Monday, 13 January 2025

(10.00 am)

(Proceedings delayed)

(10.03 am)

LADY JUSTICE THIRLWALL: Good morning.

Ms Langdale.

MS LANGDALE: My Lady, may I call Ms Tomkinson.

MS JANE TOMKINSON (sworn)

Questions by MS LANGDALE

LADY JUSTICE THIRLWALL: Do sit down.

A. Thank you.

MS LANGDALE: Can you give us your name, please, and a brief summary of your career and where you work now?

A. My name is Jane Tomkinson and I would just like to say something, if that's possible.

Q. Of course.

A. So on behalf of the Countess of Chester I would like to say how truly sorry we are for the failings that led to the harm and death of children at our Trust. We wanted to issue a really clear heartfelt and sincere apology to those Families who we know the suffering continues to this day.

We and I are truly sorry.

Thank you.

Q. You are the Chief Executive of the Countess of Chester, hence making that apology?

A. Yes.

Q. You say heartfelt apology, you have obviously had a long time as an organisation to reflect on events and we will come to that --

A. Yes.

Q. -- in your evidence.

Is there anything you want to say as an overview about how things were then and how they may or may not be different now if similar circumstances arose again?

A. Well, I am really clear that there are significant changes and improvements in that organisation between the period in question and the current day.

We are developing a much better and inclusive culture, we are much more open to listening to our staff and have a much clearer and easier way for people to escalate issues and concerns at any level at any time.

Our processes and systems are much clearer and tighter and we have spent a lot of time in working with our staff so they understand what their responsibilities are in relation to patient safety concerns, how they would escalate them and what they can expect in terms of speaking out.

So the changes are very, very numerous but I would -- I would hope that today the response to anything like the events of 2015 onwards would be handled completely differently from ward through to board.

Q. You have prepared four statements for the Inquiry, three dated 27 March 2024 and one dated 11 December 2024.

Can you confirm for us that the contents are true and accurate as far as you are concerned?

A. Yes, I can.

Q. And to return to my first question, can you tell us something, it is in your statement dated 27 March, statement number 1, about your background, in particular when you were appointed as acting Chief Executive Officer of the Trust and then Chief Executive as a permanent position. So tell us something about you first and what you bring to the role?

A. Okay, so I -- I have worked in the public sector for 40 years now. I am a qualified accountant who has taken on a variety of senior roles across the NHS. I was appointed as Chief Executive Officer of Liverpool Heart and Chest Hospital in 2013 but in 2022, at the end of the year, I was asked to go into the Countess of Chester to support the organisation

following a period of absence of the, the then Chief Executive.

So I took on the acting role for a period of time from '22 until February 2024 and from February '24 I was appointed as the substantive Chief Executive of the Trust and obviously have been in that role ever since.

Q. I want to ask you some questions about what doctors and managers might have been able to say because it's one thing to criticise what they did say, but what could they have done in a difficult situation?

And you comment in your second statement at paragraph 16, about the paediatric Consultants first. You say:

"Paediatric Consultants are usually expected to speak to parents following death in line with the duty of candour and would offer to meet parents at a convenient time. Following Letby being removed from clinical duties, Ian Harvey led on all communication with Families."

Mr Harvey accepted in evidence it was crass and insensitive. But dealing with the paediatricians first, where they had suspicions and concerns about a member of staff, what do you think in line with the duty of candour they could say about that, if anything, when there were suspicions and there hadn't been a full

investigation? What would you suggest a paediatrician could say in those circumstances were it to happen today?

A. So if there were similar events those paediatricians would be able to escalate immediately to any of the Executive, but particularly to myself. They would expect an immediate response to concerns raised and, you know, we have had many examples whereby clinicians have raised something and it is an immediate response to concerns raised. They are very familiar with our Freedom to Speak Up pledges around raising concerns, investigation. But importantly, not receiving any detriment and actually being protected from such.

Q. Sorry, my question is slightly different, Ms Tomkinson.

A. Sorry.

Q. What could they say to the patients or the parents?

A. Sorry, apologies.

Q. Not within the Trust itself, fellow staff. Here you have got a member of staff, you are suspicious of her, or worried or concerned, however people put it at various times.

What can you say to a parent about a member of staff where it is a suspicion, it's not evidence-based

on a level of investigation or anything like that?

How can a paediatrician fulfil the duty of candour in those circumstances?

A. Well, I am speculating on what, what they might say. But I would suspect they would talk about concerns around fitness to practise, around competency levels that needed further review. It's very unlikely they would jump straight in and talk about suspected criminal activity at that point in time. But they would certainly have that open and honest conversation as they do now with -- with parents on the unit on a daily basis about the care of children and if anything had gone wrong what their concerns were and importantly what we were doing to understand more about the situation.

Q. So if there was something happening on a ward now, a neonatal ward or a maternity ward with a baby, and a senior member of staff was worried if something had been done properly, you would expect that to be raised with the parents straight away and say we are just looking at this aspect of care to see if that is what we ought to have done or something like that?

A. I would expect that conversation to be had with those parents immediately.

Q. Do you know if it does? Do you get feedback from maternity services to know whether that is

happening?

A. Yes, I do. And I am a frequent visitor to the unit and I have had conversations with the clinicians and with families and obviously the number of incidents are, are relatively small. But we do know that if anything out of the ordinary, I'll say, does occur, then conversations are had with those, those parents from a transparency perspective but also an assurance perspective that we know this treatment maybe didn't go quite to plan. However, please be assured that we are understanding it and telling you what's going on.

But what we see now is a much stronger presence of, of parents on the unit and there are no restrictions whatsoever about their presence throughout the period of care for their children on that unit.

Q. What about when there's ward rounds, can they be in on the ward rounds? We have heard some evidence that when there is huddles or discussions between doctors or nurses in some units it is possible for a parent to stand and listen in to that. Would that happen in your hospital?

A. It happens on a daily basis and I personally have shadowed a number of ward rounds on unit and if the parents are present at the cot side as the multi-disciplinary team are reviewing the child, the

parents are actively involved in that discussion.

Some have questions, others don't want to raise anything. But it's -- it's not a purely clinical process. It's also one that's integrating with those families and some of the families are, you know, very, very proactive in raising issues.

Q. And what about if there was a hot debrief about something that had gone wrong. Again, would a parent be allowed to be present for that or is that to support staff alone in that situation?

A. Initially it would be for the staff alone to understand what the issues are and a discussion would be had about how to involve those families and parents in reporting back on those issues.

Q. Can we look now, please, at INQ0103147, page 1. I am just going take you to a couple of press releases at the time.

This is one, 7 July in 2016 and at paragraph 3 reference to:

"Nevertheless we have seen in some of our most poorly babies, those with high dependency needs, an increase in neonatal mortality rates for 2015 and 2016 compared to previous years. In light of this we have asked for an independent review of our neonatal service from the Royal College of Paediatrics and Child

Health."
We know of course at that stage there were concerns and suspicions of the paediatricians.
And if we can also go to another press release when you have had a chance to look at that one?
(Pause)
Have you read that?
A. Oh, sorry, yes.
Q. Yes. Then we can look at INQ0006049, page 1, please.
This is a press release 8 February 2017 and we see the third paragraph commenting on the RCPCH report:
"In the report, there is no single cause or fact identified to explain the increase we have had in the mortality numbers. The review makes a total of 24 recommendations across a range of areas including compliance with standards, staffing, competencies, leadership, teamworking and culture. We are already working to implement these recommendations."
And at the bottom we see from Mr Harvey:
"This means when we speak with parents we can now share full and accurate information on an individual basis. We are desperately sorry for any distress or upset this review has caused."
So at both times the hospital were aware of

suspicion or concern about Letby. But of course we don't see it in the press releases but again my question: before there had been an investigation and findings, whether that was on a civil standard of proof to balance of probabilities or a criminal standard, what could have been said, do you think, or do you think nothing could have been said because it was a member of staff and it was yet to be thoroughly investigated?
A. I think the press releases are spun in a way to in effect reduce the impact of concern and that, that may come back to that reputational piece.
It could have said there are a number of unanswered questions relating to the way children were cared for or the competencies in some areas and these will be subject to further review.
It would be very unlikely in advance of a, you know, a formal police investigation to talk about criminality. However, what we could have done was maybe flag that there were other concerns that were not addressed in those reviews and, therefore, there were still many, many questions that were left unanswered but that we were seeking answers for those families with a view to addressing those risk areas.
Q. So would it have been possible to highlight there was still an unascertained risk or potentially

risk to patients that hadn't been explored?
A. It's unlikely that it would be phrased in that way. It is more likely to have been phrased in the context of: there are still a number of unanswered questions. The reviews have not delivered the answers that we had, had hoped for and therefore more work will be ongoing to understand the cause of these involving the parents and Families of, of the children.
Q. Yes, thank you, that can go down now.
In your second statement, Ms Tomkinson, you set out the various issues raised by the parents and you summarised a letter that had been written by the parents of Mother A and B and setting out concerns about the long line and concerns about how Child A was treated.
And you also told us that Dr Jayaram had given a letter in response or drafted a response in February 2016.
Do you know if that letter was logged as a formal complaint anywhere and dealt with through a complaints system or was it an exchange of letters?
A. From, from my understanding that letter was not logged as a formal complaint and did not go through the formal complaints process which would ultimately have resulted in a letter from the Chief Executive to, to the Families.

My understanding is that an email was sent in directly from the Family to -- to the unit and that was passed informally to Dr Jayaram, who, who answered it in that way and, and therefore it was not logged as an official complaint.
Q. Would that happen now: if issues were raised between parents and doctors they might be treated in that way more informally and exchange of either verbal information or letter or would you expect it to go through a complaints process?
A. My expectation is that it would be escalated immediately to the complaints department for, for logging and review and a formal process undertaken then to investigate again involving the Families with the process and the outcome.
Q. PALS of course is one vehicle for patients, parents making complaints, isn't it?
A. Yes.
Q. How do you, if you do, analyse the complaints you are getting via PALS?
A. So PALS have got a really clear process of, of logging and then escalating those complaints to the most relevant individual to -- to undertake the complaint. We aim to get responses within 40 days and it is a very structured process with a number of review steps in

there, culminating in a draft response which is reviewed by the Medical Director and Director of Nursing who is also the Deputy Chief Exec but ultimately I review those answers and sign off every complaint letter personally.

So -- so the process is very tight, complex. But we are really clear what steps need to be delivered to get clear, open and transparent answers to complaints in a timely way.

Q. Can we have on the screen now, please, INQ0017158, page 25. And this is an extract of your first statement about staffing levels. We looked a moment ago at the press releases about the RCPCH report which commented on staffing levels?

A. Yes.

Q. You do the same in your statement from paragraphs 96 --

A. Yes.

Q. -- onwards. If we can start at the bottom of 96 and scroll through, please, Mrs Killingback, so people have a chance to read 96, 97, 98, 99 and 100.

(Pause)

A. Yes.

(Pause)

Q. And for the sake of the transcript I will read paragraph 98:

"Between January 2015 and June 2016, 65% of shifts within the neonatal unit at the Countess of Chester were staffed to British Association Perinatal Medicine recommendations. The national average for neonatal units in the UK in the same period was 58%. It is understood that the staffing levels at that time were comparable to other neonatal units in Cheshire and Merseyside and nationally. This information is recorded on the BadgerNet system. Daily BAPM levels were recorded on Badger and this information could be viewed by the Cheshire and Merseyside Neonatal Network and staff members."

My question is this: what's the point of BAPM, NICE and DHSC neonatal toolkits regarding staffing if they are more observed in the breach than compliance?

A. So I think things are very different now around staffing ratios and just to confirm that we consistently deliver at the BAPM standards for our nursing complement and that's reported informally through the divisions and but also formally to the board.

I absolutely get your point about, you know, what is the point of standards if we only talk about them when they are not being delivered?

I guess the complexity of assurance processes would

be sort of comply or explain and by default, if things are okay, they are not flagged but flagging an issue around staffing levels would fundamentally require attention from an organisation. But we do review these on a very regular basis and ensure compliance.

So we are checking but we are not reporting deviations because there aren't any, we make sure we deliver to the standards, despite the, you know, the designation of the unit being at a Level 1 currently.

Q. Is staffing still an issue in terms of the numbers?

A. Not in nursing and not in the neonatal unit. The Trust is not compliant with BAPM standards for our doctor cohort but my understanding is that is, that is applicable right across the English NHS and is a product of the availability of people to fill those posts but also for the funding.

Q. So is it an unrealistic unachievable requirement to go to my first question: to have the standards, if you don't have the doctors, you are not training the doctors, funding the doctors, you are not going to deliver on the standards?

A. I think it would be more achievable if there was a clear national plan to deliver at those levels through training numbers, through funding, but as you

are aware the funding is, is extremely tight and choices need to be made about what those priorities are.

Are units unsafe because of that, they are not reporting as being unsafe. Certainly my neonatal unit does not report as unsafe. But I think it's a recognition that not all -- all standards which come from professional bodies can consistently be, be delivered for those reasons of constraint.

Q. Can we go to paragraph 105, please, and medication. Can you tell us, just scrolling down if we can, Mrs Killingback, the same statement, paragraph 105. It's just a bit further up.

A. Yes.

Q. You say:

"Between June 2015 and June 2016 controlled medications were stored in the controlled drug cupboard which was made of steel, double-locked and alarmed. A unit with two locked compartments within Nursery 1 for the storage of non-controlled drugs."

One of the issues that's been raised on the facts of this case is how insulin should be stored. How is insulin stored in the neonatal unit?

A. Stored as -- as set out there. But I think what is different is the way the storage is accessed which is now through a bespoke in effect a swipe card.

It's called Net2 and that is absolutely aligned to an individual staff member. So the drugs can be accessed but there is a really clear audit trail of who's accessed them and when and in what quantities and my understanding is that that was not the case at the time of the harms.

Q. Can you look, please, at 106-107. CCTV. You tell us where the CCTV was fitted at the time.

A. Mmm.

Q. The Inquiry is exploring whether CCTV cameras should be in the neonatal unit in particular perhaps in the incubators, so parents perhaps who certainly in the past, maybe not with your new unit, who had to be separated from their neonate could through a mobile phone see their baby at all times just as you can if you have a child in nursery that chooses to use CCTV so you can see the children.

What is your view, do you have a view about that CCTV access to parents for their babies when they are in neonatal units and staying?

A. So this is common in a number of units, not just neonatal units, to have systems whereby patients -- sorry, families, can log in through a remote access which is, you know, highly secure to see their children in real-time.

I think the bigger issue is CCTV as in effect a security and deterrent effect on units and that is more for me about how do we balance the requirements of, of dignity and privacy for all patients, not just neonates, alongside the need to be really clear about who and when people are accessing those children.

Q. Paragraph 108, if we can. Reporting systems and inspections. You refer to the Datix Incident Reporting System?

A. Yes.

Q. What training do you -- or takes place knew in the hospital to ensure that the Datix reports are filled for each and every incident as per the policy of the hospital?

A. So full training is provided on -- on the use of the Datix system and that's open to everyone to access. The system is, is very widely used, it's reviewed on a daily basis, it's audited and if there are any issues around recording, so, for example, fields missing or maybe an incorrect assessment of the magnitude of the harm, then further training is offered to ensure that that colleagues are really consistent in the way it's utilised.

Q. You say at paragraph 110 the Trust does not have an internal inspection programme. Why is that? Is

that typical of Trusts or ...

A. I guess it means -- I guess it's more about what, what is the internal inspection programme because what we do have is a number of local accreditation systems which audit against standards, internal and external standards.

We have a very extensive ward accreditation process which is led by the Director of Nursing and Quality and Deputy Chief Executive that review standards and grades the different areas against a number of set criteria. That's, that's a relatively new thing.

It has been rolled out across the organisation and the women's and children's areas will be reviewed early on in this new calendar year so, so we do because the external inspection from bodies like the Care Quality Commission are very infrequent but obviously as part of our sort of ongoing review of safety and standards, we -- we have very rigorous processes and input through the board level safety champions in this area which is an Executive and a Non-Executive.

So I think possibly things have moved on a bit since this statement was pulled together.

Q. Paragraph 111, you say the Trust utilised the NHS England Quality Surveillance Information System. Can you tell us a bit about that?

A. Well, it's a web-based tool and it is utilised to pick up issues which support our, the external Quality Surveillance Programme and my understanding is, is that is routinely peer reviewed externally and there's reference there to an inspection in 27, and I think that's in a further exhibit, with a further review back in 2019.

And it, it was really for us a key element of our ambitions to return the unit to a Level, a Level 2 and that system has now been replaced and all information has been submitted via a different tool, which is referred to in the, in the document.

Q. What was the feedback on the neonatal unit from that 2017 inspection?

A. I -- I couldn't tell you that. But obviously I can, I can come back on that one.

Q. We will come later to the request for Level 2 designation --

A. Yes.

Q. -- in that context.

If you look, please, at paragraph 113, you say:

"During the relevant period there was no formal reporting process in place to report concerns to the police although there was a local arrangement with the police for the head of security".

Can you tell us what arrangements are in place now in terms of liaising with the police or speaking with the police?

A. So we have a really good relationship with our, our local police. There is a crime reporting line which we can and have indeed accessed a number of times last year. There is not a policy for reporting issues to the police, although we are really clear that staff are able to report any concerns externally to a wide range of bodies and -- and would be supported in doing so and I believe in I think it was the evidence of, of Professor Bowers, there was reference to developing a national tool to support the escalation for the police.

But we, we don't necessarily rely on escalation through the security team and, in, in the period of the harms that was not utilised. We use our local relationship.

Q. At paragraph 112, you refer to the neonatal care data being recorded on the BadgerNet system. Where do you send the data and who records data for the hospital? Around neonates, I should say?

A. So this is a national system where information is recorded in real-time by colleagues within the unit and my understanding is that feeds directly into the

National Audit Programme, actually it does say it there.

The BadgerNet system is, is well known and well utilised, full training for the staff there and it's just part of the way that we review data and input it into a broader clinical audit base.

Q. Have you spoken to anyone recently who inputs that data, do they find it easy to do? We have heard whether BadgerNet talks to the system when you are inputting data?

A. No.

Q. That may be an issue?

A. No, apologies, I haven't spoken to anyone about how easy or hard they find it. There are a number of systems in the NHS that you, you grapple with and colleagues are very familiar with that now but I don't know the detail.

Q. Do you know if they are up to date with putting the data in or anything like that not?

A. Yes, they are, yes.

Q. Right. Is that across the hospital or for neonates?

A. BadgerNet is, is for Women's and Children's. It's not a Trust-wide system for adult care.

Q. Mmm mm. So who have you spoken to in Women's and Children's to know that they are up to date

with putting the data in?

A. So it's part of the review process for the, the Women's and Children's governance. Obviously I have visited the, the unit and I have had discussions about whether or not the many, many systems they are required to report to are burdensome or onerous and the expectation is that information is recorded in real-time.

Q. That can come off the screen now, please, and can we have INQ0017159, page 10. This is your second statement and paragraphs 25-42 deal with support for bereaved families.

A. Yes.

Q. So if we can scroll through that and give people time to read those paragraphs, please.

(Pause)

LADY JUSTICE THIRLWALL: Can you slow down, please.

(Pause)

MS LANGDALE: Stop there. Thank you. If we go back to paragraph 35, you say "The Bereavement Office", this is back in 2015 to 2016.

A. Yes.

Q. ... would refer families to bereavement counselling if requested on occasions when the Coroner was involved in a death. Coroners officers may offer

support to families instead of bereavement officers. The Trust now has a bereavement midwife who visits families offering support and signposting families to counselling or to hospices.

Dealing with back in 2015 to 2016, was there a limit as far as you were, on the number of counselling sessions that bereaved parents could have offered by the hospital?

A. Sorry, I am not aware of any, any limitation.

My assessment based on information is that our bereavement service at the time was insufficient in many ways. So for example now we have two full time bereavement midwifes offering a much more extensive service. There is no limit to the level of access that bereaved families can have either in terms of numbers of visits or the time. It's an ongoing piece which is bespoke to families.

Q. Is that confined to where their babies have died in the hospital?

A. No, not at all. The, the midwifes are very happy to meet at the convenience of the families either in the home or at another place and we recognise that sometimes it's traumatic to return to the, you know, the scene of the bereavement and therefore that flexibility is, offers a much better and more empathetic service.

LADY JUSTICE THIRLWALL: But I think the question was where the babies have died rather than whether visits occur?

A. The what, sorry?

LADY JUSTICE THIRLWALL: Where the babies have died, was the question. Is it only for babies who have died in a hospital?

A. Sorry?

MS LANGDALE: Is it for baby loss in a hospital or baby death in a hospital as opposed to in the community?

A. Yes. So our, our bereavement midwifes would, would service the babies who have died in the hospital.

Q. But they would visit those parents wherever suited the parents better?

A. Oh, absolutely yes, yes.

Q. As you say, they might not want to come to the hospital?

A. Yes.

Q. Is that limited in resources, do you have enough resources or do you have people who would like to avail themselves of those services more than you are able to offer?

A. I am not aware of any times we have turned down requests to access the service. We have two full-time bereavement midwives which for the number of,

of bereavements and pregnancy losses would feel inadequate, nothing has been escalated in terms of a request for more resources.

But obviously if it was felt to be inadequate then we would look at it in relation to the resourcing of the whole division.

Q. So the bereavement midwife would visit the families offering support. Is it a different counsellor who gives the counselling? It is not the midwife, it is a bereavement counsellor, is it?

A. Depending on the nature of the requirement of the family, the bereavement midwife may counsel within her, you know, boundaries of practice or can signpost families to a number of other more specialist services, including third sector for that ongoing support.

Q. We asked you from paragraph 38 onwards, you deal with it, if you can tell us the position, whether there were any policies or processes in place whereby medical records would be marked up with the death of a child because we have heard from parents of babies named on the indictment that they have had to repeat what has happened to them in accessing health services in the future?

A. Yes.

Q. First of all, dealing with 2015 to 2016 and

now present day?

A. Yes.

Q. How was that issue dealt with and was it dealt with sufficiently sensitively as far as you are concerned?

A. My understanding is that in 2015/16 it was confined more to pregnancy losses than neonatal deaths and although it was flagged on the medical records for pregnancy losses I can't see where it was flagged for neonatal losses. Certainly now the medical record would very clearly set out the previous loss and those records would always be reviewed before any, any future case of pregnancy and delivery within our, our Trust.

So it has been improved. We, we implemented the bereavement guidelines back in 2019 and I think what we can offer now is a much more compassionate, comprehensive and empathetic level of support to families who can lose through pregnancy at the perinatal phase right through, right through to child death.

Q. I am going to ask now, please, if we can go to same statement, page 85, paragraphs 329 to 332, which set out the dismissal of Letby and when that occurred.

So again, if people could have an opportunity to read 329 through to 332, please, Mrs Killingback.

(Pause)

For the sake of the transcript I can say at paragraph 329, you state:

"Letby continued to be excluded from work on full pay during the course of the police investigation.

"On 25 November 2020, the Director of Human Resources and Organisation Development wrote to Letby to advise that with effect from 12 November 2020 her salary payments would cease in response to the court's judgment to remand you in custody."

On 11 December 2020, Letby was written to to advise that the Trust had decided to commence a disciplinary hearing following her being charged by Cheshire Police on 11 November 2020.

The disciplinary hearing took place we see at paragraph 331, on Monday, 4 January 2021:

"The hearing was chaired by the then Medical Director. Letby had been provided with the option of attending using an online videolink being represented by another individual such as a Union representative or submitting a written response to the allegations but she did not take up any of these options.

"Following the hearing, Darren Kilroy, the Medical Director, sent a letter to Letby dated 4 January 2021 and he reported the reasonings for the decisions as follows:

"'I do not consider it appropriate or necessary within this internal disciplinary hearing to determine whether or not I find the allegations of murder/attempted murder brought against you to be proven. That is for the criminal court to decide. However, in reaching my decision, I have taken into consideration that the burden of proof in a criminal case is far higher than in the case of an internal disciplinary hearing and that, even were you to be acquitted of these criminal charges, there would remain for the foreseeable future such a significant loss of Trust and confidence in you as a neonatal nurse both from the perception of the public, the Trust and colleagues that would make your position with the Trust untenable.

"'In addition, since being charged with these offences I am also of the opinion that your continued employment represents a serious risk to the reputation of the Trust as a responsible healthcare provider. I gave consideration to the possibility of retaining you in the employment of the Trust until such time as your case is heard, however do I not believe that is an appropriate use of public funds in light of the above findings including the fact that I believe trust in you is irretrievably broken down'."

My question for you, Ms Tomkinson, do you think it's widely understood that you don't need to be sure or certain that someone has caused deliberate harm before they can be prevented from working in a hospital and caring for babies widely understood within the hospital, I mean?

A. I would hope and suspect that that is widely known now. Our processes for withdrawing staff who are suspected of behaviours outside our Trust values is, is much tighter. I think what is evident from this is the inordinate amount of time between the suspension on full pay and the ultimate termination.

But certainly, the, certainly the way our Chief People Officer escalates issues of concern and grievances and potential suspensions means it's much more open than it was and is reported very frequently to the Executives.

Q. Similarly, where investigations are required, because there is suspicion about a member of staff I am not talking about this case, I am talking generally whether it is around competencies or anything else, is there an understanding that there is a need for expediency in investigations because if there is suspension on full pay and the investigation isn't happening, it's not good for anyone, is it?

A. So this has been the subject of attention in previous years around the pace with which cases are, are reviewed and decisions given to employees and I think following a suicide in one of the London Trusts, and the guidance is that investigations need to be taken quickly and empathetically with full support to, to the people, but the suspension is, is classed as a neutral act but we are in the NHS only bound to suspend if we either suspect somebody of delivering deliberate harm or someone undermining an investigation and those are the only two real criteria for suspension.

The, the guidance is that colleagues are, are encouraged to find alternatives for people who do not fall into those categories but nevertheless need to be removed from a place of work.

Q. A patient-facing role?

A. Yes.

Q. So find an administrative role or something?

A. Yes.

Q. That doesn't, that protects from risk pending investigation?

A. Yes.

Q. It is a neutral step, isn't it, and it should be understood as a neutral step?

A. Yes.

Q. Particularly round child protection: protecting children from risk is everyone's responsibility, risk of harm in a hospital or anywhere, isn't it?

A. It is. And I think that in a case of suspicions of child harm, the individual would be suspended on the basis of the safety concerns and not redeployed into a -- a non-front line role.

Q. I want to move to policies now, policies that were in place at the time of events and the ones you have got now, starting with safeguarding.

If we can go, please, to INQ0009485, page 1, this is the safeguarding and promoting the welfare of children policy that was in place at the time.

We see if we go to page 3, an Executive introduction from Ms Kelly Director of Nursing which places very much front and centre a key message: this organisation is governed by legislation to discharge safeguarding and promoting the welfare of children and if we see above it says:

"Every adult has a responsibility to protect children and as employees of the Trust we are duty bound always to act in the best interests of a child about whom we may have concerns."

Do you see in the top paragraph?

And we also see at page 4, named doctors for safeguarding. So if you were to look at this policy you can see it's Dr Isaac and Dr Mittal.

A. Yes.

Q. And again if we see page 30, a specific section, Speak Out Safely:

"Responsibility of all members of staff to ensure high standards of care, treatment are provided for all patients and that all patients are safely in our care. From time to time, staff may have concerns about the care or treatment given to any patients including children and young people and may wish to discuss these with managers. They will be dealt with seriously and promptly."

So on the face of it key messages are included and the people to whom contact should be made?

A. (Nods)

Q. The 2022 policy, if we can go to that, please, INQ0014166, page 1, I think this one reaches 50 pages, so it's longer, my first observation: it is a lengthy document, isn't it, this up-to-date policy?

A. Mm-hm.

Q. Let's see if we have got key messages from the beginning. If we go to page 3, it's more legalistic than its predecessor, or at least the one in 2015 to

2016, isn't it?

If we look at the third paragraph:

"To be effective ... requires staff members to acknowledge their individual responsibility for safeguarding and promoting the welfare of children as well as the commitment of Trust management to support them in this ..."

Paragraph 3, setting out duties under the Children Act 2004.

And if we scroll through it, page 4, definitions, categories, interventions, general principles, categories of abuse?

A. Mmm.

Q. There is a diagram at page 8. Scroll through a bit more, a bit slower I think so people can see the various headings.

We can keep going, thank you.

(Pause)

Stop when we get to page 37, please, Mrs Killingback.

(Pause)

Thank you.

If we stop at appendix 1 before we get there that is quite a definitional document, isn't it, legalistic in tone and I am wondering how practical it is for anyone

in a hospital concerned or worried about what they need to do who should they speak to and what should they do?

A. Yes.

Q. That would take quite a lot of time to go through.

Then when we get to this appendix we see a list of titles but no names. Is there a reason those roles aren't populated with names?

A. I would suspect that they are not populated because obviously the names change as people come and go within the safeguarding team and through the safeguarding training, we ensure that people know who those key individuals are and I absolutely agree with you that the complexity of policies which seem to be written for, you know, every single circumstance are really unwieldy and -- and difficult.

The way we cut through all of this complexity is by being really clear about our safeguarding team and lead who is absolutely available to support people if they have any form of safeguarding concern at all and she is very well known throughout the whole organisation.

Q. And do you have her name or other names on notices or anywhere around the hospital?

A. Yes, we do.

Q. So what would a notice look like, what does it

say?

A. Who to contact in the case of, her name is Gill Cooper and obviously we, we know who the safeguarding doctors are but there are also clinical risk leads and child death support leads. So it's, it's quite a complex number of people who are involved in different aspects. But the presence of Gill Cooper in our organisation ensures that people are really clear who to contact if there are any safeguarding issues.

Q. I see she's the author contact of the policy in the table at the bottom?

A. Yes, yes.

Q. Who is the policy written for, then, so if staff rely on training or messaging within the hospitals what is the purpose of spending ages on the policy? Who looks at this stuff?

A. For me it's a backstop. So safeguarding training is mandated for everyone in the Trust whether in a clinical role or not and there are different levels of training dependent on your role.

I guess the policy is there to provide absolute clarity for queries so if the safeguarding issue was, for example, a County Lines query, the information's in there, it would take a while to get to it but it is set out in the -- in the index but this is for every member

of staff in the organisation on the basis that every single member of staff has got a responsibility in keeping children and young people safe.

Q. They have. But do you think a bullet point list, 9 or 10 things they need to think about like which external organisations could be contacted, when and whether the police might be contacted or not contacted, some really practical points but it would take a long time to distill them, wouldn't it, because they'd need to be right?

A. You are absolutely right and when you move on to sort of managing child death policies and SUDiC policies, these are documents with hundreds of pages. You know, one of -- one of the learnings we might want to think about going forward is a consistent set of NHS policies with really clear summaries because every organisation has its own bespoke one and there are no really quick ways to pick up: well, so if I have got safeguarding issues, what are the five or six things that I absolutely need to look at?

And I would hope through this we will be able to streamline not just these policies but policies per se. You know, we are a medium-sized district general hospital, we have 2,000 policies. I mean, it's an industry in itself and it really does need

streamlining.

Q. It does, looking at these. But would you agree with me -- we are going to go through each area of policy -- the policies in place at the time at the Countess of Chester were consistent with policies in place at the time?

A. Yes.

Q. Indeed the safeguarding one was helpful, key message and who you contact?

A. Yes.

Q. So it's not a case of saying they didn't have any policies or management didn't know what the policies should be. The policies are there, aren't they?

A. (Nods)

Q. With some thought when we go through some of them, would you agree with that?

A. You are absolutely right. I think what was evident from what happened in 2015/16 was that safeguarding in particular was not integral to discussions or investigations, they were not involved in reviewing any of the cases and were kept quite arm's length.

Q. Well, pausing there, because the Inquiry has heard evidence from the people responsible for safeguarding. It is quite clear at human level the

concerns were being discussed --

A. Yes.

Q. -- between members of staff.

One of the things that neither of the policies then and now flag up is safeguarding as an issue if the suspicions or concerns are about a member of staff's behaviour. People think of safeguarding as operating for children in the community, don't they? Is there more understanding now about safeguarding applies to the conduct of staff in hospital as well, you need to be careful or potentially aware that those rare cases exist when a member of staff is causing deliberate harm?

A. I think that this would be really clear in the hospital around safeguarding. Again not just with children and young people but all, all vulnerable people that we, we come across.

So this is well known in the Countess of Chester now and, as I say, the safeguarding team, and there are 13 of them, are very, very visible and are very well connected to the multi-agencies required to keep people safe internally and externally.

Q. In your career, and before taking on this role, were you aware of the Allitt case and the Sir Cecil Clothier Report and the Inquiry? The Inquiry is interested in the corporate memory of the Allitt

Inquiry?

A. Yes.

Q. And what people understood from that case and the risk of a nurse being on a unit deliberately causing harm, would you have been aware of that around 2015 to 2016?

A. Yes, I was. Yes.

Q. How were you made aware of it?

A. How was I -- well obviously there was a really high profile in the media at, at the time. The Clothier Report was made available. Obviously, it's quite an unusual case and therefore one to pay attention to so I was, I was aware of it. Obviously as time progressed, I think it was about 2008, then the detail of the Clothier Report, you know, sort of faded in a way.

But the recognition that that had happened was not forgotten by me or I am hoping many of my colleagues and you know the, the ability of somebody who wants to cause harm should always be recognised in a healthcare setting when there are unusual events as we know with, you know, Southport, Shipman, Winterbourne View.

Q. Page 49 of this current policy, if we can look at that flowchart. This is included within the safeguarding and it raises the issues: is there a clear and legitimate purpose for sharing information? Can you

see the second box?
A. Yes.
Q. Again my question is: do you think that is helpful to have this flowchart in a safeguarding policy? I just wondered why this one appears here.
A. I can't answer the question why it appears here. I -- I don't necessarily think it's helpful because clear and legitimate, I understand the, the data security requirements there. But it's so open to interpretation it could in theory close down information sharing.
Q. Without a further explanation about safeguarding concerns and protecting children being a need to share information that could worry someone, couldn't it, about whether they were able to pass on information, just left without any further explanation?
A. Yes, and we know that the multi-agency failures which have led to harm and death in children and vulnerable adults because of the lack of sharing information; but also the Information Commissioner is really clear about the requirements of information governance and sometimes there could be some conflict between those two things.
Q. That can come down now, please and we can have a look at the Speak Out Safely: Raising Concerns about

Patient Care policy in place at the time.
That's at INQ0014171, page 1. Again, if we can scroll to the bottom of page 1, the purpose and over the next page1, "Raising concerns". Just pause there, "Raising concerns", if we can, to read.
And the "Being open" guidelines in the next paragraph as well.
(Pause)
If we then go to page 4 and 5, Public Interest Disclosure Act, whistleblowing, and particularly the examples on page 5.
"The following are examples of behaviours which may constitute malpractice where a concern may be raised.
"Systemic failings, for example, using broken equipment that could endanger patients or colleagues;
"Acts of violence, aggressive behaviour or discretion towards patients or staff;
"Inappropriate relationships between colleagues and patients;
"Substance or alcohol misuse that could potentially affect or be affecting the ability to work;
"The concealment of any of the above."
I suppose suspicions or concerns about a member of staff harming patients and children could be added there --

A. Mmm.
Q. -- to make it express?
A. Yes.
Q. But aside from that, if we look at the next page, page 6, again, at the time designated officers named in the document.
You also provided for us a document entitled "Patient safety is the responsibility of everyone at the Trust: safety and quality".
If you go to INQ0014138, page 1, this is Medical Director and the Director for Nursing and Quality at the time and if we go through the document, again if we can go through so people can read it.
(Pause)
INQ0014139, page 1.
I think each page we will have to go 139, 140, 141, et cetera, to get each page. But if we see this document, it sets out it very clearly if we can do that, please.
(Pause)
146 is the last one. And indeed we have seen that Just Culture Guide, Dr Jayaram produced that to the Inquiry.
So that information, that's a leaflet, is it? I have seen a hard copy of that. You wouldn't know how

that was circulated at the time.
A. No.
Q. But it sets out the position.
A. Yes, I don't know what was circulated at, at the time. It looks like this is some sort of presentation available for staff.
Q. If we see Freedom to Speak Up policy now in November 2022 and revised in July 2023, it's INQ0014172, page 1, and if we can go through this, please, it's not a lengthy document. It's about nine pages if we can just scroll through that.
(Pause)
We see on the last page names, people to contact, page 10.
Much clearer with flowcharts, would you agree?
A. (Nods)
Q. Who writes your policies? Do the Countess of Chester have their own team doing it and indeed every Trust have their own team doing it or is there a template from NHS England? How does it work getting your policies put together?
A. So we don't have a policy development team given that the policies are so different depending on, on what the topic area is. The policies are written by subject experts and consulted with peers. There are

generally no standard NHS templates and that was maybe the point I was making before about whether or not for consistency there could or should be, but the policies are checked and validated by our Director of Corporate Affairs and go through a governance process for ultimate sign-off by our operational management board and Board of Directors. But it's very much bespoke to those subject areas.

Q. That one can come down and then the last one, please, before we have our morning break can we have on the screen INQ0014153. And this is the Trust's current policy on patient complaints I think from January 2023.

Again, if you scroll through to page 5, we see on page 5 a table again with the role, rather than the names.

Is that, as you say, for fear of people changing roles?

A. Yes.

Q. So what about complaints information, how would you readily know if you were a patient or a member of staff who to go to to make a complaint?

A. So the complaints process is communicated to patients through their episode and we have a very structured way of making sure that complaints end up with the Complaints Team. I get many, many directly to

myself and I know how to escalate, as do the divisions through their governance structures, but the complaints process has been subject to very, very significant review and in terms of timeliness of response is, is much more effective then it was.

But we, we review complaints in terms of the themes, the numbers, the response times through our operational management board but also through the Board of Directors where we also link it in with incidents.

Q. If we go to page 12 of the document, please, we see there:

"The complaint received and logged identifying moderate/severe harm."

What are you looking for there?

A. I -- I don't know why that step's there because the level of harm is irrelevant in a complaints process.

Q. And you, in that, on that page the document refers to complaints received relating to open Serious Incidents.

Can you tell us how it works alongside Serious Incidents Reviews?

A. Well, a Serious Incident Review would not preclude a full investigation into a complaint, nor the

interaction with, with families. The Serious Incident Reviews which, which now come through -- through the team, through the Patient Safety Incident Response Framework that's primarily about learning from the incident, where obviously the complaints are very personal to a family or a relative and the two things, although they, they are linked, they are very, very different and are handled differently.

Q. Can we go to page 13, please, at the top. As you said earlier, the Head of Complaints will determine the timeframe following an initial complaint assessment and in consultation with the complainant.

What roughly is your average turnaround with a complaint?

A. We set ourselves a target of a conclusion of a complaint within 40 days, with the intention to reduce that to 28 days in the new financial year.

That is monitored. Sometimes it takes a lot longer certainly if it's multi-agency or if it is a particularly complex complaint. But what we do is ensure that complainants are kept appraised of any delays, obviously with an apology, throughout the process of the complaint.

Q. How big is your Complaints Team you said Head of Complaints, how many people are involved in managing

complaints?

A. The Complaints Team is relatively small. Three, I think. But the actual investigation of the complaint sits within the divisions who are obviously subject experts in, in that area.

Q. We see "Responding to complaints", ultimately the response comes from you and you will get a draft response --

A. Yes.

Q. -- from the Investigating Divisional Manager or clinician no doubt have input as you see fit?

A. Yes, absolutely. The -- the draft response is developed by the division, is reviewed by the division and I am in effect the last part of the change in terms of ensuring that the, the response answers the questions of the complainant and sometimes they are quite complex.

But certainly, the clinical body have been fully involved and we set out who those individuals are right at the start of the complaint. So your complaint is being investigated by all of these staff named with titles, so the complainant knows exactly who has actually done the review.

Q. You say:

"Where appropriate, an apology will be offered."

Do you do that on behalf of the Trust?

A. I do. And the words "where appropriate" I always offer an apology because if, if somebody has had cause to write to the organisation with issues, I -- I feel that that should be apologised for because quite clearly in their, their patient journey something has been wrong, so we absolutely do not hold back on being open and transparent with apologies.

MS LANGDALE: Thank you. My Lady, that may be a good time to break.

LADY JUSTICE THIRLWALL: Thank you very much, Ms Langdale. So we will break now and we will start again at 20 to 12.

(11.25 am)

(A short break)

(11.40 am)

LADY JUSTICE THIRLWALL: Yes, Ms Langdale.

MS LANGDALE: Thank you. The next policy please, INQ0014962, page 1. This is risk management and risk management awareness. If we can go to page 12, please. If we can blow up that chart at the top, appendix A.

High-level risk committee's reporting arrangements to the board.

And we see there how in effect Quality, Safety and Patient Experience Committee at the time chaired by Mr Higgins, Deputy Head of the Governors, the board.

They can report to the board and then we see Board of Directors can report to the Council of Governors.

My question for you surrounds the role of the Council of Governors. Can you understand when it was a public meeting why they would not be informed about suspicions or concerns about a member of staff or not? What do you think the role was there of Sir Duncan and others to report to the Council of Governors in a sensitive area where a member of staff is being investigated or concerns arise from their conduct?

A. So if we think that the Council of Governors -- excuse me -- is there in effect to hold the Non-Executive to account, their meetings are pretty key in the assurance process.

I suppose the question would be at what point would the Council of Governors be informed. Certainly if an issue happened of significant concern the head of the Council of Governors would be -- would be informed immediately and it is likely that if there were suspicions of criminality or deliberate harm to patients, that would be shared at a private meeting of the Council of Governors until such time as the police were happy with us to -- to share it more broadly given that obviously it is a public meeting and that the

boundaries between the sharing of information but not undermining the police investigation were, were pretty clear.

But my understanding is the Council of Governors were not informed either privately or in public about the concerns.

Q. So tell me what a private meeting with the Council of Governors is. Is that no extra members of the public there or what's that about?

A. No, so it would be purely the Council of Governors which is obviously made up a number of bodies where very sensitive information could be shared, where conversations could be had or questions asked in an open and transparent way but in a safe environment without any fear of anything then breaching a criminal investigation.

Q. So would you share the information as a Chief Executive or would you expect the Chair of the Board of Governors to be sharing with the Council of Governors?

A. The Chair, obviously I would brief the Chair and the Chair would share it immediately with the, the lead governor and then through a private meeting.

Q. So how many private meetings have you had with Council of Governors over the years? I am just trying to get a sense of how common that is or isn't.

A. I mean, the answer to that question is none. But obviously we have not had any issues of that sensitivity particularly anything which would sort of bounce up to criminality, no, and I have been on a Foundation Trust board for many, many years.

Q. But would you agree that you wouldn't share it in a public meeting, that you were suspicious or investigating whether a nurse might have committed a criminal offence?

A. It would be shared in the context of that there were concerns about whether or not any, any practice was impacting on patient care. We would not share with the governors in that forum concerns of criminality until the point where the police were happy for us to do so because that forum it would immediately be cascaded out into the local community and, and right across our staff because there are a number of staff who sit on that Council.

So it would be phrased in a way to say: there are concerns around practice and competency which we are investigating and obviously we will keep you updated.

But it's very unlikely we would go straight for the "we suspect harm".

Q. So is practice and competencies a bit of a euphemism for that or can it sometimes be practice and

competencies, not training people well enough in a genuine sense or -- you nodded about a euphemism, is it a euphemism?

A. Yes, you are absolutely right. So it is this balance of alerting a body like the Council of Governors to an issue, so there's something going on here and we are looking at it but we don't have enough information to share with you at this point in time, but we will keep you appraised.

So you are absolutely right, there's an element of spin on that wording. But it's getting the balance of not setting hares running that could undermine anything else publicly or there are a criminal perspective.

Q. And undermine a member of staff until the evidence was established?

A. Yes. I mean, there are a number of staff members on our Council of Governors and confidentiality in a hospital is very, very hard to manage. So it's getting the balance right and that's quite a difficult judgement call.

Q. Why is it hard to manage? I mean, people are people everywhere, but you are not the first to say I think someone else said it is hard to keep secret in a hospital. What is it about the culture of a hospital that makes people say that, as you just have?

A. So I say the Countess is a family of 6,000 members of staff all doing, doing different things having different roles. But they speak to each other and they are interested and the pace of work in a hospital, particularly a district general hospital, is very, very intense and people share information maybe from a -- the lens of being a gossip or the lens of: well, I know more than you. But it is pretty impossible to keep the lid on all but the absolute small amount of information that would be held watertight.

Q. Can we go to page 14 of this policy, please. It's the risk scoring matrix. Is that the same now, those rankings?

A. Yes, it is, yes.

Q. And the way they are classified sometimes, it looks a bit crude to an outsider.

A. Mmm.

Q. Why -- why are they classified in this way, do you know, and by all means say if you don't?

A. I think this is a standard way of scoring risk right across the industry. It is very crude and it's very open to interpretation. However, it brings together the likelihood and the severity of an incident and therefore allows local managers, practitioners and the Board to assess where attention should be focused

based on the magnitude of risk.

Q. It was uncontroversial across the evidence that clearly the risk of babies being deliberately harmed or killed is catastrophic as a risk?

A. Correct.

Q. But in terms of where this risk appeared either on the Risk Register on generally, or there was a paucity of evidence about that, in fact you can see on the screen INQ0004657, page 1, we see the top entry in October 2016, so after the deaths of O and P in July, that's where a risk is recorded in those terms:

"Potential damage to reputation of neonatal service and wider Trusts due to apparent increased mortality within the neonatal unit."

That's the only place that appears.

Does that surprise you, that the Risk Team and methods of evaluation, it doesn't appear anywhere in that related documentation?

A. Yes. Personally, I would be exceedingly unhappy to have been presented with a Risk Register that looked like that and we do review them very frequently in the Countess now.

Q. Would you have been unhappy in 2016? I mean --

A. Absolutely, absolutely.

Q. -- time moves on?

A. Reputational risk is just nothing compared to the risk of harm to patients, I wouldn't have even scored it in that way but, you know, obviously I -- I wasn't in the position at the time but that is pretty shocking to me.

Q. I suppose if babies are being harmed, it's because the babies are being harmed, that is the risk and the reputation follows that nobody trusts the care?

A. Yes.

Q. So I suppose it depends exactly what is that intended to communicate. But in terms of telling you about the situation on the ground, did that tell you anything, does that tell you anything?

A. Yes, it does. It tells me that the, the culture is focused on something other than the primary job of keeping patients safe. It says to me that there is an element of spin in the issue and that the governance processes that led to a scoring and a risk descriptor like that are -- are absolutely out of kilter with the reality of what was happening.

Q. Where do you see spin in that?

A. The what, sorry?

Q. Where do you see spin in that?

A. The spin about reputational damage. Words

like "apparent". When it wasn't apparent, there was increased mortality. There's -- it's been written in a way to convey a message which for me is not the reality of what was going on.

Q. That can come down, please.

LADY JUSTICE THIRLWALL: Just before it does, Ms Langdale, I think you said that it was entered in October 16, that is the review date, of course it was --

MS LANGDALE: Sorry July 2016.

LADY JUSTICE THIRLWALL: Thank you, just for the record.

A. 11 July after the deaths of two Triplets.

That can come down, please, and then if we can have INQ0014160 page 1, this is April 2023, SUDiC guidance. 151 pages of it. I am not going to suggest we scroll through all of that, but if we go to page 8, and if we can allow people a chance to read paragraphs 18 through to 31.

(Pause)

So we see at paragraph 24, Ms Tomkinson:

"The Consultant paediatrician or senior medical practitioner should ensure that the Joint Agency Response is triggered by informing the police if not already involved and children's social care. The designated doctor for child deaths and specialist nurse

depending on local arrangements should be informed at the earliest possibility to decide the timing of the Joint Agency Response meeting."

So how confident are you that when a SUDiC is triggered that that Joint Agency Response meeting would happen and that the police would be notified?

A. Very confident given the focus and the training around this and the absolute tenacity of our clinical and wider safeguarding body in managing these incidents.

Q. And do you have confidence that the clinical team understand a Sudden and Unexpected Death without suspicion of somebody causing deliberate harm but Sudden and Unexpected Death triggers the SUDiC process?

A. They do and we are very clear about what "unexpected" means and the care pathway of a child and the importance of triggering the external agency review at the earliest possible opportunity.

Q. If we go to page 100 please, Mrs Killingback, we see:

"Child death notification to be sent via email to CDOP."

And there are names and details given there.

Appendix 2B to be completed by emergency department, paediatric nurse. If we move to 2B,

page 101 and then 102, setting out contact details.

Page 123, quick reference guide to child death, Acute Life-Threatening Event, known as ALTE Process.

I am going to come to the child death guidelines. Do you think there is confusion within the documentation we are going to go to between what to do with a child death and what to do with a Sudden and Unexpected Death?

A. It's very confusing, isn't it, the whole document for me is, is far too complex and wordy and it's difficult to pick out the real issues within there and the real, really key actions that need to be taken.

The definition of the "sudden and unexpected" and of the pathway linked to the sort of out of hospital deaths, the CDOP, it is massively confusing to -- to practitioners. This, this document is actual a Pan Cheshire and Merseyside document and has been written with a slightly different lens but again it is a document that seems to have been written to have covered every eventuality anywhere and, and therefore has ended up being quite complex.

Locally we would in the incidence of a Sudden and Unexpected Death we would rely on the expertise of our safeguarding team and the child death doctor to sort of unpick that complexity so colleagues were really supported in this.

Q. And we see as you say because it's CDOP if we go to page 130, appendix 2I, final SUDiC case review, if we go over a summary of that and if we go to page 133, the CDOP identify a Child Death Review analysis form.

And that continues from 134 if we just scroll through the information requested 135, 36, 37, 38. If we scroll to page 148 and stop there. At page 148 it should be 2(k), the Child Death Checklist Template. And scroll to the end of that, please.

So that template to be filled in by a nurse or a doctor, it looks like. You wouldn't know, would you, whether admin can support or Risk and Safety Teams can support filling in the documentation or not?

A. I mean, yes, there is admin support to this. But the, the information requested would very much be known by a healthcare practitioner and some of it, the hospital side of it would, would be hopefully evident from the patient care record which is electronic and easily accessed.

But it is a very, very long and complex form.

Q. And if we go to page 1 again to see the genesis of the form, as you say as Cheshire East, Cheshire West and Chester, Halton and Warrington.

It then says:

"For deaths of children who are not normally

resident in Cheshire, please also refer to relevant local guidelines."

So something else?

A. Mmm, yes, that's obviously the Countess of Chester serves a population of North Wales, Flintshire and the guidelines in Wales are different, it's a different system, it's called the PRUDIC, not the SUDiC, so I think that is reference to children from Flintshire.

Q. If we have that document down now, please, and the Countess of Chester document guideline in the event of a child death which is INQ0014161, page 1. Sorry, that is not that one. It's 14161.

So this is a Countess of Chester document, isn't it?

A. Yes, it is.

Q. Can we have a look at page 5 first. That sets out guidance, doesn't it:

"Please discuss individual children with the Coroner"?

A. Yes.

Q. But it sets out there -- you tell us what it sets out there?

A. Sorry, which paragraph are you referring to?

Q. 1.4.2 on page 5.

A. Sorry, 142?

Q. Yes, 1.4.2.

A. Sorry, if you just repeat your question?

Q. Yes, the purpose of this policy "Managing Child Death", what does it set out at 1.4.2?

A. So this is about the support to the families and the compassionate side of what is a very legal and clinical process. So this is the things that we, that can be offered to families, to give them mementos of their child and all of this is available to any, any bereaved parent and is, is used not that there are obviously many, many child deaths but we have had good feedback on the empathy and compassion this shows to -- to those parents who want a memento.

Q. And this policy is 40 pages, isn't it, and sets out from the Countess of Chester's perspective what should be done when a child dies?

A. Yes.

Q. But we see reference above the section I have just asked you to comment upon where it says:

"It may be deemed necessary to follow the management of Sudden Unexpected Death in Infants And Children (SUDiC) where a death occurs within 24 hours of admission or is an unexpected death."

Would you expect them to follow the policy we have

just looked at, the 160 pages, if it was a Sudden and Unexpected Death?

A. Yes, indeed, yes. That I guess that is the primary document, this is the more local lens for, for the Countess and really picks up things that are not incorporated in the very formal legal document of SUDiC.

Q. Well, if we go to page 30 and 31, there's a checklist, isn't there, for staff following the death of a child.

Dr Brearey told the Inquiry that it took him six hours or so to complete forms after a child death. We didn't ask him which ones he completed but as an indication, that is a long time, isn't it, to spend on this task?

A. (Nods)

Q. Do you think, looking at the two documents we have, SUDiC and this, it could be streamlined and made clearer?

A. Absolutely. These, these documents read like a bit of a -- it is a really bad descriptor but a bit of a brain dump on absolutely anything that can happen anywhere and I think we have sort of lost the purpose of this document and information that will actually add value in terms of review, in terms of learning, in terms of assessment that could then be used further down the

line for a broader purpose.

But I agree a six-hour document is, it is not uncommon but it's not a good use of clinical time at a point when clearly a child has lost their lives.

Q. That document can come down and then there is a 2024 policy, INQ0108408, page 34, please. We see here if we go over to page 35, that is page 34, 35:

"If in doubt follow SUDiC pathway in addition to this document."

Now it tells you that at page 35 it looks like.

Can you see at the bottom?

A. Yes, yes.

Q. "If in doubt follow SUDiC", so 35 pages in. Again, do you think it would be helpful just to say at the outset on the front of any document relating to SUDiC or child death what document needed to be filled in and why?

A. It would and, you know, this is really throwing out a lot of good learning around how do we improve -- how do we improve our system for recording things making sure that we have the right information for whatever process follows.

But making it easy for people to -- to undertake these, these things and you know, a 35-page document is not ever going to be read in detail and will rely on

experts to support a colleague in, in filling them in but this, this also here -- Dr Davis has responsibility for managing child death and has dedicated time to ensure that we get these policies right but also that the training and support to people who fill this stuff in is available.

Q. It's in fact 51 pages, it's just --

A. Is it, sorry --

Q. -- you are told: if in doubt follow the other one in addition, so two, two routes of filling in forms.

If we go to page 37, give me one moment --

Thank you I am corrected. Thank you. It's actually an 18-page document, it's just part of a longer document?

A. Right.

Q. So it is shorter than 51. I am gratefully corrected for that.

A. Still not good.

Q. But you have to go some way in before you are told you might want to check if it is another process. If we go to page 37, please, INQ37 page 4 of 18.

"Neonates":

"All deaths of babies less than 28 days old are subject to additional reporting requirements. Initial management should follow this document and an decisions

proforma needs to be completed as well as CDOP referral."

I am not suggesting you will be the only Trust doing this multiple referring, it has to be done and we have heard evidence from Dr Camilla Kingdon as well about this topic from the RCPCH and when referrals are made but it is not straightforward, is it, for busy clinicians on the face of it?

A. No. I -- I sort of totted up eight layers of governance relating to neonatal and child incidents. That is a long pathway to get to the board.

I suppose what it does is at every level does gives colleagues the opportunity to record, to understand, to share, to pick up peer learning, but also for external agencies to have a real-time view of, of what is happening in units and to, well, in theory pick up trends, if there are any that need to be shared more broadly.

Q. Do you know how detailed the form completion would have been in 2015 to 2016 around Sudden and Unexpected Deaths?

A. I'm sorry, I don't know that.

Q. That can come down, please, and if we can go to part of your statement, your first statement that deals with Medical Examiners, INQ0017158, beginning at

page 46. Actually the page before, 45. If we start at paragraph 174, and read from 174-178.

(Pause)

Using paragraphs 177 and 178, can you tell us when the Trust started to recruit and establish a Medical Examiner Office and how that's developed and why you say you think the system will be more effective once the statutory system is rolled out in 2024?

A. So I think as set out in 177, there was quite a long lead time with this and the recruitment didn't really start until 2021.

We now have three Medical Examiners who review 100% of all deaths with the exception of deaths that are immediately referred to the Coroner is my understanding.

The process will pick up certain issues as set out in paragraph 175 but what is possibly more useful understanding learning, not just the governance around the reason for a death, is the Mortality Review process which scrutinises deaths with a different lens and looks for avoidability of, of harm.

But obviously they are two very different things but the Medical Examiner role is now well embedded within the organisation and our Patient Safety Director Dr Benton, he links in with the Medical Examiner as well as the Medical Director to ensure that we are picking up

any issues but they do have regular contact.

Q. You say at paragraph 178:

"It's understood that a Medical Examiner is rarely trained in neonatology or obstetrics."

That is the position at the moment; even if it is a neonatal death you wouldn't expect it to be someone with that expertise necessarily.

Would they, irrespective of expertise, speak to families, though, or parents?

A. Sorry, could you say --

Q. Would they speak to the parents of a child who had died, a Medical Examiner, so not a neonatology qualified Medical Examiner, but would they speak to the parents as part of this process?

A. My understanding is they don't. It's more of a desktop exercise to pick up the bullet points set out on, on 175.

The discussion with the Families would be taken with our own clinicians. Some of our Medical Examiners are external to the Trust, but none of them have got paediatric or neonatal experience.

Q. When you say at the end of 178 then that:

"They essentially provide checks and balances to attending practitioner is appropriate, alongside considering all other aspects of care including any

family concerns."

As far as you are concerned, family concerns aren't a face-to-face meeting, they are either recorded or handed to the Medical Examiner by what route?

A. I'm not sure how practical it would be for every single death to have a face-to-face meeting with, you know, what is the equivalent of a whole time individual doing this. Clearly, children and neonatal deaths are very, very small in number but the number of adult deaths are significant and unless anything was flagged routinely it would be very difficult to do that.

Q. Thank you. That can go down, please. I am going to ask you some questions about data collection now, if I may.

Can we have on the screen, please, two documents, the first is INQ0108781, and it's a document prepared by the Inquiry legal team and, Ms Tomkinson, it's just so that you can see the Countess of Chester evidence around the number of deaths that the Inquiry has received. You can see there Dr Brearey conducted a Mortality Review and listed the numbers at paragraph 1, at paragraph 2 Ms Powell sent Dr Brearey an email with the subject line "Annual Mortality Numbers".

And then paragraph 3:

"In readiness for an Executive meeting,

Ms Millward, Head of Risk and Patient Safety and Ms Kelly, Director of Nursing, prepared a position paper on neonatal mortality and the below is taken directly from that paper."

And we see it was obviously not straightforward for Ms Millward and Ms Kelly who say:

"Data discrepancies between the differing systems in place has led to a number of challenges in obtaining an accurate account of the neonatal unit activity over time. Having reviewed the outputs from Meditech, BadgerNet's neonatal specific electronic patient record healthcare evaluation data and that recorded within the Trust Bereavement Office the annual number of deaths occurring within the neonatal unit recorded from January 2010 up to and including June 2016 is as follows ..."

And we see the numbers set out there?

A. Mmm.

Q. A second document prepared by the Inquiry legal team, INQ0108782, with the assistance of Core Participants including Dr Brearey, sets out deaths in 2015 and 2016 linked to the Countess and we see at page 2 what reviews included, which children or babies, page 3, page 4 and page 5.

We have heard evidence from Professor Knight from

MBRRACE who was clear that the report on the data for 2015 to 2016 would not have been possible to see for the Countess of Chester management until 2018, it's two years before that data is fed back when the appropriate steps have been taken to determine its accuracy.

That can come down as well.

Do you now have data or analysis of trends or clusters of data in real-time or continuous viewing available to you?

A. The answer to that is yes, we do. Obviously the -- the numbers are extremely low but we have real-time data which starts from a daily update on incidents and deaths right through to the formal recording that goes through the governance structures and the Executive Team and to the Board of Directors.

So there is real-time data and it is scrutinised as you referred to in a previous document, extremely closely.

But not just the mortality, the incidents are, are scrutinised on a daily and weekly basis and escalated if, if required.

Q. And you deal with that in your statement at INQ0017158, page 36. We see paragraph 141, if we can read from 141 to 146.

A. Yes.

(Pause)

Q. In terms of neonates and maternity services, what are the forums where there's learning or discussion around the data that you get back, how is the data helpful?

A. So there are various ways of recording the incidents and the issues, so the primary document is the Datix one but that is -- is simply a forum for highlighting that an incident has occurred and giving it an initial assessment on harm.

The process for review will be really be dependent on the severity of the, the incident from a very, very local real-time review right through to what they call a swarm which is the -- the bigger learning piece and ultimately a decision will be made on whether it needs to form part of the Patient Safety Response Framework.

Between those, there are -- there are also what we call after action reviews and 72-hour reviews. So these are all formal and tried and tested methodologies for collecting information, for identifying the learning and then disseminating to the relevant people and that is done on a rolling basis. There are no sort of formal stops in that process and it is undertaken on a weekly escalation basis. So there is, again, it's really

complex.
I'm not sure I have answered your question. But it's -- there are so many different ways of doing it.
Q. Who draws down the data? You say it is available to you in real-time so what's, is it a clinician, are they risk people, who in the hospital now looks at the data that's coming back?
A. So the Datix incident data is reviewed initially every single day by our --
Q. Sorry, I don't mean from your internal Datix monitoring.
A. Oh, sorry.
Q. I mean from MBRRACE, or --
A. Oh, the MBRRACE.
Q. -- the QSPEC. Who's looking at the information or the numbers that you are being sent?
A. So it's reviewed by the governance team but remember that we sort of input into MBRRACE and the collation of it is done at a system-wide basis. But any of our neonatal leadership team can access MBRRACE to either input or to see. There is reference in the document about the timeliness of the reporting.
My understanding is it's still pretty out of date in MBRRACE, so there are other ways to get the data which we -- we use through network.

Q. And what's the most valuable data, where do you get the most valuable data in real-time from in terms of using it for patient safety to know what's happening at the time, can you give us an example of what's been helpful, maybe you can't now and you would need to go away and send it back to us where the data has been informative and you have been able to do something as a consequence of it when you have dug into it?
A. So I think the process we have in place now makes reviewing and access so, so much easier.
So every single morning at 8 o'clock we have a senior leadership team involving clinicians, Executives and various other people and that is about reviewing the organisation in terms of what's going on, in its broadest sense, but part of that meeting is focused on incidents and is a specific elements around the Women's and Children's Division and the incidents that have happened.
So knowing in real-time what has gone on in that division but importantly what people are doing about it, so my question is always what have we done to stop this happening again? And the magnitude of indents ranges from fairly low grade to some significant ones.
So, for example, today I read an incident of a baby

who was dropped when the mother had a faint. So immediately the team are reviewing that incident to try and identify how we could have addressed this blood pressure issue and what we can do in future.
The recording of the incident and the cascade of learning will be done in a much more formal way through the weekly safety reviews, the weekly safety bulletins, which are available to all staff but if there are any sort of significant or maybe more complex learnings, they will be picked up potentially through audit days, through divisional governance, and potentially brought to the board.
So it's a bit of horses for courses. It depends on what the incident is and how we respond within that Patient Safety Response Framework.
Q. And the bulletins, are they emailed to staff? They all have an NHS email do they?
A. Yes, they are emailed but they are also popped up in your coffee areas. They are discussed, we do a monthly learning and sharing forum where case studies are brought along. It's multi-factored and I have to say we have had really good feedback from that method.
Q. Volume of email traffic. One person gave evidence to the effect that being cc'd into emails a lot of the time means they increase in number. I suppose it

might not always be clear what you are being asked to do. Is that still a thing, you cc a number of people or is it very focused email traffic?
A. Yes, the -- the cc or even worse, the bcc facility creates a huge amount of traffic. However, an important communication like that should not be copied to all and you get pretty adept at sifting through the things that need looking at and understanding what needs attention and I did hear that piece of evidence and I agree about the volume. I'm not sure I agree with the way that it's, it was handled at the time.
Q. If you can go, please, to INQ0014065, page 1, Mrs Killingback, thank you, that is a bulletin you have sent bringing us more up to date in February 2024. A weekly bulletin from you and it's following the CQC report. While we are getting that up, the CQC, what do you see its role is and what's your professional relationship as a Chief Executive with the CQC like?
A. So the CQC obviously have a regulatory role which is, is pretty broad in its application.
I have always had a really good relationship with the CQC and I know they get a lot of bad press. However, and I am also a CQC Well-Led Inspector, so I should maybe declare that interest but I have always

found them to be thorough, tenacious and objective, certainly in the work I have done with them and if they identify things through the course of their regulatory work, these are things that need looking at and addressing but there is no point in getting feedback from a CQC on their findings and not sharing it with the broader Trust and, therefore, you will see reference in the bulletin to the information in there but also we held a number of team briefs specifically to ensure that people understand what was found and why what their role is potentially in addressing those CQC concerns.

Q. For example, in 2024 and we know there was an earlier one, 2022 inspections, with you, how inquiring are they now, do they ask direct questions about worries you have or concerns or where things might be going wrong?

A. They do and in fairness, in my role as an inspector we always did. You know, what are the issues keeping you awake at night? And that question would be asked through, you know, directly to board colleagues but also to focus groups with clinicians or nursing staff or Council of Governors. So they are, they are inquiring but my experience with the CQC is don't, don't wait to be asked stuff. Share it in real-time if there is an issue that, that we are looking at of concern and

that relationship works really well.

Q. In this bulletin that you send to staff, you speak of pledges to you.

"Freedom to Speak Up. My pledge is to you."

You say:

"I actively encourage colleagues to speak out if they have concerns about the care or treatment of a patient, colleague or themselves."?

A. Yes.

Q. Then over the page at page 2:

"Any concerns raised in good faith will be investigated fully, openly and transparently. This can be done anonymously or if you do share your name, you will be provided with feedback on the issue you have raised.

"If any colleague raises a concern and feels like they have come to any detriment because of it, let me or another member of the Executive Team know and you will be kept safe and supported."

A. Yes.

Q. Why do you see that you need to send that message if it's not obvious?

A. So I am a huge advocate of Freedom to Speak Up and introduced these pledges which are mine, they are not written down in a book, they are my pledges when

I was in Liverpool Heart and Chest and for a number of years we sat as number one in the index with the Freedom to Speak Up National Guardian.

I feel it's really important that we set the culture and tone to speak up from the absolute top of the shop and the point there about detriment and supporting people in my phrase, it's "I have got your back", should give them the confidence to speak up when they fear detriment from raising something.

So I reiterate these pledges very frequently on induction which may be the first day of employment with the Trust and at the monthly team brief and to anyone else who will listen and what I say to colleagues is: remember these, tuck them away, and the day you need them refer to them and come and talk to me if you aren't getting the support or recognition you need through the other channels.

And this is fundamental to a cultural shift in the, in the strength of Freedom to Speak Up as a really clear mechanism to raise concerns.

Q. And how much training do staff in the hospital now get on that, on Freedom to Speak Up, do they have half days, days or how is it embraced?

A. It's mandated, there are three levels of Speak Up training.

So the first level is for everyone, Speak Up training. The second level, which is for sort of managers and leaders, is Listen Up training. And the third level is for the board and I can't actually remember what it's called but these are mandated levels of training that, that people have to undertake and we, we routinely monitor it and currently we are sitting over 92% have gone through at least the basic level training. But again it's reiterated in other forums as well, it is not just do the training and close the book, it's about how in practice do we temperature check on how people are feeling about it.

Q. Let's have a look if we can at the CQC report for February 2024 which is INQ0014186, page 1. So we see there the overall ratings "our service is caring", a~"good" for that. "Overall Trust quality rating: requires improvement."

So what's your reflection upon that? Do you think that's right and do you think the areas they have identified that's right? How would you describe where the hospital's at now?

A. So the CQC came in in October 23, so that was, what, 9, 10 months into my part-time tenure because I was only part-time with Liverpool Heart and Chest at the time and I was really clear from the outset that

Countess of Chester needs to move from "requires improvement" or from a Well-Led perspective into "outstanding" because I knew what "outstanding" looked like, I had done it before, and it just creates such a different culture in the organisation.

So to be honest I could have done with a bit more time before they came in but it was what it was. I think what I was really pleased about was that Well-Led had moved in a short space of time from "inadequate" to "requires improvement" and that similarly maternity and children's services had moved from "inadequate" to "requires improvement".

Now, I never thought I would say those words that I would be pleased about "requires improvement" but from the base the Trust had and the timeframe and the absolute ambition not just of myself and the Executive to move it to "outstanding" is absolutely shared by, by the leaders and the staff within the organisation.

So we took the feedback very seriously, there is a comprehensive action plan and when they come back again, I am hoping for yet more improvement.

Q. If we look at parts that refer to maternity or neonates, if we go to page 4, so the initiative they identified as outstanding practice, what was that?

A. It's the bullet points set out, out below. So

there's "outstanding" practice, the first one is about how we worked with the family of a stillborn to create something to share with other families to support their, their younger children with dealing with a loss. Reference there to the personalised care for babies, Children and Young People and their families and a lot of this was done in conjunction with the Maternity Voices Programme, but also supported by the Maternity Safety Programme, which I am pleased to say we have now exited.

So there were a number of "outstanding" practice areas that were communicated to the CQC in their discussions with staff and obviously shared more broadly through their, their governance and communications processes.

Q. If we go to page 9, in relation to storage of medicines:

"Trust should ensure medicines are being stored securely ... to embed changes made to the post-operative care of women and birthing people following obstetric surgery ... should continue to embed the changes made to the triage systems and processes."

Was any of that a surprise to have that highlighted or were the team on to those points?

A. No. It's a level of detail that the CQC got

into. Quite clearly, I would expect that these very, very basic things are, are done routinely and it doesn't wait for an inspection to flag that there are issues. Some of the issues will be addressed particularly the one around the proximity of the maternity theatre in our new build which opens in the summer. Some were just addressed immediately as, you know, real "business as usual" basics.

So it's one of those things. It's irritating because it was an own-goal but nevertheless they spotted it and we address it.

Q. Leadership. There's reference there:

"Significant period of change and churn in senior leadership meant the Trust's board lacked stability."

And if we go over the page to page 10:

"The Trust was seeking to recruit permanent leaders at the time of our inspection."

How is the position now with leaders at the Trust?

A. Well --

Q. Obviously you're a permanent position. What about others around you?

A. Sorry?

Q. What about others around you? You are now a permanent position --

A. Yes.

Q. -- but how is it?

A. So remember at the time, I wasn't -- I hadn't been appointed on a substantive basis and pretty much all the Executive posts were filled with colleagues who had, like myself, doubled up from Liverpool Heart and Chest.

Delighted to report that there are no vacancies at the minute and we have a team of absolute A grade individuals who know what good looks like, have the right values and absolutely support and drive that ambition to be outstanding. So they'd come back and see something entirely different now.

Q. If you go to page 13, please. In fact it begins on page 12 in bold, the point at the bottom of page 12:

"Staff did not always feel respected, supported and valued. The Trust needed to do more to ensure there was an open culture where patients, their families and staff could raise concerns without fear."

And if we go to page 13, paragraph 2, we see that:

"The 2023 National Staff Survey was open for the staff to complete at the time of our inspection which meant the most recent results available for review are from the 2022 survey and those results showed staff did not always feel respected, supported or valued."

So, the surveys were a couple of years ago now. But looking at this, how do you respond to something like that in terms of culture? How can you change that culture, you as the Chief Executive?

A. So I have two priorities: patient safety and experience and staff safety and experience. They are the priorities.

Those surveys results were, quite frankly, deeply shocking. The Countess was I think one off the bottom whereas my other Trust, Liverpool Heart and Chest, was routinely if not number one in the country in the top four and those results at least gave an indication of how, how people were feeling and therefore what we could do to engage our staff to address the issues.

The culture change is going to take time. But from the most recent survey -- we have just had some early results -- we have actually improved in 26 out of the 30 indicators and in six out of the seven sort of key people promise areas.

Q. What's that survey? Was that an internal --

A. It's the staff survey. It's the most recent one, so the results aren't out yet, so --

Q. Can we have them when they are? When do you expect the results to be out?

A. So we have the results for our Trust. What we

don't have is the results that benchmark against other Trusts, but we can certainly provide you with it.

Q. Are there comments? Do staff make comments or is it tick box?

A. They do, yes, yes. Now, the early view I have seen does not have any staff comments. But the trend is, is more positive. More staff filled in that survey and --

Q. What was the response rate, roughly, do you know?

A. 40, about 43%. The national average is 45 and Countess was routinely between 39, 40%. Not good enough though. I'm used to, you know, 60% response rates.

But we're sort of turning the tanker on, on this and, you know, there are green shoots of positivity; people can feel an improvement, they can feel a more inclusive and open and supportive culture with, with really visible leadership and, you know, I pride myself and my exec team of that constant visibility.

So, for example, and I know I'm going off a bit of a --

Q. Continue, please.

A. So when I came, the executive officers were in a different building, you know, a good quarter of a mile from the hospital. The priority was to get back in that

hospital, so not only could I walk round much, much more easily but people will call in. We can, we can go and talk to people in real-time if there are issues.

And that visibility, that support and listening culture that the Executive are leading from the top with, is making a huge difference to how people feel about their, their place of work. So I -- I think that's really positive.

Q. Over the page, page 14:

"The Trust applied duty of candour appropriately. The Trust Serious Incident reports included explicit reference to duty of candour and details for how this had been carried out. The report showed patients received an apology without delay after an incident had occurred. The Trust monitored compliance with the requirement to complete the duty of candour within 10 days of an incident occurring."

How do you keep duty of candour to the forefront of staff's minds, its importance and what needs to be done, how do you do that in practice?

A. So duty of candour is a compulsory field on this Datix incident reporting system and it applies to, I think there are three criteria when duty of candour would apply. But the teams work on the basis of even if not all the formal three criteria for duty of candour is

fulfilled they are open and honest with, with our patients.

So the training comes through our local induction because sometimes it needs to be a bit more bespoke for a particular area. We monitor it through divisional governance. We refresh training through different forums. So for example we had a half-day with the GMC last year with our doctors to refresh their knowledge and training around duty of candour.

So it's a sort of a multi-factored way of ensuring that people absolutely understand their responsibilities and how at board level we, we get the assurance that it is happening as appropriate in accordance with the guidelines.

Q. Page 15, please, Freedom to Speak Up. We see there in the second paragraph under "Freedom to Speak Up":

"Following the review the Trust refreshed the policy and relaunched Freedom to Speak Up across the Trust. The relaunch included the recruitment and training of new Freedom to Speak Up champions and the implementation of a new Freedom to Speak Up network. At the time of our inspection the Trust had over 30 trained champions and a waiting list for staff to become champions. The network comprised of the Freedom to

Speak UP Executive Director, Non-Executive Director lead and the Freedom to Speak Up Guardian and the champions."

Are you still at that number, around 30 change champions?

A. Indeed we are not because we now have 70 and a waiting list. So, you know, there is a real, real body of support for this and people want to become champions. They see the benefit and colleagues around them are very appreciative. So it's a very significant number now.

Q. And what training and support do they get for that role because the Inquiry has heard, for example from Hayley Griffiths, who had a number of roles, some perhaps in conflict with the Speak Up Safely role. What support do the champions get?

A. They have formal training, which is the recognised training through the Guardians' office. They have frequent forums with our Freedom to Speak Up Guardian, Helen, and they have forums which include our Chief Operating Officer to update on any, any guidance changes and they are involved in the production of reports we take to our people committee and to our board around numbers, themes, trends, who is speaking up, what the issues are.

So there's a, you know, again there is

a multi-factored set of ways to train people and clearly when new guidance comes out from the Guardians' office, it's cascaded immediately.

Q. Why do you think there is some enthusiasm for taking the role up?

A. Well, it's another -- you know, it's another good thing on a CV for people who have ambitions. It's exposure to, you know, Executive level input which some people find, find really positive. It's an opportunity to speak to people with a slightly different hat on.

Remember, they don't get involved in the grunt work of investigating the concerns; they are a conduit. But they can see the benefit of it and therefore, you know, have jumped on this and are real advocates for speaking out.

Q. Do the people who have those roles take on other roles as well? I mean is there a limit to how many extra roles you can take on now?

A. I mean, the -- so the guardian is a bespoke role. She has no other, no other responsibilities.

For champions it is, it is an absolute add on to their role. You know, any -- there are examples right across our professional groups including Consultant doctors who have taken on the role. It's not a burden in terms of time. Obviously the training requires

input, but people -- no one has come forward to say, "Look I can't do this because it's a significant impact." If they did, we would have that conversation.

Q. The neonatal unit now, page 74. We can see if we can scroll down the bottom of pages 74 and 75 what was said about that unit. If people read that.

(Pause)

Then if we go to page 77, a comment on the staffing, at the bottom:

"Neonatal unit staffing:

"The neonatal staff rotas for June to September showed the unit had always been staffed with higher numbers than recommended by the British Association for Perinatal Medicine for a Level 1 unit."

It has of course stayed a Level 1 unit, which it was placed temporarily many years ago now.

I think -- what's the position about Level 2? Can we have a document on the screen actually, one that you sent to a number of representatives from NHS England, INQ0108408-0007.

Who are the recipients of that letter from you?

A. So Richard Barker is the Regional Director. Graham Urwin is the Chief Executive of the Integrated Care Board. Michael Gregory was the Regional Medical Director. James McLean, the Regional Nurse,

Andrew Bibby was the Head of Specialist Commissioning, Chris Douglas is the Integrated Care Board Director of Nursing and Rowan Pritchard-Jones is the Medical Director for the Integrated Care Board.

Q. So tell us what you were requesting here?

A. This, this letter was a culmination of a number of meetings that we had had with these colleagues plus more who, who were copied into the letter, but it's not referred to on there, whereby we, the organisation was very keen to see restoration to operation at a full Level 2.

Given that the temporary restrictions on the operation of the unit had been implemented in 2016, with a view to lifting those restrictions as soon as possible, the meetings were held to give information assurance to the decision makers around this.

So the reference there to Professor Simon Kenny, he is a paediatrician, he's actually a Consultant paediatric urologist but he's the national lead for Children and Young Peoples Services from Alder Hey and also the head of the North West Neonatal Network Kelly Harvey were involved in the meetings and were, you know, without question fully supportive of us returning to a Level 2.

And the reason why returning to Level 2 was so

critical was it absolutely restricts the numbers of babies we can care for and the complexity of those babies and that impacts on the families, many of whom are transported to other units or children who -- we have seen twins separated in units because of the restrictions, but also our ability to recruit the best possible clinicians who want to do the more complex work and the team have been working for many, many years now on the basis that, you know, some day soon we will see this designation restored.

So I think there are some documents that accompany this which sort of set out the timeline and process to, to see that redesignation established.

And I wrote to them in -- when was it -- April 24 formally requesting that we could start that trajectory to get to Level 2. But fast-forward to January 25 and there has been no progress, which is incredibly frustrating for the families, for the staff and for our, you know, our future plans within that new Women's and Children's building.

Q. Is the roadmap and the dates INQ0108408, page 20, is that what you were thinking of with the roadmap?

A. Yes, it is, yes, with a really clear timeline.

Q. So that never got off to starting?

A. No, it has not progressed.

MS LANGDALE: My Lady, I see the time, I wonder if that's a convenient moment.

LADY JUSTICE THIRLWALL: Yes, thank you. Just if I can ask this question before we go. I'm not asking you to answer it, but has there been any response to your letter?

A. There has been a response but only extremely recently, like last week, so quite disappointing.

LADY JUSTICE THIRLWALL: Yes. Thank you. So we will break now and we will start again at 2 o'clock.

(12.56 pm)

(The luncheon adjournment)

(2.00 pm)

LADY JUSTICE THIRLWALL: Ms Langdale.

MS LANGDALE: Ms Tomkinson, picking up on the question you were just asked by my Lady, I have seen over the luncheon adjournment the response to you from Christine Douglas, Executive Director of Nursing and Care, the NHS Cheshire and Merseyside Integrated Care Board and that letter dated 6 January 2025 will be served on Core Participants. I don't want to take you to that now.

But the bottom line is a meeting has been suggested in January 2025 between you and Ms Douglas. Are you

able to update us after that meeting?

A. No meeting has happened.

Q. No, not yet. It is suggested one in Jan 2025 so?

LADY JUSTICE THIRLWALL: Would you be prepared to update on the meeting?

A. Absolutely, it is not in the diary yet though.

Q. Thank you.

Your third statement if we can go to this please, INQ0017160, page 2, you deal with governance arrangements that have changed since 2015 to 2016, so can we have paragraphs 6 through to 9 on the screen, please. If we scroll down a bit, thank you.

So you set out the new divisional structure that's in place from -- has been in place since January 2023. Can you tell us what that is?

A. So when I joined the Trust, there was no sort of formal operational board, so a board that would oversee delivery of performance accountable to the Board of Directors and would be populated by a, a dominance of clinical leaders and I am clear that the organisation needs to be clinically led. That doesn't mean I am a clinician, because I am not, but we needed dominance of those clinicians around the decision-making table. So that forum, which has meant monthly ever

since, is well-populated by the divisional leadership teams plus a variety of other clinicians and managers who attend in other capacities.

Q. In terms of getting information to the board, the Trust board there was a route for that as well in the past, wasn't there, via the Quality Safety Patient Committee through to could have been Women's Governance Board, but either way you could get to the Board of Directors. So why is it different this way in terms of accountability?

A. I think it's about robustness of understanding of what those committees are designed to do and the subcommittees are assurance committees of the board. The chair of the Quality Group is now a clinician and an ex-doctor and the transition of information from what I call ward to board is much clearer and more tightly controlled and that is due in part to the changes around the Executive structure. But also some of the changes to the membership of those boards' sub committees.

Q. So Chair of Quality being a clinician, how important do you think that is?

A. It's hugely important on the basis that if it's not a clinician and the primary purpose of the committee is around patient quality and safety, then it's quite difficult to challenge effectively without

that in-depth knowledge now there are other clinicians sitting on that board, but the role of the chair is absolutely fundamental to me in terms of understanding the key issues, the risks and importantly the assurances or lack of them.

Q. And if we look at paragraph 9, indeed you repeat there "a clear and robust divisional reporting process for reporting to the board".

A. Yes.

Q. "Now clear board oversight if perinatal services and all neonatal deaths are formally reported to the board."

A. Yes. The, so all deaths are reported in the, in the performance framework to the board on a monthly basis. But the perinatal review group which is chaired by our Director of Midwifery is in attendance, once a quarter, Natasha Macdonald comes to the board, presents the information, and takes questions from the Board of Directors.

So again I was talking about that sort of a tier of governance. It is still complex. However, there is a direct line of sight between one the clinical leaders in that division, which is that Director of Midwifery and her attendance at the board.

So there are a number of forums she can raise and

escalate things but she has that ear of the board without restriction.

Q. So if we look, please, at INQ0002607, page 1, that is the committee structure in September 2015. I just want to be clear what you are saying about the committees, the number or types of committees and we might need to enlarge that if we can.

A. Okay. Sorry.

Q. So what is it about the committee structure the way the committees are done that you have changed or think should have been changed to make governance of neonatal services stronger?

A. So all of those committees are still in operation, although the Terms of Reference and the membership have changed significantly. Their, their roles are to give assurance to the board of directors but also to deep dive into areas of concern.

The Chair of all of those committees has changed and whereas back in 2015/16 my understanding is there was a dominance of Executive Directors on those committees, the dominance now is with the Non-Executive Directors that obviously bring that independence and objectivity.

Q. And what do you consider the role of the board is in scrutinising quality and performance?

A. Well, we have -- the board has to be assured that we are delivering on our requirements on performance targets, on quality indicators, on harm and risk and on financial management. And the Board of Directors is serviced with a number of reports which are produced monthly.

But also it takes another layer of assurance via the sub committees through the Chair's reports that go directly to the Board of Directors. They are presented by a Non-Executive Director at the board and colleagues are able to ask questions if there are any, any matters or issues arising.

Q. Do your Non-Executive Directors now have clinical expertise in some cases?

A. So we have, we have a doctor on the board, sorry, on the Non-Executive, we have a nurse, and they are the clinical representatives for the Non-Executive side of the board.

Q. Do you consider that a key component of such scrutiny by the board is ensuring that sufficient clinical expertise including amongst Non-Executive Directors?

A. Yes, it certainly does. We can't have an objective board with overreliance on Executives. We need that independent challenge. Are the number of

clinical colleagues on our board sufficient for the agenda? That's subject to opinion.

There's certainly room for more but historically there's been, there was a shift from ex NHS directors sitting on boards and Non-Executive roles to actually the dominance being from other sectors and industry.

Q. You have described how the board learns from events in the hospital now through the reporting channels. In your experience, how do boards learn and take lessons from what's happened in other hospitals?

A. So they would be reliant on board sub committees or directors bringing information to the board and the board needs to get the balance of its primary purpose which is that overseeing delivery role with opportunities to bring in other information from other areas and what we tend to do in the Countess is the board business is primarily about the Countess but we hold frequent board development days where we can dive into benchmarking and understand what's going on.

We utilise the national Getting It Right First Time model, model hospitals, and we have guest speakers from other organisations attending those development days sharing their view of good practice.

Q. And we have seen indeed in 2015 to 2016 and I am sure now neonatal networks in the region between

doctors, discussions about mortalities et cetera. Is there any effort to go outside a region, I mean across the country, not just your region, but to have discussions and learning across regions?

A. I am not aware of that, that broader role of the network. The reports that come from the confidential Inquiries into deaths would certainly pick up that national landscape but there's been quite a significant time delay between the incidents and the learning being shared.

Q. The Inquiry has received evidence, I don't know if you heard Dr Benneyworth talking, from the HSSIB, about the plethora of recommendations and how on the frontline it can be overwhelming, so many recommendations from Inquiries, Reviews, how do you know how to prioritise?

Do you have anything to say about that in terms of Medical Directors knowing, for example, which items to prioritise, month by month, with so many recommendations coming in?

A. You are quite right, there are, you know, something like 130 regulatory bodies in the NHS all with a some sort of role in checking up on what organisations do and they always have recommendations.

And identifying the priorities in there is really

important and I guess it depends where the information has come from.

So our board routinely reviews all the recommendations from Inquiries and action plans will be produced accordingly. But let's say it is the review undertaken by the Human Tissue Authority. That would be put into the hands of the division and their governance to review, to prioritise and to identify the mechanism for embedding and checking back on the audit.

So we are not reviewing everything at board level. We are delegating where appropriate and really focusing on the things that have the highest impact or would give the biggest risk. But we have quite a good way of linking different recommendations from different bodies together now at board level.

Q. How do you do that?

A. So it's a -- it's a matrix which picks up themes from the different Inquiries and reports. The, the primary focus is around the CQC report because that's our overall regulator. But things will come in from other areas which we need to address and if there's parity between that CQC report and something from another body, we would integrate and bring the two together.

Q. In terms of preparation for a CQC visit, we

heard there might be meetings across wards with managers meeting perhaps six weeks ahead just to discuss matters. What is the type of preparation that Trusts such as yourself undertake when there's going to be a visit?

A. So obviously a lot of the CQC visits are unannounced, so there's no prep. But something like Well-Led, you do have a smaller window of preparation.

We don't prep for CQC visits because we do ongoing review of ourselves against the standards and the Key Lines of Enquiry and have regular relationship meetings with the CQC.

So we ensure that our teams know what those Key Lines of Enquiry are, they need access to previous reports.

But we certainly wouldn't have them in a room and say: right, well, you need to see this, this and this because being around inspector that comes over really badly. You have got to have embedded those standards and processes so anyone can drop in on any given day and find things are right.

Q. Do you agree, Dr Benneyworth in a collaboration -- a group of arm's-length bodies collaborating suggested that some or found some recommendations from Inquiries or reviews may not be relevant to particular providers or could promote

inequalities by negatively impacting certain patient groups if implemented but providers can feel they are not empowered to reject recommendations.

Does that resonate with you or not?

A. No, it, it doesn't. I can't recall reading anything where I would say, you know, we are just going to ignore this. Sometimes if they are not relevant and they don't apply, it is a bit of a comply or explain thing.

But we would never just reject something because it was, we felt it wasn't a priority for us, we would always go through the process of review so I wouldn't necessarily recognise that.

Q. I suppose it is the other way round: would you reject something that wasn't a priority for you even if the recommendation had been made to do it from a different review or Inquiry?

A. So we would negotiate with the report writer for a trajectory for when we would look at it. It might not be priority now, but in a year's time we will address this.

Q. So you wouldn't feel you had to follow it or feel pressure, you would look to see whether it was appropriate for your needs or what you were providing?

A. Oh yes. It is nothing you would ever feel

pressure over. You might not necessarily agree with it, you know, recognising the volume of things but it's not a pressure thing because every regulator is there to improve and that's where we are.

Q. Paragraph 25 of your statement, INQ0017160, page 7, you were asked whether you have any reflections on the issue of how senior managers should be made more accountable, whether through regulation or otherwise.

Can you give us your views on that, please?

A. I do feel there should be some professional regulation and depending on the professional route senior managers come through they may still be affiliated to bodies that regulate them so in the example of myself, I am still a member of my professional body and I am regulated through that.

However, it's really inconsistent and there are no set standards, no in effect core values and no register for, for this. But I think given the history and you know certainly the learnings through, through this case and the Inquiry, it feels that the time is right and I don't accept criticism that this could have a chilling effect on stopping people taking these roles up. They should absolutely welcome and embrace a regulatory framework that makes things safer for patients.

Q. You refer to the fact that there is

professional regulation, so a number of managers will be doctors and nurses already regulated by the GMC or the NMC.

In your experience, do you have any experience of those regulators taking action against doctors or nurses in the context of their senior management role as opposed to a clinical role?

A. No, I have no experience at all. I have got plenty of experience of the clinical roles but none at all for their managerial roles. What I would say is my experience with the GMC and the NMC is it takes a huge amount of time to see a referral to conclusion which is not helpful for the colleague and also the organisation.

Q. The Inquiry heard evidence from Professor Bowers, an employment law expert, and one of the issues raised and I think by Professor Dixon-Woods as well, was the concept of a counter grievance. Concerns are raised and then there is a counter grievance and doctors, and presumably nurses, can find themselves subject to threat of referral to a disciplinary.

Is that something you have ever come across in your time as a Chief Executive, the sort of counter grievance when concerns have been raised about someone's work?

A. Yes, I have, yes, and it's not just confined

to clinical roles. I have seen -- it's not exactly proliferation, but certainly an increase in the response to a performance management process being a grievance, which is extremely difficult for all involved and can potentially derail a clear and objective process in the performance management side because people shy away from being the subject of a grievance.

So --

Q. So can you just unpack that a bit more for me please, so performance management when you are talking to somebody about their abilities to do a particular aspect of the job --

A. Yes.

Q. -- or work. So give us an example, obviously we don't need names, details, nothing like that, but give us an example of the type of situation you are describing?

A. So the example I will give you is around a member of our admin team who -- whose performance was not up to the level we would expect in a number of ways. Performance conversations were instigated with the manager and the response was to put in a grievance of bullying against the manager. So of course, in that situation, it's extremely difficult to objectively performance manage whilst at the same time the manager

doing that is subject to an investigation under a grievance. And I am seeing this happening more and more frequently.

Q. And you said earlier it puts people off performance managing. In terms of patients now, let's take it to the clinical space, what's the effect of that if this puts people off performance managing?

A. From a clinical perspective, I mean, in my experience it's actually way more common in a non-clinical arena than in the clinical arena although we are -- we are very clear that there have been instances where clinical failures, not in this current Trust but a clinical failure in a previous Trust resulted in a very complex series of legal processes including a tribunal for unfair treatment and it got very expensive and very difficult and clinical colleagues associated with it were left, you know, impacted.

So it's rarer in the clinical arena but it's not unheard of.

Q. That document can come down, please, and can we have INQ0108722, page 1. This is NHS Employers' Use of Settlement Agreements and Confidentiality Clauses document dated May 2024. It's page 1. If we look at page 2. NHS employers manage the relationships with NHS

Trade Unions on behalf of the Secretary of State for Health and Social Care, the overview on page 3, What is a Settlement Agreement on page 4 and Legal Requirements for a Valid Settlement Agreement on page 5.

The Kark Report, you may be familiar with that --

A. Yes.

Q. -- looked at settlement agreements and one of the conclusions made was this:

"It is not necessarily the agreement itself which is an issue but the nature of the reference that follows the director out of an employment into another.

"An agreement ought not to be able to prevent a reference from being full, open and honest."

Do you agree with that?

A. I do agree with that. And certainly I have seen references that are tempered just to give the basic facts of when an employment finished and started, days sick but obviously under the new Fit and Proper Persons Regulations the requirement for more fulsome and open references is, is very clear.

Q. And in your experience, was that needed, was that needed the recommendation that it should be very clear, that references should be fuller and open and honest?

A. Absolutely right. Yes. Certainly there was

a period of time whereby there was a caution around an open and honest reference on the basis that if that subsequently led to maybe a post being withdrawn or some sort of detriment then the organisation or the individual giving it could be sued and that was a real worry.

But we have to have an honest way of communicating to other employers when there are concerns.

Q. How does the Fit and Proper Person Test work from your perspective to address that?

A. Well, it's been enhanced from something which was very tick box about bankruptcy and criminal records to a much broader test whereby if there is full honesty in the way the process is completed then it would give that information without fear of retribution.

Q. Finally from me, Ms Tomkinson, you applied to the Countess of Chester in December 2022, didn't you, for the interim position and that is permanent in 2024.

What has the impact been first of all of you applying as an individual and thinking about that and if you can more widely within the hospital the events that happened in 2015 and '16 and the conviction of Letby, how has that impacted generally in terms of morale in the hospital or how people feel about the situation?

A. So on the basis of, you know, feedback from

teams and people and, you know, correspondence I have had from colleagues, it was a very welcome appointment. This sounds like I am blowing my own trumpet but it's based on information I have had.

Now, remember, I had a long history at the Countess of Chester as the Finance Director and Deputy Chief Executive up to 2011. I also applied for the Chief Executive's role when it was awarded in 2012, I wasn't successful but I had a history and a positive history with a lot of the people who were still in post and it's also my local hospital and I felt an affection but also an ability to be able to really support the turnaround programme.

So for me personally, it was difficult to come in and see some of the issues that were still evident in the Countess of Chester. The impact of the harms and deaths will never leave that hospital and rightly so. We will never forget it.

But people actually want the ambition, they want to focus on the future, learn from the past, but reshape the future in a different way and certainly the feedback I have had is that myself and the new Executive Team are making a significant difference at pace on delivery and culture and it's very welcomed.

Q. There was you deal with it in your fourth

statement and Simon Holden gave some evidence about there was a fundraising effort, wasn't there, to raise money. Do you want to tell us something about that?

A. So I think the Babygrow Appeal was launched -- I am guessing 2012, it is actually in the document apologies, I don't know the exact date.

Q. That's right.

A. Yes, to raise funds for a new neonatal unit because the old unit was very constrained by geography, it was dark, there were minimal facilities for parents to stay, if any, and it was not fit for purpose.

The fundraising appeal was designed to pay for a new unit which would have integrated family care at its heart and I think initially the target was to raise £3 million. There were some hiccups along the way and the decision was taken I think in 2018, to pause or to stop the fundraising and to in effect change the scope of the unit to sit within that financial envelope.

And that is the unit our neonates are cared for now and it is a wonderful facility. It's absolutely wonderful and meets the needs of parents, families and staff. So it was successful but it took a very long time to get there.

Q. And indeed I think Letby and other members of staff were approached at the time --

A. Yes.
Q. -- to provide photographs and profiles --
A. Yes.
Q. -- in conjunction with the local newspaper to assist the fundraising, is that right, there were a number of members of staff --
A. Yes, she and others were, yes.
Q. -- who had done that, and the atmosphere as far as you are aware in the neonatal unit now, how would you describe that?
A. So there are a number of things, quite clearly the Inquiry has had an impact on our teams either participating directly in giving oral evidence, providing witness statements, or in the preceding police investigation.

The team are excited for the future and moving to the new building but very much want to recognise when we can reinstate the Level 2 and again that's something which is hanging over the unit which it is difficult to manage because in their view if, you know, I as Chief Executive have been really pushing for this, with, you know, evidence and documents for nearly two years now and I have got no traction, what hope is there? And what we have to do is give them hope that we can restore those services for families, patients and staff at

significant pace because that is what they took on those roles for.

But they are, they are buoyant and, you know, they come in every day and we do not ever suffer from inadequacies on staffing because people are sick but there are a number of issues that really do need to be resolved which are possibly out of my hands.

MS LANGDALE: Thank you. Those are my questions, there will be some more from Mr Baker, King's Counsel and perhaps your own counsel, I think.

LADY JUSTICE THIRLWALL: Thank you, Ms Langdale. Mr Baker.

Questions by MR BAKER

MR BAKER: Ms Tomkinson, I ask questions on behalf of two of the Family groups.

The Families are concerned by two things: one is reflections on what went wrong and the other is genuine reassurance that this won't happen again.

A. Yes.
Q. And looking at the first question, reflections on what went wrong, to what extent do you think this was a cultural failing within the Trust rather than a failing of proper policies or protocols?
A. Policies and processes were there, they weren't followed. And in my view this is a relationship

and cultural issue which absolutely undermined what should have been really robust ways of escalating issues.
Q. Yes. So if we look at the types of policies that were in place at the time. There was a duty of candour and a very clear duty of candour protocol?
A. Yes.
Q. And an understanding of what the duty of candour was?
A. Yes.
Q. And it simply wasn't followed?
A. (Nods)
Q. There was a Speak Out Safely policy --
A. Yes.
Q. -- in place written down and communicated to people working within the Trust and not only was it not followed, the Families would say the Chief Executive sought to deliberately subvert it?
A. (Nods)
Q. There are also changes of communication, as it turned out, all the way to the Chief Executive, if necessary that were followed but didn't result in anything happening.

So if we look at the systems that were in place, the protocols, they all failed, didn't they?

A. They did.
Q. And they failed because culturally they weren't followed?
A. Correct.
Q. Now, you were asked at the very start of the questioning how things have changed and you said there's now a more open culture -- and I am paraphrasing because my ability to write things down isn't as good as it used to be -- but much more open to listening to staff, systems and processes, much more clearer on how to escalate concerns and patient safety issues and what they can expect in terms of speaking out and paediatricians would be able to escalate directly to the Chief Executive.

But in tangible terms, in terms of what has changed --
A. Yes.
Q. -- it's very difficult for you to point to things, isn't it, and say: this part of the culture has changed or this protocol is now different because protocols didn't matter as it turned out, and culture is very intangible isn't it, certainly in this environment?
A. (Nods)
Q. Because the reality is that if asked in 2015 or 2017 the senior Executives at the Countess of Chester

would have said: we have an open culture, we have a Speak Out Safely policy, we understand candour, and we have a positive patient safety orientated culture. Exactly as you have said.

So how do you reassure the Families the culture has changed?

A. So you can have all the policies and processes in the world but unless people feel accountable for following them, then they will never be effective and the accountability piece comes from a number of areas. One is around the expectations of the senior leadership in implementation but also audit and embedding.

But also with my lens, the culture is very much influenced by not just the words but the style and the action of the leaders and obviously I wasn't there at the time but from what I have read it feels like lip service was paid to Speak Out Safely, that there was a culture of fear, that the board was dominated by the views of a number of individuals, it was not a unitary board and that people were -- well, we know potentially threatened with punitive action if they didn't toe a particular line.

So if culture is a product of those behaviours and relationships, it was a bad one and people can say oh, yes we had all of this. But if you have a culture where

people feel closed down, that they don't feel safe that they don't feel senior leadership is approachable and open, then it will not deliver the safety culture that we would want for our patients.

And certainly my style is, is very, very different from that which was the leadership style in 2015 and from the Families' perspective and again it's just, I just cannot put into words what they must be feeling but what I can do is give them assurance that the culture there is very different, it's open, the relationships are positive and -- in the main because I can't say with certainty in every little pocket of 33 different specialties everyone feels safe.

All the mechanisms are there for it to be a safe organisation where people come forward and are listened to and, you know, I say I have an open-door policy which, which is true that that office is right in the heart of the hospital and I have conversations with portering staff, with hygiene staff, with patients, with clinicians, with Commissioners and I respond to requests to have conversations very, very quickly which possibly in the past that culture wasn't there.

So if I create that environment for people to operate in and my Executives are absolutely aligned to that and that cascades through the management tier,

I can assure as much as possible that the culture is different.

Q. But do you understand the cynicism on the part of the Families when they say Tony Chambers would have said exactly the same thing to us?

A. I do but, you know, the proof of the pudding is in the actions and the manner and the style and the track record and you can say anything but if it's not backed up with, with evidence, which I can, then it is meaningless.

But I really do accept the scepticism about, you know, words from somebody in a leadership position. But conversations can be had about how -- how do we -- do we make sure that the culture is different.

Q. Can I go to a few things that you have said, first of all in your witness statement. Paragraph 12 of your third statement, give me a moment while I bring up the so it's INQ0017160, paragraph 12, please, Mrs Killingback.

So this is about formal reporting processes in place to report concerns. Now, you point out at the start during the relevant period there were no formal reporting processes in place to report concerns such as concerns about Lucy Letby to the police.

Now, the opening part of that paragraph provides

implicitly that those systems are now in place but in fact in your evidence you confirm that there are no protocols in place for calling the police?

A. No, you are absolutely right. There are, we do not have a formal policy about how to escalate to the police.

What we do is have clarity on if there are concerns about escalation to leadership through local management up to the Executives and we are really clear about how we interact with the police and how we use our relationship and the telephone line to raise things and, indeed, four issues have been raised to the police in the last 12 months and the police have taken those investigations very seriously at pace and actions have been taken.

Q. The thing is, though, it was open in 2016 and indeed it happened that people who had concerns that were being escalated --

A. Yes.

Q. -- All the way to the highest level, the Chief Executive, about calling the police and there were discussions in June or July 2016 about calling the police and the Chief Executive said "Let's not do that", the Inquiry may conclude.

Surely of all things, that's a place for a protocol

that says: you are obliged to call the police in this position?

A. I would not disagree with you and I think certainly Professor Bowers made, made a similar point. Absolutely, we need clarity on the sort of issues and concerns that need to be escalated to the police and how people can do that.

There was nothing to stop anyone in the day and I accept the fact there was no formal policy to do it, there was nothing to stop anyone going to the police other than, from my reading, potential retribution through regulatory or other actions which if we link back to the culture piece is not the case now.

Q. But they did what you might expect them to do, the paediatricians and nurses to the Directors of Medical Director and Nursing Director, and the Medical and Nursing Director up to the Executive Board, the Chief Executive. At every stage up to the Chief Executive talking about police being called and the Chief Executive said "no" we would say the evidence shows.

So to suggest that anyone could have come out of that system and called the police themselves which of course they could have done --

A. Yes.

Q. -- it's unhelpful, isn't it, and the Families will say: well, of all the things that might have been done, all the changes that might have been made just the very basic step of having a protocol that says you call the police in these circumstances --

A. Yes.

Q. -- would be an obvious one.

And if the Families were looking for genuine change or genuine progress in culture, then writing that down might be a hallmark to them of something being done?

A. Yes, I agree entirely, indeed.

Q. Bereavement midwives.

A. Yes.

Q. You raised a question of bereavement midwives. How many bereavement midwives are there?

A. We have two full time bereavement midwives.

Q. And do they also work as midwives as well?

A. No, they are, that is their role.

Q. Now, a bereavement midwife is trained to provide support to those who have suffered the loss of a baby?

A. Yes.

Q. But they are not trained to provide formal counselling or therapy?

A. No.

Q. What they do is they signpost into adult mental health services?

A. That's correct, yes.

Q. How many appointments on average does the bereavement midwife have with affected families?

A. I can't answer that. Remember, the bereavement midwives also support pregnancy loss as well as stillbirth or subsequent death. But we can get that information to you.

Q. And their general caseload, you don't know what their caseload is?

A. It should be relatively low, given what we know about the numbers of deaths and stillbirths. What I can't tell you is how many early pregnancy loss visits they are involved in. But that information is definitely available.

Q. And so you don't know how many appointments on average a bereavement midwife would have with a person who suffers baby loss, whether it is one or three or ...

A. It will very much depend on the need of the patient. Some people don't want any contact. Others want very frequent contact for a protracted period of time but there is no limit to either input or the time period if families need that support.

Q. And if the support that's needed is formal, so

it's counselling or psychiatric assessment and care, the bereavement midwife can't do that, they just signpost them into mental health services?

A. Well, we have a perinatal mental health midwife as well who can -- who can offer some, some support -- we also have detective access to psychological services. We don't have a psychologist on site but we have a very good and strong relationship with Cheshire and Wirral Partnership who provide those services and on the same site.

Q. But do they get priority for a review referral through a bereavement midwife over and above if they had a referral from a GP, for example?

A. I don't know, I don't know that pathway but I can certainly come back to you.

Q. But there's no system within the hospital that ensures that those parents have counselling or that they have access to psychiatric treatment if they need it. Whether it be therapeutic or pharmacological?

A. Well, there is no set formula because it's so dependent on, on the family. But they would absolutely have access to all of those things.

Q. They would do likewise if they had a referral from their GP but again bereavement midwives as a service are trained to deal with people who suffered

baby loss?
A. That's right yes.
Q. But they don't actually provide any, any treatment or they don't actually provide any counselling or anything that might be needed in the event that a parent has suffered psychologically because of the loss of a baby?
A. So they would, they would signpost to the experts but they also have a hotline into our Fetal Medicine Service, which is a Consultant-led service that can offer that support as well.
Q. Yes, but the fetal medicine specialists, they assess the health of babies, unborn babies, they don't provide counselling or psychiatric treatment?
A. No, not counselling in that way.
Q. No.
A. No.
Q. And finally you may not know the answer to this question but the Families would be grateful if it could be provided. Your evidence was that it was the aim of the Trust to respond to complaints within 40 days.
A. Yes.
Q. What is the average response time for complaints within the Trust at the moment, median or

mean?
A. I don't know what the average is. But we, we certainly see conclusion in at least 90% of cases within 40 days.
Q. So it may be that you can provide confirmation of this but you would say 90% of complaints are resolved within 40 days?
A. Within 40 days, but it is monitored. But I will certainly provide that clarity.
MR BAKER: I am grateful, my Lady, I have no more questions.
LADY JUSTICE THIRLWALL: Thank you very much, Mr Baker.
Mr Kennedy.

Questions by MR KENNEDY

MR KENNEDY: Can I just take you back to a question which Mr Baker was asking about culture.
A. Yes.
Q. And just ask this follow-up question. If, as you say, culture is set at the top, how do you ensure that the culture that you believe is appropriate trickles down to levels below you in the organisation?
A. So if part of the translation of culture is around the values and behaviours of the leadership, we have a very clear framework for what the expectations

are for both those areas.
We also have a Civility Charter which has been developed by our staff which makes it clear that we expect colleagues to be treated respectfully.
In terms of how it's cascaded, that process and that information is shared through our operational management board and through the divisional structure. So I have an expectation and this is embedded through individual objectives that colleagues adhere to the Trust's values and behaviours and will be held to account if they -- if they do not demonstrate those on an ongoing basis.
Q. And how do you, how are you policing that? If you are holding them to account, how do you police when they need to be held to account?
A. Well, I would expect an escalation through -- it might be through HR process or Freedom to Speak Up or more informal mechanisms to say that people have not been adhering to the Trust's values. We have invoked disciplinary processes on the basis of values not being adhered to and that applies to every single member of staff, so, you know, bumping up to 6,000 people are expected to know those and to deliver them on an ongoing basis.
Q. And so if we just go back to cascading down

for a moment. Is your are your FTSU or Freedom to Speak Up pledges, is that part of cascading?
A. It absolutely is, yes.
Q. All right.
A. And I read the bulletin that went out today following team brief and again they are reiterated there. So just many, many mechanisms for making sure that people are clear on that.
Q. A separate topic, please and it's how information comes across your desk or comes across the desk of the senior leadership team.
You gave some evidence in answer to Ms Langdale's questions about things which are out of the ordinary?
A. Yes.
Q. And that was in the context of conversations between doctors and parents about things that were --
A. Yes.
Q. -- out of the ordinary.
Does the out of the ordinary come across your desk and if so, how?
A. Well, depending on -- on what it is and that's a real generality, I understand that. It absolutely does because the out of the ordinary is communicated at the daily 8 am meeting and things are either followed up or passed to the division through that pre-session.

Q. So if we take an example, you mentioned earlier in your evidence the baby who was dropped because the mother had a blood pressure drop?

A. Yes, yes.

Q. Is that something that will come across your desk at 8 am?

A. Yes, it would because it is an incident which would then be worked through.

Q. Then just conscious of time, how is that worked through? So what happens to that concern, it comes across your desk?

A. Yes.

Q. What happens to it from that point on?

A. So it's the formal Incident Review process which is done at divisional level. So as part of the Datix system there is a closure process. So incidents are logged but the person responsible for reviewing them is handed the incident and the system then records what the outcome is.

But for something that was slightly more unusual then I would personally be notified what the outcome was.

Q. And just in terms of gauging what is slightly more unusual, is the only example we have so far is the a baby being dropped?

A. Yes, yes.

Q. Does that fall into the slightly more unusual category?

A. Oh, yes.

Q. Right.

A. Yes.

Q. So matters come up to you and then go back down to the division for investigation?

A. They very rarely would come to me directly.

Q. Sorry, they come across the 8 o'clock meeting?

A. Yes. So the Executive are fully appraised of all incidents but we would tend to discuss the more severe or unusual ones.

Q. But they may then go down to the division for investigation?

A. Oh 100% they would, yes.

Q. Do they come back to the Executive Team at a later stage once they have been investigated to be signed off or ...

A. If they -- if they were significant harm, yes, absolutely. We wouldn't sign them off, we would review the data and pick up the learning but we need that two-way flow of information for, for bigger issues.

Q. And if there is learning, how is that cascaded?

A. So that is cascaded through the divisional processes or I think I referred to the weekly safety bulletin and the sharing and learning events. What we are currently doing is trying to develop a learning database so colleagues can access things in real-time through in effect one lens, because it is a bit clunky at the minute, but certainly the sharing and the learning is absolute crucial so we don't repeat errors.

Q. So the weekly safety bulletin, is that the same as the example that we looked at in answer to Ms Langdale's questions, the one which we saw your FTSU pledges, is that the weekly safety bulletin?

A. No, that is just my weekly Executive comms.

Q. Right.

A. The Director of Nursing and Deputy Chief Executive produces the weekly safety bulletin.

Q. Very well. So it is passed on electronically to staff in that way?

A. Yes, it is, yes.

Q. You talked also in the course of your evidence about a monthly team brief?

A. Yes.

Q. Is that relevant to the cascading of communication from this type of event that we are talking about to the staff?

A. Probably not. But if there were very significant learnings linked to something a bit more systemic, then absolutely it would be picked up through there. What we try to do is to share good practice through that team brief and that would be a mechanism but we wouldn't generally talk about, you know, about incidents at that forum. It's a different thing.

Q. So is it higher level than specific incidents?

A. It is higher level -- I mean we, we dip up and down depending what the issue is.

Q. And it's attended by whom? It is open to whom and attended by whom?

A. It is open to everyone so it is online because we don't actually have any big face-to-face facilities so we had one last week and I think there were 150 colleagues online. Now, you might say 150 out of nearly 6,000 is not great. We have to recognise, you know, clinical priorities.

But what we do ask is that colleagues who attend that team brief cascade it. It's also referenced in my weekly bulletin with a link to the video of it and there are printouts in all the areas.

So, you know, it is a multi factored thing but do 6,000 people read it? No, absolutely not.

Q. And the monthly team brief, is that a two-way

exercise or is that -- are people logging on to listen or can they interact with the process?

A. They can.

You know, I will say there is a Q&A, I think I have only ever had about two questions and they are always about car parking. But what we say if there is a question or issue that somebody wants to raise but doesn't want to do it publicly they send an email through and we pick it up through that mechanism through our comms team.

Q. Thank you, I will move on then.

Just briefly in terms of complaints, you were again asked by Mr Baker about timeframes. What is done about monitoring the frequency of complaints or any trends that may come out of complaints?

A. So it is monitored on a monthly basis, complaints, incidents and concerns. We don't just focus now on formal complaints. We also do work on concerns raised more informally so that is reviewed to pick up themes and trends in terms of where things have happened, what the issue is, whether or not there is a broader learning piece and that goes to the board in the quarterly report and also through the Quality and Safety Committee.

Q. So it's reviewed monthly by?

A. It's reviewed monthly by the operational board.

Q. So the operational management board?

A. Yes.

Q. And then goes quarterly to the Trust board?

A. To the Board of Directors but also to the Quality and Safety group who might want to deep dive into it.

Q. Very well. You mentioned in passing earlier the Quality Group or the Quality Safety Group?

A. Yes.

Q. And you said it's chaired by an ex-doctor?

A. Yes.

Q. Is that the Non-Executive that you described --

A. Yes.

Q. -- as being a former doctor?

A. Yes.

Q. Or a doctor?

A. Yes, yes, Dr Halsaw

Q. All right. Last point for me is this: you talked about the -- what we are dealing with here is the incidence of somebody causing deliberate harm. What do you say to the parents of those who were killed and harmed, what do you say to them now about how the Trust

would be able to identify that type of malicious actor?

A. So I think it's about the mitigations because any, any healthcare professional knows how to do harm if they were that way inclined. So what do we do to wrap round systems and processes to absolutely mitigate it and highlight it if deliberate harm was done?

And I think there are four things which are crucial: one is clinical process and pathways and clarity on standardisation. The second is around governance which is the collection and escalation of data. The third is physical environment so that is things like security access but also CCTV when appropriate, but the fourth and possibly the most effective is back to that culture which we have discussed a lot today, because if we have the relationships, the trust, the openness, the ability to speak out and the recognition that if we suspect somebody of doing harm, the right thing is to speak up immediately.

Then if we are creating those, that you know, that continuum of four things which are all mitigating against risk, it creates an environment which in my view and the view of my clinicians is -- is as safe as it can be, given the deliberate malicious actor can do things.

Q. And did you operate a similar system when you

were at the Liverpool Heart and Chest or a similar thought process?

A. So it was a very different environment at Heart and Chest. We didn't have anything as formal as that. But at the Countess obviously things just need to be a bit clearer and more focused given the -- you know, the breadth of work, we do, which we are focusing on neonatal, and rightly so, but there are 600 beds and 33 specialties and half a million patient contacts.

So we have got to make sure that it is applicable to everything which is why it is more complex at the Countess.

MR KENNEDY: Very well, my Lady, those are my questions, thank you.

LADY JUSTICE THIRLWALL: Thank you very much indeed, Mr Kennedy. Any other questions?

One or two from me if I may, Ms Tomkinson.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Is my note accurate, did you say there are 2,000 policies --

A. Yes.

LADY JUSTICE THIRLWALL: -- currently in the Countess of Chester

Is that typical so far as you know from your colleagues who are Chief Executives of other hospitals

in a hospital of that size?
A. That is probably about right. And servicing and keeping them updated and cascaded and embedded is extremely difficult.
So any form of standardisation across the NHS would be extremely welcome.
LADY JUSTICE THIRLWALL: Thank you. That was my second question and then the third part of it was: do you have any idea how much time, whether clinician time or managerial time or a mixture, is spent on formulating policies?
A. A significant amount. Remember, they are reviewed on a rolling basis.
LADY JUSTICE THIRLWALL: Yes.
A. So it might be three years before a policy is updated. But to produce something from scratch is massively time-consuming. Clinicians have time and job plans for similar duties but it is a big burden and, you know, let's be honest, quite bureaucratic in a number of areas.
LADY JUSTICE THIRLWALL: Yes. And Dr Brearey was saying he has, for example, 25% protected time for it.
A. Yes.
LADY JUSTICE THIRLWALL: That is what we call it in the judiciary, but 25% time for management.

A. Yes.
LADY JUSTICE THIRLWALL: In fact 100% of his time, his paid time, is on clinical duties, so the 25% is done in what people like to talk about as their own time?
A. Yes.
LADY JUSTICE THIRLWALL: In other words, unpaid. Is that fairly typical?
A. I think it depends on the service and the personal clinician. Remembering that job plans can be anywhere from, you know, 10 paid activities a week up to 14. But it very much varies on the role and the input of the clinician.
LADY JUSTICE THIRLWALL: So can I put it another way. Is it unusual for clinicians or indeed managers for that matter to be working outside the job plan in terms of the percentages?
A. No, it's not unusual at all.
LADY JUSTICE THIRLWALL: No, thank you. We have heard evidence, I don't know if you have had a chance to read any of it, from Sir Gordon Messenger and from Jeremy Hunt.
A. Yes.
LADY JUSTICE THIRLWALL: And each of them were suggesting that there are far too many targets for hospitals to have to deal with and that is very

diverting of energy.
Are they right in that respect from your perspective?
A. So I don't have a problem with targets because they are generally about how long patients have waited for care or the quality of that care. So there are a lot of targets and there's a lot of monitoring.
LADY JUSTICE THIRLWALL: How many are there, do you think?
A. Oh, absolutely dozens and dozens.
LADY JUSTICE THIRLWALL: I think we were told it is in the hundreds.
A. Oh there will be, when pick up all of the -- and it is not just the targets, it is the requirements of regulatory bodies as well.
But also it's how you delegate those targets and how you actually just roll them into business as usual and --
LADY JUSTICE THIRLWALL: So it may be then that it is a slightly more sophisticated question. If you removed targets altogether it isn't because you no longer want to know how long people are having to wait in any particular department because you probably do want to know that.
But it's a question of how you do it and if you set

targets, I assume a lot of management time can be spent on monitoring the target rather than what you have just described as rolling it into business as usual. Have I got that right, have I understood what you have said correctly?
A. Sort of.
LADY JUSTICE THIRLWALL: You explain what you mean then.
A. It's --
LADY JUSTICE THIRLWALL: How to roll it into business as usual.
A. Okay. So for me a target gives focus on what the priorities are through the Government so if this is our elective Government, those priorities should reflect the needs of the population. And anything that has a target is monitored and reviewed and acted upon. If targets were abolished, it would be down to local discretion to decide what was important and certainly when I talk to patients none of them like waiting so I think we are duty bound to absolutely minimise waiting through targets, minimise harms through, you know, infection targets and a whole raft of human resources targets which are about competency and diversity.
When I say business as usual, that is about are processes and systems being set up? So the data is

collected seamlessly, that the reporting is done seamlessly and that staff are really focused on understanding not just the exceptions but pre-empting pressure areas before they manifest as a target being missed. And that is sort of and parcel of the health service and good governance from my perspective.

LADY JUSTICE THIRLWALL: And so -- I mean, again it is very interesting to hear a different perspective, so the fact that you have got 100 -- over 100 targets and therefore 100 priorities does not lead to any difficulty in knowing what's the priority?

A. I -- I don't think so, my Lady. I think it gives focus. That's not the only focus because we have Trust priorities and service and specialty priorities which actually come from the divisions as well.

So the culture is we need to deliver on these because they are good for patients but actually we will devote equal time to innovation or research or expanding our offering and that -- that culture is embedded. Some people don't like the word "target" in healthcare.

LADY JUSTICE THIRLWALL: So what other word would they prefer?

A. I have pondered over this for many years and I can't come up with an answer. But what I always say is a target is about the quality of care and how long

people wait for that care so we shouldn't have a problem with it.

LADY JUSTICE THIRLWALL: So those are all timing targets?

A. Those are but obviously there are other targets.

LADY JUSTICE THIRLWALL: There are other sorts of targets?

A. Yes.

LADY JUSTICE THIRLWALL: Thank you.

So going back to the question about policies, the 2,000 policies that you have, is there any merit in just reducing the number of policies?

A. Oh, yes.

LADY JUSTICE THIRLWALL: And is there any merit in reducing the length of the policies?

A. Oh, yes.

LADY JUSTICE THIRLWALL: We have looked at a few today. And what's the plan for doing any of that? I am not suggesting you have got one but is there one?

A. So we are certainly reviewing all the policies through our excellent Director of Corporate Governance to see where there is duplication, where we can streamline, where we can steal from another organisation. But a policy might be 130 pages long for

good reason but actually we need to have a four of five page summary which sets out the key issues so people can very quickly be signposted where they need to be putting attention.

LADY JUSTICE THIRLWALL: Yes, I think we looked at the now very lengthy child protection or safeguarding policy.

A. Yes, yes.

LADY JUSTICE THIRLWALL: And I think you said well, the point is people know who to ask.

A. That's right.

LADY JUSTICE THIRLWALL: As to what to do.

A. Yes.

LADY JUSTICE THIRLWALL: Which of course may well be the answer but it rather suggests that all the time that is being spent on something very elaborate may well be better spent elsewhere?

A. You know, in all of that there is a -- a requirement through things like NHS Litigation Authority to be very clear on things, how we -- how we set out our stall in relation to doing certain things so there are some absolute must-dos but --

LADY JUSTICE THIRLWALL: I think it is NHS Resolution now, isn't it?

A. Yes, it is, yes.

LADY JUSTICE THIRLWALL: Thank you.

One last matter which I meant to ask you about. You mentioned BadgerNet.

A. Yes.

LADY JUSTICE THIRLWALL: And the input made there by people working in the hospital, and I thought I heard some evidence but I may have misremembered this, that BadgerNet was becoming less used.

Are you aware of that?

A. No, I am not, sorry.

LADY JUSTICE THIRLWALL: All right.

So then moving on to MBRRACE.

A. Yes.

LADY JUSTICE THIRLWALL: And you mentioned that one of the issues with that is the timelag between the kind of final polished data and data going in?

A. Yes.

LADY JUSTICE THIRLWALL: But were you aware that there is now an online real-time version of MBRRACE which clinicians have -- well, the hospitals have access to?

A. Yes, I was aware but my understanding is although there is real-time access.

LADY JUSTICE THIRLWALL: Yes.

A. The comparative reports are only produced very

infrequently so you can look at the themes and trends right across the NHS but there are moves to make that much more timely.

LADY JUSTICE THIRLWALL: Yes. But in terms of what is available to the clinicians in your hospital or any other hospital --

A. Yes.

LADY JUSTICE THIRLWALL: -- they have got their current data --

A. That's right.

LADY JUSTICE THIRLWALL: -- and how it compares with their own previous data.

A. Yes, yes.

LADY JUSTICE THIRLWALL: As well as the regional comparisons for that earlier period.

A. That's right, yes.

LADY JUSTICE THIRLWALL: And are you aware, this is not a question that we asked, I'm sure we could, but are you aware of how much use, if any, the paediatricians or the managers in the Countess of Chester are making of MBRRACE at the moment?

A. No, I'm sorry, I don't know the answer to that.

LADY JUSTICE THIRLWALL: All right. Thank you. Anybody want to ask any questions arising out of any

that have? No. Thank you very much indeed, Ms Tomkinson, you are free to go.

MS LANGDALE: My Lady it may be a good time to take the afternoon break before the next witness but we are in your hands. We are ready to do either.

LADY JUSTICE THIRLWALL: Very good I suppose if we start the next witness at 25 past we can then run through without putting too much of a burden on the shorthand writer. So we will rise now and come back there are at 25 past 3.

(3.11 pm)

(A short break)

(3.25 pm)

LADY JUSTICE THIRLWALL: Mr De La Poer.

MR DE LA POER: My Lady, the next witness is Ms Marquis who is coming to speak to the Royal College of Nursing and I wonder if she might come forward please.

LADY JUSTICE THIRLWALL: Do come forward, please Ms Marquis.

MS PATRICIA MARQUIS (affirmed)

Questions by MR DE LA POER.

LADY JUSTICE THIRLWALL: Do sit down.

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

A. Yes, Patricia Ann Marquis.

Q. Ms Marquis, is it correct that you have provided to the Inquiry two witness statements, one dated 21 March and the other 3 July both of last year?

A. Yes.

Q. And is the content of those witness statements true to the best of your knowledge and belief?

A. Yes.

Q. Did you qualify as a Registered Nurse in 1986?

A. I did.

Q. And bringing us forward to more recently, were you confirmed as the Director of the Royal College of Nursing England in 2022?

A. I was, yes.

Q. Was that following a period of about three years where you undertook that role on an interim basis?

A. Not three years where I undertook it on an interim basis, I was in and out of the job a few times but yes.

Q. So let's just deal with who the Royal College of Nursing is or what it is. Was it founded in 1916?

A. It was.

Q. And is it the largest professional body for nurses in the world?

A. It is, yes.

Q. And is its current membership something of the order of half a million people?

A. Yes, around 560,000.

Q. So just over. And does it as one of its functions seek to influence Government policy for the benefit of its members?

A. It does, yes.

Q. And does it also act to represent its members in certain contexts?

A. We do, both individually and collectively, yes.

Q. And are those the two principal functions of the College?

A. They are. But I think it's important to say we operate both as a Trade Union, which is what perhaps is described as the more traditional representative function but also as a professional Royal College, so we have two dual functions, Trade Union and professional Royal College.

Q. And does the RCN provide free confidential advice and information on a broad range of topics, including legal, employment and nursing practice?

A. Yes, it does.

Q. Now it is a separate and distinct organisation

from the Nursing and Midwifery Council; is that correct?
A. It is, absolutely, yes.
Q. And what is the RCN's -- what is nature of the RCN's relationship with the NMC?
A. So we would meet with them as an organisation that we would seek to influence at times in a general representative function and also as a Royal College to try to ensure that the function that the NMC is doing is there for the public and for patients but also is mindful of the needs of its -- the people that it regulates, so nursing -- nurses and nursing associates.
And we would also interact with them on an individual basis, where we may be representing individuals who are going through proceedings, for example, with the NMC.
Q. Is it a good and positive relationship, would you say?
A. I would say yes, but there is, there are often challenges of one nature or another, whether that's around the processes for example at the NMC so there are in the public domain concerns around some of how the NMC operates and we -- we may be raising concerns about how the NMC operates at any point in time. So there will be positive things and positive interactions much of the

time but there will also be occasions where we have got differences of views and may be raising concerns both on behalf of either individuals or collectively on behalf of the profession.
Q. Similarly, with the Care Quality Commission, does the RCN have a relationship with the CQC?
A. Less so with the CQC than we would with the NMC but we do have a relationship, we do meet on ad hoc basis with people at the CQC to discuss issues of concern or of mutual interest around regulation of health and social care settings that impacts on our members and we may at times work to raise issues about organisations for example with the CQC.
Q. Now, if we turn to the educational role that the RCN plays, can you just describe for us briefly, please, what education does the Royal College of Nursing provide to its members?
A. So as our professional Royal College function we have an interest in ensuring that patient care that is being delivered by nurses is as up to standard and up to best clinical practice as it should be. We have a range of forums, so you would call them sort of special interest groups of nurses that are working in particular areas of practice, who alongside some of our advisers may develop programmes or guidance about what

up-to-date clinical practice would look like in a -- you know, whatever the clinical area may be.
Our role is we have no regulatory authority and there's nothing that we do that is mandatory to anybody. We don't assess anybody's clinical practice and we don't provide education to support someone to become, for example, a Registered Nurse in the first place or gain another formal qualification in nursing.
Q. Now, Sir Cecil Clothier, when writing his report about Beverley Allitt, at Recommendation 13 said this:
"The main lessons from our Inquiry and our principal recommendation is that the Grantham disaster should serve to heighten awareness in all those caring for children of the possibility of malevolent intervention as a cause of unexplained clinical events."
A. (Nods)
Q. Now, that was over two decades ago.
To your knowledge, what steps have the Royal College taken to ensure that any training or educational material it provides ensures that that principle is included?
A. So whilst I have worked at the Royal College for quite a long time in various roles, my knowledge of what initially the response of the Royal College was, if

I am honest, would be limited. I was still in clinical practice when the report came out and, in fact, just for interest, was involved in looking at the recommendations in the area that I worked in to introduce and update practitioners at that time on some of the recommendations that -- that were made at that time.
In terms of subsequently, so we have developed guidance over the years around safeguarding children, caring for children, competencies, frameworks, et cetera around looking after both children and neonates and included within that guidance is usually reference to malevolent practice by other practitioners.
I would reflect that both in terms of our own guidance and in general practice experience, that there's been a number of other reports into children between the care of children between then and now, and guidance as it gets updated often reflects whatever that priority is at that moment in time and we have had a number of iterations of our guidance over recent years which have been submitted to -- some of which have been submitted to the Inquiry, where the thread of real focus on malevolent individual practice is still there but it's not the priority, the priority has turned to families, systems, other things that have been picked up through subsequent -- sadly, subsequent reviews.

Q. So if we just seek to consider this question by reference to some guidance which was in place at the time and I know you have had a chance to remind yourself of the detail of this document this morning.

INQ0102686, please.

So you tell me if I am wrong about this but given the title this may be thought to be the absent touchstone for the very issues that this Inquiry is looking into, would you agree in terms of the panoply of guidance that no doubt the RCN has distributed?

A. From an RCN perspective yes.

Q. This is the one we would turn to first?

A. (Nods)

Q. Having had an opportunity to consider the detail of this, this morning, and knowing that I was going to ask you to identify anywhere within this that would assist with the issue of a practitioner confronted with a situation where there is a possibility that a colleague is responsible for the harm, is there anywhere that we can look within this text that would help that person or bring that possibility to mind and if so, can you help direct us to it?

A. Yes, I think it is on page 18, the last paragraph or the last point that is made.

Q. So if we go to page 18, please, we will see

the part to which you are referring.

A. So under the "Managing allegations", it's quite difficult because of the overlay of the archive piece.

Q. Yes.

A. Thank you. So you have a duty to act, if you have concerns about the behaviour of a colleague or student, you should report them to the structures that were in place at that time.

So that's where it would reference concerns around colleagues.

Q. So a reminder of the obligation which I think comes from the NMC but which is adopted by the RCN as one of the expectations for members?

A. Yes.

Q. But in terms of what Sir Cecil Clothier was talking about, about the importance of when you approach a situation that you don't know what's gone wrong, the fact that one of the matters that you should think about, do we see that particular line of thought anywhere within this guidance?

A. No, I would, I would concede at that point. There are two subsequent iterations of this guidance, which we don't seem to have furnished the Inquiry with earlier. They have been sent to you subsequently.

Q. Yes, I can confirm and I am sure that you will be willing to exhibit those to a further witness statement so that we have them formally, but I think you sent to the Solicitor to the Inquiry this morning --

A. We did.

Q. -- or at least the organisation two further documents.

A. Yes.

Q. So you can deal with the relevant parts in that witness statement.

But just focusing upon this document before you can summarise what you know of those later documents.

So do you think it's fair to say that by the time we reach the guidance that's applicable for 2015/16/17, that really, Sir Cecil Clothier's wish, his exhortation that people should not forget, had in fact largely been forgotten?

A. I -- I probably wouldn't go as far as to say largely been forgotten but I think it has, it's evident, slipped down the list of priorities that are being picked up by our guidance and also by the documents that we are trying to pull together and reference. Our guidance is, is guidance on top of usually pulling together other, other people's guidance to bring it all into one place.

But yes, I do accept that it's not in the forefront of the document and of the guidance.

Q. And again people will be able to see the documents when you exhibit them to that further witness statement you have kindly said you will provide. But do you think that in the latest version of this equivalent guidance, that the issue that Sir Cecil was identifying is adequately dealt with or do you think that the wording could be tightened up even further?

A. I think it has been improved from where it is. It is now much more in the centre of the document and in the things that you should be looking for but I would reflect and would say, yes, it could be improved further.

Q. Because really what Sir Cecil was talking about, do you agree, is that when you are presented with that situation where you have a concern that you really need to include that as part of your thinking and so it needs to be front and centre at that early stage and what this guidance, which you say has been improved to some degree, is really looking at the back end once you've worked out that a colleague is responsible or may be, then it tells you what to do?

A. Yes.

Q. Well, we will leave that with you and perhaps

in your witness statement you can reflect upon that as well, please.

A. (Nods)

Q. I would like to turn to the topic of Freedom to Speak Up and in particular what you say in your second statement about the recognition by the Royal College of Nursing that there is a conflict of interest situation as between an RCN representative and the Freedom to Speak Up Guardian role and what I mean by that is that the same person ought not in the RCN's view occupy the same role?

A. Yes.

Q. And why do you think that conflict exists, what's led the RCN to identify that conflict?

A. So as you can see from my statement, there was a long deliberation around where -- what we should do to -- to address or consider this particular point.

The conflict, as we see it, comes from the fact that the primacy of the two roles is quite different so Freedom to Speak Up Guardians are Freedom to Speak Up Guardians and that is what they exist to do. An RCN representative, and particularly an RCN steward, their primary role is not the same, it is different and they will be supporting members through a whole range of things, you know, at any one time if they are supporting

a group, you know, a range of different people, individual members.

So the concern is two-fold really for us. One is about the primacy of the role and confusion around the role in which a member may be going to speak to someone and concern that if they are -- for example, if somebody is being represented or is raising concerns directly, are they raising them as an RCN representative for that RCN representative to guide them to discuss, to guide them what to do, which would be often referral to the Freedom to Speak Up Guardian; so we would see them as working together but not trying to replace and do the same thing.

So the conversation people come to us to ask, "I have got these concerns, what should I do?" and we would refer them to the Freedom to Speak Up Guardian in that instance.

But often if someone -- the majority of the work that our stewards and representatives are doing is not about speaking up. It is about, you know, "My employer is disciplining me" or I am, there's, "I am really unhappy about the annual leave allocation that I have been given." You know, those sorts of things.

So there are lots and lots of conversations that members want to have with someone with absolute

confidence to know that that is confidential to them and so it would remain confidential in terms of the support that that representative was giving to that individual member.

If there were issues of, of -- if a member was known as an RCN representative to be concerned about someone, sorry, representing someone about whom there were concerns we were also concerned that in what role would they be going to speak to them: as a representative or as a Freedom to Speak Up Guardian? And the confusion for other members around if they -- if another member may have concerns about the same person that is being represented by one of our representatives, where are they to go? They have nowhere else to go.

Q. So a situation in which genuine confusion may arise, I mean, isn't there perhaps a really acute problem with it, and I would like you to consider this; that if somebody is a steward for the RCN and they are approached as a Freedom to Speak Up Guardian to be told about a problem with a nurse that that immediately places them in a conflict position because ordinarily they would be representing the interests of the nurse, they would be listening sympathetically to the nurse's position and doing their best to improve the position for the nurse, whereas in fact they may be receiving

a complaint about a nurse?

A. (Nods).

Q. So a number of problems, do you agree?

A. Yes, yes.

Q. So why do you think it took until 2022 for it to be official policy that the same person could not occupy both roles?

A. I think because at that point, we, we had by then got a number of people who had started to become Freedom to Speak Up Guardians and, and the conversation took -- our, our internal structures for making decisions are sometimes a bit complex and take a while to work through. So you'll see a reference it had to go through various committees to also get agreed.

There were individuals who were -- really wished to continue in both roles and we needed to work through and some people's jobs relate to those things, so again we just needed to work through some of the practicalities to get agreement through those committees, but also to explore and be clear in our own minds that we did think this was the right decision and then work through the implications for a number of individuals for whom it affected.

Q. But if we take a step back. The whole concept of Freedom to Speak Up emerged 2015 or so and really

started to hit hospitals by 2016, we know that, and 17 is where the guardian role started to take up. But as an idea, it's been around for seven years, at least, prior to that decision and, of course, prior to that there was, as we know from the Countess of Chester, the Speak Up Safely regime, which not every hospital operated, but again it was well known that there was a sort of equivalent role for a designated officer under that.

Just members of the public may think that seven years-plus is a very long time for that to be figured out and in the meantime a number of individuals may have been put in an extremely difficult situation which they may not have easily been able to resolve. Do you think that's fair?

A. I think that is fair, although I think in reality Freedom to Speak Up Guardians beyond -- really didn't start to come into practice until 2017 and beyond, and it was a fairly slowish introduction in various, in lots of organisations and our conversations did start, as I say, and did take a while to work through. But I would acknowledge that it took a while for us to get to the point of making that decision and implementing that decision.

Q. My next topic is a brief one and that relates

to the management of medicine and in particular insulin. We don't need to deal with controlled drugs which are the subject of their own regime, which is statutory. But when it comes to insulin, do you agree that we have seen a number of instances in the past, including the facts that this Inquiry is investigating, where insulin has been used effectively as a weapon by practitioners, clinicians to hurt patients?

A. Yes.

Q. Does the RCN have a view on whether or not there needs to be some kind of extra safeguards built in around insulin in light of what we have seen? Is that something the RCN has considered bearing in mind that any additional administration or safeguards may impact upon its members?

A. It's not something that I am aware that we have considered as a, as a formal position to take.

As you can see, much of our guidance on medicines management we develop in conjunction with other relevant organisations trying to replace some of the guidance that existed previously. I think it's an interesting point. It's certainly something that we can consider, reconsider our position on. But at the moment, I don't think we have a position one way or the other.

Q. Because of course there are two sides to it.

On the one side, and most importantly, it protects patients but better accountability, better safeguards built around it also provides potentially some protection for those who routinely administer insulin?

A. I think it would need to be considered in the round because whilst it is obviously used as a weapon as you describe, it is also a very widely used drug very, very positively for 99% of the time, et cetera.

So there's just -- I would imagine there would need to be some real clinical consideration about the implications of, of changing the way it may be stored or used and thinking about the impact that that might have on patients who obviously are dependent on using insulin in many, many cases.

Q. We are going to turn now to the RCN's role representing individuals. Your witness statement deals with the fact that the RCN represents individuals who have raised a grievance, is that right?

A. Yes.

Q. The RCN also represents individuals when the subject of fitness to practise proceedings by the NMC, is that right?

A. Yes.

Q. On the facts that this Inquiry is investigating there was also -- there was an occasion

when there was a Royal College service review, where there appears to have been some form of representation, whether formal or informal, or support.

Is that an area where you would expect members to be bringing somebody from the RCN to support them when being interviewed by a service review or is it fact-specific?

A. Not -- we wouldn't necessarily represent people or support people. If they asked we would take it on a case-by-case basis as to what, what the review was, what their role in the review, et cetera, was. But it may happen sometimes and other times it won't happen.

Q. So the two main circumstances that I have touched upon, that of a grievance procedure and responding to fitness to practise proceedings, is there any difference in the way that the representative from the RCN would be expected to approach their role as representative in those two different circumstances?

A. In a grievance versus a --

Q. An NMC fitness to practise?

A. Yes. So for a grievance in the majority of cases, that would be from a member approaching us, same with NMC, approaching us with some area of concern, some issue of concern that they wish to address with their employer and the representative, whether that be an

elected representative, a steward or whatever, or whether that be an RCN member of staff would work through with that individual what their concern was, what the approach might be and whether taking a grievance might be the right approach or not very much led by the information that the individual member is presenting to you and to guide to the right process. Some people do not always understand the processes that are available to them.

And then a grievance would be supported by the representative, the elected representative or the member of staff. The member would usually write their grievance, they would give you the information of it, the representative would help shape it into something logical and that makes sense to people, et cetera, but the content would be owned by the individual member.

For the NMC, all of our members who have been reported to the NMC are represented by our legal team, not by representatives or local RCN officers. They would be represented by the legal team and the advocacy done by an advocate.

Q. Within the grievance, would you expect the non-legal representative to have an advocacy role, in other words, to speak on the member's behalf at the grievance hearing, to make points for them or are they

there -- or is the expectation that they are in a supportive role simply to ensure that the person feels empowered to say what they want to say?

A. The latter. In most cases, you wouldn't expect the representative to do most of the talking. They may raise or guide or question to help someone get their story across if they are very nervous for example, but you wouldn't expect them to be delivering the grievance to the panel or whatever the process is whether that be a representative or a member of staff.

That, that would be -- their role would be to guide and support the member to get their grievance across in that case. Different obviously if you are being represented by a legal person at the NMC. Obviously the individual member would speak for themselves but they would again be guided by a legal representative.

Q. Now, on a number of occasions throughout your statement, I can take you to any examples if you want me to, you use the word, as I am sure you recall, "collaboratively", that the RCN is engaging with people "collaboratively" and is that an important word when it comes to characterising how you would expect RCN members and representatives to engage with anybody else?

A. Yes. We don't -- we don't typically take an adversarial approach either to our members or to

employers and other stakeholders.

I think as a Trade Union with a dual role, maybe that influences the way we approach things, but we also maintain the boundary of knowing what's our role and being able to challenge organisations particularly other stakeholders when we are not happy with what -- but we would generally try to work collaboratively with people.

Q. Now, the Inquiry has received evidence from, among others, and there are several sources for this John Bowers KC, an employment expert, who spoke to the Inquiry about the way in which the grievance process has been misused within the NHS. We heard from the witness before you today Ms Tomkinson who talked about the weaponisation of the grievance process to respond when there are competence concerns about a particular individual.

Is that a concern that the RCN is aware of? Does the RCN see that happening and is that something that the RCN is at all concerned about given the potential impact on patient safety and the good functioning of the NHS?

A. It's not of particular concern to us. I think the -- I'm pretty clear that the way both our representatives and our staff operate is not to be weaponising it or using it as a tool to avoid.

Members will ask often to put a grievance in and there's oftentimes when we will say, "No, we don't think that's the right course of action" for a variety of reasons. But we wouldn't be promoting the use of it as a tool to delay or to distract, or whatever the word was, from whatever the issue in hand is.

We would only support a member to raise a grievance where we thought that it was genuinely an issue that needed to be raised and, sadly, in truth, in many cases employers are not always doing the right thing by their staff and so there are occasions when we may lodge a grievance in the middle of some other process. But it will be because we think there is something that an employer is doing that isn't fair to that individual.

Q. Do your staff and advisers and representatives receive training on the importance of ensuring that the focus on patient safety is not lost when they are acting in their representative function?

A. It is part of our -- it is part of our reps' training and our staff training absolutely to do that.

I think it is, it is clear that when the majority of what our members raise with us is done in confidentiality and that's maintained and it's not that there's elements, key elements of patient safety involved in everything that our representatives or our

staff are doing. But absolutely we would operate within a framework of confidentiality, but recognising and, you know, knowing that should there be concerns around the way an organisation, for example, is dealing with something what we would seek to raise those concerns ourselves.

Q. Now, if it be the case -- and we are dealing entirely hypothetically -- that the grievance process is being routinely misused, so we're not talking of occasionally but it is routinely being misused, would the RCN regard itself as having a role to play in setting that situation right?

A. Again, I think we would need to take it case by case. Yes, we, I -- we would be concerned if, if any process is being routinely abused by either an employer or by representatives and members.

But I think we would ... Trying to suggest -- I would be concerned about the suggestion that it is being routinely done in that way. We would -- that would not be our experience of the way certainly that our representatives are operating and our staff are operating; that they are deliberately using a grievance as a way to deviate away from whatever a core issue is.

It would be used when there is a concern about whatever's being done and legitimately something to be

raised as a grievance.

Q. Now, turning to the RCN's awareness of Letby at the time. Again you deal with this in your witness statement. I am just going to headline, I hope accurately, what you say.

Firstly, we know that Letby worked at the Liverpool Women's Hospital. Was the RCN aware of any concerns about her during that period?

A. No.

Q. Next, once she was working at the Countess of Chester, was the RCN aware of any concerns about her during that period?

A. Only when she was in contact with our representative but before that, no.

Q. And other than through that contact with your representative, was the RCN aware of any concerns about how Letby was being treated at the Countess of Chester Hospital, so, in other words, any of your nursing staff confidentially approaching the RCN in order to raise a concern on her behalf?

A. Other than her representative?

Q. Yes, other than through her representative?

A. No.

Q. Was the RCN as an organisation aware of Letby contacting her representative at the hospital at the

time?

A. We were aware that she was in contact with her representative, yes.

Q. So really just trying to understand the degree to which when a hospital representative for example is contacted by a member, that is fed back to the centre of the organisation --

A. Yes.

Q. -- so that it is an official case officially recorded where notes and records of what's said are passed back to the RCN.

Are you satisfied all that have occurred as it should have in relation to Letby's dealing with the RCN at the time?

A. So we have got a couple of processes that operate for contacts from members with us. A large -- a large proportion of contacts to the RCN come through our call centre so, which operates sort of 8 to 8, seven days a week.

A lot of members will contact us initially through that system and then be allocated a representative, either a local representative or a member of staff depending on the situation.

Individuals go directly to reps. The process, which is laid out very clearly, is that reps should

record on our case management system all contacts, all enquiries as we describe them, from individual members or indeed groups of members on our system, on our case management system. That is audited.

They get supervised and to the best of our knowledge, the majority of the time, people record what advice and contacts they are having with members, but I can't guarantee that that is the case all of the time.

Q. But in terms of Letby's case, which no doubt has been the subject of some internal scrutiny, are you satisfied that the RCN was seized of the facts it ought to have been seized of at the time that they were taking place in the hospital?

A. So in terms of the review of the case file, I think we would say that there was probably some -- the paperwork wasn't as, as -- what's the word? I can't think of the word but -- thorough as it, as it should have been or could have been from the local representative.

Q. From the local rep. Just so that we are clear. We are not here talking about what might be described as a steward, who I think was Hayley Griffiths, this is Tony Millea, is that right?

A. No, Tony's a member of staff.

Q. He's a member of staff. So who is

the representative who perhaps didn't give sufficient information?

A. So Tony's records are as complete as we can see. So the staff record is complete.

In terms of her local representative Hayley, her support, as, as would be described, there are very limited records from Hayley's interactions with her, with Lucy, or with the Trust.

Q. So, for example, did the RCN know about any support given around the Royal College of Children -- Paediatrics visit?

A. Sorry, I am not quite sure what you're --

Q. So the RCPCH --

A. Yes, review.

Q. -- visited, they conducted a service review.

We know from the evidence that we have heard that Hayley Griffiths gave some support, met with some of the people conducting the review. Was that the sort of information that was passed on to the RCN or wasn't?

A. No, that wasn't on the case file. No.

Q. In terms of any developments as a result of the RCN's internal investigation into what occurred and its involvement, what changes has the RCN made in terms of its way it approaches things, any of its policies, any of the training it provides? Can you help us with

that?

A. Yes. So I think in terms of individuals, so there is a structure already in place around individuals. So a representative at local level, elected representative stewards support and supervision, a clear requirement of keeping records up to date and our expectation -- and so we audit those things.

We, we have, not directly as a result of this case but more generally, recently are reviewing all of those things to ensure that particularly supervision, so supervision is the time when if things are not on the case file actually recorded, those are conversations that should happen that could then pick up those issues that are being missed in terms of the written document.

So ensuring that our supervision, that everyone is engaging properly in supervision, so that there are some changes and some tightening around the supervision element.

Reiterating our need to have robust records again is one of the things that we really recognise, not again just from this case but from others, the importance of keeping good records and ensuring that critical information is on file so that people are understanding, you know, what's actually happening with an individual in the support.

And then, finally, I think around the training and support for our representatives, and it links back to the point around -- I will focus on this: so the training and support recognising that we haven't been as explicit as we could have been to date around referencing and reminding our representatives around their safeguarding requirements that you alluded to earlier around raising concerns themselves.

It is covered and it is in there, but actually thinking through how we can improve that to make it clear so that we have got conversations that are particular to the sort of information our representatives may be receiving and putting that in the context of the training they receive from their employer.

Q. Now, I would just like to go back to a previous question, which explains why I was confused and it was my confusion, but perhaps you can help with this. When we look at the transcript of the grievance hearing, Ms Griffiths didn't attend that grievance hearing.

A. Yes.

Q. In fact, Mr Millea attended and is recorded as being the Trade Union rep?

A. Yes.

Q. Is that what the RCN would have expected to happen in terms of an employee of the RCN being at that hearing rather than the local rep?

A. It varies. It varies. So depending on the local situation, if there -- in some organisations we have no local rep, so it would always be a member of staff that would be picking up a grievance. In other organisations, we have one or more representative and depending on the individual they may well be supporting them.

In some cases, as it would appear happened here, there may be somebody who is taking on the more formal representative role, which is what I would describe Tony as doing, in terms of attending the formal hearings, et cetera. But where there's a lot of support to an individual for example or lots of meetings just in practical terms that is more difficult for someone who is based.

So Tony would have had a patch that was a lot more than one organisation, not be there on a daily basis, not able to make regular catch-ups or whatever, then there may be somebody who's the formal representative and someone who is representing them but is in a more support role.

Q. Has the RCN reviewed what its employee is

recorded as saying at that grievance hearing?
A. Not specifically to my knowledge. If there's something that you want to draw my attention to --
Q. Well, if you haven't reviewed it, I don't want to put you on the spot beyond if I just take one example; that what he's recorded as suggesting to the hearing is:
"Damage to the Trust too. They were protecting themselves as this would have been in the paper."
Regardless of whether that is true or not, and I am not commenting upon the truth of that statement, is that the sort of language the sort of comment that you would be expecting from somebody representing a member in a grievance hearing?
A. Again, I am not quite clear of the context.
I mean, obviously I'm clear of the context but the conversation around it. But I -- what I am aware of is that so you would expect organisations for example -- sorry, organisations -- representatives to challenge if we are faced with a situation where we are not clear about why X or Y is happening to an individual to say: You know, "If you have got more evidence that you are not presenting we need to understand that evidence." Or, "Why are you not escalating to this place or that place to enable that evidence to be presented?"

And I think in this case, what I am aware of is that Tony did raise with the organisation, with the Trust questions about whether they were going to engage the police for example at a certain point and if they hadn't, why not if they were that concerned?
Q. So language around that you would regard as being --
A. I would expect --
Q. -- appropriate and part of his role?
A. Yes.
Q. All right. We will turn to your final topic, which is recommendations, and you've set out a number of recommendations. There are just two that I would like to ask you about or seek your view on, which aren't included in your list.
A. Okay.
Q. So the first is whether the RCN has a view on board members holding multiple roles and if I just give you an example from our facts: that Alison Kelly was the Director of Nursing, which means that she operated under the unitary board principle of having a collective responsibility to the board that she was operating under.
She was of course simultaneously ultimately the line manager or the ultimate line manager for Letby.

She was the ultimate line manager for Letby's immediate line manager Eirian Powell. She was the Trust's lead for safeguarding and she was a Speak Out Safely designated officer and so plainly a number of roles, very often all aligned. But one can immediately see how there is a possibility for conflict.
Does the RCN have a view about how the most senior management within a Trust should be dividing those important roles and whether it's appropriate for one person to hold quite so many?
A. I can't answer that. We -- I haven't had that debate and I wouldn't want to give an organisational view when we haven't had that discussion explicitly.
Q. Does it follow from that that isn't particularly a problem that the RCN has identified up until now as impacting adversely on its members?
A. Not in the way that's been described.
So I think there have been discussions over the years around particularly nurse directors carrying multiple portfolios, not necessarily exactly as you describe them, but around -- and again not necessarily around -- well, some of it is around conflict, but some of it's also around expecting one person to be able to have a, you know, a very wide brief, which means that they can't necessarily function in the way or focus in

the way that we would hope they would be able to particularly on nursing from our perspective.
So there are -- there have been conversations round the role of Executive nurses and what that should look like, but not in the context that you are describing.
Q. In the context of what has been looked at, has any conclusion been reached? Is there any lobbying or engagement that's occurred to try and address what has been perceived as a potential problem?
A. Usually at local level because every Trust structure is different, so there's not a one-size-fits-all approach and often the conversations are around individual portfolios and how that combination of portfolios comes together. So not at collective level. But at local level there may be questions, particularly where there's Trust boards being reorganised, mergers, various things that happen where the conversation comes up around what is or isn't appropriate for board members to be holding.
Q. The second area for potential recommendation is the regulation of senior managers. Does the RCN have a view about whether or not senior managers should be the subject of regulation?
A. Again, I think there's been discussions around that and we haven't taken a view. Obviously all nurse

directors are regulated and are regulated by the NMC as a Registered Nurse midwife or whatever.

What we do think is that a boards and senior managers at board level should be equally accountable for lots of things for board level decisions on areas across the board, so staffing levels for example.

One of our really big concerns and the way in which lots of our guidance is angled is around concerns about decisions that Executives are making around staffing levels for example and that not sitting solely with one person but board accountability and people taking the risk, the patient risk element collectively as a board, collectively and individually as a board, is something we believe is, should be -- should be how it is.

Q. Now, we know there is a consultation open at the moment. Is the RCN proposing formally to respond to that as an organisation?

A. We will, yes.

MR DE LA POER: Well, given that by the sound of it the RCN has yet to finalise its position in terms of what it will say, I won't ask you to address that. You have already answered my previous question.

Ms Marquis, thank you very much indeed for answering my questions.

There are no Core Participant questions, my Lady.

LADY JUSTICE THIRLWALL: There are no questions from me either. So thank you very much indeed, Ms Marquis, for coming to give your evidence. You are free to go.

A. Thank you.

LADY JUSTICE THIRLWALL: That's the evidence for today?

MR DE LA POER: It is, my Lady.

LADY JUSTICE THIRLWALL: Have we got a final position on the evidence for tomorrow yet, Mr De La Poer? I know there was someone who was unable to come.

MR DE LA POER: Yes, I understand that some material will be read into the Inquiry record. My belief is that that will be how we start tomorrow and then we have two further witnesses for the balance of the day as previously advertised.

LADY JUSTICE THIRLWALL: Thank you, and the reason for that being the illness of one of the witnesses, first --

MR DE LA POER: Yes.

LADY JUSTICE THIRLWALL: I am sure that has already been communicated but just in case it hasn't, now you know. So we will start again tomorrow at 10 o'clock.

(4.17 pm)

(The Inquiry adjourned until 10.00 am, on Tuesday, 14 January 2025)

I N D E X