some were expected, cannot say if there is a link
4 between them at the moment."
5 You go on to say there was mention of a forensic
6 paediatric pathologist?
7 **A.** Yes.
8 **Q.** Now, in what circumstances do you understand
9 that a forensic paediatric pathologist will be relevant?
10 **A.** Normally there would be a -- a pathologist
11 involved in every unexpected death that didn't always
12 happen because of the shortage of paediatric
13 pathologists generally, certainly from those unexpected
14 deaths. Because we didn't have a clear reason, we were
15 suggesting that for those ones there be a full pathology
16 review.
17 **Q.** One word that I am particularly focusing on,
18 let me make it clear: forensic. When would a forensic
19 paediatric pathologist normally be appropriate?
20 **A.** That would normally be if there was a concern
21 about somebody -- some foul play.
22 **Q.** So it does rather appear, do you agree, that
23 at that stage, you are encouraging investigation --
24 **A.** Yes.
25 **Q.** -- of a crime or potential crime without

1 involving the police?
2 **A.** Can I perhaps clarify. It may be that when
3 I used the word "forensic" I wasn't meaning it in the
4 context that perhaps we have inferred today. It would
5 have been a very detailed and thorough pathological
6 review.
7 **Q.** I mean, that is the word that you chose in
8 your witness statement?
9 **A.** Yes.
10 **Q.** It is a term of art, is it not, the forensic?
11 **A.** Yes.
12 **Q.** -- paediatric pathologist?
13 **A.** Yes.
14 **Q.** Do you know whether the gentleman you named,
15 Tony Beswick, is in fact a -- whether or not he is, I am
16 not suggesting he is or he isn't, but do you know
17 whether he is?
18 **A.** I'm not sure he was -- I think named by
19 somebody from the review team.
20 **Q.** I understand. You suggest that he may be able
21 to assist in the case note or postmortem examination?
22 **A.** There was a significant shortage of people who
23 could conduct Casenote Reviews in the country. There
24 are no many who could do it so that was a name that came
25 at that time.

1 **Q.** Two more issues about the review and then we
2 will just move on to the aftermath. The first is in
3 relation to the conversations you had with the
4 Executives about the reasoning behind why the police
5 weren't called.
6 What you say in your witness statement is: in
7 discussions about calling the police, the Medical
8 Director had clearly made up his mind and cited advice
9 from colleagues within the Trust. He requested a review
10 be completed before any police contact."?
11 **A.** Yes.
12 **Q.** Largely it speaks for itself. Firstly, is
13 that your recollection of --
14 **A.** Yes.
15 **Q.** -- his presentation?
16 **A.** Yes.
17 **Q.** Cited advice from colleagues?
18 **A.** Yes.
19 **Q.** What advice did he cite?
20 **A.** I can't remember the exact position of the
21 individual. But he said there was somebody working
22 within the organisation who had been a senior police
23 officer who had given him advice that to call the police
24 would be such a massive impact on the organisation that
25 they had to be very careful before they did that because

1 of the reputational risk, because of the other concerns
2 about what that would do for the organisation as
3 a whole. That was my recollection of the conversation
4 at the time.
5 **Q.** And that was reported to you, that is
6 obviously one side of the balance.
7 **A.** Yes.
8 **Q.** The other side of the balance is there may be
9 a murderer who needs to be detected and stopped?
10 **A.** Yes.
11 **Q.** At the time, did you find it an inappropriate
12 way of reasoning to not calling the police or did you
13 think that that was a reasonable approach?
14 **A.** At the time that was the judgment that the
15 senior management was making within that organisation.
16 It was that organisation's role to call the police, but
17 I accept that us coming from outside could have had
18 a stronger comment on it.
19 **Q.** But you are not sitting there as an entirely
20 passive person you will have a reaction to --
21 **A.** Yes.
22 **Q.** -- what somebody is telling you is their
23 reasoning in relation to a very important decision. Do
24 you have any recollection of thinking, well, "That
25 sounds fine to me" or, on the flip-side, "That's

1 a terrible approach to take"?
2 **A.** I remember thinking the situation has been
3 mitigation at the individual that they had concerns
4 about was no longer working in clinical practice.
5 Therefore, at that time the reasoning seemed
6 appropriate.
7 **Q.** So your reaction to being told that was "That
8 sounds reasonable to me"?
9 **A.** Was if our review couldn't find anything else
10 then the police would be called.
11 **Q.** The second point you have touched on already
12 when I inadvertently confused you about April and July.
13 You know that Letby was moved out of the clinical role?
14 **A.** Yes.
15 **Q.** At the same time the unit was downgraded.
16 **A.** Yes.
17 **Q.** Did you investigate whether or not the
18 increase in the mortality had persisted past that point?
19 **A.** That had only been a fairly short period,
20 I think it was 7 July, and revisited in September so it
21 was less than two months.
22 **Q.** Two months?
23 **A.** Yes.
24 **Q.** But nevertheless, was that something that you
25 enquired into?

1 **A.** We did and we noticed that there had not been
2 any further unexplained deaths.
3 **Q.** And did you ascribe any significance to that
4 at the time or potential significance in the context of
5 weighing up what the right thing to do was?
6 **A.** We certainly noticed it and continued to
7 monitor, yes.
8 **Q.** I mean there are two obvious explanations that
9 might spring to mind one because the unit has been
10 downgraded which some people have cited?
11 **A.** Yes.
12 **Q.** The other is that Letby's been moved off the
13 ward?
14 **A.** Yes.
15 **Q.** Was a thought process that you engaged with at
16 all trying to understand why there had been this change?
17 **A.** We considered it, but also we would be aware
18 that the unit would be considering it as well and other
19 staff in the unit will have noticed that as well.
20 **Q.** We are going to bring up your letter which you
21 sent on 5 September, INQ009611, we are in the final part
22 of my questioning for you. If we go to the second page,
23 we can see two action requires, these were both
24 immediate actions, is that right?
25 **A.** Yes.

1 **Q.** Because you had jumped ahead of the report?
2 **A.** Yes.
3 **Q.** To get these processes undergoing immediately?
4 **A.** Yes, I think from, from after this review we
5 instigated the process of a two-week letter where we
6 would send a letter swiftly after review with any
7 immediate actions.
8 **Q.** And in fact you had foreshadowed both of these
9 in the meeting on 2 September?
10 **A.** Yes.
11 **Q.** HR investigation, "It is important that the
12 Trust takes immediate steps to formalise the actions you
13 are taking with the nurse. Our understanding is that
14 an allegation has been made and therefore a process of
15 investigation needs to be put in place which sets out
16 the nature of the allegation and the process you follow
17 to investigate it."
18 Are you there envisaging a disciplinary process?
19 **A.** The process we suggested was an NHPS which is
20 an independent investigation if allegations have been
21 made against an individual about clinical practice.
22 **Q.** But does it have the effect of a disciplinary,
23 in other words "You are accused of doing something
24 wrong, we are investigating whether you have done
25 something wrong"?

1 **A.** I suppose it could be put like that, yes.
2 **Q.** Because you have used the word allegation?
3 **A.** Yes.
4 **Q.** Which generally is reserved for suggestions
5 that somebody has done something they shouldn't have
6 done?
7 **A.** Yes, yes.
8 **Q.** So you have recommended that this process is
9 undertaken. I mean, can we be frank. The allegation
10 was she may be murdering babies, is that fair?
11 **A.** Yes, yes.
12 **Q.** And so your proposal is that whether or not
13 she is murdering babies should be undertaken in
14 accordance with the NHPS process?
15 **A.** The issue behind this was that she returned
16 from leave and was moved to non-clinical duties and
17 a process wasn't followed for doing that.
18 **Q.** This was a protective measure to try and stop
19 the Trust being sued for constructive dismissal?
20 **A.** Yes. It could be seen as that.
21 **Q.** Yes, so that is its origin but what you are in
22 fact saying is you need to ask, to follow the NHPS
23 process to investigate whether she has been killing
24 babies?
25 **A.** When you put it like that yes, I can see that.

1 **Q.** But that is what it means isn't it?
2 **A.** Yes, yes.
3 **Q.** That should have said, do you agree. You need
4 to phone the police"?
5 **A.** Yes.
6 **Q.** And whilst that may be a pragmatic solution to
7 a potential employment claim, do you agree that that is
8 not in fact appropriate?
9 **A.** Knowing now what I know now, yes, that's not
10 appropriate.
11 **Q.** Knowing what you knew at the time, bearing in
12 mind you knew what the allegation was that you put in
13 your letter?
14 **A.** Yes, it did not feel as strong as that at the
15 time. I know how that sounds. It did not feel as
16 strong as that at the time.
17 **Q.** Do you see how that might, might give the
18 Chairman of the Board of Directors or somebody else who
19 reads it false reassurance?
20 **A.** Yes.
21 **Q.** Because it's all framed in quite oblique
22 language, allegation?
23 **A.** Yes.
24 **Q.** And somebody who's not aware of all the
25 circumstances might read that and think oh we just need

1 some kind of disciplinary process to sort all this out?
2 **A.** Yes.
3 **Q.** In terms of the Casenote Review, you describe
4 this as a detailed forensic Casenote Review. What does
5 the word forensic mean in that context?
6 **A.** I think a detailed Casenote Review was what
7 I meant.
8 **Q.** Yes. Tautology?
9 **A.** Yes.
10 **Q.** Is it right you didn't actually mean anything
11 by the word forensic that wasn't imported by the word
12 detailed?
13 **A.** Correct.
14 **Q.** You contemplate the following minimum
15 elements. Were you expecting that the hospital would
16 turn its own independent mind to your proposal and
17 consider whether additional measures might need to be
18 added?
19 **A.** I think including all interventions and
20 details of nursing and medical observations and
21 activities -- we had expected that may uncover some of
22 the issues around who was there and who did what and
23 some of the findings.
24 **Q.** I am sure it's me and the resonance of the
25 room, can I just ask to you keep your voice up very

1 slightly?
2 **A.** Sorry.
3 **Q.** No need to apologise. It is a large room and
4 I have been asking you questions for a long time. I am
5 really just focusing on the word "minimum" here. You
6 seem to be allowing for the possibility that if the
7 hospital thinks about it, it might come up with other
8 things it needs to do too?
9 **A.** Yes.
10 **Q.** Option 3 is examination with relevant
11 paediatric pathologist of the postmortem findings and
12 any additional information.
13 Now, the run-up to this is at least two senior
14 doctors, we see that in the body of the paragraph,
15 whether neonatology or pathology. So are we just
16 understanding what you are saying needs to happen, as
17 far as you are concerned it could be that they choose
18 two neonatologists which would fulfil that first
19 criteria but if they did they are also going to need
20 a pathologist as well in order to satisfy your third
21 criteria?
22 **A.** Yes.
23 **Q.** Or, they might choose a neonatologist and
24 a pathologist in which case they probably don't need an
25 extra pathologist for your option 3?

1 **A.** Correct.
2 **Q.** Is that how you had in mind, what you need is
3 for everyone's of these cases pathology input?
4 **A.** If possible, yes.
5 **Q.** Well, I mean, what you are not saying is if
6 possible -- I appreciate it is a recommendation?
7 **A.** We were expecting pathology input, yes.
8 **Q.** This is the minimum is what you are saying?
9 **A.** Yes, yes.
10 **Q.** And you include in your list rare conditions
11 such as air embolism?
12 **A.** Yes.
13 **Q.** I mean, that is contemplating in the context
14 of what you were told by Dr Jayaram and your own
15 internal discussion at lunchtime that these children may
16 have been injected with air?
17 **A.** Yes.
18 **Q.** But your recommendation is that that's all
19 done before there's any question of involving the
20 police?
21 **A.** I'm not sure that air embolism is only by
22 injection, I don't know.
23 **Q.** No, of course not. But in the context of the
24 discussions you have had air embolism has come up
25 because Dr Jayaram has told you?

1 **A.** Yes.
2 **Q.** That they investigated?
3 **A.** Yes.
4 **Q.** As to whether that provided an explanation for
5 the mottling?
6 **A.** Yes.
7 **Q.** Deliberate administration of air. You have
8 had a discussion at lunchtime where a number of
9 chemicals and insulin and air embolism are discussed as
10 a method of murder.
11 **A.** Yes.
12 **Q.** And here we are, four days later, and you are
13 encouraging that that is one of the things that their
14 investigation looks for?
15 **A.** Yes.
16 **Q.** And is that not another clear indication to
17 you that this has taken a wildly wrong turn and if those
18 are things that need investigating the police need to be
19 called?
20 **A.** Yes.
21 **Q.** Recommendation 4: "Details of all staff with
22 access to the unit for four hours before the death of
23 each infant." Now, you are not here asking who was
24 allocated to care for the baby who was on duty. You
25 have used this phrase: staff with access.

1 **A.** Mmm.
2 **Q.** That isn't actually something for
3 a neonatologist or a pathologist to be looking into is
4 it?
5 **A.** True.
6 **Q.** Do you agree?
7 **A.** Yes.
8 **Q.** I mean that's something that a police officer
9 would be investigating, you would expect that to appear
10 in a list of lines of investigation, do you agree?
11 **A.** Yes, yes.
12 **Q.** I mean at this point, do you think that you
13 have slightly put yourself in the position of an
14 investigating police officer as to the sort of things
15 that need to be investigated?
16 **A.** That is certainly how it reads, yes.
17 **Q.** Do you think that that is in fact in part how
18 you were thinking?
19 **A.** I think it may be, yes.
20 **Q.** Because that, would you agree, is another
21 recommendation that as you were writing it you should
22 have thought this is a police matter --
23 **A.** Yes.
24 **Q.** -- do you agree? Thank you, that can come
25 down.

1 You had contact with Jane Hawdon in the context of
2 finding out if she would be available to conduct the
3 review; is that right?
4 **A.** I'm not sure I would only have had that very
5 initial contact. The -- Ian Harvey emphasised it was
6 important to keep it very separate.
7 **Q.** Yes.
8 **A.** I think my recollection is because of the very
9 public nature of the whole process, that the names of
10 those people doing the case reviews would be kept
11 private.
12 **Q.** Dr Hawdon says that she didn't know at any
13 stage prior to producing her report that there were
14 allegations against a member of staff.
15 **A.** That is possible.
16 **Q.** You weren't the only person she spoke to, she
17 also had contact with Ian Harvey?
18 **A.** I don't --
19 **Q.** But so far as you are concerned --
20 **A.** I would have only spoken to her about her
21 availability and her willingness to have her name put
22 forward to the Countess of Chester Hospital.
23 **Q.** Bearing in mind what was sitting in the
24 background --
25 **A.** Yes.

1 **Q.** -- and had been the subject of so much of the
2 visit --
3 **A.** Yes.
4 **Q.** -- do you think that's something you should
5 have alerted to her to?
6 **A.** Yes.
7 **Q.** So that if she agreed to do it she did so
8 understanding the situation she was getting involved in?
9 **A.** Yes.
10 **Q.** And what she might need to be alert for?
11 **A.** Yes.
12 **Q.** I mean, she's the person doing the forensic
13 Casenote Review, isn't she?
14 **A.** Well, we put four -- there were four names
15 I think put forward of whom two were available?
16 **Q.** Yes.
17 **A.** I don't recollect what my contact with them
18 was beyond saying "are they available?" And then
19 I passed them over.
20 **Q.** Now, when it comes to drafting the report, see
21 if we can do this at a relatively high level. There is
22 a suggestion that the Consultants said it was a gut
23 feeling. I don't know whether you had a chance to look
24 back over the notes, but that was something that the
25 nurses said?

1 **A.** Yes, it is.
2 **Q.** But it was attributed to the Consultants --
3 **A.** Yes.
4 **Q.** -- via the report and can you see that by
5 attributing that to the Consultants it might be thought
6 that their allegations are perhaps less well-founded
7 than they might otherwise have been?
8 **A.** Yes, I accept that.
9 **Q.** If we look at the close out form,
10 INQ0010170 -- no, forgive me, that's the wrong
11 reference. We can take that down.
12 Maybe I can deal with it this way. That includes
13 the phrase "unsubstantiated allegations"; I don't know
14 if you recall that?
15 **A.** I think so, it was a very early close-out
16 form, it wasn't completed it was just the first part.
17 **Q.** Yes. Again, the fact that that was even
18 written might be thought to suggest that not much was
19 thought of what was being suggested in terms of its
20 cogency?
21 **A.** Yes.
22 **Q.** Do you think that does -- I mean, we have got
23 a misattribution of gut feeling, we have got an
24 unsubstantiated allegation. Do you think in fact a fair
25 representation of your state of mind was you didn't

1 think there was much in this?
2 **A.** At that time, I think, yes, there was such
3 a strong feeling from management that there was not much
4 in it.
5 **Q.** When you sent the draft, you included the
6 phrase "it does contain some fairly strong
7 recommendations"?
8 **A.** Yes.
9 **Q.** Is there any particular recommendation you
10 have in mind or do you think that perhaps overstates it
11 rather?
12 **A.** I am just trying to recall all the detailed
13 recommendations. There wasn't a particular one in mind,
14 no.
15 **Q.** Dr Shortland sent an email the report went out
16 in Dr Shortland's name?
17 **A.** Yes.
18 **Q.** INQ00012748. I hope I haven't added an extra
19 digit there. I think I might have. Put in 12748, thank
20 you, page 4. Dr Shortland's email right in the middle,
21 28th:
22 "Quite an interesting and complex review. Good to
23 have David M leading that one, almost felt a bit like
24 Grantham situation 30 years ago and my only question was
25 why they didn't involve the police if they had those

1 suspicions, otherwise looks like a good report with very
2 clear recommendations."
3 Now, we know that Dr Shortland a was a junior
4 doctor at a Nottingham hospital at the time that
5 Beverley Allitt carried out murders in Grantham nearby?
6 **A.** Yes.
7 **Q.** And that he retrieved sick infants from
8 Grantham Hospital. Did you understand that when he said
9 "the Grantham situation" he was referring to
10 Beverley Allitt?
11 **A.** Yes.
12 **Q.** Is this not an extremely significant moment
13 when Dr Shortland is saying that? That he's actually
14 saying that having read your report and not taken any
15 part in the review at all, he can see similarities with
16 a murderous nurse?
17 **A.** Yes.
18 **Q.** Is that another occasion when you should have
19 hit pause on the report and said: we need to make sure
20 the police are brought in?
21 **A.** Yes.
22 **Q.** "When the report was sent it came with the
23 sentence "will not distribute or share it more widely
24 without your permission".
25 That sentence is in breach of or contrary to the

1 policy in that you have made it clear in the policy that
2 you will share it without permission in the event it
3 contains recommendations that go to patient safety that
4 aren't followed?
5 **A.** But we would always inform the Chief Executive
6 first.
7 **Q.** You will always tell them but that is not the
8 same as asking permission.
9 **A.** Okay. The sharing with them would be the
10 result of a dialogue. We wouldn't -- in practice we
11 would share it if we had I think three times asked for
12 evidence that action had happened or that the Trust had
13 reported and if they hadn't then we would go ahead and
14 report it to another body.
15 **Q.** There were two versions of the report as we
16 have already covered?
17 **A.** Yes.
18 **Q.** Whose idea was it to create two versions?
19 **A.** I think it might have been mine. I wrote the
20 original version with all the information that we had.
21 I wrote it in a way that those paragraphs that are in
22 green could be removed for wider dissemination because
23 of the sensitivity of the allegations that had been
24 made.
25 **Q.** Just thinking about it now. Do you think it

1 was a good idea to do it in that way?
2 **A.** What I had done subsequently was to write the
3 full report and then let the organisation redact it as
4 needed.
5 **Q.** And perhaps for it to be clear that redactions
6 have been applied?
7 **A.** Yes.
8 **Q.** We are going to look briefly at three areas of
9 the report.
10 **A.** Yes.
11 **Q.** The first one is your conclusion about
12 leadership, INQ0009618 page 13.
13 Forgive me a moment. It must be over the page,
14 please. Paragraph 4.3. "Does the unit have clear and
15 engaged leadership and good team working?"
16 "Yes generally, but there are some areas where
17 communication could be strengthened."
18 I am not going to read it all out now but the next
19 paragraph is positively glowing isn't it with the
20 quality of the leadership of this department?
21 **A.** Yes.
22 **Q.** And?
23 **A.** That is the generally.
24 **Q.** It is just significant because if it's being
25 suggested by anybody at any time that the explanation

1 for the increase in neonatal mortality was because of
2 a lack of good leadership, they would not find support
3 for that in your report would they?
4 **A.** Correct.
5 **Q.** In fact, they would find quite the contrary?
6 **A.** Yes.
7 **Q.** We don't need to bring it up but you also
8 identify that the SUDiC guidance was not being followed,
9 is that right?
10 **A.** Not completely, yes not completely followed.
11 **Q.** And the third matter is at page 24, could we
12 go over the page, please. "Are there any identifiable
13 common factors or failings" -- this is the crux of the
14 report in the sense that this is the single bespoke
15 factor that you were asked to consider.
16 The first paragraph doesn't reach any conclusion
17 about that?
18 **A.** Correct.
19 **Q.** It just gives a list of facts. And then it
20 says a number of recommendations. You point out that
21 staffing levels were inadequate although you are not
22 judging those by reference to how they were before the
23 spike occurred or anything like that. You are just
24 making an observation that they weren't good enough at
25 the time?

1 **A.** Yes.
2 **Q.** There is a comment about how there had
3 sometimes been delay, but again you are not saying that
4 every case that you were looking at fell into that
5 category or that that was a common factor or failing?
6 **A.** Mm-hm.
7 **Q.** And then you say most infants had undergone
8 a postmortem but didn't include systematic tests for
9 toxicology.
10 So that isn't in fact a potential cause. That's
11 a recommendation for how there might be better detection
12 of the reasons; do you agree?
13 **A.** Yes. Yes.
14 **Q.** And fourthly over the page, you suggest that
15 an independent reviewer for unexpected deaths would be
16 an improvement which is again not a potential cause but
17 a way in which potential causes might be identified in
18 the future?
19 **A.** Yes.
20 **Q.** You say the personnel issues cannot be
21 resolved formally until this is completed.
22 What is that a reference to?
23 **A.** I'm not sure.
24 **Q.** But does it come to this, as you told us
25 before but this is an important point: the RCPCH went in

1 being asked to identify an explanation or explanations
2 for the increase in neonatal mortality and you did not
3 identify any?
4 **A.** Correct.
5 **Q.** We can take that down. Six of the
6 recommendations were under the heading of immediate.
7 Was it your expectation as per the guidance that that
8 report would immediately be shared with those who
9 participated?
10 **A.** I had thought the report had been shared
11 particularly -- the full report had been shared in the
12 middle of November with the senior team, with the senior
13 doctors, with Alison Kelly, with Eirian. I thought they
14 had all seen the report with the green sections in it.
15 **Q.** But if changes are going to be made for
16 example SUDiC?
17 **A.** Yes.
18 **Q.** You were concerned that if there was another
19 sudden and unexpected death that the right protocol, and
20 that could happen in theory at any time?
21 **A.** Yes.
22 **Q.** Any Consultant, any doctor any nurse involved
23 in that would need to know what your recommendation was?
24 **A.** Yes so we recommended that the report be
25 circulated as soon as possible as soon as the final

1 report was issued.
2 **Q.** Did you subsequently exchange email
3 correspondence with Dr Brearey and with Mr Harvey, where
4 firstly you were informed that the report wasn't in
5 wider circulation and, secondly, that you were
6 encouraging Mr Harvey to make sure that all of those who
7 made allegations against Ms Letby saw the full version?
8 **A.** Yes, I had thought that they had seen it
9 in November, because the response back on 15 November
10 from Ian Harvey was that it included comments from the
11 two doctors and those other nurses who I have mentioned.
12 It emerges from looking at the subsequent papers
13 that they had seen it in his office for an hour without
14 being able to take it away which is insufficient.
15 **Q.** Well, if departmental change is going to take
16 place, everyone needs to see it and consider it at their
17 leisure?
18 **A.** Absolutely. And that was our recommendation
19 from the beginning from the proposal that we would write
20 it in a way that it could be shared.
21 **Q.** And is it overstating the matter to suggest
22 that bearing in mind these were patient safety
23 recommendations that you were making, that it put
24 patient safety at risk for that report not to be given
25 to everybody in that unit?

1 **A.** Yes.
2 **Q.** But is that overstating or is that a fair --
3 **A.** Yes, to withhold sharing that report would
4 have increased the risk or the risk would have been
5 reduced by sharing that report.
6 **MR DE LA POER:** Ms Eardley, thank you for answering
7 my questions.
8 My Lady, there are some Rule 10 questions.
9 **LADY JUSTICE THIRLWALL:** Very good. Mr Baker.
10 Questions by MR BAKER
11 **MR BAKER:** Mrs Eardley, I ask questions on behalf
12 of the Families of 12 children. I am going to ask you
13 some very specific questions about candour and the role
14 of candour in these investigations.
15 **A.** Yes.
16 **Q.** Now first of all as of 2016, the Royal College
17 would have understood the importance of the duty of
18 candour?
19 **A.** Yes.
20 **Q.** And the role that it played in ensuring that
21 affected individuals were kept informed about safety
22 critical issues that were relevant?
23 **A.** Yes.
24 **Q.** Was there any system in place at the
25 Royal College in 2016 to ensure that candour issues were

1 formalised and an agreement was reached in relation to
2 them of any service users?
3 **A.** Not directly from the Royal College but there
4 was as part of my correspondence with Ian Harvey at the
5 beginning there was a conversation, email conversation.
6 **Q.** We will come on to that in a moment.
7 **A.** Okay.
8 **Q.** But it would be right to say there was no
9 formal agreement as part of a contract that's formed
10 when a service review was undertaken that specified
11 a duty to agree a structure when it came to informing
12 people or being candid with affected patients for
13 example?
14 **A.** Correct service reviews were usually carried
15 out without specific patient case note detail.
16 **Q.** But a service review had the potential to
17 reveal issues that involved individual patients?
18 **A.** Yes.
19 **Q.** And so trigger a duty of candour obligation?
20 **A.** Yes.
21 **Q.** And so would you agree that it would have been
22 sensible to have some formalised process in place so
23 that individuals who were entering into contracts with
24 the Royal College for service reviews understood how
25 material and information would be used in respect of

1 a duty of candour?
2 **A.** Yes, that would be helpful.
3 **Q.** Now in terms of the actual type of agreement,
4 the client, so the individual in this case or
5 organisation, the Countess of Chester Hospital, would
6 own the report that you created?
7 **A.** Yes.
8 **Q.** And so you would lose all control of that
9 report once it was finalised and provided to the client?
10 **A.** We would obviously retain our copy but the
11 agreement usually was how that report was used as
12 a responsibility of the client.
13 **Q.** So in reality you had no control about how it
14 would be used?
15 **A.** No.
16 **Q.** And had you encountered issues in the past
17 where Trusts had not been entirely upfront with the
18 College about how material would be used other than this
19 case?
20 **A.** Not that I can recall. I usually maintained
21 a good dialogue with my client contact, usually the
22 Medical Director and we would discuss dissemination.
23 **Q.** Had you encountered problems with Trusts being
24 honest and open with the College other than the Countess
25 of Chester?

1 **A.** Not generally as I can recall. It was some
2 time ago but I can't remember any specifics. There was
3 one other case which --
4 **Q.** So if we could look at the chronology you
5 created, INQ0012748. And if we could go, please,
6 to October 2016, which is on page 4. Can you see an
7 entry just dated October 2016, programme board written
8 update, where it says "Two recent reviews have become
9 much more complex than initially anticipated mainly due
10 to the management our clients not being open and honest
11 with their paediatric team and/or not responding to our
12 requests for data."
13 Now I assume that one of these is referring to the
14 Countess of Chester, is it?
15 **A.** Yes.
16 **Q.** So it wasn't unique was it for Trusts not to
17 be entirely upfront with the College about what the
18 College was being asked to do or indeed, I would
19 suggest, how those reports were going to be used?
20 **A.** Those were the only two situations that I can
21 recall.
22 **Q.** So save for, and of course I don't ask you to
23 identify the other Trust, but one of them is the
24 Countess of Chester?
25 **A.** Yes.

1 **Q.** These two Trusts were unique in all of your
2 experience of Royal College service reviews?
3 **A.** As I can recall, yes, they stood out.
4 **Q.** But it is easy to see by November of that year
5 if we look down 11 November from "Paeds", there is
6 a reference here to Dr Brearey contacting you. The
7 paediatricians have seen a redacted report and made some
8 comments which were forwarded to the RCPCH on
9 15 November confirming draft report had been seen by the
10 Execs and they were comments that had been taken into
11 account.
12 Did that not start alarm bells running or ringing
13 about how the Countess of Chester was using the report,
14 if it was providing redacted versions or not providing
15 full versions to affected individuals?
16 **A.** Yes, that did concern me.
17 **Q.** Because if we go to INQ009595, which is the
18 review proposal, and we look on, please, to page 4 of
19 that, this is a review proposal that was sent to
20 Ian Harvey on 30 June and signed off by him?
21 **A.** Yes.
22 **Q.** Can you see under 3.3, you say:
23 "Each review we conduct is tailored specifically to
24 the service or individual in question but will always be
25 conducted using tested principles including ..."

1 Item 2 is:
2 "A commitment that findings will be shared as far
3 as possible with those involved."
4 **A.** Yes.
5 **Q.** That had been effectively a term of the
6 agreement from the outset?
7 **A.** Yes, yes.
8 **Q.** Now, "shared as far as possible with those
9 involved" doesn't extend to patients who might be
10 affected?
11 **A.** No, would be all those interviewed. Sometimes
12 an organisation would -- would limit some of its
13 circulation, would sometimes redact copies before they
14 disseminated them, but we would expect the whole report
15 to be disseminated to all those involved.
16 **Q.** Yes. So it may that be very sensitive
17 material --
18 **A.** Yes.
19 **Q.** -- is omitted and one can assume there might
20 be exceptional reasons for doing that in some cases?
21 **A.** Yes.
22 **Q.** But generally the expectation was that in
23 terms of the individuals working within the Trust who
24 would be affected it would be provided to them and they
25 would be allowed to see the outcome?

1 **A.** We would write the reports with that in mind.
2 **Q.** Yes.
3 **A.** So we would write them appropriately with the
4 kind of language that would be suitable for
5 dissemination for those that were interviewed.
6 **Q.** It isn't a part of this proposal or indeed the
7 terms that the Royal College enters into with the
8 Countess of Chester that there be an expectation that it
9 be disclosed to Families who might be affected we are
10 going to come on to your email to Ian Harvey in
11 a moment, but in terms of the agreement there is no
12 section that specifies the need to be candid with the
13 affected Families, is there?
14 **A.** Not -- these terms are core terms for our
15 reviews. We knew from the first conversation that the
16 report was likely to be published. We would encourage
17 organisations to put it in their board papers, we knew
18 this one was highly sensitive in terms of media
19 interest.
20 **Q.** You didn't mean to give the impression that
21 this is a sort of boilerplate contract, but just to be
22 clear, if you look at page -- if we go back to page 2 of
23 this document --
24 **A.** Yes.
25 **Q.** -- it is quite clear that it is a bespoke

1 document to the Countess of Chester --
2 **A.** Yes.
3 **Q.** -- hospital.
4 So it sets out the terms of the agreement with
5 them.
6 Now, if we go then to your emails with Ian Harvey,
7 if we turn first of all to, forgive me a moment, so it's
8 INQ0009599.
9 Now, the proposal that we have just been to is
10 dated 30 June and it is agreed. So the contract in
11 effect is formulated on 30 June. So here we are just
12 having discussions with Mr Harvey about mechanics and
13 what's going to be happening and you say in this email:
14 "Finally, I was just wondering what the position is
15 regarding the parents of the infants who died. Would
16 they be expecting to meet us? I have not included for
17 that and we wouldn't usually meet them in a review like
18 this as we are not intending to go over every case again
19 in detail but we just need to confirm the duty of
20 candour arrangements are in place."
21 Mr Harvey responds to you on the following day, so
22 13 July, and if we go to INQ0009615, and to page 2, so
23 at the top of the particulars of claim is the main body
24 of an email from Ian Harvey it says:
25 "Re the parents, we made every effort to contact

1 the parents of every baby who had died due to the
2 increased incidents period before the story was in the
3 local paper. Address and phone number changes mean that
4 we couldn't contact all. Part of the conversation was
5 that we would share the findings of the review with
6 them. To my knowledge none has requested seeing the
7 review team."
8 What did you take that to mean?
9 **A.** I took that to mean that the duty of candour
10 was being followed by the Countess of Chester Trust,
11 there was dialogue with the Families, and that yes, our
12 report would be shared with them.
13 **Q.** Is that --
14 **A.** At that time we obviously hadn't done the
15 review, we hadn't got the details and information so ...
16 **Q.** I mean, what it's saying that they have not
17 been able to contact everybody. I mean, do you know --
18 did you go back and ask how many they had actually been
19 able to contact?
20 **A.** No, we didn't -- we didn't pursue it beyond
21 that.
22 **Q.** I mean insofar as the Families who I represent
23 are concerned, the Mother of Child C is the only one who
24 actually finds out about this review at or about this
25 time and she finds out about it through a leak in the

1 newspaper rather than being contacted?
2 **A.** Okay.
3 **Q.** None of the others were contacted who
4 I represent.
5 **A.** That is concerning.
6 **Q.** Yes. But if you --
7 **A.** Because that is not what this email says.
8 **Q.** This is as of I should say July 2016; they
9 find out about it later.
10 **A.** Yes. As I say, usually within the RCPCH's
11 remit at the time we would -- depending on the nature of
12 the review we would seek to talk to patient family
13 representatives but that was not when we were looking at
14 something like this.
15 **Q.** But, you see, one of the issues and I think on
16 reflection the fact that it isn't a contract term that
17 candour is followed, the fact that really it's dealt
18 with in a very informal way by you, you raise it, it is
19 a good thing you raised it?
20 **A.** Yes.
21 **Q.** But it is in an informal way, it is not part
22 of the terms of the agreement?
23 **A.** Yes.
24 **Q.** It does leave the Royal College to be
25 potentially fobbed off, doesn't it, about candour?

1 **A.** It -- reading that, it appears as such, yes.
2 It is the responsibility of the Trust to liaise
3 with the Families under duty of candour requirements.
4 **Q.** Yes.
5 **A.** So my email was double-checking they were
6 doing that. I had that confirmation that that was being
7 done. So we left it there.
8 **Q.** But you don't have a list, for example, of:
9 I have contacted this number of patient Families, these
10 remain uncontacted, we are making ongoing efforts to
11 contact them. It's all very loose, isn't it, actually
12 on reflection what Ian Harvey says?
13 **A.** It is, yes. I -- I hate to say that was
14 outside our remit but we weren't focusing on that at the
15 time but reading that assurance, yes, that is very
16 loose.
17 **Q.** I mean, you may have been misled by it, that
18 is one thing. But again, if there had been a formal
19 arrangement in relation to the duty of candour within
20 the proposal and the contractual documents --
21 **A.** Yes.
22 **Q.** -- it would have put the Royal College in
23 a much stronger position, wouldn't it, when it came to
24 issues like this?
25 **A.** As I say, I accept that this was not intended

1 to be a Casenote Review. Had it been a Casenote Review
2 there would be a whole issue about communication with
3 Families, this was not intended to be.
4 **MR BAKER:** Thank you, my Lady, I have no further
5 questions.
6 **LADY JUSTICE THIRLWALL:** Thank you very much,
7 Mr Baker. Mr Skelton.
8 Questions by MR SKELTON
9 **MR SKELTON:** Ms Eardley, I ask questions on behalf
10 of one of the other Family groups.
11 **A.** Okay.
12 **Q.** You have been asked in detail about the
13 pre-review phase where you were in contact with
14 Ian Harvey.
15 **A.** Yes.
16 **Q.** I just want to revisit that briefly, please,
17 and then I will turn on to your review and your
18 decision-making there?
19 **A.** Yes.
20 **Q.** The Terms of Reference which eventually were
21 agreed left it open for you to identify any identifiable
22 common factors or failings that might in part or in
23 whole explain the apparent increase in mortality?
24 **A.** Yes.
25 **Q.** So everything was on the table for the College

1 reviewing team. Wasn't it obvious from the start that
2 when you are coming to look at mortality of specific
3 children, that you had to look at their notes?
4 **A.** It was not -- we were looking at the whole,
5 the numbers. We weren't intending to look at the
6 individual children.
7 **Q.** But --
8 **A.** I hear what you say.
9 **Q.** How could you scientifically -- your
10 background as an engineer I think?
11 **A.** Yes.
12 **Q.** Even medically which you were very familiar
13 with?
14 **A.** Yes.
15 **Q.** How could you identify why more children than
16 expected had died without understanding why each child
17 had died and looking to identify in their notes and in
18 discussion with their treating professionals, the common
19 factors medically which would link them. You couldn't
20 do that, could you?
21 **A.** No. That's why we recommended a specific case
22 note review to look into that in detail.
23 **Q.** Yes, I think the key point really was that
24 from the start that issue, that very issue at the heart
25 of the Terms of Reference that I have quoted --

1 **A.** Yes.
2 **Q.** -- required a Casenote Review?
3 **A.** Yes.
4 **Q.** And you were given some information by
5 Ian Harvey. I have sensed a great degree of discomfort
6 throughout your evidence about the way in which this
7 review was set up and conducted. Is that fair?
8 **A.** Looking back absolutely, yes.
9 **Q.** Well, as soon as he raised concerns about
10 suspicions of potential murder, that must have raised
11 some degree of concern and alarm in your mind as to
12 whether or not you were in a zone where you could assist
13 meaningfully?
14 **A.** Yes. Yes.
15 **Q.** And they were, as I think Mr De La Poer put to
16 you, of the utmost gravity; the murder of babies in
17 a hospital couldn't be more serious?
18 **A.** (Nods).
19 **Q.** So, in those circumstances, the only
20 appropriate course really was to say "We can't do this
21 and you need to get someone else to look at this
22 properly" from the start.
23 **A.** I agree.
24 **Q.** And if the concerns were at that level, the
25 only organisation that really is equipped and

1 experienced to look at these sorts of things is the
2 police. They have the full panoply of investigative
3 powers which others don't. So, for example, they can
4 get whatever expert reports they want, they can
5 interview people, they can seize documents, notes,
6 et cetera. None of those things is within the power of
7 an independent pathologist or an independent clinician
8 who may be brought in. Is that correct?
9 **A.** Yes.
10 **Q.** Did you pick up at the beginning before you
11 went there that Ian Harvey's view was that the
12 Consultants were misplaced in their concerns? That
13 somehow they had got this wrong and that he needed help
14 to demonstrate that?
15 **A.** I think that's a good summary of our
16 perceptions at the time, yes.
17 **Q.** Do you think that's an appropriate use of the
18 College? The Consultants, for example, are members of
19 your College, Ian Harvey is not, and of course
20 corporately the Trust is not, but you were put in
21 a position where your members, two of your members, well
22 as it turned out more than two of your members, are
23 concerned about deliberate harm to children. You are
24 brought in by the hospital who employs those Consultants
25 to disprove their concerns.

1 That isn't an appropriate situation to get yourself
2 into, is it?
3 **A.** I think the -- the issue round them being
4 members of the College is an important one but it's
5 a different role. We are not a College coming into
6 represent or support members. We have to be objective
7 and independent. But yes, we heard their concerns, we
8 should well have acted differently.
9 **Q.** Yes, leaving aside the membership point?
10 **A.** Yes.
11 **Q.** I can see you have to be independent. Just
12 because your members think something doesn't mean you
13 have to agree with them obviously. But leaving aside
14 that, you were being used to some extent weren't you in
15 a way which wasn't appropriate for an independent
16 review?
17 **A.** With hindsight, yes, I would agree.
18 **Q.** In fact based on what Mr Harvey told you; he
19 wanted to use the Royal College to disprove the
20 Consultants' concerns without addressing them directly?
21 **A.** He wanted to see if there was any other factor
22 that could possibly have been a cause.
23 **Q.** Why is it then that the Terms of Reference
24 don't say that because on the face of it the Terms of
25 Reference I have read out to you, which Mr De La Poer

1 went through, open up everything. But in fact you in
2 your head, and repeatedly in evidence today, have said
3 you were in fact excluding that concern deliberate harm,
4 from your review.
5 **A.** Yes.
6 **Q.** So why is that not apparent from the Terms of
7 Reference?
8 **A.** I can't say. I can only think it was too
9 awful to contemplate. Knowing now what I know, which we
10 didn't know then.
11 **Q.** You have used the word "hindsight" a lot and
12 similar phrases. I would like to kick away that crutch
13 to some extent I am afraid because actually based on
14 what you were told, you were being told there were
15 concerns that potentially with criminality your Terms of
16 Reference which you put in your report include that as
17 a possibility because they don't exclude anything?
18 **A.** Yes.
19 **Q.** That isn't a rational position to find
20 yourself in, is it?
21 **A.** No.
22 **Q.** Day 1 of the review you already knew about the
23 increase in mortality, that is baked into the Terms of
24 Reference?
25 **A.** Yes.

1 **Q.** And likewise the unexpected nature of the
2 children's deaths?
3 **A.** Yes.
4 **Q.** And you already knew that a nurse was alleged,
5 or at least thought to have been connected to the
6 deaths?
7 **A.** Well, she had been on duty at the time.
8 **Q.** Yes correlated?
9 **A.** Correlated.
10 **Q.** And there were concerns by the Consultants
11 that she was in fact connected, there was a causal link?
12 **A.** Yes, yes.
13 **Q.** As you are speaking to Ian Harvey you start to
14 be given more information, I presume this must have led
15 to a degree of discombobulation on your part, that in
16 fact the situation was far more complex than you had
17 previously envisaged?
18 **A.** (Nods).
19 **Q.** In that very first discussion with him and
20 Alison Kelly?
21 **A.** Yes.
22 **Q.** The pattern isn't a normal pattern for deaths.
23 The babies didn't respond to resuscitation in the normal
24 way. The only common denominator is the single nurse
25 and the clinicians had threatened to go to the police.

1 This is all more information and it is all significant
2 isn't it?
3 **A.** Yes.
4 **Q.** And when you thought about who you were
5 talking to, you are talking to the Director of Nursing
6 and the then Medical Director who's an orthopaedic
7 surgeon. Were you aware of their background?
8 **A.** Yes.
9 **Q.** And neither of them was qualified to express
10 a view on neonatal medicine, were they?
11 **A.** At their level of authority I thought they
12 would be, they would have had a view on that. They were
13 not qualified clinically but they would have management
14 responsibility to understand the issues.
15 **Q.** Well, they had management responsibilities and
16 they had their own healthcare training and experience?
17 **A.** Yes, yes.
18 **Q.** One is an orthopaedic surgeon and one is
19 nurse?
20 **A.** Yes.
21 **Q.** But they are not neonatal doctors either of
22 them?
23 **A.** No.
24 **Q.** So the specialist knowledge, the experience
25 the judgment rests with a different specialty?

1 **A.** Yes.
2 **Q.** And did you consider that as a factor. You
3 have two senior people they are senior managers, but
4 neither of them in fact had a specialism in neonatology
5 who are dismissing the concerns of the people who do
6 have a specialist knowledge in neonatology. Did that
7 factor in?
8 **A.** Not in such an articulate way, no.
9 **Q.** Does it make sense as I put it to you now?
10 **A.** It does.
11 **Q.** Did either of them offer an alternative
12 explanation to you, an alternative hypothesis? So there
13 was only one working hypothesis which had been raised by
14 the Consultants that connected the deaths, this was the
15 nurse, and as Mr De La Poer put it to you that it could
16 have been just a statistical anomaly, a failure of
17 inadequate care and/or deliberate harm.
18 Was there any other hypothesis put to you that you
19 needed to look at?
20 **A.** There were some concerns about the transport
21 service. There were some concerns as I recall that
22 being a Level 2 unit was perhaps over extending in terms
23 of its capability to look after the very, very premature
24 infants.
25 Those were the factors that we were looking at,

1 whether the staff and the expertise was appropriate,
2 whether the transport came on time, whether the
3 Consultant cover was sufficient, those were the areas
4 that we were focusing on.
5 **Q.** But I think you have accepted, haven't you,
6 that you couldn't determine whether those factors in
7 fact --
8 **A.** Correct.
9 **Q.** -- had led to the increased mortality; that
10 was beyond the scope of your review?
11 **A.** Yes.
12 **Q.** And indeed objectively implausible?
13 **A.** Yes. At the end of the review we concluded
14 that those factors weren't accounting for the increase
15 in mortality specifically.
16 **Q.** I think in fact you, although you did make
17 a very clear finding about the understaffing of the
18 unit, number one, that is a common problem with district
19 general hospital neonatal units, so this wasn't unique
20 to Chester?
21 **A.** Correct.
22 **Q.** Number two, it didn't cause the increase in
23 mortality, as far as you found?
24 **A.** Correct, we couldn't find a correlation there.
25 **Q.** No, and without correlation there can't be

1 causation.
2 So what did they think had caused this increase, if
3 anything?
4 **A.** They? Senior management?
5 **Q.** Ian Harvey and Alison Kelly, who you spoke to
6 on the very first morning of your review.
7 **A.** I don't know what they thought was causing it.
8 **Q.** So you had an open field to look for anything?
9 **A.** I think they wanted us to disprove that it was
10 Nurse Letby.
11 **Q.** Which you accepted was an inappropriate use of
12 the Royal College?
13 **A.** Yes.
14 **Q.** I am going to ask you briefly -- I am very
15 conscious that I am treading into the sort of time when
16 we should have finished --
17 **A.** This is important.
18 **Q.** Can I ask you about the interviews that you
19 had with Dr Jayaram and Dr Brearey, please.
20 **A.** Yes.
21 **Q.** Is it easier for you to look at your
22 handwritten notes or your typed notes?
23 **A.** Handwritten notes.
24 **Q.** It might be easier for you. If it proves
25 problematic for others who are looking at them, can we

1 change?
2 **A.** I am very happy, yes.
3 **Q.** I don't think there are any major
4 discrepancies?
5 **A.** No, that is fine.
6 **Q.** I have not correlated it?
7 **A.** They just look familiar to me, that is all.
8 **Q.** Okay fine. In that case it is INQ0010124.
9 Just picking up finally before I move into the detail of
10 this, the police are mentioned as a possibility by
11 Ian Harvey on a number of occasions and you were asked
12 by Mr De La Poer about the consequences of calling in
13 the police.
14 It seems to have been dealt with in a way which
15 sounded rather apocalyptic as if the unit would suddenly
16 become a crime scene, or at least it would lead to its
17 closure or such reputational catastrophe that it would
18 close its doors to patients. Do you think that is
19 a fair and realistic view or well-informed view?
20 **A.** I think it's such a rare occurrence there
21 was -- there was uncertainty, there was certainly
22 a perception that we picked up from Ian Harvey and
23 Alison Kelly that to call the police because of the
24 media interest and the perception that everything would
25 have to stop and there would be alarm raised amongst

1 patients, that was their driving concern.
2 **Q.** Did you test that though?
3 **A.** No.
4 **Q.** Because in one sense Lucy Letby had gone, she
5 had been gone for months. In another sense the actual
6 crimes that she might have or she was alleged to have
7 committed were even further back?
8 **A.** Yes.
9 **Q.** They started, as we now know, in June 15 and
10 ended in June -- or thereabouts -- 16?
11 **A.** Yes.
12 **Q.** So to some extent there isn't any need for the
13 police to close the unit, for example, because the
14 perpetrator is not there and the crimes took place many
15 months ago?
16 **A.** Yes.
17 **Q.** On the other sense the police can in fact do
18 things rather discreetly, can't they? Was there any
19 reason to think that wouldn't be the case?
20 **A.** No, no reason at all. I think I recall the
21 perception in my head was that that would be such
22 a major step and I think that's reflected in the notes
23 that it was considered to be such a major step to call
24 the police because it would be, I guess, an admission
25 that they had a murderer amongst their staff and that

1 seemed too big to contemplate.
2 **Q.** Do you know what in fact happened when the
3 police were called?
4 **A.** I know it was reported but it was relatively
5 low key.
6 **Q.** But it didn't cause a catastrophe in terms of
7 the service?
8 **A.** No, no.
9 **Q.** So in fact that concern might have been rather
10 alarmist?
11 **A.** Yes.
12 **Q.** Page 6, please, and towards the bottom where
13 I think it says -- can you see -- I think it's Steve?
14 **A.** Yes.
15 **Q.** Can you see that?
16 "Things all okay until last June"
17 Do you see that?
18 **A.** Yes.
19 **Q.** So this is the narrative that you are now
20 getting the full story in fact of exactly what happened
21 and I think this is the Consultants really are unfurling
22 everything to you?
23 **A.** Yes, yes.
24 **Q.** That they are worried with and that they think
25 has happened?

1 **A.** Yes.
2 **Q.** Right from the beginning?
3 **A.** Yes.
4 **Q.** The story in brief was that babies start to
5 die unexpectedly in June and they begin to investigate
6 or think about what the cause is. And the key issue at
7 the start is that they can't find a medical explanation?
8 **A.** Yes.
9 **Q.** So they start to see if there is another
10 explanation and they identify a member of staff?
11 **A.** (Nods).
12 **Q.** That in itself is significant?
13 **A.** Yes.
14 **Q.** And the staff member that they identify is
15 a nurse, we now know it's Lucy Letby, and that became
16 readily apparent to you. Those are two of the factors
17 to start with. If we go further on to page 8, please.
18 **A.** Yes.
19 **Q.** This is Ravi -- I think it is Ravi at the top?
20 **A.** Yes.
21 **Q.** Can you see about a third of the way down, it
22 says "Ravi"?
23 **A.** Yes.
24 **Q.** Stephen crossed out and then it is "Ravi" and
25 then he says -- do you want to read out those three

1 lines if you can?
2 **A.** "It is how the babies collapsed, no
3 indication, didn't respond physiologically how they
4 should have done. Seven of them [that was seven
5 paediatricians] so not always the same one talk to each
6 other."
7 So it was a while before they realised that they
8 were all experiencing these collapses.
9 **Q.** Yes, but several there are several things
10 here. So it is how they collapsed?
11 **A.** Yes.
12 **Q.** These babies aren't expected to collapse in
13 this way?
14 **A.** Yes.
15 **Q.** And they then don't respond to the usual
16 medical interventions?
17 **A.** Yes.
18 **Q.** The various drugs and things that are
19 intervened?
20 **A.** Yes.
21 **Q.** So another two red flags here?
22 **A.** Yes.
23 **Q.** As to something clinically unusual that he's
24 mentioning to you?
25 **A.** Yes.

1 **Q.** And then the next point is that this is
2 an independent view so it's not just the two that are
3 talking to you, Steve and Ravi, it is the other
4 Consultants are all starting to come to this view
5 independently?
6 **A.** Yes, yes.
7 **Q.** There is no problem of group think, it is
8 individual thinking?
9 **A.** Only when they start talking to each other
10 they realise they had all experienced the same, each
11 individually thought it was a one-off I suspect, yes.
12 **Q.** Yes, so they are not conspiring to make up an
13 allegation?
14 **A.** No.
15 **Q.** They are all independently coming to it and
16 pooling their thoughts?
17 **A.** Yes.
18 **Q.** And by definition becoming even more
19 concerned?
20 **A.** Yes.
21 **Q.** Because they probably second-guessed their own
22 judgment and now in fact it proves that they are all
23 having the same thoughts?
24 **A.** Yes.
25 **Q.** If we go a bit further down you can see it

1 says that -- I'm sorry to the bottom of the page, the
2 very last bit, do you mind reading that out as well for
3 those that can't understand your writing?
4 **A.** "Nurse on shift at all times. Spoke to Ian
5 and Alison. CQC is in the place of delay."
6 That would have been in February.
7 **Q.** So it is just the bit?
8 **A.** "Nurse on shift at all times.
9 Spoke to Ian and Alison" -- that being Ian Harvey
10 and Alison Kelly -- "CQC is in the place so delayed."
11 So that would have been around February when CQC
12 was doing a visit so my inference is from what they said
13 that they weren't listened to because CQC were visiting.
14 **Q.** Yes, so they tried to do something about it?
15 **A.** Yes.
16 **Q.** They couldn't find a medical explanation, they
17 looked for another explanation and they found the nurse
18 that was on shift. They raised it with the Executives.
19 It didn't go anywhere and your impression is in fact
20 it's because the CQC were looking at the unit?
21 **A.** That is obviously what they were told, we are
22 too busy with CQC at the moment.
23 **Q.** Yes. So they had been fobbed off?
24 **A.** Yes.
25 **Q.** If we go on to the next page, please. Just

1 underneath the box, so do you want to if you could just
2 read about the first sort of seven or eight lines?
3 **A.** Yes, of course. "At the time of talking to
4 Ian and Alison, Eirian had decided to put the nurse on
5 day shifts not nights as staff member had been through
6 all the harrowing episodes. Pastoral care. Six out of
7 9 mortalities at night midnight to 4 am. Outcome of the
8 conversation then to keep a watch. No one expected
9 collapses at night when she was on days but collapses
10 happened in daytime."
11 **Q.** If you could stop there?
12 **A.** Yes.
13 **Q.** So the last bit of information, I think you
14 said earlier that you weren't told about the --
15 **A.** It's there.
16 **Q.** Not only the correlation with the nurse but
17 the correlation with her shifts?
18 **A.** Yes, it is there.
19 **Q.** In fact, you were told that?
20 **A.** Yes.
21 **Q.** The collapses occurred at night when she was
22 there, they stopped when she left, they moved to the day
23 when she started the days?
24 **A.** Yes.
25 **Q.** So another piece of information --

1 **A.** Yes.
2 **Q.** -- that you are getting.
3 If we go on to, please, page 9, sorry, further
4 down. I will just read it out for you.
5 Dr Jayaram starts to say to you: they wondered if
6 they were missing something. So this is the point at
7 which they are really opening up to you about what they
8 are trying to think about and this is when they start to
9 raise the possibility of an air embolus. So they are
10 trying to work out that if it was this nurse, how she
11 had actually done it?
12 **A.** Yes.
13 **Q.** The possibility of air embolus is raised. And
14 I think at one point Dr Jayaram describes the sort of
15 chill that came over him when he thought about this. Do
16 you remember that?
17 **A.** I think so, yes, I remember him saying that.
18 **Q.** I'm afraid I haven't got the reference for
19 that particular bit but I can read out the bit from the
20 transcript of it. He says:
21 "When thinking forensic, what happens with air
22 embolism? Looked at the case studies. Last
23 observations? Chilling."
24 **A.** Yes.
25 **Q.** He says.

1 "Just like what happened. Babies unresponsive to
2 any inputs, list of them, odd skin discolouration, blue
3 with eyelids of pink. [Query] injecting air into
4 babies. Went to see new Execs."
5 Then it says:
6 "OB and S as have to cancel ..."
7 I don't quite know what OB and S means?
8 **A.** OB and S?
9 **Q.** Observation?
10 **A.** Obstetrician? Yes.
11 **Q.** So as far as you were concerned, what is being
12 raised with you is another factor that they did?
13 **A.** Yes.
14 **Q.** That he identified and discussed?
15 **A.** Yes.
16 **Q.** Which was this odd skin discolouration?
17 **A.** Yes.
18 **Q.** Having looked at the air embolism and
19 correlated that. So you have a potential cause of
20 murder --
21 **A.** (Nods)
22 **Q.** -- and they are unable to exclude it. It's
23 beyond a Consultant paediatricians' toolkit --
24 **A.** Yes.
25 **Q.** -- to assess this, isn't it?

1 **A.** Yes.
2 **Q.** Someone else has to?
3 **A.** Yes.
4 **Q.** So stepping back and obviously the Stockport
5 issue is also raised with you at one point and you
6 discussed that with Mr De La Poer?
7 **A.** Beg your pardon, sorry.
8 **Q.** The Stockport?
9 **A.** Yes.
10 **Q.** The murders in Stockport --
11 **A.** Stepping Hill, yes.
12 **Q.** -- by a nurse?
13 **A.** Yes, I wasn't familiar with that at the time,
14 but yes.
15 **Q.** Did you know what they were referring to when
16 Stockport was mentioned?
17 **A.** Dimly. I knew there had been some issues.
18 I have obviously looked it up since.
19 **Q.** You have been given a lot of information in
20 this meeting over a very short period of time, almost
21 all of which was new?
22 **A.** Yes.
23 **Q.** And it's very detailed?
24 **A.** Yes.
25 **Q.** And it must have been rather heartfelt from

1 them, they must have been rather -- it must have been
2 quite an intense experience to listen to all of that?
3 **A.** (Nods)
4 **Q.** Isn't it obvious at that stage that this is
5 far beyond the capabilities of the Royal College and in
6 fact this is an urgent situation that needs
7 intervention?
8 **A.** Yes.
9 **Q.** The upshot, as we know, leaving aside the
10 advice that you gave is that you recommend further
11 investigation. Now, I have to put to you that that
12 recommendation was not an appropriate thing to do and
13 the reason for that was that the time had passed; that
14 many babies had died; that in fact at this point the
15 opportunity could have been taken -- well, it could have
16 been taken months and months before to have a forensic
17 pathology review or a forensic medical review. It was
18 going to add extra time in a situation which required
19 immediate intervention.
20 Do you accept that?
21 **A.** We absolutely should have encouraged the
22 police to be called, yes.
23 **Q.** You should have advised the Trust in no
24 uncertain terms that it had to occur straight away?
25 **A.** Yes.

1 **Q.** One of the reasons that that was required was
2 that appreciating that there were knock-on effects,
3 potentially a police investigation which may have been
4 significant and certainly Dr Brearey was concerned about
5 that, as you may know.
6 But Lucy Letby had been suspended, she hadn't been
7 dismissed and she hadn't been struck off the nursing
8 register?
9 **A.** Yes.
10 **Q.** So there was the risk, a real risk, that she
11 could be reinstated?
12 **A.** Yes.
13 **Q.** There was a real risk that she could seek
14 employment at another hospital?
15 **A.** Yes.
16 **Q.** At any time?
17 **A.** Yes.
18 **Q.** If she in fact was the murderer, patients
19 would have been put at real risk?
20 **A.** Yes.
21 **Q.** That, I put to you, should have been on your
22 mind and the minds of your fellow reviewers when you
23 thought about the appropriate steps that needed to be
24 taken and the timeliness of those steps?
25 **A.** Yes.

1 **Q.** Can I ask you just lastly about Dr Brearey and
2 his evidence. He hasn't given his evidence to this
3 Inquiry yet orally but he put in a statement. In his
4 statement, in a number of points, he is critical of the
5 College for not helping him and his colleagues --
6 **A.** Yes.
7 **Q.** -- when they needed help?
8 **A.** Yes.
9 **Q.** The reason, I think you already understand why
10 he must be feeling like that, is because he explained
11 everything he had to you --
12 **A.** Yes.
13 **Q.** -- with Dr Jayaram --
14 **A.** Yes.
15 **Q.** -- to try to go to those that should have
16 helped him?
17 **A.** Yes.
18 **Q.** His bosses, the Executives, it hadn't worked,
19 and so they were running out of options. Arguably they
20 should have called the police, but that is a matter for
21 him.
22 But do you see why he felt let down by the College
23 and what is your response?
24 **A.** I completely accept they both had a horrible
25 time, particularly having seen the documents that I have

1 seen for this Inquiry. The conversations that happened
2 within the management team and how hard they strived to
3 get this situation resolved quickly.
4 I can only apologise for the fact that we weren't
5 able to support them as they had asked.
6 **Q.** I have taken you through most of the sort of
7 salient bits of information that you were given by the
8 two Consultants and indeed by Mr Harvey?
9 **A.** Yes.
10 **Q.** If you think about all of those factors, and
11 what they told you, would you characterise that as being
12 no evidence that Lucy Letby was connected to the deaths
13 or would you characterise it as being a serious basis
14 for suspicion?
15 **A.** I think with all those factors put together
16 and without the overarching stress and pressure that we
17 were under at the time it is clear there was enough
18 evidence there.
19 **Q.** It certainly isn't something that should
20 conceivably have been dismissed by anyone, is it?
21 **A.** I beg your pardon?
22 **Q.** It should not have been dismissed by anyone,
23 that information that you were given on the first day of
24 your review?
25 **A.** I agree. I agree and particularly the two

1 doctors have behaved with such dignity as well and
2 politeness throughout. They have -- yes, they have done
3 very well.
4 **MR SKELTON:** Thank you. Thank you my Lady, I'm
5 sorry ...
6 **LADY JUSTICE THIRLWALL:** Ms Scolding, I see you
7 there, it is very nice to see you.
8 Do you have any questions?
9 **MS SCOLDING:** No, I don't have any questions.
10 Thank you very much, my Lady.
11 **LADY JUSTICE THIRLWALL:** Very good to hear that
12 also, given the time, thank you.
13 Mr de la Poer, is that the end of the evidence for
14 today?
15 **MR DE LA POER:** It is.
16 **LADY JUSTICE THIRLWALL:** Thank you all very much
17 I know we have run over time three times, we will do our
18 best to do a bit better next week. But thank you again
19 and we will start at 10 o'clock on Monday.
20 Thank you for your evidence.
21 **(5.10 pm)**
22 (The Inquiry adjourned until 10.00 am
23 on Monday, 11 November 2024)
24
25

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