Tuesday, 3 December 2024

(10.00 am)

LADY JUSTICE THIRLWALL: Mr De La Poer.

MR DE LA POER: My Lady, our first witness this morning is Mr Simon Holden. I wonder if he might come forward to the witness box, please.

LADY JUSTICE THIRLWALL: Do come forward, Mr Holden.

MR SIMON HOLDEN (sworn)

Questions by MR DE LA POER

LADY JUSTICE THIRLWALL: Do sit down, Mr Holden, and I will just begin with an apology that you were here for so much of yesterday and we didn't reach you.

A. Okay, no --

LADY JUSTICE THIRLWALL: So thank you for your forbearance. Mr De La Poer.

MR DE LA POER: Please could you give us your full name?

A. Simon Holden.

Q. Mr Holden, is it correct that you provided to the Inquiry a witness statement dated 21 May of this year?

A. Yes.

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

A. Yes.

Q. By background, are you a professional accountant and chartered surveyor?

A. Yes.

Q. Were you the Chief Finance Officer at the Countess of Chester between 26 February 2016 and 31 March 2024?

A. Yes, but there was various roles within that.

Q. I think initially you were in post on an interim basis; is that right?

A. Yes.

Q. There was also a period of time where a colleague had come back to work --

A. Yes.

Q. -- and there was a splitting of responsibilities or a sharing?

A. Yes.

Q. Was the effect of the varying roles that you had over this period that during the period that we are focused upon, which is to say 2016 through to 2017, that you did not attend Board of Directors meetings between August 2016 and January 2017?

A. Yes.

Q. And that you also did not attend all of the Executive Team or Executive Directors Group meetings;

instead it was on an invitation basis?

A. Yes, that's right.

Q. That invitation coming from Mr Chambers?

A. Yes.

Q. Principally based upon the fact that you had something to contribute about the finances to those meetings?

A. Yes, yes.

Q. Now, your witness statement, Mr Holden, is 26 pages long and on over 50 occasions you can take from me you say either that you cannot recall or you can't remember --

A. Yes.

Q. -- or some variation upon that.

Was the issue of the neonatal unit mortality and as it emerged the concerns about a particular member of staff something that you were paying attention to at the time?

A. It -- it -- I was aware that the discussions were ongoing. I was at weekly Executive Team meetings and the board meetings leading up to July '16. But my focus was on the financial position of this Trust because when I joined in January 16, the Trust was running a £10 million deficit. You needed to sort of close the old year because our year end was 31 March,

your new year started 1 April.

So my initial six-month appointment was all focused on money and updating the board and the Executives on money, but equally you were a member of the board and you were a corporate director and therefore had corporate responsibility for everything.

Q. Of course, as you have told us that during the period August 2016 to January 2017 you were not as engaged during that period with the board?

A. Yes, yes.

Q. In terms of your first awareness of a problem on the neonatal unit, you tell us in your witness statement that you think that was an emerging concern but that you have a note in relation to a meeting on 29 June that there was a confidential issue about the neonatal unit; is that correct?

A. Yes.

Q. At that stage, so 29 June and that meeting, do you recall whether there was any discussion about a member of staff or a nurse being the concern?

A. Yes, I can, I can remember there was -- as it was articulated there was a view of increased mortality and the view there could be an individual. But I --

Q. An individual -- could you just finish that sentence?

A. An individual involved. But that -- that was presented to the Exec Team and I can't recall who presented it, and it was quite quickly discounted with a view we need more information, there needs to be some further investigations into what is the cause.

Q. In terms of what was being suggested about the individual's involvement, was it as general as you have just described it or was there a suggestion that it might be inadvertent or incompetently caused harm or deliberately caused harm?

A. I think -- I think in my statement I said it was emerging over time. Initially it was just, we've -- there is a perceived increase in mortality. There is a view it could be an individual but equally there are alternative hypotheses as to what could be driving it.

Q. Well, let's have a look, you have used the word "hypotheses", INQ0101091 and we are going to go to page 396 which is your notes of a meeting on 6 July.

So we see in the centre of the page:

"Executive Director, 6 July, test the hypotheses it is one nurse. Previous action. Feel actions are appropriate. All agreed with Consultants' actions. Nurse on two-week leave."

So that's what you have recorded --

A. Yes.

Q. -- in your notes.

In terms of the "testing the hypotheses it is one nurse", what did you understand was being tested there?

A. I -- I think, I think it was being presented by Ian Harvey and Alison Kelly and there was a view there needed to be further investigation to find out whether that hypotheses that was put forward was right or whether it was something else.

Q. Now, the Inquiry has received evidence that suggests that at an earlier meeting which you are not recorded as being present at that the thought was to look to see whether or not there was a change when the nurse was off; in other words --

A. Yes.

Q. -- did the pattern stop?

Does that resonate with your recollection in terms of the detail of the hypotheses?

A. No, no, I can't recall those conversations.

Q. So far as you were aware from the meetings that you did attend, we know as a matter of fact the pattern did stop, that the sudden and unexpected collapses stopped, the deaths stopped.

Did you ever attend a meeting after this point at which any of the Executives drew attention to that fact and attributed any significance to it or potential

significance?

A. I can -- I can recall conversations that the unit had gone from a Level 2 unit to a Level 1 unit but it had retained the staffing levels at a Level 2 staffing.

So I can remember conversations about the unit having good staffing levels to meet a Level 1 unit and, at that stage, I think there was weekly monitoring of performance to the Executive Directors. But that was one of the hypotheses that was being discussed in the meeting; that the unit being downgraded was a better place for it.

Q. So as you understand, that was one change made in July?

A. Yes.

Q. The other change was that the nurse who is the subject of this note --

A. Yes.

Q. -- was removed. You have described conversations where you -- tell me if I am wrong about this, this is for you to comment upon, that the conversations about the fact that the deaths had stopped were being discussed in the context of the downgrade of the unit.

Was anybody saying in these meetings: but the other

thing that's changed is the nurse isn't on the unit?

A. I can't -- I can't recall conversations about the nurse being moved, possibly being as a factor as the staffing levels.

Q. Thank you. We are going to take that down, please, and we are going to just speak briefly about the Risk Register entry that we know was made on 11 July.

You comment upon this in your witness statement, probably the easiest thing for you to do is for you to bring up paragraph 50, please, in your statement in front of you, page 8, because you explain to us what you understand the phrase "potential damage to reputation of the neonatal service" is. Do you have that in front of you?

A. Not yet, in the folder?

Q. My fault for failing to communicate. It is page 8, it's right at the bottom, paragraph 50.

A. Sorry.

Q. I will read out what you say there:

"My understanding of the meaning of 'potential damage to reputation of neonatal service' was that the neonatal service at the hospital had a reputation with both the public opting for routine maternity services and charitable fundraising and the wider NHS network for the commissioning and allocation of work. Any perceived

reputational damage may have led to less work being referred and undertaken at the hospital."

I just want to pick out some of the things that you have pointed at there. In terms of the reputation with the public, which is the first element, one of the matters that you draw attention to is charitable fundraising. Now, did you understand that there was a concern that if people thought less of the neonatal unit, less money could be raised by charitable means?

A. Yes, it's worth understanding the hospital has a revenue budget to run the hospital and pay the doctors and nurses and then there was a separate registered charity and within the separate registered charity, there was a neonatal appeal to lead -- to replace the neonatal unit. Nurse Letby was the face of that appeal, in effect, and when I arrived at the Trust, they'd -- they had a target of £4 million to generate to build a new neonatal unit and they'd received £2 million, but the costs of running the charity were -- were exceeding the income even at that stage before any adverse publicity.

So the 2 million they had raised was diminishing.

Q. I just want to ask you about what you have just told us there about Letby being the face of the charity. What do you mean by that?

A. There was a charitable appeal specifically for the new neonatal unit and there was various promotional material and leaflets and posters and Lucy Letby appeared on quite a few of those.

Q. So were there discussions in the Executive meetings around --

A. No.

Q. -- that concern?

A. No, not around any individual nurse. I -- I refer to my note here, the conversations were about assuring the population of Chester, ladies who were due to give birth next week, that the unit was safe and equally there was a discussion about should we suspend the fundraising? Should we pause it? Should we keep it going?

But it was with, with regard to the charitable side of the ...

Q. That is the first part that you have spoken about. The second part is the wider NHS network for commissioning and allocation of work. So there are you referring to the cycle that -- the commissioning cycle where the hospital has to put in a bid for work and as a result, funding is allocated to it on that basis?

A. Yes.

Q. Crudely?

A. Crudely, yes.

Q. So there was also a concern, was there, amongst the Executives that if the neonatal unit had a poor reputation, that less money may be provided in the future?

A. I think, I think the concern was in downgrading the unit to Level 2 to Level 1, it could stay at a Level 1 unit, if the commissioners took that view.

Q. If it stayed at a Level 1 unit, it will get less money?

A. Yes.

Q. In terms of the formulation of potential damage to reputation and neonatal service, were you part of any conversation which came up with that form of words?

A. No.

Q. Do you recall there being a discussion at the Executive meetings that you attended in the terms that you have included in paragraph 50; in other words that people were saying: we are worried about the charity and whether we need to stop that and whether that will mean less money and that we are worried about whether we are going to get money in the next commissioning round if we are still a Level 1.

Were those the sort of discussions that were taking place?

A. It wasn't that explicit but I can remember when it -- that risk was put on the Risk Register and shared -- the narrative was shared with the Executive Team and everyone accepted that was a, a good summary of various different people's perspective on it.

Q. Finally on this topic, just going back to what you tell us about Letby being the face of the -- or part of the face of the charitable fundraising effort. Was that connection ever made in the meetings when you are talking about the charity, that of course one --

A. No.

Q. -- of the people --

A. No.

Q. -- who's been -- well, the person who's been suspended is connected with our charity?

A. No, it wasn't explicitly raised at that time.

Q. Are you able to say whether that was in anybody else's mind from what was said and how people were saying it?

A. I -- I can't and I can't remember anyone saying it round the 16/17 period.

Q. But that was a connection that you drew, did you, at the time, a thought process that you had?

A. Not -- not explicitly at the time. It was -- it was more to do with: we are running an appeal for a new neonatal unit, whilst at the same time we are downgrading our neonatal unit and what would we do if we decided not to have a neonatal unit, we have generated £2 million of charitable donations, how could you give that back to the public?

It was those sort of -- we need to deliver the charitable appeal to replace the neonatal unit. Those were the conversations.

Q. I suppose it's just when first speaking to this entry, you expressly drew attention to the fact that Letby was a face of that charitable --

A. Yes.

Q. -- effort?

A. Yes.

Q. And was that a thought that you had at the time that you acknowledged?

A. No, because I -- I -- to be quite honest I didn't know who Lucy Letby was, so I wouldn't put the face with the name at the time. I had only just arrived in a Trust that employed 6,000 people, so ...

Q. So why did you tell us a few moments ago about the fact that she was the face, how was that relevant to what you were talking about?

A. Well, I think what was relevant was the neonatal appeal was definitely a consideration, discussed: what do we do? Do we pause it? Do we keep it going? I think it was only subsequently it became apparent that all the documentation had Lucy Letby's picture on it. But that was after the 16/17 discussion.

Q. Well, that may have been when it became apparent to you but anybody who knew about that documentation and knew about the nurse --

A. Yes.

Q. -- would have been able to make that link at the time --

A. Yes.

Q. -- when talking about the charitable ...

A. Yes, yes.

Q. So I would like to move forward in time, please, to 16 March of 2017, which and I am not here referring you to your statement for the time being.

This was a meeting at which Sue Hodkinson reported that she had spoken to Dr Jayaram the day before and that he had told her about three cases that he was particularly concerned about. Now, sitting there now, do you have a recollection of that meeting?

A. No.

Q. Well, if we bring up the note, please,

INQ0003344, just attempt to prompt your memory before we come to the entry I am going to ask you about.

This includes reference on this first page if you look one-third of the way down: on behalf of all bullied and intimidated.

So it's very serious language that is being used there to report about how, as we understand it, all of the Consultant paediatricians were feeling, that is the reference to "all" and obviously the language of "bullied and intimidated" is exactly the sort of language that Executive Directors will not want to hear, particularly when it is they who are being suggested as the bullies and the cause of the intimidation.

So does that prompt your recollection about this meeting in terms of the atmosphere of it?

A. I can remember Sue Hodkinson feeding into an Exec team at some point to say how the Consultants were feeling as a body. I was very much on the edge of those discussions because there was different views in the meetings about how it should proceed.

Q. Thinking about that meeting, which may very well be this meeting that we are talking about here, what was the attitude in that meeting towards the concerns that the Consultants were being reported as having about being bullied and intimidated?

A. I can't -- I can't recall. I can recall Sue reporting it to the meeting. I can't recall how anyone reacted to that other than my own recollection.

Q. Well, let's try it this way. Was your impression that the response was: well, they have no reason to feel that? Or was the response: this is a really serious situation and we need to understand better why they are feeling that way?

A. I think -- I think the response was: there's no reason to feel that. But there was various different things going on and various people dealing with bits of work and I was very much on the outside of that.

Q. If we go to page 2, three-quarters of the way down, we see that you made or are recorded as making a contribution to this meeting.

About two-thirds of the way down we can pick it up:

"Sue: Ravi cannot see perceived gap between nurses and doctors."

Do you see that entry there? That's after a long passage attributed to Tony Chambers. We can then see action plan against Alison Kelly's initials.

And Sue saying:

"I could pick up with Ravi."

A reference to template and then next to your name:

"Playing for time".

A. I don't know what that entry is.
Q. Well, I suppose two obvious interpretations. The first is that you were suggesting that the Consultants were playing for time, the second was that the Executives needed to play for time. Can you help whether it's either of those or --
A. I honestly can't remember at all or using that language.
Q. Thank you. We can take that down. Now, there was a meeting on 19 April, I don't think we will need to bring this up, but you make notes about it and you refer to those notes in your witness statement.
In this meeting there's discussion about CDOP, the Child Death Overview Panel?
A. Yes.
Q. I am sure you can bring to mind the reference.
My question simply about that was: did you actually understand what was being talked about in terms of the detail or were you just making a note of what people were saying?
A. I think by that stage, if -- if my memory's correct, that's after the KC's advice to the board that that was one of the --
Q. Correct.
A. -- potential routes to go down.

I think everyone seemed to think that was the correct route to go down. I don't think there was any dissension in the meeting.
Q. It's just that your reference is to CDOP, there is no reference in your note to the police. Is that because the focus was upon CDOP rather than --
A. I think it was going to -- to CDOP but I think it had been explained to me the police were a member of CDOP, so by definition ...
Q. There are two entries in your interview with Facere Melius that I would like to ask you about. INQ0012998 and it's page 5, the first entry, bottom quarter of the page. So do you see there is a large paragraph there in the lower half of the page and I would like to pick it up with the sentence that says: "But then equally ..."
So I am sure that will be highlighted for you in just a moment. The start of the line halfway down:
"But then equally ..."
So if we just read this through:
"But then equally I know Tony was meeting with Lucy's parents because I think Lucy lived -- she lived on her own, you know. You have got a member of staff who's being victimised and the parents are saying 'Look you know this, she's never done anything wrong'. Then

the poor girl's in bits and you've got all these Consultants are picking on her. They have got no evidence."
So it's just that passage there. Now, my question really was: is this the way in which the other Executives who were the ones dealing with this issue were talking about it in the meetings that you attended?
A. Yes.
Q. So if we break that down a little. Was it being suggested that Letby had been victimised?
A. That was my impression from discussions with the Executives.
Q. Next, we can see "the poor girl is in bits", in other words, she's very upset and then this:
"... and you have got all these Consultants are picking on her."
Again, was it your understanding that the way in which the Consultants were being spoken about was that they were picking on Letby?
A. The -- I think the Facere Melius is, is clumsy language and it's been transcribed from a Teams call or shorthand. But the content of that was my understanding following this Executive Team meetings.
Q. Finally "they have got no evidence".
Again --

A. Again.
Q. -- is that the sentiment, even if not your precise phrase --
A. Yes, that --
Q. -- about what?
A. That was the sentiment where Alison and Ian had looked at it and we had commissioned internal reviews and reviews had gone on and I was told the reviews didn't show anything. So that was the sentiment in those meetings.
Q. Page 11, please, you were asked about this in your witness statement, right at the bottom of your answer. So if we look at the bottom six lines perhaps just to run up to it:
"It's probably from when I go back to being a Chief Exec, you know. I am a lovely finance director now but I think you need to have that culture of challenging, you know, every asset and Execs and every report of staff off being ..."
Forgive me, I have started the sentence too late, it is my fault.
If we go to the previous sentence:
"I was gonna say I have witnessed bullying, witnessed some behaviours that I don't think are appropriate. It's probably when I go back to being

a Chief Exec, you know, I am a lovely finance director now."

I apologise for that?

A. Yes, I ...

Q. So I suppose the first question is: did you witness bullying at the Countess of Chester?

A. On reflection and, like I say, I had never seen my Facere Melius played back to me, I wouldn't say I had witnessed bullying. But I think positions became extreme and there was a level of firmer and firmer interaction.

Q. You also use the -- "some behaviours I don't think are appropriate", so perhaps a slightly lesser description of behaviour that might be described as bullying.

Did you see inappropriate behaviour?

A. No.

Q. So what do you mean by "positions became firmer and firmer", whose position became firmer and firmer?

A. I think over time the position between Tony Chambers and the neonatal Consultants became strained and it became obviously strained and I think each party grew further apart.

Q. My final topic is this and we have heard

conflicting evidence on this point, but you were in post at the time that Tony Chambers left the Trust?

A. (Nods)

Q. Were you aware of a vote of no confidence that was being proposed in him?

A. I was aware there was a Medical Staff Committee meeting being called. I was aware Tony was anxious about it. I think the vote of no confidence was one of the possible outcomes of the meeting.

I -- I didn't -- my -- my understanding was the meeting wasn't explicitly called to vote on a vote of no confidence. But the fact the Medical Staff Committee was meeting, that could have been one of the outcomes.

Q. The other part of what we have heard evidence, and again there is conflicting evidence on the point so I just want to hear what you have to say about it, is was there any suggestion that Mr Chambers' relationship with other directors whether Non-Executive or Executive, had broken down at the same time?

A. No. I -- I think the relationship with the board, Execs and Non-Execs appeared to me to still be in place. But I'm not 100% sure of what other conversations could have gone on behind closed doors.

Q. No.

A. But outwardly to me the relationship appeared

firm.

Q. So you didn't perceive the board as being dysfunctional at that time?

A. No, no.

MR DE LA POER: Yes, Mr Holden, thank you very much indeed for answering my questions. My Lady, there are no Rule 10 questions.

LADY JUSTICE THIRLWALL: I don't have any questions for you either.

A. Okay, thank you.

LADY JUSTICE THIRLWALL: I think we may have thought we would take half an hour and I see we have taken 32 minutes, but thank you very much for coming. You are free to go.

A. Thank you.

LADY JUSTICE THIRLWALL: I think Ms Langdale may not have shared your confidence that you would be finished in half an hour. Do you mind if we just simply wait for the next witness to come up?

MR DE LA POER: I should say my Lady that she would be absolutely right to be dubious.

LADY JUSTICE THIRLWALL: Yes, she did have some evidence in favour of that.

MR DE LA POER: She certainly did.

MS LANGDALE: My Lady, may I call Mr Higgins.

LADY JUSTICE THIRLWALL: Yes, certainly, Mr Higgins, do come forward.

MR ANDREW HIGGINS (sworn)

Questions by MS LANGDALE

LADY JUSTICE THIRLWALL: Do sit down.

A. Thank you.

MS LANGDALE: Mr Higgins, you have prepared a statement for the Inquiry, do you have it in front of you there?

A. Yes, I do.

Q. Can you confirm the contents are true and accurate as far as you are concerned?

A. Yes.

Q. Can you tell us firstly something about your background, your career and how you became a Non-Executive Director with the Trust?

A. I was -- I had trained as a chartered accountant, and I spent 33 years, plus some months, with one of the large firm of accountants and advisers and after that time, I retired from the firm and I was -- with the intention of looking for some Non-Executive positions.

We had just moved into the area from Manchester, not a very big leap, but so -- and at the same time as it happened in 2011, I came across an advertisement for

a role with the Countess. And so naturally, sort of it being one of the key service providers within the area, I was attracted to it as somewhere where I hoped I could make some kind of a contribution to some of the essential public services that were provided and that was how my association with the Countess started.

Q. You tell us it was essentially an opportunity to give something back?

A. That was -- that was the objective, yes.

Q. So a sense of public service and contribution?

A. Yes.

Q. You tell us in your statement about the inductions and trainings that you received in relation to the role. Can I just ask you about safeguarding training and whether at any time you were given any training about what to do when a member of staff is suspected of causing harm to a child. Was that anything you were ever given any induction or training on?

A. I don't recollect safeguarding specifically being part of the training that took place or the briefings that took place around the time of the induction process.

Over time I do recollect that there was training briefings, whatever you want to call them, provided to the board as a whole around safeguarding

responsibilities and -- and that kind of thing. But at no time do I recollect the specific of, as you have just described it, harm to a child and reporting to the police.

I don't recollect that coming up in either a briefing or training or anything of that nature.

Q. What about necessary actions and investigation when a baby suddenly unexpectedly dies; anything like that in the training you received?

A. No, nor that.

Q. Who would you as a Non-Executive Director rely upon to inform you what external bodies or investigations were required if a baby suddenly and unexpectedly died?

A. I think my first ports of call, so to speak, would be the Director of Nursing and the Medical Director. Because they were -- I knew and could see that they were intimately involved of any occurrence of that nature. So I think that would have been where I would have gone first to become informed.

Q. So Ms Kelly and Mr Harvey?

A. Correct.

Q. You tell us at paragraph 6 of your statement that following the publication of the report of the Mid Staffordshire NHS Foundation Trust Inquiry in 2013 the

Countess reviewed its policies on whistleblowing and raising concerns about patient care and they were amalgamated into one policy.

There was a Speak Out Safely steering group, wasn't there, of which you became a member?

A. Yes.

Q. Can we just go briefly to a few documents around this. Firstly, the Speak Out Safely and whistleblowing policy, INQ0003014, and if we could go to page 6, please. We see here designated officers under this Speak Out Safely policy. Mr Harvey is Medical Director, Mark Brandreth, Director of Planning, Partnership and Development, Ms Kelly, Director of Nursing, Debbie O'Neill, Finance Officer, Sue Hodkinson, Human Resources and you are listed as the chair of Quality, Safety and Patient Experience Committee and Senior Independent Non-Executive Director and Hayley Cooper, Staff-Side Chair and RCN rep.

Do you know how the designated officers were put together and chosen as a group?

A. I think firstly because of those seven people, five were effectively the -- the members of the steering group, being the Medical Director or Ian Harvey, Alison Kelly, Sue Hodkinson, and myself and Hayley Cooper, I'm not sure whether she was formally

a member of the steering group but she quite often participated in those discussions.

When I saw the -- there were numerous sessions of the group where the policy and a redraft of the policy was discussed and I don't recollect any particular discussion or process whereby Mark Brandreth and Debbie O'Neill were added to that list. But I thought since the policy was specifically for -- well across the Trust, I thought that their inclusion was to address matters that may not be related to issues of patient care or safety but more generally.

Q. If we go to page 14 of the policy, we see the flowchart for concerns: raising concerns with a line manager. If you can't do that, raise with a staff representative, head of service. If you can't do that, raise with a designated officer.

So the designated officers are identified there.

There are a number of Executives, aren't there, who are designated officers who might be expected to be involved if there was any internal investigations, the same for Mrs Hodkinson as HR. Do you think the selection of a group of designated officers who may be involved themselves in internal matters investigating suspicions and concerns was the wisest combination for that group?

A. I -- I think I make reference in my statement somewhere -- I'm afraid I can't remember the paragraph, that I felt and discussed with colleagues around the table that I felt that potentially there was a conflict of interest around some of the membership of the -- of the steering group in that Executive managers could become involved or overseeing investigations into areas for which they had responsibility and that seemed to me to be a potential sort of bear trap around actually dealing with -- with matters.

And I always felt, to be frank, that the way that this ultimately played out across the NHS whereby the appointment of an independent guardian was, was mandated, was by far the better way of, of resourcing or at least heading up a function of this kind.

Q. Why do you think that?

A. Because I always set great store by having some independence of those who are responsible for managing -- either managing the Trust or providing patient care within it and it seemed to me that a referral to outside parties was a healthy indicator that the Trust was not attempting to hide or cover up anything that was going on.

Q. You say, indeed you do refer to it in your statement at paragraph 34:

"With the requirement to nominate guardians in 2016-17, the steering group raised the need for all members to undergo training."

You attended Freedom to Speak Up Guardians training in February 2017?

A. Yes.

Q. You were formally appointed as a Freedom to Speak Up Guardian?

A. Yes.

Q. Did your colleagues -- when you raised concerns about the issues identified for Executives in some way may be being involved already in investigations, did they agree with you about those concerns?

A. I think that they understood the point I was making. At the time, there didn't seem to be a particular alternative in that the policy was being promoted, I mean firstly the policy was being promoted by people who had a full portfolio of other, other responsibilities and it was clear that there was -- there was -- I remember discussions about treating to fund somebody from outside or a new appointment.

And at the time, I think given the financial situation that Mr Holden has just described, it was clear that there were no funds available to fill the

role in that way. So I think my colleagues, as I say, understood what I was saying but were really in the position where there was no alternative but to carry on with the -- because there was no other resource available to do it.

Q. So it had to rely on Mr Harvey, Ms Kelly and Ms Kelly already having safeguarding responsibilities and other portfolios?

A. I think rely on the group as a whole which included me and to a certain extent I think I and -- I think my colleagues on the group as well probably saw it that I was providing something of an independent presence around the table because again I think I say that in terms of the actual work and nuts and bolts of specific investigations, there was only once that I actually got directly involved myself which was absolutely nothing to do with -- with the neonatal position or unit. And -- and was purely a question of sort of stretched resources that -- that just couldn't otherwise provide some input into this so I provided it, I provided some, not all of it but some.

Q. In terms of numbers, and you may not have them off the top of your head, in the period 2016, 2015, 2016, 2017, how many complaints were coming through or concerns were coming through this Speak Up Safely route,

do you remember discussing at the steering groups many concerns?

A. Yes, indeed. There was a log and the log, I remember, went to a few pages. So I suspect that on an annual basis, this is just a feeling because I can't remember the specific number, but in the 10s, maybe 30, 30 per annum and the objective really was to encourage people to come forward. So the number coming forward was seen as a measure that was important because if, if that log was unpopulated then clearly the system wasn't working at all.

Q. How did you promote the system --

A. I think --

Q. -- within the hospital?

A. I think the principal route was through the policy, through actually putting the policy out there.

Because the way I understood the policy that its primary purpose was to make all staff aware, because it started off saying: well, patient safety and care is the responsibility of everybody within the Trust. So the policy was -- was the document that was intended to provide the kind of the blueprint and the "what to do" instructions if somebody had such a concern and they wanted to raise it.

So promotion of the policy was absolutely key in

promoting speaking out safely as -- as a topic and as an objective.

Q. And how was that done within the hospital, how was it made available to staff in the hospital?

A. Well, I -- I think we, we talked at times about the -- the appointment or identification of champions within different parts of the hospital, so that there was a network of people who might be, shall we say, tasked with being more aware and familiar with the policy and using that and that was one thought. I think the -- I -- I honestly don't know the way in which the policy itself was promoted other than those kind of thoughts. But I think it was pushed out in the same way that other policies are.

Q. Can we just briefly look at minutes of a meeting on 20 February 2017 which is INQ0098375, page 3. It is a meeting Mr Higgins with yourself, Ms Kelly, Ms Cooper and Mr Cross, Mrs Hodkinson has sent apologies by the looks of the attendance list. If we look at box 6.

AK, that is Ms Kelly, presumably said that "we need to consider whether the concerns raised by paediatricians in the NNU need to be formally logged".

When this was raised -- can you remember this being raised as an issue first of all and do you know it was

time as to why it was being raised suddenly, when it hadn't been raised before February 2017?

A. I really can't -- I really can't recollect. I -- I must admit I didn't sort of view the Speak Out Safely steering group and this particular situation. I -- I think, as I said, I viewed the policy as a means and, and an encouragement for staff to raise concerns that they would not otherwise have raised.

The policy talks about or talked about the escalation of any issues and how that would sort of work. And what it, what it ended up saying was that ultimately for something that was, couldn't be resolved in any other way it would go to the Chief Executive or failing that, to the chair of the Trust.

At this time, I was -- it was, well, because I was totally aware that the matter of the underlying cause of the concerns was already being dealt with by the Chief Executive, the Medical Director, and the chair of the Trust was kind of intimately involved in what was going on.

Q. So when it says there "we should monitor the situation through normal routes", is that what you understood was happening, because there was an awareness of the Chief Executive -- the board -- that it's just being, it's being monitored and addressed?

being raised at this point?

A. I do remember talking -- talking about this. Why specifically that minute appears for this particular meeting. I can't say.

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

So nothing is said about formally logging it then.

We know, Mr Higgins, that at this time, the Consultants have been warned that someone or there may be or there are references to GMC and at round the same time it appears here about whether they have been formally logged.

Did you know the backdrop or why it might be being raised at this time?

A. I certainly was not aware of any implications that the Consultants were going to be reported to the GMC. I was aware, however, that the kind of the tensions around -- around the entire situation had sort of worsened over time and that there was -- the relationship between the Executives and the Consultants had become very, very difficult.

Q. Did that assist your thinking or not at the

A. I think -- I'm not sure I would ever use normal routes for this situation that -- that everybody found themselves in. But different routes, I think, I think that's how I would put it.

Q. If we go, please, to another document INQ0098434, page 2, this is a meeting held on 24 April 2017, a Speak Out Safely meeting. If we look at that second box, please read that.

A. Page 2.

Q. Yes, box 2. There we are. Review of the minutes:

"Members reviewed the minutes of the previous meetings held on 20 February which had been circulated that morning. Members did not recall agreeing not to formally log the concerns raised by the paediatricians. Hayley Cooper asked how it could be logged as nothing had been received in writing and it had also been logged elsewhere ...internal/external reviews. Ian Harvey had also had a conversation with one of the Consultants who requested it to be logged under Speak Out Safely."

Do you know why this was raised, and there seems to be competing views about what had actually happened?

A. I'm -- I'm afraid I can't say why, why it was raised. I -- I don't, I don't recollect that.

Q. Just to complete that, at INQ0098458, page 1,

this is a meeting, Tuesday 6 June 2017.
Can you have a look at the top of the box there:
"As part of the joint Countess of Chester police investigation in neonates, the police have requested copies of any notes from meetings where neonates discussed."
If you could:
"Members did not recall agreeing not to formally log the concerns raised by the paediatricians but the notes from the meeting on 20 February state that this was agreed. AK added that concerns were raised and whether these needed formally logging."
So it continues. There appears to be some confusion about what's recorded to have been agreed or what's been asked here. If you can shed any light please do and if you can't, so be it.
A. I think this was part of a -- a continuing discussion about how the steering group should recognise or formally recognise the concerns raised by the neonatal Consultants or not include them within the documentation that was generated by that group.
And frankly, I think these were kind of indecisive conversations in that everybody seemed to recognise that the -- that the logging of the -- of the -- of the concerns was not likely to change the way in which the

Trust was addressing those concerns in terms of following them up or investigating them and therefore, I think that's why we -- we kept returning to it because it was just unclear how it would -- how it should be treated by this group and -- and indeed what impact the logging would have.
Q. Hayley Cooper's evidence -- or Griffiths evidence -- was that the Speak Out Safely committee glossed over the issues on the NNU. First of all, would you agree with that and, secondly, if so, was that because you understood and knew it was being addressed elsewhere?
A. I think that that is I think that's an accurate way of describing it. There were no really sort of I suppose there were no structured or substantive discussions around the precise conduct or progress of investigations that were taking place even though the people around the table, perhaps Ms Cooper rather less so, were aware of, of these matters.
So I think, I think yes, the group did gloss over them and for my part I -- I did feel that as I say in my own mind I could not resolve the question as to if this were logged, what difference is it going to make? I mean the only -- the aspect of that that I reproached approach myself for, particularly having gone through

all of this, was that I think what that failed to do was to, was to recognise or understand fully the position of the Consultants and I -- I did not, I was not fully aware of precise, the nature of or at least I understood that relations were becoming difficult but I don't think I understand -- I understood the extent to which they had been -- they had become so strained as to become virtually -- well, I mean almost a breakdown.
Q. That can go down, thank you. How many times did you actually hear from any of the Consultants? Were you in the meeting where they did attend one board meeting when they did attend?
A. There was one later on in the process because the -- I think -- the first meeting in July 2016, I was not at that one. And then also the meeting on the 10 January.
Q. You weren't at that one?
A. I wasn't at that one either.
Q. No.
A. So --
Q. Don't worry about the dates. Can you remember how many times you heard from Consultants yourself directly?
A. In -- in the formal meeting once.
Q. So once in one of the formal meetings.

Did you ever informally speak with them?
A. No, I didn't.
Q. You say, and perhaps it helps to have it on screen, Mr Higgins, at Facere Melius interview INQ0003058, page 15, you say halfway through this paragraph:
"I mean, one observation that would make sense I kept missing meetings at which the Consultants turned up. I can't remember when this was. I think this must have been in Susan's times when Ravi and John Gibbs came along. I think we all felt that and in fairness John Gibbs in particular, very kind of objective and, you know, kind of reasoned and reasonable exposition and description and explanation of where our Consultants were coming from what they had done a timeline and I think a lot of us came out for that, you know, blimey, if we had the opportunity to have a conversation like this. But from, you know, they turned up at different times when Tony and Ian were there. Maybe the fact is they were actually either kind of somehow suppressed from expressing in those terms but, you know, there was a lot of kind of shocking stuff, an awful lot of sympathy from where the consultants were from and it's just -- it's a massive, massive shame that that kind of meeting of minds or kind of that emotional link gives

a hell of a sight earlier on the whole process for everyone."

We can see what you have said. Would you like to expand on this? You said you met the Consultants once, was this the board meeting you are referring to when you spoke with them, with Dr Gibbs there as well?

A. Yes, it is.

Q. That is the time you had a chance to hear from them and that is what you observe. How do you reflect upon that now, how much time you had with the Consultants during the period in question?

A. I feel that I made a mistake in not personally pursuing a line that may have been open to me. The reason that I hesitated or didn't do that was because aware that the situation was strained and incredibly fraught, and also subject to some formal HR processes, I frankly thought that if I were to directly sort of independently intervene, then I could have made a bad situation even worse.

Going through this whole process I think that either as chair of QSPEC or as a member of the Freedom to Speak Up group, I probably had some, some standing or ground from which to do that and I should have done but didn't.

Q. In your Facere Melius interview, and that can

go down, you refer to doing a double-take on being asked to chair QSPEC because you had basically financial experience and expertise and not clinical or a medical background?

A. (Nods)

Q. Sir Duncan yesterday said he didn't see that as an issue. I don't know. Do you still see that that would have been preferable for a chair of QSPEC or not?

A. I think at the time that I had the conversation with Sir Duncan, there were no Non-Executives on the board with medical experience. So it would not have been possible to -- to appoint somebody with that kind of background because they were not on the board at that time and I -- I viewed it as a big, big challenge.

But I viewed it as one that personally I was interested in getting away from the numbers, I felt that this was at the core of what the Countess was about and so really in terms of trying to -- trying to do something that would help the Trust, it seemed sensible. And I think the discussions that we had at that time was that the chair's role was not to know everything about, about everything that the committee was talking about, considering or overseeing or monitoring but that the real role was to bring together a group of people with

all the requisite skills to do that job as -- as a corporate, as a collective rather than the chair doing it individually and it was on that basis that I -- I kind of embarked on -- on that role.

Q. You set out at paragraph 29 some of your key working relationships and how they were. Could you tell us about those in your words with the various people that you were working with?

A. Shall I take them in the order that I --

Q. Yes, yes, and don't feel constrained by that, whatever you wish to say about them.

A. No. Well, Sir Duncan: I -- I mean, I felt at the time of the recruitment process because I was part of the group that went through various -- through the interview process, I thought that we were incredibly lucky as a -- as I describe there. I mean, basically a small/medium-sized district general hospital to have somebody like that come through the door, I thought that we were very lucky and I -- I found that Duncan was always -- was always very, very supportive, could be, could be very challenging at times but in a constructive kind of way. So I -- I think I had a very good relationship with the chair and learned a lot from him.

Ian, Ian Harvey: I thought -- I thought the appointment of a full time Medical Director was actually

a really, really good thing. Prior to that, the Medical Director role had been fulfilled by a Consultant who was still pursuing sort of clinical responsibilities and that kind of thing so I felt somebody getting in it full time was a good thing.

I mean, Ian and I had a -- I think a good cordial relationship, but I'm not sure how to characterise but it wasn't the kind of thing where we would slope off the pub after work to have a drink together but it was perfectly cordial and businesslike, that's how I would describe that.

Q. You say in here you found him to be:

"... sometimes distant and occasionally reluctant to engage fully. Often appeared more of a theoretician than a practical manager."

Why do you say he seemed more of a theoretician than a practical manager?

A. Well, I think it's a question of somebody sort of taking a broad management role by virtue of a qualification that is narrower than the role they have taken. And I say that because as an accountant I know lots of accountants get put on all sorts of roles, but sheer numbers do not qualify you for -- for a wider kind of portfolio and responsibility.

So I always felt that Ian's management skills of

people were not as well developed as his sort of skills around clinical issues and those kind of things.

Q. You say:

"He seemed more comfortable discussing the highly esoteric statistics behind the standardised hospital mortality index or hospital standard mortality rate than the challenges in resolving any non-compliant practices in clinical teams."

Why do you say that, did you have conversations about hospital mortality indexes with him or anything like that?

A. Well, the -- I think it was the example that came to mind straight away because in terms of the sort of the -- some of the more esoteric information that came through because some of the statistics behind the derivation of mortality indices well were very, very difficult, frankly.

Ian always seemed very on top of those and much more so than I was, and I suspect most of the people in the room, so that was that bit.

The other -- the other -- the bit about non-compliant practices in clinical teams, that actually relates specifically to direct experience I have, again nothing to do with the reason that brings us here, but when I said I got involved in one Speak Out Safely

instance then I -- we ended up with a kind of -- part of the thing was that the everybody involved, including the line managers, should get a full run-down of what's come through a particular process and investigation.

I took part in one of those with Ian and I felt that I was having to take the initiative and really sort of, shall we say, fire the bullets because Ian was reluctant to do so and it was probably not something that was within his -- his normal comfort zone of operation.

Q. Mr Chambers, how was your relationship with him and your impressions of him?

A. Again, perfectly cordial. But not close. Not close. It was, I suppose by virtue of the -- the heavier or the heavy duties of the Chief Executive then opportunities to spend a lot of time with the Chief Executive were -- were relatively rare.

So it was not as easy to build a close relationship. But again, I think it was always kind of businesslike.

Q. You say as you have now not a close working relationship, but felt Tony was keen to manage the message given to Non-Exec colleagues. What do you mean "manage the message"?

A. That was prompted by really the issue that as

the years had sort of after I joined in 2011, things got more difficult, resources generally got more strained progressively and there was a lot of discussion about some of the actions that were proposed or proposed to be taken to kind of not resolve those difficulties but to -- to lighten the load a bit or to improve the situation.

Many of those proved too difficult to put in place and I think when the Chief Executive was challenged on why those weren't working. I think at that time he became kind of more defensive because there wasn't a ready answer and so therefore I am not saying the Non-Executives were being awkward but it was -- there were difficult questions to answer and we clearly were not getting sufficient traction on improvements in -- in certain areas.

Q. You say of Ms Kelly:

"I relied on her to a large extent as eyes and ears on the ground and I tried to support her in promoting key issues on safety and quality."

A. Yes.

Q. Would you like to expand on that working relationship?

A. I think part of it was driven by the fact that the machinery that drove the QSPEC agenda and material

was not exclusively, but to a large extent, nurse led and it came out of -- out of the resources that were immediately under the Director of Nursing's control and therefore almost inevitably to -- to really to go through the agenda and understand or prepare around some of the papers that -- and items that were coming before the committee, then the Director of Nursing was probably the natural port of call. Not on everything, but on a fair proportion of what was coming through.

And I think it was that kind of necessity that really formed the basis of our working relationship.

Q. And you say of Mrs Hodkinson your:

"... main interaction with Sue was on Freedom to Speak at matters. We had a friendly relationship and co-operated well on issues that involved us both."

A. Yes.

Q. Finally, Mr Cross. You had many dealings with Mr Cross. You say:

"I found him positive and helpful but I always sensed that he was conscious of managing his relationships with Non-Execs so that we didn't set hares running unnecessarily."

Would you like to expand on that?

A. Part -- that comment was driven largely by my experience on the Audit Committee which Mr Cross was,

was one of the principal Executives kind of looking after or supporting that -- that committee and we -- we had an outsource internal audit who produced all sorts of reports with improvements and actions that needed to be taken and this was monitored on an ongoing basis.

And it always surprised me how easy it was to put something on that -- on that log but how difficult it was to take something off and how frequently dates got changed and pushed back and the principal kind of defender of -- of the challenges around this was Mr Cross.

So -- and that's what prompted that comment.

Q. You say "good working relationships with all Non-Exec colleagues".

In terms of the Board of Directors, you say at paragraph 30 you think that the Board of Directors was apparently cohesive and this was manifested in its deals with the Council of Governors and in its public meetings.

We know issues surrounding the neonatal unit were not discussed at the Council of Governors or in public meetings but did you think that form of governance was effective for other areas of importance for the hospital, it clearly wasn't relevant to what we are dealing with but generally as a matter of governance?

A. I beg your pardon? Are you referring to public meetings?

Q. Did it work well, the Council of Governors and the public meetings?

A. Oh, I think the relationship with the Council of Governors did -- did work well. They were -- many of them were very, very kind of active and diligent in their roles and their responsibilities for the public board meetings then, the members of the public quite often comprised governors and maybe nobody else. Occasionally somebody from the local press, but they were, they were very assiduous in -- in coming to board meetings and very, very engaged.

I think -- and it was Mr Cross who was principally the person who -- who kind of -- I was going to say ran that relationship but serviced that -- that relationship from the point of view of the Executive and yes, it seemed to work very well.

Q. Why do you use the word "apparently": "I think the Board of Directors was apparently cohesive"?

A. Yes. Well, I think I address that at the end of the paragraph because I think that I always sensed and I must admit that from a personal point of view I always found the public meetings -- I was never comfortable that they were -- it was a forum in which it

was possible to really dig into something really, really sensitive or indeed really confidential and therefore I always thought there was a sense of kind of theatre about them, that was not the same as substantive sort of discussion or challenge.

And I think as time -- I have spoken previously about pressures increasing generally across the board, and I think this led to the Non-Executive cadre on the board feeling that there were places where Executive -- or management within the Trust might not have been as effective or as incisive as it could have been and the more that the pressures escalated generally, then the more that those kind of issues showed and therefore it didn't derail any -- any board business, but I think there was an underlying -- sort of an underlying current whereby Non-Executives were feeling less comfortable about the performance of the Trust as a whole and I suppose by -- by inference or responsibility some of the Executive Directors.

Q. You say at the end of the paragraph:

"It was said more than once, often in informal discussions among Non-Exec colleagues, that the Countess had an optimism bias that suppressed problems and exaggerated successes. In a climate of escalating pressures this bias undermined the cohesion of the

board."

Optimism bias. Can you give us an example of where you felt something was exaggerated or ...

A. I am just -- I -- I struggle to think of an example of where something was exaggerated.

Q. Well, successes exaggerated is what you said, or alternatively suppressed problems then, either. Can you think of one?

A. I think suppression of problems was -- was more -- I think that the organisation was probably more comfortable in -- in celebrating and lauding achievement and good performance than it was in kind of admonishing and doing something about poor performance.

So -- and that was kind of part of that sort of general tone, I think, within the organisation because I think right from when I joined the Countess really sort of saw itself as -- as a very sort of, you know, a good place to work, and a good operator.

Q. When you say "admonishing poor performance" what was it about admonishing that was difficult or you sensed that was less comfortable territory?

A. Calling it out. So if -- if there was -- I mean, within the -- within the monthly or the board reporting, the integrated performance report, there were a whole succession of measures across all sorts of

things. That quite often was spattered in red, ie it was less than expected or required performance. And I think that the drilling down into why that was happening and actually doing something about it seemed to be quite difficult in a number of areas sometimes for very good reason.

But I think there was an element whereby there was sort of a reluctance to do that.

Q. You were asked whether the management and government processes of the hospital failed to protect the babies on the neonatal unit from the actions of Letby and you identify three contributory factors.

The first bullet point, paragraph 31, a lack of focus. Agenda were too long. Can you expand on that for us?

A. Yes. I was thinking of QSPEC there in that papers for the meeting could quite often be 200, maybe 300 pages and because of the involvement in clinicians and nurses around the table, then they were held on a Monday and the starting time was 12 o'clock and by 2 o'clock then the clinicians may have clinics or other responsibilities, the nurses needed to get back to things.

So it was a strict -- well, I tried to make it strict, but basically we had two hours in which to

transact the business and quite often there was an awful lot to get through. So it meant that to really kind of drill down into things could sometimes be difficult because there just wasn't really sufficient time.

Q. And how long did you get the papers in advance?

A. I think maybe a week. Probably a week. Quite often there would be gaps in the papers because there were things to follow but those would follow subsequently, occasionally on the day, which was not something that I was very keen on.

Q. Your second point is that it was apparent that divisions did not always deal with similar quality and safety issues in the same way.

What do you say about that?

A. What I -- what I meant by that was that the governance structure was essentially a pyramid that was -- relied upon the original indication and escalation of points according to a kind of a system. So it was sort of -- sort of a filter.

So really in the case of QSPEC we were reliant upon what was fed into the system at the bottom and how well that was filtered and dealt with as it went through divisional management and up to Executive management and then to board subcommittee and we -- we received minutes

of quite a few of the governance, governance committees within the divisions and sometimes it felt like they were -- they were very kind of adept and very focused for obvious reasons on particularly things like the following up of incidents. But in terms of driving a corporate agenda of improvement in either quality measures or safety, principally this was about quality measures, it sometimes felt like the enthusiasm or the urgency from the board downwards didn't somehow got dissipated as it went down the line and therefore they weren't sort of fully aligned and fully sort of focused on exactly the same things.

Q. And your final point over the page in your statement:

"A failure effectively to engage with all frontline staff, many processes were nurse led and didn't always involve the level of clinician engagement that they seemed to merit."

Can you expand on that, please?

A. Well, I think that that kind of -- sorry, may I just --

Q. It's at the top of page 14 of your statement, your third bullet point about governance and management?

A. Yes, yes.

I think that's -- I think that's because the -- as

I said before a lot of the kind of machinery was nurse led and with a pretty clearly defined management structure. I think amongst the clinicians there was a whole sort of series of teams with their own leaders who -- different personalities sort of responded in different ways to these things.

So I don't think it had quite the coherence in terms of the structure or the dissemination of, you know, objectives or shared objectives that was apparent in the -- in the nurse management structure and that's what I was thinking of there.

Q. Well, I suppose you have your Director of Nursing supporting nurses and you have a Medical Director there to support doctors, presumably.

So the structure itself of having those people at the top, if you like, should that have provided some sort of equality around that issue or do you think more was needed?

A. I think that -- I think that maybe around the clinicians' side it was more challenging because the nursing side you had the -- the top and sort of divisional management but you also had wards which sort of formed the focus or clinical -- clinical areas, clinics that formed the focus of sort of slightly lower level management units.

In the case of the clinicians I think it was, it was quite -- more challenging in that they were not necessarily totally associated with a ward in the same way that most nursing staff would be.

And I remember discussions about clinicians having to undertake safari rounds, as they called them, which meant that to address, to actually find or to treat their, their entire list of patients for whom they were responsible they had to go from ward to ward to ward because the bed situation meant they could almost be anywhere in the hospital.

MS LANGDALE: Understood. My Lady, I notice the time.

LADY JUSTICE THIRLWALL: So we will take a 15-minute break and we will start again at a quarter to 12.

(11.29 am)

(A short break)

(11.45 am)

LADY JUSTICE THIRLWALL: Yes.

MS LANGDALE: Mr Higgins, questions now about the actual management of the increased neonatal mortality which you address from paragraph 47 in your statement. If I can deal with QSPEC briefly.

Where suspicions about a member of staff were

integral to any concerns, would that have prevented it from being discussed openly in QSPEC?

A. Yes, excuse me. Yes, I -- I think it did. The membership was drawn from right across the Trust, different levels and it didn't seem appropriate -- an appropriate forum to discuss something so confidential and sensitive.

Q. The Inquiry has seen the limited references where they are in the QSPEC meetings. But given that was the position, it was difficult to discuss the paediatricians' concerns in such a broad group, wasn't it?

A. Yes. Yes, it was.

Q. You were having informal conversations you tell us with Ms Kelly at the time before QSPEC and of course we know you were part of the briefing around the extraordinary board meeting at 5 July 2016, you deal with at paragraph 53. Is that when you first became aware at the board meeting briefing about suspicions about a nurse or were you aware of it at another stage via Ms Kelly, can you remember now?

A. I can remember. I -- I wasn't aware before, before that date or that time.

Q. 5 July?

A. Yes.

Q. When you became aware, was Letby mentioned by name or not?

A. No.

Q. So what can you remember about being told at that time?

A. I think my first reaction was that the -- the absolute priority was around actions to try and stop it happening again and by that I mean to reduce the number of -- the number of deaths. So the stepping down of the -- of the unit was, was one of the primary things.

Q. Let's take the meetings in time. I just meant the first conversation when you became aware when someone mentioned it. Did you --

LADY JUSTICE THIRLWALL: You were asked what were you told at the time.

MS LANGDALE: What were you told on 5 July in that Non-Executive meeting with Sir Duncan before the extraordinary board meeting, can you remember what you were told?

A. I can't remember specifically what we were told at that time. I mean my -- my recollection of slightly more broadly at that point in time, I was aware that -- that a member of staff was a common factor around, around the incidents and the deaths, but that's what I recollect, nothing much beyond that.

Q. If you have a look at the notes Ms Fallon made, INQ0102040 page 2, does that help with that Non-Executive meeting?

So, as you say, reducing the unit to Level 1. Does that prompt your memory in any way?

A. No, I was just trying to read the writing.

LADY JUSTICE THIRLWALL: It's not very easy.

A. Yes. I mean, well, that seems to me to be an accurate sort of summary of the headlines around the discussion.

MS LANGDALE: We know -- that can come down -- you missed the meeting in January. You were aware of the RCPCH review and you tell us at paragraph 55 you did receive and read a copy of the RCPCH Report before the end of 2016 but you can't remember the precise date.

A. No, I cannot.

Q. Do you remember if you had the full copy with the green text in it?

A. I had a copy, I don't know whether it had any green text.

Q. Did it say anything about a nurse?

A. No, it didn't. The copy that -- the copy that I had was in my evidence outline, there was a copy of the -- the copy for dissemination. Curiously mine did not say on the front "for dissemination".

Q. So yours must have been the confidential copy, was it?

A. No, no, no. No. Mine was the same as the one for dissemination, it just didn't have that title on the front.

So not being able to remember precisely when I got it but it was exactly the same copy as the one for dissemination.

Q. So do you remember reading anything about the nurse or HR processes that might be required to investigate allegations about a nurse, anything like that?

A. No, I don't, because the first time I saw the 33-page report as opposed to the 31-page report was when it came in my evidence outline bundle. I hadn't seen that before.

Q. So you are clear about that, are you, Mr Higgins, that when the Inquiry sent you that copy, you hadn't seen that one before?

A. Absolutely.

Q. Reflecting on that, do you understand why that would be the case or not?

A. No.

Q. You were interviewed by the RCPCH on 2 September 2016, if we can go please to INQ0014605,

page 21. See at the bottom:

"Andrew Higgins: longest steady member of the board."

See the various notes there, have a read before we turn over the page.

If we can go to page 22 and you describe here:

"View came from doctors, team itself, so needed an external opinion. I know what it was based on took a bit of time then about [question mark] whether to involve the police. Wanted to try to unpick this as best we could. Accept recommendation independent review is the best way to challenge/corroborate. Need to keep shutters down and contain situation. Not sure where to go next.

"DM [that is the interviewer}: legal advice from Trust solicitor? Not initially but discussions have now taken place. Lots connected with HR staff."

The reference -- is that you saying :

"Need to keep shutters down [plus] contain situation. Not sure where to go next"?

A. I think what I was referring to was -- and this may just be my -- my perception, but I sort of felt like it felt a bit like the board was caught in a Catch 22 situation whereby the whole issue about reporting to the police, you needed to have evidence or

something concrete on which to base that -- that reporting to the police and yet we didn't have any.

So it was a situation that -- that was really difficult to -- to resolve. And in the meantime, well, it rolled on. The thing about keeping the shutters down I think was just the fact that the thing -- the whole situation was clearly not unrecognised across the Trust, I don't think, so in terms of staff morale and everything else, it clearly was an issue.

Q. Why was there a need to do that? I understand what you have said about the employee's position and not being able to publicly discuss that or not discussing that in a broad meeting such as QSPEC. But "need to keep the shutters down and contain the situation", what needed containing.

A. Well, I don't remember using that language.

Q. All right.

A. So ...

Q. Standing back now, what did you think needed to be done then and what was done?

A. Sorry, at which point?

Q. What did you think needed to be done at that time? You referred earlier that your first thought was for other babies or children and having to, when you knew there were suspicions how did you -- let's use

manage, contain, who knows, whichever word you prefer. But what did you think needed to be done when you were aware of suspicions and concerns about a nurse harming babies?

A. What I -- I mistakenly thought was that the scope of the RCPCH review would provide some clarification, shed some light on the question of the involvement of a member of staff. What I realised subsequently was that the review that I saw was a review of the unit and really addressing what would need to -- not exclusively, but how to, what the Trust would need to do to take the unit back from whichever -- I'm sorry, whichever way round it is from Level 1 to 2 or whether it's vice versa.

Q. Do you think -- going back to what you said originally about your appointment on QSPEC, in terms of the board now, and the Non-Executive Directors, do you think it would have helped to have a clinically qualified member of the team in terms of the RCPCH review, and then reading Dr Hawdon's review potentially and assessing where she had arrived at, do you think it would have been helpful to have somebody medically qualified?

A. Absolutely it would have been, yes.

Q. The RCPCH Report, you read the parts that you

read. What did you glean from that at the time?
A. It confirmed I think a number of, a number of the issues that had been highlighted or at least raised in internal reviews, principally around levels of staffing and those kind of issues. It also referred to the -- an element of disconnection between the paediatricians and the Executive management and really calling out the -- the difficulties or the issues that that created.
So, as I say, it was -- it was about the unit itself. But I think no massive surprises but a good blueprint to try and resolve that. Unfortunately, it offered no resolution of the other issue.
Q. In terms of the Dr Hawdon Casenote Review that was undertaken next, did you have a clear understanding about what that involved, what was going to be produced?
A. Well, clearly that had come out of the RCPCH review and, again, I mistakenly thought that that was going to be a relatively thorough review of some of the cases that again would shed light on the -- the question of the involvement of a member of staff. And again what I was surprised to find was that Dr Hawdon had effectively sort of said: well, I've done a quick desktop and not covered all the cases either.
So I misunderstood what, what that was, what that

about?
A. I think I -- I took it with a pinch of salt in that what was clearly happening was that there were very fraught discussions and exchanges taking -- taking place and I think one the major targets in the Executive Team was probably the Chief Executive himself, so it didn't surprise me that he may have been the one providing the most emphasis around the bad behaviour of the Consultants.
But I just kind of took that as sort of something in the heat of the moment that may or may not be a fair characterisation of what was truly going on.
Q. You tell us at paragraph 63 that in February 2017 you chaired a QSPEC meeting and Mr Harvey gave a high level view of steps taken following the publication of the RCPCH Report and progress on the recommended in-depth Mortality Reviews.
You also say:
"The minutes record in that meeting it was agreed that from April the committee would be seeking assurance rather than reassurance and be more challenging."
Why was that an issue that had arisen or was being commented upon?
A. That -- that comment was, it appears in the same set of minutes quite close to the comments about

was going to cover. I thought it would fill the gap that the RCPCH report had left in my eyes.
Q. Did you ever ask to see the Dr Hawdon report?
A. No, I didn't.
Q. Did you -- I am not suggesting it was only you who would be responsible for this -- think to ask her to come to the board meeting or any other specialist to come to the board meeting to discuss the medicine involved here?
A. No, I didn't.
Q. You tell us at paragraph 62, this is the meeting around February 2017, you say:
"I didn't see a copy of Dr Hawdon's review or her letter dated 29 October. At the time I felt that the board was informed about the concerns of the paediatricians but this was always in the context of them being a difficult group to deal with that had exhibited bad behaviour, a characterisation that came predominantly from Tony Chambers, supported by Ian Harvey."
And then you follow that with saying you hadn't had the opportunity of hearing about these concerns directly from the Consultants at this point.
But for someone who hadn't had that opportunity, what did you make of bad behaviour or what was that

neonatal reviews. It wasn't -- it wasn't really driven by the -- by the neonatal reviews but it was --
Q. Understood.
A. It was more a kind of frustration at lack of progress on other issues and things repeatedly coming back with no sort of further sign of resolution. And it was something that I was frustrated about. I know Alison Kelly was as well.
Q. So the actions and follow-up wasn't as tight as you would like it to be?
A. Not in every case, no.
Q. Why do you think that was? I am not asking about the neonatal unit for a moment, but more widely, why was that?
A. I think -- I suppose the obvious answer is that -- is that the pressures that the entire Trust were was under and -- and I think the other aspect of it is that different teams had sort of different micro-cultures and some responded better than others to the prompts or requests or demands that were placed on them.
Q. You were there at the board meeting when Mr Medland QC was there as well, weren't you, in April --
A. Yes.

Q. -- 2017?
A. Yes, I was.
Q. Tell us how you remember that meeting?
A. I think I remember -- I remember it principally as a sort of a bit of an extension of the Catch 22 comment I made before about because we were having -- having gone, Mr Medland having gone through it, then he informed us that there was no evidence that a crime had been committed and yet if legitimate or sort of informed concerns remain, then you should go to the police.
So I think that that took it beyond the Catch 22 in that really I think it was an invitation to accept legitimate concerns, no matter where they sat.
Q. We know subsequent to that meeting what happened and there was indeed a referral to the police in May. When that referral was made, did you think it was going in that direction of travel from early January 2017 or earlier, how soon upon you was that referral to the police as far as you were concerned?
A. I think it was, I -- I think throughout from the very start of 2017, when there was quite clearly an unanswered question that was hanging over the Trust and the -- and the events at the neonatal unit I think it was probably only in April when Mr Medland came and

addressed us that I really kind of -- it really crystallised in -- into -- into the kind of, you know, sort of refer to the police or, well, I think it was pushing us very clearly in that direction.
Q. You told Facere Melius and indeed you tell us you were having conversations before QSPEC and informally with Ms Kelly but if we can go to INQ0003058, the very bottom of page 12, the last three lines and then into the top of page 13, this is your interview, Mr Higgins, and you refer to:
"... a lot of discussions with Alison Kelly and that would include, you know, informal things and all the rest of it."
If we can just put page 13 on because I have read the bottom of page 12.
So page 13, top paragraph only, if that can be enlarged, thank you.
"... a lot of things that there was apparent and I think this is probably apparent in the initial meetings, was that it was kind of viewed as pretty inconceivable that any individual could have done this ... I know the nurse, the initial reaction of nursing group was to kind of draw in the ranks to support and that maybe, you know, set the tone as to how some of this got reported. But perhaps the level of which that

got reported, because the initial feeling was that if you sort of think: well, how can this possibly be the case, then you want to treat the individual fairly. And recognising that if this were an unfounded acquisition then, you know, something that could absolutely destroy one person's life. If you do that then, you know, you don't want to do that unthinkingly. So the fact that the impact, you know, there was a meeting at which the impact statement got the read out in that context I don't find sort of massively shocking, just surprising really, why do you find it different?"
So just first of all dealing with that comment "pretty inconceivable any individual could have done this", is that a conversation that you had with Ms Kelly and more broadly, how difficult it was to think that that could have occurred?
A. I think probably the first thing I am doing there is expressing what was in my mind because to be frank, I did find it pretty inconceivable that any -- any individual could have done this. The discussions with -- with Alison Kelly I think were kind of more about kind of where things were up to and from that, I certainly, I certainly got a clear sense of the, the feeling amongst the -- the nursing community that they were kind of being singled out.

Q. And singled out in what way and for what?
A. By -- by the paediatricians. I suppose the implication would be that they were some kind of scapegoat for something that was unexplained. At that point nobody knew for sure what -- what -- what the root of all of this was.
Q. You do make direct reference there that if this were an unfounded accusation as opposed to a mistaken accusation, "unfounded" you say there. Was that a phrase that anyone used to you that this was an unfounded accusation?
A. No, that's my language.
Q. Right.
A. It's more a point of principle than anything else. But no, that's me.
Q. So in terms of your understanding at the time, did you, as far as you were aware of them, consider the concerns genuine of the paediatricians or not or did you not were you not able to form a view about that because you didn't know enough?
A. I couldn't really form a view on that and that's where the -- the fact that I had a -- because of meetings that I had or hadn't attended I sort of had a personal disconnect. Some -- some of the direct interaction I hadn't been part of. I wasn't able to say

one way or the other.
Q. That can come down, thank you. You tell us at paragraph 66 at the extraordinary board meeting on 2 May you were advised by Mr Harvey the next step was to consider a police investigation. We know how that followed.
Then at the top of the page, you say:
"I personally never felt that there was any implication that the board should avoid bringing in the police to protect the Trust's reputation and I never heard anyone voice such a thought."
Can you just set out for us how you see this issue of protecting reputation and whether if at all it impacted around this time and with this decision?
A. From my point of view I never thought it was an issue or should be an issue, because in the list of priorities it was right down at the bottom.
The priority was to -- was to resolve -- was to get an answer to -- to what had gone on but equally, I know that some of the documentation talks about sort of represent -- protecting reputation or whatever words are used, but I never sensed amongst any of my colleagues certainly round the board table that -- that that was kind of a serious or an overriding consideration.
The -- the fact of the reputation was more about

the publicity and the impact that would have upon the families and upon the staff across the Trust and I think those were the key elements of that.
Q. Indeed you say that was a general consensus that police involvement may be traumatic, it was families and staff, and it was about being certain it was the right thing to do
A. Yes, thinking that you had to have been able to have some kind of evidence that -- that you -- on which to base your -- your trip to the police.
Q. What do you say Mr Cross's contribution was on the issue of a police investigation?
A. Well, I think because he was somebody with -- he was the person with the most experience of such things around the board table, so I think that he -- well, certainly I listened to him in terms of the potential impact of the police coming in and the kind of sort of - "disruption" isn't quite the right word but, but really the -- the fact that really it would sort of mean all bets were off in terms of, in terms of what had been going on to date.
Q. More broadly, did you think, Mr Higgins, that you were adequately briefed by the Executives in respect of the decisions that were being taken for the RCPCH Report, for Dr Hawdon and then when you ultimately

referred to the police?
A. There are clearly some things that I misunderstood or got wrong around those -- those reviews.
Whether that is because I was misled or because I didn't ask the right questions is difficult to say. But I feel that we all had an opportunity to ask more questions and I didn't.
Q. Indeed you weren't at that meeting on January 10. If you miss a meeting, do you get notes or minutes or catch up with your colleagues informally? How does that work?
A. Well, I can't actually remember when I got the minutes of that meeting, but I did have copies that I had retained and I had a bundle of minutes that came quite some time after as a kind of a set which included those of the 10 January which seemed to indicate that possibly I -- the minutes may not have come out or I may not have got them until some time in maybe 2017.
Q. You weren't at the meeting on 10 January where the apology offered to Letby was reported to the board and I don't know if you ever read the statement from Letby about her described experience to the board. Did you see that statement or anything from her?
A. I have seen it because it was in some of the

evidence bundles.
Q. So you saw that via the Inquiry?
A. Yes, yes.
Q. At the time, what did you understand was happening in terms of Consultants being required to apologise or mediate with Letby, were you sighted on any of that?
A. I think I was sighted after the event mainly because I wasn't at the 10 January meeting and when I kind of was able to re-engage with the situation as it currently stood later that month, or early February, I think it had almost moved on from there because clearly the request or demand for an apology had clearly caused an awful lot of consternation.
Q. You offer your reflections and one of them early on at paragraph 77:
"One of the strongest conclusions I have drawn is that the police should have been involved earlier. For too long the Trust treated investigations into the increase in death too much like those in other Mortality or Serious Incident Reviews."
How do you think that situation was arrived at?
A. I think -- I think because there were laid down sort of procedures around investigating mortality right across the hospital, then the -- the hospital and

the board, the board kind of reverted to some reliance on those things.

But in going through all of this, the -- the thing that struck me above all else was that there were no skills or experience to investigate potential crime and there was an element that was missing and that's why I say I think my reflection on this is that had we gone to the police back in July 2016, then the whole thing might have come to some kind of resolution far quicker and in a better way. I think we -- it never struck me at the time but I think that we were -- we were trying to answer questions that we weren't equipped to answer.

Q. You also say:

"I think the basic mistake was that each group tried to come up with definitive answers before escalating further up the line."

So you mean -- tell us what you mean?

A. Some of this comes back to kind of the pyramid and the filter bit whereby -- because the review is conducted in late 2015 around this and then Thematic Reviews in early 2016, all of which proved inconclusive in terms of getting a definitive answer around what had been happening and I think we kind of repeated that as it went up -- up the -- up the chain.

Everybody had a crack at finding what the answer

was but nobody succeeded, nobody could. And really that proved to be I think a big delayer in terms of taking decisive action and resolving things a lot quicker.

Q. You say at paragraph 78:

"I think concerns about the neonatal data should have been raised earlier."

You tell us when it was reviewed in QSPEC in January 15, neonatal deaths and stillbirths, it was presented to QSPEC, the increase in deaths being described as perceived.

What do you say about that now?

A. I think that comment came from the fact that QSPEC really received two principal papers around what had -- the mortality trend in the unit, the first one was the one I am referring to there, the second one came in I think July or August 2016 and showed some of the charts.

The charts were -- without any fancy statistical review were stark. And I think they would have been had the data to the end of 2015 been included within that first report and I think at that point I think I said of that first report that no red flags were -- were issued.

Q. That is Ms Fogarty's report, that review?

A. Well, it was the one that was headed up by Dr Brigham, I think.

Q. Yes, that one.

A. Yes.

Q. Who provided the second report?

A. That was the -- it was done through the Risk Department, so it was done through Ruth Millward was the person that, that headed that up at the time. So it was -- and it was I think it was Alison Kelly and Ruth Millward had signed it off, so to speak, it was their names on the report but my understanding was that they were using data and information originated from within the unit itself.

Q. You say:

"A more in-depth and rigorous challenge might have brought issues to the surface quicker."

What are you thinking there?

A. Well, again, if -- if the -- if the first review had been -- perhaps presented things in a slightly different way, rather than a perceived increase in mortality to produce the actual statistics, as I say, in a chart which was relatively stark, I think as committee members we should have been on more notice that, that, you know, this wasn't -- wasn't a perception. These were actual human lives that --

Q. You also say at paragraph 79 that:

"Once issues started to be considered by the board

in extraordinary private meetings, information about developments was sometimes communicated through informal discussions and briefings rather than formal meetings."

Sir Duncan has told us he would meet regularly with Execs. Were you having informal discussions on a regular basis as well?

A. I think these were because obviously there were lots of gatherings of different natures so there were lots of discussions going on but it seemed to me or looking back on this, I think that the -- it would have been better had the board recognised if -- if the public meetings were not -- were not the best forum to discuss these things, if QSPEC was not the best forum, then we should have established one more formally that could have exercised oversight and involvement -- oversight of what was going on and progress being made and participating in decision-making.

And I -- I kind of feel that as -- either as senior independent director or as chair of QSPEC I should have -- I should have pressed that but again it was something I didn't.

Q. You say:

"I think it's therefore difficult to be sure if all board members always knew the same things at the same time."

That can influence a dynamic on a board, can't it, who feels confident to speak up --

A. Yes, it can.

Q. -- and give an opinion if they think they haven't got all the information a colleague has?

A. Yes, it's an issue.

Q. Did you find naturally there were more dominant voices around the board? Sometimes that's the case even when people have the same information. But when there's a disparity of information, that can be applicable?

A. Around this subject or in fact around almost any subject, I don't think the dynamic around the board table was like that. It was respectful and it felt like a kind of, you know, a gathering of -- of equals. Voices were not suppressed, certainly not that I could see.

Q. And you say:

"I think it is also apparent that the depiction the paediatric Consultants as a badly behaved bunch of troublemakers was a very one-sided view of what was going on.

"Taking all these factors together I think that more regular formal meetings of the board in private from July 2016 onwards would have presented greater

opportunity to understand the neonatal issues more deeply, to challenge more closely progress made on their resolution and to examine more critically the handling of the situation by Executive management."

A. Yes.

Q. You do say at paragraph 87 -- finally from me, Mr Higgins, you say this:

"What I do see is a combination of imperfect structures, systems, people and actions that contributed to a series of tragic outcomes. I am very uncomfortable with singling out individuals as prime enablers of Letby's crime. I believe that any of us who were involved in the Countess' handling of events in any way share a collective responsibility for what happened. This responsibility is down to understandable human failings, not malign intent."

Would you like to expand on that? Not the last sentence --

A. No.

Q. -- but the broader picture that you are commenting on there?

A. Well, I think you have directed me to some of the things that I thought we should have done, some of the things that I personally should have done. And I think there were omissions along the way,

misunderstandings, certainly on my part, and had we formalised that much more, I am not saying it would definitely have avoided them but it might have provided a forum in which those misunderstandings or, you know, misconceptions could have been dispelled.

MS LANGDALE: Thank you, Mr Higgins. There are some more questions, my Lady from Mr Jamieson.

Questions by MR JAMIESON

MR JAMIESON: My Lady, thank you. Mr Higgins, good afternoon.

A. Good afternoon.

Q. My name is Alex Jamieson, I ask you some questions on behalf of the Families in this case. There are three short topics that I would like your assistance with, please.

A. Sure.

Q. For the first one, Mrs Killingback, please can we have on the screen INQ0009246. It's going to be the NHS Foundation Code of Governance from 2014 and I would really like your assistance with the essence of the NED role, please. Can we go to page 13.

Although it's the 13th page, it is in fact the first substantive page of this document, all that was in front of it was introduction. Can you see in the fifth paragraph down:

"As part of their role as members of the unitary board, Non-Executive Directors should constructively challenge and help promote and help develop proposals on strategy."

A. (Nods)

Q. This is the first mention of NEDs in this document and this is the distillation of their role and can we see that "constructive challenge" is the first responsibility that is mentioned there.

A. (Nods)

Q. Thank you. Just to drop through and to illustrate what that means, can we next look very briefly at page 17. We simply note that this is the section that is dealing with leadership and what that means and there are then a number of subparagraphs.

If we go to 18, over the page, please, can we see that at the third paragraph down:

"All Directors, Executives and Non-Executives have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigations values and standards."

So we are familiar with that, but underneath:

A.1.M. The second sentence:

"In particular, NEDs should scrutinise the performance of Executives, receive adequate information

and monitor the reporting of performance."

Then this sentence:

"They should satisfy themselves as to the integrity of, amongst other things, clinical information."

Is that something that you appreciated at the time that you had a responsibility to satisfy yourself that the clinical information that you were being presented with had integrity?

A. Yes, yes, it was.

Q. Thank you.

Then the final aspect of this document, please, to look at is again what that means. If we go to page 31, very briefly, we are on to the sub heading "Information and support" and what that tells us at 5A is that:

"The Board of Directors should be supplied in a timely manner with relevant information in a form ... of a quality appropriate to enable them to discharge their functions".

Over the page again, the last reference to this document, please, in particular the second paragraph: B.5.2:

"The Board of Directors and in particular NEDs may reasonably wish to challenge assurance it has received from Executive Management. They need not seek to appoint a relevant adviser for each and every subject

area, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis."

The paragraph underneath we will just note in passing, I won't read it but it makes provision for the board to obtain independent advice on a variety of subjects to allow them to do that.

So that can come down, thank you, Mrs Killingback.

Drawing it all together, is what is required not just constructive challenge but independently informed critical challenge? Not just critical challenge but you yourself have to have the independent information to allow you to perform that function?

A. I mean, independently sourced and derived?

Q. When I say "independent" I mean you yourself have the information that allows you to perform that function wherever you derive it from?

A. Yes, I think certainly -- certainly if I can, if as a Non-Executive you think that the board information excludes something which is important to your assessment of performance or -- or anything else, then yes, you should -- you should call that out. So yes.

Q. Yes. But if a subject area being discussed is

one in which you yourself hold no information or understanding, beyond what the Executive is providing to you, how will you challenge what they say?

A. I think through discussion and drilling down into the -- into the subject that you are -- you are looking at. I'm not -- I am not quite sure whether this is a question about how an accountant can question medical matters or something else.

Q. That is the context but really I am dealing with the generality and if I can borrow a phrase that you have used in this context. If you rely on an individual in this case, I think you have said Alison Kelly --

A. Yes.

Q. -- to be your eyes and ears, on a particular subject matter, all of the information that you receive from that individual will come with their views, with their biases, whether conscious or unconscious?

A. I see, I see.

Q. How do you challenge that?

A. Well, I think one way you do it is that if there is something that you feel unsure about or maybe is so important then -- then you corroborate it through different sources.

Q. Yes.

A. So you seek to validate it by reference to other people. So when I talked about the Director of Nursing in that way, I didn't mean to suggest that she was the sole and only source of information. In fact, far from it.

Q. Thank you.

May I move to the second topic, please, and it's the culture and the tone of the Countess of Chester?

A. Yes.

Q. You have been asked a number of questions about this, I won't repeat them but I did just want to see if there was a line that could be drawn between two sets of observations that you have made.

So you have it, it's page 11 and page 12 of your statement, paragraph 29, you have given us some short pen portraits of the senior Executives and my learned friend Ms Langdale King's Counsel has taken you through that.

May I just pick out a couple of phrases that you have used in relation to Tony Chambers, his keenness to "manage the message" and your observation that he had a reluctance to identify managerial failure as a cause of poor performance.

Then secondly in relation to Stephen Cross, you observe that he managed his relationships with the

Non-Executives and prevented hares running and would dilute demands for action.

Could I draw those together as a common theme, as a preoccupation with presentation over the substance of an issue, would that be a fair summary?

A. I'm not sure I would characterise it in -- in that way. I think the comments about the Chief Executive were really more about avoiding the questions that didn't have any ready or full answers.

Q. Sorry, I missed the second half of that. Avoiding the questions that ...

A. That didn't have any ready or full answers, so knowing that it was not a complete answer to the question that was put.

Q. Yes.

A. I think in the question of Mr Cross, that comes back to -- I mean, as I said before that a lot of that was my experience on the Audit Committee about not wanting to impose a whole raft of further actions on top of those that were already sort of in the hands of the Executive or the people who were working for them.

Q. Focusing for a moment just on what you said about Tony Chambers and avoiding the part of the question to which there is no answer. I did wonder if there was a line to be drawn between that and the

observation that you have been taken to already, second half of your paragraph 30, if you wouldn't mind just looking at that, and the observation that your NEDs had made or your Non-Executive colleagues had made that the Countess had an optimism bias that suppressed problems and exaggerated successes.

That does seem very similar to what you have observed in Mr Chambers; avoiding the problems to which there is no answer and focusing on the solutions that have been achieved, even if to some different issue?

A. Yes, I -- I can see exactly why you link the two and I would agree that there is a linkage. I am not -- I don't think it was avoidance of problems, it was inability to solve them which is not quite the same thing but yes, I agree there is a link between the two.

Q. But in the light of all of your experience and the reflections since, can you see the obvious and present danger in that approach because if there is we are dealing with a hospital where the business is caring for the sick and the saving of lives. If there is a problem which -- and if the approach is to play down concerns that can't be met, and to play up successes, then subsisting dangers could be masked and ignored.

A. I see your point. But my experience, my view of -- of all my colleagues around the board table was

that you could make excuses as to why your deficit was bigger than it was planned to be or should have been or whatever, to an extent you could make excuses about why some targets in the board report were not being met.

But I never sensed that any of them would say: well, this is a matter of patient safety and, you know, extreme matter of patient safety and therefore I am just going to ignore it. I never sensed that anybody had that attitude towards that.

Q. But if that's the culture, if that is the rhythm when issues of extreme patient safety such as we are dealing with here, then the muscle memory of the organisation will be to do the same, won't it?

A. You may be right.

MR JAMIESON: Yes. Thank you very much, my Lady, those are all my questions.

I should say there were three topics but I am conscious that I have had my time and that can be dealt with in submissions.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Thank you very much, Mr Jamieson.

I have just one question if I may, Mr Higgins.

Can we go to INQ0003058, page 12-13. We have looked at it already. There was just one thing I wanted

to pick up with you, if I have got the right page reference. Yes.

So you have been asked a bit about the top of page 13 when you are speaking to Darren Thorne and you are talking in particular about the initial meetings. It was kind of viewed as pretty inconceivable that any individual could have done this and you have acknowledged that was your view.

We know, we have heard from Alison Kelly, that it was her view that one of her nurses could have done this. Then when you were giving your evidence earlier you were referring to the nurses generally feeling scapegoated. But in your -- in what you were saying here you refer to a single nurse and I just wondered if it was a slip of the tongue or whether there was not only the initial reaction of the nursing group to drawing the ranks to support but whether they also felt as a group the suggestion being made was one that reflected on all of them?

A. No, I -- I think -- I think really what I -- what I meant to convey was the first, that they were sort of drawing in to support.

LADY JUSTICE THIRLWALL: Rallying round.

A. Rather than saying this was a slight on the nursing community as a whole.

LADY JUSTICE THIRLWALL: Thank you, that is clear.
Then you say this as sort of an observation:
"... that maybe ... set the tone as to how some of this got reported."
I just wanted to explore that. Are you saying there that because people, and here the nurses, were supporting the individual that would have affected the way information was being passed on, or the way it was being reported; in other words, this can't be true? Is that what you are getting at?
A. I think it certainly influenced a view that this -- this can't be true because there was a body of people who were saying "this can't be true".
So I think that and the whole grievance process gave voice to that view and sort of muted the Consultants, I think.
LADY JUSTICE THIRLWALL: Yes. Well, thank you. Anybody want to ask anything else? No. Well, thank you very much indeed, Mr Higgins, for coming to give your evidence and you are now free to go.
A. Thank you.
MS LANGDALE: My Lady, Mr Oliver is next and I think he is ready to give evidence.
LADY JUSTICE THIRLWALL: Very good, we will just let Mr Higgins disappear from the scene and then we will

take Mr Oliver.

MR GEORGE EDWIN OLIVER (sworn)

Questions by MS BROWN

MS BROWN: Could you please give your name?
A. My full name is George Edwin Oliver.
Q. You have provided a witness statement to the Inquiry dated 5 June 2024 and I think there is a correction you wish to make at paragraph 102 regarding the cite of the Terms of Reference and the RCPCH Report cite which I will ask you about when we get to that stage in the evidence.
But save from that paragraph, is that statement true, to the best of your knowledge and belief?
A. That's correct.
Q. In terms of your background, Mr Oliver, you have a BSc in electrical engineering, your career has been predominantly in retail including as regional manager for Marks & Spencer Merseyside, between 1995 and 2016 you were involved and for periods chair of the Ronald McDonald house at Alder Hey Children's Hospital which provided accommodation for families and children being treated there and I believe from 2006 you were appointed as a Non-Executive Director at Alder Hey?
A. That's correct.
Q. You left that post in 2013?

A. Yes.
Q. In 2013 you were appointed as a Non-Executive Director at the Countess of Chester. So by that stage you had already had seven years' experience as a Non-Executive Director and also that experience being in a Hospital Trust?
A. That's correct.
Q. As well as a board member, you chaired the People and Operational Development Committee, you were chairman of the Charitable Funds Committee and you were a member of the Audit Committee?
A. Correct.
Q. In terms of the time commitment, is it correct that your time commitment as a Non-Executive Director was three days a month?
A. Yes.
Q. And did you consider that was adequate to fulfil not only your membership of the board but those other committee commitments?
A. Yes.
Q. When did you cease to be a Non-Executive Director at the Countess of Chester?
A. In August 2019.
Q. Just dealing with your role as chair of the Charitable Fund Committee, you were involved I think at

time with the Babygrow Appeal?
A. Yes.
Q. Were you aware at the time that Lucy Letby was the face of the campaign and her face appeared on some of the posters, I believe?
A. I was not aware that she was labelled as the face of the Babygrow Appeal. I was aware that there were photographs, certainly in the charity office, of Nurse Letby holding a very small babygrow?
Q. And --
A. But there was no name label to that particular photograph.
Q. Were you aware of that when you were, as a board member, dealing with the issues and did that cause any consternation, was it the subject of any comment?
A. No, I was aware and no.
Q. So it wasn't until after -- after these matters that you became aware of that?
A. Yes.
Q. It had no bearing on how you dealt with these matters?
A. No.
Q. Thank you. Just dealing with training, Mr Oliver. You deal with this in paragraph 26 of your

statement and you recall being trained in safeguarding and in speaking up at Alder Hey. Did you receive any training to this effect when you were at the Countess of Chester?

A. I think wherever -- excuse me, I didn't receive any outside of the hospital training, no induction training at the Countess. I had had an awful lot of experience of training in the past, not only with Alder Hey but in my time with McDonald's and even Chamber of Commerce and Liverpool City Council. And so at the time in the Countess, I think we built in -- a formal board training session was billed for, according to the code, I think it was about every three years.

Q. So when you arrived at the Countess of Chester to commence your role as the NED there, was there an initiation programme or a programme of training that you would have gone through or was the fact that you had already received this training at Alder Hey meant that you didn't go through it?

A. I think I had already received an awful lot of training before and I don't recollect going to any official training when I got to the Countess.

Q. Is that -- just to be clear -- because it wasn't offered to you or because you didn't see the need

to attend it?

A. I wouldn't have, if it had been there I wouldn't have turned it down. But I am not clear as to whether it was offered or possibly whether I felt having just come from Alder Hey, a specialised children's hospital and the McDonald house with all the things that you are trained there via McDonald's, you know, I didn't feel that I was -- I was missing out.

Q. In terms of the policies, the Countess of Chester had policies, their own policies regarding safeguarding and Speak Up. Were you aware they had policies, these policies?

A. Yes, they would have come through the people in OD committee.

Q. Were you familiar with their contents at the time?

A. Yes.

Q. In terms of the role of NED you deal with this at paragraph 50 of your statement, and you recall an induction meeting about the role of NED. Is that induction meeting you are referring to one that happened at the Countess of Chester or is that a previous occasion?

A. It was actually the very first one, 13 years, right at the very beginning.

Q. Sorry, right at the beginning of the time when you started at the Countess of Chester?

A. No, when I joined the board at Alder Hey.

Q. Alder Hey, so 2006?

A. Yes, it was in Leeds, I remember it vividly.

Q. In terms of your understanding when you got to the Countess of Chester about your role and the role you played as a Non-Executive Director, what was your understanding of the role during your period at the Countess of Chester?

A. My role is -- was same as what we have been doing for over -- over the years. It was working very closely with the Executive Team. The word "challenge" yet again came up and I think I tended to look at -- by "challenge" it can imply conflict, it can imply different things. At the first induction course I went to it was vividly put over -- the word "challenge" was aggressively put to the gathered group that were there of inductees to the role of Non-Exec Director and I tended to ensure that I think that I had a good working relationship with the Executive Teams that I have worked with, both at Alder Hey and the Countess and my view has always been in my management style is that the challenge needs to be constructive and without being too confrontational.

Q. In relation to the NHS Foundation Trust Code Governance, were you aware of that and aware of the fact that that meant you as a board member were responsible for ensuring the quality and safety of the healthcare services?

A. Yes.

Q. That policy also speaks about constructively challenging and scrutinising the performance of the Executive. Were you aware that that was your role?

A. Yes.

Q. If we can turn now to the events from July 2016. On 5 July 2016 there was a public board meeting that you attended and prior to this, there was a private NEDs meeting. We know that from a note that one of your fellow NEDs Ross Fallon kept.

Is that a meeting that you can recall?

A. The content, no. But I can remember that there was the format of these pre-board or the board meetings was that where possible the Non-Execs would meet with the chair, ideally about an hour before, not necessarily with a pre-arranged agenda, but with a case I had brought some of that format from my time at Alder Hey, where for example the Chair would call an unofficial meeting before a board meeting and sometimes would lead with the: right, now you have got the

opportunity, what's keeping you awake at night?
Q. On --
A. I am just saying -- I am not saying Sir Duncan said that but it was the previous chair at Alder Hey that used to introduce that and I looked and I mentioned it to Sir Duncan is that maybe we should have these meetings as they weren't always able to be had because of time restraints.
Q. The meeting on 5 July, that was an occasion on which it appears from the note that certainly the neonatal unit was discussed and there was mention of unexplained and unexpected deaths, that there was to be an external review and significantly that the unit was to be downgraded.
Do you remember being informed of that?
A. Yes.
Q. So you can't recall the meeting itself but you do recall that at some point you became aware of that?
A. Yes.
Q. At that time, when you became aware of those issues, were you also made aware of the fact that there was a concern about a nurse being involved?
A. I am not really sure as to when the subject actually came round to a particular nurse was involved and so on. I think we -- we were informed at that time

and again I don't recollect really when fully that we were actually told a nurse, it is suspected a nurse could be involved.
Q. The public board meeting that you did attend on 5 July, there was no reference in that to the downgrading of the unit or of neonatal mortality but following that meeting, there was an extraordinary board meeting that was set up and was held on 14 July and that I think was a board meeting that you weren't able to attend?
A. Correct.
Q. Do you recall receiving the minutes of this meeting and just really particularly as to whether it was by receipt of the minutes that that informed you either of the downgrading of the unit or of the issue with the nurse or do you think you were informed of those matters orally?
A. I think I was informed orally.
Q. Do you recall ever receiving the minutes of this meeting?
A. No.
Q. If we can move on, then, to 10 January. In the intervening period, between July and January, can you recall at any point being given an update as to the review that was being -- going on by the RCPCH?

A. No.
Q. At that meeting, on 10 January, the RCPCH report was discussed. You had not been at the meeting of 14 July and I think your evidence is that you hadn't seen the draft of the Terms of Reference or indeed the final Terms of Reference of the RCPCH?
A. That is correct.
Q. Did you nevertheless have an understanding what have the RCPCH were reviewing?
A. In -- in broad terms, yes. I suppose it's -- it's looking at it, I could possibly have expected it to be looking at a bit more detail and trying to move things on to a different level of understanding as to what -- what had happened and the next, and with a view to the next way forward.
It's only afterwards when I have seen the Terms of Reference is that the report basically does what the Terms of Reference asked for and it does nothing more.
Q. So from that, do I understand that -- did you understand that the RCPCH was going to give an answer as to whether the nurse was or was not responsible for the deaths? Was that your understanding?
A. I'm not sure whether I expected them to do that. But once I had seen the Terms of Reference it didn't actually ask for that, it --

Q. When do you think you did see the Terms of Reference?
A. Just recently.
Q. In relation to the report itself, the report of the RCPCH was being discussed at the January meeting. Do you recall at what point or whether you received the RCPCH report?
A. In time for the meeting and then we were not allowed to keep a copy of it because of HR restraints.
Q. So we will hear from her but my understanding is Ms Fallon's evidence is that you were given a copy of the report at this meeting, allowed to read it at the meeting and then not take it away. Is that your recollection as well?
A. I think so, yes. I -- I do not remember coming out of the meeting, I don't recollect that with a copy of that report.
Q. Do you recollect whether it was the copy of a report that mentioned the nurse in it or whether it was the slightly shorter version that didn't have that passage in, or can you not now recall?
A. I'm afraid I can't remember that, sorry.
Q. Just looking at that meeting, Mr Harvey outlined that the report had been received from the RCPCH and then if we could put up INQ0003237, these are

the minutes of that meeting and if we can go to page 2.

At the top there, what Mr Harvey is setting out is the RCPCH have reported and they have suggested that there is a further review done of the individual cases and that was commissioned by -- from Dr Hawdon and that review had been completed and we see there three lines down: review not yet circulated.

We have seen and we have gone through the point that you understood your position was to challenge as a NED. Were you in a position to challenge having not seen that review?

A. Probably not to the in-depth amount that it -- it required. Maybe this was a time that like at these meetings is that when the challenge could have been more explicit than it may have been. But again I just looked at the report and I wasn't sure how it actually moved us as a board to the next stage.

Q. We will just see at the bottom of that paragraph it says, this is Mr Harvey speaking:

"The case reviews very much reinforce what is in the review when it comes to issues of leadership, escalation, timely intervention and does not highlight any single individual."

Did you accept that summary at the time?

A. Yes.

Q. Mr Chambers then we see goes on to say that:

"Once we have the final four reviews from Alder Hey we can draw a line under this first part of the review itself."

Again, did you understand, Mr Oliver, that at this stage the investigations were still incomplete?

A. Yes. As I said, I wasn't clear at that time as to how on reflection how that moved us as a board on to the next stage.

Q. Given that those investigations were still incomplete and that you hadn't seen Jane Hawdon's report, did that mean that you were concerned that what was being proposed at the time was for the nurse to be returned to the ward?

A. I don't think I was -- I was concerned about the discussion or the conversations that were coming about the nurse going back to the ward and so on.

What I thought the report hadn't shown was how would that be actually achieved and I wasn't clear with all that had gone on before that and so on, and the report didn't tackle it because it wasn't asked to in the Terms of Reference. My main thing is as an output as a thing to achieve I wasn't clear as to how that actually was going to be achieved.

Q. Because the situation at this stage is that

you have seen, as I understand it, the RCPCH, you have read that in the meeting. You haven't seen the report of Dr Hawdon, you are aware that the investigation is incomplete?

A. Yes.

Q. And you are aware at this stage of the allegations that have been made by the Consultants or the concerns the Consultants have that Letby may be involved in deliberately harming patients?

A. Yes.

Q. Really it's understanding why on that information you felt able to support the proposition that the nurse should return to the ward at that stage. You know of course she didn't in fact return but that was the decision of the board at this stage.

A. I didn't feel that that was the -- the decision of the board at that stage that there was a -- it was clear-cut and certain that Letby would return to the neonatal unit.

And again my, my personal thoughts and at the time were with all that had gone on and the comments that had been made and the relationship breakdowns between the Consultants and some of the nurses, and senior team, I just, at that time, was thinking to myself: how can this actually be achieved?

Q. In relation to the Consultants' action, we will see if we can go to page 4 of that, the minutes, that Mr Chambers referred to the claim:

"The unsubstantiated claim the issue was down to one individual's actions and behaviours. We did explore supervised practice of the individual. This was not supported by clinical colleagues. The individual submitted a grievance."

And then there's the reading out of a statement from the nurse and discussion of the grievance.

Were you concerned, given your knowledge of the Speak Up policy that at this stage it appeared that the Consultants who had raised the concerns were in fact being asked to apologise and then mediate in a way that was contrary to the Speak Up policy?

A. Again it's, it's -- I'm afraid, it's the same reply, is that I read the part that the Consultants were being asked to apologise and mediate the return to the unit. And, again, and I hadn't progressed that in my own mind or talked to anybody else about it, is that I did think with all that had gone on and been said, I wouldn't -- I was not aware of the plan of action to do those two things: to get the apology and to get the nurse back on to the unit.

Q. If we can just look at now document

INQ0003518. So this document that's going to come up now, Mr Oliver, this is the report, the very short report that Mr Harvey put before the board on 10 January and it set out that there had been a report by the RCPCH. It doesn't make clear that there were concerns or an inability to get to the bottom of the unexpected and unexplained deaths and therefore Jane Hawdon was instructed.

But it does, if we go over the page to page 2, ask the Board to make a number of recommendations.

The first question is do you consider that you were being given the correct information at this stage to make the decisions that we're going to look about in relation to returning the staff member to work?

A. No.

Q. If we look down there at point c, what the board is asked to do is to support the Executive in assisting the staff member's return to work on the neonatal unit.

In relation to that, the investigations were not complete and you hadn't seen Dr Hawdon's report and only briefly seen the RCPCH report.

Why at that point, Mr Oliver, were the board not challenging such a significant decision -- putting a nurse that the Consultants were concerned about back

on the ward -- in the absence of really having all the information before you to test that?

A. I can only say it -- it's something that we look back on and it should have been challenged more than it was and because it was a clear point at that time, that as I said the -- the view of saying she should return or she should go back to the unit and so on, but it was how that was going to be achieved and that was not challenged openly at the time.

Q. I think at the meeting, we don't need to go back to it, I can read you the section, at that meeting on 10 January, you are quoted as saying:

"We are where we are. We took the decision for the right reasons. The next stage is critical not just for the reputation of the Trust but also for the unit and the individual."

Can you just explain what you meant by that if you're able to recall?

A. I have said in my statement, excuse me, that I couldn't actually remember saying it. If I did say it --

Q. It's INQ0003237, page 5, if it would be helpful to have it in front of you. Sorry to interrupt.

A. If I did say it, it could well have been out of a small amount of frustration that we weren't moving

the whole process of where we were trying to get to with this event.

Q. Do you recall the decision you are referring to? Is that the decision to take Letby off the ward, that we took that decision?

A. Yes.

Q. Is that what you are referring to?

A. Yes.

Q. When you say:

"The next stage is critical, not just for the reputation of the Trust but also for the unit and the individual."

What do you think your concerns were about the next stage?

A. Well, the next stage would be contacting the police.

Q. But at that meeting, was it your understanding that the reports had said that there wasn't --

A. Yes.

Q. -- there it does not highlight any single individual, that it was an unsubstantiated explanation that there was a causal link to the individual, that that was what Mr Harvey and Mr Chambers were saying to you. Were you accepting that was the position at that stage?

A. Yes, and at every review it did keep coming back to the board irrespective of the fact that the paediatricians continued to make the same statements and so on.

So at some stage, the board had made decisions on the information that it had at that time. I personally believe that they were the right decisions.

Whether, on reflection, things could have been done slightly differently, in a different way, I'm not really sure. But it was -- you know, the decisions were taken.

So it was a case of whether it was a off-the-cuff comment that was made in the room that, "we are where we are and we've made these decisions for the right reasons we think." When --

Q. So perhaps if I could summarise, Mr Oliver.

You felt that the decision to take Letby off the ward had been the right one?

A. Yes.

Q. But at that meeting, 10 January, what you understood you were being told by the Executive was that there was no further concern about Letby, is that correct?

A. I'm not saying it is -- it's as obviously placed as that at all. What I'm saying is they kept coming back to the fact that there was no evidence or no

factual evidence that there was a concern about Letby and going back on to the ward.

And, again, it was thought of: well, if we're planning -- if we are planning to do this, just how on earth are we going to do it? And at the time it's a private thought and maybe I should have been more blunt and factual about it and said it. But I couldn't see with where we were in the situation how that could be achieved.

MS BROWN: If we could go then to a meeting on 13 April. This was a meeting that was attended --

LADY JUSTICE THIRLWALL: Sorry, Ms Brown. It's a quarter past 1.

MS BROWN: It is. There is only one more meeting I'm going to. I don't know if it would be convenient just to finish that.

LADY JUSTICE THIRLWALL: Yes, of course.

MS BROWN: Yes. Mr Oliver, there was then a meeting on 13 April. If we could put this up. This is the last document that I will need to put up, INQ0003236. This was the meeting that was attended by the barrister Mr Medland.

Can you just give your impression of what happened at this meeting, what you recall from this meeting?

A. Medland, Mr Medland was called in from his

position as a legal expert, a QC as he was at the time, and he came in and examined all of the -- the evidence and the reviews that we'd done as a board and so on and he said certain things at certain times.

I remember him saying "There is no evidence of a crime", but then he countered that by saying, "If there are still genuine concerns, in well-minded people, you should go to the police."

Q. And I think just to --

A. I think he was --

Q. Just to finish the picture. On 2 May there was a further extraordinary board meeting and on that occasion that next step was taken and the board were informed that there was an intention to go to the police?

A. Yes. I think Medland was actually guiding us in the direction of that.

Q. Looking back now, Mr Oliver, do you have any reflections on what you were informed by the Executive and where challenges could have been made by the Non-Executives, such as yourself, to have either gone to the police earlier or have ensured that no decisions or a firm decision was made at an earlier stage to remove Letby from the ward?

A. I think I state in my I think it's reflections

or recommendations is that in situations like this there will always be close scrutiny of the timetables that are kept for these, these procedures to follow.

And there were, I think, a number of times when it's possible, yes, that the programme events could have been pulled tighter and could have been done sooner.

I then think if, if that is the case, I mean there were times when things could have been brought forward. But then if that had been the case, would we have not done other reviews? Would we have tried to short-circuit that? It was an attempt by the Board to cover every eventuality hopefully and make sure that we looked at every way forward to do that and I'm afraid it, it does take some time, times can slip. But I'm sure if you actually look at the timetable and narrow it all down again, things could have been done sooner; yes.

MS BROWN: Thank you. I have got no further questions. The Chair may have some.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Just one really, picking up on your last observation. You were listening I think to the evidence of your predecessor, witness Mr Higgins.

A. Yes.

LADY JUSTICE THIRLWALL: And he made the observation that he felt really that the Board and the

Executive as well obviously were trying to carry out an investigation for which you simply didn't have the expertise. Is that an observation that you agree with or not?

A. Yes. I think the thing that there could have been more clinical presence around the procedures and the protocols and so on is something that I would agree with.

I think at the time is that they were also, you know, working, working at the Trust three days a week -- three days a month, sorry. You, I suspect, do tend to miss out on an awful lot of operational day-to-day issues which I know at the induction, when you become a Non-Exec, you are warned very much about becoming too involved in and we may have missed things that would have been helpful.

But nothing springs out that I think we were not kept as appraised as we should have been during this time. Nothing jumps out to say I really think this, this was wrong or this shouldn't have happened. I was happy with the information we were given.

LADY JUSTICE THIRLWALL: Thank you. Does anybody want to ask anything?

MS BROWN: There are no other questions.

LADY JUSTICE THIRLWALL: Thank you very much

indeed. You are free to go. We will take the break now and start again at 20 past 2.

(1.21 pm)

(The luncheon adjournment)

(2.19 pm)

LADY JUSTICE THIRLWALL: Would you like to come forward, I think you were given about three different messages, please come forward.

A. Sorry.

LADY JUSTICE THIRLWALL: You don't need to be sorry, we do. There's three of us.

MS RACHEL HOPWOOD (affirmed)

Questions by MS BROWN

LADY JUSTICE THIRLWALL: Do sit down.

A. Thank you.

LADY JUSTICE THIRLWALL: Ms Brown.

MS BROWN: Could you please give your full name?

A. Rachel Hopwood.

Q. You provided a statement to the Inquiry dated 24 May 2024 and is that true to the best of your knowledge and belief?

A. That's correct.

Q. Just dealing with your experience, you are a chartered accountant?

A. I am.

Q. In October 2010 you were appointed as a Non-Executive Director of the Western Cheshire Primary Care Trust and in April 2011 as a Non-Executive Director of the Community Care Western Cheshire?

A. I was a Non-Executive Adviser first at the PCT and then a Non-Executive Director of both the board and also of the Western Cheshire Primary Care.

Q. Then in December 2011 you were appointed as a Non-Executive Director at the Countess of Chester?

A. That's correct.

Q. Did you hold those -- is it three Non-Executive Director positions concurrently?

A. So I was concurrent in terms of the community care and the PCT but then I resigned from the PCT and community care to joint the Countess of Chester board.

Q. So whilst you were the Non-Executive Director at the Countess of Chester, that was the only Non-Executive Director position you held?

A. Correct.

Q. In terms of your roles in addition to sitting on the board, you understandably as an accountant chaired the Audit Committee, you were also a member of QSPEC and I think from July 2016 you acted as deputy chair to Sir Duncan Nichol?

A. That is correct. I was initially on the

Audit Committee but then I assumed the chair after I think about 15 months or so.

Q. In relation as we said the audit, your experience of that is obvious. In relation to QSPEC, you clearly didn't have any clinical training, how did you view the role you played on QSPEC and whether you were able appropriately to contribute to that committee?

A. So I think at the time where QSPEC was dealing with safety, care and patient experience, clearly I -- as you say I didn't have any clinical background so I very much relied on the reports and the -- the verbal assurances that I got at QSPEC. QSPEC as I recall was very well attended.

There were both the clinical leads for urgent care and for Planned Care as well as nursing leads for the -- for the divisions. There were also other clinicians around the table from therapy services, pharmacy et cetera so I felt it was -- it had a wide membership from a clinical perspective but clearly as an accountant I -- I was very reliant on the data I was being given through the clinical lens.

I did feel that as a patient myself, my family and wider family were within the community of the Countess of Chester, so I did feel from a patient experience perspective I could have a lens in terms of that

experience but not from obviously a safety.

Q. In a sense there's two aspects, isn't there, because one aspect is what you were contributing to the committee but there was also the fact that sitting on that committee informed your knowledge in order for you to be an effective board member and did you think that was a helpful aspect of it?

A. Certainly at the time I did. I know the -- I know that it could be perceived as, you know, some conflicts between the committees but I found it very helpful to sit on that committee at the time because, as you say, I think that there were -- there were not any clinical NEDs until Mrs Fallon joined in 2016 and I certainly found it helpful to understand more about the inner workings of those agendas.

Q. At paragraph 2, you set out your understanding of the role of a Non-Executive Director and you refer to the Code of Conduct of accountability which is the predecessor document of the Code of Governance and you say there that you understood it was a part of your role to scrutinise the performance of management. Can you just expand on that a little in terms of what you saw your role as being?

A. So I certainly saw my role as being one of constructive challenge. Clearly with a finance

background I felt, you know, I had very much been recruited -- when the job was advertised it was for expressions of interest from people with accounting and finance backgrounds. So the hospital at the time there were multiple cost improvement plans, it was a time of financial pressure.

So, you know, very much I felt that it was there to look at the evidence look at the assurances that were being given and ask challenging questions and I feel that, you know, as a Non-Executive, you know, it was certainly there were some challenging questions that were asked.

Q. As you say your focus, the reason you were recruited was because of your accountancy experience but you understood, did you, that the board had collective responsibility for patient safety?

A. Absolutely. I understood the concept of a unitary board but, you know, clearly collective responsibility as opposed to sole responsibility and there would -- I would, you know, expect any board to be made up of different constituents of skillsets to get the most out of a well working board.

Q. Sorry to interrupt. In terms of training, you deal with this, I am going on in your statement and you talk about attending training that brought to your

attention the need to hold Executives to account and you also refer to safeguarding training and guidance on whistleblowing?

A. (Nods)

Q. Just very briefly, when and where were you receiving that training?

A. So I would have seen policies in committee, the policies you are specifically referring I believe I saw in Audit Committee and QSPEC as well as main board.

I also remember safeguarding training that was delivered in person that was out of the training centre at the Countess. I actually specifically -- I know I received children's safeguarding training. I specifically actually remember the adult safeguarding children, you know, particularly around keeping people with disabilities and cognitive issues safe. So we were receiving training.

Q. So for someone coming in as a NED with no clinical background, did you feel the training you were given as a NED coming in was appropriate and brought you up to the skill level you needed to be effective?

A. I think -- I mean obviously we have talked about some very specific trainings. I felt well supported by the trainings that were offered by that

were offered by MIAA and our external auditor KPMG, they tended to bring together either chairs of audit or Non-Executives in group settings and then would be talking about some of the wider strategic issues that NEDs were facing in performing their responsibilities and also in terms of specific issues at the time.

So I did feel that holistically there was good support and I also personally found it extremely helpful the guidance and support I received from Sir Duncan who obviously had a very experienced NHS background and I felt was very generous with his time in terms of helping me.

Q. Turning to that on that topic that you were at a point the deputy chair. What did that role involve?

A. So at the time that role didn't seem to involve anything other than I had existingly been doing potentially just stepping in for the chair at meetings that he wasn't able to attend, I had no, you know, additional responsibilities in the job spec.

I wasn't given more remuneration, there was nothing about it. I had seen the -- the form, there had been a previous Chief Executive, Sir Duncan was very active in the Trust so I didn't feel I would be stepping-- I would be required to actually do much more than I was, I was existingly doing in terms of meeting attendance

and I think as it happened, I only went I think to two things on behalf of the chair, one, the meeting with the Consultants at the end of January 2016, which I am sure you are going to get to, and also I think I went to an award ceremony on behalf of the chair.

Q. In terms of the time commitment, you have touched on that briefly?

A. Yes.

Q. But you say in your statement that three days per month advertised was unrealistic?

A. Yes.

Q. Can you just explain that a little?

A. I think -- you know, I think reflection and hindsight to a wonderful thing. At the time I felt incredibly busy, I felt, you know, the size and scale of the papers, you know, the number of committees I was sitting on, it was a lot. You know, there was, there was -- I had obviously had experience at the Primary Care Trust, it was at a different level in terms of volume, size and scale.

And I certainly think that, you know, if you look at how small a relative group of NEDs we were covering the district general hospital, I think on reflection, we -- it would have been helpful to be bigger.

Q. Just in terms of the tone of the board

meetings, you say in paragraph 9:

"I never felt unable to debate and constructively challenge in meetings."

What was the dynamic at board meetings in terms of the participation of Non-Execs?

A. Well, I felt it was good. I felt that we covered a broad range of topics. I felt that, you know, when I heard my colleagues ask questions I thought they had purpose, I didn't think they were leading questions or questions to -- for the sake of asking a question. I thought they had purpose, I thought they were looking for assurance so I thought the challenge was good, it was taken -- you know, and sometimes the challenge was robust but it was taken in good part as part of us all gaining assurances and I never personally felt, you know, unnecessary tension.

Q. Despite the fact that you didn't have clinical experience you always felt in a position where you could contribute and your voice would be listened to; is that fair?

A. Yes, I think -- you know, I found Mrs Kelly very, very patient and, you know, was very happy to answer questions. I -- I certainly, you know, never felt in any way, you know, up until the end -- up until 2017 I never felt in any way dismissed or discarded or

treated anything other than hugely professionally.

Q. We will come to that at the end of your evidence in 2017.

In terms of now turning to the specifics of the period of 2016/2017 there was a board meeting on 5 July, a public board meeting that you attended and at that board meeting the neonatal unit wasn't raised but helpfully you kept a note of a private NED meeting that was held before and if we just could have that on screen INQ0102040 and it's 002.

This is your note. Can you recall -- first of all, can you recall who else attended and then the nature of the discussion?

A. I think -- I think the note you are referring to is actually Mrs Fallon's note.

Q. Oh, I'm sorry.

A. It is not my note.

Q. Yes, but in terms of that note --

A. Obviously I have been -- I have been provided with the note as part of this Inquiry. I can't say I can recall in detail the briefing before or who was in the room. But, you know, I do recall that we were told that it was going to be -- the unit was going to be downgraded.

Q. Did you feel that that was something that

should have been discussed with you in advance, it was presented to you as what was happening.

A. I -- I don't know if -- if I thought that or not. I -- I think on reflection obviously it's a long time ago, but things seemed to be moving quickly and, you know, sometimes just with the logistics of getting the board together, because obviously we weren't in the hospital on a daily basis, I'm not sure I would have had a thought on that specific topic that, you know, because I don't think we were presented with anything, I think we were just informed.

Q. In relation to that, was there any discussion as far as you can recall about a concern about a nurse being connected with it?

A. I -- I really can't recall but I think I would have done because I'm definitely clear that that was when we were shown the -- the chart at the subsequent meeting that I -- that was around one individual but I can't remember if that individual was named.

Q. We know that it wasn't discussed at the board meeting. Was that a pattern that some of these, we know the matters with Letby weren't discussed at public board meetings.

But the downgrading of the unit, did it surprise you that that wasn't a matter that was discussed at the

public board meeting, given that a few days later a public announcement was made about that?

A. I don't -- at the time, I think this meeting was immediately before a board so I'm not sure I would have had the time to reflect and think about should it then be on the -- the agenda of a board. It wasn't -- in answer to your question it certainly wasn't common practice as far as I can recall for things not to be -- to go through boards. There was the odd occasion when maybe something was commercially sensitive, that I recall us taking items out of board.

Q. But you felt the public board meetings were an effective forum for discussing the issues?

A. Yes, I did, I did.

Q. If we can turn then now to the meeting of 14 July. That is INQ0003238. Were you aware -- well, when it comes up, were you aware prior to this meeting I think you said it was at this meeting that you learnt about Letby for the first time?

A. Yes.

Q. Were you given any advance warning of what was going to be discussed at this meeting or were you --

A. Not as -- not as far as I'm aware and I don't recall being, you know, on extraordinary boards being given pre -- pre-notice of, you know, apart from the

topic we are going to discuss X, but certainly not giving -- given notes or briefings.

Q. So you are aware it was going to concern the downgrading of the unit but in terms of the responses you made to the issue of the nurse the responses you gave were --

A. Yes.

Q. -- in the moment so to speak?

A. Yes.

Q. If we could just turn to page 6 of the notes of that meeting -- sorry, it is number 004, it's internal. Thank you. We see there in the middle of the pages clearly the downgrade of the unit had been discussed and Dr Brearey and Dr Jayaram attended this meeting and it says there Dr Jayaram stated that what he would say next was confidential.

Can you just give a flavour of what you recall Dr Jayaram and Dr Brearey set out at that meeting in terms of the level of their concern and what they were saying to you?

A. I recall being shown a -- a chart of shift patterns I think it was to -- to death, but I don't recall any other specifics that they were saying.

Q. That chart, did that highlight Lucy Letby's name on it?

A. I can't honestly recall. I was aware it was one -- it was one individual but it was a pattern they had done that was for one individual but I -- I can't honestly if Letby's name came on or --

Q. What did you understand in essence was the concern of Dr Jayaram and Dr Brearey; what were they bringing to the board? So there is a concern, there was a -- was that you understood it to be a nurse?

A. Yes, I mean, I certainly understood that it was linked to a rise in deaths in the death rate and I definitely understood that they were, they were pointing to concerns about an individual and I think I am correct in saying I understood that that individual had been moved to non-clinical duties.

Q. Well, we will come to that in a moment. Because at that stage, in a very literal way you had two Consultants who were in fact literally speaking up to you -- unusual at a board to have two Consultants present speaking up -- and they were voicing concerns and those concerns went to patient safety and the possibility that harm was being done to a child and the future possibility of harm.

Why, given the training you have had, you spoke about you have been trained in safeguarding and on Speak Out and were familiar with the policies, why do you

think that it wasn't raised at that meeting, that -- the policy of Speak Out which would have meant of course referral to the LADO?

A. Yes.

Q. You acknowledge that in your statement looking back with hindsight, but why at the time was that not recognised by the board?

A. I have reflected on that a lot, as you can imagine, because there was a whole board of, you know, of Executives and Non-Executives plus two paediatricians and none of us identified this as a whistleblowing. And I think the only thing that I can conclude is at that point, we, we went -- it was almost like, you know, we went down a rabbit hole of safety and trying to triangulate data which I think was quite common in terms of QSPEC, trying to find reasons.

So rather as you rightly point out that initial actually we don't need to prove any data, this is, this is a theory, but it's protect -- it's a disclosure under the Act and therefore all the safeguards to the clinicians themselves under that Act should be -- you know, should be actioned and the LADO should be informed and from that there would have been a conversation that ...

Instead, we got into this triangulation of report,

you know, can we find the reasons why this, you know, this is one scenario. But are there any other scenarios? And I think, you know, in the context of reasons for safety reasons and concerns, often being complex, multi-factoral, when actually the -- the reason was frighteningly simple.

Q. In terms of what you did deal with at the board, one of the matters was what action needs to be taken in relation to the nurse and if we can go to page 6, 006, you then we see -- well, to put it in context, Mrs Fallon had raised the issue of competency of the nurse and at the bottom of that top paragraph Dr Brearey had responded saying that if there had been a competence issue this would have been flagged up. So certainly Dr Brearey was saying their concern was deliberate harm, not competence.

Then you pick up and say how practical it was for the staff member to work under supervision.

So at the time there you were clearly concerned or it seems -- well, you say what your concerns were?

A. Well, I was listening clearly in the -- in the moment to what the Consultants were saying. I would have clearly also looked to Mr Harvey as the clinical lead for guidance from a board perspective because that's where I would typically get my -- my highest

levels of clinical assurance from.
You know and I guess as we have said I have no clinical background but even I could see that supervision would be challenging. You know, how would you do it? And there in the minutes then followed a discussion and, you know, obviously the nurse wasn't put under clinical supervision.
Q. Well, just picking up on that because Mr Wilkie picked up -- he had the same concerns as you and there is multiple references to Mr Wilkie expressing his concerns about whether Letby should be supervised on the ward and whether that eliminated the risk that being concerned about given the gravity of the risk that was concerned. As you say, in a sense that's not something you need clinical experience for.
But in fact the decision that the board went away with was that Letby was going to be supervised and Mr Wilkie has given evidence that he had a sleepless night and went and spoke to Alison Kelly about it the next day. Were you not concerned at that point that the board was going away with a view that Letby could be supervised, you have clearly raised the issue?
A. Yes.
Q. But it doesn't seem to have been followed through at that meeting?

A. Yes, I think that's -- I think that's a fair observation in hindsight. You know, if I look at these, these meeting minutes there are not clear actions with accountable you know -- I think on here, you know, Mr Chambers states he is going to take personal oversight and follow it -- follow it through.
But yes, I -- I didn't personally go and then seek further assurances that my colleague did.
Q. The meeting then moved to discuss first of all the police and if we can go to page 8 and whilst -- it says Mr Cross outlined his understanding of what action the police would take if they were called to investigate the matter.
Just briefly, what was your understanding about what was being discussed in terms of calling the police and whether there was concern about calling the police at that time?
A. I'm not sure, clearly I can see from the minutes --
Q. Yes.
A. -- we had a discussion but I'm not sure I can remember the specifics of that discussion.
Q. The next point coming on to discussing was the Terms of Reference for the RCPCH. Again prior to dealing with this on the spot, as it were, had you been

circulated or seen the draft Terms of Reference?
A. No.
Q. What did you understand to be or did you understand, have a clear understanding of what the RCPCH was being asked to do in your mind?
A. I -- I think at the time I thought the review would go some way to triangulate the data. Clearly in hindsight, I did not have a clear view and understanding of what had been commissioned.
Q. Isn't it the case that in fact given the significance of the issue those Terms of Reference should have been considered very seriously at the board and if you didn't have the opportunity to do so there, if it had just been presented to you, that time should have been taken to scrutinise those?
A. I think for certain the Terms of Reference needed -- need great scrutiny. I'm not sure as a non-clinician, whether even in the broad context I would have been the right person to -- to scrutinise and provide full assurance. I think I would have had to have relied on other clinical colleagues but I think clearly multiple number of clinicians reviewing the Terms of Reference would have been appropriate.
Q. Just at the very end of that meeting we can see your concern if we go to page 9 because you say:

"Mrs Hopwood stated she felt this was fine but that another board meeting be held post review as a minimum unless there is a need to get together sooner."
A. Yes.
Q. In fact, we know that there wasn't a board meeting, a full board meeting, to discuss this until January. Do you think in retrospect you should have followed that up or did you in fact try to follow that up and find out what was happening?
A. I -- I mean, clearly in retrospect I can see the report was published in October from the pack. So clearly in hindsight, we should have had a board meeting before January to review the report.
I mean, I absolutely wish I had followed up but I also think, you know, that the board actions were primarily the responsibility of the Executive and in this case Mr Chambers, because he was taking lead to make sure that we were acting, but I totally accept I should have followed it up as well.
Q. We see in fact that these minutes, they are not as is sometimes the case -- they are not listed by a table of actions?
A. Yes. I think I made reference to that.
Q. If we can then go to 19 September, this was the QSPEC meeting 0003178. This was a meeting where you

sat on a QSPEC meeting where Mr Harvey just gave a verbal report, if we can go to page 2, of the review, of the RCPCH review and he says there that the College -- in the middle of the paragraph:

"The College have recommended the Trust commission a forensic review carried out by two independent paediatricians."

That was the view then, in fact of course we know it was Dr Hawdon, a sole paediatrician, who carried it out.

At that point, was it -- and indeed should it have started to ring any alarm bells for you at this point, the RCPCH hadn't -- I think you use the term triangulated, but they hadn't and that at this stage the police needed to be reconsidered as an option as the people who could investigate the RCPCH, not having been able to?

A. I mean clearly in hindsight, you know, as you suggest I wish that had been the action taken.

I think at the time I was -- I didn't necessarily have an expectation of reviews, obviously reviews being thorough but reviews weren't necessarily quick, so it perhaps wouldn't have surprised me if things took time.

Q. If we can then go to the board meeting that did then discuss the RCPCH report, so this is the

meeting of 10 January and the reference is INQ0003237.

Now, one of the issues is what information the board had available to them. What is your recollection of when you saw and indeed what version you saw of the RCPCH report?

A. So I definitely have recollection of a meeting where Mr Harvey came in -- there were two -- two doors in the boardroom that we used to meet in and Mr Harvey's office was off the room that we didn't commonly go into and I remember Mr Harvey bringing reports into the room at the start of the meeting and then those reports going back.

I can't honestly say can I remember whether it was the -- I have obviously seen both in the pack, which version I saw, but I do recall having very little time, it's obviously a complex report to read, you know, before somebody, which I think it's not unreasonable to assume was Mr Harvey, started talking about what it was I was reading.

Q. Why did you understand you weren't allowed to take the report away with you?

A. I -- I really can't remember. I definitely didn't challenge it.

Q. Did it strike you at the time or any of your colleagues as unusual that this very important report

that was looking into an issue of the utmost importance was something that you weren't being given time to properly consider?

A. I think the take-away not necessarily because of the confidentiality of some of the data that was in there. But I absolutely think we should have had -- I think you can obviously keep -- keep documents, you know, in close quarters, ie not just have documents, you know, unsupervised but you can give someone a lot of time to read it. So I think we could have had longer to read and digest, maybe then go away and then have a meeting.

Q. Looking at that meeting, we see that Mr Harvey sets out the review of the RCPCH so it seems likely that that was -- that recollection of reading the report would have been at this meeting, but you can't assist?

A. Sorry, can you --

Q. It seems likely that your recollection of reading the RCPCH would have been on 10 January?

A. I think it would be likely.

Q. So the report that you have had a chance to read briefly and you say you can't recall whether it was the redacted or unredacted version, ie the version that had Letby referred to or not, but Mr Harvey then goes on if we can go to page 2, to explain that one of the

recommendations of the report was for there to be a further review and that was the Jane Hawdon review but that report hadn't been circulated.

Then if we see further down, first of all, Mr Harvey gives a summary and he says the case reviews very much reinforce what is in the reviews.

So he is summarising Jane Hawdon saying case reviews reinforce what is in the RCPCH review, it comes down to issues of leadership, escalation, timely intervention and does not highlight any single individual.

Then Mr Chambers says:

"There are some outstanding matters, one final, four reviews from Alder Hey, once we have that we can draw a line under this first part."

So did you looking back understand that there was still an incomplete aspect to the investigation?

A. Well, I think by the nature they were -- they were talking about more -- I think just remind me, can I just go back to page 1 of this?

Q. Yes, of course.

A. Sorry, then to 2, please. So I -- I think by saying they -- they needed to commission the in-depth and there was still some postmortem results I would have understood there was still some more work to do, that

this wasn't drawing the line. But I would absolutely, you know, of -- of relied on Mr Harvey's clinical interpretation of what the report was saying.

Q. Yes, and that's the issue, isn't it?

A. Yes.

Q. Because as someone who is challenged there as a Non-Executive to challenge, these very important reports, one of which you accepted you hadn't really had time to absorb and one you hadn't seen, was this a situation where that challenge should have been no, we need to -- we need more time to consider this certainly because what you were being asked to do and I am going to take you to the moment when you were being asked to consider putting the nurse back on the unit?

A. I think on reflection we needed the two paediatricians in the room who had been in the room in July.

Q. If we can just go to page -- I am going to have to flick, I'm afraid, between documents but if we can just go to INQ0003518, this is -- it is going to come up -- the very brief report that Mr Harvey presented to the board on 10 January setting out the fact that the RCPCH had reported that noting there had been a grievance and then what had gone on following that.

Over the page, we see what the board is being asked to do and we will see at (c) there you are being asked to support the Executive in assisting the staff member's return to work and implementing the recommendations of the grievance.

It's the case, isn't it, that really you were being asked to support the Executive on such a key decision given the risk, if it was an incorrect decision, on inadequate information; would you say that's fair?

A. I mean obviously I have read the -- read the papers as part of the review. I can't say I can recall this meeting. So I can see I was there.

Q. Yes. So you can't -- you can't assist on whether you felt or how you felt about supporting the Executive in the return of Letby to the ward?

A. Because this particular meeting I really don't have a recollection of?

Q. But it is the case, isn't it, looking back over the minutes that you were being asked to support her return having not seen --

A. Yes, I mean clearly.

Q. -- the documents?

A. Reading the minutes you -- you couldn't -- no one reasonable could reach any other conclusion.

LADY JUSTICE THIRLWALL: I'm sorry to interrupt,

Ms Brown, but can we just be clear.

This document was produced when, when was it given to the --

MS BROWN: At the meeting.

LADY JUSTICE THIRLWALL: At the extraordinary board meeting?

MS BROWN: Yes, so if we go back to INQ0003237. That's the meeting when Mr Harvey gives an overview and our understanding is that that's the overview that this document, the document we have just seen, relates to, Mr Harvey's overview.

LADY JUSTICE THIRLWALL: Thank you.

MS BROWN: There is just one other matter in relation to that meeting, if we could go to on to page 6 of the document we have got up there. Did you have a concern at the time about the leaking of the RCPCH report to the press?

A. So I remember feeling very strongly and I think if you look at various minutes as been shared with me, I often ask questions about candid feedback and patients being -- being informed. I felt very strongly at the time that we needed to make sure that we were communicating in the appropriate and timely way and a supported way with the families.

I'm afraid that I didn't have a very, very strong

view on responsible reporting of maybe some, some aspects of the media and I felt there would be nothing worse than waking up to some sensational story for clickbait, when we -- you know, if the hospital hadn't -- hadn't communicated in the appropriate way.

Q. Was your concern about any group speaking to the press, any particular group of people reporting that?

A. No and I think, I think the handwritten minutes, I -- we had a conversation about various constituents of stakeholders and it was just any stakeholder.

Q. Yes, I just need to correct this. I think this has been referred to before, so it's on page 6 where it says:

"Mrs Hopwood asked that the assurances that the report will not be leaked to the press by Consultants ..."

The handwritten note of the meeting that you are referring to, if we can just turn to that, INQ0003332, page 23, it's a minor point but it just needs to be made clear what's on the minutes don't seem to reflect what's on the handwritten more contemporaneous note. So INQ0003332 and page 23.

We see there Mrs Hopwood asked that these

assurances the report will not be leaked to the press but there's no reference there to that being by Consultants. It then goes on:

"Mr Chambers replied that this would part of the conversation with clinicians who will be very clear about the expectations."

But the note doesn't appear to be that your concern was about the Consultants?

A. Yes, it was more general.

LADY JUSTICE THIRLWALL: Yes, it looks as though the two things have been taken together --

MS BROWN: Yes, it seems there has been a --

A. I think there is a couple of instances of that.

LADY JUSTICE THIRLWALL: Do you remember this part of the meeting, or again do you not have any memory?

A. Sorry?

LADY JUSTICE THIRLWALL: Do you recall this part of the meeting?

A. I -- I definitely recall being very concerned for the parents.

LADY JUSTICE THIRLWALL: Yes.

A. I don't recall in any way being focused on one group who were somehow, you know, the agents who were going to leak. It was, you know, because we were

talking about this report obviously being shared with a number of stakeholders because, you know, clearly it wasn't -- it would be circulated.

MS BROWN: I think it's in reviewing these notes for this hearing that you have picked up that didn't ring true and checked the handwritten notes.

A. Yes, yes.

Q. If we can then go to the meeting of 26 January. This is the meeting that you attended on Sir Duncan Nichol's behalf. It's INQ0003523, so this is a meeting that was attended by all the Consultants and Mr Harvey, Mrs Kelly, Mr Chambers, and you were there on behalf of Sir Duncan Nichol.

At this meeting, just to put it in context, Mr Harvey is discussing the RCPCH review with the Consultants here and if we can go over to page 2 and just highlight a few of the things that were said at that meeting. At the top, Mr Chambers is talking about the grievance had indicated there had been victimisation of the nurse. Further down, there is a need to draw a line under the Lucy issue.

Further down, the board had noted that an apology would be requested from the Consultants.

We see at the bottom of the page it appears that Mr Harvey stated the report would be released to

everyone at the same time, some issue about who had seen the report.

Is this a meeting that you recall and, if so, what were your impression of this meeting?

A. I -- I can recall this meeting because it was so unusual that I was asked to step in for Sir Duncan and it was with very little notice. I -- I think my impressions of it at the time were it was -- it was a more tense meeting -- I mean, I hadn't attended Executive clinician meetings, I had obviously attended boards and committees but I hadn't attended what I would describe as an operational meeting.

So I thought it was a little more tense than I would experience at a board or a subcommittee. It seemed -- it seemed cordial. I wouldn't have described it as very aggressive or, you know, unreasonable. I think if I had, I would have gone back to Sir Duncan and said, you know: the tone of that was totally inappropriate and either on the clinician's behalf or Mr Chambers' behalf, I think body language was -- was tense. I think I picked up on the body language.

But I wasn't sighted at that point on anything that had happened in the grievance process and now obviously as part of this Inquiry I have been given the grievance documentation. So now my reading of the meeting, having

seen some of the interviews that were conducted I think particularly Mr Brearey's interview I was particularly taken aback by the tone of that, I perhaps now have a slightly different view of the meeting and I can see how it might have appeared more confrontational than at the time I was -- I was aware of.

Q. Because even setting aside what you know subsequently there were a few things there that might have caused alarm or concern sitting on the meeting they are talking about -- you had heard Dr Brearey and Dr Jayaram speaking about their concerns back in July and there's reference to then victimisation of a nurse and an apology needed from the Consultants it wasn't just on the face of it that striking you as completely contrary to the Speak Up policy?

A. Again I think I had -- I would refer you to -- I mean, I absolutely accept your point in hindsight. We were --

Q. Not even in hindsight. At the time you are sitting there. You have in person heard Dr Jayaram and Dr Brearey express their concerns and I presume in the 14 July maybe you can tell, you assumed their concerns were genuine?

A. Yes, for certain, for certain.

Q. You are now being told in fact the Speak Out

Safely process has even been highlighted by being referred to and it's being referred to there's been victimisation and needing an apology from the Consultants when you are aware they had raised what you at the time thought were valid concerns?

A. Yes.

Q. Regardless of what had gone on, why was that not causing you concern from a Speak Out perspective?

A. I think the -- the -- that failure in July to -- to recognise the safeguarding which would then of put the grievance on halt because the grievance would not have gone across, the grievance was sort of spanning to a different place.

I was aware that, you know, and I think it states some of the statements that had been made, so it allowed Letby to create a -- an alternative narrative around victimisation and grievance when everything should have been focused on safety and obviously taking the steps to report to LADO and safeguarding.

So I'm -- I totally accept your point.

Q. Yes.

A. But -- but it wasn't something that registered with me at the time.

Q. If we can just then turn to what happened subsequently. There was a meeting on 13 April when

Mr Medland spoke to the board and spoke about the possibility of going to CDOP, the Child Death Overview Panel then, and if we could just turn to INQ0003236, page 5.

At that meeting first of all, what was your understanding of what was being said in terms of contact the police at this point?

A. So, sorry, I'll just ...

Q. In terms of -- maybe we should go back to page 4 in terms of -- well, let's stay on page 5 because there is another point I am going to come to. Just your view, first of all, before we come to the notes about what you were being told about involvement of the police?

A. So I think there still seemed to be -- I mean certainly in my mind from the minutes -- a confusion about how many cases we were looking at, you know I can see I asked would it be four cases, eight cases? So there was still a lack of clarity in messaging certainly in my mind about what it was I was -- I was asking for that clarity.

But I certainly understood -- I think I felt that Mr Medland had said we had gone through steps and then the next step was the police. I didn't take it as the first step was if -- you know, if you have reasonable

doubt, you go to the police.

I think the way he did the chronology certainly maybe misled me into thinking you did this triangulation of data, and then if that still was not ...

Q. So he was suggesting at that point, did you understand, that you would go to CDOP and then potentially go to the police?

A. Yes.

Q. Just on the page we have got up now, just really in terms of communication with the parents, because you raised this on a number of occasions we see Mrs Hopwood asked if there was a plan to communicate this to the Families and then a need to have some pre-emptive lines to the Families and then further down asked if the report had been shared with the Families.

It seems that you were raising a concern about communication with the Families and --

A. We are --

Q. And that follows through just -- we won't turn to the next meeting but the following meeting that was in May, when at that stage the police were contacted, you returned to that and you ask about communication and a single point of contact.

A. Yes.

Q. So just your thoughts on how the board handled

communication with the parents?

A. Well, as you say, I think I also referred to it in the January meeting and, you know, I got assurances there were plans and draft plans and very much from a communication to parent perspective, I saw that as being first and foremost operational, you know typically, clinicians, nursing staff would communicate obviously in this case given the seriousness of the situation, I would have expected that communication to be with the Medical Director and indeed Mr Chambers who had said in July that he was taking personal responsibility for the role, I can see in hindsight I wish I had asked foresight of the written plan because I took reassurance from being told there was a plan that the communications were happening.

But I never saw the communications or asked to see the communications.

Q. Thank you.

If you can just -- if I could just ask you to return to your statement, that can go down. Return to your statement where you have some reflections at the end of your statement. You talk about, with hindsight, views about Letby being suspended earlier and the recognition that there was whistleblowing going on, which we have covered.

But you deal at paragraph 83 with you felt access on the board to more detailed metrics including number of deaths, that's something that you felt would have been helpful, do you think that would have alerted you to the problem at an earlier stage?

A. I -- I definitely think that the timeliness of metrics around mortality was and, and certainly independent assurances, so if I think back to December 2015 and QSPEC, when that was -- I think the first time I was aware that there was a concern of a raise in deaths in the neonatal units, I gained assurance with a reference to the MBRRACE, MBRRACE data showing that the Trust was still 10% under national average.

So we were still reporting below average even -- and I understood it in the context of even with those five extra deaths we were still 10% under, obviously with a non-clinical background. Obviously by going back through the notes and, you know, I think in the report at the time it was referred to, you know, the most recent MBRRACE data shows it turned out that data was actually I think related to 2014 and the period before.

So actually it didn't relate to the period it was being compared against at all.

Q. So what would have been helpful to you on the

Q. Yes.

A. I went to a QSPEC meeting and, you know, these are busy meetings, there were probably over 20 people in the room and I was -- and Mr Harvey I am sure it was announced that I was the Children's Champion and no one had mentioned this to me. I went home -- I was, I was absolutely horrified because I had never -- I had no idea what this was. I -- I had never experienced anything like it before in my -- in my time at the Countess where I just found myself announced as something without consultation.

I -- I went home and I did something which actually I don't think I did before or since and I actually sent an email the next day to Duncan just expressing the -- well, the first thing I did was I met immediately after with Ian and Alison Kelly and Andrew and, you know, basically expressed how could I be put in this situation and, you know, I think I put in my statement.

Q. If we could maybe have up 0003122 because this is the email you sent.

A. Thank you. You know, I was told -- I think -- I think Mr Harvey in a joking way said yes, they were all wondering where you were and I was like: I haven't been told, and the Consultants were wondering why you hadn't been in touch and it's like: I didn't even know.

board was up to date current data --

A. Yes, absolutely.

Q. I think at paragraph 89 you talk about general disbelief across the Executive Team and a blind spot. Very, very briefly, how do you think that affected the approach of the Executive throughout this period of July?

A. Well, I do think this -- this presumption that there wasn't a frighteningly simple explanation, but instead safety issues are complex, multi-factoral, you know, we -- we kept, you know, receiving updates about, you know, was it the type of -- you know, how many, the numbers that were coming into the unit, was it about the criticality or the -- and, you know, were the babies more sick? You know, we kept looking for lots and lots of different factors but as I say there was a frighteningly simple factor.

Q. Then just one final topic. In July 2017, so after the meetings we have been going to, you attended a QSPEC meeting and I think you were then told rather than consulted that you were going to be put in the position of the Children's Champion and if you could just explain what your response was to that and why you had concerns?

A. My response?

Q. Had you been informed at all?

A. No.

Q. Were you subsequently informed about what the Children's Champion was?

A. No, it was then incredibly vague. I had I think two meetings with Mr Harvey. I think there was reference to the RCPCH report which I hadn't got a copy of and I hadn't seen since January. I note that actually in that report it was an Executive Director position, not a Non-Executive Director position.

I think -- you know, I had -- I think I had been briefed that, you know, they felt that relationships had broken down sufficiently between the Executives and the paediatricians that it wasn't -- this couldn't be an Executive role. I felt they wanted a mediation role between the Executive and the -- and the paediatricians which I was in no way qualified to do. I had no mediation or HR skills, I felt it was an operations role and that if they needed outside support that would be a more appropriate and neither did I have, you know, as I have pointed out any clinician background to be credible to a paediatric unit.

Q. We see -- we could see on the screen there that you draw the attention you feel it was you were put into an unacceptably uncomfortable position, awkward --

A. Yes.
Q. Professional embarrassment or awkwardness and so on.
What did it make you feel or did it cause you to reflect on what that said about Mr Harvey's attitude towards the paediatricians and the seriousness with which he was taking the idea of there being a Children's Champion? Did you think about that aspect of it? So there was the aspect on you but there was also the aspect on how serious this role was being taken?
A. I think at the time it felt very throwaway, almost like we need to be seen to have this -- this role. It didn't feel well thought out. You know, there was -- there was no articulation. As I say, I am sure I had two meetings with Mr Harvey about it and then I had a subsequent meeting with the paediatricians in October which I know was in the pack. Although I don't think I have seen those minutes before, I think it's clear from those minutes neither myself or the paediatricians knew what the role was at that point and I do remember going back to the Trust office and I certainly spoke to Mr Cross and then I think at a later date to Sir Duncan just laying out how what some of the paediatricians' examinations and needs versus my ability that I was in no way suited and neither did

I have a time commitment that would allow me to say attend these weekly meetings which was the support they were looking for.
Q. Subsequently that role developed --
A. And subsequently that role was obviously directed I think to a much more suitable NED. But I do regret not following up with the paediatricians after that meeting to say: I cannot -- I cannot be what you need me to be.
MS BROWN: Yes. Thank you very much. I have no further questions. I think there are a few questions.

Questions by MR JAMIESON

MR JAMIESON: Mrs Hopwood, good afternoon. My name is Alex Jamieson, I ask you questions on behalf of some of the Families. My learned friend Ms Brown has in fact asked you about most of the topics that I would have done so.
The first topic, communication with the parents, is obviously particularly important to the Families but we have heard your evidence about the reassurance that the Executives gave you and indeed the reflections that you wish you had checked that what you were being told was true and accurate and so I have no questions on that topic.
But I do have a couple of questions on that last

topic that you were just covering with Ms Brown, that of the Children's Champion.
As I understand the sequence from your statement, you are told that you have been appointed to this role in the July meeting of the QSPEC. From the document that was just put up on the very next morning at 9 o'clock in the morning, you email Sir Duncan Nichol to express your grave misgivings about having been appointed to that role?
A. Yes.
Q. And the manner in which that has happened and thereafter you have one or perhaps two meetings with Ian Harvey --
A. Yes.
Q. -- in which you discuss your suitability for the role and how it was that you were appointed for a role that no consultation had been undertaken with you.
There is just one, and so when we get to the end of that sequence, Mr Harvey can have been in no doubt that you did not put yourself forward for that role?
A. That is correct.
Q. With that, please may we just look at a meeting minute and just, Mrs Killingback, before I give you this reference, when it comes up on the

screen, it's really important that only the top half of the document comes up on the screen. The INQ is INQ0004449, it is the minute of your meeting with the Consultants and the reason I have just given that direction is because I know you shared some really quite personal information with the Consultants --
A. I did.
Q. -- which is not relevant to my question so doesn't need to come up on the screen?
A. Thank you.
Q. But it's really the first interaction so just the top half, please, not at all that bottom half of the page, just the Ian Harvey paragraph. That is absolutely perfect.
So we can see this is the meeting, this is your first meeting with the Consultants that comes after that sequence that we have established and we can see a number of names very familiar to the Inquiry in the attendees.
You are there along with Mr Ian Harvey. The first thing that he is minuted as having said is this introduction:
"Not all of you may be aware that one of the requirements of the College Review was that we should have a Children's Champion. Rachel has put herself

forward ... "
That was not accurate?
A. No.
Q. That was not true?
A. Clearly I didn't even know that I was being appointed until the QSPEC in the July.
Q. No, yes. As we have been through before he was in this meeting saying this: he had had you reacting to his announcement at the QSPEC and at least one, perhaps two, meetings with you before we get to here.
A. Yes.
Q. Yes. Did you challenge that assertion?
A. I think, I think so in short answer, no. I don't believe I have seen these minutes and the reason I don't believe that is there a number of factual inaccuracy in them about some of the personal data that we have had both on this page and on other pages.
Q. Okay.
A. And even -- and they are quite long minutes. Even if I had read them over from a -- what was in the table, I absolutely wouldn't of left some of those factual inaccuracies stated if at the time because to me the two most critical ones are actually on the last page.
Q. Okay.

A. Which is my personal email address and my personal mobile number, both of which are wrong.
Q. Right, okay. Well, I think then for fairness and for completion --
A. Yes.
Q. -- I should ask you -- I have read that sentence from --
A. Yes.
Q. -- the first paragraph as fact?
A. Yes.
Q. Was that said in the meeting?
A. I --
Q. "Rachel has put herself forward"?
A. I can't remember if that was said. It might not -- I can't remember if those words were said.
Q. Well, that's important clarification that you give. Please may that come down.
But the impression that you had drawn from the process -- I listened to your words as you were giving evidence before, the impression that Mr Harvey had given you was that we need to be seen to have this role, that it was about appearances rather than substance?
A. I think, I think that that was my view based on the fact that nobody could articulate to me what this role was.

Q. Yes. No, I am not suggesting anybody said that to you out loud, but that was the clear impression --
A. Yes, because I would expect a well thought out role to have clear terms of reference.
Q. And it's a powerful title, isn't it, Children's Champion?
A. It is a very powerful title.
Q. Was it expressed to you whether or not there was an expectation that you would speak to families or to children in the current role?
A. No, it wasn't and I'm not sure that at the time I would have -- I would have seen it through that lens, although obviously I am aware that subsequently particularly out of the Ockenden review that, you know where the role of the Children's Champion was discussed, that -- that was a constituent part of it but that obviously pre-date -- postdates this period.
I think it was 2020 or between 2020 and 2022. But I don't think at the time I would have seen an NED role.
Q. I'm so sorry --
A. Sorry, a Non-Executive Director role as --
Q. For which your time commitment I think was three days a month --
A. It was, yes.

Q. And you had a number of other duties to fit into that period of time?
A. No, I just don't think I would have seen a Non-Executive Director role as being the primary communication point with parents.
Q. No, quite. We agree, if I may say so. Similarly a Non-Executive to be the primary conduit of information from the clinicians?
A. Yes.
Q. If I may say so you have said a number of times you have drawn attention to the fact that you yourself have no clinical background, so a non-clinician NED to be the main conduit of information and concerns from the clinicians on the NNU to the board, you were never a person who was going to be suitable for that role?
A. Yes, I think -- I think I said that.
Q. Yes.
A. I didn't have a clinical background so I couldn't see that I was credible to the paediatricians.
LADY JUSTICE THIRLWALL: Yes, you did say that.
MR JAMIESON: May I finally just ask you one factual thing to tie up a loose end.
You have mentioned in your statement what we have

come to know as the Brigham review that was presented to the December 2015 QSPEC and you have drawn some reflections about some of the contents of that document?

A. Yes.

Q. The Inquiry has received evidence that when that document was presented to QSPEC, it was expressed by Julie Fogarty, the Head of Midwifery. She said out loud that this is a document that only deals with obstetric care, it does not deal with neonatal care although it's fair to say that that is not within the minutes of that meeting.

You were in that meeting. Did you come away with that impression that that document dealt only with obstetric care?

A. No, I don't, I don't think -- I don't think I did. And I don't think I would have done with something that was headed up -- I think the NNU.

Q. Yes, the document has a misleading title?

A. Document headed up and I don't think -- I don't think I would have made the distinction between the two groups.

MR JAMIESON: Thank you.

My Lady that was the third topic with the other witness and it occurred to me I should probably deal with it here.

Thank you very much, those are all my questions.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Thank you, Mr Jamieson. No other questions? May I just ask a couple of questions, if I may.

Going back to a quite different topic but early on you said that you had been recruited for your financial background and I think one or two others had a similar sort of background and you mentioned that there were multiple cost improvement plans and it was a time of financial pressures.

So is a cost improvement plan a cost reduction plan?

A. A cost -- I am trying to think -- it was CIP trying to think what the CIP stood for. It might have been Cost Improvement Plan?

LADY JUSTICE THIRLWALL: What was the effect of it, was it to try and reduce costs?

A. Yes, I mean I think in the context of the hospital that I recall, the Trust, when I first joined the Trust in 2011 it had been a period of surpluses and we went into -- I think very common with the sector -- a period of cost challenges. So that meant a deficit --

LADY JUSTICE THIRLWALL: Yes.

A. -- as opposed to a surplus so there was a lot

of pressure in terms of making -- making the budget balance. There were a lot of winter bed pressures. There was a lot -- the commissioning landscape had changed, I think, 2010 and so there were a lot of -- a lot of changes and focuses in terms of changing across the Commissioners' landscape. There was social care pressures, A&E targets, bed pressures, it was a very, very busy hospital.

LADY JUSTICE THIRLWALL: Yes. Thank you. But the gist of it is that there had been surplus and now there was deficit.

A. Yes.

LADY JUSTICE THIRLWALL: That had to be sorted out by reducing costs, is that how you -- did you have to reduce costs?

A. Well, all of a sudden there was great pressure, it was would either be reducing costs or looking for other income streams.

LADY JUSTICE THIRLWALL: One or the other, perhaps both.

A. Yes.

LADY JUSTICE THIRLWALL: I don't know. Thank you.

Then would you just cast your mind -- we will find the document if we need to -- but it was the manuscript note that you had pointed out said something different

from that which was recorded in the printed minutes, do you remember? I think the reference is INQ0003332, page 23 which we looked at earlier. If this is not the right reference, perhaps we will work on memory.

Yes. I think we can all hold in our minds what was in the minute and:

"Mrs Hopwood asked that there are assurances that the report will not be leaked to the press ... Mr Chambers replied that this would form part of the conversations with clinicians where we will be very clear about the expectations."

So his response appears to be directed to telling the clinicians that they mustn't leak it?

A. Yes.

LADY JUSTICE THIRLWALL: Had you said anything to suggest that your concern was that it would be the clinicians who would leak it?

A. No, no, I think -- I think my concern was genuinely -- it was through the lens of receiving it as a parent.

LADY JUSTICE THIRLWALL: How it would feel.

A. Not for who was going to leak it and in fact I believe in a subsequent meeting, you know, we were informed about, you know, where I think it was a solicitor who had leaked a document and that resulted

in a great parental stress which had obviously been notified to the Trust.

So I don't think I was coming through it from a who is doing it; it was from a receiving --

LADY JUSTICE THIRLWALL: Yes.

A. -- perspective.

LADY JUSTICE THIRLWALL: Thank you.

One other thing -- you may not be able to help about this, but we know that in the early period between 2010 and 2015 there was a shift from three divisions to two. Do you remember that?

A. A shift from?

LADY JUSTICE THIRLWALL: Three divisions to two divisions: Urgent Care and Planned Care?

A. I can't say.

LADY JUSTICE THIRLWALL: It may be you don't know anything about it, that's fine. It only just occurred to me you might be able to help.

Those are all my questions.

Anybody have anything else? No. Good. Thank you very much indeed, Ms Hopwood, you are free to go.

A. Thank you.

LADY JUSTICE THIRLWALL: Is that a convenient moment to take the break.

MS BROWN: Yes, it is.

LADY JUSTICE THIRLWALL: And if we start at 10 to 4, are we likely to finish the witness by 4.30?

MS BROWN: I don't know if it is possible to have a 10-minute break, just to make sure, if that is suitable?

LADY JUSTICE THIRLWALL: We will take 10 minutes, so we will be back in at quarter to 4 please.

(3.34 pm)

(A short break)

(3.45 pm)

LADY JUSTICE THIRLWALL: Have we got Mrs Fallon? Yes, would you like to come forward?

MS ROSALIND FALLON (affirmed)

Questions by MS BROWN

LADY JUSTICE THIRLWALL: Do sit down.

MS BROWN: Could you please give your name?

A. Rosalind Fallon.

Q. You provided a witness statement to the Inquiry dated 13 June 2024 and is that true to the best of your knowledge and belief?

A. Yes.

Q. In terms of your qualifications, you qualified as a Registered Nurse in 1980 and a midwife in 1982 and worked in clinical roles until 1998. Did any of your clinical roles involve working on a neonatal ward?

A. Not actually working on a neonatal ward but as a midwife, I worked very closely with the neonatal unit.

Q. Those were in hospitals other than the Countess of Chester?

A. Yes, yes.

Q. Having worked in clinical roles you then moved into non-clinical roles within the NHS. In 2006 you obtained a Master of Science degree in Health Informatics and some of the roles you have held is 2007 to 2013 you worked for NHS Cumbria with roles as Deputy Director and the Director of Performance and Planning?

A. Yes.

Q. April 2014 to December 2015 as the Director of Performance and Improvement at Liverpool Community Health NHS Trust?

A. Yes.

Q. In terms of your role as a Non-Executive Director, you were appointed to that role at the Countess of Chester on 1 May 2016 and I think remained in that role until 31 January 2024?

A. Yes.

Q. And that was your first appointment I think as a Non-Executive Director?

A. Yes.

Q. From May 2016 when you were appointed until

after the police were contacted, so the period that this Inquiry is focused upon, you were the only Non-Executive Director with a clinical background or medical leadership experience on the board?

A. Yes.

Q. In addition to attending board meetings, you sat on the Quality Safety and Patient Experience Committee, QSPEC, and also on the People and Organisational Development Committee?

A. Yes.

Q. The time commitment for your role as a NED at this time was, I believe, three days a month?

A. That's right, yes.

Q. Did you consider that period was adequate to fulfil the duties on the board and your committees and other duties you had as a Non-Exec?

A. Well, I frequently did he more than three days a month but I had enough of my own time to be able to make that time up.

Q. So it took longer than three days?

A. Yes.

Q. But you felt able to complete the work you needed to do it, albeit it took longer?

A. Yes, exactly.

Q. In terms of the role of NED, you talk in your

statement at paragraph 14 about holding Executive Directors to account the delivery of regulatory requirements.

Were you also aware of the obligation under the NHS Trust Foundation Code of Governance that as a Board of Directors as a whole you were responsible for the quality and safety of healthcare services?

A. Yes.

Q. That code sets out -- I am not going to go to it but the code sets out the roles of Non-Executive Director and uses phrases of "constructively challenge" and "scrutinising the performance of management"?

A. Yes.

Q. Was that your understanding of what your role was?

A. Yes.

Q. You say in your statement, and this is paragraph 16, that there was a potential tension between an Executive Director role and a NED role. Can you just expand a little by what you mean about that tension?

A. I think at the time my -- my thoughts were that I had worked as an Executive Director in two organisations previously, so there's always a tendency to get into the operational detail and I recognise that I needed to not get into the operational detail but

actually be able to look at the whole picture and, you know, in order to be able to add value and constructively challenge.

Q. So you were clear in your mind of the distinction between the Executive role and the Non-Executive role?

A. I was, yes.

Q. In terms of the atmosphere around the board table at the Countess of Chester, within meetings, how did you feel that operated in practice in terms of the communication, in terms of the ability for Non-Execs to participate, what was the atmosphere like within the boardroom?

A. I think the atmosphere was professional. I always felt the opportunity if I needed to raise a question or -- or a challenge that I was allowed to do so. So I didn't see when everybody was round the table that there was an issue.

Q. You say, talking about that, this is paragraph 81:

"I did not feel my presence on the board played to my strengths as a clinician."

What did you mean by that?

A. I think that whilst I was on the -- the Quality -- or the QSPEC as it was called then, I --

I suppose I wasn't consulted, if you like, sort of in terms of -- of clinical issues. Now, that could be my own inexperience as a NED and trying to really start to understand and try to be effective in that role which I recognise was -- could have taken some time.

So I felt that once -- later, as I became more involved with other things, when I became the chair of the Quality and Safety Committee, when I became the Children's Champion, I really felt that my clinical background was more valuable then.

Q. There is a distinction of course between whether you felt that you were being listened to and respected as a clinician, albeit as a Non-Executive Director or whether you felt able to put forward your views which side of that was it, was it that you felt difficulty in putting forwards your views or that you felt you were putting forward your views and they weren't being listened to?

A. No, I think I could put forward my views and I believe when I did put forward views, they were listened to.

Q. Just staying with this issue of relationships within the board and the atmosphere on the board, you say about Ian Harvey you did not find him easy to discuss issues with. Why was that? What was the

difficulty with Ian Harvey that you experienced?

A. It's quite a difficult one to put a finger on, really, and -- but I felt that I didn't, I mean, I could ask questions in the board and I would get my answers in the board. I didn't get -- I didn't feel that I had an opportunity just to have some informal conversations with him that sometimes you get more -- you get a bit more detail than you might not get at the board to understand what the specific issues are.

Q. Because of course one problem that can be the discussion is that one side isn't listening to the other side and it's just whether that was your impression, that in fact you weren't being properly listened to in the boards?

A. I wouldn't say I wasn't being properly listened to in the board. I just felt that the relationships particularly with Ian Harvey didn't develop as well as they have done with other medical directors that I have worked with subsequently. Now, some of that could just be my own experience as I have become more experienced as a NED as well as just personality types.

Q. What about with Mr Chambers, how was your relationship with him?

A. Again, it was -- it was cordial but I didn't

actually spend very much time with him outside, in fact I don't think I had, I had one meeting with him when I first started. That was the only one-to-one meeting I had with him outside the -- outside the board meetings.

Q. I think in terms of one-to-one meetings you discuss it in terms of training when you started that you saw -- you met with all the Executives individually and with all the NEDs individually?

A. That's right, yes.

Q. But beyond those meetings, there wasn't any -- any formal training when you joined that you can recall?

A. No, no.

Q. And --

A. Sorry, I did -- there was a staff induction that they had for everybody that joined the Trust and I did attend the day of the staff induction training. But that was to anybody at the Trust, it wasn't specific to a NED role.

Q. Looking back now, do you feel there are training or was training that would have been helpful to you as a first time NED coming in?

A. I think so, definitely.

Q. What would that training have been?

A. I think how to constructively challenge more

understanding of the -- the organisation. I felt that I had to go out and find -- find the information for myself which then became more time-consuming, rather than understanding of -- of how the organisation worked.

So I eventually understood how the committees worked but it was difficult to understand the -- the processes that actually brought the information to the committees.

Q. I think in relation to committees in terms of QSPEC, and this is paragraph 54 of your statement, you say you were unclear at the time of the obligations to attend meetings and maintain engagement with issues relevant to the committees or groups in between meetings, so this seems to be a bit of a lack of understanding about exactly the extent of your role. Clearly you had to attend the meetings of committees you were a member of, but beyond that there was some uncertainty in your mind?

A. Sorry, could you just?

Q. Was there some uncertainty in your mind about what was expected of you as a member of QSPEC other than attending the meetings?

A. Exactly. Yes, I didn't receive any induction into -- into QSPEC, I attended the meetings, read the papers and worked it out from there.

Q. Your meeting, or your individual meetings you had when you joined with all the members of the Executive Committee, was that something that you initiated or was that something that all board members were asked to -- to meet everybody else?

A. I initiated it.

Q. In terms of safeguarding training with your clinical experience I think you say you were up to date with your safeguarding training; is that the case?

A. Yes, I had had some safeguarding training in 2015.

Q. Given your safeguarding training and your role, your clinical experience as a nurse and then as a midwife, when the Consultants -- and we are going to go to the meeting but when the Consultants came to speak to you at the 14 July board, why looking back, we know that no one at that meeting did refer to safeguarding, but the Consultants were raising a concern about an adult, in this case a member of staff who they thought was harming babies and indeed was in a position where that could be an ongoing risk. Why is it, do you think, that that didn't immediately make you think in terms of safeguarding?

A. I don't know the answer to that as to why I didn't, but when I've thought about safeguarding since

and realised that I should have considered safeguarding at that point, but unfortunately, I didn't.

Q. Related to that is I think you say that you hadn't received formal guidance on whistleblowing or Freedom to Speak Up but you were aware that a policy existed but weren't familiar with the detail. Were you familiar with the basic principles that one shouldn't be penalised or there should be no recrimination for speaking out and that if it -- if you were speaking out about a safeguarding concern, the LADO should be informed; did you have that understanding?

A. I had an understanding around the -- the -- that one shouldn't be penalised for speaking up. I don't recall actually understanding the role of the LADO at the time.

Q. Again in terms of that meeting, which we will come to in a bit more detail, but you were faced with a situation where you physically had two Consultants who were in fact speaking to you and in fact talking about their concerns in relation to harm being done to babies.

Again really the same question. Why do you think it was that you didn't think in terms of the Speak Up -- this is a Speak Up situation, I need to go and look at the policy to see what it says or raise are we applying the policy?

A. I don't know.

Q. In terms then of the events. If we can go first to consider the meeting on 5 July. We know that there was a public board meeting then and we know at that public board meeting the issue of the neonatal unit wasn't raised, but thanks -- I misattributed to your colleague, but in fact it is your note that fortunately you made because that is what alerts us to the fact that there was a private NED meeting on, before I think prior to the board meeting, if we could have that up, it's INQ0102040.

Can you in fact now recall that meeting, it will come up on screen but I am sure you are familiar with the note, do you actually have a recollection beyond the note of that meeting?

A. No, I don't actually recall the meeting, it was only when I was doing the preparation work for the Inquiry and looked through my notebooks that I found that -- that note.

I thought the first time I heard about the issue was a week later.

Q. Of course that note, it does talk about the neonatal unit external review, the reduction of level, the downgrading of the unit. It doesn't mention anything about a nurse.

Do you think if -- if an issue of a nurse potentially being linked to deaths had been raised in that meeting, that would be something you would have remembered?

A. Well, I think for two reasons I would have remembered it anyway. I think I would have written it because whilst they are not detailed notes, they -- they capture the essence of it and I was very clear in my mind that the first time I understood the issue about the nurse was the following week.

Q. At the 14 July meeting?

A. It was actually two days before that.

Q. Yes. If we can come to that in a moment.

Just returning to the meeting on 5 July, can you recall, although you can't recall that meeting being aware -- made aware of the downgrading of the unit before the 14 July meeting?

A. Yes, because we were told at that pre NED meeting.

Q. So you don't recall the meeting?

A. Yes.

Q. But you are aware that you were told and you do recall you went into the 14 July meeting knowing that the unit had been downgraded?

A. I knew, yes.

Q. Turning then to the meeting you are referring to on 12 July, just tell us how you came to be aware of the issue and the concerns about a nurse on the neonatal ward?

A. Well, it was just a chance conversation as I was walking out of a POD meeting with Ed Oliver who was here this morning and Ed asked me, do you know what's going on in neonates? And I didn't, I can't remember the -- the verbatim but he told me he had heard there was an issue with a nurse potentially harming babies.

So he asked me did I know anything about it? I had heard nothing at that point which is why I know I hadn't heard anything prior to then.

Q. I don't think he had a recollection but you recall I think then going to Sir Duncan Nichol?

A. That's right. We went down straight away to see Sir Duncan and it was a brief meeting, I didn't take any notes of the meeting. But he did confirm basically that what Ed had heard was in fact correct and that he was going to call an extraordinary board meeting that week.

Q. At that point when you hear there's a concern about a nurse and a concern about a nurse being connected to deaths on the neonatal unit, did you

respond? For example, did you raise any concern about is the nurse still on the unit? Or can you not recall a discussion of that nature?

A. I don't recall. I did know at some point but I don't know whether it was at that meeting or at the board meeting that she was actually on holiday, so she wasn't at work.

Q. Do you think if you had been aware that or felt that she was working that you that would have been an instinctive response you would have given or can you just not assist?

A. I think if I had known she was still working I would have instinctively questioned it.

Q. If we can come then to the meeting of 14 July.

So this -- you were aware of the issue about the nurse and you are aware at this meeting, did you understand that was going to be discussed or did you understand it was going to be focused on the downgrade or indeed all of it?

A. I expected it to be all of it.

Q. We see from the notes of the meeting that Mr Chambers opens the meeting talking about the change in mortality rate. Then if we can go to page 4, so INQ0003238, and page, 4 so just to set it in context, the meeting has already discussed the neonatal unit, the

mortality increase and the downgrade of the unit and Dr Brearey and Dr Jayaram are present and we have got a note there that Dr Jayaram stated what he was to say next was confidential and not to be minuted.

Can you recall now and just give us an overview of the level of concern that Dr Jayaram and Dr Brearey were expressing and really what they were saying to you as a board?

A. What they were saying was they had seen an increase in both unexplained and unexpected deaths, that they -- they talked about a number of reviews, they-- I think they said something along the lines of they had looked at everything that they could and that they had also looked at shift patterns and -- and found that there was a particular nurse that had been on duty for many of the shifts that babies had died.

Q. Then if we go to page 5, we see here that you pick up at the bottom:

"Mrs Fallon stated that there is a point in time where a change in data can be seen and asked in terms of that member of staff how long they have been on the unit."

Then Mr Brearey comes back and talks about competence.

Going over the page:

"The individual has been praised by a transport Consultant during resuscitation ... inconceivable ... where there has been a competence issue".

So it seems that the exchange, but please correct me if you can recall it, is that you were raising, was there an issue with the competency of this nurse, was she doing something negligently that could have been causing the death? Dr Brearey is saying no, it's not about competence because he would have expected that to have been flagged up?

A. That's correct.

Q. That left presumably in your mind, if there had been doubt before that what Dr Brearey and Dr Jayaram were saying, is that the connection between this nurse is not competence which might be the most obvious and clearly was one of your concerns as a nurse that it might be that. They were saying, no, our concern is that this is deliberate?

A. Yes.

Q. You understood that?

A. I understood that.

Q. We see then Mrs Hopwood then brings up the issue about how practical it was for the staff member to work under supervision and Mr Wilkie picks up this theme and is concerned about the risk.

We know that actually at the end of that board meeting Mr Wilkie went on to the following day, because he was still concerned about it, to see Mrs Kelly. But at that board meeting it ended with the situation where Lucy Letby was going to be under supervision.

In retrospect, was that something you should have challenged more thoroughly?

A. Well, I think we have got a differing recall of the outcome of the meeting.

Q. Yes.

A. I appreciate what Mrs Hopwood and Mr Wilkie said. But I clearly understood when we left that meeting that she wasn't going to go back on the unit.

Q. In fact, on the 14th we know from other documents that you won't have seen that Letby was being spoken to and at that point it was the intention that she was going back to supervised practice and it was a few days later that there was a change in view. But anyway your understanding at the time was that she was not going back to practise?

A. That was my understanding.

Q. If you had understood she was going to practise, back to practise in a supervised nature, what would have been your response?

A. I would have challenged it.

Q. On the basis of what? On the basis of practicality of supervision or --

A. No, that if there was a question mark around her practice that until we got to the bottom of it, that she shouldn't work on the unit.

Q. So although no one was talking in safeguarding, you recognise that once there was a concern the right response was to take her off the unit?

A. Yes, yes.

Q. The meeting then went on to discuss a few other matters. It discussed the police, and we see if we can go to page 8, Mr Cross outlined his understanding of what action the police would take if they were called to investigate the matter. Can you recall that? Can you recall Mr Cross explaining what would happen if the police were called?

A. Well, this has been caricatured a number of times now, so I'm not quite sure whether --

Q. Just try and recall and if you don't have a recollection, that's your evidence. But do you recall --

A. I do recall --

Q. -- at the time?

A. -- a reference to we'd have tapes around and

you wouldn't be able to get in the unit and there would be a huge disruption to, to the unit.

Q. Do you recall that at this meeting?

A. Yes, yes.

Q. What effect did that have on you or on the board?

A. I don't know what effect it had at that time because if that's what -- if we were as a board were absolutely sure that that was the thing to do, well, we would have had to do it.

But I think there was doubt all across the -- not in terms of the, the suspicion but in terms of the evidence. There was doubt all across the room that we just didn't quite have the evidence to -- to do that.

Q. So, as I understand it, your recollection is the reason you weren't going to the police was more about lack of evidence in your mind than about disruption?

A. Yes.

Q. Did you feel you were being, by Mr Cross setting this out, that you were being persuaded not to go to the police or was this just a factual statement of what he considered would happen?

A. I think it was a factual statement.

Q. Then in relation to the RCPCH and their review

and, in fact, this is where all the Non-Execs focus on different issues and this is the issue that you focus on in the meeting and you focus on: what is the review going to look at?

Now, obviously key to what the review was going to look at would have been the draft Terms of Reference. As far as you're aware, had you been shown prior to this meeting the draft Terms of Reference to consider?

A. No.

Q. Can you recall whether you were in fact shown them? The notes are somewhat unclear about whether you were shown them at this meeting? Do you think you were shown them?

A. No, I didn't see the draft Terms of Reference.

Q. You were asking a number of questions and we see there you asked if the external review would look at staffing. Then you ask if there was a direct correlation would they uncover this and then you refer to ask about the individual and how many of those babies involved had the individual been on shift for.

Now, obviously there's two aspects of staffing: one might be are there generally enough staff, qualified staff on the unit and the other one might be are the RCPCH going to look at whether this nurse was responsible.

What did you understand the RCPCH report was going to do? Try to remove yourself from the knowledge of what it did, but what did you understand they were going to go in and do?

A. I believe that I understood they were going to look at staffing as a whole. But the question I asked was: would it actually pinpoint if there was an issue with this particular nurse of which I think Mr Harvey said that as part of that process any issues will be outed.

So I expected from that to -- if there was a direct correlation that we would get it from that report.

Q. I think that your recollection is borne out by:

"Mrs Fallon asked if there was a direct correlation, would they uncover this?"

And we see what is said in response:

"Mr Harvey replied that as part of the process any issues will be outed and we will advise them of the supervision of staff as it will be part of the measures we have undertaken."

Did you, regardless of what the note says, did you understand you were being told that yes, if there was a direct correlation they would uncover this?

A. That was my understanding.

Q. If we can go then to INQ0003178. Just one matter. I'm not going to go back to the meeting, but that meeting ended with Mrs Hopwood saying that there should be another board meeting to review the situation.

A. Yes.

Q. And we know, in fact, it wasn't reviewed at a board meeting until January?

A. (Nods)

Q. How do you think that slipped through the net? Did you ask for another one, another board meeting, was that discussed when you were in the hospital at another time?

A. I don't know how it slipped through the net. But I do recall that we had other -- there were some other conversations at some point through, through that autumn. Whether they were just updates on where the reviews had got to, but there ...

Well, as you know, there definitely wasn't another board meeting, but I personally didn't go and ask for another board meeting.

Q. And you say conversations. You were presumably in the -- because you sat on several committees, you were in the hospital at other times and presumably came across your fellow Non-Execs and some of the board members at other times other than the meetings

or would you only really meet at meetings?
A. Well, both. We would meet, we would only meet at meetings in terms of we would only go into meetings. But whilst we were there we would have chance conversations, but I feel sure that -- because we discussed it at the Quality and Safety Committee on 19 September.
Now, there would only be three Non-Executives at the Quality and Safety Committee, so I don't know whether the other NEDs that didn't sit on quality -- on QSPEC rather would be -- would have been appraised.
Q. And if we could just look at that meeting 19 September. If we go on to page 2, this is the meeting that Mr Harvey gives a verbal update and he explains that the review had recommended that the Trust commission a forensic review of the cases that sparked the external review in the first place, so carried out by two independent paediatricians.
So it's clear that in fact, the RCPCH certainly hadn't established whether there was a correlation so your expectation hadn't been realised in that sense and in fact what was being suggested was something further was needed.
At that point, did that cause you to rethink the approach and think, well, maybe at this point what we

need is an investigation by the police because the police had been referred to obviously on 14 July --
A. Yes.
Q. -- and there is still an investigation. Did that occur to you at that time?
A. It didn't occur to me at that point because I had expected the -- the report to have identified if there was correlation. It didn't. But what it did do was recommend these further detailed forensic reviews of case notes.
Q. And in the chronology, what happened next was the meeting of 10 January and if we can just call up INQ0003237. So this is the meeting where the RCPCH report was discussed and can you recall now whether it was at this meeting or prior to this meeting that you saw the RCPCH report, in what circumstances you were shown it and what version it was?
There's quite a few questions there in one. But if you just tell us what you know about the RCPCH report?
A. Well, to the best of my recollection, I went into a board meeting and received a paper which was the RCPCH report.
Q. Do you have any recollection about whether that report referred to Letby, referred to the nurse, had a section dealing with that?

A. Well, I didn't actually get a chance to read the report because I was given the report when I went in, there was a very detailed discussion, I had to hand the report back when I left. So I -- I, if I'm being really honest, barely read it.
Q. Nevertheless, you understood that was the report that was looking at the issue about the neonatal unit and what it had -- potentially going to at least address the issue or the concerns raised about the nurse?
A. Yes.
Q. You understood, presumably through the QSPEC, that in fact there was then a further report commissioned by Jane Hawdon and we see -- you may not have known it was by Jane Hawdon -- but a further report had been commissioned?
A. (Nods)
Q. We see, if we go on to page 2 there, that that in-depth review in brackets had not yet been circulated.
So as a NED, and you've explained that you understood it was your role to challenge, you are being then asked to make decisions, one of which was concerned with the return of the nurse to the unit and one of which concerned how the Consultants would be treated in terms of needing to make an apology and so on.

When you hadn't read the RCPCH report and when you hadn't seen the further review by Dr Hawdon, should you at that point have said, "We need time, we need to look at these documents" in order to be in a position to make, well, a very serious decision.
A. I should have, yes.
Q. Just in fairness, Ms Fallon, I want to point out what was being said at this meeting. Mr Harvey, you see at the bottom of that first paragraph, he summarises the report, the Dr Hawdon report, and says:
"The case reviews [that's the case reviews by Dr Hawdon] very much reinforce what is in the review [and that presumably is the RCPCH review]. It comes down to issues of leadership, escalation, timely intervention and does not highlight any single individual."
Then Mr Chambers goes on to say:
"Once we have received final four reviews from Alder Hey we can draw a line under this first part of the review."
So we are going on to yet another layer. The RCPCH haven't concluded the issue, it's gone to Dr Hawdon and it's now going on again. So it's incomplete.
But what did you think you were being told by Mr Harvey and Mr Chambers then about the involvement of

the nurse? Do you recall feeling you were being informed about the concerns about that nurse?

A. Well, I thought we were being told that the reviews had identified no concern around the nurse and that it was deemed she should go back on to the unit.

Q. Your acceptance of the decision -- we know of course she didn't go back on the unit -- but your acceptance that that was an appropriate approach for her to go back on unit and for the Consultants to apologise, that was based on your understanding that you were being told that there were no concerns about this nurse now?

A. I was being told that there were no concerns.

Q. If we can just look at page 4 of that. This was the meeting as well where Mrs Hodkinson read out the statement from Letby, do you recall that?

A. I do, yes.

Q. What effect did that have --

A. Yes.

Q. -- or just sort of describe how that unfolded in the meeting?

A. Well, it was clearly quite an emotional impact statement. I think the thing that concerned me more than anything was, well, firstly, that the Consultants had raised an issue and they were -- that was the right thing for them to do. We had made a decision for Letby

not to go back on the unit and that was the right thing to do.

What was highlighted during that meeting, I can't remember whether it was during the statement itself or after, that there were references to individuals talking about making inappropriate comments such as "angel of death" in what I understood at the time to be a staff restaurant which I felt that, regardless of what the outcome of any investigation had been, that it's not an appropriate comment.

Q. So is it right to say that what you understood you were being told was the nurse wasn't involved. You were then read a letter, which we won't go to but does indeed refer to phrases such as "angel of death", "murderer on the unit" and so on. Is that why, and if we can look on page 5, does that help you to explain or can you explain your comment there:

"Mrs Fallon referred to members of staff hearing some comments and that from the Board's perspective this is unacceptable behaviour from the Consultants."

A. That's what I was referring to.

Q. So you are not referring to the behaviour about raising a concern. In fact, that was something they should have done if they had concerns?

A. Absolutely. It was about hearing those

comments.

Q. Did you consider at this point, we know you didn't on the 14th, but did this cause you to think something's gone awry here because I have heard the Consultants and presumably in the 14 January you believed that -- 14 July you accepted their concerns to be genuine, and now we have ended up in a situation of the Consultants apologising?

A. What I should have challenged at that meeting was why didn't we have the Consultants in the room and I believe if we had had the Consultants in the room at that meeting that it would have -- we would have had a totally different conversation.

Q. Then the next meeting was the meeting on 13 April and that was the meeting, I don't think we need to turn to the minutes of that, but that was the meeting where Mr Medland, the barrister, attended. And what did you understand him to be saying to the board at that point?

A. Well, I understood he was invited to the meeting to give an expert opinion on whether we should, we should make a referral to the police.

What I was hearing from him was he didn't feel that there was enough evidence. However, I can't remember now whether he had met with the Consultants before the

meeting or after the meeting.

Q. He had already met with the Consultants --

A. Yes.

Q. -- before.

A. So that was when he said the clinicians still believe that there's an issue and he made the recommendation then to initially approach the CDOP, police representative on CDOP.

Q. Yes.

A. That I saw that then as the beginning of the process for -- for police referral.

Q. That process with the CDOP and then again, we don't need to turn to it, but we know there was then a meeting in May --

A. Yes.

Q. -- when in fact it went from the CDOP and then it was very clearly going to the police?

A. Yes.

Q. In the meeting, just staying with the meeting of 13 April, there is a note there in the minutes:

"Mrs Fallon asked if we can get a timeline to speak to Dr Hawdon so we are clear when we can speak to her."

At that point, why did you feel it was necessary to speak to Dr Hawdon?

A. I don't think I necessarily did.

When I looked back over the minutes and tried to think what did I mean at that time, I think I was using the word "we" in the generic sense as the Trust as opposed to ... So I expected the Medical Director along with the, the --

Q. I think there was a suggestion that Mr Medland asking her about what she meant by a forensic review and were you thinking that we needed to -- someone needed to speak to her about what she meant by that, or if you can't recall --

A. Yes, I can't remember exactly.

MS BROWN: Yes, thank you very much. I have no further questions. I don't believe there are any other questions unless the Chair and my Lady has some questions for you.

LADY JUSTICE THIRLWALL: No, I have no questions.

Thank you very much indeed, Mrs Fallon. I know you have been sitting there for what seems like hours and probably is hours, I don't mean there but over there, in the room. So thank you very much for coming and you are now free to go.

A. Thank you.

LADY JUSTICE THIRLWALL: So we will rise now at 4.29 until 10 o'clock tomorrow morning.

(4.29 pm)

(The Inquiry adjourned until 10.00 am, on Wednesday, 5 December 2024)

I N D E X