

Tuesday, 3 December 2024

1
2 (10.00 am)
3 **LADY JUSTICE THIRLWALL:** Mr De La Poer.
4 **MR DE LA POER:** My Lady, our first witness this
5 morning is Mr Simon Holden. I wonder if he might come
6 forward to the witness box, please.
7 **LADY JUSTICE THIRLWALL:** Do come forward,
8 Mr Holden.
9 MR SIMON HOLDEN (sworn)
10 Questions by MR DE LA POER
11 **LADY JUSTICE THIRLWALL:** Do sit down, Mr Holden,
12 and I will just begin with an apology that you were here
13 for so much of yesterday and we didn't reach you.
14 **A.** Okay, no --
15 **LADY JUSTICE THIRLWALL:** So thank you for your
16 forbearance. Mr De La Poer.
17 **MR DE LA POER:** Please could you give us your full
18 name?
19 **A.** Simon Holden.
20 **Q.** Mr Holden, is it correct that you provided to
21 the Inquiry a witness statement dated 21 May of this
22 year?
23 **A.** Yes.
24 **Q.** Is the content of that witness statement true
25 to the best of your knowledge and belief?
1

1 instead it was on an invitation basis?
2 **A.** Yes, that's right.
3 **Q.** That invitation coming from Mr Chambers?
4 **A.** Yes.
5 **Q.** Principally based upon the fact that you had
6 something to contribute about the finances to those
7 meetings?
8 **A.** Yes, yes.
9 **Q.** Now, your witness statement, Mr Holden, is
10 26 pages long and on over 50 occasions you can take from
11 me you say either that you cannot recall or you can't
12 remember --
13 **A.** Yes.
14 **Q.** -- or some variation upon that.
15 Was the issue of the neonatal unit mortality and as
16 it emerged the concerns about a particular member of
17 staff something that you were paying attention to at the
18 time?
19 **A.** It -- it -- I was aware that the discussions
20 were ongoing. I was at weekly Executive Team meetings
21 and the board meetings leading up to July '16. But my
22 focus was on the financial position of this Trust
23 because when I joined in January 16, the Trust was
24 running a £10 million deficit. You needed to sort of
25 close the old year because our year end was 31 March,
3

1 **A.** Yes.
2 **Q.** By background, are you a professional
3 accountant and chartered surveyor?
4 **A.** Yes.
5 **Q.** Were you the Chief Finance Officer at the
6 Countess of Chester between 26 February 2016 and
7 31 March 2024?
8 **A.** Yes, but there was various roles within that.
9 **Q.** I think initially you were in post on an
10 interim basis; is that right?
11 **A.** Yes.
12 **Q.** There was also a period of time where
13 a colleague had come back to work --
14 **A.** Yes.
15 **Q.** -- and there was a splitting of
16 responsibilities or a sharing?
17 **A.** Yes.
18 **Q.** Was the effect of the varying roles that you
19 had over this period that during the period that we are
20 focused upon, which is to say 2016 through to 2017, that
21 you did not attend Board of Directors meetings between
22 August 2016 and January 2017?
23 **A.** Yes.
24 **Q.** And that you also did not attend all of the
25 Executive Team or Executive Directors Group meetings;
2

1 your new year started 1 April.
2 So my initial six-month appointment was all focused
3 on money and updating the board and the Executives on
4 money, but equally you were a member of the board and
5 you were a corporate director and therefore had
6 corporate responsibility for everything.
7 **Q.** Of course, as you have told us that during the
8 period August 2016 to January 2017 you were not as
9 engaged during that period with the board?
10 **A.** Yes, yes.
11 **Q.** In terms of your first awareness of a problem
12 on the neonatal unit, you tell us in your witness
13 statement that you think that was an emerging concern
14 but that you have a note in relation to a meeting on
15 29 June that there was a confidential issue about the
16 neonatal unit; is that correct?
17 **A.** Yes.
18 **Q.** At that stage, so 29 June and that meeting, do
19 you recall whether there was any discussion about
20 a member of staff or a nurse being the concern?
21 **A.** Yes, I can, I can remember there was -- as it
22 was articulated there was a view of increased mortality
23 and the view there could be an individual. But I --
24 **Q.** An individual -- could you just finish that
25 sentence?
4

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

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

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

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

19 So we see in the centre of the page:

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

24 So that's what you have recorded --

25 A. Yes.

5

1 significance?

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

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

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

15 A. Yes.

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

18 A. Yes.

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

25 Was anybody saying in these meetings: but the other

7

1 Q. -- in your notes.

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

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

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

14 A. Yes.

15 Q. -- did the pattern stop?

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

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

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

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

6

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

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

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

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

15 A. Not yet, in the folder?

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

18 A. Sorry.

19 Q. I will read out what you say there:

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

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

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

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

22 So the 2 million they had raised was diminishing.

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

9

1 **A.** Crudely, yes.

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

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

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

12 **A.** Yes.

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

17 **A.** No.

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

11

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

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

7 **A.** No.

8 **Q.** -- that concern?

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

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

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

24 **A.** Yes.

25 **Q.** Crudely?

10

1 Were those the sort of discussions that were taking
2 place?

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

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

13 **A.** No.

14 **Q.** -- of the people --

15 **A.** No.

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

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

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

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

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

12

1 A. Not -- not explicitly at the time. It was --
2 it was more to do with: we are running an appeal for
3 a new neonatal unit, whilst at the same time we are
4 downgrading our neonatal unit and what would we do if we
5 decided not to have a neonatal unit, we have generated
6 £2 million of charitable donations, how could you give
7 that back to the public?

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

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

14 A. Yes.

15 Q. -- effort?

16 A. Yes.

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

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

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

13

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

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

6 So it's very serious language that is being used
7 there to report about how, as we understand it, all of
8 the Consultant paediatricians were feeling, that is the
9 reference to "all" and obviously the language of
10 "bullied and intimidated" is exactly the sort of

11 language that Executive Directors will not want to hear,
12 particularly when it is they who are being suggested as
13 the bullies and the cause of the intimidation.

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

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

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

15

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

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

10 A. Yes.

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

13 A. Yes.

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

15 A. Yes, yes.

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

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

24 A. No.

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

14

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

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

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

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

16 About two-thirds of the way down we can pick it up:
17 "Sue: Ravi cannot see perceived gap between nurses
18 and doctors."

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

22 And Sue saying:

23 "I could pick up with Ravi."

24 A reference to template and then next to your name:

25 "Playing for time".

16

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

17

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

19

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

18

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

20

1 a Chief Exec, you know, I am a lovely finance director
 2 now."
 3 I apologise for that?
 4 **A.** Yes, I ...
 5 **Q.** So I suppose the first question is: did you
 6 witness bullying at the Countess of Chester?
 7 **A.** On reflection and, like I say, I had never
 8 seen my Facere Melius played back to me, I wouldn't say
 9 I had witnessed bullying. But I think positions became
 10 extreme and there was a level of firmer and firmer
 11 interaction.
 12 **Q.** You also use the -- "some behaviours I don't
 13 think are appropriate", so perhaps a slightly lesser
 14 description of behaviour that might be described as
 15 bullying.
 16 Did you see inappropriate behaviour?
 17 **A.** No.
 18 **Q.** So what do you mean by "positions became
 19 firmer and firmer", whose position became firmer and
 20 firmer?
 21 **A.** I think over time the position between
 22 Tony Chambers and the neonatal Consultants became
 23 strained and it became obviously strained and I think
 24 each party grew further apart.
 25 **Q.** My final topic is this and we have heard

21

1 firm.
 2 **Q.** So you didn't perceive the board as being
 3 dysfunctional at that time?
 4 **A.** No, no.
 5 **MR DE LA POER:** Yes, Mr Holden, thank you very much
 6 indeed for answering my questions. My Lady, there are
 7 no Rule 10 questions.
 8 **LADY JUSTICE THIRLWALL:** I don't have any questions
 9 for you either.
 10 **A.** Okay, thank you.
 11 **LADY JUSTICE THIRLWALL:** I think we may have
 12 thought we would take half an hour and I see we have
 13 taken 32 minutes, but thank you very much for coming.
 14 You are free to go.
 15 **A.** Thank you.
 16 **LADY JUSTICE THIRLWALL:** I think Ms Langdale may
 17 not have shared your confidence that you would be
 18 finished in half an hour. Do you mind if we just simply
 19 wait for the next witness to come up?
 20 **MR DE LA POER:** I should say my Lady that she would
 21 be absolutely right to be dubious.
 22 **LADY JUSTICE THIRLWALL:** Yes, she did have some
 23 evidence in favour of that.
 24 **MR DE LA POER:** She certainly did.
 25 **MS LANGDALE:** My Lady, may I call Mr Higgins.

23

1 conflicting evidence on this point, but you were in post
 2 at the time that Tony Chambers left the Trust?
 3 **A.** (Nods)
 4 **Q.** Were you aware of a vote of no confidence that
 5 was being proposed in him?
 6 **A.** I was aware there was a Medical Staff
 7 Committee meeting being called. I was aware Tony was
 8 anxious about it. I think the vote of no confidence was
 9 one of the possible outcomes of the meeting.
 10 I -- I didn't -- my -- my understanding was the
 11 meeting wasn't explicitly called to vote on a vote of no
 12 confidence. But the fact the Medical Staff Committee
 13 was meeting, that could have been one of the outcomes.
 14 **Q.** The other part of what we have heard evidence,
 15 and again there is conflicting evidence on the point so
 16 I just want to hear what you have to say about it, is
 17 was there any suggestion that Mr Chambers' relationship
 18 with other directors whether Non-Executive or Executive,
 19 had broken down at the same time?
 20 **A.** No. I -- I think the relationship with the
 21 board, Execs and Non-Execs appeared to me to still be in
 22 place. But I'm not 100% sure of what other
 23 conversations could have gone on behind closed doors.
 24 **Q.** No.
 25 **A.** But outwardly to me the relationship appeared

22

1 **LADY JUSTICE THIRLWALL:** Yes, certainly,
 2 Mr Higgins, do come forward.
 3 **MR ANDREW HIGGINS (sworn)**
 4 **Questions by MS LANGDALE**
 5 **LADY JUSTICE THIRLWALL:** Do sit down.
 6 **A.** Thank you.
 7 **MS LANGDALE:** Mr Higgins, you have prepared
 8 a statement for the Inquiry, do you have it in front of
 9 you there?
 10 **A.** Yes, I do.
 11 **Q.** Can you confirm the contents are true and
 12 accurate as far as you are concerned?
 13 **A.** Yes.
 14 **Q.** Can you tell us firstly something about your
 15 background, your career and how you became
 16 a Non-Executive Director with the Trust?
 17 **A.** I was -- I had trained as a chartered
 18 accountant, and I spent 33 years, plus some months, with
 19 one of the large firm of accountants and advisers and
 20 after that time, I retired from the firm and I was --
 21 with the intention of looking for some Non-Executive
 22 positions.
 23 We had just moved into the area from Manchester,
 24 not a very big leap, but so -- and at the same time as
 25 it happened in 2011, I came across an advertisement for

24

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

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

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

10 **Q.** So a sense of public service and contribution?

11 **A.** Yes.

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

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

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

25

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

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

6 **A.** Yes.

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

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

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

27

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

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

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

10 **A.** No, nor that.

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

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

21 **Q.** So Ms Kelly and Mr Harvey?

22 **A.** Correct.

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

26

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

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

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

17 So the designated officers are identified there.

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

28

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

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

16 **Q.** Why do you think that?

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

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

29

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

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

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

22 **Q.** In terms of numbers, and you may not have them
23 off the top of your head, in the period 2016, 2015,
24 2016, 2017, how many complaints were coming through or
25 concerns were coming through this Speak Up Safely route,

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1 "With the requirement to nominate guardians in
2 2016-17, the steering group raised the need for all
3 members to undergo training."

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

6 **A.** Yes.

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

9 **A.** Yes.

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

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

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

30

1 do you remember discussing at the steering groups many
2 concerns?

3 **A.** Yes, indeed. There was a log and the log,
4 I remember, went to a few pages. So I suspect that on
5 an annual basis, this is just a feeling because I can't
6 remember the specific number, but in the 10s, maybe 30,
7 30 per annum and the objective really was to encourage
8 people to come forward. So the number coming forward
9 was seen as a measure that was important because if, if
10 that log was unpopulated then clearly the system wasn't
11 working at all.

12 **Q.** How did you promote the system --

13 **A.** I think --

14 **Q.** -- within the hospital?

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

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

25 So promotion of the policy was absolutely key in

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

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

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

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

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

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

33

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

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

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

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

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

35

1 being raised at this point?

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

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

10 So nothing is said about formally logging it then.

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

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

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

25 **Q.** Did that assist your thinking or not at the

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

5 **Q.** If we go, please, to another document
6 INQ0098434, page 2, this is a meeting held on
7 24 April 2017, a Speak Out Safely meeting. If we look
8 at that second box, please read that.

9 **A.** Page 2.

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

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

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

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

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

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1 this is a meeting, Tuesday 6 June 2017.

2 Can you have a look at the top of the box there:

3 "As part of the joint Countess of Chester police
4 investigation in neonates, the police have requested
5 copies of any notes from meetings where neonates
6 discussed."

7 If you could:

8 "Members did not recall agreeing not to formally
9 log the concerns raised by the paediatricians but the
10 notes from the meeting on 20 February state that this
11 was agreed. AK added that concerns were raised and
12 whether these needed formally logging."

13 So it continues. There appears to be some
14 confusion about what's recorded to have been agreed or
15 what's been asked here. If you can shed any light
16 please do and if you can't, so be it.

17 **A.** I think this was part of a -- a continuing
18 discussion about how the steering group should recognise
19 or formally recognise the concerns raised by the
20 neonatal Consultants or not include them within the
21 documentation that was generated by that group.

22 And frankly, I think these were kind of indecisive
23 conversations in that everybody seemed to recognise that
24 the -- that the logging of the -- of the -- of the
25 concerns was not likely to change the way in which the

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1 all of this, was that I think what that failed to do was
2 to, was to recognise or understand fully the position of
3 the Consultants and I -- I did not, I was not fully
4 aware of precise, the nature of or at least I understood
5 that relations were becoming difficult but I don't think
6 I understand -- I understood the extent to which they
7 had been -- they had become so strained as to become
8 virtually -- well, I mean almost a breakdown.

9 **Q.** That can go down, thank you. How many times
10 did you actually hear from any of the Consultants? Were
11 you in the meeting where they did attend one board
12 meeting when they did attend?

13 **A.** There was one later on in the process because
14 the -- I think -- the first meeting in July 2016, I was
15 not at that one. And then also the meeting on the
16 10 January.

17 **Q.** You weren't at that one?

18 **A.** I wasn't at that one either.

19 **Q.** No.

20 **A.** So --

21 **Q.** Don't worry about the dates. Can you remember
22 how many times you heard from Consultants yourself
23 directly?

24 **A.** In -- in the formal meeting once.

25 **Q.** So once in one of the formal meetings.

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1 Trust was addressing those concerns in terms of
2 following them up or investigating them and therefore,
3 I think that's why we -- we kept returning to it because
4 it was just unclear how it would -- how it should be
5 treated by this group and -- and indeed what impact the
6 logging would have.

7 **Q.** Hayley Cooper's evidence -- or Griffiths
8 evidence -- was that the Speak Out Safely committee
9 glossed over the issues on the NNU. First of all, would
10 you agree with that and, secondly, if so, was that
11 because you understood and knew it was being addressed
12 elsewhere?

13 **A.** I think that that is I think that's an
14 accurate way of describing it. There were no really
15 sort of I suppose there were no structured or
16 substantive discussions around the precise conduct or
17 progress of investigations that were taking place even
18 though the people around the table, perhaps Ms Cooper
19 rather less so, were aware of, of these matters.

20 So I think, I think yes, the group did gloss over
21 them and for my part I -- I did feel that as I say in my
22 own mind I could not resolve the question as to if this
23 were logged, what difference is it going to make?
24 I mean the only -- the aspect of that that I reproached
25 approach myself for, particularly having gone through

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1 Did you ever informally speak with them?

2 **A.** No, I didn't.

3 **Q.** You say, and perhaps it helps to have it on
4 screen, Mr Higgins, at Facere Melius interview
5 INQ0003058, page 15, you say halfway through this
6 paragraph:

7 "I mean, one observation that would make sense
8 I kept missing meetings at which the Consultants turned
9 up. I can't remember when this was. I think this must
10 have been in Susan's times when Ravi and John Gibbs came
11 along. I think we all felt that and in fairness
12 John Gibbs in particular, very kind of objective and,
13 you know, kind of reasoned and reasonable exposition and
14 description and explanation of where our Consultants
15 were coming from what they had done a timeline and
16 I think a lot of us came out for that, you know, blimey,
17 if we had the opportunity to have a conversation like
18 this. But from, you know, they turned up at different
19 times when Tony and Ian were there. Maybe the fact is
20 they were actually either kind of somehow suppressed
21 from expressing in those terms but, you know, there was
22 a lot of kind of shocking stuff, an awful lot of
23 sympathy from where the consultants were from and it's
24 just -- it's a massive, massive shame that that kind of
25 meeting of minds or kind of that emotional link gives

40

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

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

7 **A.** Yes, it is.

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

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

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

25 **Q.** In your Facere Melius interview, and that can

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

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

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

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

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

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

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

5 **A.** (Nods)

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

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

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

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

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

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

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

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

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

25 So I always felt that Ian's management skills of

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1 people were not as well developed as his sort of skills
 2 around clinical issues and those kind of things.
 3 **Q.** You say:
 4 "He seemed more comfortable discussing the highly
 5 esoteric statistics behind the standardised hospital
 6 mortality index or hospital standard mortality rate than
 7 the challenges in resolving any non-compliant practices
 8 in clinical teams."

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

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

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

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

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

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

17 **Q.** You say of Ms Kelly:

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

21 **A.** Yes.

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

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

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

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

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

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

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

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

25 **A.** That was prompted by really the issue that as

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

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

12 **Q.** And you say of Mrs Hodgkinson your:

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

16 **A.** Yes.

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

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

23 Would you like to expand on that?

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

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

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

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

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

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

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

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

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

20 **Q.** You say at the end of the paragraph:

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

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

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

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

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

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

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

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1 board."

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

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

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

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

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

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

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

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

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

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

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

16 **A.** Yes. I was thinking of QSPEC there in that
 17 papers for the meeting could quite often be 200, maybe
 18 300 pages and because of the involvement in clinicians
 19 and nurses around the table, then they were held on
 20 a Monday and the starting time was 12 o'clock and by
 21 2 o'clock then the clinicians may have clinics or other
 22 responsibilities, the nurses needed to get back to
 23 things.

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

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

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

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

19 Can you expand on that, please?

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

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

24 **A.** Yes, yes.

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

55

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

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

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

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

15 What do you say about that?

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

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

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

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

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

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

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

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

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

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

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

17 (11.29 am)

18 (A short break)

19 (11.45 am)

20 **LADY JUSTICE THIRLWALL:** Yes.

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

25 Where suspicions about a member of staff were

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

3 **A.** No.

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

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

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

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

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

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

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

3 **A.** Yes, excuse me. Yes, I -- I think it did.

4 The membership was drawn from right across the Trust,
5 different levels and it didn't seem appropriate -- an
6 appropriate forum to discuss something so confidential
7 and sensitive.

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

13 **A.** Yes. Yes, it was.

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

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

24 **Q.** 5 July?

25 **A.** Yes.

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

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

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

7 **LADY JUSTICE THIRLWALL:** It's not very easy.

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

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

16 **A.** No, I cannot.

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

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

21 **Q.** Did it say anything about a nurse?

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

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

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

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

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

13 A. No, I don't, because the first time I saw the
14 33-page report as opposed to the 31-page report was when
15 it came in my evidence outline bundle. I hadn't seen
16 that before.

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

20 A. Absolutely.

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

23 A. No.

24 Q. You were interviewed by the RCPCH on
25 2 September 2016, if we can go please to INQ0014605,

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

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

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

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

17 Q. All right.

18 A. So ...

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

21 A. Sorry, at which point?

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

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1 page 21. See at the bottom:

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

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

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

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

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

18 The reference -- is that you saying :

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

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

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

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

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

24 A. Absolutely it would have been, yes.

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

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1 read. What did you glean from that at the time?

2 **A.** It confirmed I think a number of, a number of
3 the issues that had been highlighted or at least raised
4 in internal reviews, principally around levels of
5 staffing and those kind of issues. It also referred to
6 the -- an element of disconnection between the
7 paediatricians and the Executive management and really
8 calling out the -- the difficulties or the issues that
9 that created.

10 So, as I say, it was -- it was about the unit
11 itself. But I think no massive surprises but a good
12 blueprint to try and resolve that. Unfortunately, it
13 offered no resolution of the other issue.

14 **Q.** In terms of the Dr Hawdon Casenote Review that
15 was undertaken next, did you have a clear understanding
16 about what that involved, what was going to be produced?

17 **A.** Well, clearly that had come out of the RCPCH
18 review and, again, I mistakenly thought that that was
19 going to be a relatively thorough review of some of the
20 cases that again would shed light on the -- the question
21 of the involvement of a member of staff. And again what
22 I was surprised to find was that Dr Hawdon had
23 effectively sort of said: well, I've done a quick
24 desktop and not covered all the cases either.

25 So I misunderstood what, what that was, what that
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1 about?

2 **A.** I think I -- I took it with a pinch of salt in
3 that what was clearly happening was that there were very
4 fraught discussions and exchanges taking -- taking place
5 and I think one the major targets in the Executive Team
6 was probably the Chief Executive himself, so it didn't
7 surprise me that he may have been the one providing the
8 most emphasis around the bad behaviour of the
9 Consultants.

10 But I just kind of took that as sort of something
11 in the heat of the moment that may or may not be a fair
12 characterisation of what was truly going on.

13 **Q.** You tell us at paragraph 63 that in
14 February 2017 you chaired a QSPEC meeting and Mr Harvey
15 gave a high level view of steps taken following the
16 publication of the RCPCH Report and progress on the
17 recommended in-depth Mortality Reviews.

18 You also say:

19 "The minutes record in that meeting it was agreed
20 that from April the committee would be seeking assurance
21 rather than reassurance and be more challenging."

22 Why was that an issue that had arisen or was being
23 commented upon?

24 **A.** That -- that comment was, it appears in the
25 same set of minutes quite close to the comments about
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1 was going to cover. I thought it would fill the gap
2 that the RCPCH report had left in my eyes.

3 **Q.** Did you ever ask to see the Dr Hawdon report?

4 **A.** No, I didn't.

5 **Q.** Did you -- I am not suggesting it was only you
6 who would be responsible for this -- think to ask her to
7 come to the board meeting or any other specialist to
8 come to the board meeting to discuss the medicine
9 involved here?

10 **A.** No, I didn't.

11 **Q.** You tell us at paragraph 62, this is the
12 meeting around February 2017, you say:

13 "I didn't see a copy of Dr Hawdon's review or her
14 letter dated 29 October. At the time I felt that the
15 board was informed about the concerns of the
16 paediatricians but this was always in the context of
17 them being a difficult group to deal with that had
18 exhibited bad behaviour, a characterisation that came
19 predominantly from Tony Chambers, supported by
20 Ian Harvey."

21 And then you follow that with saying you hadn't had
22 the opportunity of hearing about these concerns directly
23 from the Consultants at this point.

24 But for someone who hadn't had that opportunity,
25 what did you make of bad behaviour or what was that
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1 neonatal reviews. It wasn't -- it wasn't really driven
2 by the -- by the neonatal reviews but it was --

3 **Q.** Understood.

4 **A.** It was more a kind of frustration at lack of
5 progress on other issues and things repeatedly coming
6 back with no sort of further sign of resolution. And it
7 was something that I was frustrated about. I know
8 Alison Kelly was as well.

9 **Q.** So the actions and follow-up wasn't as tight
10 as you would like it to be?

11 **A.** Not in every case, no.

12 **Q.** Why do you think that was? I am not asking
13 about the neonatal unit for a moment, but more widely,
14 why was that?

15 **A.** I think -- I suppose the obvious answer is
16 that -- is that the pressures that the entire Trust were
17 was under and -- and I think the other aspect of it is
18 that different teams had sort of different
19 micro-cultures and some responded better than others to
20 the prompts or requests or demands that were placed on
21 them.

22 **Q.** You were there at the board meeting when
23 Mr Medland QC was there as well, weren't you, in
24 April --

25 **A.** Yes.
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1 Q. -- 2017?
 2 A. Yes, I was.
 3 Q. Tell us how you remember that meeting?
 4 A. I think I remember -- I remember it
 5 principally as a sort of a bit of an extension of the
 6 Catch 22 comment I made before about because we were
 7 having -- having gone, Mr Medland having gone through
 8 it, then he informed us that there was no evidence that
 9 a crime had been committed and yet if legitimate or sort
 10 of informed concerns remain, then you should go to the
 11 police.

12 So I think that that took it beyond the Catch 22 in
 13 that really I think it was an invitation to accept
 14 legitimate concerns, no matter where they sat.

15 Q. We know subsequent to that meeting what
 16 happened and there was indeed a referral to the police
 17 in May. When that referral was made, did you think it
 18 was going in that direction of travel from early
 19 January 2017 or earlier, how soon upon you was that
 20 referral to the police as far as you were concerned?

21 A. I think it was, I -- I think throughout from
 22 the very start of 2017, when there was quite clearly an
 23 unanswered question that was hanging over the Trust and
 24 the -- and the events at the neonatal unit I think it
 25 was probably only in April when Mr Medland came and

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1 got reported, because the initial feeling was that if
 2 you sort of think: well, how can this possibly be the
 3 case, then you want to treat the individual fairly. And
 4 recognising that if this were an unfounded acquisition
 5 then, you know, something that could absolutely destroy
 6 one person's life. If you do that then, you know, you
 7 don't want to do that unthinkingly. So the fact that
 8 the impact, you know, there was a meeting at which the
 9 impact statement got the read out in that context
 10 I don't find sort of massively shocking, just surprising
 11 really, why do you find it different?"

12 So just first of all dealing with that comment
 13 "pretty inconceivable any individual could have done
 14 this", is that a conversation that you had with Ms Kelly
 15 and more broadly, how difficult it was to think that
 16 that could have occurred?

17 A. I think probably the first thing I am doing
 18 there is expressing what was in my mind because to be
 19 frank, I did find it pretty inconceivable that any --
 20 any individual could have done this. The discussions
 21 with -- with Alison Kelly I think were kind of more
 22 about kind of where things were up to and from that,
 23 I certainly, I certainly got a clear sense of the, the
 24 feeling amongst the -- the nursing community that they
 25 were kind of being singled out.

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1 addressed us that I really kind of -- it really
 2 crystallised in -- into -- into the kind of, you know,
 3 sort of refer to the police or, well, I think it was
 4 pushing us very clearly in that direction.
 5 Q. You told Facere Melius and indeed you tell us
 6 you were having conversations before QSPEC and
 7 informally with Ms Kelly but if we can go to INQ0003058,
 8 the very bottom of page 12, the last three lines and
 9 then into the top of page 13, this is your interview,
 10 Mr Higgins, and you refer to:

11 "... a lot of discussions with Alison Kelly and
 12 that would include, you know, informal things and all
 13 the rest of it."

14 If we can just put page 13 on because I have read
 15 the bottom of page 12.

16 So page 13, top paragraph only, if that can be
 17 enlarged, thank you.

18 "... a lot of things that there was apparent and
 19 I think this is probably apparent in the initial
 20 meetings, was that it was kind of viewed as pretty
 21 inconceivable that any individual could have done this
 22 ... I know the nurse, the initial reaction of nursing
 23 group was to kind of draw in the ranks to support and
 24 that maybe, you know, set the tone as to how some of
 25 this got reported. But perhaps the level of which that

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1 Q. And singled out in what way and for what?

2 A. By -- by the paediatricians. I suppose the
 3 implication would be that they were some kind of
 4 scapegoat for something that was unexplained. At that
 5 point nobody knew for sure what -- what -- what the root
 6 of all of this was.

7 Q. You do make direct reference there that if
 8 this were an unfounded accusation as opposed to
 9 a mistaken accusation, "unfounded" you say there. Was
 10 that a phrase that anyone used to you that this was
 11 an unfounded accusation?

12 A. No, that's my language.

13 Q. Right.

14 A. It's more a point of principle than anything
 15 else. But no, that's me.

16 Q. So in terms of your understanding at the time,
 17 did you, as far as you were aware of them, consider the
 18 concerns genuine of the paediatricians or not or did you
 19 not were you not able to form a view about that because
 20 you didn't know enough?

21 A. I couldn't really form a view on that and
 22 that's where the -- the fact that I had a -- because of
 23 meetings that I had or hadn't attended I sort of had
 24 a personal disconnect. Some -- some of the direct
 25 interaction I hadn't been part of. I wasn't able to say

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1 one way or the other.

2 **Q.** That can come down, thank you. You tell us at
3 paragraph 66 at the extraordinary board meeting on 2 May
4 you were advised by Mr Harvey the next step was to
5 consider a police investigation. We know how that
6 followed.

7 Then at the top of the page, you say:

8 "I personally never felt that there was any
9 implication that the board should avoid bringing in the
10 police to protect the Trust's reputation and I never
11 heard anyone voice such a thought."

12 Can you just set out for us how you see this issue
13 of protecting reputation and whether if at all it
14 impacted around this time and with this decision?

15 **A.** From my point of view I never thought it was
16 an issue or should be an issue, because in the list of
17 priorities it was right down at the bottom.

18 The priority was to -- was to resolve -- was to get
19 an answer to -- to what had gone on but equally, I know
20 that some of the documentation talks about sort of
21 represent -- protecting reputation or whatever words are
22 used, but I never sensed amongst any of my colleagues
23 certainly round the board table that -- that that was
24 kind of a serious or an overriding consideration.

25 The -- the fact of the reputation was more about

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1 referred to the police?

2 **A.** There are clearly some things that
3 I misunderstood or got wrong around those -- those
4 reviews.

5 Whether that is because I was misled or because
6 I didn't ask the right questions is difficult to say.
7 But I feel that we all had an opportunity to ask more
8 questions and I didn't.

9 **Q.** Indeed you weren't at that meeting on
10 January 10. If you miss a meeting, do you get notes or
11 minutes or catch up with your colleagues informally?
12 How does that work?

13 **A.** Well, I can't actually remember when I got the
14 minutes of that meeting, but I did have copies that
15 I had retained and I had a bundle of minutes that came
16 quite some time after as a kind of a set which included
17 those of the 10 January which seemed to indicate that
18 possibly I -- the minutes may not have come out or I may
19 not have got them until some time in maybe 2017.

20 **Q.** You weren't at the meeting on 10 January where
21 the apology offered to Letby was reported to the board
22 and I don't know if you ever read the statement from
23 Letby about her described experience to the board. Did
24 you see that statement or anything from her?

25 **A.** I have seen it because it was in some of the

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1 the publicity and the impact that would have upon the
2 families and upon the staff across the Trust and I think
3 those were the key elements of that.

4 **Q.** Indeed you say that was a general consensus
5 that police involvement may be traumatic, it was
6 families and staff, and it was about being certain it
7 was the right thing to do

8 **A.** Yes, thinking that you had to have been able
9 to have some kind of evidence that -- that you -- on
10 which to base your -- your trip to the police.

11 **Q.** What do you say Mr Cross's contribution was on
12 the issue of a police investigation?

13 **A.** Well, I think because he was somebody with --
14 he was the person with the most experience of such
15 things around the board table, so I think that he --
16 well, certainly I listened to him in terms of the
17 potential impact of the police coming in and the kind of
18 sort of - "disruption" isn't quite the right word but,
19 but really the -- the fact that really it would sort of
20 mean all bets were off in terms of, in terms of what had
21 been going on to date.

22 **Q.** More broadly, did you think, Mr Higgins, that
23 you were adequately briefed by the Executives in respect
24 of the decisions that were being taken for the RCPCH
25 Report, for Dr Hawdon and then when you ultimately

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1 evidence bundles.

2 **Q.** So you saw that via the Inquiry?

3 **A.** Yes, yes.

4 **Q.** At the time, what did you understand was
5 happening in terms of Consultants being required to
6 apologise or mediate with Letby, were you sighted on any
7 of that?

8 **A.** I think I was sighted after the event mainly
9 because I wasn't at the 10 January meeting and when
10 I kind of was able to re-engage with the situation as it
11 currently stood later that month, or early February,
12 I think it had almost moved on from there because
13 clearly the request or demand for an apology had clearly
14 caused an awful lot of consternation.

15 **Q.** You offer your reflections and one of them
16 early on at paragraph 77:

17 "One of the strongest conclusions I have drawn is
18 that the police should have been involved earlier. For
19 too long the Trust treated investigations into the
20 increase in death too much like those in other Mortality
21 or Serious Incident Reviews."

22 How do you think that situation was arrived at?

23 **A.** I think -- I think because there were laid
24 down sort of procedures around investigating mortality
25 right across the hospital, then the -- the hospital and

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

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

13 **Q.** You also say:

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

17 So you mean -- tell us what you mean?

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

25 Everybody had a crack at finding what the answer

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1 **Q.** Yes, that one.

2 **A.** Yes.

3 **Q.** Who provided the second report?

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

12 **Q.** You say:

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

15 What are you thinking there?

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

24 **Q.** You also say at paragraph 79 that:

25 "Once issues started to be considered by the board

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

4 **Q.** You say at paragraph 78:

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

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

11 What do you say about that now?

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

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

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

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

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

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

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

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

22 **Q.** You say:

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

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1 That can influence a dynamic on a board, can't it,
 2 who feels confident to speak up --
 3 **A.** Yes, it can.
 4 **Q.** -- and give an opinion if they think they
 5 haven't got all the information a colleague has?
 6 **A.** Yes, it's an issue.
 7 **Q.** Did you find naturally there were more
 8 dominant voices around the board? Sometimes that's the
 9 case even when people have the same information. But
 10 when there's a disparity of information, that can be
 11 applicable?

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

18 **Q.** And you say:
 19 "I think it is also apparent that the depiction the
 20 paediatric Consultants as a badly behaved bunch of
 21 troublemakers was a very one-sided view of what was
 22 going on.

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

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

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

8 Questions by MR JAMIESON

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

11 **A.** Good afternoon.

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

16 **A.** Sure.

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

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

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

5 **A.** Yes.

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

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

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

19 **A.** No.

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

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

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

5 **A.** (Nods)

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

10 **A.** (Nods)

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

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

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

22 So we are familiar with that, but underneath:

23 A.1.M. The second sentence:

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

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1 and monitor the reporting of performance."

2 Then this sentence:

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

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

9 **A.** Yes, yes, it was.

10 **Q.** Thank you.

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

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

19 Over the page again, the last reference to this
20 document, please, in particular the second paragraph:

21 B.5.2:

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

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

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

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

14 **A.** Yes.

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

19 **A.** I see, I see.

20 **Q.** How do you challenge that?

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

25 **Q.** Yes.

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

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

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

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

15 **A.** I mean, independently sourced and derived?

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

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

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

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

6 **Q.** Thank you.

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

9 **A.** Yes.

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

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

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

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

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

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

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

10 **Q.** Sorry, I missed the second half of that.

11 Avoiding the questions that ...

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

15 **Q.** Yes.

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

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

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

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

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

14 **A.** You may be right.

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

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

20 Questions by LADY JUSTICE THIRLWALL

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

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

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

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

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

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

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

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

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

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

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

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

23 **LADY JUSTICE THIRLWALL:** Rallying round.

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

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1 **LADY JUSTICE THIRLWALL:** Thank you, that is clear.
 2 Then you say this as sort of an observation:
 3 "... that maybe ... set the tone as to how some of
 4 this got reported."
 5 I just wanted to explore that. Are you saying
 6 there that because people, and here the nurses, were
 7 supporting the individual that would have affected the
 8 way information was being passed on, or the way it was
 9 being reported; in other words, this can't be true? Is
 10 that what you are getting at?
 11 **A.** I think it certainly influenced a view that
 12 this -- this can't be true because there was a body of
 13 people who were saying "this can't be true".
 14 So I think that and the whole grievance process
 15 gave voice to that view and sort of muted the
 16 Consultants, I think.
 17 **LADY JUSTICE THIRLWALL:** Yes. Well, thank you.
 18 Anybody want to ask anything else? No. Well, thank you
 19 very much indeed, Mr Higgins, for coming to give your
 20 evidence and you are now free to go.
 21 **A.** Thank you.
 22 **MS LANGDALE:** My Lady, Mr Oliver is next and
 23 I think he is ready to give evidence.
 24 **LADY JUSTICE THIRLWALL:** Very good, we will just
 25 let Mr Higgins disappear from the scene and then we will
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1 **A.** Yes.
 2 **Q.** In 2013 you were appointed as a Non-Executive
 3 Director at the Countess of Chester. So by that stage
 4 you had already had seven years' experience as
 5 a Non-Executive Director and also that experience being
 6 in a Hospital Trust?
 7 **A.** That's correct.
 8 **Q.** As well as a board member, you chaired the
 9 People and Operational Development Committee, you were
 10 chairman of the Charitable Funds Committee and you were
 11 a member of the Audit Committee?
 12 **A.** Correct.
 13 **Q.** In terms of the time commitment, is it correct
 14 that your time commitment as a Non-Executive Director
 15 was three days a month?
 16 **A.** Yes.
 17 **Q.** And did you consider that was adequate to
 18 fulfil not only your membership of the board but those
 19 other committee commitments?
 20 **A.** Yes.
 21 **Q.** When did you cease to be a Non-Executive
 22 Director at the Countess of Chester?
 23 **A.** In August 2019.
 24 **Q.** Just dealing with your role as chair of the
 25 Charitable Fund Committee, you were involved I think at
 95

1 take Mr Oliver.
 2 **MR GEORGE EDWIN OLIVER (sworn)**
 3 Questions by MS BROWN
 4 **MS BROWN:** Could you please give your name?
 5 **A.** My full name is George Edwin Oliver.
 6 **Q.** You have provided a witness statement to the
 7 Inquiry dated 5 June 2024 and I think there is
 8 a correction you wish to make at paragraph 102 regarding
 9 the cite of the Terms of Reference and the RCPCH Report
 10 cite which I will ask you about when we get to that
 11 stage in the evidence.
 12 But save from that paragraph, is that statement
 13 true, to the best of your knowledge and belief?
 14 **A.** That's correct.
 15 **Q.** In terms of your background, Mr Oliver, you
 16 have a BSc in electrical engineering, your career has
 17 been predominantly in retail including as regional
 18 manager for Marks & Spencer Merseyside, between 1995 and
 19 2016 you were involved and for periods chair of the
 20 Ronald McDonald house at Alder Hey Children's Hospital
 21 which provided accommodation for families and children
 22 being treated there and I believe from 2006 you were
 23 appointed as a Non-Executive Director at Alder Hey?
 24 **A.** That's correct.
 25 **Q.** You left that post in 2013?
 94

1 time with the Babygrow Appeal?
 2 **A.** Yes.
 3 **Q.** Were you aware at the time that Lucy Letby was
 4 the face of the campaign and her face appeared on some
 5 of the posters, I believe?
 6 **A.** I was not aware that she was labelled as the
 7 face of the Babygrow Appeal. I was aware that there
 8 were photographs, certainly in the charity office, of
 9 Nurse Letby holding a very small babygrow?
 10 **Q.** And --
 11 **A.** But there was no name label to that particular
 12 photograph.
 13 **Q.** Were you aware of that when you were, as
 14 a board member, dealing with the issues and did that
 15 cause any consternation, was it the subject of any
 16 comment?
 17 **A.** No, I was aware and no.
 18 **Q.** So it wasn't until after -- after these
 19 matters that you became aware of that?
 20 **A.** Yes.
 21 **Q.** It had no bearing on how you dealt with these
 22 matters?
 23 **A.** No.
 24 **Q.** Thank you. Just dealing with training,
 25 Mr Oliver. You deal with this in paragraph 26 of your
 96

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

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

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

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

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

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

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

4 **Q.** Alder Hey, so 2006?

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

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

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

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1 to attend it?

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

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

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

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

17 **A.** Yes.

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

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

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

6 **A.** Yes.

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

10 **A.** Yes.

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

16 Is that a meeting that you can recall?

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

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1 opportunity, what's keeping you awake at night?

2 **Q.** On --

3 **A.** I am just saying -- I am not saying Sir Duncan
4 said that but it was the previous chair at Alder Hey
5 that used to introduce that and I looked and I mentioned
6 it to Sir Duncan is that maybe we should have these
7 meetings as they weren't always able to be had because
8 of time restraints.

9 **Q.** The meeting on 5 July, that was an occasion on
10 which it appears from the note that certainly the
11 neonatal unit was discussed and there was mention of
12 unexplained and unexpected deaths, that there was to be
13 an external review and significantly that the unit was
14 to be downgraded.

15 Do you remember being informed of that?

16 **A.** Yes.

17 **Q.** So you can't recall the meeting itself but you
18 do recall that at some point you became aware of that?

19 **A.** Yes.

20 **Q.** At that time, when you became aware of those
21 issues, were you also made aware of the fact that there
22 was a concern about a nurse being involved?

23 **A.** I am not really sure as to when the subject
24 actually came round to a particular nurse was involved
25 and so on. I think we -- we were informed at that time

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1 **A.** No.

2 **Q.** At that meeting, on 10 January, the RCPCH
3 report was discussed. You had not been at the meeting
4 of 14 July and I think your evidence is that you hadn't
5 seen the draft of the Terms of Reference or indeed the
6 final Terms of Reference of the RCPCH?

7 **A.** That is correct.

8 **Q.** Did you nevertheless have an understanding
9 what have the RCPCH were reviewing?

10 **A.** In -- in broad terms, yes. I suppose it's --
11 it's looking at it, I could possibly have expected it to
12 be looking at a bit more detail and trying to move
13 things on to a different level of understanding as to
14 what -- what had happened and the next, and with a view
15 to the next way forward.

16 It's only afterwards when I have seen the Terms of
17 Reference is that the report basically does what the
18 Terms of Reference asked for and it does nothing more.

19 **Q.** So from that, do I understand that -- did you
20 understand that the RCPCH was going to give an answer as
21 to whether the nurse was or was not responsible for the
22 deaths? Was that your understanding?

23 **A.** I'm not sure whether I expected them to do
24 that. But once I had seen the Terms of Reference it
25 didn't actually ask for that, it --

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1 and again I don't recollect really when fully that we
2 were actually told a nurse, it is suspected a nurse
3 could be involved.

4 **Q.** The public board meeting that you did attend
5 on 5 July, there was no reference in that to the
6 downgrading of the unit or of neonatal mortality but
7 following that meeting, there was an extraordinary board
8 meeting that was set up and was held on 14 July and that
9 I think was a board meeting that you weren't able to
10 attend?

11 **A.** Correct.

12 **Q.** Do you recall receiving the minutes of this
13 meeting and just really particularly as to whether it
14 was by receipt of the minutes that that informed you
15 either of the downgrading of the unit or of the issue
16 with the nurse or do you think you were informed of
17 those matters orally?

18 **A.** I think I was informed orally.

19 **Q.** Do you recall ever receiving the minutes of
20 this meeting?

21 **A.** No.

22 **Q.** If we can move on, then, to 10 January. In
23 the intervening period, between July and January, can
24 you recall at any point being given an update as to the
25 review that was being -- going on by the RCPCH?

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1 **Q.** When do you think you did see the Terms of
2 Reference?

3 **A.** Just recently.

4 **Q.** In relation to the report itself, the report
5 of the RCPCH was being discussed at the January meeting.
6 Do you recall at what point or whether you received the
7 RCPCH report?

8 **A.** In time for the meeting and then we were not
9 allowed to keep a copy of it because of HR restraints.

10 **Q.** So we will hear from her but my understanding
11 is Ms Fallon's evidence is that you were given a copy of
12 the report at this meeting, allowed to read it at the
13 meeting and then not take it away. Is that your
14 recollection as well?

15 **A.** I think so, yes. I -- I do not remember
16 coming out of the meeting, I don't recollect that with
17 a copy of that report.

18 **Q.** Do you recollect whether it was the copy of
19 a report that mentioned the nurse in it or whether it
20 was the slightly shorter version that didn't have that
21 passage in, or can you not now recall?

22 **A.** I'm afraid I can't remember that, sorry.

23 **Q.** Just looking at that meeting, Mr Harvey
24 outlined that the report had been received from the
25 RCPCH and then if we could put up INQ0003237, these are

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1 the minutes of that meeting and if we can go to page 2.
 2 At the top there, what Mr Harvey is setting out is
 3 the RCPCH have reported and they have suggested that
 4 there is a further review done of the individual cases
 5 and that was commissioned by -- from Dr Hawdon and that
 6 review had been completed and we see there three lines
 7 down: review not yet circulated.

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

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

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

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

24 Did you accept that summary at the time?

25 **A.** Yes.

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

5 **A.** Yes.

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

10 **A.** Yes.

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

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

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

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1 **Q.** Mr Chambers then we see goes on to say that:
 2 "Once we have the final four reviews from Alder Hey
 3 we can draw a line under this first part of the review
 4 itself."

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

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

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

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

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

25 **Q.** Because the situation at this stage is that

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

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

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

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

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

25 **Q.** If we can just look at now document

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

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

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

15 **A.** No.

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

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

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

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

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

6 **A.** Yes.

7 **Q.** Is that what you are referring to?

8 **A.** Yes.

9 **Q.** When you say:

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

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

15 **A.** Well, the next stage would be contacting the
16 police.

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

19 **A.** Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 **A.** Yes.

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

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

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

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

10 **MS BROWN:** If we could go then to a meeting on
11 13 April. This was a meeting that was attended --

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

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

17 **LADY JUSTICE THIRLWALL:** Yes, of course.

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

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

25 **A.** Medland, Mr Medland was called in from his
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1 or recommendations is that in situations like this there
2 will always be close scrutiny of the timetables that are
3 kept for these, these procedures to follow.

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

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

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

19 Questions by LADY JUSTICE THIRLWALL

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

23 **A.** Yes.

24 **LADY JUSTICE THIRLWALL:** And he made the
25 observation that he felt really that the Board and the
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1 position as a legal expert, a QC as he was at the time,
2 and he came in and examined all of the -- the evidence
3 and the reviews that we'd done as a board and so on and
4 he said certain things at certain times.

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

9 **Q.** And I think just to --

10 **A.** I think he was --

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

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

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

25 **A.** I think I state in my I think it's reflections
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1 Executive as well obviously were trying to carry out an
2 investigation for which you simply didn't have the
3 expertise. Is that an observation that you agree with
4 or not?

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

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

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

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

24 **MS BROWN:** There are no other questions.

25 **LADY JUSTICE THIRLWALL:** Thank you very much
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1 indeed. You are free to go. We will take the break now
2 and start again at 20 past 2.

3 (1.21 pm)

4 (The luncheon adjournment)

5 (2.19 pm)

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

9 **A.** Sorry.

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

12 MS RACHEL HOPWOOD (affirmed)

13 Questions by MS BROWN

14 **LADY JUSTICE THIRLWALL:** Do sit down.

15 **A.** Thank you.

16 **LADY JUSTICE THIRLWALL:** Ms Brown.

17 **MS BROWN:** Could you please give your full name?

18 **A.** Rachel Hopwood.

19 **Q.** You provided a statement to the Inquiry dated
20 24 May 2024 and is that true to the best of your
21 knowledge and belief?

22 **A.** That's correct.

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

25 **A.** I am.

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

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

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

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

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

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

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

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

10 **A.** That's correct.

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

13 **A.** So I was concurrent in terms of the community
14 care and the PCT but then I resigned from the PCT and
15 community care to join the Countess of Chester board.

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

19 **A.** Correct.

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

25 **A.** That is correct. I was initially on the

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1 experience but not from obviously a safety.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 **A.** (Nods)

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

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

11 I also remember safeguarding training that was
12 delivered in person that was out of the training centre
13 at the Countess. I actually specifically -- I know
14 I received children's safeguarding training.

15 I specifically actually remember the adult safeguarding
16 children, you know, particularly around keeping people
17 with disabilities and cognitive issues safe. So we were
18 receiving training.

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

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

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

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

8 **A.** Yes.

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

11 **A.** Yes.

12 **Q.** Can you just explain that a little?

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

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

25 **Q.** Just in terms of the tone of the board

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1 meetings, you say in paragraph 9:

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

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

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

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

21 **A.** Yes, I think -- you know, I found Mrs Kelly
22 very, very patient and, you know, was very happy to
23 answer questions. I -- I certainly, you know, never
24 felt in any way, you know, up until the end -- up until
25 2017 I never felt in any way dismissed or discarded or
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1 should have been discussed with you in advance, it was
2 presented to you as what was happening.

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

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

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

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

24 But the downgrading of the unit, did it surprise
25 you that that wasn't a matter that was discussed at the
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1 treated anything other than hugely professionally.

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

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

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

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

16 **Q.** Oh, I'm sorry.

17 **A.** It is not my note.

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

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

25 **Q.** Did you feel that that was something that
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1 public board meeting, given that a few days later
2 a public announcement was made about that?

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

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

14 **A.** Yes, I did, I did.

15 **Q.** If we can turn then now to the meeting of
16 14 July. That is INQ0003238. Were you aware -- well,
17 when it comes up, were you aware prior to this meeting
18 I think you said it was at this meeting that you learnt
19 about Letby for the first time?

20 **A.** Yes.

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

23 **A.** Not as -- not as far as I'm aware and I don't
24 recall being, you know, on extraordinary boards being
25 given pre -- pre-notice of, you know, apart from the
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1 topic we are going to discuss X, but certainly not
 2 giving -- given notes or briefings.
 3 **Q.** So you are aware it was going to concern the
 4 downgrading of the unit but in terms of the responses
 5 you made to the issue of the nurse the responses you
 6 gave were --

7 **A.** Yes.

8 **Q.** -- in the moment so to speak?

9 **A.** Yes.

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

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

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

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

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

4 **A.** Yes.

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

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

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

25 Instead, we got into this triangulation of report,

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

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

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

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

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

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

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

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

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

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

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1 levels of clinical assurance from.

2 You know and I guess as we have said I have no
3 clinical background but even I could see that
4 supervision would be challenging. You know, how would
5 you do it? And there in the minutes then followed
6 a discussion and, you know, obviously the nurse wasn't
7 put under clinical supervision.

8 **Q.** Well, just picking up on that because
9 Mr Wilkie picked up -- he had the same concerns as you
10 and there is multiple references to Mr Wilkie expressing
11 his concerns about whether Letby should be supervised on
12 the ward and whether that eliminated the risk that being
13 concerned about given the gravity of the risk that was
14 concerned. As you say, in a sense that's not something
15 you need clinical experience for.

16 But in fact the decision that the board went away
17 with was that Letby was going to be supervised and
18 Mr Wilkie has given evidence that he had a sleepless
19 night and went and spoke to Alison Kelly about it the
20 next day. Were you not concerned at that point that the
21 board was going away with a view that Letby could be
22 supervised, you have clearly raised the issue?

23 **A.** Yes.

24 **Q.** But it doesn't seem to have been followed
25 through at that meeting?

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1 circulated or seen the draft Terms of Reference?

2 **A.** No.

3 **Q.** What did you understand to be or did you
4 understand, have a clear understanding of what the RCPCH
5 was being asked to do in your mind?

6 **A.** I -- I think at the time I thought the review
7 would go some way to triangulate the data. Clearly in
8 hindsight, I did not have a clear view and understanding
9 of what had been commissioned.

10 **Q.** Isn't it the case that in fact given the
11 significance of the issue those Terms of Reference
12 should have been considered very seriously at the board
13 and if you didn't have the opportunity to do so there,
14 if it had just been presented to you, that time should
15 have been taken to scrutinise those?

16 **A.** I think for certain the Terms of Reference
17 needed -- need great scrutiny. I'm not sure as
18 a non-clinician, whether even in the broad context
19 I would have been the right person to -- to scrutinise
20 and provide full assurance. I think I would have had to
21 have relied on other clinical colleagues but I think
22 clearly multiple number of clinicians reviewing the
23 Terms of Reference would have been appropriate.

24 **Q.** Just at the very end of that meeting we can
25 see your concern if we go to page 9 because you say:

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1 **A.** Yes, I think that's -- I think that's a fair
2 observation in hindsight. You know, if I look at these,
3 these meeting minutes there are not clear actions with
4 accountable you know -- I think on here, you know,
5 Mr Chambers states he is going to take personal
6 oversight and follow it -- follow it through.

7 But yes, I -- I didn't personally go and then seek
8 further assurances that my colleague did.

9 **Q.** The meeting then moved to discuss first of all
10 the police and if we can go to page 8 and whilst -- it
11 says Mr Cross outlined his understanding of what action
12 the police would take if they were called to investigate
13 the matter.

14 Just briefly, what was your understanding about
15 what was being discussed in terms of calling the police
16 and whether there was concern about calling the police
17 at that time?

18 **A.** I'm not sure, clearly I can see from the
19 minutes --

20 **Q.** Yes.

21 **A.** -- we had a discussion but I'm not sure I can
22 remember the specifics of that discussion.

23 **Q.** The next point coming on to discussing was the
24 Terms of Reference for the RCPCH. Again prior to
25 dealing with this on the spot, as it were, had you been

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1 "Mrs Hopwood stated she felt this was fine but that
2 another board meeting be held post review as a minimum
3 unless there is a need to get together sooner."

4 **A.** Yes.

5 **Q.** In fact, we know that there wasn't a board
6 meeting, a full board meeting, to discuss this until
7 January. Do you think in retrospect you should have
8 followed that up or did you in fact try to follow that
9 up and find out what was happening?

10 **A.** I -- I mean, clearly in retrospect I can see
11 the report was published in October from the pack. So
12 clearly in hindsight, we should have had a board meeting
13 before January to review the report.

14 I mean, I absolutely wish I had followed up but
15 I also think, you know, that the board actions were
16 primarily the responsibility of the Executive and in
17 this case Mr Chambers, because he was taking lead to
18 make sure that we were acting, but I totally accept
19 I should have followed it up as well.

20 **Q.** We see in fact that these minutes, they are
21 not as is sometimes the case -- they are not listed by
22 a table of actions?

23 **A.** Yes. I think I made reference to that.

24 **Q.** If we can then go to 19 September, this was
25 the QSPEC meeting 0003178. This was a meeting where you

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1 sat on a QSPEC meeting where Mr Harvey just gave
 2 a verbal report, if we can go to page 2, of the review,
 3 of the RCPCH review and he says there that the
 4 College -- in the middle of the paragraph:
 5 "The College have recommended the Trust commission
 6 a forensic review carried out by two independent
 7 paediatricians."

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

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

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

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

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

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

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

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

17 **A.** Sorry, can you --

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

20 **A.** I think it would be likely.

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

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1 meeting of 10 January and the reference is INQ0003237.

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

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

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

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

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

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

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

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

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

12 Then Mr Chambers says:

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

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

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

21 **Q.** Yes, of course.

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

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1 this wasn't drawing the line. But I would absolutely,
 2 you know, of -- of relied on Mr Harvey's clinical
 3 interpretation of what the report was saying.
 4 **Q.** Yes, and that's the issue, isn't it?
 5 **A.** Yes.
 6 **Q.** Because as someone who is challenged there as
 7 a Non-Executive to challenge, these very important
 8 reports, one of which you accepted you hadn't really had
 9 time to absorb and one you hadn't seen, was this
 10 a situation where that challenge should have been no, we
 11 need to -- we need more time to consider this certainly
 12 because what you were being asked to do and I am going
 13 to take you to the moment when you were being asked to
 14 consider putting the nurse back on the unit?
 15 **A.** I think on reflection we needed the two
 16 paediatricians in the room who had been in the room in
 17 July.
 18 **Q.** If we can just go to page -- I am going to
 19 have to flick, I'm afraid, between documents but if we
 20 can just go to INQ0003518, this is -- it is going to
 21 come up -- the very brief report that Mr Harvey
 22 presented to the board on 10 January setting out the
 23 fact that the RCPCH had reported that noting there had
 24 been a grievance and then what had gone on following
 25 that.

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1 Ms Brown, but can we just be clear.
 2 This document was produced when, when was it given
 3 to the --
 4 **MS BROWN:** At the meeting.
 5 **LADY JUSTICE THIRLWALL:** At the extraordinary board
 6 meeting?
 7 **MS BROWN:** Yes, so if we go back to INQ0003237.
 8 That's the meeting when Mr Harvey gives an overview and
 9 our understanding is that that's the overview that this
 10 document, the document we have just seen, relates to,
 11 Mr Harvey's overview.
 12 **LADY JUSTICE THIRLWALL:** Thank you.
 13 **MS BROWN:** There is just one other matter in
 14 relation to that meeting, if we could go to on to page 6
 15 of the document we have got up there. Did you have
 16 a concern at the time about the leaking of the RCPCH
 17 report to the press?
 18 **A.** So I remember feeling very strongly and
 19 I think if you look at various minutes as been shared
 20 with me, I often ask questions about candid feedback and
 21 patients being -- being informed. I felt very strongly
 22 at the time that we needed to make sure that we were
 23 communicating in the appropriate and timely way and
 24 a supported way with the families.
 25 I'm afraid that I didn't have a very, very strong

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1 Over the page, we see what the board is being asked
 2 to do and we will see at (c) there you are being asked
 3 to support the Executive in assisting the staff member's
 4 return to work and implementing the recommendations of
 5 the grievance.
 6 It's the case, isn't it, that really you were being
 7 asked to support the Executive on such a key decision
 8 given the risk, if it was an incorrect decision, on
 9 inadequate information; would you say that's fair?
 10 **A.** I mean obviously I have read the -- read the
 11 papers as part of the review. I can't say I can recall
 12 this meeting. So I can see I was there.
 13 **Q.** Yes. So you can't -- you can't assist on
 14 whether you felt or how you felt about supporting the
 15 Executive in the return of Letby to the ward?
 16 **A.** Because this particular meeting I really don't
 17 have a recollection of?
 18 **Q.** But it is the case, isn't it, looking back
 19 over the minutes that you were being asked to support
 20 her return having not seen --
 21 **A.** Yes, I mean clearly.
 22 **Q.** -- the documents?
 23 **A.** Reading the minutes you -- you couldn't --
 24 no one reasonable could reach any other conclusion.
 25 **LADY JUSTICE THIRLWALL:** I'm sorry to interrupt,

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1 view on responsible reporting of maybe some, some
 2 aspects of the media and I felt there would be nothing
 3 worse than waking up to some sensational story for
 4 clickbait, when we -- you know, if the hospital
 5 hadn't -- hadn't communicated in the appropriate way.
 6 **Q.** Was your concern about any group speaking to
 7 the press, any particular group of people reporting
 8 that?
 9 **A.** No and I think, I think the handwritten
 10 minutes, I -- we had a conversation about various
 11 constituents of stakeholders and it was just any
 12 stakeholder.
 13 **Q.** Yes, I just need to correct this. I think
 14 this has been referred to before, so it's on page 6
 15 where it says:
 16 "Mrs Hopwood asked that the assurances that the
 17 report will not be leaked to the press by Consultants
 18 ..."
 19 The handwritten note of the meeting that you are
 20 referring to, if we can just turn to that, INQ0003332,
 21 page 23, it's a minor point but it just needs to be made
 22 clear what's on the minutes don't seem to reflect what's
 23 on the handwritten more contemporaneous note. So
 24 INQ0003332 and page 23.
 25 We see there Mrs Hopwood asked that these

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1 assurances the report will not be leaked to the press
 2 but there's no reference there to that being by
 3 Consultants. It then goes on:
 4 "Mr Chambers replied that this would part of the
 5 conversation with clinicians who will be very clear
 6 about the expectations."
 7 But the note doesn't appear to be that your concern
 8 was about the Consultants?
 9 **A.** Yes, it was more general.
 10 **LADY JUSTICE THIRLWALL:** Yes, it looks as though
 11 the two things have been taken together --
 12 **MS BROWN:** Yes, it seems there has been a --
 13 **A.** I think there is a couple of instances of
 14 that.
 15 **LADY JUSTICE THIRLWALL:** Do you remember this part
 16 of the meeting, or again do you not have any memory?
 17 **A.** Sorry?
 18 **LADY JUSTICE THIRLWALL:** Do you recall this part of
 19 the meeting?
 20 **A.** I -- I definitely recall being very concerned
 21 for the parents.
 22 **LADY JUSTICE THIRLWALL:** Yes.
 23 **A.** I don't recall in any way being focused on one
 24 group who were somehow, you know, the agents who were
 25 going to leak. It was, you know, because we were
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1 everyone at the same time, some issue about who had seen
 2 the report.
 3 Is this a meeting that you recall and, if so, what
 4 were your impression of this meeting?
 5 **A.** I -- I can recall this meeting because it was
 6 so unusual that I was asked to step in for Sir Duncan
 7 and it was with very little notice. I -- I think my
 8 impressions of it at the time were it was -- it was
 9 a more tense meeting -- I mean, I hadn't attended
 10 Executive clinician meetings, I had obviously attended
 11 boards and committees but I hadn't attended what I would
 12 describe as an operational meeting.
 13 So I thought it was a little more tense than
 14 I would experience at a board or a subcommittee. It
 15 seemed -- it seemed cordial. I wouldn't have described
 16 it as very aggressive or, you know, unreasonable.
 17 I think if I had, I would have gone back to Sir Duncan
 18 and said, you know: the tone of that was totally
 19 inappropriate and either on the clinician's behalf or
 20 Mr Chambers' behalf, I think body language was -- was
 21 tense. I think I picked up on the body language.
 22 But I wasn't sighted at that point on anything that
 23 had happened in the grievance process and now obviously
 24 as part of this Inquiry I have been given the grievance
 25 documentation. So now my reading of the meeting, having
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1 talking about this report obviously being shared with
 2 a number of stakeholders because, you know, clearly it
 3 wasn't -- it would be circulated.
 4 **MS BROWN:** I think it's in reviewing these notes
 5 for this hearing that you have picked up that didn't
 6 ring true and checked the handwritten notes.
 7 **A.** Yes, yes.
 8 **Q.** If we can then go to the meeting of
 9 26 January. This is the meeting that you attended on
 10 Sir Duncan Nichol's behalf. It's INQ0003523, so this is
 11 a meeting that was attended by all the Consultants and
 12 Mr Harvey, Mrs Kelly, Mr Chambers, and you were there on
 13 behalf of Sir Duncan Nichol.
 14 At this meeting, just to put it in context,
 15 Mr Harvey is discussing the RCPCH review with the
 16 Consultants here and if we can go over to page 2 and
 17 just highlight a few of the things that were said at
 18 that meeting. At the top, Mr Chambers is talking about
 19 the grievance had indicated there had been victimisation
 20 of the nurse. Further down, there is a need to draw
 21 a line under the Lucy issue.
 22 Further down, the board had noted that an apology
 23 would be requested from the Consultants.
 24 We see at the bottom of the page it appears that
 25 Mr Harvey stated the report would be released to
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1 seen some of the interviews that were conducted I think
 2 particularly Mr Brearey's interview I was particularly
 3 taken aback by the tone of that, I perhaps now have
 4 a slightly different view of the meeting and I can see
 5 how it might have appeared more confrontational than at
 6 the time I was -- I was aware of.
 7 **Q.** Because even setting aside what you know
 8 subsequently there were a few things there that might
 9 have caused alarm or concern sitting on the meeting they
 10 are talking about -- you had heard Dr Brearey and
 11 Dr Jayaram speaking about their concerns back in July
 12 and there's reference to then victimisation of a nurse
 13 and an apology needed from the Consultants it wasn't
 14 just on the face of it that striking you as completely
 15 contrary to the Speak Up policy?
 16 **A.** Again I think I had -- I would refer you to --
 17 I mean, I absolutely accept your point in hindsight. We
 18 were --
 19 **Q.** Not even in hindsight. At the time you are
 20 sitting there. You have in person heard Dr Jayaram and
 21 Dr Brearey express their concerns and I presume in the
 22 14 July maybe you can tell, you assumed their concerns
 23 were genuine?
 24 **A.** Yes, for certain, for certain.
 25 **Q.** You are now being told in fact the Speak Out
 148

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

6 **A.** Yes.

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

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

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

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

21 **Q.** Yes.

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

24 **Q.** If we can just then turn to what happened
25 subsequently. There was a meeting on 13 April when
149

1 doubt, you go to the police.

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

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

8 **A.** Yes.

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

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

18 **A.** We are --

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

24 **A.** Yes.

25 **Q.** So just your thoughts on how the board handled
151

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

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

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

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

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

22 But I certainly understood -- I think I felt that
23 Mr Medland had said we had gone through steps and then
24 the next step was the police. I didn't take it as the
25 first step was if -- you know, if you have reasonable
150

1 communication with the parents?

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

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

18 **Q.** Thank you.

19 If you can just -- if I could just ask you to
20 return to your statement, that can go down. Return to
21 your statement where you have some reflections at the
22 end of your statement. You talk about, with hindsight,
23 views about Letby being suspended earlier and the
24 recognition that there was whistleblowing going on,
25 which we have covered.
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1 But you deal at paragraph 83 with you felt access
 2 on the board to more detailed metrics including number
 3 of deaths, that's something that you felt would have
 4 been helpful, do you think that would have alerted you
 5 to the problem at an earlier stage?
 6 **A.** I -- I definitely think that the timeliness of
 7 metrics around mortality was and, and certainly
 8 independent assurances, so if I think back to
 9 December 2015 and QSPEC, when that was -- I think the
 10 first time I was aware that there was a concern of
 11 a raise in deaths in the neonatal units, I gained
 12 assurance with a reference to the MBRRACE, MBRRACE data
 13 showing that the Trust was still 10% under national
 14 average.

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

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

25 **Q.** So what would have been helpful to you on the
 153

1 **Q.** Yes.

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

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

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

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

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1 board was up to date current data --

2 **A.** Yes, absolutely.

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

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

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

25 **A.** My response?

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1 **Q.** Had you been informed at all?

2 **A.** No.

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

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

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

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

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

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1 topic that you were just covering with Ms Brown, that of
 2 the Children's Champion.
 3 As I understand the sequence from your statement,
 4 you are told that you have been appointed to this role
 5 in the July meeting of the QSPEC. From the document
 6 that was just put up on the very next morning at
 7 9 o'clock in the morning, you email Sir Duncan Nichol to
 8 express your grave misgivings about having been
 9 appointed to that role?
 10 A. Yes.
 11 Q. And the manner in which that has happened and
 12 thereafter you have one or perhaps two meetings with
 13 Ian Harvey --
 14 A. Yes.
 15 Q. -- in which you discuss your suitability for
 16 the role and how it was that you were appointed for
 17 a role that no consultation had been undertaken with
 18 you.
 19 There is just one, and so when we get to the end of
 20 that sequence, Mr Harvey can have been in no doubt that
 21 you did not put yourself forward for that role?
 22 A. That is correct.
 23 Q. With that, please may we just look at
 24 a meeting minute and just, Mrs Killingback, before
 25 I give you this reference, when it comes up on the

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1 I have a time commitment that would allow me to say
 2 attend these weekly meetings which was the support they
 3 were looking for.

4 Q. Subsequently that role developed --

5 A. And subsequently that role was obviously
 6 directed I think to a much more suitable NED. But I do
 7 regret not following up with the paediatricians after
 8 that meeting to say: I cannot -- I cannot be what you
 9 need me to be.

10 MS BROWN: Yes. Thank you very much. I have no
 11 further questions. I think there are a few questions.

12 Questions by MR JAMIESON

13 MR JAMIESON: Mrs Hopwood, good afternoon. My name
 14 is Alex Jamieson, I ask you questions on behalf of some
 15 of the Families. My learned friend Ms Brown has in fact
 16 asked you about most of the topics that I would have
 17 done so.

18 The first topic, communication with the parents, is
 19 obviously particularly important to the Families but we
 20 have heard your evidence about the reassurance that the
 21 Executives gave you and indeed the reflections that you
 22 wish you had checked that what you were being told was
 23 true and accurate and so I have no questions on that
 24 topic.

25 But I do have a couple of questions on that last

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1 screen, it's really important that only the top half of
 2 the document comes up on the screen. The INQ is
 3 INQ0004449, it is the minute of your meeting with the
 4 Consultants and the reason I have just given that
 5 direction is because I know you shared some really quite
 6 personal information with the Consultants --

7 A. I did.

8 Q. -- which is not relevant to my question so
 9 doesn't need to come up on the screen?

10 A. Thank you.

11 Q. But it's really the first interaction so just
 12 the top half, please, not at all that bottom half of the
 13 page, just the Ian Harvey paragraph. That is absolutely
 14 perfect.

15 So we can see this is the meeting, this is your
 16 first meeting with the Consultants that comes after that
 17 sequence that we have established and we can see
 18 a number of names very familiar to the Inquiry in the
 19 attendees.

20 You are there along with Mr Ian Harvey. The first
 21 thing that he is minuted as having said is this
 22 introduction:

23 "Not all of you may be aware that one of the
 24 requirements of the College Review was that we should
 25 have a Children's Champion. Rachel has put herself

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1 forward ... "

2 That was not accurate?

3 **A.** No.

4 **Q.** That was not true?

5 **A.** Clearly I didn't even know that I was being
6 appointed until the QSPEC in the July.

7 **Q.** No, yes. As we have been through before he
8 was in this meeting saying this: he had had you reacting
9 to his announcement at the QSPEC and at least one,
10 perhaps two, meetings with you before we get to here.

11 **A.** Yes.

12 **Q.** Yes. Did you challenge that assertion?

13 **A.** I think, I think so in short answer, no.

14 I don't believe I have seen these minutes and the reason
15 I don't believe that is there a number of factual
16 inaccuracies in them about some of the personal data that
17 we have had both on this page and on other pages.

18 **Q.** Okay.

19 **A.** And even -- and they are quite long minutes.

20 Even if I had read them over from a -- what was in the
21 table, I absolutely wouldn't of left some of those
22 factual inaccuracies stated if at the time because to me
23 the two most critical ones are actually on the last
24 page.

25 **Q.** Okay.

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1 **Q.** Yes. No, I am not suggesting anybody said
2 that to you out loud, but that was the clear
3 impression --

4 **A.** Yes, because I would expect a well thought out
5 role to have clear terms of reference.

6 **Q.** And it's a powerful title, isn't it,
7 Children's Champion?

8 **A.** It is a very powerful title.

9 **Q.** Was it expressed to you whether or not there
10 was an expectation that you would speak to families or
11 to children in the current role?

12 **A.** No, it wasn't and I'm not sure that at the
13 time I would have -- I would have seen it through that
14 lens, although obviously I am aware that subsequently
15 particularly out of the Ockenden review that, you know
16 where the role of the Children's Champion was discussed,
17 that -- that was a constituent part of it but that
18 obviously pre-date -- postdates this period.

19 I think it was 2020 or between 2020 and 2022. But
20 I don't think at the time I would have seen an NED role.

21 **Q.** I'm so sorry --

22 **A.** Sorry, a Non-Executive Director role as --

23 **Q.** For which your time commitment I think was
24 three days a month --

25 **A.** It was, yes.

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1 **A.** Which is my personal email address and my
2 personal mobile number, both of which are wrong.

3 **Q.** Right, okay. Well, I think then for fairness
4 and for completion --

5 **A.** Yes.

6 **Q.** -- I should ask you -- I have read that
7 sentence from --

8 **A.** Yes.

9 **Q.** -- the first paragraph as fact?

10 **A.** Yes.

11 **Q.** Was that said in the meeting?

12 **A.** I --

13 **Q.** "Rachel has put herself forward"?

14 **A.** I can't remember if that was said. It might
15 not -- I can't remember if those words were said.

16 **Q.** Well, that's important clarification that you
17 give. Please may that come down.

18 But the impression that you had drawn from the
19 process -- I listened to your words as you were giving
20 evidence before, the impression that Mr Harvey had given
21 you was that we need to be seen to have this role, that
22 it was about appearances rather than substance?

23 **A.** I think, I think that that was my view based
24 on the fact that nobody could articulate to me what this
25 role was.

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1 **Q.** And you had a number of other duties to fit
2 into that period of time?

3 **A.** No, I just don't think I would have seen
4 a Non-Executive Director role as being the primary
5 communication point with parents.

6 **Q.** No, quite. We agree, if I may say so.
7 Similarly a Non-Executive to be the primary conduit of
8 information from the clinicians?

9 **A.** Yes.

10 **Q.** If I may say so you have said a number of
11 times you have drawn attention to the fact that you
12 yourself have no clinical background, so a non-clinician
13 NED to be the main conduit of information and concerns
14 from the clinicians on the NNU to the board, you were
15 never a person who was going to be suitable for that
16 role?

17 **A.** Yes, I think -- I think I said that.

18 **Q.** Yes.

19 **A.** I didn't have a clinical background so
20 I couldn't see that I was credible to the
21 paediatricians.

22 **LADY JUSTICE THIRLWALL:** Yes, you did say that.

23 **MR JAMIESON:** May I finally just ask you one
24 factual thing to tie up a loose end.

25 You have mentioned in your statement what we have

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

4 **A.** Yes.

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

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

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

18 **Q.** Yes, the document has a misleading title?

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

22 **MR JAMIESON:** Thank you.

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

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

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

12 **A.** Yes.

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

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

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

21 **A.** Yes.

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

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

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1 Thank you very much, those are all my questions.

2 Questions by LADY JUSTICE THIRLWALL

3 **LADY JUSTICE THIRLWALL:** Thank you, Mr Jamieson.

4 No other questions? May I just ask a couple of
5 questions, if I may.

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

12 So is a cost improvement plan a cost reduction
13 plan?

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

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

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

24 **LADY JUSTICE THIRLWALL:** Yes.

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

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

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

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

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

14 **A.** Yes.

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

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

21 **LADY JUSTICE THIRLWALL:** How it would feel.

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

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

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

5 **LADY JUSTICE THIRLWALL:** Yes.

6 **A.** -- perspective.

7 **LADY JUSTICE THIRLWALL:** Thank you.

8 One other thing -- you may not be able to help
9 about this, but we know that in the early period between
10 2010 and 2015 there was a shift from three divisions to
11 two. Do you remember that?

12 **A.** A shift from?

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

15 **A.** I can't say.

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

19 Those are all my questions.

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

22 **A.** Thank you.

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

25 **MS BROWN:** Yes, it is.

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

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

5 **A.** Yes, yes.

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

12 **A.** Yes.

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

16 **A.** Yes.

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

21 **A.** Yes.

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

24 **A.** Yes.

25 **Q.** From May 2016 when you were appointed until

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1 **LADY JUSTICE THIRLWALL:** And if we start at 10 to
2 4, are we likely to finish the witness by 4.30?

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

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

8 (3.34 pm)

9 (A short break)

10 (3.45 pm)

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

13 MS ROSALIND FALLON (affirmed)

14 Questions by MS BROWN

15 **LADY JUSTICE THIRLWALL:** Do sit down.

16 **MS BROWN:** Could you please give your name?

17 **A.** Rosalind Fallon.

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

21 **A.** Yes.

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

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

5 **A.** Yes.

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

10 **A.** Yes.

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

13 **A.** That's right, yes.

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

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

20 **Q.** So it took longer than three days?

21 **A.** Yes.

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

24 **A.** Yes, exactly.

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

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

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

8 **A.** Yes.

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

13 **A.** Yes.

14 **Q.** Was that your understanding of what your role
15 was?

16 **A.** Yes.

17 **Q.** You say in your statement, and this is
18 paragraph 16, that there was a potential tension between
19 an Executive Director role and a NED role. Can you just
20 expand a little by what you mean about that tension?

21 **A.** I think at the time my -- my thoughts were
22 that I had worked as an Executive Director in two
23 organisations previously, so there's always a tendency
24 to get into the operational detail and I recognise that
25 I needed to not get into the operational detail but

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1 I suppose I wasn't consulted, if you like, sort of in
2 terms of -- of clinical issues. Now, that could be my
3 own inexperience as a NED and trying to really start to
4 understand and try to be effective in that role which
5 I recognise was -- could have taken some time.

6 So I felt that once -- later, as I became more
7 involved with other things, when I became the chair of
8 the Quality and Safety Committee, when I became the
9 Children's Champion, I really felt that my clinical
10 background was more valuable then.

11 **Q.** There is a distinction of course between
12 whether you felt that you were being listened to and
13 respected as a clinician, albeit as a Non-Executive
14 Director or whether you felt able to put forward your
15 views which side of that was it, was it that you felt
16 difficulty in putting forwards your views or that you
17 felt you were putting forward your views and they
18 weren't being listened to?

19 **A.** No, I think I could put forward my views and
20 I believe when I did put forward views, they were
21 listened to.

22 **Q.** Just staying with this issue of relationships
23 within the board and the atmosphere on the board, you
24 say about Ian Harvey you did not find him easy to
25 discuss issues with. Why was that? What was the

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1 actually be able to look at the whole picture and, you
2 know, in order to be able to add value and
3 constructively challenge.

4 **Q.** So you were clear in your mind of the
5 distinction between the Executive role and the
6 Non-Executive role?

7 **A.** I was, yes.

8 **Q.** In terms of the atmosphere around the board
9 table at the Countess of Chester, within meetings, how
10 did you feel that operated in practice in terms of the
11 communication, in terms of the ability for Non-Execs to
12 participate, what was the atmosphere like within the
13 boardroom?

14 **A.** I think the atmosphere was professional.
15 I always felt the opportunity if I needed to raise
16 a question or -- or a challenge that I was allowed to do
17 so. So I didn't see when everybody was round the table
18 that there was an issue.

19 **Q.** You say, talking about that, this is
20 paragraph 81:

21 "I did not feel my presence on the board played to
22 my strengths as a clinician."

23 What did you mean by that?

24 **A.** I think that whilst I was on the -- the
25 Quality -- or the QSPEC as it was called then, I --

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1 difficulty with Ian Harvey that you experienced?

2 **A.** It's quite a difficult one to put a finger on,
3 really, and -- but I felt that I didn't, I mean, I could
4 ask questions in the board and I would get my answers in
5 the board. I didn't get -- I didn't feel that I had
6 an opportunity just to have some informal conversations
7 with him that sometimes you get more -- you get a bit
8 more detail than you might not get at the board to
9 understand what the specific issues are.

10 **Q.** Because of course one problem that can be the
11 discussion is that one side isn't listening to the other
12 side and it's just whether that was your impression,
13 that in fact you weren't being properly listened to in
14 the boards?

15 **A.** I wouldn't say I wasn't being properly
16 listened to in the board. I just felt that the
17 relationships particularly with Ian Harvey didn't
18 develop as well as they have done with other medical
19 directors that I have worked with subsequently. Now,
20 some of that could just be my own experience as I have
21 become more experienced as a NED as well as just
22 personality types.

23 **Q.** What about with Mr Chambers, how was your
24 relationship with him?

25 **A.** Again, it was -- it was cordial but I didn't

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1 actually spend very much time with him outside, in fact
 2 I don't think I had, I had one meeting with him when
 3 I first started. That was the only one-to-one meeting
 4 I had with him outside the -- outside the board
 5 meetings.

6 **Q.** I think in terms of one-to-one meetings you
 7 discuss it in terms of training when you started that
 8 you saw -- you met with all the Executives individually
 9 and with all the NEDs individually?

10 **A.** That's right, yes.

11 **Q.** But beyond those meetings, there wasn't any --
 12 any formal training when you joined that you can recall?

13 **A.** No, no.

14 **Q.** And --

15 **A.** Sorry, I did -- there was a staff induction
 16 that they had for everybody that joined the Trust and
 17 I did attend the day of the staff induction training.
 18 But that was to anybody at the Trust, it wasn't specific
 19 to a NED role.

20 **Q.** Looking back now, do you feel there are
 21 training or was training that would have been helpful to
 22 you as a first time NED coming in?

23 **A.** I think so, definitely.

24 **Q.** What would that training have been?

25 **A.** I think how to constructively challenge more

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1 **Q.** Your meeting, or your individual meetings you
 2 had when you joined with all the members of the
 3 Executive Committee, was that something that you
 4 initiated or was that something that all board members
 5 were asked to -- to meet everybody else?

6 **A.** I initiated it.

7 **Q.** In terms of safeguarding training with your
 8 clinical experience I think you say you were up to date
 9 with your safeguarding training; is that the case?

10 **A.** Yes, I had had some safeguarding training in
 11 2015.

12 **Q.** Given your safeguarding training and your
 13 role, your clinical experience as a nurse and then as
 14 a midwife, when the Consultants -- and we are going to
 15 go to the meeting but when the Consultants came to speak
 16 to you at the 14 July board, why looking back, we know
 17 that no one at that meeting did refer to safeguarding,
 18 but the Consultants were raising a concern about an
 19 adult, in this case a member of staff who they thought
 20 was harming babies and indeed was in a position where
 21 that could be an ongoing risk. Why is it, do you think,
 22 that that didn't immediately make you think in terms of
 23 safeguarding?

24 **A.** I don't know the answer to that as to why
 25 I didn't, but when I've thought about safeguarding since

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1 understanding of the -- the organisation. I felt that
 2 I had to go out and find -- find the information for
 3 myself which then became more time-consuming, rather
 4 than understanding of -- of how the organisation worked.

5 So I eventually understood how the committees
 6 worked but it was difficult to understand the -- the
 7 processes that actually brought the information to the
 8 committees.

9 **Q.** I think in relation to committees in terms of
 10 QSPEC, and this is paragraph 54 of your statement, you
 11 say you were unclear at the time of the obligations to
 12 attend meetings and maintain engagement with issues
 13 relevant to the committees or groups in between
 14 meetings, so this seems to be a bit of a lack of
 15 understanding about exactly the extent of your role.
 16 Clearly you had to attend the meetings of committees you
 17 were a member of, but beyond that there was some
 18 uncertainty in your mind?

19 **A.** Sorry, could you just?

20 **Q.** Was there some uncertainty in your mind about
 21 what was expected of you as a member of QSPEC other than
 22 attending the meetings?

23 **A.** Exactly. Yes, I didn't receive any induction
 24 into -- into QSPEC, I attended the meetings, read the
 25 papers and worked it out from there.

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1 and realised that I should have considered safeguarding
 2 at that point, but unfortunately, I didn't.

3 **Q.** Related to that is I think you say that you
 4 hadn't received formal guidance on whistleblowing or
 5 Freedom to Speak Up but you were aware that a policy
 6 existed but weren't familiar with the detail. Were you
 7 familiar with the basic principles that one shouldn't be
 8 penalised or there should be no recrimination for
 9 speaking out and that if it -- if you were speaking out
 10 about a safeguarding concern, the LADO should be
 11 informed; did you have that understanding?

12 **A.** I had an understanding around the -- the --
 13 that one shouldn't be penalised for speaking up.
 14 I don't recall actually understanding the role of the
 15 LADO at the time.

16 **Q.** Again in terms of that meeting, which we will
 17 come to in a bit more detail, but you were faced with
 18 a situation where you physically had two Consultants who
 19 were in fact speaking to you and in fact talking about
 20 their concerns in relation to harm being done to babies.

21 Again really the same question. Why do you think
 22 it was that you didn't think in terms of the Speak Up --
 23 this is a Speak Up situation, I need to go and look at
 24 the policy to see what it says or raise are we applying
 25 the policy?

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1 A. I don't know.

2 Q. In terms then of the events. If we can go
3 first to consider the meeting on 5 July. We know that
4 there was a public board meeting then and we know at
5 that public board meeting the issue of the neonatal unit
6 wasn't raised, but thanks -- I misattributed to your
7 colleague, but in fact it is your note that fortunately
8 you made because that is what alerts us to the fact that
9 there was a private NED meeting on, before I think prior
10 to the board meeting, if we could have that up, it's
11 INQ0102040.

12 Can you in fact now recall that meeting, it will
13 come up on screen but I am sure you are familiar with
14 the note, do you actually have a recollection beyond the
15 note of that meeting?

16 A. No, I don't actually recall the meeting, it
17 was only when I was doing the preparation work for the
18 Inquiry and looked through my notebooks that I found
19 that -- that note.

20 I thought the first time I heard about the issue
21 was a week later.

22 Q. Of course that note, it does talk about the
23 neonatal unit external review, the reduction of level,
24 the downgrading of the unit. It doesn't mention
25 anything about a nurse.

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1 Q. Turning then to the meeting you are referring
2 to on 12 July, just tell us how you came to be aware of
3 the issue and the concerns about a nurse on the neonatal
4 ward?

5 A. Well, it was just a chance conversation as
6 I was walking out of a POD meeting with Ed Oliver who
7 was here this morning and Ed asked me, do you know
8 what's going on in neonates? And I didn't, I can't
9 remember the -- the verbatim but he told me he had heard
10 there was an issue with a nurse potentially harming
11 babies.

12 So he asked me did I know anything about it? I had
13 heard nothing at that point which is why I know I hadn't
14 heard anything prior to then.

15 Q. I don't think he had a recollection but you
16 recall I think then going to Sir Duncan Nichol?

17 A. That's right. We went down straight away to
18 see Sir Duncan and it was a brief meeting, I didn't take
19 any notes of the meeting. But he did confirm basically
20 that what Ed had heard was in fact correct and that he
21 was going to call an extraordinary board meeting that
22 week.

23 Q. At that point when you hear there's a concern
24 about a nurse and a concern about a nurse being
25 connected to deaths on the neonatal unit, did you

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1 Do you think if -- if an issue of a nurse
2 potentially being linked to deaths had been raised in
3 that meeting, that would be something you would have
4 remembered?

5 A. Well, I think for two reasons I would have
6 remembered it anyway. I think I would have written it
7 because whilst they are not detailed notes, they -- they
8 capture the essence of it and I was very clear in my
9 mind that the first time I understood the issue about
10 the nurse was the following week.

11 Q. At the 14 July meeting?

12 A. It was actually two days before that.

13 Q. Yes. If we can come to that in a moment.

14 Just returning to the meeting on 5 July, can you
15 recall, although you can't recall that meeting being
16 aware -- made aware of the downgrading of the unit
17 before the 14 July meeting?

18 A. Yes, because we were told at that pre NED
19 meeting.

20 Q. So you don't recall the meeting?

21 A. Yes.

22 Q. But you are aware that you were told and you
23 do recall you went into the 14 July meeting knowing that
24 the unit had been downgraded?

25 A. I knew, yes.

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1 respond? For example, did you raise any concern about
2 is the nurse still on the unit? Or can you not recall
3 a discussion of that nature?

4 A. I don't recall. I did know at some point but
5 I don't know whether it was at that meeting or at the
6 board meeting that she was actually on holiday, so she
7 wasn't at work.

8 Q. Do you think if you had been aware that or
9 felt that she was working that you that would have been
10 an instinctive response you would have given or can you
11 just not assist?

12 A. I think if I had known she was still working
13 I would have instinctively questioned it.

14 Q. If we can come then to the meeting of 14 July.

15 So this -- you were aware of the issue about the
16 nurse and you are aware at this meeting, did you
17 understand that was going to be discussed or did you
18 understand it was going to be focused on the downgrade
19 or indeed all of it?

20 A. I expected it to be all of it.

21 Q. We see from the notes of the meeting that
22 Mr Chambers opens the meeting talking about the change
23 in mortality rate. Then if we can go to page 4, so
24 INQ0003238, and page, 4 so just to set it in context,
25 the meeting has already discussed the neonatal unit, the

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1 mortality increase and the downgrade of the unit and
 2 Dr Brearey and Dr Jayaram are present and we have got
 3 a note there that Dr Jayaram stated what he was to say
 4 next was confidential and not to be minuted.

5 Can you recall now and just give us an overview of
 6 the level of concern that Dr Jayaram and Dr Brearey were
 7 expressing and really what they were saying to you as
 8 a board?

9 **A.** What they were saying was they had seen
 10 an increase in both unexplained and unexpected deaths,
 11 that they -- they talked about a number of reviews,
 12 they-- I think they said something along the lines of
 13 they had looked at everything that they could and that
 14 they had also looked at shift patterns and -- and found
 15 that there was a particular nurse that had been on duty
 16 for many of the shifts that babies had died.

17 **Q.** Then if we go to page 5, we see here that you
 18 pick up at the bottom:

19 "Mrs Fallon stated that there is a point in time
 20 where a change in data can be seen and asked in terms of
 21 that member of staff how long they have been on the
 22 unit."

23 Then Mr Brearey comes back and talks about
 24 competence.

25 Going over the page:

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1 We know that actually at the end of that board
 2 meeting Mr Wilkie went on to the following day, because
 3 he was still concerned about it, to see Mrs Kelly. But
 4 at that board meeting it ended with the situation where
 5 Lucy Letby was going to be under supervision.

6 In retrospect, was that something you should have
 7 challenged more thoroughly?

8 **A.** Well, I think we have got a differing recall
 9 of the outcome of the meeting.

10 **Q.** Yes.

11 **A.** I appreciate what Mrs Hopwood and Mr Wilkie
 12 said. But I clearly understood when we left that
 13 meeting that she wasn't going to go back on the unit.

14 **Q.** In fact, on the 14th we know from other
 15 documents that you won't have seen that Letby was being
 16 spoken to and at that point it was the intention that
 17 she was going back to supervised practice and it was
 18 a few days later that there was a change in view. But
 19 anyway your understanding at the time was that she was
 20 not going back to practise?

21 **A.** That was my understanding.

22 **Q.** If you had understood she was going to
 23 practise, back to practise in a supervised nature, what
 24 would have been your response?

25 **A.** I would have challenged it.

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1 "The individual has been praised by a transport
 2 Consultant during resuscitation ... inconceivable ...
 3 where there has been a competence issue".

4 So it seems that the exchange, but please correct
 5 me if you can recall it, is that you were raising, was
 6 there an issue with the competency of this nurse, was
 7 she doing something negligently that could have been
 8 causing the death? Dr Brearey is saying no, it's not
 9 about competence because he would have expected that to
 10 have been flagged up?

11 **A.** That's correct.

12 **Q.** That left presumably in your mind, if there
 13 had been doubt before that what Dr Brearey and
 14 Dr Jayaram were saying, is that the connection between
 15 this nurse is not competence which might be the most
 16 obvious and clearly was one of your concerns as a nurse
 17 that it might be that. They were saying, no, our
 18 concern is that this is deliberate?

19 **A.** Yes.

20 **Q.** You understood that?

21 **A.** I understood that.

22 **Q.** We see then Mrs Hopwood then brings up the
 23 issue about how practical it was for the staff member to
 24 work under supervision and Mr Wilkie picks up this theme
 25 and is concerned about the risk.

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1 **Q.** On the basis of what? On the basis of
 2 practicality of supervision or --

3 **A.** No, that if there was a question mark around
 4 her practice that until we got to the bottom of it, that
 5 she shouldn't work on the unit.

6 **Q.** So although no one was talking in
 7 safeguarding, you recognise that once there was
 8 a concern the right response was to take her off the
 9 unit?

10 **A.** Yes, yes.

11 **Q.** The meeting then went on to discuss a few
 12 other matters. It discussed the police, and we see if
 13 we can go to page 8, Mr Cross outlined his understanding
 14 of what action the police would take if they were called
 15 to investigate the matter. Can you recall that? Can
 16 you recall Mr Cross explaining what would happen if the
 17 police were called?

18 **A.** Well, this has been caricatured a number of
 19 times now, so I'm not quite sure whether --

20 **Q.** Just try and recall and if you don't have
 21 a recollection, that's your evidence. But do you
 22 recall --

23 **A.** I do recall --

24 **Q.** -- at the time?

25 **A.** -- a reference to we'd have tapes around and

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1 you wouldn't be able to get in the unit and there would
2 be a huge disruption to, to the unit.

3 **Q.** Do you recall that at this meeting?

4 **A.** Yes, yes.

5 **Q.** What effect did that have on you or on the
6 board?

7 **A.** I don't know what effect it had at that time
8 because if that's what -- if we were as a board were
9 absolutely sure that that was the thing to do, well, we
10 would have had to do it.

11 But I think there was doubt all across the -- not
12 in terms of the, the suspicion but in terms of the
13 evidence. There was doubt all across the room that we
14 just didn't quite have the evidence to -- to do that.

15 **Q.** So, as I understand it, your recollection is
16 the reason you weren't going to the police was more
17 about lack of evidence in your mind than about
18 disruption?

19 **A.** Yes.

20 **Q.** Did you feel you were being, by Mr Cross
21 setting this out, that you were being persuaded not to
22 go to the police or was this just a factual statement of
23 what he considered would happen?

24 **A.** I think it was a factual statement.

25 **Q.** Then in relation to the RCPCH and their review
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1 What did you understand the RCPCH report was going
2 to do? Try to remove yourself from the knowledge of
3 what it did, but what did you understand they were going
4 to go in and do?

5 **A.** I believe that I understood they were going to
6 look at staffing as a whole. But the question I asked
7 was: would it actually pinpoint if there was an issue
8 with this particular nurse of which I think Mr Harvey
9 said that as part of that process any issues will be
10 outed.

11 So I expected from that to -- if there was a direct
12 correlation that we would get it from that report.

13 **Q.** I think that your recollection is borne out
14 by:

15 "Mrs Fallon asked if there was a direct
16 correlation, would they uncover this?"

17 And we see what is said in response:

18 "Mr Harvey replied that as part of the process any
19 issues will be outed and we will advise them of the
20 supervision of staff as it will be part of the measures
21 we have undertaken."

22 Did you, regardless of what the note says, did you
23 understand you were being told that yes, if there was
24 a direct correlation they would uncover this?

25 **A.** That was my understanding.
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1 and, in fact, this is where all the Non-Execs focus on
2 different issues and this is the issue that you focus on
3 in the meeting and you focus on: what is the review
4 going to look at?

5 Now, obviously key to what the review was going to
6 look at would have been the draft Terms of Reference.
7 As far as you're aware, had you been shown prior to this
8 meeting the draft Terms of Reference to consider?

9 **A.** No.

10 **Q.** Can you recall whether you were in fact shown
11 them? The notes are somewhat unclear about whether you
12 were shown them at this meeting? Do you think you were
13 shown them?

14 **A.** No, I didn't see the draft Terms of Reference.

15 **Q.** You were asking a number of questions and we
16 see there you asked if the external review would look at
17 staffing. Then you ask if there was a direct
18 correlation would they uncover this and then you refer
19 to ask about the individual and how many of those babies
20 involved had the individual been on shift for.

21 Now, obviously there's two aspects of staffing: one
22 might be are there generally enough staff, qualified
23 staff on the unit and the other one might be are the
24 RCPCH going to look at whether this nurse was
25 responsible.
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1 **Q.** If we can go then to INQ0003178. Just one
2 matter. I'm not going to go back to the meeting, but
3 that meeting ended with Mrs Hopwood saying that there
4 should be another board meeting to review the situation.

5 **A.** Yes.

6 **Q.** And we know, in fact, it wasn't reviewed at
7 a board meeting until January?

8 **A.** (Nods)

9 **Q.** How do you think that slipped through the net?
10 Did you ask for another one, another board meeting, was
11 that discussed when you were in the hospital at another
12 time?

13 **A.** I don't know how it slipped through the net.
14 But I do recall that we had other -- there were some
15 other conversations at some point through, through that
16 autumn. Whether they were just updates on where the
17 reviews had got to, but there ...

18 Well, as you know, there definitely wasn't another
19 board meeting, but I personally didn't go and ask for
20 another board meeting.

21 **Q.** And you say conversations. You were
22 presumably in the -- because you sat on several
23 committees, you were in the hospital at other times and
24 presumably came across your fellow Non-Execs and some of
25 the board members at other times other than the meetings
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1 or would you only really meet at meetings?

2 **A.** Well, both. We would meet, we would only meet
3 at meetings in terms of we would only go into meetings.

4 But whilst we were there we would have chance
5 conversations, but I feel sure that -- because we
6 discussed it at the Quality and Safety Committee on
7 19 September.

8 Now, there would only be three Non-Executives at
9 the Quality and Safety Committee, so I don't know
10 whether the other NEDs that didn't sit on quality -- on
11 QSPEC rather would be -- would have been appraised.

12 **Q.** And if we could just look at that meeting
13 19 September. If we go on to page 2, this is the
14 meeting that Mr Harvey gives a verbal update and he
15 explains that the review had recommended that the Trust
16 commission a forensic review of the cases that sparked
17 the external review in the first place, so carried out
18 by two independent paediatricians.

19 So it's clear that in fact, the RCPCH certainly
20 hadn't established whether there was a correlation so
21 your expectation hadn't been realised in that sense and
22 in fact what was being suggested was something further
23 was needed.

24 At that point, did that cause you to rethink the
25 approach and think, well, maybe at this point what we

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1 **A.** Well, I didn't actually get a chance to read
2 the report because I was given the report when I went
3 in, there was a very detailed discussion, I had to hand
4 the report back when I left. So I -- I, if I'm being
5 really honest, barely read it.

6 **Q.** Nevertheless, you understood that was the
7 report that was looking at the issue about the neonatal
8 unit and what it had -- potentially going to at least
9 address the issue or the concerns raised about the
10 nurse?

11 **A.** Yes.

12 **Q.** You understood, presumably through the QSPEC,
13 that in fact there was then a further report
14 commissioned by Jane Hawdon and we see -- you may not
15 have known it was by Jane Hawdon -- but a further report
16 had been commissioned?

17 **A.** (Nods)

18 **Q.** We see, if we go on to page 2 there, that that
19 in-depth review in brackets had not yet been circulated.

20 So as a NED, and you've explained that you
21 understood it was your role to challenge, you are being
22 then asked to make decisions, one of which was concerned
23 with the return of the nurse to the unit and one of
24 which concerned how the Consultants would be treated in
25 terms of needing to make an apology and so on.

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1 need is an investigation by the police because the
2 police had been referred to obviously on 14 July --

3 **A.** Yes.

4 **Q.** -- and there is still an investigation. Did
5 that occur to you at that time?

6 **A.** It didn't occur to me at that point because
7 I had expected the -- the report to have identified if
8 there was correlation. It didn't. But what it did do
9 was recommend these further detailed forensic reviews of
10 case notes.

11 **Q.** And in the chronology, what happened next was
12 the meeting of 10 January and if we can just call up
13 INQ0003237. So this is the meeting where the RCPCH
14 report was discussed and can you recall now whether it
15 was at this meeting or prior to this meeting that you
16 saw the RCPCH report, in what circumstances you were
17 shown it and what version it was?

18 There's quite a few questions there in one. But if
19 you just tell us what you know about the RCPCH report?

20 **A.** Well, to the best of my recollection, I went
21 into a board meeting and received a paper which was the
22 RCPCH report.

23 **Q.** Do you have any recollection about whether
24 that report referred to Letby, referred to the nurse,
25 had a section dealing with that?

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1 When you hadn't read the RCPCH report and when you
2 hadn't seen the further review by Dr Hawdon, should you
3 at that point have said, "We need time, we need to look
4 at these documents" in order to be in a position to
5 make, well, a very serious decision.

6 **A.** I should have, yes.

7 **Q.** Just in fairness, Ms Fallon, I want to point
8 out what was being said at this meeting. Mr Harvey, you
9 see at the bottom of that first paragraph, he summarises
10 the report, the Dr Hawdon report, and says:

11 "The case reviews [that's the case reviews by
12 Dr Hawdon] very much reinforce what is in the review
13 [and that presumably is the RCPCH review]. It comes
14 down to issues of leadership, escalation, timely
15 intervention and does not highlight any single
16 individual."

17 Then Mr Chambers goes on to say:

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

21 So we are going on to yet another layer. The RCPCH
22 haven't concluded the issue, it's gone to Dr Hawdon and
23 it's now going on again. So it's incomplete.

24 But what did you think you were being told by
25 Mr Harvey and Mr Chambers then about the involvement of

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1 the nurse? Do you recall feeling you were being
2 informed about the concerns about that nurse?

3 **A.** Well, I thought we were being told that the
4 reviews had identified no concern around the nurse and
5 that it was deemed she should go back on to the unit.

6 **Q.** Your acceptance of the decision -- we know of
7 course she didn't go back on the unit -- but your
8 acceptance that that was an appropriate approach for her
9 to go back on unit and for the Consultants to apologise,
10 that was based on your understanding that you were being
11 told that there were no concerns about this nurse now?

12 **A.** I was being told that there were no concerns.

13 **Q.** If we can just look at page 4 of that. This
14 was the meeting as well where Mrs Hodkinson read out the
15 statement from Letby, do you recall that?

16 **A.** I do, yes.

17 **Q.** What effect did that have --

18 **A.** Yes.

19 **Q.** -- or just sort of describe how that unfolded
20 in the meeting?

21 **A.** Well, it was clearly quite an emotional impact
22 statement. I think the thing that concerned me more
23 than anything was, well, firstly, that the Consultants
24 had raised an issue and they were -- that was the right
25 thing for them to do. We had made a decision for Letby

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1 comments.

2 **Q.** Did you consider at this point, we know you
3 didn't on the 14th, but did this cause you to think
4 something's gone awry here because I have heard the
5 Consultants and presumably in the 14 January you
6 believed that -- 14 July you accepted their concerns to
7 be genuine, and now we have ended up in a situation of
8 the Consultants apologising?

9 **A.** What I should have challenged at that meeting
10 was why didn't we have the Consultants in the room and
11 I believe if we had had the Consultants in the room at
12 that meeting that it would have -- we would have had
13 a totally different conversation.

14 **Q.** Then the next meeting was the meeting on
15 13 April and that was the meeting, I don't think we need
16 to turn to the minutes of that, but that was the meeting
17 where Mr Medland, the barrister, attended. And what did
18 you understand him to be saying to the board at that
19 point?

20 **A.** Well, I understood he was invited to the
21 meeting to give an expert opinion on whether we should,
22 we should make a referral to the police.

23 What I was hearing from him was he didn't feel that
24 there was enough evidence. However, I can't remember
25 now whether he had met with the Consultants before the

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1 not to go back on the unit and that was the right thing
2 to do.

3 What was highlighted during that meeting, I can't
4 remember whether it was during the statement itself or
5 after, that there were references to individuals talking
6 about making inappropriate comments such as "angel of
7 death" in what I understood at the time to be a staff
8 restaurant which I felt that, regardless of what the
9 outcome of any investigation had been, that it's not an
10 appropriate comment.

11 **Q.** So is it right to say that what you understood
12 you were being told was the nurse wasn't involved. You
13 were then read a letter, which we won't go to but does
14 indeed refer to phrases such as "angel of death",
15 "murderer on the unit" and so on. Is that why, and if
16 we can look on page 5, does that help you to explain or
17 can you explain your comment there:

18 "Mrs Fallon referred to members of staff hearing
19 some comments and that from the Board's perspective this
20 is unacceptable behaviour from the Consultants."

21 **A.** That's what I was referring to.

22 **Q.** So you are not referring to the behaviour
23 about raising a concern. In fact, that was something
24 they should have done if they had concerns?

25 **A.** Absolutely. It was about hearing those

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1 meeting or after the meeting.

2 **Q.** He had already met with the Consultants --

3 **A.** Yes.

4 **Q.** -- before.

5 **A.** So that was when he said the clinicians still
6 believe that there's an issue and he made the
7 recommendation then to initially approach the CDOP,
8 police representative on CDOP.

9 **Q.** Yes.

10 **A.** That I saw that then as the beginning of the
11 process for -- for police referral.

12 **Q.** That process with the CDOP and then again, we
13 don't need to turn to it, but we know there was then
14 a meeting in May --

15 **A.** Yes.

16 **Q.** -- when in fact it went from the CDOP and then
17 it was very clearly going to the police?

18 **A.** Yes.

19 **Q.** In the meeting, just staying with the meeting
20 of 13 April, there is a note there in the minutes:

21 "Mrs Fallon asked if we can get a timeline to speak
22 to Dr Hawdon so we are clear when we can speak to her."

23 At that point, why did you feel it was necessary to
24 speak to Dr Hawdon?

25 **A.** I don't think I necessarily did.

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1 When I looked back over the minutes and tried to
 2 think what did I mean at that time, I think I was using
 3 the word "we" in the generic sense as the Trust as
 4 opposed to ... So I expected the Medical Director along
 5 with the, the --
 6 **Q.** I think there was a suggestion that Mr Medland
 7 asking her about what she meant by a forensic review and
 8 were you thinking that we needed to -- someone needed to
 9 speak to her about what she meant by that, or if you
 10 can't recall --
 11 **A.** Yes, I can't remember exactly.
 12 **MS BROWN:** Yes, thank you very much. I have no
 13 further questions. I don't believe there are any other
 14 questions unless the Chair and my Lady has some
 15 questions for you.
 16 **LADY JUSTICE THIRLWALL:** No, I have no questions.
 17 Thank you very much indeed, Mrs Fallon. I know you
 18 have been sitting there for what seems like hours and
 19 probably is hours, I don't mean there but over there, in
 20 the room. So thank you very much for coming and you are
 21 now free to go.
 22 **A.** Thank you.
 23 **LADY JUSTICE THIRLWALL:** So we will rise now at
 24 4.29 until 10 o'clock tomorrow morning.
 25 **(4.29 pm)**

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1 **(The Inquiry adjourned until 10.00 am,**
 2 **on Wednesday, 5 December 2024)**

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