

Witness Name: Kristian
Garsed
Statement No.: 1
Exhibits: KG/1 – KG/17
Dated: 08/11/2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF KRISTIAN GARSED

I, Kristian Garsed, will say as follows: -

Background Professional History

1. I am currently employed by the Nursing and Midwifery Council (NMC), as the Regulation Adviser (RA) for the North East of England and Yorkshire, in the Employer Link Service (ELS) which is currently part of the Professional Practice Directorate. I am professionally qualified as a Barrister however I am currently unregistered as it is not a requirement of the NMC that I hold a practising certificate in the role I am now employed in. I was called to the Bar of England and Wales by Inner Temple in 2006, and practised in general common law, at 4 King's Bench Walk during from 2006 to 2011. In 2011, I joined what was then called the Regulatory Legal Team (RLT) at the NMC initially as a Lawyer / Case Presenter, and I then later became a Senior Lawyer. In 2014 I was called to the Bar of Northern Ireland (again, I am currently unregistered and non-practising whilst I am in my current role at the NMC). In 2016, I was promoted by the NMC to Regulation Adviser (RA), initially responsible for the Wales, the North West of England, the Isle of Man. Since then, I have additionally at other times been the RA for Scotland, and Northern Ireland. In 2021 I was appointed as a fee-paid Employment Judge, and I sat part-time at the East London Employment Tribunal, in addition to my RA role from 2022 to 2023 at which time I chose to resign that appointment. I was also appointed in 2021 as a fee paid First-tier Tribunal Judge in the Health, Education and Social Care Chamber (Mental Health), and I continue to sit part-time in that appointment in addition to my role as RA at the NMC.

The NMC's powers, the regulatory framework and associated guidance

2. The NMC is a statutory professional regulatory body established by the Nursing and Midwifery Order 2001 (the 2001 Order). Article 3 (2) of the 2001 Order (as amended) establishes and describes the principal functions of the NMC which are: *"to establish from*

time to time standards of education, training, conduct and performance for nurses, midwives and nursing associates and to ensure the maintenance of those standards.”

3. Article 3 (4) of the 2001 Order describes the over-arching objective of the NMC as being *“the protection of the public”*.
4. Part V of the 2001 Order (Articles 21 – 36) establishes and describes the NMC’s Fitness to Practise function and jurisdiction.
5. Article 22 of the 2001 Order (as amended) defines the allegations which can be made to the NMC, against a registrant which could indicate impairment of fitness to practise. Advising an employer to make a referral to the NMC about a registered nurse therefore requires there to be some form of allegation which could correspond to one of the six statutory categories of impairment set out in Article 22 (1) (a) of the Nursing & Midwifery Order 2001 which are:
 - a) Misconduct.
 - b) Lack of competence.
 - c) Conviction or caution in the UK or abroad.
 - d) Physical or mental ill health.
 - e) Not having the necessary knowledge of English.
 - f) Determinations by other health or care professional bodies in the UK or licensing bodies elsewhere.
6. The NMC produces and publishes *‘The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates’* (‘the Code’) as the reference point for understanding and determining whether or not a registrant’s fitness to practise is currently impaired, within those statutory categories [KG/1 INQ0002419].
7. If we are aware of a concern, and we have advised that a referral should be made, but a referral is not then received, the NMC can instead open a fitness to practise case, by using the power to do so contained in Article 22 (6) of the 2001 Order:

“If an allegation is not made under paragraph (1) but it appears to the Council that there should be an investigation into the fitness to practise of a registrant or into his entry in the register it may refer the matter in accordance with paragraph (5) and this Order shall apply as if it were an allegation made under paragraph (1).”

8. Article 29 (5) sets out the substantive sanctions which can be imposed upon the conclusion that an allegation is 'well founded' (Article 22 (3)). The sanctions available are:
- Article 29 (5) (a), a striking-off order
 - Article 29 (5) (b), a suspension order for a maximum period of one year
 - Article 29 (5) (c), a conditions of practice order for a maximum period of three years
 - Article 29 (5) (d) a caution order for not less than one year and not more than five years.
9. Article 31 (2) (as amended) contains the statutory basis upon which a practice committee of the NMC can impose an interim order: *"if the Practice Committee is satisfied that it is necessary for the protection of members of the public or is otherwise in the public interest, or is in the interests of the person concerned, for the registration of that person to be suspended or to be made subject to conditions, it may— (a) make an order directing the Registrar to suspend the person's registration (an "interim suspension order"), or (b) make an order imposing conditions with which the person must comply (an "interim conditions of practice order"), during such period not exceeding eighteen months as may be specified in the order."*
10. The latest version of the NMC's current guidance describing *'Interim orders, their purpose, and when we impose them'* is attached as [KG/2 INQ^{INQ0017805}]. As a RA I have, and had at the relevant time, no role in deciding whether to apply for, or determining when to impose, interim orders.

Regulation Adviser (RA) role

11. The RAs are members of a team at the NMC known as the Employer Link Service (ELS). The ELS was initially introduced by the NMC in late 2015 as a pilot project, and then was substantively launched in April 2016.
12. The NMC established the ELS as a response to recommendation 232 in the 'Mid Staffordshire NHS Foundation Trust Public Inquiry Report' (the Francis Report) which was that: *"The Nursing and Midwifery Council could consider a concept of employment liaison officers, similar to that of the General Medical Council, to provide support to directors of nursing. If this is impractical, a support network of senior nurse leaders will have to be engaged in filling this gap."*
13. The ELS was therefore established primarily in order to facilitate closer working between the NMC and healthcare providers, particularly with regard to bringing about improvement

in relation to the making of fitness to practise referrals. The ELS team was accordingly initially located within the Fitness to Practise Directorate, then in the Strategy and Insight Directorate, and is currently part of the Professional Practice Directorate at the NMC.

14. The role purpose of a RA, according to the job description current when I was appointed and at the relevant time [KG/3 INQ[INQ0108438]], was to *“develop effective regulatory relationships with employers, with the aim of improving the appropriateness, timeliness and quality of employer fitness to practise (FtP) referrals, and the progression of cases through the FtP process with increased timeliness - with fewer appropriate referrals unreported.”*

The key accountabilities in that job description are:

- *To build and maintain effective regulatory relationships with very senior representatives of employers of NMC registrants, focused on increasing appropriate employer engagement and cooperation with the FtP process, such that measurable benefits are delivered with regard to:*
 - i. *Improved appropriateness, quality and timeliness of FtP referrals*
 - ii. *Improved timeliness of progression of FtP cases*
- *To represent NMC in a professional and cooperative manner, in support of NMC's goal to protect the public, acting as a credible ambassador for NMC and effectively sharing information, to:*
 - i. *Other healthcare regulators, including participation in risk and quality summits*
 - ii. *Senior employer stakeholders, including Directors of Nursing, HR Directors and Chief Executives, and Local Supervising Authority Midwifery Officers*
- *To provide advice and support to senior employer stakeholders, influencing them to achieve the desired outcome, through:*
 - i. *Advice on making referrals*
 - ii. *Advice on revalidation*
 - iii. *Advice and explanation on the FtP process*
 - iv. *Support for progressing serious and urgent cases*
 - v. *Advice and support for unblocking delays in timely case progression*
- *To take and coordinate action with employers in response to data and trends*

- *To analyse complex issues, leading to conceptualising, creating and championing truly new and improved NMC processes, methods and techniques - through employer engagement*
- *To make a marked contribution to defining the business strategies of the Employer Link Service, and to the FtP Directorate through working closely with employers*
- *To work closely and effectively with all functions and teams across NMC, especially FtP, ensuring that interactions with employers align with corporate NMC messages*
- *To operate in an evidence-based manner, prioritising activities accordingly.”*

15. The RA role therefore includes providing *ad hoc* professional regulatory advice to Chief Nurses / Directors of Nursing within both NHS Trusts and independent healthcare providers, and other representatives of employers in health and care, as well as other regulators and other stakeholders, including advising about potential referrals. This can be as a result of direct contact with a RA, routine engagement, or through the ELS telephone advice line for employers which operates from Monday to Friday, from 09.00am to 17.00, and which is provided by one (or two on Mondays and Fridays) RA / s who are on call on a rota system.

16. The ELS and the RA role are not functions of the NMC described in 2001 Order and we instead operate by reason of policy and convention, and RAs have no statutory power or authority.

17. RAs can advise an employer to make a referral to the NMC in respect of registered nurses or midwives (and now, in England only, nursing associates) against whom there may be allegations of an impaired fitness to practise. RAs can also advise employers not to make a referral, or that they should further investigate or manage concerns locally first, before any referral may be needed, but RAs cannot mandate that their advice be followed. An employer can apply the advice as they choose, and an employer can make a referral to the NMC at any time without reference to the ELS or a RA, although the NMC does encourage employers to contact the ELS first before making a decision about whether or not to make a referral. If we advise that a referral should be made but that advice is not followed and the referral is not made, the NMC can open a case under Article 22 (6) of the 2001 Order.

18. Once a referral has been received, the first stage of the fitness to practise process is consideration of the allegation at screening to determine whether or not to proceed to a substantive investigation. At this stage the majority of decisions relating to whether or not

to seek an interim order are made. The RAs have no involvement in: any decisions relating to the progression of a substantive allegation of impaired fitness to practise; or conducting interim order risk assessment, or advising on or deciding whether to apply for interim orders. These decisions and activities are the responsibility of the operational teams in the Fitness to Practise section, within what is now the Professional Regulation Directorate. Initially a referral is considered by the screening teams, then the investigation teams, then the case preparation and presentation teams as a referral moves through the process. At the relevant time, Fitness to Practise was a Directorate in its own right, however this has now changed, and this function sits alongside Registration and Revalidation, within the overall Professional Regulation Directorate.

19. As a RA providing pre-referral advice to an employer at the relevant time which I have been asked about, the written guidance available to me to assist me in my task, was set out in the 'Employer Link Service Regulation Adviser Manual' (originally produced 28 July 2015) (the RA manual) [KG/4 **INQ0108447**]. In particular I would have been required to approach the provision of advice about a local concern about a nurse or midwife to employers by reference to the following section at pp. 42 – 43, headed 'Local Issues'. By way of explanation of the acronyms used in the extract below, DoN stands for 'Director of Nursing', CN stands for 'Chief Nurse' and HoM stands for 'Head of Midwifery'. It is also important to note that although the extract below refers to 'the NMC threshold for referral' the 2001 Order does not include or define a statutory threshold for making a referral to the NMC, and the NMC has not produced any specific policy threshold for advising when a fitness to practise referral should or should not be made by an employer or any other party / potential referrer. There is no test to be applied and instead the advice given will always be specific to the particular circumstances, having been determined by the RA using their professional judgment and discretion. The 'Local Issues' section provides as follows:

"Local Issues:

One of the key services that the RA provides is discussions about individual nurses or midwives where concerns are being handled locally or where the DoNs/CNs or HoMs is considering action. These discussions provide the DoNs/CNs or HoMs with an opportunity to discuss local problems, thresholds for referral to the NMC, local management and patient safety issues.

RAs should discuss all instances of nurses or midwives causing concern and work with the DoNs/CNs or HoMs to identify issues that can be managed locally and limit inappropriate or poorly timed referrals to the NMC. In both commenting on how to deal

with nurses and midwives that are below the NMC threshold for referral and in discussing the DoNs/CNs or HoMs clinical governance arrangements, the RA is an adviser and not in a position to provide formal decisions. The RA does not have a role in quality assuring the DoNs/CNs or HoMs local governance or investigation processes however they should encourage the DoNs/CNs or HoMs to reflect on whether their local systems are effective and if they have taken appropriate action in individual cases. The responsibility for taking action on issues, whether referring to the NMC or dealing with the matter locally, sits firmly with the DoNs/CNs or HoMs.

The outcomes of these conversations will be that the RA advises the DoNs/CNs or HoMs to:

- 1. refer the nurse or midwife to the NMC for investigation. The RA should encourage the provision of appropriate evidence, remind the DoNs/CNs or HoMs of the importance of continuing local action and manage expectations around outcomes*
- 2. deal with the issue locally, with monitoring and review, for future update with the RA*
- 3. deal with the issue locally*

In all cases the RA should exercise caution and provide advice based on the best available information. The RA should consider the RA case referral checklist (Annexe E) when discussing a potential case with the DoNs/CNs or HoMs. The RA should not make 'snap decisions' when considering how to deal with a potential case and should not rely on anecdote. If the RA is unable to advise about referral at that time, RAs should request DoN/CN or HoMs send them further information about the local issue (for example a local report) which they can review before providing further advice. This information would not constitute an official referral, but would be used by the RA to consider whether to advise referral. The RA should discuss the potential case with the AD ELS if they are still unsure once they have received the information.

If the RA advises not to refer, they should discuss what steps the DoNs/CNs or HoMs could take, which may include liaising with HR or Occupational Health to produce an internal action plan for dealing with the concern. The RA should record the proposed action in the meeting note and follow up with the DoNs/CNs or HoMs at subsequent meetings. There will be instances where the threshold for referral is not reached initially but is met as a result of subsequent actions by the nurse or midwife and the RA should pick these up through ongoing monitoring."

20. Annexe E – the RA Case Referral Checklist is at p. 64 of the RA manual and provides the following considerations:

Annexe E – RA Case Referral Checklist

	Considerations
1.	<i>Has there been a breach of NMC Code/standards?</i>
2.	<i>If yes, how serious? In the event there has been a breach of NMC Code/standards, which specific NMC Code/standards have been breached?</i>
3.	<i>If no, does it require any follow up?</i>
4.	<i>Are there any other organisations involved in the case? For example, police; NHS Counter Fraud; CQC. If so, how does it affect our need to take action?</i>
5.	<i>What is the risk to patients/public in allowing the nurse or midwife to continue to practise unfettered?</i>
6.	<i>Has any local investigation taken place and what has been the outcome?</i>
7.	<i>What arrangements are in place to minimise the risk to patients? For example, local conditions, contingent removals, supervision etc.</i>
8.	<i>What arrangements are in place for remediation?</i>
9.	<i>Does the local investigation and management satisfy you that the issue is being appropriately managed?</i>
10.	<i>Are there any reputational risks to the NMC such as significant press coverage or if the case involves a high profile nurse/midwife?</i>
11.	<i>Does the nurse/midwife have any FtP history with the NMC?</i>

The call with Alison Kelly on 18 May 2017

21. I spoke to Ms Alison Kelly (Ms Kelly), Director of Nursing at the Countess of Chester Hospital NHS Foundation Trust (the Trust), by telephone on 18 May 2017. The purpose of this call was to respond to Ms Kelly's request to speak to either my colleague Tony Newman whom she had spoken to previously about Lucy Letby via the ELS advice line, or to me as the Regulation Adviser for the Trust at the time. Ms Kelly had contacted the ELS on 17 May 2017 to make her request for a discussion. I called her back as I was available to speak to her, and because I considered that it was my responsibility to do so, as RA for Wales, the North West of England and the Isle of Man. I called her initially on 18 May 2017 at 09.30am but she was unavailable, and she then called me back at 13.54.
22. A note of that call is at [KG/5 INQ0002449]. I made this note as a contemporaneous summary of the information I was given and the advice that I provided in response to that information. The record that I made was created on the same date as the call. I believe that this is a reasonably full and accurate summary, however it is not an absolutely complete record of the discussion as the call was not audio recorded.
23. In advance of this call, I received an email from Ms Kelly on 18 May 2017 at 10.51am. Attached to the email was a document entitled 'Regulators and stakeholder brief 18 May' and another document entitled 'External stakeholder FAQs 18 May' both of which I read in preparation for my call with Ms Kelly. The email and attachments are attached to this statement as [KG/6 INQ0101921] [KG/7 INQ0108445] [KG/8 INQ0017393]. I did not receive any other information from the Trust, in advance of my discussion with Ms Kelly at 13.54 on 18 May 2017.
24. In preparation for the call, I also checked the NMC records, and read the records made by my colleague Tony Newman (Regulation Adviser) following his earlier discussions and contact with Ms Kelly, on 12 July 2016, 29 November 2016, 05 January 2017 and 06 February 2017.
25. I was aware of the contact between Tony Newman and Ms Kelly earlier than 18 May 2017, as a result of ordinary intra-team discussions, and because his advice was discussed and considered through the peer review and benchmarking processes which the ELS has always operated to provide quality assurance and good governance, in relation to the advice we provide externally. I cannot recall the specifics of any prior discussions of this case, however I believe that I spoke to Tony Newman soon after he first advised Ms Kelly, as he would have informed me in my capacity as the RA for the Trust and the region. I believe that I confirmed that I agreed with the advice he gave. Having checked the NMC records, the benchmarking meeting at which the advice given by Tony Newman to Ms

Kelly on 12 July 2016 was discussed and agreed by other ELS and screening team colleagues, took place on 24 August 2016. I was not present as I had given my apologies however, I would have been sent the notes following the meeting. The relevant extract from the meeting minutes is attached to this statement as [KG/9 INQ0108433].

26. At the conclusion of the call on 18 May 2017, I advised Ms Kelly, that at the time of that discussion; *“at this stage, as she has been advised previously, there is nothing which could amount to an identifiable or sustainable allegation of impaired fitness to practise, however the outcome of the police investigation has the potential to be very significant, and if this individual or any other registrant is identified as having been involved in the deliberate endangerment or murder of any of the infants in question, then plainly a referral / referrals would be necessary. Accordingly we will need to be updated as matters progress.”* [KG/5 INQ0002449]

27. My advice to Ms Kelly was based on my understanding of this matter derived from the documents I had reviewed ahead of our call, including the records made by my colleague Tony Newman, and the information which Ms Kelly shared with me during the call, which was as follows:

- a) I was informed by Ms Kelly that the police investigation which had been announced would interview Lucy Letby along with other staff from the neonatal unit, as witnesses, as part of an investigation *“to examine the circumstances of the deaths / near deaths, to determine if there has been any deliberate harm to, or endangerment of, these children, and then only if so, to identify the person or persons responsible.”*
- b) Regarding Lucy Letby, as recorded in my note of the call, Ms Kelly told me: *“as she had explained to [TN: Tony Newman] previously there was a view held by several medical colleagues that a registrant (Lucy Letby) may be the common denominator, and are quite strong in their view that she may be the cause. This is largely based on an identification of her as having been present on most, but not all of the occasions, when infants collapsed and or died. However, as is noted in the RCPCH [Royal College of Paediatrics and Child Health] review there is no certain picture of who was present on these occasions, and the most in depth analysis undertaken of the staffing situation, did not extend to non-clinical staff. In addition, the registrant has apparently a very good professional history and a high degree of clinical credibility and was not present on all of the relevant occasions. Other staff were present on a similar number of relevant occasions. The registrant has been moved to a different area and a non-clinical role primarily to support her,*

by enabling her to work in a different area outside of the pressure of that clinical environment and to protect her from the stress of being under a degree of suspicion from the medical team." This was my first conversation with Ms Kelly about this matter, and so this was the first time I had received any information about Lucy Letby, or the approach taken by the Trust, directly from her. My recollection is that in relation to the indication that the suspicion was largely based on presence, the only other component of the suspicion was that the medical colleagues simply felt that there was something inherently suspicious about Lucy Letby. I cannot recall what other questions I asked, or what answers were provided in relation to that part of the discussion. I recognise and accept that it would have been useful to explore this in as much detail as possible and would do so in similar circumstances should they arise in the future.

- c) The information given to me by Ms Kelly was that whilst there was a view by some medical colleagues that Lucy Letby was potentially *'the common denominator'*, that view was based on her presence on some, but not all of the occasions, when infants had collapsed and / or died. It was not suggested to me by Ms Kelly that those medical colleagues had explicitly accused Lucy Letby of any act or omission in connection with those incidents, or that there was any evidence available to support any concern about her on their part.
- d) Therefore, as far as I was aware at the time of the call there was no allegation or evidence, only anecdotal suspicion which it was necessary to be cautious about relying on as a reason to advise to make a referral. Rather than an identified (or evidenced, and therefore sustainable) allegation of some particular behaviour, the indication given to me was only the suggestion that she was a 'common denominator' and that this was based on presence alone. It was also indicated to me by Ms Kelly, that this suspicion was probably misplaced as other staff were present on a similar number of relevant occasions. I was also informed that Lucy Letby had not been arrested, charged or suggested to be a suspect by the police, and that she had a *'good professional history and high degree of clinical credibility'* and was at that time *'employed in a non-clinical role primarily to support her'*, which was information which I then necessarily had to consider in terms of whether she represented any risk and in ensuring that my advice was fair and objective.

28. When providing Ms Kelly with advice I applied my experience and understanding of the relevant statutory framework, the Code, the RA Manual, and my professional judgment, to my factual understanding of the case, as follows:

- a) I took account of the guidance on discussing and advising on 'Local Issues' in the RA Manual at pp. 42 - 43, and I identified that this was an issue that was being, and could continue to be, managed locally. Whilst being conscious that, in accordance with the RA Manual, I was '*acting as an adviser ... [and] not in a position to provide formal decisions*' [KG/4 INQ 0108445] and had no role in quality assuring the Trust's local governance or investigation processes, I did question Ms Kelly to ensure that local action had been taken and was considered by her to be effective. She assured me that the Trust had taken local action by re-deploying Lucy Letby to a non-clinical role. Although the Trust's priority was suggested as supporting the individual, I also inferred that the other consideration was to address any potential risk from Lucy Letby working in a clinical context. I concluded that as she remained employed and had no other employment, this would also effectively manage any potential clinical risk at that time. In the event that I had been later informed, as I would have expected to be in such circumstances, that Lucy Letby had left her employment I would have advised to make an immediate referral as at that point there would have been no continuing local management of any potential risk.
- b) With reference to the six statutory categories of impairment set out in Article 22 (1) (a) of the 2001 Order and the Code, and on considering the case referral checklist from the RA Manual, nothing described to me by Ms Kelly appeared to amount to an allegation of any action or inaction by Lucy Letby, which could constitute grounds for a fitness to practise referral to the NMC at that time.
- c) Although Lucy Letby is now convicted of murder and attempted murder, and this is of course of the utmost seriousness in terms of wrongdoing, at the time I was told that Lucy Letby had not been accused of anything specifically and that there was no evidence of any particular activity or behaviour, which could constitute a breach of the Code, or any other professional standards issued by the NMC. Whilst I was informed that there was a general suspicion about her presence, I was also told that there were other factors I should consider which could suggest that any suspicion or concern about her presence as a neonatal nurse, on a neonatal unit, was mistaken (namely that she was not present on all of the occasions when infants collapsed or died, that there was no certain picture of who was present on these occasions, and that she had a good professional history and a high degree of clinical credibility) (applying Annexe E – RA Case Referral Checklist, Consideration 1 and Consideration 2).

- d) I was advised that the police were investigating the circumstances of the deaths, not that they were investigating Lucy Letby or any other individual / s, and that Lucy Letby would be interviewed as a witness. There was no need for me to encourage Ms Kelly to raise a concern about Lucy Letby with the police, as they were already involved. My advice also took account of the general principle that regulatory investigations typically follow criminal investigations, so as not to prejudice them, and the outcome of a police investigation would be highly relevant to any eventual decision by the NMC on whether or not to take any regulatory action, and what if any regulatory action to take, including any decision to seek an interim order, which at the time the NMC would not ordinarily have done until after a person had been charged with an offence. I was also conscious that as the police were now involved, if the police were concerned about Lucy Letby or any other individuals as a result of their investigation, it would be open to the police to make a referral to the NMC as soon as they considered any such referral to be appropriate. I also informed Ms Kelly that *'as the outcome of the police investigation has the potential to be very significant ... we will need to be updated as matters progress'* and that she should thereafter *'wait for the police investigation to develop and to keep us regularly updated with any meaningful developments'* (applying Annexe E – RA Case Referral Checklist, Consideration 3 and Consideration 4).
- e) I was informed that the employer considered that Lucy Letby represented no risk at that time as she had a *'good professional history and high degree of clinical credibility'* and was at that time *'employed in a non-clinical role primarily to support her'*, and that in any event any potential risk was being appropriately managed by the continuing and sole employer moving Lucy Letby to a non-clinical role within the organisation (applying Annexe E – RA Case Referral Checklist, Consideration 5, Consideration 7, Consideration 9 and Consideration 11).
- f) I was also informed that a previous external investigation (by the Royal College of Paediatrics and Child Health (RCPH)) had been completed and concluded in November 2016, with *'no certain picture of who was present on these occasions'* and that *'the most in depth analysis of the staffing situation, did not extend to non-clinical staff'* (applying Annexe E – RA Case Referral Checklist, Consideration 4 and Consideration 6).
- g) The advice I gave therefore was that if the police investigation did reach a stage at which there was a person or persons identified as being suspected of being responsible for such criminality as had been suggested to me was the objective of

the investigation, namely 'deliberate endangerment or murder', including Lucy Letby, then 'plainly' a referral, or referrals, would be necessary as in those circumstances there would be an allegation which could amount to either misconduct and / or could eventually result in a criminal conviction or caution (Article 22 (1) (a)). The use of the word 'plainly', should in my view have indicated that in those circumstances it would have been clear that the NMC should receive a fitness to practise referral, but also equally there could be lesser circumstances in which a fitness to practise referral may have been appropriate (as misconduct, and criminal convictions or cautions are not the only types of allegation of impaired fitness to practise). In any event, there was no lesser concern ever raised about Lucy Letby, and she was ultimately arrested during the police investigation, immediately following which event, I advised that a referral was urgently required.

29. On 18 May 2017 at 15.12 [KG/10 INQ0108441], after I had spoken to Ms Kelly, I sent an email update to the ELS officer team, Claire Davidson (the Executive Manager in Fitness to Practise), Matthew McClelland (the Director of Fitness to Practise), Peter Pinto De Sa (the Assistant Director for the Office of the Chair and Chief Executive), Caitriona Rafter (the High Profile Team Manager), Tony Newman (RA), Sue Ward (the Assistant Director for ELS), and Frances Cottle (Senior Lawyer). This email set out the history of ELS involvement and the advice given previously by Tony Newman (RA) and by me on 18 May 2017 (there is a contemporaneous error in this email, in that that the date Tony Newman first spoke with the Trust is given as 12 July 2017, when this should be 12 July 2016). I was not told either at the time, or anytime later, by senior NMC colleagues that the approach taken by me or my colleagues in ELS was flawed or that we should have acted or advised differently.

30. I did not speak to Ms Kelly again about Lucy Letby until I met with her on 15 June 2017, and I did not receive any follow-up or updates from her in that time. In terms of follow up, I explained to Ms Kelly that she should contact me, if there were any material developments during the police investigation. It is recorded in my note of this call that I had stated '*we will need to be updated as matters progress*' and that she should '*keep us regularly updated with any meaningful developments*' [KG/5 INQ0002449]. Whilst I do not believe that it was unreasonable to rely on Ms Kelly as a Director of Nursing at a NHS Trust to keep me and the NMC informed, I also recognise and accept that it was open to me to seek updates at a regular frequency, and that I did not do that.

Meeting with Alison Kelly on 15 June 2017

31. I attended a meeting with Ms Kelly at the Trust Headquarters on 15 June 2017. The purpose of this meeting was primarily as an introductory meeting as we had not met in person ever previously, and my first interaction with Ms Kelly had been the call on 18 May 2017. This meeting was also for the purpose of routine engagement with Ms Kelly as a Director of Nursing at the Countess of Chester NHS Foundation Trust, an employer organisation within the parts of the country I was responsible for as a Regulation Adviser at that time (Wales, the North West of England and the Isle of Man).
32. My knowledge of the police investigation was no different at the time of this meeting, as compared to my knowledge at the time of the call in May 2017. As I have already noted above it was open to me to have sought an update sooner than this meeting, however I did not do that. Rather I relied upon Ms Kelly to inform me whenever there was a material update to be provided from the Trust in relation to the police investigation.
33. At the meeting I introduced myself and provided an update on the development of the ELS, and a general update on the NMC's regulatory activities and priorities. She gave me an update on behalf of the Trust which was specifically an update on the police investigation and Lucy Letby. This meeting, and my note of the meeting, followed the format indicated as the meeting structure to follow in the RA manual and was therefore a typical exchange and record of that exchange, for an introductory or follow-up ELS engagement meeting.
34. My note of that meeting is at [KG/11 INQ0002450]. I believe that this note is a reasonably full summary of the discussion at that meeting, but it should not be considered to be a transcript of the meeting.
35. At pages 7 – 8 of [KG/11 INQ0002450] I have recorded a summary of the conversation regarding Lucy Letby. This is the part of the note at section 2 titled 'Trust Update' and therefore this was my record of the update provided at the meeting by Ms Kelly.
36. As can be seen from the note, I was informed again that Lucy Letby at the time of this meeting had not been arrested or identified by the police as a suspect, and no staff had been interviewed as witnesses. I was also told that Lucy Letby remained employed and remained deployed in a non-clinical role but with additional support being provided to her, in order to prevent her becoming 'overly deskilled'. I cannot recall what other questions I asked, or what answers were provided in relation to that part of the discussion. Again, I do recognise and accept that it would have been useful to explore this in as much detail as possible and would do so in similar circumstances should they arise in the future. I was not asked by Ms Kelly to give, and did not provide, any further advice about any action

which could or should have been taken by Ms Kelly or the NMC at that time. Although I was not asked to give advice, it would have been open to me as a RA to volunteer advice, however I did not do so as I was not provided with any information which was materially different from the information I had been given during the call on 18 May 2017.

37. Whilst I do not recall specifically asking again to be kept updated by Ms Kelly on any material developments in the police investigation, I understood and believed from what I had said in our previous discussion and the tenor of the discussion at this meeting that I would be kept informed. I recognise that it would have been open to me to seek updates at a regular frequency, and I acknowledge that I did not do that.

Further involvement with regards to the Lucy Letby case and the NMC's Interim Order decision making / application

38. The next communication I received from Ms Kelly about the police investigation was on 09 October 2017 to which I responded on 13 October 2017 [KG/12 INQ0002451]. In her email the only update given was that the *"police investigation is now progressing to its next stage. By this, I mean that the Police will be inviting a significant number of staff to be interviewed (including the registrant LL). This will obviously put the spotlight again back on the unit (with potential media interest) and I just wanted you to be made aware of this. Significant staff support is in place whilst staff go through this process, recognising the need to keep the neonatal unit operating safely."* In my reply I thanked Ms Kelly for the update on the police investigation and offered to look into her unrelated concern about not having been communicated with directly by the NMC about the early review of student placements. I do not have any record of receiving a response.

39. My next involvement in this matter came after I was made aware via media reports shared with me by NMC colleagues in the communications team, of the arrest of Lucy Letby.

40. I immediately contacted Ms Kelly on 03 July 2018 in my capacity as RA for Wales, the North West of England and the Isle of Man, and advised that a referral should be made as urgently as possible and within no less than 48 hours.

41. On 04 July 2018 I contacted DC Paul Hughes, I believe at the request of Ms Clare Strickland, the Deputy Director of Fitness to Practise at the time, to advise that I had spoken with Alison Kelly the previous day to request an urgent referral [KG/13 INQ0006212].

42. The referral from Ms Kelly, in relation to Lucy Letby, was received on 05 July 2018.

43. On 06 July 2018 I again spoke with Alison Kelly, and I then relayed the key points from that discussion by email to Matthew McClelland (Director of Fitness to Practise), Richard Reid (Senior Lawyer), Clare Strickland (Deputy Director, Fitness to Practise), Claire Davidson (Executive Manager, Fitness to Practise) and Lucy Dennett (Assistant Director, ELS) [KG/14 INQ0002461]. I provided this update to assist my colleagues in Fitness to Practise in their consideration of the referral which had been received the previous day. Once contact had been established with Cheshire Constabulary, and the referral had been received by the NMC on 05 July 2018 my involvement came to a close.
44. On 19 July 2018 I replied to an email from my colleague Richard Reid (Senior Lawyer) and confirmed that as *“now there is an active FtP case in respect of LL in my view the proper way forward is for you and your team to undertake all necessary correspondence with all relevant parties as the NMC makes its early investigations / enquiries.”* [KG/15 INQ 0002462] Once I had passed contact with the Trust to Richard Reid and the screening team, I had no further involvement with the progression of the case, the interim order decision making, or liaison with the Trust or the police.
45. I have been informed by the Solicitor to the Inquiry that after the referral was received by the NMC on 05 July 2018, the NMC did not then apply for an interim order restricting or suspending Lucy Letby from practising as a nurse until after she had been charged with 8 counts of murder and 10 counts of attempted murder in November 2020. I had no involvement in the decision by the NMC not to apply for an interim order. It is not part of the function of a RA to have any involvement in decision making about seeking an interim order.
46. On 01 January 2019, I ceased to be the RA for the North West of England and the Isle of Man, and that responsibility was transferred to a newly recruited RA (Ms Sondra Roberto) and I received no information or updates internally or externally, about the Lucy Letby referral after that point in time.

NHS England Regional Quality Surveillance Group Meeting discussions regarding the Trust

47. The only other information I received regarding the events at the Trust, was from meeting papers for, and discussions at, the NHS England, Regional Quality Surveillance Group (RQSG) Meetings, which I attended on behalf of the NMC in my capacity as RA for Wales, the North West of England and the Isle of Man.

48. These meetings were hosted quarterly by NHS England as multilateral meetings at which risk and quality issues in health and care, could be monitored and discussed at a regional level. These meetings were attended by representatives of NHS England, NHS Improvement, the Care Quality Commission, Public Health England, the General Medical Council, the NMC and Local Government.
49. I attended RQSG meetings at which the neonatal unit at the Trust, and then once initiated, the police investigation, were discussed on; 16 September 2016, 01 December 2016, 03 March 2017, 23 June 2017, 15 September 2017 and 08 December 2017. The confidential meeting packs and minutes for these meetings would need to be sought by the Inquiry, from NHS England.
50. The information discussed at those meetings reflected the chronology and information which I was otherwise aware of from my involvement as described in this statement.

Conclusions

51. I have reflected carefully and extensively on my involvement in this matter and the advice I gave and have considered whether if faced now with a similar situation to what was at the time an unprecedented situation, I and / or the ELS is likely to have provided different advice.
52. On considering and applying the legislation, the Code and the current guidance, including the NMC's fitness to practise policy principles (see paragraphs 56 – 59 below), which together are the foundation of the NMC's approach to fitness to practise, I believe that ELS would be unlikely to advise an employer to make a fitness to practise referral where there is no specific allegation, or any evidence available, but instead a suspicion about presence which the employer indicates is probably mistaken, and where the registrant is described as having a good professional history, where their employment continues, and the employer is providing reassurance to the NMC that there is no unmanaged risk.
53. However, if the information we receive were to more specifically describe sufficiently serious wrongdoing, and / or an unmanaged risk, and there was some evidence available to support those concerns, then I am confident that the advice would be that a referral should be made in response to such factors.
54. As acknowledged previously in this statement I could potentially have sought more information at the time of my discussions with Ms Kelly and in the intervening and subsequent periods. I am aware that the NMC has recently introduced new guidance

describing and supporting a 'Culture of Curiosity' which in the future can assist ELS RAs and other NMC colleagues in obtaining the most complete and reliable picture of a concern as possible, upon which we give pre-referral advice, and make our regulatory decisions within the fitness to practise process.

55. It appears that advising that a referral was needed sooner than the arrest, would not have affected the action being taken locally to manage risk by the Trust as the employer, or by the police. As noted in the NMC's written opening statement to the Inquiry [KG/16 INQ0107956] at paragraph 40: *"The NMC was only made aware of concerns about LL after she had been removed from the neonatal unit at CoCH, and so the NMC has not identified any steps it could have taken that would have prevented harm to the babies who were injured or murdered."*
56. Since the relevant time, during 2017 and 2018, the NMC introduced a set of 'Aims and principles for fitness to practise' [KG/17 INQ0108440] as part of a piece of work known during the development period as 'The Fitness to Practise Strategy'. The 12 policy principles now, alongside the older RA Manual and Referral Checklist, together with the Code and the NMC's legislative framework, inform our approach to advising on potential referrals. Were a similar situation to arise, ELS would be obliged to have regard to all of the principles, but I believe that principles 2 and 4 would be particularly relevant to a situation like the one I was presented with in May and June 2017.
57. Policy Principle 2 states: *"Fitness to practise is about managing the risk that a nurse, midwife or nursing associate poses to people receiving care or members of the public in the future. It isn't about punishing people for past events."*
58. Policy Principle 4 states: *"Employers should act first to deal with concerns about a nurse, midwife or nursing associate's practice, unless the risk to people receiving care or the public is so serious that we need to take immediate action."*
59. Policy Principle 4 is expanded upon as follows: *"Employers are closer to the sources of risk to people receiving care and members of the public, and better able to recognise and manage them. If they need to, they can intervene directly and quickly in a nurse, midwife or nursing associate's practice, and do so in a targeted way dealing specifically with the risks. We are further away from the sources of possible harm, and have a more limited range of options to prevent it. We only need to become involved early on if the nurse, midwife or nursing associate poses a risk of harm to people receiving care or the public that the employer can't manage effectively (perhaps because the nurse, midwife or nursing associate has left), meaning the nurse, midwife or nursing associate's right to practise needs to be withdrawn or restricted immediately."*

60. In addition, in similar circumstances should they arise in the future I and the other RAs in the ELS, would (and already do) involve the clinical adviser team, and our safeguarding team (both of which have since been established at the NMC), at the earliest opportunity and I anticipate that their additional expertise will continue to, now and in future, support the most comprehensive and robust approach to the provision of advice at the pre-referral stage.

Statement of Truth

61. I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed: **Personal Data**_____

Dated: _____08 November 2024_____