

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.

1

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

3

**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.

2

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

4

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

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

14 **Q.** Sorry, my question is slightly different,  
15 Ms Tomkinson.

16 **A.** Sorry.

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

19 **A.** Sorry, apologies.

20 **Q.** Not within the Trust itself, fellow staff.

21 Here you have got a member of staff, you are suspicious  
22 of her, or worried or concerned, however people put it  
23 at various times.

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

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1 happening?

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

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

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

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

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1 on a level of investigation or anything like that?

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

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

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

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

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

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1 parents are actively involved in that discussion.

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

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

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

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

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

20 "Nevertheless we have seen in some of our most  
21 poorly babies, those with high dependency needs,  
22 an increase in neonatal mortality rates for 2015 and  
23 2016 compared to previous years. In light of this we  
24 have asked for an independent review of our neonatal  
25 service from the Royal College of Paediatrics and Child

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1 Health."

2 We know of course at that stage there were concerns  
3 and suspicions of the paediatricians.

4 And if we can also go to another press release when  
5 you have had a chance to look at that one?

6 (Pause)

7 Have you read that?

8 **A.** Oh, sorry, yes.

9 **Q.** Yes. Then we can look at INQ0006049, page 1,  
10 please.

11 This is a press release 8 February 2017 and we see  
12 the third paragraph commenting on the RCPCH report:

13 "In the report, there is no single cause or fact  
14 identified to explain the increase we have had in the  
15 mortality numbers. The review makes a total of 24  
16 recommendations across a range of areas including  
17 compliance with standards, staffing, competencies,  
18 leadership, teamworking and culture. We are already  
19 working to implement these recommendations."

20 And at the bottom we see from Mr Harvey:

21 "This means when we speak with parents we can now  
22 share full and accurate information on an individual  
23 basis. We are desperately sorry for any distress or  
24 upset this review has caused."

25 So at both times the hospital were aware of

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1 risk to patients that hadn't been explored?

2 **A.** It's unlikely that it would be phrased in that  
3 way. It is more likely to have been phrased in the  
4 context of: there are still a number of unanswered  
5 questions. The reviews have not delivered the answers  
6 that we had, had hoped for and therefore more work will  
7 be ongoing to understand the cause of these involving  
8 the parents and Families of, of the children.

9 **Q.** Yes, thank you, that can go down now.

10 In your second statement, Ms Tomkinson, you set out  
11 the various issues raised by the parents and you  
12 summarised a letter that had been written by the parents  
13 of Mother A and B and setting out concerns about the  
14 long line and concerns about how Child A was treated.

15 And you also told us that Dr Jayaram had given  
16 a letter in response or drafted a response in  
17 February 2016.

18 Do you know if that letter was logged as a formal  
19 complaint anywhere and dealt with through a complaints  
20 system or was it an exchange of letters?

21 **A.** From, from my understanding that letter was  
22 not logged as a formal complaint and did not go through  
23 the formal complaints process which would ultimately  
24 have resulted in a letter from the Chief Executive to,  
25 to the Families.

11

1 suspicion or concern about Letby. But of course we  
2 don't see it in the press releases but again my  
3 question: before there had been an investigation and  
4 findings, whether that was on a civil standard of proof  
5 to balance of probabilities or a criminal standard, what  
6 could have been said, do you think, or do you think  
7 nothing could have been said because it was a member of  
8 staff and it was yet to be thoroughly investigated?

9 **A.** I think the press releases are spun in a way  
10 to in effect reduce the impact of concern and that, that  
11 may come back to that reputational piece.

12 It could have said there are a number of unanswered  
13 questions relating to the way children were cared for or  
14 the competencies in some areas and these will be subject  
15 to further review.

16 It would be very unlikely in advance of a, you  
17 know, a formal police investigation to talk about  
18 criminality. However, what we could have done was maybe  
19 flag that there were other concerns that were not  
20 addressed in those reviews and, therefore, there were  
21 still many, many questions that were left unanswered but  
22 that we were seeking answers for those families with  
23 a view to addressing those risk areas.

24 **Q.** So would it have been possible to highlight  
25 there was still an unascertained risk or potentially

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1 My understanding is that an email was sent in  
2 directly from the Family to -- to the unit and that was  
3 passed informally to Dr Jayaram, who, who answered it in  
4 that way and, and therefore it was not logged as an  
5 official complaint.

6 **Q.** Would that happen now: if issues were raised  
7 between parents and doctors they might be treated in  
8 that way more informally and exchange of either verbal  
9 information or letter or would you expect it to go  
10 through a complaints process?

11 **A.** My expectation is that it would be escalated  
12 immediately to the complaints department for, for  
13 logging and review and a formal process undertaken then  
14 to investigate again involving the Families with the  
15 process and the outcome.

16 **Q.** PALS of course is one vehicle for patients,  
17 parents making complaints, isn't it?

18 **A.** Yes.

19 **Q.** How do you, if you do, analyse the complaints  
20 you are getting via PALS?

21 **A.** So PALS have got a really clear process of, of  
22 logging and then escalating those complaints to the most  
23 relevant individual to -- to undertake the complaint.  
24 We aim to get responses within 40 days and it is a very  
25 structured process with a number of review steps in

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

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

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

14 **A.** Yes.

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

17 **A.** Yes.

18 **Q.** -- onwards. If we can start at the bottom of  
19 96 and scroll through, please, Mrs Killingback, so  
20 people have a chance to read 96, 97, 98, 99 and 100.

21 (Pause)

22 **A.** Yes.

23 (Pause)

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

13

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

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

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

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

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

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

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

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

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

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

25 I guess the complexity of assurance processes would

14

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

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

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

13 **A.** Yes.

14 **Q.** You say:

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

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

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

16

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

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

9 **A.** Mmm.

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

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

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

17

1 that typical of Trusts or ...

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

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

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

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

23 **Q.** Paragraph 111, you say the Trust utilised the  
24 NHS England Quality Surveillance Information System.

25 Can you tell us a bit about that?

19

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

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

10 **A.** Yes.

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

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

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

18

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

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

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

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

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

19 **A.** Yes.

20 **Q.** -- in that context.

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

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

20

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

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

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

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

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

21

1 with putting the data in?

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

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

13 **A.** Yes.

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

16 (Pause)

17 **LADY JUSTICE THIRLWALL:** Can you slow down, please.

18 (Pause)

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

22 **A.** Yes.

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

23

1 National Audit Programme, actually it does say it there.

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

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

10 **A.** No.

11 **Q.** That may be an issue?

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

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

19 **A.** Yes, they are, yes.

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

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

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

22

1 support to families instead of bereavement officers.

2 The Trust now has a bereavement midwife who visits  
3 families offering support and signposting families to  
4 counselling or to hospices.

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

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

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

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

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

24

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

4 **A.** The what, sorry?

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

8 **A.** Sorry?

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

11 **A.** Yes. So our, our bereavement midwives would,  
12 would service the babies who have died in the hospital.

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

15 **A.** Oh, absolutely yes, yes.

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

18 **A.** Yes.

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

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

25

1 now present day?

2 **A.** Yes.

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

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

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

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

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

25 (Pause)

27

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

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

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

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

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

24 **A.** Yes.

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

26

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

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

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

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

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

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

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

28

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

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

29

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

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

16 **Q.** A patient-facing role?

17 **A.** Yes.

18 **Q.** So find an administrative role or something?

19 **A.** Yes.

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

22 **A.** Yes.

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

25 **A.** Yes.

31

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

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

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

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

30

1 **Q.** Particularly around child protection:  
2 protecting children from risk is everyone's  
3 responsibility, risk of harm in a hospital or anywhere,  
4 isn't it?

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

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

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

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

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

25 Do you see in the top paragraph?

32



1 And we also see at page 4, named doctors for  
 2 safeguarding. So if you were to look at this policy you  
 3 can see it's Dr Isaac and Dr Mittal.  
 4 **A.** Yes.  
 5 **Q.** And again if we see page 30, a specific  
 6 section, Speak Out Safely:  
 7 "Responsibility of all members of staff to ensure  
 8 high standards of care, treatment are provided for all  
 9 patients and that all patients are safely in our care.  
 10 From time to time, staff may have concerns about the  
 11 care or treatment given to any patients including  
 12 children and young people and may wish to discuss these  
 13 with managers. They will be dealt with seriously and  
 14 promptly."  
 15 So on the face of it key messages are included and  
 16 the people to whom contact should be made?  
 17 **A.** (Nods)  
 18 **Q.** The 2022 policy, if we can go to that, please,  
 19 INQ0014166, page 1, I think this one reaches 50 pages,  
 20 so it's longer, my first observation: it is a lengthy  
 21 document, isn't it, this up-to-date policy?  
 22 **A.** Mm-hm.  
 23 **Q.** Let's see if we have got key messages from the  
 24 beginning. If we go to page 3, it's more legalistic  
 25 than its predecessor, or at least the one in 2015 to  
 33

1 in a hospital concerned or worried about what they need  
 2 to do who should they speak to and what should they do?  
 3 **A.** Yes.  
 4 **Q.** That would take quite a lot of time to go  
 5 through.  
 6 Then when we get to this appendix we see a list of  
 7 titles but no names. Is there a reason those roles  
 8 aren't populated with names?  
 9 **A.** I would suspect that they are not populated  
 10 because obviously the names change as people come and go  
 11 within the safeguarding team and through the  
 12 safeguarding training, we ensure that people know who  
 13 those key individuals are and I absolutely agree with  
 14 you that the complexity of policies which seem to be  
 15 written for, you know, every single circumstance are  
 16 really unwieldy and -- and difficult.  
 17 The way we cut through all of this complexity is by  
 18 being really clear about our safeguarding team and lead  
 19 who is absolutely available to support people if they  
 20 have any form of safeguarding concern at all and she is  
 21 very well known throughout the whole organisation.  
 22 **Q.** And do you have her name or other names on  
 23 notices or anywhere around the hospital?  
 24 **A.** Yes, we do.  
 25 **Q.** So what would a notice look like, what does it  
 35

1 2016, isn't it?  
 2 If we look at the third paragraph:  
 3 "To be effective ... requires staff members to  
 4 acknowledge their individual responsibility for  
 5 safeguarding and promoting the welfare of children as  
 6 well as the commitment of Trust management to support  
 7 them in this ..."  
 8 Paragraph 3, setting out duties under the  
 9 Children Act 2004.  
 10 And if we scroll through it, page 4, definitions,  
 11 categories, interventions, general principles,  
 12 categories of abuse?  
 13 **A.** Mmm.  
 14 **Q.** There is a diagram at page 8. Scroll through  
 15 a bit more, a bit slower I think so people can see the  
 16 various headings.  
 17 We can keep going, thank you.  
 18 (Pause)  
 19 Stop when we get to page 37, please,  
 20 Mrs Killingback.  
 21 (Pause)  
 22 Thank you.  
 23 If we stop at appendix 1 before we get there that is  
 24 quite a definitional document, isn't it, legalistic in  
 25 tone and I am wondering how practical it is for anyone  
 34

1 say?  
 2 **A.** Who to contact in the case of, her name is  
 3 Gill Cooper and obviously we, we know who the  
 4 safeguarding doctors are but there are also clinical  
 5 risk leads and child death support leads. So it's, it's  
 6 quite a complex number of people who are involved in  
 7 different aspects. But the presence of Gill Cooper in  
 8 our organisation ensures that people are really clear  
 9 who to contact if there are any safeguarding issues.  
 10 **Q.** I see she's the author contact of the policy  
 11 in the table at the bottom?  
 12 **A.** Yes, yes.  
 13 **Q.** Who is the policy written for, then, so if  
 14 staff rely on training or messaging within the hospitals  
 15 what is the purpose of spending ages on the policy? Who  
 16 looks at this stuff?  
 17 **A.** For me it's a backstop. So safeguarding  
 18 training is mandated for everyone in the Trust whether  
 19 in a clinical role or not and there are different levels  
 20 of training dependent on your role.  
 21 I guess the policy is there to provide absolute  
 22 clarity for queries so if the safeguarding issue was,  
 23 for example, a County Lines query, the information's in  
 24 there, it would take a while to get to it but it is set  
 25 out in the -- in the index but this is for every member  
 36

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

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

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

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

37

1 concerns were being discussed --

2 **A.** Yes.

3 **Q.** -- between members of staff.

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

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

17 So this is well known in the Countess of Chester  
18 now and, as I say, the safeguarding team, and there are  
19 13 of them, are very, very visible and are very well  
20 connected to the multi-agencies required to keep people  
21 safe internally and externally.

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

39

1 streamlining.

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

7 **A.** Yes.

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

10 **A.** Yes.

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

14 **A.** (Nods)

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

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

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

38

1 Inquiry?

2 **A.** Yes.

3 **Q.** And what people understood from that case and  
4 the risk of a nurse being on a unit deliberately causing  
5 harm, would you have been aware of that around 2015 to  
6 2016?

7 **A.** Yes, I was. Yes.

8 **Q.** How were you made aware of it?

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

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

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

40

1 see the second box?

2 **A.** Yes.

3 **Q.** Again my question is: do you think that is  
4 helpful to have this flowchart in a safeguarding policy?  
5 I just wondered why this one appears here.

6 **A.** I can't answer the question why it appears  
7 here. I -- I don't necessarily think it's helpful  
8 because clear and legitimate, I understand the, the data  
9 security requirements there. But it's so open to  
10 interpretation it could in theory close down information  
11 sharing.

12 **Q.** Without a further explanation about  
13 safeguarding concerns and protecting children being  
14 a need to share information that could worry someone,  
15 couldn't it, about whether they were able to pass on  
16 information, just left without any further explanation?

17 **A.** Yes, and we know that the multi-agency  
18 failures which have led to harm and death in children  
19 and vulnerable adults because of the lack of sharing  
20 information; but also the Information Commissioner is  
21 really clear about the requirements of information  
22 governance and sometimes there could be some conflict  
23 between those two things.

24 **Q.** That can come down now, please and we can have  
25 a look at the Speak Out Safely: Raising Concerns about

41

1 **A.** Mmm.

2 **Q.** -- to make it express?

3 **A.** Yes.

4 **Q.** But aside from that, if we look at the next  
5 page, page 6, again, at the time designated officers  
6 named in the document.

7 You also provided for us a document entitled  
8 "Patient safety is the responsibility of everyone at the  
9 Trust: safety and quality".

10 If you go to INQ0014138, page 1, this is Medical  
11 Director and the Director for Nursing and Quality at the  
12 time and if we go through the document, again if we can  
13 go through so people can read it.

14 (Pause)

15 INQ0014139, page 1.

16 I think each page we will have to go 139, 140, 141,  
17 et cetera, to get each page. But if we see this  
18 document, it sets out it very clearly if we can do that,  
19 please.

20 (Pause)

21 146 is the last one. And indeed we have seen that  
22 Just Culture Guide, Dr Jayaram produced that to the  
23 Inquiry.

24 So that information, that's a leaflet, is it?

25 I have seen a hard copy of that. You wouldn't know how

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1 Patient Care policy in place at the time.

2 That's at INQ0014171, page 1. Again, if we can  
3 scroll to the bottom of page 1, the purpose and over the  
4 next page1, "Raising concerns". Just pause there,  
5 "Raising concerns", if we can, to read.

6 And the "Being open" guidelines in the next  
7 paragraph as well.

8 (Pause)

9 If we then go to page 4 and 5, Public Interest  
10 Disclosure Act, whistleblowing, and particularly the  
11 examples on page 5.

12 "The following are examples of behaviours which may  
13 constitute malpractice where a concern may be raised.

14 "Systemic failings, for example, using broken  
15 equipment that could endanger patients or colleagues;

16 "Acts of violence, aggressive behaviour or  
17 discretion towards patients or staff;

18 "Inappropriate relationships between colleagues and  
19 patients;

20 "Substance or alcohol misuse that could potentially  
21 affect or be affecting the ability to work;

22 "The concealment of any of the above."

23 I suppose suspicions or concerns about a member of  
24 staff harming patients and children could be added there

25 --

42

1 that was circulated at the time.

2 **A.** No.

3 **Q.** But it sets out the position.

4 **A.** Yes, I don't know what was circulated at, at  
5 the time. It looks like this is some sort of  
6 presentation available for staff.

7 **Q.** If we see Freedom to Speak Up policy now in  
8 November 2022 and revised in July 2023, it's INQ0014172,  
9 page 1, and if we can go through this, please, it's not  
10 a lengthy document. It's about nine pages if we can  
11 just scroll through that.

12 (Pause)

13 We see on the last page names, people to contact,  
14 page 10.

15 Much clearer with flowcharts, would you agree?

16 **A.** (Nods)

17 **Q.** Who writes your policies? Do the Countess of  
18 Chester have their own team doing it and indeed every  
19 Trust have their own team doing it or is there  
20 a template from NHS England? How does it work getting  
21 your policies put together?

22 **A.** So we don't have a policy development team  
23 given that the policies are so different depending on,  
24 on what the topic area is. The policies are written by  
25 subject experts and consulted with peers. There are

44

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

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

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

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

18 **A.** Yes.

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

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

45

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

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

13 What roughly is your average turnaround with  
 14 a complaint?

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

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

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

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

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

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

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

15 What are you looking for there?

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

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

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

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

46

1 complaints?

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

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

9 **A.** Yes.

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

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

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

23 **Q.** You say:

24 "Where appropriate, an apology will be offered."

25 Do you do that on behalf of the Trust?

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

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

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

13 (11.25 am)

14 (A short break)

15 (11.40 am)

16 **LADY JUSTICE THIRLWALL:** Yes, Ms Langdale.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 based on the magnitude of risk.

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

5 **A.** Correct.

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

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

15 That's the only place that appears.

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

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

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

25 **A.** Absolutely, absolutely.

55

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

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

14 **A.** Yes, it is, yes.

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

17 **A.** Mmm.

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

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

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1 **Q.** -- time moves on?

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

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

10 **A.** Yes.

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

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

22 **Q.** Where do you see spin in that?

23 **A.** The what, sorry?

24 **Q.** Where do you see spin in that?

25 **A.** The spin about reputational damage. Words

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

5 **Q.** That can come down, please.

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

9 **MS LANGDALE:** Sorry July 2016.

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

12 **A.** 11 July after the deaths of two Triplets.  
13 That can come down, please, and then if we can have  
14 INQ0014160 page 1, this is April 2023, SUDiC guidance.  
15 151 pages of it. I am not going to suggest we scroll  
16 through all of that, but if we go to page 8, and if we  
17 can allow people a chance to read paragraphs 18 through  
18 to 31.

19 (Pause)

20 So we see at paragraph 24, Ms Tomkinson:

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

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1 page 101 and then 102, setting out contact details.

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

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

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

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

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

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

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

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

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

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

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

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

23 And there are names and details given there.

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

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

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

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

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

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

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

24 It then says:

25 "For deaths of children who are not normally

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1 resident in Cheshire, please also refer to relevant  
 2 local guidelines."  
 3 So something else?  
 4 **A.** Mmm, yes, that's obviously the Countess of  
 5 Chester serves a population of North Wales, Flintshire  
 6 and the guidelines in Wales are different, it's  
 7 a different system, it's called the PRUDIC, not the  
 8 SUDiC, so I think that is reference to children from  
 9 Flintshire.  
 10 **Q.** If we have that document down now, please, and  
 11 the Countess of Chester document guideline in the event  
 12 of a child death which is INQ0014161, page 1. Sorry,  
 13 that is not that one. It's 14161.  
 14 So this is a Countess of Chester document, isn't  
 15 it?  
 16 **A.** Yes, it is.  
 17 **Q.** Can we have a look at page 5 first. That sets  
 18 out guidance, doesn't it:  
 19 "Please discuss individual children with the  
 20 Coroner"?  
 21 **A.** Yes.  
 22 **Q.** But it sets out there -- you tell us what it  
 23 sets out there?  
 24 **A.** Sorry, which paragraph are you referring to?  
 25 **Q.** 1.4.2 on page 5.

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1 just looked at, the 160 pages, if it was a Sudden and  
 2 Unexpected Death?  
 3 **A.** Yes, indeed, yes. That I guess that is the  
 4 primary document, this is the more local lens for, for  
 5 the Countess and really picks up things that are not  
 6 incorporated in the very formal legal document of SUDiC.  
 7 **Q.** Well, if we go to page 30 and 31, there's  
 8 a checklist, isn't there, for staff following the death  
 9 of a child.  
 10 Dr Brearey told the Inquiry that it took him six  
 11 hours or so to complete forms after a child death. We  
 12 didn't ask him which ones he completed but as  
 13 an indication, that is a long time, isn't it, to spend  
 14 on this task?  
 15 **A.** (Nods)  
 16 **Q.** Do you think, looking at the two documents we  
 17 have, SUDiC and this, it could be streamlined and made  
 18 clearer?  
 19 **A.** Absolutely. These, these documents read like  
 20 a bit of a -- it is a really bad descriptor but a bit of  
 21 a brain dump on absolutely anything that can happen  
 22 anywhere and I think we have sort of lost the purpose of  
 23 this document and information that will actually add  
 24 value in terms of review, in terms of learning, in terms  
 25 of assessment that could then be used further down the

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1 **A.** Sorry, 142?  
 2 **Q.** Yes, 1.4.2.  
 3 **A.** Sorry, if you just repeat your question?  
 4 **Q.** Yes, the purpose of this policy "Managing  
 5 Child Death", what does it set out at 1.4.2?  
 6 **A.** So this is about the support to the families  
 7 and the compassionate side of what is a very legal and  
 8 clinical process. So this is the things that we, that  
 9 can be offered to families, to give them mementos of  
 10 their child and all of this is available to any, any  
 11 bereaved parent and is, is used not that there are  
 12 obviously many, many child deaths but we have had good  
 13 feedback on the empathy and compassion this shows to --  
 14 to those parents who want a memento.  
 15 **Q.** And this policy is 40 pages, isn't it, and  
 16 sets out from the Countess of Chester's perspective what  
 17 should be done when a child dies?  
 18 **A.** Yes.  
 19 **Q.** But we see reference above the section I have  
 20 just asked you to comment upon where it says:  
 21 "It may be deemed necessary to follow the  
 22 management of Sudden Unexpected Death in Infants And  
 23 Children (SUDiC) where a death occurs within 24 hours of  
 24 admission or is an unexpected death."  
 25 Would you expect them to follow the policy we have

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1 line for a broader purpose.  
 2 But I agree a six-hour document is, it is not  
 3 uncommon but it's not a good use of clinical time at  
 4 a point when clearly a child has lost their lives.  
 5 **Q.** That document can come down and then there is  
 6 a 2024 policy, INQ0108408, page 34, please. We see here  
 7 if we go over to page 35, that is page 34, 35:  
 8 "If in doubt follow SUDiC pathway in addition to  
 9 this document."  
 10 Now it tells you that at page 35 it looks like.  
 11 Can you see at the bottom?  
 12 **A.** Yes, yes.  
 13 **Q.** "If in doubt follow SUDiC", so 35 pages in.  
 14 Again, do you think it would be helpful just to say at  
 15 the outset on the front of any document relating to  
 16 SUDiC or child death what document needed to be filled  
 17 in and why?  
 18 **A.** It would and, you know, this is really  
 19 throwing out a lot of good learning around how do we  
 20 improve -- how do we improve our system for recording  
 21 things making sure that we have the right information  
 22 for whatever process follows.  
 23 But making it easy for people to -- to undertake  
 24 these, these things and you know, a 35-page document is  
 25 not ever going to be read in detail and will rely on

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

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

8 **A.** Is it, sorry --

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

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

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

15 **A.** Right.

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

18 **A.** Still not good.

19 **Q.** But you have to go some way in before you are  
20 told you might want to check if it is another process.

21 If we go to page 37, please, INQ37 page 4 of 18.

22 "Neonates":

23 "All deaths of babies less than 28 days old are  
24 subject to additional reporting requirements. Initial  
25 management should follow this document and an decisions  
65

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

3 (Pause)

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

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

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

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

21 But obviously they are two very different things  
22 but the Medical Examiner role is now well embedded  
23 within the organisation and our Patient Safety Director  
24 Dr Benton, he links in with the Medical Examiner as well  
25 as the Medical Director to ensure that we are picking up  
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1 proforma needs to be completed as well as CDOP  
2 referral."

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

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

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

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

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

23 **Q.** That can come down, please, and if we can go  
24 to part of your statement, your first statement that  
25 deals with Medical Examiners, INQ0017158, beginning at  
66

1 any issues but they do have regular contact.

2 **Q.** You say at paragraph 178:

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

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

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

10 **A.** Sorry, could you say --

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

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

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

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

23 "They essentially provide checks and balances  
24 to attending practitioner is appropriate, alongside  
25 considering all other aspects of care including any  
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1 family concerns."

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

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

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

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

24 And then paragraph 3:

25 "In readiness for an Executive meeting,

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1 MBRRACE who was clear that the report on the data for  
2 2015 to 2016 would not have been possible to see for the  
3 Countess of Chester management until 2018, it's  
4 two years before that data is fed back when the  
5 appropriate steps have been taken to determine its  
6 accuracy.

7 That can come down as well.

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

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

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

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

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

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

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

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

17 And we see the numbers set out there?

18 **A.** Mmm.

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

25 We have heard evidence from Professor Knight from

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1 **A.** Yes.

2 (Pause)

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

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

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

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

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1 complex.

2 I'm not sure I have answered your question. But  
3 it's -- there are so many different ways of doing it.

4 **Q.** Who draws down the data? You say it is  
5 available to you in real-time so what's, is it  
6 a clinician, are they risk people, who in the hospital  
7 now looks at the data that's coming back?

8 **A.** So the Datix incident data is reviewed  
9 initially every single day by our --

10 **Q.** Sorry, I don't mean from your internal Datix  
11 monitoring.

12 **A.** Oh, sorry.

13 **Q.** I mean from MBRRACE, or --

14 **A.** Oh, the MBRRACE.

15 **Q.** -- the QSPEC. Who's looking at the  
16 information or the numbers that you are being sent?

17 **A.** So it's reviewed by the governance team but  
18 remember that we sort of input into MBRRACE and the  
19 collation of it is done at a system-wide basis. But any  
20 of our neonatal leadership team can access MBRRACE to  
21 either input or to see. There is reference in the  
22 document about the timeliness of the reporting.

23 My understanding is it's still pretty out of date  
24 in MBRRACE, so there are other ways to get the data  
25 which we -- we use through network.

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1 who was dropped when the mother had a faint. So  
2 immediately the team are reviewing that incident to try  
3 and identify how we could have addressed this blood  
4 pressure issue and what we can do in future.

5 The recording of the incident and the cascade of  
6 learning will be done in a much more formal way through  
7 the weekly safety reviews, the weekly safety bulletins,  
8 which are available to all staff but if there are any  
9 sort of significant or maybe more complex learnings,  
10 they will be picked up potentially through audit days,  
11 through divisional governance, and potentially brought  
12 to the board.

13 So it's a bit of horses for courses. It depends on  
14 what the incident is and how we respond within that  
15 Patient Safety Response Framework.

16 **Q.** And the bulletins, are they emailed to staff?  
17 They all have an NHS email do they?

18 **A.** Yes, they are emailed but they are also popped  
19 up in your coffee areas. They are discussed, we do  
20 a monthly learning and sharing forum where case studies  
21 are brought along. It's multi-factored and I have to  
22 say we have had really good feedback from that method.

23 **Q.** Volume of email traffic. One person gave  
24 evidence to the effect that being cc'd into emails a lot  
25 of the time means they increase in number. I suppose it

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1 **Q.** And what's the most valuable data, where do  
2 you get the most valuable data in real-time from in  
3 terms of using it for patient safety to know what's  
4 happening at the time, can you give us an example of  
5 what's been helpful, maybe you can't now and you would  
6 need to go away and send it back to us where the data  
7 has been informative and you have been able to do  
8 something as a consequence of it when you have dug into  
9 it?

10 **A.** So I think the process we have in place now  
11 makes reviewing and access so, so much easier.

12 So every single morning at 8 o'clock we have  
13 a senior leadership team involving clinicians,  
14 Executives and various other people and that is about  
15 reviewing the organisation in terms of what's going on,  
16 in its broadest sense, but part of that meeting is  
17 focused on incidents and is a specific elements around  
18 the Women's and Children's Division and the incidents  
19 that have happened.

20 So knowing in real-time what has gone on in that  
21 division but importantly what people are doing about it,  
22 so my question is always what have we done to stop this  
23 happening again? And the magnitude of incidents ranges  
24 from fairly low grade to some significant ones.

25 So, for example, today I read an incident of a baby

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1 might not always be clear what you are being asked to  
2 do. Is that still a thing, you cc a number of people or  
3 is it very focused email traffic?

4 **A.** Yes, the -- the cc or even worse, the bcc  
5 facility creates a huge amount of traffic. However,  
6 an important communication like that should not be  
7 copied to all and you get pretty adept at sifting  
8 through the things that need looking at and  
9 understanding what needs attention and I did hear that  
10 piece of evidence and I agree about the volume. I'm not  
11 sure I agree with the way that it's, it was handled at  
12 the time.

13 **Q.** If you can go, please, to INQ0014065, page 1,  
14 Mrs Killingback, thank you, that is a bulletin you have  
15 sent bringing us more up to date in February 2024.  
16 A weekly bulletin from you and it's following the CQC  
17 report. While we are getting that up, the CQC, what do  
18 you see its role is and what's your professional  
19 relationship as a Chief Executive with the CQC like?

20 **A.** So the CQC obviously have a regulatory role  
21 which is, is pretty broad in its application.

22 I have always had a really good relationship with  
23 the CQC and I know they get a lot of bad press.  
24 However, and I am also a CQC Well-Led Inspector, so  
25 I should maybe declare that interest but I have always

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

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

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

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

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

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

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

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

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

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1 that relationship works really well.

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

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

5 You say:

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

9 **A.** Yes.

10 **Q.** Then over the page at page 2:

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

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

20 **A.** Yes.

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

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

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

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

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

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

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

6 So to be honest I could have done with a bit more  
7 time before they came in but it was what it was.

8 I think what I was really pleased about was that  
9 Well-Led had moved in a short space of time from  
10 "inadequate" to "requires improvement" and that  
11 similarly maternity and children's services had moved  
12 from "inadequate" to "requires improvement".

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

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

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

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

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1 into. Quite clearly, I would expect that these very,  
2 very basic things are, are done routinely and it doesn't  
3 wait for an inspection to flag that there are issues.

4 Some of the issues will be addressed particularly the  
5 one around the proximity of the maternity theatre in our  
6 new build which opens in the summer. Some were just  
7 addressed immediately as, you know, real "business as  
8 usual" basics.

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

12 **Q.** Leadership. There's reference there:

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

15 And if we go over the page to page 10:

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

18 How is the position now with leaders at the Trust?

19 **A.** Well --

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

22 **A.** Sorry?

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

25 **A.** Yes.

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

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

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

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

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

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

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1 **Q.** -- but how is it?

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

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

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

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

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

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

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

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

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

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

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

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

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

25 **A.** So we have the results for our Trust. What we  
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1 hospital, so not only could I walk round much, much more  
2 easily but people will call in. We can, we can go and  
3 talk to people in real-time if there are issues.

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

9 **Q.** Over the page, page 14:

10 "The Trust applied duty of candour appropriately.  
11 The Trust Serious Incident reports included explicit  
12 reference to duty of candour and details for how this  
13 had been carried out. The report showed patients  
14 received an apology without delay after an incident had  
15 occurred. The Trust monitored compliance with the  
16 requirement to complete the duty of candour within  
17 10 days of an incident occurring."

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

21 **A.** So duty of candour is a compulsory field on  
22 this Datix incident reporting system and it applies to,  
23 I think there are three criteria when duty of candour  
24 would apply. But the teams work on the basis of even if  
25 not all the formal three criteria for duty of candour is  
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1 don't have is the results that benchmark against other  
2 Trusts, but we can certainly provide you with it.

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

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

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

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

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

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

22 **Q.** Continue, please.

23 **A.** So when I came, the executive officers were in  
24 a different building, you know, a good quarter of a mile  
25 from the hospital. The priority was to get back in that  
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1 fulfilled they are open and honest with, with our  
2 patients.

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

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

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

18 "Following the review the Trust refreshed the  
19 policy and relaunched Freedom to Speak Up across the  
20 Trust. The relaunch included the recruitment and  
21 training of new Freedom to Speak Up champions and the  
22 implementation of a new Freedom to Speak Up network. At  
23 the time of our inspection the Trust had over 30 trained  
24 champions and a waiting list for staff to become  
25 champions. The network comprised of the Freedom to  
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1 Speak UP Executive Director, Non-Executive Director lead  
2 and the Freedom to Speak Up Guardian and the champions."

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

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

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

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

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

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

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

7 (Pause)

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

10 "Neonatal unit staffing:

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

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

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

21 Who are the recipients of that letter from you?

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

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

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

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

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

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

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

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

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

5 **Q.** So tell us what you were requesting here?

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

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

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

25 And the reason why returning to Level 2 was so

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

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

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

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

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

25 **Q.** So that never got off to starting?

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1 able to update us after that meeting?

2 **A.** No meeting has happened.

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

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

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

8 **Q.** Thank you.

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

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

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

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1 **A.** No, it has not progressed.

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

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

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

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

12 (12.56 pm)

(The luncheon adjournment)

14 (2.00 pm)

15 **LADY JUSTICE THIRLWALL:** Ms Langdale.

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

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

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

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

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

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

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

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

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

9 **A.** Yes.

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

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

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

25 So there are a number of forums she can raise and  
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1 **A.** Well, we have -- the board has to be assured  
2 that we are delivering on our requirements on  
3 performance targets, on quality indicators, on harm and  
4 risk and on financial management. And the  
5 Board of Directors is serviced with a number of reports  
6 which are produced monthly.

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

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

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

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

23 **A.** Yes, it certainly does. We can't have an  
24 objective board with overreliance on Executives. We  
25 need that independent challenge. Are the number of  
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1 escalate things but she has that ear of the board  
2 without restriction.

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

8 **A.** Okay. Sorry.

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

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

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

24 **Q.** And what do you consider the role of the board  
25 is in scrutinising quality and performance?  
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1 clinical colleagues on our board sufficient for the  
2 agenda? That's subject to opinion.

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

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

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

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

24 **Q.** And we have seen indeed in 2015 to 2016 and  
25 I am sure now neonatal networks in the region between  
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1 doctors, discussions about mortalities et cetera. Is  
2 there any effort to go outside a region, I mean across  
3 the country, not just your region, but to have  
4 discussions and learning across regions?

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

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

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

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

25 And identifying the priorities in there is really

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

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

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

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

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

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

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

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

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

16 **Q.** How do you do that?

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

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

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

4 Does that resonate with you or not?

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

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

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

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

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

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

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

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

9 Can you give us your views on that, please?

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

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

25 **Q.** You refer to the fact that there is  
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1 to clinical roles. I have seen -- it's not exactly  
2 proliferation, but certainly an increase in the response  
3 to a performance management process being a grievance,  
4 which is extremely difficult for all involved and can  
5 potentially derail a clear and objective process in the  
6 performance management side because people shy away from  
7 being the subject of a grievance.

8 So --

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

13 **A.** Yes.

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

18 **A.** So the example I will give you is around  
19 a member of our admin team who -- whose performance was  
20 not up to the level we would expect in a number of ways.  
21 Performance conversations were instigated with the  
22 manager and the response was to put in a grievance of  
23 bullying against the manager. So of course, in that  
24 situation, it's extremely difficult to objectively  
25 performance manage whilst at the same time the manager  
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1 professional regulation, so a number of managers will be  
2 doctors and nurses already regulated by the GMC or the  
3 NMC.

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

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

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

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

25 **A.** Yes, I have, yes, and it's not just confined  
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1 doing that is subject to an investigation under  
2 a grievance. And I am seeing this happening more and  
3 more frequently.

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

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

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

21 **Q.** That document can come down, please, and can  
22 we have INQ0108722, page 1. This is NHS Employers' Use  
23 of Settlement Agreements and Confidentiality Clauses  
24 document dated May 2024. It's page 1. If we look at  
25 page 2. NHS employers manage the relationships with NHS  
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1 Trade Unions on behalf of the Secretary of State for  
2 Health and Social Care, the overview on page 3, What is  
3 a Settlement Agreement on page 4 and Legal Requirements  
4 for a Valid Settlement Agreement on page 5.

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

6 **A.** Yes.

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

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

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

14 Do you agree with that?

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

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

25 **A.** Absolutely right. Yes. Certainly there was  
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1 teams and people and, you know, correspondence I have  
2 had from colleagues, it was a very welcome appointment.  
3 This sounds like I am blowing my own trumpet but it's  
4 based on information I have had.

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

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

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

25 **Q.** There was you deal with it in your fourth  
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1 a period of time whereby there was a caution around an  
2 open and honest reference on the basis that if that  
3 subsequently led to maybe a post being withdrawn or some  
4 sort of detriment then the organisation or the  
5 individual giving it could be sued and that was a real  
6 worry.

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

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

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

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

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

25 **A.** So on the basis of, you know, feedback from  
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1 statement and Simon Holden gave some evidence about  
2 there was a fundraising effort, wasn't there, to raise  
3 money. Do you want to tell us something about that?

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

7 **Q.** That's right.

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

12 The fundraising appeal was designed to pay for  
13 a new unit which would have integrated family care at  
14 its heart and I think initially the target was to raise  
15 £3 million. There were some hiccups along the way and  
16 the decision was taken I think in 2018, to pause or to  
17 stop the fundraising and to in effect change the scope  
18 of the unit to sit within that financial envelope.

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

24 **Q.** And indeed I think Letby and other members of  
25 staff were approached at the time --  
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1 A. Yes.  
 2 Q. -- to provide photographs and profiles --  
 3 A. Yes.  
 4 Q. -- in conjunction with the local newspaper to  
 5 assist the fundraising, is that right, there were  
 6 a number of members of staff --  
 7 A. Yes, she and others were, yes.  
 8 Q. -- who had done that, and the atmosphere as  
 9 far as you are aware in the neonatal unit now, how would  
 10 you describe that?  
 11 A. So there are a number of things, quite clearly  
 12 the Inquiry has had an impact on our teams either  
 13 participating directly in giving oral evidence,  
 14 providing witness statements, or in the preceding police  
 15 investigation.  
 16 The team are excited for the future and moving to  
 17 the new building but very much want to recognise when we  
 18 can reinstate the Level 2 and again that's something  
 19 which is hanging over the unit which it is difficult to  
 20 manage because in their view if, you know, I as Chief  
 21 Executive have been really pushing for this, with, you  
 22 know, evidence and documents for nearly two years now  
 23 and I have got no traction, what hope is there? And  
 24 what we have to do is give them hope that we can restore  
 25 those services for families, patients and staff at

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1 and cultural issue which absolutely undermined what  
 2 should have been really robust ways of escalating  
 3 issues.  
 4 Q. Yes. So if we look at the types of policies  
 5 that were in place at the time. There was a duty of  
 6 candour and a very clear duty of candour protocol?  
 7 A. Yes.  
 8 Q. And an understanding of what the duty of  
 9 candour was?  
 10 A. Yes.  
 11 Q. And it simply wasn't followed?  
 12 A. (Nods)  
 13 Q. There was a Speak Out Safely policy --  
 14 A. Yes.  
 15 Q. -- in place written down and communicated to  
 16 people working within the Trust and not only was it not  
 17 followed, the Families would say the Chief Executive  
 18 sought to deliberately subvert it?  
 19 A. (Nods)  
 20 Q. There are also changes of communication, as it  
 21 turned out, all the way to the Chief Executive, if  
 22 necessary that were followed but didn't result in  
 23 anything happening.  
 24 So if we look at the systems that were in place,  
 25 the protocols, they all failed, didn't they?

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1 significant pace because that is what they took on those  
 2 roles for.  
 3 But they are, they are buoyant and, you know, they  
 4 come in every day and we do not ever suffer from  
 5 inadequacies on staffing because people are sick but  
 6 there are a number of issues that really do need to be  
 7 resolved which are possibly out of my hands.  
 8 MS LANGDALE: Thank you. Those are my questions,  
 9 there will be some more from Mr Baker, King's Counsel  
 10 and perhaps your own counsel, I think.  
 11 LADY JUSTICE THIRLWALL: Thank you, Ms Langdale.  
 12 Mr Baker.  
 13 Questions by MR BAKER  
 14 MR BAKER: Ms Tomkinson, I ask questions on behalf  
 15 of two of the Family groups.  
 16 The Families are concerned by two things: one is  
 17 reflections on what went wrong and the other is genuine  
 18 reassurance that this won't happen again.  
 19 A. Yes.  
 20 Q. And looking at the first question, reflections  
 21 on what went wrong, to what extent do you think this was  
 22 a cultural failing within the Trust rather than  
 23 a failing of proper policies or protocols?  
 24 A. Policies and processes were there, they  
 25 weren't followed. And in my view this is a relationship

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1 A. They did.  
 2 Q. And they failed because culturally they  
 3 weren't followed?  
 4 A. Correct.  
 5 Q. Now, you were asked at the very start of the  
 6 questioning how things have changed and you said there's  
 7 now a more open culture -- and I am paraphrasing because  
 8 my ability to write things down isn't as good as it used  
 9 to be -- but much more open to listening to staff,  
 10 systems and processes, much more clearer on how to  
 11 escalate concerns and patient safety issues and what  
 12 they can expect in terms of speaking out and  
 13 paediatricians would be able to escalate directly to the  
 14 Chief Executive.  
 15 But in tangible terms, in terms of what has  
 16 changed --  
 17 A. Yes.  
 18 Q. -- it's very difficult for you to point to  
 19 things, isn't it, and say: this part of the culture has  
 20 changed or this protocol is now different because  
 21 protocols didn't matter as it turned out, and culture is  
 22 very intangible isn't it, certainly in this environment?  
 23 A. (Nods)  
 24 Q. Because the reality is that if asked in 2015  
 25 or 2017 the senior Executives at the Countess of Chester

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

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

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

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

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

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

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

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

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

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

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

25 Now, the opening part of that paragraph provides

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

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

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

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

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

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

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

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

19 **A.** Yes.

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

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

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

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

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

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

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

25 **A.** Yes.

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

3 **A.** That's correct, yes.

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

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

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

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

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

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

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

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

6 **A.** Yes.

7 **Q.** -- would be an obvious one.

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

11 **A.** Yes, I agree entirely, indeed.

12 **Q.** Bereavement midwives.

13 **A.** Yes.

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

16 **A.** We have two full time bereavement midwives.

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

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

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

22 **A.** Yes.

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

25 **A.** No.

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

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

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

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

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

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

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

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1 baby loss?

2 **A.** That's right yes.

3 **Q.** But they don't actually provide any, any  
4 treatment or they don't actually provide any counselling  
5 or anything that might be needed in the event that  
6 a parent has suffered psychologically because of the  
7 loss of a baby?

8 **A.** So they would, they would signpost to the  
9 experts but they also have a hotline into our Fetal  
10 Medicine Service, which is a Consultant-led service that  
11 can offer that support as well.

12 **Q.** Yes, but the fetal medicine specialists, they  
13 assess the health of babies, unborn babies, they don't  
14 provide counselling or psychiatric treatment?

15 **A.** No, not counselling in that way.

16 **Q.** No.

17 **A.** No.

18 **Q.** And finally you may not know the answer to  
19 this question but the Families would be grateful if it  
20 could be provided. Your evidence was that it was the  
21 aim of the Trust to respond to complaints within 40  
22 days.

23 **A.** Yes.

24 **Q.** What is the average response time for  
25 complaints within the Trust at the moment, median or

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1 are for both those areas.

2 We also have a Civility Charter which has been  
3 developed by our staff which makes it clear that we  
4 expect colleagues to be treated respectfully.

5 In terms of how it's cascaded, that process and  
6 that information is shared through our operational  
7 management board and through the divisional structure.  
8 So I have an expectation and this is embedded through  
9 individual objectives that colleagues adhere to the  
10 Trust's values and behaviours and will be held to  
11 account if they -- if they do not demonstrate those on  
12 an ongoing basis.

13 **Q.** And how do you, how are you policing that? If  
14 you are holding them to account, how do you police when  
15 they need to be held to account?

16 **A.** Well, I would expect an escalation through --  
17 it might be through HR process or Freedom to Speak Up or  
18 more informal mechanisms to say that people have not  
19 been adhering to the Trust's values. We have invoked  
20 disciplinary processes on the basis of values not being  
21 adhered to and that applies to every single member of  
22 staff, so, you know, bumping up to 6,000 people are  
23 expected to know those and to deliver them on an ongoing  
24 basis.

25 **Q.** And so if we just go back to cascading down

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1 mean?

2 **A.** I don't know what the average is. But we, we  
3 certainly see conclusion in at least 90% of cases within  
4 40 days.

5 **Q.** So it may be that you can provide confirmation  
6 of this but you would say 90% of complaints are resolved  
7 within 40 days?

8 **A.** Within 40 days, but it is monitored. But  
9 I will certainly provide that clarity.

10 **MR BAKER:** I am grateful, my Lady, I have no more  
11 questions.

12 **LADY JUSTICE THIRLWALL:** Thank you very much,  
13 Mr Baker.

14 Mr Kennedy.

15 Questions by MR KENNEDY

16 **MR KENNEDY:** Can I just take you back to a question  
17 which Mr Baker was asking about culture.

18 **A.** Yes.

19 **Q.** And just ask this follow-up question. If, as  
20 you say, culture is set at the top, how do you ensure  
21 that the culture that you believe is appropriate  
22 trickles down to levels below you in the organisation?

23 **A.** So if part of the translation of culture is  
24 around the values and behaviours of the leadership, we  
25 have a very clear framework for what the expectations

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1 for a moment. Is your are your FTSU or Freedom to Speak  
2 Up pledges, is that part of cascading?

3 **A.** It absolutely is, yes.

4 **Q.** All right.

5 **A.** And I read the bulletin that went out today  
6 following team brief and again they are reiterated  
7 there. So just many, many mechanisms for making sure  
8 that people are clear on that.

9 **Q.** A separate topic, please and it's how  
10 information comes across your desk or comes across the  
11 desk of the senior leadership team.

12 You gave some evidence in answer to Ms Langdale's  
13 questions about things which are out of the ordinary?

14 **A.** Yes.

15 **Q.** And that was in the context of conversations  
16 between doctors and parents about things that were --

17 **A.** Yes.

18 **Q.** -- out of the ordinary.

19 Does the out of the ordinary come across your desk  
20 and if so, how?

21 **A.** Well, depending on -- on what it is and that's  
22 a real generality, I understand that. It absolutely  
23 does because the out of the ordinary is communicated at  
24 the daily 8 am meeting and things are either followed up  
25 or passed to the division through that pre-session.

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1 Q. So if we take an example, you mentioned  
2 earlier in your evidence the baby who was dropped  
3 because the mother had a blood pressure drop?  
4 A. Yes, yes.  
5 Q. Is that something that will come across your  
6 desk at 8 am?  
7 A. Yes, it would because it is an incident which  
8 would then be worked through.  
9 Q. Then just conscious of time, how is that  
10 worked through? So what happens to that concern, it  
11 comes across your desk?  
12 A. Yes.  
13 Q. What happens to it from that point on?  
14 A. So it's the formal Incident Review process  
15 which is done at divisional level. So as part of the  
16 Datix system there is a closure process. So incidents  
17 are logged but the person responsible for reviewing them  
18 is handed the incident and the system then records what  
19 the outcome is.  
20 But for something that was slightly more unusual  
21 then I would personally be notified what the outcome  
22 was.  
23 Q. And just in terms of gauging what is slightly  
24 more unusual, is the only example we have so far is the  
25 a baby being dropped?

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1 A. So that is cascaded through the divisional  
2 processes or I think I referred to the weekly safety  
3 bulletin and the sharing and learning events. What we  
4 are currently doing is trying to develop a learning  
5 database so colleagues can access things in real-time  
6 through in effect one lens, because it is a bit clunky  
7 at the minute, but certainly the sharing and the  
8 learning is absolute crucial so we don't repeat errors.  
9 Q. So the weekly safety bulletin, is that the  
10 same as the example that we looked at in answer to  
11 Ms Langdale's questions, the one which we saw your FTSU  
12 pledges, is that the weekly safety bulletin?  
13 A. No, that is just my weekly Executive comms.  
14 Q. Right.  
15 A. The Director of Nursing and Deputy Chief  
16 Executive produces the weekly safety bulletin.  
17 Q. Very well. So it is passed on electronically  
18 to staff in that way?  
19 A. Yes, it is, yes.  
20 Q. You talked also in the course of your evidence  
21 about a monthly team brief?  
22 A. Yes.  
23 Q. Is that relevant to the cascading of  
24 communication from this type of event that we are  
25 talking about to the staff?

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1 A. Yes, yes.  
2 Q. Does that fall into the slightly more unusual  
3 category?  
4 A. Oh, yes.  
5 Q. Right.  
6 A. Yes.  
7 Q. So matters come up to you and then go back  
8 down to the division for investigation?  
9 A. They very rarely would come to me directly.  
10 Q. Sorry, they come across the 8 o'clock meeting?  
11 A. Yes. So the Executive are fully apprised of  
12 all incidents but we would tend to discuss the more  
13 severe or unusual ones.  
14 Q. But they may then go down to the division for  
15 investigation?  
16 A. Oh 100% they would, yes.  
17 Q. Do they come back to the Executive Team at  
18 a later stage once they have been investigated to be  
19 signed off or ...  
20 A. If they -- if they were significant harm, yes,  
21 absolutely. We wouldn't sign them off, we would review  
22 the data and pick up the learning but we need that  
23 two-way flow of information for, for bigger issues.  
24 Q. And if there is learning, how is that  
25 cascaded?

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1 A. Probably not. But if there were very  
2 significant learnings linked to something a bit more  
3 systemic, then absolutely it would be picked up through  
4 there. What we try to do is to share good practice  
5 through that team brief and that would be a mechanism  
6 but we wouldn't generally talk about, you know, about  
7 incidents at that forum. It's a different thing.  
8 Q. So is it higher level than specific incidents?  
9 A. It is higher level -- I mean we, we dip up and  
10 down depending what the issue is.  
11 Q. And it's attended by whom? It is open to whom  
12 and attended by whom?  
13 A. It is open to everyone so it is online because  
14 we don't actually have any big face-to-face facilities  
15 so we had one last week and I think there were 150  
16 colleagues online. Now, you might say 150 out of nearly  
17 6,000 is not great. We have to recognise, you know,  
18 clinical priorities.  
19 But what we do ask is that colleagues who attend  
20 that team brief cascade it. It's also referenced in my  
21 weekly bulletin with a link to the video of it and there  
22 are printouts in all the areas.  
23 So, you know, it is a multi factored thing but do  
24 6,000 people read it? No, absolutely not.  
25 Q. And the monthly team brief, is that a two-way

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1 exercise or is that -- are people logging on to listen  
2 or can they interact with the process?  
3 **A.** They can.  
4 You know, I will say there is a Q&A, I think I have  
5 only ever had about two questions and they are always  
6 about car parking. But what we say if there is  
7 a question or issue that somebody wants to raise but  
8 doesn't want to do it publicly they send an email  
9 through and we pick it up through that mechanism through  
10 our comms team.

11 **Q.** Thank you, I will move on then.  
12 Just briefly in terms of complaints, you were again  
13 asked by Mr Baker about timeframes. What is done about  
14 monitoring the frequency of complaints or any trends  
15 that may come out of complaints?

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

25 **Q.** So it's reviewed monthly by?  
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1 would be able to identify that type of malicious actor?  
2 **A.** So I think it's about the mitigations because  
3 any, any healthcare professional knows how to do harm if  
4 they were that way inclined. So what do we do to wrap  
5 round systems and processes to absolutely mitigate it  
6 and highlight it if deliberate harm was done?

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

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

25 **Q.** And did you operate a similar system when you  
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1 **A.** It's reviewed monthly by the operational  
2 board.  
3 **Q.** So the operational management board?  
4 **A.** Yes.

5 **Q.** And then goes quarterly to the Trust board?  
6 **A.** To the Board of Directors but also to the  
7 Quality and Safety group who might want to deep dive  
8 into it.

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

11 **A.** Yes.

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

13 **A.** Yes.

14 **Q.** Is that the Non-Executive that you  
15 described --

16 **A.** Yes.

17 **Q.** -- as being a former doctor?

18 **A.** Yes.

19 **Q.** Or a doctor?

20 **A.** Yes, yes, Dr Halsaw

21 **Q.** All right. Last point for me is this: you  
22 talked about the -- what we are dealing with here is the  
23 incidence of somebody causing deliberate harm. What do  
24 you say to the parents of those who were killed and  
25 harmed, what do you say to them now about how the Trust  
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1 were at the Liverpool Heart and Chest or a similar  
2 thought process?

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

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

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

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

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

18 Questions by LADY JUSTICE THIRLWALL

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

21 **A.** Yes.

22 **LADY JUSTICE THIRLWALL:** -- currently in the  
23 Countess of Chester

24 Is that typical so far as you know from your  
25 colleagues who are Chief Executives of other hospitals  
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1 in a hospital of that size?

2 **A.** That is probably about right. And servicing  
3 and keeping them updated and cascaded and embedded is  
4 extremely difficult.

5 So any form of standardisation across the NHS would  
6 be extremely welcome.

7 **LADY JUSTICE THIRLWALL:** Thank you. That was my  
8 second question and then the third part of it was: do  
9 you have any idea how much time, whether clinician time  
10 or managerial time or a mixture, is spent on formulating  
11 policies?

12 **A.** A significant amount. Remember, they are  
13 reviewed on a rolling basis.

14 **LADY JUSTICE THIRLWALL:** Yes.

15 **A.** So it might be three years before a policy is  
16 updated. But to produce something from scratch is  
17 massively time-consuming. Clinicians have time and job  
18 plans for similar duties but it is a big burden and, you  
19 know, let's be honest, quite bureaucratic in a number of  
20 areas.

21 **LADY JUSTICE THIRLWALL:** Yes. And Dr Brearey was  
22 saying he has, for example, 25% protected time for it.

23 **A.** Yes.

24 **LADY JUSTICE THIRLWALL:** That is what we call it in  
25 the judiciary, but 25% time for management.

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1 diverting of energy.

2 Are they right in that respect from your  
3 perspective?

4 **A.** So I don't have a problem with targets because  
5 they are generally about how long patients have waited  
6 for care or the quality of that care. So there are  
7 a lot of targets and there's a lot of monitoring.

8 **LADY JUSTICE THIRLWALL:** How many are there, do you  
9 think?

10 **A.** Oh, absolutely dozens and dozens.

11 **LADY JUSTICE THIRLWALL:** I think we were told it is  
12 in the hundreds.

13 **A.** Oh there will be, when pick up all of the --  
14 and it is not just the targets, it is the requirements  
15 of regulatory bodies as well.

16 But also it's how you delegate those targets and  
17 how you actually just roll them into business as usual  
18 and --

19 **LADY JUSTICE THIRLWALL:** So it may be then that it  
20 is a slightly more sophisticated question. If you  
21 removed targets altogether it isn't because you no  
22 longer want to know how long people are having to wait  
23 in any particular department because you probably do  
24 want to know that.

25 But it's a question of how you do it and if you set

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1 **A.** Yes.

2 **LADY JUSTICE THIRLWALL:** In fact 100% of his time,  
3 his paid time, is on clinical duties, so the 25% is done  
4 in what people like to talk about as their own time?

5 **A.** Yes.

6 **LADY JUSTICE THIRLWALL:** In other words, unpaid.  
7 Is that fairly typical?

8 **A.** I think it depends on the service and the  
9 personal clinician. Remembering that job plans can be  
10 anywhere from, you know, 10 paid activities a week up to  
11 14. But it very much varies on the role and the input  
12 of the clinician.

13 **LADY JUSTICE THIRLWALL:** So can I put it another  
14 way. Is it unusual for clinicians or indeed managers  
15 for that matter to be working outside the job plan in  
16 terms of the percentages?

17 **A.** No, it's not unusual at all.

18 **LADY JUSTICE THIRLWALL:** No, thank you. We have  
19 heard evidence, I don't know if you have had a chance to  
20 read any of it, from Sir Gordon Messenger and from  
21 Jeremy Hunt.

22 **A.** Yes.

23 **LADY JUSTICE THIRLWALL:** And each of them were  
24 suggesting that there are far too many targets for  
25 hospitals to have to deal with and that is very

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1 targets, I assume a lot of management time can be spent  
2 on monitoring the target rather than what you have just  
3 described as rolling it into business as usual. Have  
4 I got that right, have I understood what you have said  
5 correctly?

6 **A.** Sort of.

7 **LADY JUSTICE THIRLWALL:** You explain what you mean  
8 then.

9 **A.** It's --

10 **LADY JUSTICE THIRLWALL:** How to roll it into  
11 business as usual.

12 **A.** Okay. So for me a target gives focus on what  
13 the priorities are through the Government so if this is  
14 our elective Government, those priorities should reflect  
15 the needs of the population. And anything that has  
16 a target is monitored and reviewed and acted upon. If  
17 targets were abolished, it would be down to local  
18 discretion to decide what was important and certainly  
19 when I talk to patients none of them like waiting so  
20 I think we are duty bound to absolutely minimise waiting  
21 through targets, minimise harms through, you know,  
22 infection targets and a whole raft of human resources  
23 targets which are about competency and diversity.

24 When I say business as usual, that is about are  
25 processes and systems being set up? So the data is

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

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

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

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

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

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

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

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

8 **A.** Yes, yes.

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

11 **A.** That's right.

12 **LADY JUSTICE THIRLWALL:** As to what to do.

13 **A.** Yes.

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

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

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

25 **A.** Yes, it is, yes.

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

3 **LADY JUSTICE THIRLWALL:** So those are all timing  
4 targets?

5 **A.** Those are but obviously there are other  
6 targets.

7 **LADY JUSTICE THIRLWALL:** There are other sorts of  
8 targets?

9 **A.** Yes.

10 **LADY JUSTICE THIRLWALL:** Thank you.

11 So going back to the question about policies, the  
12 2,000 policies that you have, is there any merit in just  
13 reducing the number of policies?

14 **A.** Oh, yes.

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

17 **A.** Oh, yes.

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

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

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1 **LADY JUSTICE THIRLWALL:** Thank you.

2 One last matter which I meant to ask you about.

3 You mentioned BadgerNet.

4 **A.** Yes.

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

9 Are you aware of that?

10 **A.** No, I am not, sorry.

11 **LADY JUSTICE THIRLWALL:** All right.

12 So then moving on to MBRRACE.

13 **A.** Yes.

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

17 **A.** Yes.

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

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

24 **LADY JUSTICE THIRLWALL:** Yes.

25 **A.** The comparative reports are only produced very

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

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

7 **A.** Yes.

8 **LADY JUSTICE THIRLWALL:** -- they have got their  
9 current data --

10 **A.** That's right.

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

13 **A.** Yes, yes.

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

16 **A.** That's right, yes.

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

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

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

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1 **A.** Yes, Patricia Ann Marquis.

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

5 **A.** Yes.

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

8 **A.** Yes.

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

10 **A.** I did.

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

14 **A.** I was, yes.

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

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

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

23 **A.** It was.

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

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1 that have? No. Thank you very much indeed,

2 Ms Tomkinson, you are free to go.

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

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

11 **(3.11 pm)**

**(A short break)**

13 **(3.25 pm)**

14 **LADY JUSTICE THIRLWALL:** Mr De La Poer.

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

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

21 **MS PATRICIA MARQUIS (affirmed)**

22 **Questions by MR DE LA POER.**

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

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

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1 **A.** It is, yes.

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

4 **A.** Yes, around 560,000.

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

8 **A.** It does, yes.

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

11 **A.** We do, both individually and collectively,  
12 yes.

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

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

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

24 **A.** Yes, it does.

25 **Q.** Now it is a separate and distinct organisation

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1 from the Nursing and Midwifery Council; is that correct?

2 **A.** It is, absolutely, yes.

3 **Q.** And what is the RCN's -- what is nature of the  
4 RCN's relationship with the NMC?

5 **A.** So we would meet with them as an organisation  
6 that we would seek to influence at times in  
7 a general representative function and also as  
8 a Royal College to try to ensure that the function that  
9 the NMC is doing is there for the public and for  
10 patients but also is mindful of the needs of its -- the  
11 people that it regulates, so nursing -- nurses and  
12 nursing associates.

13 And we would also interact with them on an  
14 individual basis, where we may be representing  
15 individuals who are going through proceedings, for  
16 example, with the NMC.

17 **Q.** Is it a good and positive relationship, would  
18 you say?

19 **A.** I would say yes, but there is, there are often  
20 challenges of one nature or another, whether that's  
21 around the processes for example at the NMC so there are  
22 in the public domain concerns around some of how the NMC  
23 operates and we -- we may be raising concerns about how  
24 the NMC operates at any point in time. So there will be  
25 positive things and positive interactions much of the

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1 up-to-date clinical practice would look like in a -- you  
2 know, whatever the clinical area may be.

3 Our role is we have no regulatory authority and  
4 there's nothing that we do that is mandatory to anybody.  
5 We don't assess anybody's clinical practice and we don't  
6 provide education to support someone to become, for  
7 example, a Registered Nurse in the first place or gain  
8 another formal qualification in nursing.

9 **Q.** Now, Sir Cecil Clothier, when writing his  
10 report about Beverley Allitt, at Recommendation 13 said  
11 this:

12 "The main lessons from our Inquiry and our  
13 principal recommendation is that the Grantham disaster  
14 should serve to heighten awareness in all those caring  
15 for children of the possibility of malevolent  
16 intervention as a cause of unexplained clinical events."

17 **A.** (Nods)

18 **Q.** Now, that was over two decades ago.

19 To your knowledge, what steps have the  
20 Royal College taken to ensure that any training or  
21 educational material it provides ensures that that  
22 principle is included?

23 **A.** So whilst I have worked at the Royal College  
24 for quite a long time in various roles, my knowledge of  
25 what initially the response of the Royal College was, if

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1 time but there will also be occasions where we have got  
2 differences of views and may be raising concerns both on  
3 behalf of either individuals or collectively on behalf  
4 of the profession.

5 **Q.** Similarly, with the Care Quality Commission,  
6 does the RCN have a relationship with the CQC?

7 **A.** Less so with the CQC than we would with the  
8 NMC but we do have a relationship, we do meet on ad hoc  
9 basis with people at the CQC to discuss issues of  
10 concern or of mutual interest around regulation of  
11 health and social care settings that impacts on our  
12 members and we may at times work to raise issues about  
13 organisations for example with the CQC.

14 **Q.** Now, if we turn to the educational role that  
15 the RCN plays, can you just describe for us briefly,  
16 please, what education does the Royal College of Nursing  
17 provide to its members?

18 **A.** So as our professional Royal College function  
19 we have an interest in ensuring that patient care that  
20 is being delivered by nurses is as up to standard and up  
21 to best clinical practice as it should be. We have  
22 a range of forums, so you would call them sort of  
23 special interest groups of nurses that are working in  
24 particular areas of practice, who alongside some of our  
25 advisers may develop programmes or guidance about what

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1 I am honest, would be limited. I was still in clinical  
2 practice when the report came out and, in fact, just for  
3 interest, was involved in looking at the recommendations  
4 in the area that I worked in to introduce and update  
5 practitioners at that time on some of the  
6 recommendations that -- that were made at that time.

7 In terms of subsequently, so we have developed  
8 guidance over the years around safeguarding children,  
9 caring for children, competencies, frameworks, et cetera  
10 around looking after both children and neonates and  
11 included within that guidance is usually reference to  
12 malevolent practice by other practitioners.

13 I would reflect that both in terms of our own  
14 guidance and in general practice experience, that  
15 there's been a number of other reports into children  
16 between the care of children between then and now, and  
17 guidance as it gets updated often reflects whatever that  
18 priority is at that moment in time and we have had  
19 a number of iterations of our guidance over recent years  
20 which have been submitted to -- some of which have been  
21 submitted to the Inquiry, where the thread of real focus  
22 on malevolent individual practice is still there but  
23 it's not the priority, the priority has turned to  
24 families, systems, other things that have been picked up  
25 through subsequent -- sadly, subsequent reviews.

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

5 INQ0102686, please.

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

11 A. From an RCN perspective yes.

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

13 A. (Nods)

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

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

25 Q. So if we go to page 18, please, we will see  
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1 Q. Yes, I can confirm and I am sure that you will  
2 be willing to exhibit those to a further witness  
3 statement so that we have them formally, but I think you  
4 sent to the Solicitor to the Inquiry this morning --

5 A. We did.

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

8 A. Yes.

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

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

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

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

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1 the part to which you are referring.

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

5 Q. Yes.

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

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

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

15 A. Yes.

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

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

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

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

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

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

24 A. Yes.

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

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1 in your witness statement you can reflect upon that as  
 2 well, please.  
 3 **A.** (Nods)  
 4 **Q.** I would like to turn to the topic of Freedom  
 5 to Speak Up and in particular what you say in your  
 6 second statement about the recognition by the  
 7 Royal College of Nursing that there is a conflict of  
 8 interest situation as between an RCN representative and  
 9 the Freedom to Speak Up Guardian role and what I mean by  
 10 that is that the same person ought not in the RCN's view  
 11 occupy the same role?

12 **A.** Yes.

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

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

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

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

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

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

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1 a group, you know, a range of different people,  
 2 individual members.  
 3 So the concern is two-fold really for us. One is  
 4 about the primacy of the role and confusion around the  
 5 role in which a member may be going to speak to someone  
 6 and concern that if they are -- for example, if somebody  
 7 is being represented or is raising concerns directly,  
 8 are they raising them as an RCN representative for that  
 9 RCN representative to guide them to discuss, to guide  
 10 them what to do, which would be often referral to the  
 11 Freedom to Speak Up Guardian; so we would see them as  
 12 working together but not trying to replace and do the  
 13 same thing.

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

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

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

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1 a complaint about a nurse?

2 **A.** (Nods).

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

4 **A.** Yes, yes.

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

8 **A.** I think because at that point, we, we had by  
 9 then got a number of people who had started to become  
 10 Freedom to Speak Up Guardians and, and the conversation  
 11 took -- our, our internal structures for making  
 12 decisions are sometimes a bit complex and take a while  
 13 to work through. So you'll see a reference it had to go  
 14 through various committees to also get agreed.  
 15 There were individuals who were -- really wished to  
 16 continue in both roles and we needed to work through and  
 17 some people's jobs relate to those things, so again we  
 18 just needed to work through some of the practicalities  
 19 to get agreement through those committees, but also to  
 20 explore and be clear in our own minds that we did think  
 21 this was the right decision and then work through the  
 22 implications for a number of individuals for whom it  
 23 affected.

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

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

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

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

25 **Q.** My next topic is a brief one and that relates  
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1 On the one side, and most importantly, it protects  
 2 patients but better accountability, better safeguards  
 3 built around it also provides potentially some  
 4 protection for those who routinely administer insulin?

5 **A.** I think it would need to be considered in the  
 6 round because whilst it is obviously used as a weapon as  
 7 you describe, it is also a very widely used drug very,  
 8 very positively for 99% of the time, et cetera.

9 So there's just -- I would imagine there would need  
 10 to be some real clinical consideration about the  
 11 implications of, of changing the way it may be stored or  
 12 used and thinking about the impact that that might have  
 13 on patients who obviously are dependent on using insulin  
 14 in many, many cases.

15 **Q.** We are going to turn now to the RCN's role  
 16 representing individuals. Your witness statement deals  
 17 with the fact that the RCN represents individuals who  
 18 have raised a grievance, is that right?

19 **A.** Yes.

20 **Q.** The RCN also represents individuals when the  
 21 subject of fitness to practise proceedings by the NMC,  
 22 is that right?

23 **A.** Yes.

24 **Q.** On the facts that this Inquiry is  
 25 investigating there was also -- there was an occasion  
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1 to the management of medicine and in particular insulin.  
 2 We don't need to deal with controlled drugs which are  
 3 the subject of their own regime, which is statutory.  
 4 But when it comes to insulin, do you agree that we have  
 5 seen a number of instances in the past, including the  
 6 facts that this Inquiry is investigating, where insulin  
 7 has been used effectively as a weapon by practitioners,  
 8 clinicians to hurt patients?

9 **A.** Yes.

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

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

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

25 **Q.** Because of course there are two sides to it.  
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1 when there was a Royal College service review, where  
 2 there appears to have been some form of representation,  
 3 whether formal or informal, or support.

4 Is that an area where you would expect members to  
 5 be bringing somebody from the RCN to support them when  
 6 being interviewed by a service review or is it  
 7 fact-specific?

8 **A.** Not -- we wouldn't necessarily represent  
 9 people or support people. If they asked we would take  
 10 it on a case-by-case basis as to what, what the review  
 11 was, what their role in the review, et cetera, was. But  
 12 it may happen sometimes and other times it won't happen.

13 **Q.** So the two main circumstances that I have  
 14 touched upon, that of a grievance procedure and  
 15 responding to fitness to practise proceedings, is there  
 16 any difference in the way that the representative from  
 17 the RCN would be expected to approach their role  
 18 as representative in those two different circumstances?

19 **A.** In a grievance versus a --

20 **Q.** An NMC fitness to practise?

21 **A.** Yes. So for a grievance in the majority of  
 22 cases, that would be from a member approaching us, same  
 23 with NMC, approaching us with some area of concern, some  
 24 issue of concern that they wish to address with their  
 25 employer and the representative, whether that be an  
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1 elected representative, a steward or whatever, or  
 2 whether that be an RCN member of staff would work  
 3 through with that individual what their concern was,  
 4 what the approach might be and whether taking  
 5 a grievance might be the right approach or not very much  
 6 led by the information that the individual member is  
 7 presenting to you and to guide to the right process.  
 8 Some people do not always understand the processes that  
 9 are available to them.

10 And then a grievance would be supported by  
 11 the representative, the elected representative or the  
 12 member of staff. The member would usually write their  
 13 grievance, they would give you the information of it,  
 14 the representative would help shape it into something  
 15 logical and that makes sense to people, et cetera, but  
 16 the content would be owned by the individual member.

17 For the NMC, all of our members who have been  
 18 reported to the NMC are represented by our legal team,  
 19 not by representatives or local RCN officers. They  
 20 would be represented by the legal team and the advocacy  
 21 done by an advocate.

22 **Q.** Within the grievance, would you expect the  
 23 non-legal representative to have an advocacy role, in  
 24 other words, to speak on the member's behalf at the  
 25 grievance hearing, to make points for them or are they

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1 employers and other stakeholders.

2 I think as a Trade Union with a dual role, maybe  
 3 that influences the way we approach things, but we also  
 4 maintain the boundary of knowing what's our role and  
 5 being able to challenge organisations particularly other  
 6 stakeholders when we are not happy with what -- but we  
 7 would generally try to work collaboratively with people.

8 **Q.** Now, the Inquiry has received evidence from,  
 9 among others, and there are several sources for this  
 10 John Bowers KC, an employment expert, who spoke to the  
 11 Inquiry about the way in which the grievance process has  
 12 been misused within the NHS. We heard from the witness  
 13 before you today Ms Tomkinson who talked about the  
 14 weaponisation of the grievance process to respond when  
 15 there are competence concerns about a particular  
 16 individual.

17 Is that a concern that the RCN is aware of? Does  
 18 the RCN see that happening and is that something that  
 19 the RCN is at all concerned about given the potential  
 20 impact on patient safety and the good functioning of the  
 21 NHS?

22 **A.** It's not of particular concern to us. I think  
 23 the -- I'm pretty clear that the way both our  
 24 representatives and our staff operate is not to be  
 25 weaponising it or using it as a tool to avoid.

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1 there -- or is the expectation that they are in  
 2 a supportive role simply to ensure that the person feels  
 3 empowered to say what they want to say?

4 **A.** The latter. In most cases, you wouldn't  
 5 expect the representative to do most of the talking.  
 6 They may raise or guide or question to help someone get  
 7 their story across if they are very nervous for example,  
 8 but you wouldn't expect them to be delivering the  
 9 grievance to the panel or whatever the process is  
 10 whether that be a representative or a member of staff.

11 That, that would be -- their role would be to guide  
 12 and support the member to get their grievance across in  
 13 that case. Different obviously if you are being  
 14 represented by a legal person at the NMC. Obviously the  
 15 individual member would speak for themselves but they  
 16 would again be guided by a legal representative.

17 **Q.** Now, on a number of occasions throughout your  
 18 statement, I can take you to any examples if you want me  
 19 to, you use the word, as I am sure you recall,  
 20 "collaboratively", that the RCN is engaging with people  
 21 "collaboratively" and is that an important word when it  
 22 comes to characterising how you would expect RCN members  
 23 and representatives to engage with anybody else?

24 **A.** Yes. We don't -- we don't typically take an  
 25 adversarial approach either to our members or to

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1 Members will ask often to put a grievance in and  
 2 there's oftentimes when we will say, "No, we don't think  
 3 that's the right course of action" for a variety of  
 4 reasons. But we wouldn't be promoting the use of it as  
 5 a tool to delay or to distract, or whatever the word  
 6 was, from whatever the issue in hand is.

7 We would only support a member to raise a grievance  
 8 where we thought that it was genuinely an issue that  
 9 needed to be raised and, sadly, in truth, in many cases  
 10 employers are not always doing the right thing by their  
 11 staff and so there are occasions when we may lodge  
 12 a grievance in the middle of some other process. But it  
 13 will be because we think there is something that  
 14 an employer is doing that isn't fair to that individual.

15 **Q.** Do your staff and advisers and representatives  
 16 receive training on the importance of ensuring that the  
 17 focus on patient safety is not lost when they are acting  
 18 in their representative function?

19 **A.** It is part of our -- it is part of our reps'  
 20 training and our staff training absolutely to do that.

21 I think it is, it is clear that when the majority  
 22 of what our members raise with us is done in  
 23 confidentiality and that's maintained and it's not that  
 24 there's elements, key elements of patient safety  
 25 involved in everything that our representatives or our

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1 staff are doing. But absolutely we would operate within  
2 a framework of confidentiality, but recognising and, you  
3 know, knowing that should there be concerns around the  
4 way an organisation, for example, is dealing with  
5 something what we would seek to raise those concerns  
6 ourselves.

7 **Q.** Now, if it be the case -- and we are dealing  
8 entirely hypothetically -- that the grievance process is  
9 being routinely misused, so we're not talking of  
10 occasionally but it is routinely being misused, would  
11 the RCN regard itself as having a role to play in  
12 setting that situation right?

13 **A.** Again, I think we would need to take it case  
14 by case. Yes, we, I -- we would be concerned if, if any  
15 process is being routinely abused by either an employer  
16 or by representatives and members.

17 But I think we would ... Trying to suggest --  
18 I would be concerned about the suggestion that it is  
19 being routinely done in that way. We would -- that  
20 would not be our experience of the way certainly that  
21 our representatives are operating and our staff are  
22 operating; that they are deliberately using a grievance  
23 as a way to deviate away from whatever a core issue is.

24 It would be used when there is a concern about  
25 whatever's being done and legitimately something to be  
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1 time?

2 **A.** We were aware that she was in contact with  
3 her representative, yes.

4 **Q.** So really just trying to understand the degree  
5 to which when a hospital representative for example is  
6 contacted by a member, that is fed back to the centre of  
7 the organisation --

8 **A.** Yes.

9 **Q.** -- so that it is an official case officially  
10 recorded where notes and records of what's said are  
11 passed back to the RCN.

12 Are you satisfied all that have occurred as it  
13 should have in relation to Letby's dealing with the RCN  
14 at the time?

15 **A.** So we have got a couple of processes that  
16 operate for contacts from members with us. A large --  
17 a large proportion of contacts to the RCN come through  
18 our call centre so, which operates sort of 8 to 8, seven  
19 days a week.

20 A lot of members will contact us initially through  
21 that system and then be allocated a representative,  
22 either a local representative or a member of staff  
23 depending on the situation.

24 Individuals go directly to reps. The process,  
25 which is laid out very clearly, is that reps should  
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1 raised as a grievance.

2 **Q.** Now, turning to the RCN's awareness of Letby  
3 at the time. Again you deal with this in your witness  
4 statement. I am just going to headline, I hope  
5 accurately, what you say.

6 Firstly, we know that Letby worked at the Liverpool  
7 Women's Hospital. Was the RCN aware of any concerns  
8 about her during that period?

9 **A.** No.

10 **Q.** Next, once she was working at the Countess of  
11 Chester, was the RCN aware of any concerns about her  
12 during that period?

13 **A.** Only when she was in contact with  
14 our representative but before that, no.

15 **Q.** And other than through that contact with  
16 your representative, was the RCN aware of any concerns  
17 about how Letby was being treated at the Countess of  
18 Chester Hospital, so, in other words, any of your  
19 nursing staff confidentially approaching the RCN in  
20 order to raise a concern on her behalf?

21 **A.** Other than her representative?

22 **Q.** Yes, other than through her representative?

23 **A.** No.

24 **Q.** Was the RCN as an organisation aware of Letby  
25 contacting her representative at the hospital at the  
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1 record on our case management system all contacts, all  
2 enquiries as we describe them, from individual members  
3 or indeed groups of members on our system, on our case  
4 management system. That is audited.

5 They get supervised and to the best of our  
6 knowledge, the majority of the time, people record what  
7 advice and contacts they are having with members, but I  
8 can't guarantee that that is the case all of the time.

9 **Q.** But in terms of Letby's case, which no doubt  
10 has been the subject of some internal scrutiny, are you  
11 satisfied that the RCN was seized of the facts it ought  
12 to have been seized of at the time that they were taking  
13 place in the hospital?

14 **A.** So in terms of the review of the case file,  
15 I think we would say that there was probably some -- the  
16 paperwork wasn't as, as -- what's the word? I can't  
17 think of the word but -- thorough as it, as it should  
18 have been or could have been from the local  
19 representative.

20 **Q.** From the local rep. Just so that we are  
21 clear. We are not here talking about what might be  
22 described as a steward, who I think was  
23 Hayley Griffiths, this is Tony Millea, is that right?

24 **A.** No, Tony's a member of staff.

25 **Q.** He's a member of staff. So who is  
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1 the representative who perhaps didn't give sufficient  
2 information?

3 **A.** So Tony's records are as complete as we can  
4 see. So the staff record is complete.

5 In terms of her local representative Hayley, her  
6 support, as, as would be described, there are very  
7 limited records from Hayley's interactions with her,  
8 with Lucy, or with the Trust.

9 **Q.** So, for example, did the RCN know about any  
10 support given around the Royal College of Children --  
11 Paediatrics visit?

12 **A.** Sorry, I am not quite sure what you're --

13 **Q.** So the RCPCH --

14 **A.** Yes, review.

15 **Q.** -- visited, they conducted a service review.

16 We know from the evidence that we have heard that  
17 Hayley Griffiths gave some support, met with some of the  
18 people conducting the review. Was that the sort of  
19 information that was passed on to the RCN or wasn't?

20 **A.** No, that wasn't on the case file. No.

21 **Q.** In terms of any developments as a result of  
22 the RCN's internal investigation into what occurred and  
23 its involvement, what changes has the RCN made in terms  
24 of its way it approaches things, any of its policies,  
25 any of the training it provides? Can you help us with

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1 And then, finally, I think around the training and  
2 support for our representatives, and it links back to  
3 the point around -- I will focus on this: so the  
4 training and support recognising that we haven't been as  
5 explicit as we could have been to date around  
6 referencing and reminding our representatives around  
7 their safeguarding requirements that you alluded to  
8 earlier around raising concerns themselves.

9 It is covered and it is in there, but actually  
10 thinking through how we can improve that to make it  
11 clear so that we have got conversations that are  
12 particular to the sort of information our  
13 representatives may be receiving and putting that in the  
14 context of the training they receive from their  
15 employer.

16 **Q.** Now, I would just like to go back to  
17 a previous question, which explains why I was confused  
18 and it was my confusion, but perhaps you can help with  
19 this. When we look at the transcript of the grievance  
20 hearing, Ms Griffiths didn't attend that grievance  
21 hearing.

22 **A.** Yes.

23 **Q.** In fact, Mr Millea attended and is recorded as  
24 being the Trade Union rep?

25 **A.** Yes.

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1 that?

2 **A.** Yes. So I think in terms of individuals, so  
3 there is a structure already in place around  
4 individuals. So a representative at local level,  
5 elected representative stewards support and supervision,  
6 a clear requirement of keeping records up to date and  
7 our expectation -- and so we audit those things.

8 We, we have, not directly as a result of this case  
9 but more generally, recently are reviewing all of those  
10 things to ensure that particularly supervision, so  
11 supervision is the time when if things are not on the  
12 case file actually recorded, those are conversations  
13 that should happen that could then pick up those issues  
14 that are being missed in terms of the written document.

15 So ensuring that our supervision, that everyone is  
16 engaging properly in supervision, so that there are some  
17 changes and some tightening around the supervision  
18 element.

19 Reiterating our need to have robust records again  
20 is one of the things that we really recognise, not again  
21 just from this case but from others, the importance of  
22 keeping good records and ensuring that critical  
23 information is on file so that people are understanding,  
24 you know, what's actually happening with an individual  
25 in the support.

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1 **Q.** Is that what the RCN would have expected to  
2 happen in terms of an employee of the RCN being at that  
3 hearing rather than the local rep?

4 **A.** It varies. It varies. So depending on the  
5 local situation, if there -- in some organisations we  
6 have no local rep, so it would always be a member of  
7 staff that would be picking up a grievance. In other  
8 organisations, we have one or more representative and  
9 depending on the individual they may well be supporting  
10 them.

11 In some cases, as it would appear happened here,  
12 there may be somebody who is taking on the more  
13 formal representative role, which is what I would  
14 describe Tony as doing, in terms of attending the formal  
15 hearings, et cetera. But where there's a lot of support  
16 to an individual for example or lots of meetings just in  
17 practical terms that is more difficult for someone who  
18 is based.

19 So Tony would have had a patch that was a lot more  
20 than one organisation, not be there on a daily basis,  
21 not able to make regular catch-ups or whatever, then  
22 there may be somebody who's the formal representative  
23 and someone who is representing them but is in a more  
24 support role.

25 **Q.** Has the RCN reviewed what its employee is

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1 recorded as saying at that grievance hearing?

2 **A.** Not specifically to my knowledge. If there's  
3 something that you want to draw my attention to --

4 **Q.** Well, if you haven't reviewed it, I don't want  
5 to put you on the spot beyond if I just take one  
6 example; that what he's recorded as suggesting to the  
7 hearing is:

8 "Damage to the Trust too. They were protecting  
9 themselves as this would have been in the paper."

10 Regardless of whether that is true or not, and I am  
11 not commenting upon the truth of that statement, is that  
12 the sort of language the sort of comment that you would  
13 be expecting from somebody representing a member in  
14 a grievance hearing?

15 **A.** Again, I am not quite clear of the context.

16 I mean, obviously I'm clear of the context but the  
17 conversation around it. But I -- what I am aware of is  
18 that so you would expect organisations for example --  
19 sorry, organisations -- representatives to challenge if  
20 we are faced with a situation where we are not clear  
21 about why X or Y is happening to an individual to say:  
22 You know, "If you have got more evidence that you are  
23 not presenting we need to understand that evidence."  
24 Or, "Why are you not escalating to this place or that  
25 place to enable that evidence to be presented?"

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1 She was the ultimate line manager for Letby's immediate  
2 line manager Eirian Powell. She was the Trust's lead  
3 for safeguarding and she was a Speak Out Safely  
4 designated officer and so plainly a number of roles,  
5 very often all aligned. But one can immediately see how  
6 there is a possibility for conflict.

7 Does the RCN have a view about how the most senior  
8 management within a Trust should be dividing those  
9 important roles and whether it's appropriate for one  
10 person to hold quite so many?

11 **A.** I can't answer that. We -- I haven't had that  
12 debate and I wouldn't want to give an organisational  
13 view when we haven't had that discussion explicitly.

14 **Q.** Does it follow from that that isn't  
15 particularly a problem that the RCN has identified up  
16 until now as impacting adversely on its members?

17 **A.** Not in the way that's been described.

18 So I think there have been discussions over the  
19 years around particularly nurse directors carrying  
20 multiple portfolios, not necessarily exactly as you  
21 describe them, but around -- and again not necessarily  
22 around -- well, some of it is around conflict, but some  
23 of it's also around expecting one person to be able to  
24 have a, you know, a very wide brief, which means that  
25 they can't necessarily function in the way or focus in

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1 And I think in this case, what I am aware of is

2 that Tony did raise with the organisation, with the  
3 Trust questions about whether they were going to engage  
4 the police for example at a certain point and if they  
5 hadn't, why not if they were that concerned?

6 **Q.** So language around that you would regard as  
7 being --

8 **A.** I would expect --

9 **Q.** -- appropriate and part of his role?

10 **A.** Yes.

11 **Q.** All right. We will turn to your final topic,  
12 which is recommendations, and you've set out a number of  
13 recommendations. There are just two that I would like  
14 to ask you about or seek your view on, which aren't  
15 included in your list.

16 **A.** Okay.

17 **Q.** So the first is whether the RCN has a view on  
18 board members holding multiple roles and if I just give  
19 you an example from our facts: that Alison Kelly was the  
20 Director of Nursing, which means that she operated under  
21 the unitary board principle of having a collective  
22 responsibility to the board that she was operating  
23 under.

24 She was of course simultaneously ultimately the  
25 line manager or the ultimate line manager for Letby.

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1 the way that we would hope they would be able to  
2 particularly on nursing from our perspective.

3 So there are -- there have been conversations round  
4 the role of Executive nurses and what that should look  
5 like, but not in the context that you are describing.

6 **Q.** In the context of what has been looked at, has  
7 any conclusion been reached? Is there any lobbying or  
8 engagement that's occurred to try and address what has  
9 been perceived as a potential problem?

10 **A.** Usually at local level because every Trust  
11 structure is different, so there's not  
12 a one-size-fits-all approach and often the conversations  
13 are around individual portfolios and how that  
14 combination of portfolios comes together. So not at  
15 collective level. But at local level there may be  
16 questions, particularly where there's Trust boards being  
17 reorganised, mergers, various things that happen where  
18 the conversation comes up around what is or isn't  
19 appropriate for board members to be holding.

20 **Q.** The second area for potential recommendation  
21 is the regulation of senior managers. Does the RCN have  
22 a view about whether or not senior managers should be  
23 the subject of regulation?

24 **A.** Again, I think there's been discussions around  
25 that and we haven't taken a view. Obviously all nurse

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1 directors are regulated and are regulated by the NMC as  
2 a Registered Nurse midwife or whatever.

3 What we do think is that a boards and senior  
4 managers at board level should be equally accountable  
5 for lots of things for board level decisions on areas  
6 across the board, so staffing levels for example.

7 One of our really big concerns and the way in which  
8 lots of our guidance is angled is around concerns about  
9 decisions that Executives are making around staffing  
10 levels for example and that not sitting solely with one  
11 person but board accountability and people taking the  
12 risk, the patient risk element collectively as a board,  
13 collectively and individually as a board, is something  
14 we believe is, should be -- should be how it is.

15 **Q.** Now, we know there is a consultation open at  
16 the moment. Is the RCN proposing formally to respond to  
17 that as an organisation?

18 **A.** We will, yes.

19 **MR DE LA POER:** Well, given that by the sound of it  
20 the RCN has yet to finalise its position in terms of  
21 what it will say, I won't ask you to address that. You  
22 have already answered my previous question.

23 Ms Marquis, thank you very much indeed for  
24 answering my questions.

25 There are no Core Participant questions, my Lady.

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1 **(The Inquiry adjourned until 10.00 am,**  
2 **on Tuesday, 14 January 2025)**

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1 **LADY JUSTICE THIRLWALL:** There are no questions  
2 from me either. So thank you very much indeed,  
3 Ms Marquis, for coming to give your evidence. You are  
4 free to go.

5 **A.** Thank you.

6 **LADY JUSTICE THIRLWALL:** That's the evidence for  
7 today?

8 **MR DE LA POER:** It is, my Lady.

9 **LADY JUSTICE THIRLWALL:** Have we got a final  
10 position on the evidence for tomorrow yet,  
11 Mr De La Poer? I know there was someone who was unable  
12 to come.

13 **MR DE LA POER:** Yes, I understand that some  
14 material will be read into the Inquiry record. My  
15 belief is that that will be how we start tomorrow and  
16 then we have two further witnesses for the balance of  
17 the day as previously advertised.

18 **LADY JUSTICE THIRLWALL:** Thank you, and the reason  
19 for that being the illness of one of the witnesses,  
20 first --

21 **MR DE LA POER:** Yes.

22 **LADY JUSTICE THIRLWALL:** I am sure that has already  
23 been communicated but just in case it hasn't, now you  
24 know. So we will start again tomorrow at 10 o'clock.

25 **(4.17 pm)**

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1 **I N D E X**

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