Tuesday, 15 October 2024

(10.00 am)

LADY JUSTICE THIRLWALL: Good morning.

Ms Langdale.

MS LANGDALE: Good morning. May I call, please, Nicola Lightfoot.

MS NICOLA LIGHTFOOT (affirmed)

Questions by MS LANGDALE

LADY JUSTICE THIRLWALL: Do sit down.

A. Thank you.

MS LANGDALE: Ms Lightfoot, you have prepared a statement for the Inquiry dated 31 March 2024.

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

A. Yes, that's correct.

Q. Have you got it with you?

A. I have, yes.

Q. So if I refer you to paragraphs you have it there?

A. Yes.

Q. You tell us that you worked as a Band 6 deputy ward manager during 2011 to 2015 on the children's unit. Can you tell us what that role entailed and also set out, as much as you would like to, your experience before taking that role; how long you had been a nurse

and your experience?

A. Okay. So I completed my nurse training '93 to '96. It was specific in paediatrics. I started my role on the children's ward at Chester in January '97 as a junior staff nurse at that point.

After a few years I took on a role as senior staff nurse and then after that, I also took on the deputy ward manager role which was classed as a sort of Sister role.

I have been an acting manager on the unit for a short period of time as well. I have worked on that unit ever since.

My role involves day-to-day clinical management of my own patient workload at times. I am responsible for running the unit which is across three areas. I have management responsibilities on day-to-day runnings of the ward, managing patient flow from the admissions that we have in, supporting my colleagues and junior staff.

Part of my deputy ward manager role is also completing appraisals, sickness reviews, any disciplinaries with any staff, dealing with parent complaints.

So it's two-fold really. There is some management of the staff and then the day-to-day runnings of clinical duties as well.

Q. So in 2011 how long had you been working as a nurse or practising?

A. So I qualified in -- the end of '96 and started, sort of, '97', so nearly 20 years is that? Get my fingers you out.

Q. A considerable time.

A. Yes, yes.

Q. So you have a lot of experience.

Did you overlap in your role as a deputy manager on the children's unit with the managers on the neonatal unit?

A. No. We have always worked quite independently. Although we are logistically next to each other, they have always run very separately, separate areas and specialties.

So I may have been involved in some of the contact with managers during meetings and such but the day-to-day runnings of the neonatal unit, we had no involvement of. Very little awareness even in a management role, even as deputy manager, as to any day-to-day issues or things that are happening within the neonatal unit.

Q. What about the managers there, which ones did you overlap with in management meetings?

A. So I might have been to meetings with

Eirian Powell. Usually, if I was representing the manager -- the manager would usually go to these meetings; obviously I would stand in as deputy manager in their absence.

Q. Right.

A. So it wasn't a regular thing but that's where I might have come across --

Q. Her.

A. -- the management.

Q. And what about Yvonne Griffiths or Yvonne Farmer, dealings with any of them?

A. Similar. I might have just sat, sat in the same meeting but no other interaction other than sort of friendly "hellos", you know, when passing. If we had gone to the unit to borrow equipment or vice versa if they'd have come over.

Q. We know, and I am going to come on to the specifics, that you were Letby's mentor during her final placement in 2011. But can you tell us first of all, as you do at paragraph 5 onwards, what the Mentorship Module (Teaching and Assessment Module) was about in 2011? How did the scheme work? What was it supposed to achieve?

A. Okay. So, so my mentorship training was, actually, a module. I had to complete a piece of work

and a number of assessments. It was an official qualification at that time.

It's since changed since. There isn't actually the formal training and qualification now.

So I completed that. That was something that was routine for senior nurses at a certain point into their career. It was a sort of natural progression as you became a senior staff nurse that you would complete that course to enable you to support and mentor students.

Q. And support and mentor students, was that their way of achieving qualification, you were helping them to achieve their qualification and develop into independent nurse practitioners?

A. Absolutely. So throughout, obviously, the nurse training at that point was a three-year course and students would have various placements across different specialties, some community placements, some hospital placements.

Towards the end of their third year we expected a bit more autonomy, them to be able to work a little bit more independently, and in the placement that I was mentor to Lucy, and it was her final placement, so that is the placement prior to becoming a qualified nurse. So it's quite pivotal and particularly important to ensure that that student is ready to qualify because as

a student, you do obviously have your own responsibility, however you are supported and the main responsibility lies with your mentor and the qualified staff you are working with.

Obviously that transition to go from that to an independent worker although albeit under still supervision we have a sort of preceptorship programme that we support newly-qualified staff in is really quite a change.

So you have to be absolutely sure that that person is at that point ready to qualify and take on that responsibility.

Q. So in the first year, then, so first year students you say need basic orientation to the role and you teach basic skills like ward routeing, observations, and completing documentation but by the time of the third year, they are about to qualify so expectations are different, as you have just said.

A. Absolutely, absolutely, and you work almost more remotely, you allow that independence.

They -- in the first and second year often they are on your shoulder, they are behind you, they are observing a lot. Obviously we would try and encourage participation in those skills and that is how you learn, you know, often, you know, watching what is done and

then, under support, completing that task yourself.

By the time they are in the third year, we would allocate our third year students their own patient workload of two or three patients. They would independently plan that care, with your supervision, based on their nursing assessments, the condition of the child, you are observing their interaction with the family and other members of the multi-disciplinary team.

But we are expecting them, as I said before, to work more autonomously, come back, touching base every so often, but I would expect a third year to be able to go and plan their own care for their patients, recognising their priorities, delivering that care and assessing and evaluating how that care has impacted on the condition the child.

Q. And what kind of mentor were you, certainly in final placements? Had you mentored many third year students?

A. Yes, so at that point, I -- I had been qualified sort of almost 15 years. We have -- we all have had a number of students over, over every year. I had mentored an awful lot of students, first years, second years, third years.

I think I personally in the first year perhaps the expectations I would have are not quite so high because

they have got time to develop. By the time they get to third year, my professional responsibility and my duty of care as a nurse is to ensure that that student qualifies and is safe, can deliver effective care; that I am happy that that protects them as a practitioner.

I am happy that that protects their colleagues as a safe practitioner and, more importantly, the children and the families that they are looking after and that's is my primary focus.

It doesn't always make you very popular especially I have found in my experience that students that have been weaker or I have felt were lacking in some areas are often quite defensive. Often may have said, "Oh, I find, I find you difficult" or "I find you intimidating", but my primary responsibility is to ensure that that person is safe for all of those reasons I have just, I have just said.

Q. And how many had you failed? When you are asked about this with the police in 2018, how many third year students had you failed at that time, would you say, roughly?

A. Yes, I couldn't, I couldn't put a number on it but I have, I have failed a few. And as you probably have seen and for anybody that isn't aware, any student that is failed in that final placement has the

opportunity to repeat that placement to try and achieve the competencies that they have not met.

So the student training and the placements have a number of competencies that we expect the nurse to achieve. If, as we go through the time of that placement, we are finding that that member of staff is struggling to meet some of those objectives, at that point we will action plan for it, we will raise issues as we go along -- it's unfair to put them all at the end and that student have no awareness of what areas that they need further work and support in.

Q. And you do the marking, don't you? As a mentor you mark --

A. Yes.

Q. -- it is fed back to the University of Chester and then they pass or fail or they give them feedback as appropriate?

A. Absolutely. So at that point there was what we called an OSCE, which was a practical test, and basically it was to assess that student's ability to co-ordinate care for a number of patients. It included a medication ward round, which obviously has to work within the -- the Nursing and Midwifery Council guidance for administration of medicine.

So there is right and wrong ways of completing it;

that's not a subjective assessment.

The competency-based assessment is a little bit more subjective. But I would say that in my experience I have seen sufficient students in practice to know what students perhaps need additional support.

Q. You tell us at paragraph 15 that you were Letby's mentor during her final placement 23 May to 31 July and you say:

"... it became apparent to me that Lucy didn't have overall characteristics to be a successful registered nurse."

What did you mean by that?

A. So obviously students have to have a certain academic ability which is assessed by the university. They have assignments that they have to pass and they also obviously have their ward assessments to pass as well.

We see students that actually are extremely academic but actually from a personality and characteristic point of view they don't seem to blend into the role of being a children's nurse, which includes characteristics of empathy, being kind, being friendly, being able to establish good relationships with our families.

This is a position of trust. It is an honoured

position to provide care to sick children and their families and they come as a whole.

We expect our students and our staff to be able to establish a working relationship with that family. They need to be able to trust that you know what you are doing, that you are going to provide the best care possible for their child in a very distressing and anxious situation.

They want to feel supported in that they feel that you know what they are doing.

So, actually, those kind of traits are really vital in becoming a competent practitioner.

Q. What were your concerns about those traits as far as Lucy Letby was concerned?

A. So, as I said, I have mentored a number of students over the years. I am well aware that actually when you are under assessment, it can feel intimidating so I very much tried to stand back and allow Lucy to perform without feeling I was over her shoulder putting that pressure on, that perceived pressure that she had, and I would allow her to go and establish these relationships and perform the duties that we have talked about previously and then I would just touch base and reassess.

Sorry, could you just repeat the question again?

Q. No, you have answered it, I think.

A. Okay.

Q. If you answer this question, please. Did you discuss any concerns you had with her directly about her communication with patients or families?

A. Yes, absolutely. So as I say, we address things that we -- we do -- at that point we have an initial interview, we class it, and that's where we would say to the student: this is what we expect you to have achieved by the end of this placement. What would you like to achieve? What areas do you feel you haven't had opportunity to experience yet?

We then do a halfway interview and we will assess where they are with those competencies: is there anything flagging up that we need to do further work on that we need to put additional support in with, and at that point if we feel there are things that need working on we will liaise with the university which is what we did.

We also had our practice facilitators who worked within the hospital and they would also provide support to you as the mentor to complete an action plan, if necessary, at that point for that student to achieve the competencies they were lacking in.

Q. If we go to your final report, we see what you

said at the time. So it's INQ0014042, page 163. So 0014042_0163?

A. I think I have from 0164 onwards, sorry.

Q. That's fine. It will come on the screen anyway so everyone can see it.

We see the front page, the final outcome for you of that placement in the third year was a fail, "has not provided sufficient evidence to demonstrate the common foundation programme outcomes".

If we go over the page, beginning 164, your final report, you start by saying:

"Since the mid-point interview Lucy worked hard to address the areas of concern highlighted by myself."

Had you failed her at the midpoint of the placement?

A. There was some -- so it's not classed as a fail.

Q. Right.

A. There was some competencies that you could say at that point "you haven't achieved these yet".

Q. Right.

A. Sometimes it's because of lack of opportunity, but the things -- one of the things that I felt she wasn't achieving at that point was under the very broad banner of "professionalism". And the things that I have

documented in this report and that I have said in my previous statements that I was concerned about was her interaction, how she communicated.

I felt it was lacking, it wasn't where it should be. I felt her clinical knowledge was not where it should be.

Q. If we look at paragraph 3 on that page --

A. Yes.

Q. -- you say she:

"... needs more experience at observing and picking up on non-verbal signs of anxiety/distress from parents and recognising when to change her approach."

A. I found -- I found Lucy to be quite cold, I didn't find a natural warmth exuding from her that I expect from a children's nurse. I appreciate as a student you feel like you are being assessed all the time. But I didn't feel it was a natural characteristic that she showed.

Non-verbal signs are absolutely crucial as a nurse. The verbal signs are obviously clear as they are verbalised to you from parents or children. But a lot of our job is interpreting those non-verbal signs that a child is distressed that -- and it perhaps might not be as obvious as crying, it could involve looking at their body language, assessing how that parent is

responding to you, how they are feeling, you know, understanding and empathising with their anxieties and responding appropriately to reassure them, as I said earlier, as part of that building a trusting relationship.

Q. Page 165, please. If we go to that.

And the fifth paragraph, go further down if we can.

A. Yes.

Q. Page 165, we are still not there.

"Lucy does demonstrate drug calculations" -- there we are, it is the penultimate paragraph on the one that's there now.

She "does demonstrate drug calculations on a regular basis", did that mean how to calculate the amount of drugs, she knew -- she was competent at that?

A. Absolutely. So within children's nursing we would always have two registered nurses to sign medications. Children's medications are often very different, they are weight-based, they are often very variable, sometimes the doses are very complex to work out, hence we would always have two people to check that that dose is correct, that that dose is appropriate, that it's been given at the right time and that there's no drug interactions or, sort of, allergic responses the child has previously had that would affect how you are

administering drugs.

We would ask the third -- the student to be the third checker. They would take no legal responsibility, obviously, for signing those medications but we would expect them to be able to calculate the volume of drug that they needed, to check that the dose is appropriate for that child's age or weight, and a lot of the drugs we regularly do, the students very quickly have awareness for because we are giving them all the time such as paracetamol.

Q. Just pausing there, the checker, is the checker checking that the infusion or the drugs being administered at the right rate? In other words, so one person puts the infusion on or sets it up and the checker comes to check the calculation and it looks the right amount?

A. So both of the people will go to complete that drugs round. We would ideally take the medication to the child's bedside. We would, as I say, ascertain that it's the right dose, that it is the right time and it's not being given too early and that it's due, and actually that it's been prescribed correctly because obviously there are occasions where human error occurs and prescriptions are incorrectly prescribed. So our responsibility is to check against our recommended

medication guidance that that is the correct dose for that child as well.

When we are then administering that, so we are independently checking even though we are alongside each other, we are independently checking all of those things. We are then ascertaining that we are giving it to the correct patient, so we are checking their name band, we are confirming verbally with the parents, asking them to confirm the name and the date of birth and any allergies, we would confirm with the child, if appropriate, and then only if we were happy with all of those things we would administer that medication and the two registered nurses would sign the drug chart which was paper at that time.

So we didn't expect Lucy to sign any drugs. But we would ask her to independently try and check to ascertain that she gets the correct dose and volume and I found that even doing the same kind of medication that she struggled to retain that information and we had to do a lot of repeating and asking her to look up and clarify for herself, which we would always recommend anyway, if you are unsure, you would check it, you know, that's where mistakes happen. But she did struggle to retain that information.

Q. You say there -- sorry, just to go back, she

struggled to retain the information about side-effects and drug usage for common drugs given.

Is that a different struggling to retention rather than calculations; do you see how you have set it out there that's what you say -- (overspeaking) --

A. So calculations -- so we have a certain drug calculation to work out the volume and that is based on how many milligrams or micrograms of that drug there are in a certain volume. So that is one part of it.

So there is a calculation to ascertain the correct volume that you are going to give and that the strength of the drug you are giving is correct because many drugs come in various strengths, so you have to ascertain because 5 millilitres of one drug would be a different strength than 5 millilitres of another drug.

As I say, there are, there are a number of very basic medications we give all the time in paediatrics, such as paracetamol, ibuprofen, basic antibiotics, stuff that, actually, after you have given a couple of times I would expect you to remember the side-effects because actually they are fairly generic and the same and actually when we would ask Lucy to verbalise during any practices, and including her official OSCE practice, to clarify some of those side-effects she couldn't verbalise them.

Q. Can we go over the page, please, to 166.

You in that second paragraph highlight the -- what you said already, I don't need you to go back on that about the non-verbal cues. We heard from Nurse T yesterday, who had Lucy for the first period in that third year, that she felt her communication skills were very positive, and something that was raised by Letby was that at the midpoint she found it -- was anxious -- you made her feel anxious.

Do you want to just comment on that, the impact of different people and the assessment of things like communication skills by different people?

A. Yes, I mean, obviously, we are all individuals, we all have various amounts of experience. We all -- we -- I would say my professional manner has always been trying to keep safety at the forefront of what I am doing, in a kind way, I would try to be encouraging. There were a number of positives that I mentioned throughout this report that I felt Lucy had shown improvement in and there were areas that I felt didn't naturally come to her.

When I was -- when you are trying to ascertain people's knowledge base, that involves having to ask questions. On occasions, as I say, I would sort of stand back and allow Lucy to go and provide care for

a group of patients. When I had then reconvened with her a few hours later to say, "Tell me about this", she actually couldn't verbalise what conditions they were, what signs of deterioration she would be looking out for.

So I had deliberately tried to stand back so I didn't -- so she didn't feel I was putting any pressure on her, but even in that situation I found she struggled to provide me with that information.

I know in Ruth Sadik, her link lecturers, one of her statements, she had also found that Lucy struggled to verbalise some, some of the questions that she had and that's very difficult to determine that person's level of knowledge. If they can't verbalise it and can't show it, then in essence it's not happening.

Q. Look at the last paragraph. You say:

"At the moment Lucy is requiring much more support, prompting and supervision than I would expect at this stage to allow her to qualify as a competent practitioner. However, I strongly feel if Lucy continues to take on board feedback and continues to work on her weaker areas and develop her practice accordingly then this is achievable in the future."

We know -- that can be taken down from the screen now.

In terms of achievable, what did you think should happen next and we know there was discussion between yourself, Ruth Sadik and others about next steps and, indeed, Ruth Sadik spoke with Letby about the next steps as well, didn't she?

A. Yes.

Q. If you go to paragraph 19 of your statement, you set out there the options that were documented by Ruth Sadik which were for Lucy to repeat her practical OSCE assessment at a later date, for Lucy to see her GP and get signed off sick for four weeks or for an interruption of her studies and go back and repeat a portion of her training.

What actually happened? There was a discussion between all of you, wasn't there, about next steps?

A. Yes.

Q. And it looks as though there was a retrieval placement put in place; is that right?

A. Absolutely.

Q. Let me take you to a document so you can see it, because I think it is signed by both you and Ms Sadik, INQ0014042_0171.

A. Yes.

Q. So that should come on the screen. So an action plan agreed, obviously with Letby's input too,

and decisions. There we are.

This is the note on 7 August, it's actually the same date as your report, setting out she's made great progress in clinical practice and retrieved five proficiencies. However, still has three outstanding.

What are AI, DI, and JI?

A. So each of the proficiencies or the competencies that I mentioned before are alphabetically ordered and in each section the A, the B, the C, the D section there is a number of competencies within each section.

Some of them are practical things, practical skills that we would expect them to achieve but from my recollection, A1, as I say, was a broader competency, proficiency, based on professionalism and that was one of my main concerns, that I still felt that she had some way to go.

All students develop, we all learn at different rates, you know, and we do take that into consideration. But by the third year, most of these should be achievable. From their first year it's very much filtered from university and from us on the ward that, actually, professionalism is, is key and how you build those professional working relationships.

Q. We know that Letby went on to do a retrieval, four-week placement, with Sarah Jayne Murphy and we will read that in, my Lady, after this evidence.

Were you aware that she then subsequently achieved the competencies and passed?

A. Yes, absolutely. As I said before, I stand by the decision I made at the time based on my experience and, actually, when you are a mentor you are not the only person making an assessment on this person. Often you do have to consider, is there a personality clash, we don't all get on with everybody we work with, we have to form professional working relationships. So I had sought other colleagues' opinions of Lucy just to reinforce to myself that I was happy I was making a non-judgmental assessment of her skills and how she was as a nurse.

Q. Did you feel criticised by her in that process?

A. No. I think at one point during a conversation Ruth had said, "Oh, she says she finds you intimidating", you know, but I think that was because I was professionally challenging her knowledge and her skills.

Often, I think I said earlier, students that are lacking in where they should be often you find provide

negative feedback almost to try and get their side in first. So I wasn't surprised she found that approach, in her words, intimidating. But I was trying to ascertain her level of knowledge and skills to ensure that she was safe, partly for her benefit as a practitioner.

Q. And Sarah Jayne Murphy, in her statement, refers to she thought that Letby had initiated an appeal process -- I don't think there was an -- we can't see any evidence of an appeal process.

A. No.

Q. It was more the comments appealing to the fact that she felt intimidated by you, or something similar.

A. So all students, if they failed a placement, had the opportunity to do a retrieval placement. It is only a very short placement. It is -- at that point it was only a further four weeks. I also verbalised that I felt I couldn't objectively continue as Lucy's mentor, she felt the same, because I genuinely didn't think that in four weeks she would be at a level that I would be happy to sign her off.

That previous document that you showed me where you -- where I had circled the fail and I had signed it, that is my professional responsibility as well. That is my professional registration. I have to be sure that

I am saying that this person is ready and safe to practise and I wasn't prepared to put my professional reputation and my professional registration on the line at that point.

Q. It looks like the second document I showed you written by Ruth Sadik but signed by you both, I think, so you were on board with the discussions about what happened next?

A. Absolutely.

Q. But she went to different nurses and different experiences?

A. Okay.

Q. Moving on then to the deaths of Child O and P, the -- two of the triplets. You tell us that you heard Letby say something. Can you set that out for us, please?

A. Yes. So as I said earlier, actually we work really as two independent units from a nursing perspective. We do help each other out when we need to but we are predominantly fairly independent. The medics cross between the two.

So we have -- I personally had quite limited information as to what had been happening. I couldn't say that I had any awareness as to what their normal level of mortality was on the unit. I didn't have

enough experience in working that neonatal unit to know that.

And the first triplet sadly passed away on one day, and on the second day, I heard that the second triplet had also passed away and as I was coming out of the break room I passed Lucy, who didn't see me, she was coming out of her unit and greeting a member of the night staff that was coming on and I heard her say something along the lines of, "You never guess what just happened".

And I felt, I felt -- I felt it was inappropriate in light of what had happened. The way she had said it seemed like she was talking about some exciting event or something, you know, that she had witnessed or seen on the unit. It wasn't an appropriate response to the death of a child. The death of a child is distressing for everybody involved whether it's expected or not. And it has a profound effect on the whole team looking after that child, and I have never, and I have never since seen a response like that to a nurse involved in a patient's passing.

Q. And Melanie Taylor who you thought she said it to confirms that was said, she described in an excited manner.

Did you take that up with anyone at the time or

mention it to Eirian Powell or somebody who was responsible in the workplace for Letby?

A. At that point, when I had heard about that second triplet, I thought, oh gosh, that's strange because there was a passing yesterday and I think that was my -- a moment where I thought perhaps there was something significant happening that I hadn't been aware of. I didn't realistically think anything more about this response other than it was inappropriate.

I think I probably will have mentioned it to somebody when I came back on the ward, another colleague, because I was quite shocked. But in hindsight, you know, perhaps I -- I could have escalated it but I -- there was nothing substantiated. There was just an inappropriate response and I didn't have the full awareness of what had been happening on the unit and their mortality rate for me to put two and two together.

Q. Nurse ZC, who has a cipher so remember that, says that in the resource room after the death of the triplets, and it was after an afternoon safety brief, you were working at one of the computers, and you were somebody she felt able to talk to at that time, and she said, "Is it not concerning that she is involved and she is always there?"

And she describes you as shrugging your shoulders and not saying anything in response. Can you remember that, her saying that to you?

A. I don't recall those specific words and that conversation. The resource room, for some clarity, is a public area where the medics and the nurses work.

Q. Do you have safety briefs in there sometimes?

A. Yes, yes, we do.

Q. Which is what she is describing, so maybe not the public there after a safety brief.

A. Yes, but it's not the privacy of the office that I would expect any concerns to be escalated.

That is not the first time that I have heard Nurse ZC comment about Lucy. I had heard her and a couple of medical colleagues on a number of occasions discussing that Lucy must be involved. I felt it was quite malicious, it was gossip. It was, at that point as far as I was aware, unsubstantiated.

Q. Did you think that even after the triplets when you yourself had heard her say that, when another nurse says to you, "She seems to be around a lot"? Did you still think it was malicious then?

A. If a member of staff had come to me with a professional concern, it is -- it would be my professional practice, and it has been previously, to

escalate that concern appropriately.
At that point, I thought it was nothing more, still, than a member of staff that disliked Lucy making ongoing unprofessional comments and judgments and supposition.
I am aware that there was also a separate complaint about Nurse ZC.
Q. Well, let's just pause there. I am focusing on Letby. We know that you said, for example, Dr Barrett and Nurse ZC had used a derogatory term about Letby, both of them say that conversation didn't happen although Dr Barrett accepts she did say "Nurse Death", she said, "I didn't have that conversation with Dr ZC".
So who else, apart from Dr ZC, when you say you were aware of people --
LADY JUSTICE THIRLWALL: Nurse ZC.
MS LANGDALE: Nurse ZC, sorry.
Who else, apart from her, were you aware was talking about Letby when you say you were aware and thought people were gossiping or it was malicious?
A. May I just clarify. In my statement I didn't hear a conversation between Nurse ZC --
Q. Right.
A. -- and Dr Barrett talking about Nurse Death. The comment was made after the second triplet passed

away by Dr Barrett on the corridor to myself --
Q. Right.
A. -- when she passed me and she said, "I see Nurse Death's on again."
Q. Right.
A. So I didn't hear a conversation per se.
Q. So you had had Dr Barrett say to you "Nurse Death" and you had had Nurse ZC saying the comment "Isn't it concerning she's involved and she's always there?", or something similar. So you had had two people raise with you concerns about Letby at that point.
But you thought they may still be gossip or malicious or what is your evidence? I don't know what you thought.
A. I did, I did, because Nurse ZC and Dr Barrett and Dr Mayberry, who I had also mentioned in my statement, were very friendly, they were often together, they were often sending text messages between each other. So the conversations that I am aware other staff had also witnessed were between those three. So I didn't feel they were independent concerns.
Q. Did you speak to Dr Mayberry about them at all? Did you tell him that she didn't seem engaged as a student or anything like that, or not?

A. I don't recall saying that to him. I didn't have that kind of relationship with him.
Q. Nurse ZC tells us that there were briefings at this point that staff were told they shouldn't be discussing deaths on the neonatal unit, infant deaths, or Letby, or disciplinary measures might be considered. Was that the case because there was concern that this was malicious gossip --
A. So the malicious gossip, as I said, was witnessed by a number of colleagues, as well as myself, and it was --
Q. Which colleagues?
A. So there were colleagues that I am aware of made a formal complaint.
Q. Yes, who were they? Tell us who they were.
A. *(Redacted)*.
Q. *(Redacted)*?
A. *(Redacted)*.
Q. Yes, about -- in support of Letby, malicious comments about Letby?
A. Yes, part of the complaint was about Nurse ZC's general professional behaviour.
Q. I'm not asking about her, I want to move on and ask about --
A. But part of it was about Lucy Letby and

allegations that they had heard her make that she would be -- she would be involved.
Q. So would you have been part of the briefings to staff to say: do not discuss her otherwise disciplinary measures would follow?
A. Absolutely, because at that point it was, it was -- there was nothing substantiated from our perspective on the children's unit that we had awareness of.
Q. But you had concerns yourself about her communication and you had heard something that you thought was inappropriate, didn't that ring --
A. Absolutely.
Q. Didn't that ring bells for you that it might be concerning?
A. No, I didn't have any other evidence other than concern about an inappropriate response. The briefings were not to silence anybody, the briefings were: this is damaging unsubstantiated, from our perspective, discussions about a neonatal colleague that were very damaging. So please do not gossip and discuss anything that we have no involvement in, that we know nothing about.
Q. Were you curious after hearing the comment about the triplets to know more about it? Did you have

any curiosity yourself about how they died, was it unexpected, was it expected, what were the circumstances, or did you think that wasn't any of your business on the children's unit?

A. I didn't recall how I felt. As I say, I feel like that was the first point I actually had some understanding of actually this seemed unusual to have two deaths in two days. But that was based on, as I say, my lack of knowledge and awareness of what is usual on the neonatal unit.

Q. So when did you first start to think the unthinkable, as some nurses have described it, that someone, or Letby, might be harming babies on the unit?

A. I imagine it will have been when I heard she had been redeployed to another department.

Q. When she went to the risk department?

A. Absolutely.

Q. What did you think was going on then?

A. I assumed that she had been removed because there was concern that she was involved in what had been happening.

Q. In what way did you think she was involved or may have been involved in what was happening?

A. As I say, my limited information that I had at the time was that there had been this unexpected number

of deaths. So I presumed at that point she must have had some kind of involvement.

I would have said, and I think I have said in my police statement, that I perhaps wouldn't have been surprised to hear that her lack of knowledge or her lack of skills may have led to a failure to recognise deterioration. But I absolutely would not have thought, knowing her as I did, that that would have been a deliberate act.

Q. You spoke, did you, with Eirian Powell much about Letby at the time? Were you aware Eirian Powell was describing her as a competent nurse?

A. Sorry, could you repeat.

Q. Were you aware that Eirian Powell was describing her as a competent nurse at this time?

A. Not that I recall.

Q. We know she moved to the risk department in July 2016. That must have been a matter of conversation for lots of people in the hospital, mustn't it? It is a significant event. You had made a link by then that there must be something that associated her with deaths on the neonatal unit at least; yes?

A. (Nods).

Q. So were there still instructions that people shouldn't discuss this at all? Did that continue,

concerns that people shouldn't be discussing it and it would be a disciplinary matter if they did?

A. I don't recall specifics but I would imagine that absolutely would have been the message to -- to not discuss it.

Q. How do you think that sits by policies such as Freedom to Speak Up and speaking up about concerns when all these people who may have different pieces in the jigsaw aren't supposed to speak up or talk about it or talk about it with each other? Do you think there was a conflict there?

A. I think there's obviously always room to professionally challenge. I think if we have concerns we should escalate them and we have and I have been involved in escalating concerns previously, as I did when I had concerns about Lucy as a student. However, these have to be in a professional manner and the gossip and tittle-tattle and unsubstantiated talk such as that, is not usually part of a formal professional response to concerns.

Q. Sometimes it's in the most informal settings that people tell us, when you are in a management role or a senior role, what's really troubling them. It's a big deal to make a formal complaint or come in and make -- to a meeting, and you use the term "escalate"

it, take it forwards through a process.

Actually, a trusted colleague where you can just say, "I am worried about this", isn't that a very valuable way of hearing concerns and complaints? It's not simply gossip because it is done informally, it may weigh heavily with the person that tells you something.

A. And I think that if that had been brought to me in a professional manner, in a professional -- as a professional complaint, I would have dealt with it as a professional complaint.

We were -- our usual practice and my usual practice to anything like that would be to have a conversation with that person in a private room, I would document that conversation I would document that person's concerns. And I would have escalated it to my manager or my head of service at that point.

This colleague ZC, ZC, I -- it was not a colleague that I --

Q. I'm not asking for comments --

A. I thought you asked me --

Q. No, no --

A. -- if a trusted colleague came to you, I thought that's what you meant.

Q. Yes, that's what -- well, you -- any colleague, I am talking about the principle now of --

A. Okay.
Q. -- freedom to speak up generally. How does it work for you that someone might tell you in an informal setting, not just that one? You indeed tell us you went back to the children's unit and would have probably said to somebody what you'd heard Letby say because it shocked you.
A. (Nods).
Q. Again, that would be natural for you to go back and say, "I have just heard someone say this." Do you think if you said it in an informal way like that, there wouldn't be a responsibility on the receiver of that comment to take it forward if they thought "Actually, that's really troubling"?
A. Yes.
Q. If they knew something else, another piece?
A. I think obviously, as you said before, this was a small piece of a puzzle that in hindsight --
Q. Yes.
A. -- perhaps I -- I could have escalated it. But with the limited information I had at that point, I didn't feel professionally I had a need to raise it further.
We have -- we encourage all of our staff to speak out, to bring any concerns, as you say, professionally

or personally to us as managers. I felt I had a good relationship with all of our members of staff and that they could do that and I, as I say, it is my professional practice to raise concerns if I feel it appropriate. But at that point, I didn't have all of the information that I am now aware of.
Q. Understood.
You also refer to an internal investigation being conducted, I think. Do you know what investigations were being done? Whether it was the RCPCH or internally, what did you think was happening?
A. I didn't really have much information about that. I knew that the Trust was looking at the mortality rate and the collapses on the neonatal unit. I really knew very little about it as I say, because we are a separate unit.
Q. Do you think you should have known? Someone should have told you, you are working in a children's unit.
A. I suppose we -- we are separate units. We are separate teams of nursing staff. Again, I imagine if it was our unit that it would be dealt with within our unit and escalated appropriately within our management hierarchy. I wouldn't necessarily expect it to be shared with the neonatal unit or midwifery or any of the

other units if it was an internal issue.
Q. And so by the time she had moved to the risk patient safety unit, did you think that was a matter that shouldn't be discussed because it obviously affected an employee and she was moved to another unit; is that broadly where you were at with that?
A. Absolutely. Absolutely. Obviously, you know, personal thoughts aside, you know, it's my job to try and maintain professionalism and set an example of as a role model, as a deputy manager, so we would discourage as much as we could general gossip about a colleague that, as I say, at that point was unsubstantiated.
Q. We know that nurses on the neonatal unit were all e-mailed with information about secondments or being able to move around the hospital for secondments. Was there any conversation like that on the children's unit about people wondering about those opportunities or generally talking about secondments at that time?
A. Not that I can recall.
MS LANGDALE: Just give me one moment.
Thank you, I have got no further questions.
A. Okay. Thank you.
MS LANGDALE: My Lady, there are no further questions from the Bar.

LADY JUSTICE THIRLWALL: Thank you very much indeed.
No, I have no questions either. Thank you very much indeed, Nurse Lightfoot, you are free to go.
MS LANGDALE: My Lady, I am going to ask Ms Bennett to read in sections of Sarah Jayne Murphy's statement to complete the mentoring.
LADY JUSTICE THIRLWALL: Thank you very much. Ms Bennett.

Statement of SARAH JAYNE MURPHY

MS BENNETT: My Lady, the Inquiry has received a statement from Sarah Jayne Murphy, nurse practitioner, which reads as follows:
My full name is Sarah Jayne Murphy. After studying at Chester University for a diploma in higher educational nursing studies, I qualified as a registered children's nurse in February 2004. A few week after I qualified, I went to work on the Children's Unit at the Countess of Chester Hospital where I worked until September 2013.
Whilst working at the Trust I completed the Teaching and Assessing in Practice module enabling me to become a mentor and an assessor for student nurses.
As part of the mentoring and assessing role, I became a sign-off mentor, meaning that I could work

with students during their final placement and their OSCEs, the Observed Structured Clinical Examination.

My day-to-day duties on the ward included managing the care of a small group of patients, assessment of patients' needs, planning, implementing, and evaluating care delivery according to changing health needs. I worked collaboratively with the wider multi-disciplinary team to ensure health needs were met and contributed to the development of services for children and young people, supervision of others including being a shift leader, development and education of student nurses.

In September 2013 I left the Trust to work as part of a nurse-led community continence team with the Wirral Community NHS Foundation Trust where I worked for a further five years as a Band 6 children's bladder and bowel nurse.

During this time, I completed a Bachelor of Science professional practice degree and the V300 independent non-medical prescribing modules.

I left Wirral Community Trust in September 2018 and came to work for the Wirral Teaching University Hospital NHS Foundation Trust at Arrowe Park Hospital with the epilepsy team.

Currently, I am a Band 7 children's epilepsy

specialist nurse. I am the lead nurse in a small team of nurses working closely with two paediatricians who specialise in epilepsy.

I am an independent nurse prescriber, run nurse-led first seizure and teenage clinics, gather clinical data for national epilepsy audit and work to develop epilepsy services for children and young people locally and regionally. I continue to work at Arrowe Park Hospital in the same role.

Mentorship of nursing students.

During the last year or so that I worked on the children's ward at the Countess of Chester Hospital, I became the link nurse for students. The role included planning student off-day rotas allocating each student with a named mentor, liaising with the university lecturers to ensure effective learning experiences for students. The Nursing and Midwifery Council state that a mentor is a mandatory requirement for pre-registration nursing students.

All student nurses were assigned a mentor and a back-up mentor and expected to work 40% of their placement time with their mentor. It was a responsibility of the mentor to get feedback from other nurses and professionals who had worked with their allocated student.

I do not have complete recollection of assessment and grading of students during placement, students had a large amount of paperwork to complete and were expected to arrange an initial meeting with their mentor to think about how their learning needs could be facilitated during the placement and to make a plan to achieve set placement outcomes.

At the midway point, a second meeting would look at progress so far and what might still need to be achieved in the second half of the placement and where the student might need further support and learning to achieve outstanding outcomes.

At the final meeting, the mentor and student would complete outstanding paperwork. The mentor would write a small report and if the outcomes were achieved then sign off the placement as complete.

There was also a section of this documentation for the student to complete.

During the student's placement their mentor would be expected to gather feedback from other nursing staff and nursing support staff that their allocated student had worked with. This might be done informally, for example if your student had worked a night shift with a colleague you might ask them for feedback at handover.

As registered nurses and mentors, we had support

from Practice Education Facilitators, PEFs, and could speak to them for advice and support. This included if a student was failing to meet learning outcomes for their placement.

Students would have support from their mentor from their peers and from university lecturers who would make visits to the ward during the placement.

As a sign-off mentor I worked with third year students in their final placement. A big part of the final placement, and always stressed to the student and mentor, was a final placement of the Observed Structured Clinical Examination. On this day, the student would be given a small group of patients to manage and would be expected to be involved in patient allocation, arranging of staff breaks, asking for updates from their colleagues about their allocated patients.

A drug round was also part of the assessment where the student would be expected to calculate the dose, prepare, administer medications.

I worked with a very capable third-year student who during her OSCE, made a drug calculation error and failed. We arranged for this examination to be redone the following week and made use of lots of opportunities for drug calculation practice. On her second attempt the student passed and was signed off. This was an

experience of failing the student that stands out for me. I can't recall failing other students during my time as a mentor.

I believe I was nurturing and encouraging -- and an encouraging mentor. I believe that I am approachable and friendly but always maintain a professional relationship with the students.

I tried to maintain a mix of working closely with my students whilst facilitating and encouraging them to arrange their own learning opportunities, practice and improve clinical and interpersonal skills.

I cannot be certain, however, having now reviewed the Royal College of Nursing's guidance for mentors, nursing students and midwives, I cannot say for certain whether this was the toolkit that I would have used. However, having said that, I might have used a toolkit that the university directed the students to use. I would have used Nursing and Midwifery Council standards to support learning and assessment in practice.

Mentorship of Letby.

I mentored Letby in her first year as a student nurse. I believe it was her first ward placement. I cannot recall the year. The nurse in charge of student allocation would have allocated Letby as my

student. I cannot recall who that was but this was the usual process.

I did not mentor Letby again during her training until I was asked to work with her at the end of her third year when she had failed her final placement and still had three elements of practice proficiencies to complete. I monitored and assessed her over a four-week period.

During her first placement I remember Letby being quiet and, I thought, shy. She did not show good interpersonal skills with children, parents, nurses or the wider team. I believe this to be Letby's lack of confidence and experience as she was very young and an only child away from home.

There was a tendency among some students to hang around the nurses station and the desk area. Letby was one of these students and often had quiet an expressionless look. I and other staff members found it awkward and quiet. I think she felt comfortable working with me but she remained quiet and never appeared particularly animated or to be enjoying herself.

At the end of the first placement I remember telling Letby that although she had passed the placement, it was important that she develop her communication skills, especially with the children and

families.

I presumed that this would come with practice and experience. I cannot recall Letby's reaction to my feedback. My conversation with Letby would have been documented in her student paperwork which I presume is held by the university.

In terms of my role as a mentor when working with Letby, I was responsible for ensuring that she had available to her the necessary learning opportunities and to ensure that she was able to achieve the required competencies and learning outcomes as part of the placement. Also, my role was to make sure that her off-duty rota allowed her to work at least 40% of her time with me.

During the time that she was working with other members of the team I would keep track of her progress by asking for feedback from those members of staff at handover or other times.

In terms of Letby's responsibilities she was required to make sure and take the initiative to facilitate her own learning. For example, if a student nurse felt that they would benefit from observing a ward round then it would be their duty to ask for this to be arranged for them. In addition, it was Letby's responsibility to ensure that she proactively arrange

the initial, midpoint, and final assessment interview dates and times.

Although the assessment date and times were often agreed between students and mentors, the student was required to communicate their schedule and availability with their mentors so that the arrangements could be agreed upon.

Letby did not work with me again until the end of her third year after she had failed her final placement with Nurse Nicola Lightfoot. As Letby had requested to work with me I had concerns that she might not work equally as well and with confidence if asked to work with another member of staff. I do understand that we can't get along with everyone but it is important professionally to be able to do this.

I discussed this with one of the PEFs, I think it was Anita Hargreaves, we agreed that Letby would work a shift with each of two other colleagues Anne Murphy and Azra Eccles.

Documentation from when Letby worked with me will be in her student paperwork which will be held by the university. This will include my comments in the first year about her need to develop her communication skills and from when we agreed that she would work alongside two of my colleagues as part of her retrieval process.

This was at the end of her first year. However, I do not have the documentation in my possession now.

There would have been documents in relation to Letby's final assessment as well but, again, I do not have access to these documents.

Nurse Lightfoot was already a very experienced and senior member of the nursing team when I joined the Trust in 2004. In her statement, university lecturer Ruth Sadik states that in her mentorship of Letby Nurse Lightfoot was "very supportive but very forthright".

I would agree with this statement and whilst it is important to have high standards and expectations from students, especially in their third year, I think that, unintentionally, Nurse Lightfoot may have been a little overwhelming or intimidating at times. This would not have been with Letby in particular.

I do not have a good recollection of the proficiencies passed and failed but looking at the documentation provided in Letby's student file, Letby had eight proficiencies still outstanding. Five of these had been and progress made over the previous weeks but three were still outstanding when Letby began the retrieval process with me.

I have set out the relevant proficiencies and what

they mean.

A1: demonstrating professional integrity, working with patients and families to review and monitor progress in care, timely documentation of care outcomes to ensure continuity of care.

D1: development of therapeutic relationships with children and family showing an appropriate level of communication, employing interpersonal skills of effective listening and communication, demonstrate evidence of being able to interpret verbally and non-verbal signs from patients and families, able to reflect on performance.

J1: evaluate and document outcomes of nursing and other interventions, working with the child and family to review and evaluate progress, ensure continuity of care for the patient, documentation actions, outcomes and progress.

The above is what was meant by the comments "Has made great progress in clinical practice and achieved five proficiencies. However, still has three outstanding AI, DI and JI".

I note my comments in the police statement where I stated:

"I believe that Lucy appealed Nicky's decision to fail her reasoning that there was a clash of

personalities between them. I felt awful as I had been approached due to Lucy requesting me to be her mentor for her final placement and she felt that we had a good relationship during her first year placement."

I have no recollection of the actual shift when Nurse Lightfoot failed Letby but I was fully aware that this had happened and at some point was made aware that Letby had asked for me to be her mentor for the retrieval of the final three competencies.

I do not know how the appeal process works and I do not know if it is normal practice for students to be able to request a mentor. I cannot recall who approached me about being a mentor for Letby's retrieval placement. On reflection of events, I do not think I would have been given a choice to refuse. I do not recall Letby herself discussing anything with me directly about being her mentor during her retrieval placement.

In terms of my police statement where I stated I felt awful, I do remember being worried about this, as the general feeling on the ward was that if Nurse Lightfoot, who is very experienced, had failed Letby, then that decision should stand. I think at the time I personally also believed that if Nurse Lightfoot had failed a student that decision should stand.

I cannot specifically recall the individuals who believed Nurse Lightfoot's decision should prevail. However, I do think it was reasonable to hold that view.

This is because Nurse Lightfoot was an experienced and professional nurse and regardless of her direct approach to dealing with certain matters, she would never fail a student without good reason.

I only have vague recollection of my discussion of Anita Hargreaves about postponing the retrieval process as I thought Letby may need time to process the events of recent days, ie failing her final assessment.

However, from the documentation provided I can see that it was agreed with the university that the retrieval process would start the next day.

I cannot remember whether Letby spoke to me at all before this final few weeks that we worked together.

I do not think it was common for students to fail in their final year. The student I mentioned earlier that failed with me had achieved all her competencies, it was just that the final OSCE placement was extremely stressful for students and sometimes mentors too. We were able to repeat that after a few days with some drug calculation practice.

I do not remember conversations with Nurse Lightfoot and/or Ruth Sadik with regards to

concerns about Letby. I do not remember the exact nature of conversations with the PEFs, but I do remember feeling very supported by them.

Due to the lapse of time, I cannot recall a conversation with Nurse Lightfoot or anyone else stating that Letby would not be ready to qualify as a nurse in four weeks' time, which was the length of the retrieval placement.

My concerns about Letby during her retrieval placement were whether she would be able to demonstrate the ability to work with other members of the nursing team, not just with me and so I arranged for her to work with Anne Murphy, who was a ward manager at the time, and with Azra Eccles, who was working as a Band 6 nurse in the children's assessment unit.

I believe it is documented that I received positive feedback from them but I cannot remember what the feedback was.

Letby worked with me and with other nurses when I was not on shift to achieve the three proficiencies documented above. I cannot remember the actions planned -- made for how these competencies might be achieved, but I do know that I would have monitored Letby very carefully and asked for feedback both from her and from other nurses that she worked with.

It would be usual for the retrieval placement to be documented but I cannot remember exactly where or how.

I would imagine the school of nursing would have a record of the documentation.

During her police interview Ruth Sadik discussed her thoughts about Lucy passing these final proficiencies and her comments relate to a conversation that she had with me. She stated:

"I spoke to Jayne to ask why she was passing her and Jayne had a lot of -- a lot of soul searching. It wasn't something she did easily but she felt that it was right to do. Now, my personal thoughts at that time were that Jayne was conflicted but that bit is because Nicky is quite a powerful person. She wanted to please Nicky but also that she -- her conscience wouldn't allow her to, and she had seen what she saw."

I cannot remember the conversation above with Ruth Sadik but I did feel conflicted at the time as Nurse Lightfoot had felt that Letby was not competent to pass the final placement. But after observing and working with Letby for a number of weeks, I had felt that she had achieved the three outstanding proficiencies.

I cannot recall a conversation with Ruth Sadik, but from my perspective, I was asked to assess Letby based

on the three proficiencies and whether she had met those. From what I had observed during my assessment I could not say that she did not meet those three proficiencies. Also, I would like to reiterate that I sought feedback from other members of staff that she worked with and so I had no reason to believe that she was performing well only just during my assessments.

If, however, the feedback I received was negative and raised concerns about Letby, this would have of course impacted my assessment on whether or not she had passed those proficiencies. I cannot recall what was meant by the quote, "she had seen what she saw."

Friendship.

I don't recall that Ruth Sadik and Letby were friends and I am not aware that they socialised together. My relationship with Letby was purely professional. I would not count her as a friend or someone that I would socialise with. Louise Newman(?) in her statement talked about friendships on Facebook which I do not use so I would not be aware of a friendship between Ruth and Letby.

Concerns or suspicions.

I left the Trust in 2013. I was never made aware of any suspicions or concerns about the conduct of Letby at any time.

My Lady, that concludes the statement.

LADY JUSTICE THIRLWALL: Thank you very much indeed, Ms Bennett. Is that a convenient moment for the break.

MS LANGDALE: It is, my Lady, 11.30?

LADY JUSTICE THIRLWALL: So we will rise now and start again at half past 11.

(11.13 am)

(A short break)

(11.30 am)

LADY JUSTICE THIRLWALL: Ms Brown.

MS BROWN: If we could call the witness, please.

JULIE CAROLE FOGARTY (sworn)

Questions by MS BROWN

LADY JUSTICE THIRLWALL: Do sit down.

A. Thank you.

MS BROWN: Could you please give your full name.

A. I am Julie Carole Fogarty.

Q. Mrs Fogarty, you provided a witness statement to the Inquiry dated 30 May 2024. Is that statement true to the best of your knowledge and belief?

A. Yes, it is.

Q. And turning to your qualifications, it is correct, is it, that you qualified as a registered general nurse in 1985, as a registered midwife in 1988,

and as a supervisor of midwives in 1996?
A. That's correct.
Q. And you also have a degree in midwifery and a postgraduate certificate in leadership behaviours.
A. That's correct.
Q. And turning to your career history, when did you first start working at the Countess of Chester Hospital?
A. So in 1987 I commenced my midwifery training as a student midwife.
Q. And when was your first role as a midwife?
A. So that would be in 1988, upon qualification as midwife.
Q. And that was at the Countess of Chester?
A. Yes.
Q. And I think approximately 12 years later, you were appointed Head of Midwifery in July 2010?
A. Yes, that's correct.
Q. And in that intervening period you worked solely at the Countess of Chester Hospital, did you?
A. Yes.
Q. And you moved, I think, from your role of Head of Midwifery to that of Associate Director of Risk and Safety in April 2017, is that correct?
A. That's correct, yes.

Q. And having worked in midwifery for all of your career up to that point, why did you make that move?
A. I was asked by the Director of Nursing at the time to go and oversee that department because the previous postholder had left.
Q. And who was the previous postholder?
A. Ruth Millward.
Q. And I think it is correct that you retired from the NHS in April 2020?
A. Yes, that's correct.
Q. So that was after three years of Director of Risk and Safety but how long in total did you work at the Countess of Chester Hospital?
A. So from 1987 to 2020, so 33 years.
Q. And how did you find the Countess of Chester as a place to work?
A. It was a happy place to work, people were proud to work within maternity services which is where was the bulk of my career.
Q. And in your role as Head of Midwifery -- you set out in your statement at paragraphs 8, 9 and 10 what your role involved. But it's correct that included in your responsibilities was ensuring midwifery care was delivered by competent midwives and best practice was followed?

A. That's correct, yes.
Q. And you also say that within your area of responsibility, was the quality of the patient experience. Can you just expand a little on what you mean by that phrase?
A. So it's making sure that women had a voice and their views were listened to and that the care they received was to the best of the ability of the staff and the services available, and that it moved in time with new initiatives as they developed within midwifery.
Q. And you say in paragraph 9 of your statement:
"I had lead responsibility for co-ordinating clinical risk activities with maternity services."
In practical terms, what does that mean?
A. So it's making sure that the midwives were trained, so they knew how to report incidents using the Datix system; that any reports that were produced were received at the Women & Children's Care Governance Board and that as a, as maternity services we reviewed any new guidance that came out, issue -- and things like the NICE guidance, that if anything new came out that they were reviewed within a timely manner and that anything that needed changes in practice that they were implemented.
Q. And your role as Head of Midwifery, did that

ever involve actually working on the ward as a midwife if -- filling in if the ward was short-staffed?
A. No, not clinically no.
Q. So there was no -- from when you took over as Head of Midwifery, there was no clinical aspect to your role?
A. No.
Q. And you say in your statement as well at paragraph 9 that you participated in the Trust managers on-call rota?
A. Yes.
Q. Can you explain what that was?
A. So out of hours there was always someone on duty for the clinical psych ward, who managed the Trust, to contact someone if there were issues with ambulance delay, staffing. So it was making decisions to try and keep the Trust safe out of hours and we reported directly to the -- there was always an executive on-call that we would escalate if we had concerns.
Q. So the on-call rota would be the most senior person on site subject to access to an executive director, is that --
A. We wouldn't be on site, we would be at home, as would the executive but we would attend if we needed to.

Q. And how often would you be asked to be on that call rota?
A. Probably a couple of times a month.
Q. And in terms of your physical presence on the ward, how often would you, you said you didn't have a clinical role, but how often would you be physically present on the maternity ward, walking around?
A. Probably three, four times a week.
Q. And where was your office in relation to the maternity ward?
A. It was in the Long House Building, which was the building virtually next door to the maternity unit.
Q. So did you have to leave one building and go into another or did you just --
A. There was a corridor, so it, it was just a corridor but I did have to leave one building, so I was based in what was known as the Long House, but it was literally next door.
Q. And in terms of the neonatal ward, would you ever have cause to visit the neonatal ward to actually walk on to that ward?
A. No, no, it wasn't in my remit, so no.
Q. And just looking at where the Head of Midwifery fitted into the divisional structure. Midwifery was part of the Planned Care Division?

A. Yes.
Q. And then at the top of the Planned Care Division there was a divisional director of Planned Care, who was that?
A. Linda Fellowes.
Q. And then again, looking at Planned Care, there would be a Head of Nursing for Planned Care and that was Carmel Healey?
A. That's correct, yes.
Q. There was your role, obviously, as Head of Midwifery, and then there would be a Medical Director for Planned Care and that was David Semple, I believe?
A. Yes.
Q. And what was his specialty as a doctor?
A. So he was an obstetrician.
Q. And in terms of that management structure of the Planned Care Division, David Semple and Carmel Healey, did they continue in practice or were those full-time management roles?
A. So Mr Semple continued clinical practice. Carmel Healey was like myself; it was a management role.
Q. And who did you report to?
A. So I reported directly to Alison Kelly, the Director of Nursing, and Linda Fellowes, the divisional director.

Q. And did you feel that this management structure, with those three -- well with your -- four posts sitting at the top of the Planned Care Division was that a management structure that worked effectively?
A. It appeared to work for me because the -- the divisional directorate, that was more the business planning side and the Director of Nursing that was the professional aspects.
Q. And to understand how it worked in practice, if you had concerns, for example with mortality rates, would you be raising those issues with the divisional director, the Medical Director of Planned Care or would you be going straight to Alison Kelly with those sort of issues?
A. I would raise them with both people.
Q. And just staying with the divisional structure for a moment. Midwifery, as you have explained, was part of the Planned Care Division, but the neonatal unit was part of the Urgent Care Division.
A. That's correct, yes.
Q. And you say in your statement at paragraph 21 that you felt that it was not good practice to have the mother in one division and her baby in another, so you are referring there to the fact that the mother when on a maternity unit would obviously be in the Planned Care

and if her baby had cause to be admitted to the neonatal unit, the baby would then be under the Urgent Care Division?
A. Yes.
Q. And what were the problems that you saw with that structure?
A. I just felt that if the two areas of care had been within the same division, there would have been more joint working, there would have been better communication and we would have been on the same journey together at the start of projects.
Q. And Dr Brearey raised this issue and you refer in fact to 20 July 2015 in your statement, at paragraph 21 as well, that the divisional structure with Urgent and Planned Care split, obstetrics, gynaecology and midwifery on one side, paediatrics and neonatal within Urgent, and that was discussed at the Quality, Safety, and patient Experience Committee that you sat on, I think, as well?
A. Yes, I did.
Q. And Dr Brearey said at that meeting that he considered the split would hinder the improvement of maternity, neonatal and paediatric services. Did you agree with that view?
A. I did, yes.

Q. And I think you have explained, but did you -- what did you understand was Dr Brearey's concern and objections to the structure?

A. It was similar to mine. The fact that we were both reporting through two different divisional lines instead of through one joint divisional line. So methods of communication sometimes were delayed.

Q. And just staying on communication there. You say that you felt that being, as you have explained now, you say in your statement that if you had been in the same division you felt there would be improved communication. Just so I am clear. You are talking there, I think, about communication in terms of the management structures, or are you also talking about communication at a nursing and doctor level?

A. More as --

Q. Nursing and midwives, I should say.

A. More as the management structure.

Q. And in terms of this Inquiry, do you feel if there had been one Women's and Children's division, as I think there was before --

A. Yes.

Q. -- and I think as there is now, do you think that you and your colleagues in the midwifery obstetrics and gynaecology might have been alerted at an earlier

stage to the concerns that we know there were in the neonatal unit?

A. Yes.

Q. And related to that, and maybe if you can just expand on that -- it might seem obvious to you, but why do you say that you think you would have been alerted to those issues earlier?

A. We would have been at meetings where they would have been potentially discussed.

Q. And related to that question, do you think that divisional split also had an effect on how the management responded to the issues because they had two chains of command going to them?

A. I don't -- I don't feel that I can comment on how the management responded.

Q. I'm just staying with communication then for a moment. In terms of the practical aspects of communication, you have explained that at management level the two units meant that you were in different meetings, but you say that the labour and neonatal units were positioned next door to one another.

Can you just explain the geography as to where the labour ward and the neonatal unit was?

A. So from a clinical position of wards, it was literally through a door. So the labour ward, you

literally went through a door and that's where the neonatal was. And also from the Consultants' point of view they were based in the same building as myself. So that eased communication as well.

Q. So just to be completely clear, the labour ward and the neonatal units weren't on different floors?

A. No.

Q. They were on the same floor. And when you said about offices, did that mean that on a daily basis you would be walking past colleagues who worked on the neonatal unit?

A. No. No. So the Consultants were in the same building but not the, not the neonatal nurses.

Q. So you worked in a different building to the Consultants?

A. No, my office was in the same building as the paediatricians, obstetricians and myself, we were all based in the Long House Building.

Q. I see, thank you.

And the Inquiry has heard some characterisations of there being hostile relationships between midwives and those working on the neonatal unit, doctors not feeling welcome on the maternity ward, tensions between nurses and midwives. Is that something you recognise?

A. It's not something that was ever escalated to

me and not something that I recognised from my time clinically working.

Q. And what was your view, your personal view of relations between midwives and nurses? You obviously worked as a midwife for a long period before you went into a management role.

A. Yes. So there -- there never seemed to be a problem, you know, there was always good communications so the minute somebody came into the labour ward and there was a potential that they may need neonatal services, you would go through as a shift leader and alert the neonatal unit to that fact so they could start to prepare.

Q. So that's at the level of midwives and nurses.

A. Nurses.

Q. At your level, at the management level, if you wanted to speak to someone on the neonatal unit about a common issue, who would be your point of contact?

A. So I would go to see the manager at the time so that was Eirian Powell.

Q. And what sort of working relationship did you have with Eirian Powell?

A. We didn't have a problem. We didn't see each other very much but if I needed to speak to her she was -- she always made herself available and we always

agreed on a plan going forward.
Q. And in practice, how would that take place, would you walk to her office, call her on the phone, just a feel of how often you would be in communication with Eirian Powell?
A. So it would be very, very infrequent. But normally I would email her to see if she's free.
Q. And in relation to Dr Brearey who was the clinical lead of the neonatal unit, what was the extent of your contact with him?
A. So, again, I would see him very infrequently because he wasn't working in the same sphere of practice as myself.
Q. And how would you describe your working relationship with Dr Brearey, or was it minimal?
A. Very -- if ever I needed to engage with him there was no issues whatsoever.
Q. And presumably you would have a great deal more contact with the Consultant obstetricians?
A. Daily.
Q. Just staying with the culture of the hospital for a moment. Generally the relationship with doctors and nurses, how would you have observed that, how would you characterise that?
A. I can only comment on the relationship between

doctors and midwives.
Q. Of course.
A. And I felt there was excellent teamworking.
Q. And relationships between staff and senior management, again, you will be dealing with staff within your unit, but what were the relationships like between staff and senior management?
A. I mean, I can -- again, I can only really comment for within maternity services and there didn't appear to be a problem. It wasn't anything that was ever escalated to me or anything that came out through any incident reporting or -- there were lots of different channels that people could go to if they needed to and they were never, they were never used.
Q. Why was that? Why were these channels never used?
A. Because obviously people didn't feel there was a need to escalate. They felt that if they wanted to speak to managers they had access.
Q. And in relation to access to managers, your relationship with Alison Kelly as the person who you reported to, or one of the people you reported to, how often would you see her?
A. So I had a monthly one-to-one with her but I would also see her at meetings and I may bump into her

on the corridor if I went to the execs' office to escalate or to drop a report off, then I may see her there.
Q. And what could you or -- could you comment about Alison Kelly's level of engagement with the issues on the maternity ward and the issues that you were dealing with?
A. So she was always engaging, if ever I had anything I need today escalate I always had access and she listened.
Q. And in relation to Tony Chambers and Ian Harvey would you have cause to have much contact with either of those?
A. I didn't see them on a regular basis but there would be meetings that they would be present at that I would also be present at.
Q. And members of the board, Sir Duncan Nichol would you come into contact with him?
A. So again, I didn't see him on a regular basis, but he may be there in the execs' office. He came to visit maternity unit when we won an award. So he was aware of what was happening but I didn't see him on a regular basis at all.
Q. And the non-executive board members, would you have known who they were?

A. Yes.
Q. Did they ever visit?
A. Yes, I mean, some of them were -- some of them were on QSPEC and there were a number of meetings that I attended that they represented -- you know, represented the non-execs on.
Q. Just one final point looking at the divisional structure, you gave an interview, I think you'll recall, to Facere Melius in -- on 14 July 2020. You recall that interview?
A. Pardon? Sorry?
Q. You had an interview --
A. Yes, yes.
Q. -- on 14 July? And one of the points you made in that interview was you felt the fact that neonatal unit being in Urgent Care and the fact that A&E also clearly was part of Urgent Care with the four-hour target that they work to, meant that the neonatal unit was swamped, what did you mean by that?
A. Well, the fact that that was a big division with a lot of competing priorities.
Q. And you also say --
LADY JUSTICE THIRLWALL: Sorry, I wonder, could you just -- I am sorry, Ms Brown.
But the neonatal unit was swamped, do you mean sort

of overlooked or do you mean too much to do? I wasn't ...

A. Yes, the fact that there was a lot of competing, so A&E had the four-hour target and I, mean that may have not been the fact, that was just my personal opinion.

LADY JUSTICE THIRLWALL: Yes, and that's what you are being asked about.

A. That that, you know, potentially because that division was very big and had a lot of competing pressures, because of the nature of the work, then the neonatal unit potentially suffered because of that.

MS BROWN: And you go on to say in that interview, which I think is what you are explaining now, that you felt it wasn't given the attention it deserves and people weren't aware of the issues in the neonatal unit.

Who are you referring to there as -- who are the people who weren't aware of the issues?

A. So the -- the Urgent Care management. But that, that may have not been correct. That was just an assumption I was making but that may not have been correct. I didn't have any hard facts. It was just a feeling.

Q. And when you are saying there people weren't aware of the issues in the neonatal unit, what issues

are you referring to there, are you talking about the issues of increased mortality or --

A. Yes.

Q. -- more generally?

A. Yes, because obviously I was interviewed in 2020 and I was aware then of the mortality issues.

Q. If we can look now at some of the committees that you sat on. We are looking first at the Women's & Children's Care Governance Board, and if I can call up INQ0015325.

My Lady, this is tab 13 of your bundle.

LADY JUSTICE THIRLWALL: Thank you.

MS BROWN: This is going to show up the Terms of Reference, I hope.

So this is a document that's the Terms of Reference. This document, Ms Fogarty, was actually -- is dated February 2016 but it appears they were updated on a, on a sort of annual basis, the Terms of Reference --

A. Yes.

Q. -- so would it be right to say that this, this document would be reflective of the year before and probably the year after?

A. Yes.

Q. And we can see there in terms of the

Women's & Children's Care Governance Board that the chair was Dr McCormack who was a consultant obstetrician and gynaecologist. How would you describe your relationship with him?

A. I would say I had an excellent working relationship with Mr McCormack.

Q. And you were the deputy chair?

A. That's correct, yes.

Q. And what did the role of deputy chair of the Women's & Children's Care Governance Board involve?

A. So if Mr McCormack was on leave, so unable to attend the meeting, then I would chair the meeting.

Q. And did you have an input into, for example, what would go on to the agenda?

A. Not, not unless I was actually going to chair the meeting.

Q. Would you discuss the agenda with Mr McCormack?

A. Not before the meeting, no.

Q. But presumably if you had something you felt would be on it you would be able to raise that with him?

A. Yes, we had a standard agenda item but any items you wanted to be received, you referred them to the risk and safety lead and she put the agenda together.

Q. And if we just look down that list, we can see, as one would expect, there are representatives from the Planned Care Division, from Midwifery, so you, Mr McCormack, the Head of Nursing for Planned Care, and then also there's representatives from the Urgent Care, Dr Jayaram, Dr Brearey, the Head of Nursing of Urgent Care.

So this was a committee that brought together -- whereas there was a division in management structures, this was the committee that brought both units together in terms of the care of women and children?

A. Yes.

Q. And if you can just in overview, what would you say the primary role was of the Women & Children's Care Governance Board?

A. So we were monitoring, so from a midwifery aspect I was there to ensure that reports that had been received in the Trust were reviewed and then received in the board. Any serious incidents that had action plans, that they were monitored until they were completed. If we had had an inspection by the CQC and there were action plans, that they were received at this board and then they were monitored until actions were completed.

Q. And presumably as deputy chair, whilst you obviously came to it with a midwifery perspective, your

position on the committee, as with everyone on the committee, was to see that this looked at things holistically, that the committee looked at both midwifery and the neonatal care?

A. Yes.

Q. That was the purpose of the board presumably?

A. So we were responsible so the -- everybody who was a member was responsible for bringing documents to the meeting and at that meeting, we all would review and challenge. However, we were aware that because it is such specialised work, we were dependent on the specialist to provide the overview.

Q. And I think if we could go over the page to page 2, we will just see the duties and responsibilities there. And we see the second bullet point down, that one of those was to:

"Provide assurance to the board lead executive of effective risk management".

Again, what does that mean in practice?

A. So if we had any concerns that were identified or any gaps or risks that we then made sure that we escalated them through this meeting.

Q. So if you had a concern, for example, about increased mortality rates, this would -- that would be the sort of thing that should be escalated through this

meeting?

A. If, if that information was brought to the meeting, yes.

Q. And going down the next bullet point, so the third bullet point:

"Review and monitor the risk registers, escalate risks to the divisional and organisational risk registers".

Again, just can you explain in simple terms what that actually in practice meant?

A. So every area had a risk register and if a new risk was identified, they would be discussed at a divisional level and then brought to this meeting for noting and escalating further.

Q. And then finally, not quite finally, the next but one down says:

"Review and monitoring ..."

And one of the things you were reviewing and monitoring was incident trends.

A. Yes.

Q. And obviously the trend that this Inquiry is concerned with is the trend of increased mortality, so that would fall -- should that be the trend that would fall within the remit of this?

A. Yes, we would be looking at the data.

Q. When you say you are looking at the data, what data would you be looking at on a regular basis?

A. So, so every month we would be looking at any new Level 1, 2 or 3 investigations, progress of action plans and any trends that were being identified that were being flagged up to us.

Q. And then just the last one that has particular relevance, three from the bottom:

"Also duties and responsibilities to ensure that clinical performance, quality monitoring and reporting mechanisms are working effectively".

So that would be one of the responsibilities of this board.

A. Yes. Yes.

Q. So in terms of -- I think you have accepted that this would be an appropriate forum to discuss concerns about increased rates in mortality, more babies dying; this would be something that would fall --

A. Yes.

Q. If there were concerns about this, this would be the place to discuss it?

A. Yes.

Q. And this would be the place that you would bring, you would expect people to bring those concerns to you?

A. You would expect them to bring those concerns, yes.

Q. And what about concerns about some commonality in terms of a member of staff being connected to deaths or collapses, would that be something that you would consider could be raised in this forum?

A. It could be, yes.

Q. So turning now to another committee that you sat on, and if I could go to INQ0002639.

So this is the Quality, Safety & Patient Experience Committee and this, we can see there at the top, was a committee that reported to the Board of Directors?

A. Yes.

Q. So there was a hierarchy here, correct me if I have this wrong, Mrs Fogarty, where the Women's & Children's Care Governance Board would take the views from the neonatal and the midwifery and look at things from the perspective of women and children and babies and then their concerns would be escalated to QSPEC?

A. Yes.

Q. And we see, just picking out some of what they say the purpose was in the Terms of Reference there, four bullet points down:

"To monitor serious untoward incidents".

How would the committee do that?
A. So the -- Ruth Millward would produce a report for that committee on numbers and progress, et cetera.
Q. So if there was a serious incident on the neonatal unit, you would expect that to come up to QSPEC?
A. So if it meets the STEIS Level 2 or 3 reporting then, yes.
Q. And it says there as well, the next bullet point:
"To review the risk register."
There seems to be some overlap here with who is looking at risk registers. Can you just explain that, was there an overlap or was this forming a different function?
A. So the review of the risk registers is when the divisions have escalated a risk that cannot be managed at divisional level and the executives need to be aware of.
Q. And it says then, three bullet points up, under the section 1 on purpose:
"To gain assurance from divisions in all matters to do with risk governance, quality, and patient experience."
How, in practice, did QSPEC gain assurance from the

divisions?
A. So if there was something that was a concern they would invite the lead Consultant or manager to QSPEC to present assurance.
Q. And if I could just turn to paragraph 33, then of your statement, where you at the end of that you refer to one other board you sat on and that was the Trust Safeguarding Board, and you say that met four times a year.
What dates were you a member of this board?
A. Throughout my time as Head of Midwifery.
Q. And who chaired that board?
A. That was chaired by Alison Kelly.
Q. And if you can recall, other than yourself and Ms Kelly, who else sat on that board?
A. So Karen Milne sat on there, she was the lead midwife for Safeguarding, her deputy, there were members from external agencies.
Q. So approximately how many members on that board, from recollection, sitting at the table?
A. About 20, if I recall.
Q. And who did that board report to?
A. I can't, I don't know that answer.
Q. And you say in your statement there were quarterly meetings to support effective delivery of

Trust Safeguarding agenda. What was the Trust's Safeguarding agenda?
A. I don't know that in detail. So I can't answer.
LADY JUSTICE THIRLWALL: So what did you think was the purpose of the board?
A. So the purpose of the board was to make sure --
LADY JUSTICE THIRLWALL: In practical terms.
A. In practical terms, they monitored things like mandatory training for safeguard to make sure that staff were getting the training. If there had been a serious case review that the Trust had looked at it and looked at the implications for the Countess and addressed any action. That there was --
LADY JUSTICE THIRLWALL: Let's take that example.
A. Yes.
LADY JUSTICE THIRLWALL: Where would the outcome of the review have been sent?
A. So, so an example being so Victoria Climbié, when that report came out, I met with Karen Milne from a midwifery perspective to look if there were any, any actions we needed to take, but that report would come at that meeting.
LADY JUSTICE THIRLWALL: To the Safeguarding Board?

A. To the Safeguarding Board, yes.
LADY JUSTICE THIRLWALL: Then does that mean -- just reflecting on what the practicalities were, does that help you remember who the board was accountable to?
A. It, it sorry, it doesn't.
LADY JUSTICE THIRLWALL: Where would we be able to find that out?
A. It should be in the Terms of Reference of the Safeguarding -- because they had Terms of Reference so it should be in that.
LADY JUSTICE THIRLWALL: It may be that we have them but you can't remember --
A. I can't remember, no.
LADY JUSTICE THIRLWALL: All right.
MS BROWN: And you speak there, and you have spoken in response to a question there about the mandatory training you are referring to. Did the Safeguarding Board, did they look at the content of that mandatory training, was that something that you would consider whether the content of the training was adequate?
A. I don't recall us -- it ever being an agenda item to actually look at the contents of the training. It only looked at the delivery, ie percentage of staff that had attended.
Q. And in terms of turning to that, if you are

unable to -- so what I was intending to ask is whether you were aware whether the training made clear who Safeguarding issues should be raised with and what the level of concern was needed before a concern was raised with the Safeguarding Board -- are you able to help with that?

A. Yes, I mean I attended the same mandatory training as my clinical midwives and we were always told that you could go to the Safeguarding team if you had a concern and it was better to escalate and it be found not to be a concern than to not escalate at all.

Q. And you said just earlier about the list of people who were trained. The Inquiry has heard evidence that there were a large number of doctors training with their six-month placement. How did you, as a hospital, approach Safeguarding training for those doctors who were rotating through the system being --

A. I -- I wasn't responsible for any, any part of doctor training. I only know from the Consultant obstetricians' point of view they attended the midwifery training alongside the midwives for Safeguarding.

But I am unable to provide information about the rotational doctors.

Q. But I am asking you here not in relation to your Head of Midwifery role but as sitting on the

Safeguarding role, how did you assure yourself as a member of a board that the doctors working there, part of the staff, were properly trained? Was there a system for seeing --

A. They were part of the statistics and it, it demonstrated that there was compliance for all members of staff. They were broken down into staff groups, the report, so you knew that doctors were getting the training.

Q. So as far as you were aware --

A. So as far as I was concerned, everybody had access to Safeguarding training.

Q. Having access is not quite the same as doing Safeguarding training. Were you looking at who had actually completed their Safeguarding training?

A. Sorry, can you repeat?

Q. Were you looking at who had actually completed Safeguarding training as opposed to simply had access to it?

A. No, it is who has completed.

Q. Mrs Fogarty, it appears that the suspicions about Letby harming babies were not in fact treated as a Safeguarding concern and it was not raised through Safeguarding channels. Given your role on the Safeguarding Board, have you got any reflections as to

why that was?

A. No. I, you know, I have never been asked as to why that was.

Q. Well, sitting on the Safeguarding Board, you have told us about your training, that you understood if there was any suspicion, even if you weren't sure, to raise it. Why, why do you think no one took that view about the concerns they had about Lucy Letby?

A. I can't answer why colleagues didn't, didn't escalate through those channels.

Q. At what point did you have suspicions, Mrs Fogarty?

A. So I became aware -- so, obviously, I was aware of three neonatal deaths in July of 2015 because I attended a Trust Serious Incident Panel but I then next became aware in June 2016.

Q. And at that point, in June 2016, you were aware of suspicions about -- a member of staff about Letby?

A. I didn't know the name but I knew there was suspicions following the death of the triplets.

Q. So whilst you may not be able to answer on behalf of other people, why, why did you not raise that as a Safeguarding concern at that point?

A. Because I didn't have enough data. I didn't

have the information, I didn't have the clinical information that was required. And I was also aware from the workstreams by the executives that there were, there were people who were appropriately trained reviewing the clinical care of the babies.

Q. You did go on, and we shall come to this in due course, but there was a point where you were the day-to-day manager of Letby -- (overspeaking) --

A. That is correct.

Q. At that point, clearly you knew exactly the person involved and the suspicions that were being raised. At that point did you not think this should be raised as a Safeguarding concern?

A. So I wasn't Lucy's direct line manager until 2018 when the police were already involved.

Q. Prior to the police being involved, did you not -- you were aware at that point that Lucy had been moved -- Letby had been moved off the unit?

A. No.

Q. Did you --

A. No, I wasn't aware that she had been moved off the unit until the -- July, July '16.

Q. And at that point, why did you not raise a Safeguarding issue at that point?

A. Because I didn't have any further information

to back up.
Q. And you are aware, were you, Mrs Fogarty, that the guidance on Working Together is that Safeguarding is everybody's responsibility?
A. Yes.
LADY JUSTICE THIRLWALL: Sorry, Ms Brown.
So did you think of raising it?
A. No, because --
LADY JUSTICE THIRLWALL: You have given a lot of reasons why you might not have done it. But I just want to see whether you actually thought of it in the first place.
A. I didn't think of it in the first place.
LADY JUSTICE THIRLWALL: And I just wonder if you might reflect now and think I wonder why that was that you didn't think of it as a Safeguarding issue.
A. I think at the time I felt that the Executive Board had initiated actions to try and review the whole situation and I didn't have the clinical component.
So my work with Sian Williams had demonstrated that Lucy was a common denominator though not involved in every collapse, but I didn't have the clinical situation because I have not got the clinical expertise to interrogate neonatal data.
LADY JUSTICE THIRLWALL: No, you have explained

that. I just wondered why you didn't think it was a Safeguarding issue. You didn't get as far as thinking of the other things, I understand that.
A. Yes.
LADY JUSTICE THIRLWALL: But it just didn't occur to you.
A. It didn't occur to me.
LADY JUSTICE THIRLWALL: Do you think, on reflection, that this is something that ought to be considered a Safeguarding issue?
A. Definitely, definitely, on reflection it is something that I would have done.
MS BROWN: And turning now, then, Mrs Fogarty to the involvement that you had with reviewing the deaths of some of the babies on the indictment from a maternity aspect, you were involved in obstetric secondary reviews, and I think you confirm in your statement that you were involved in a number of the indictment babies, certainly you were involved in the obstetric secondary reviews of Child A, Child C and Child D.
Can you just explain, assist with what an obstetric secondary review was?
A. So it is a review purely of the obstetric and midwifery care provided to a mother and it involves a comprehensive critical analysis of all care provided

from the first point of contact with maternity services to delivery or to the postnatal period, if there's a complication with the mum.
So what we are trying to do is make sure that the correct pathways were followed, the correct escalation, correct documentation, and that care met our pathways and what was expected.
Q. And in what circumstances would there be a OSR, obstetric secondary review, what would trigger one?
A. Anything where there was a poor outcome or concerns about care.
Q. And when you say poor outcome, that would be poor maternal outcome or maternal complications?
A. Maternal or neonatal outcome.
Q. And what was the procedure that you followed to conduct an obstetric secondary review? So one assumes you would examine the notes, but what else would go on? In terms of speaking to the midwives or doctors, what was the process of the review?
A. So it was purely a review of the, the case notes and the handheld record that the mum and electronic notes, if required, for the obstetric, for the OSR, the obstetric secondary review.
If we decided that it needed a further deeper

comprehensive review then obviously that would be then notifiable and it would be a root cause analysis and that would involve interviewing staff.
Q. So this was an initial paper exercise?
A. Definitely, yes.
Q. And who would generally make up the review panel?
A. So there would always be an obstetrician, a senior midwife and a risk and safety lead as a minimum.
Q. And how would you reach conclusions about whether the standards of care had been set?
A. Benchmark it against practice and get clinical guidelines.
Q. And what was the system to ensure that any issues you did identify were followed up, followed up?
A. So if we found an issue with an individual they would be spoken to. If we found a theme that would be included in the mandatory training, it would be escalated at handover so that all staff received that information.
Also we had a resource room on the labour ward where anything that we had identified from reviews, there was a poster presentation and the staff used to go in there and read those so that they were familiar with

the findings. But the most important things was that if an individual had not followed policy or their documentation wasn't accurate, that they were informed, because otherwise you are never going to improve practice if the individual wasn't aware.

Q. So as I understand it, you were looking at any individual poor practice but that the method of doing these obstetric secondary reviews would or should have picked up if there was a trend of a problem?

A. In maternity, yes.

Q. And would families be involved if an obstetric secondary review had been triggered?

A. No.

Q. And in terms of the notification of the deaths, Mrs Fogarty, in your role as Head of Midwifery, would you always be informed if a baby had died either on the maternity unit or after transfer to the neonatal unit?

A. No.

Q. Why was that? It was not something as Head of Midwifery you would need to be made aware of if there was a death on the unit?

A. It would be good practice but if a baby died in the neonatal unit it, it wasn't within my remit, the service didn't belong to me.

So I didn't always get notified of neonatal deaths.

Q. But as I understand it, if there was a poor outcome of the child, or of the mother, that would trigger an obstetric secondary review, so didn't you need to know if there was a baby that had died to trigger the review?

A. So we would know from Datix that, that -- from the Datix incident, and that would initiate our review. But I wasn't -- there wasn't a formal process where I was informed of every review.

Q. But you would always come to know, is that correct, because you would always need to do an obstetric secondary review if a baby had died?

A. Yes, providing we were aware.

Q. And in fact that clearly did happen in the case of Child A, Child C and Child D?

A. Yes.

Q. You became aware that they had died because you were involved in all three of those obstetric secondary level reviews?

A. Yes.

Q. And you say in your -- you accept in your statement, this is paragraph 69, that it was unusual to have three deaths on the NNU within two weeks.

A. Yes.

Q. And how were you able to say that, that it was unusual to have three deaths?

A. Because you -- we wouldn't be doing that number of obstetric secondary reviews in such a short period of time in relation to neonatal deaths.

Q. And you have talked at the outset a little bit about the communication and there would be, because of the geography you would see people who worked in the other units. Did you, did you go and speak to your colleagues in the NNU, did you raise it and say, "This seems very unusual"?

A. No, no.

Q. Why was that?

A. Because we had gone to a -- there had been a paediatrician present at the Serious Incident Panel and he didn't escalate any concerns.

Q. Did you think, having made the observation that you had made, that it was unusual that there were three deaths on the neonatal unit, and we will come to it in a minute, but the obstetric secondary reviews didn't, as I understand it, didn't flag a problem from the maternity side; that is correct, is it?

A. Yes, that's correct.

Q. So you've got three deaths which is unusual, you are not aware or no problem has been identified from

the maternity point of view and we've got the existence of the Women's & Children's Care Governance Board.

Did you think it was appropriate for that to be raised and then discussed at that meeting?

A. So that would be something that would be required, that would be tabled by the paediatricians because they are the experts in neonatology and when we attended the Serious Incident Panel in the July, Dr Brearey hadn't escalated any concerns.

So, therefore, I was assured because he was the -- he was the expert in neonatology.

Q. We are going to come to the meeting in just a moment.

A. Yes.

Q. But just dealing for a moment with the obstetric secondary reviews of Child A, Child C and Child D, I just want to be clear so that there is no misunderstanding. There is no reference in any of the obstetric reviews of any issue of infection on the maternity ward and from your perspective on the maternity ward, that played no part in the death of these three babies?

A. No, we never had any issues with infection at all.

Q. And where you have, as you have explained, you

came to a conclusion that at the end of the obstetric secondary review that there weren't any concerns from a maternity/obstetric perspective, in that situation as a matter of course, we will come to the 2 July meeting in a moment, but as a matter of course would you then have a meeting with your neonatal colleagues in order to understand the overview of the picture and of why in fact that baby had died?

A. No. What we would, we always recommend that they did their own review with the same intensity that we, we did for the obstetric element.

Q. But there would, as matter of course, be a roundtable discussion, so to speak?

A. So all, so they, they would be discussed at the perinatal mortality meeting that were held quarterly and -- and someone attended from Alder Hey as well, a pathologist attended from Alder Hey, and all neonatal deaths and stillbirths were discussed at that meeting and it was a joint meeting between the obstetricians and paediatricians.

Q. Thank you.

So coming now to the meeting of 2 July and it appears that there was a Serious Incident Panel meeting on 2 July and this was to discuss the three neonatal deaths and at paragraph 55 of your statement, you quote

helpfully there, the extract from the case review of Child D and it's within that case review that this Serious Incident Panel is mentioned.

And it says:

"... the Executive Serious Incident Panel on 2 July 2015; there had been three neonatal deaths in a short period of time and the circumstances were discussed to identify if there was any commonality which linked the deaths ..."

And going then at paragraph 17, you explain that that meeting was called by Alison Kelly, the Director of Nursing?

A. Yes, that's correct.

Q. And was that -- did she discuss that with you in advance or --

A. No.

Q. -- were you just asked to attend?

A. No, I was just asked to attend.

Q. And you helpfully, in your statement, you set out at paragraph 71 confirming that you attended the meeting and setting out who else attended. Alison Kelly, the Director of Nursing, Ruth Millward, the Head of Risk and Safety, Stephen Brearey, Dr Brearey, as the clinical lead of neonatal unit, Debbie Peacock, who was the Risk and Patient Safety Lead, and then Sian

Williams, the deputy director of nursing, so the deputy of Alison Kelly?

A. (Nods).

Q. And what did you understand to be the purpose of this meeting?

A. To try and explore whether there was a concern that needed further escalation and investigation.

Q. And can you recall the meeting itself, how you went about that? Did you look at the medical notes, what was the process?

A. So, no. So before I went because I knew why I was going, I reviewed the three OSR and I made a summary note in my Head of Midwifery notebook that I was able to take so that I was assured that for the three cases the mother's care had been looked at and we had no concerns, and that's how come I know who was in the meeting because I made, in my summary notes, who was present.

Q. Yes, I think --

A. I made no notes from the paediatrician element. So therefore that tells me that no concerns were escalated, otherwise I would have written that in my notes.

Q. And we have seen a copy of your handwritten note --

A. Yes.

Q. -- listing who was there.

And had you -- Mrs Fogarty, had you ever been involved in a meeting to look at commonality of three neonatal deaths in this way before --

A. Never.

Q. -- or was this a --

A. No.

Q. So this was a unique experience?

A. This was, yes.

Q. And did you have or was there discussion at the meeting of any form of checklist or agenda to assist with approaching, in a consistent way, whether there was any commonality?

A. No.

Q. So at the meeting you were looking for a common feature. Had there been a common feature identified, clearly that was going to be a very serious issue, potentially a very serious issue?

A. Yes.

Q. So was there any consideration, or did you raise at the meeting, or did anyone raise at the meeting, given the potential seriousness of what was being discussed, whether this meeting should be attended by the Consultants who were involved in the care of the

babies and were present at the -- failed in this case -- resuscitations of Child A, Child C, and Child D?

A. The paediatricians had elected to send Stephen Brearey to represent them so there was no discussion about other paediatricians. They didn't go in great detail about each individual case, you know, Dr Brearey, you know, provided a summary report, verbal report, and he didn't identify, as far as I recall, any issues that he felt warranted any further action at that time.

Q. Looking back now, given sort of the unusual nature of this meeting, looking at whether there are any common features, do you think you would have -- as a member of that meeting would you have been assisted by hearing from the Consultants who were the treating Consultants?

A. So with hindsight, really what should have happened is there should have been a total review of all three cases by someone external from the Trust.

Q. And I think you may be aware Ruth Millward, her view is that at that point, there should have been a review and so I understand, Mrs Fogarty, you are agreeing with her?

A. I agree, yes.

Q. And in addition to the issue of whether the

Consultants, the treating Consultants should have been considered or consulted, and attended the meeting, you were looking at commonality of deaths over a two-week period.

Did anyone raise or was it considered at the time whether it was also relevant to look over that two-week period whether there had been any collapses, so near deaths? We know, of course, there was -- child B, the twin of Child A, collapsed in that period.

Did anyone say, well, we should be looking, if we are looking at commonality not just at deaths but any incidents?

A. The death of Child B wasn't mentioned at all.

Q. Child B survived, fortunately, but the collapse --

A. Yes, but the collapse wasn't mentioned at that meeting at all.

Q. And again, looking back, that would have been a relevant thing to take into account, wouldn't it?

A. Definitely. Definitely.

Q. And as well, just so we are clear on what was discussed at this meeting, do you recall whether unusual rashes were discussed at the meeting of 2 July?

A. There was no clinical, no detailed clinical information given.

Q. Because the conclusion of that meeting that you were at, you participated in, was that there was going to be no further investigation at that stage. Can you assist us with how did you come to that conclusion?

A. That decision was made by the Director of Nursing.

Q. And it was -- so your evidence is, is it, that it was Alison Kelly who took the decision that no further investigation was required?

A. Yes.

Q. Did anyone dissent from that at the meeting?

A. Not at the meeting, no.

Q. And you say in paragraph 74 of your statement that you are unable to comment on the possibility that staffing factors might have anything to do with the deaths of Child A, Child C, or Child D. Was that something that was discussed as a possibility --

A. No.

Q. -- at the meeting?

A. No, it wasn't, it wasn't discussed at that meeting.

Q. And just to be clear. I've been asked to clarify, you say at paragraph 75:

"The common factor of Letby as a nurse on duty was not discussed at this meeting."

Are you clear in your recollection about that?

A. I am very clear that that, that that was not discussed.

Q. What action would have been taken if you had been given a name, do you think?

A. Well, we -- you would need to -- if you've got a name then there is a concern that's attached to one person so therefore you would, you would want to escalate that and take further action.

Q. So you are confident in that recollection?

A. I am confident in that recollection, yes.

Q. And just again to clarify as well, before we move on, you say at paragraph 36 about this meeting:

"The paediatricians did not raise any concern at that meeting ..."

You say "paediatricians" but it was -- Dr Brearey was the only paediatrician at that meeting?

A. Yes.

Q. And you are saying that he didn't raise concerns about looking at the commonality of those deaths.

A. That's correct, yes.

Q. If we can turn on now, you say in paragraph 52 of your statement, that it was also at that meeting, the meeting of 2 July that was looking at the commonality,

that a full case review of Child D would be conducted to look at the obstetric and the neonatal notes. So the point we were discussing before about the obstetric review being done and then separately the neonatal review, for Child D this process was put together.

A. Yes.

Q. And given that Child A and Child C, from the obstetric point of view there was no explanation for those, those deaths, did you feel that in fact that should have been done not only for Child D but also for Child A and Child C?

A. With hindsight definitely, that, that should have been done.

Q. And would you go as far as to say that as a matter of course when the obstetric review didn't reveal a cause of death, or an explanation for the death, that there should be this, this sort of joint process?

A. Well, from the obstetric point of view we are looking at if anything contributed to the outcome. So it wasn't always relevant to, necessarily, do a -- put the two together if the standalone paediatric review is comprehensive. But it is good practice.

Q. And if we could go to INQ0003299, we are just going to look at the cover page of the review for

Child D because this really makes the point clearly that this is a review and we can see just by the investigation team that we have got present there, the obstetric secondary review team, including you and a Consultant, Dr Davis, and then we've got the neonatal review team, Dr Brearey, and Ms Powell, the neonatal unit manager, and there is -- we won't go through it but what follows is an 18-page report with appendices, an 11-page report.

A. But these were actually two separate reviews put into one report.

Q. So that's my next question.

A. Yes.

Q. Did you physically meet to discuss this or was this compiled out of two reviews?

A. So it was compiled from the two reports, two separate assessments.

Q. And back to where we started with the two divisions, and you saying about meetings being held together. In retrospect would it have been more helpful if you had all physically sat around the same table?

A. I mean, being in two divisions shouldn't affect work such as this because that's -- this is very specific and, and because of the nature of the work and the terminology the fact that the two meet separately to

review the care, that doesn't impact on the quality of the report and the judgments.

What should really happen is the two meet separately and then when the conclusions are drawn then meet together to review the conclusions and next steps and that's what didn't happen.

Q. Didn't happen?

A. Didn't happen.

Q. There was -- so that didn't happen in terms of the first review. There was then, we see, an addendum because after the results of the post-mortem from Child D were supplied, there was then a further meeting which was attended by Dr Davies, Dr Newby --

A. Yes.

Q. -- you, Ms Powell and Debbie Peacock. Was that an actual meeting?

A. That was an actual physical meeting, yes.

Q. So whilst paper initially, this concluded, when we look at the report, with a physical meeting --

A. Yes.

Q. -- of both obstetricians and a paediatrician?

A. Yes.

Q. And at the time that this review was done, the initial review of 28 August, and certainly by the time that meeting was held, which was 12 October, sadly there

had been more deaths on the neonatal unit. There had been the death of Child E on 4 August 2015. Were you aware of that death?

A. No.

Q. Would that not have come to you by the same process of needing an obstetric secondary review?

A. I don't even recall doing an obstetric secondary review on that case.

Q. Yes, but it wouldn't have come to you in your role of Head of Midwifery?

A. It wasn't escalated to me.

Q. And had it been, had there been a system where you were aware of the fact that one of the children, another child had died within August, do you think that would have made you reconsider that decision on 2 July that there was no reason for further investigation at that stage because we now have a new component --

A. Yes.

Q. -- we have another death within a short period?

A. Definitely.

Q. And Ruth Millward, she, in her statement to the Inquiry says that was a further missed opportunity to trigger a comprehensive investigation. Are you agreeing with that?

A. I agree, yes.
Q. The case review of Child D has a distribution list that has gone down, so we needn't turn to it. But page 11 of the report shows there is a distribution list of Child D's -- we don't need to go to it, thank you -- that it would be referred to the Women's & Children's Care Governance Board as well as QSPEC and so again the same question: did you, as deputy chair, did you at that stage or it having been referred, think that this was a matter that should be tabled on the agenda having been prompted not only by 2 July but now by the review of Child D --
A. Definitely, yes. It should have been, yes.
Q. And why did you not raise that because you had been present at the Child D's review, so you were aware of the three deaths, you had now attended that review after the post-mortem.
At that point, did that prompt you to think this is something we should be discussing as --
A. I mean, I was dependent on my paediatric neonatologist specialists to be escalating concerns to -- to myself and, and they didn't.
Q. Moving forward then. So two weeks on from after the meeting after the post-mortem, the meeting, the physical meeting when Child D was discussed.

Child I died on 23 October. So the fifth death in approximately four months.
At that stage, were you -- first, were you aware of the death of Child I?
A. I don't recall being aware of the death of Child I.
Q. We know from some other evidence, Mrs Fogarty, that there were or there appeared to have been rumours at this stage within the neonatal unit.
Were you aware of any concerns about a commonality of staffing or concerns that something was strange about the increased mortality rates?
A. No.
Q. When did you first become aware that staff on the NNU had concerns that a member of staff might be involved in harming babies?
A. So I first became aware in the June '16 after the death of the triplet, the second triplet.
Q. Can I just --
A. And it wasn't concern that the staff on the neonatal. It was concern that the paediatricians had concerns. That's when I became aware of that.
Q. And prior to that, just so that I can be clear, prior to that, so prior to you becoming aware of the paediatricians' concerns after the death of O and P,

were you aware of any rumours?
A. No.
Q. If I could turn now to the review that was conducted of neonatal deaths and stillbirths from an obstetric point of view, Dr Brigham's review.
If we could turn up INQ0003222 and this is tab 7, my Lady, in your bundle.
So this was a review that was done in November, so about four months after that 2 July meeting that we have talked through in some detail, and at this stage we have gone through I. You say you weren't aware of I, but there had been five deaths on the neonatal unit from June 2015.
Whose idea was it to conduct this review that was looking at the obstetric situation?
A. So the -- so the obstetric risk leads and myself.
Q. Why did you decide to do that review?
A. We had had a perceived increase in our stillbirth and neonatal death and so we wanted to be assured that we didn't have a problem with our practice.
Q. You say "perceived" increase, but presumably there was an increase in stillbirths, is that --
A. We knew from our data that there was an increase.

LADY JUSTICE THIRLWALL: So I just wondered why it was called a "perceived" increase?
A. It's the terminology that Dr Brigham put in her report in response to a perceived increase. So it was --
LADY JUSTICE THIRLWALL: But so far as you were concerned, everyone understood it was a --
A. But we knew, we knew that that -- that there was because that's why we were meeting and we had all the records. We had the data to back it up.
LADY JUSTICE THIRLWALL: All right, thank you.
MS BROWN: And we can see there that the title is "Review of neonatal deaths and stillbirths at Countess of Chester Hospital, January 2015 to November 2015" and I think you accept in your statement, you say the title does not best describe the remit of the review.
It may be very obvious but can you just explain why that's not an appropriate title?
A. I think it should be explicit that it was purely the midwifery and obstetric care that was reviewed because that is the area of clinical practice and the expertise of the panel.
Q. And reading that without that knowledge, it's misleading, isn't it, that title?
A. It, it could be for people outside of the

Trust that don't know that that was the remit of the people involved or anybody who didn't receive a verbal update, where it was made clear at a verbal update.

Q. And you say at paragraph 88 of your statement that not only the title but on -- it's not apparent on reading the report that the review is confined to obstetric care?

A. Yes.

Q. I think in fairness, if one looks at the review team, we can see there are no neonatologists or paediatricians on that review team?

A. Yes.

Q. So that might be a clue. But it is certainly, on the face of the title and the content --

A. Yes.

Q. -- it is not clear that this is not a complete review.

And you looked at the deaths from January 2015 so that included, this has been checked, that it included the deaths of Childs A, C, D and E.

Was -- that was in terms of the neonatal deaths. Was there also concern about the stillbirths in the obstetric departments? What was the concern there?

A. Yes, we felt we had an increase so we wanted to know was it because of poor practice.

Q. And did you inform the Consultant paediatricians and the NNU senior nurses that you were doing this obstetric review? Did they know you were doing this?

A. So the paediatricians were aware, yes. One of my Consultant colleagues had informed them.

Q. And once you had done this review, that review did not identify the causes of increased mortality because you didn't identify a cause from the --

A. We were only looking at the obstetric and, actually, we had already -- what the report demonstrated was we had already done comprehensive reviews of all the cases anyway and it didn't, it didn't pick up anything that we hadn't already looked at. It was more of a thematic review.

Q. And so what did you understand was the plan to try and understand the cause or causes of the neonatal deaths? Clearly the stillbirths were completely within your remit but in terms of the neonatal deaths, you hadn't reached a conclusion. What did you understand was the plan?

A. So we were purely looking from an obstetric point of view to see if it was anything in our practice that had contributed to a poor outcome for a baby, and we didn't find any commonality or anything that we

hadn't already addressed so we knew therefore that that same level of investigation needed to be undertaken by the paediatricians.

Q. Thank you, Mrs Fogarty.

So as I understand it, there was a sense in the obstetric department and the midwifery department that, having done your review, it was now really for the paediatricians and the NNU to --

A. Yes.

Q. -- examine their side?

A. Yes.

Q. Because we have got a situation here where the maternity unit, and you have been looking at it from an obstetric point of view, you have identified clearly that we need to look at the neonatal side and it's difficult to understand why given your understanding that we needed the neonatal aspect why that wasn't raised at the Women's & Children's Care Governance Board to say, "We have done this review, we need input from our neonatal colleagues."

Was that not the very purpose, the very aim of that governance board to bring the departments together?

A. So they were already planning their review which they did in the beginning -- at the beginning of 2016.

Q. And that's Dr Brearey's thematic review --

A. Yes.

Q. -- is how we have been referring to it. And so you -- at what point were you aware that that was planned, are you able to assist?

A. I think it was when this report was produced.

Q. And in terms of this report we see it's dated November. In terms of the circulation of that report, we know that it wasn't e-mailed, in fact more widely circulated, until 9 February. Do you know what the delay was for the --

A. So the actual report, in fact the email that circulates the report states: This is a poster presentation in the resource room.

So as soon as the report was produced, it was always the practice that the resource room would have a copy of this for staff to go and be familiar with. So it would already -- it had already been actioned and all the actual incidents when they were reviewed initially that information was in the resource room. So...

Q. So regardless of that email, you are fairly confident that this was properly distributed certainly within your --

A. Yes.

Q. -- department?

A. And it actually states that on the email, that it's -- it's up, it's already up as a poster presentation which was our format.

LADY JUSTICE THIRLWALL: Sorry. Does that mean that it was, the report was in the resource room?

A. Yes. Visible, visible for staff to look at.

LADY JUSTICE THIRLWALL: So every page was there?

A. Yes, yes.

LADY JUSTICE THIRLWALL: Thank you.

A. And staff also knew to go to the resource room every week because that's where we -- that was our training method that we used. It was very effective.

MS BROWN: So if we can just look now and go through and see what was being discussed at the Women's & Children's Care Governance Board.

So if we could put up, please -- that report can go down and just maybe one more question regarding that report, Mrs Fogarty, before we take it down.

That report didn't highlight within the report itself that a neonatal review was needed and my understanding is that's because you understood that that was going ahead in any event?

A. Yes.

Q. So, yes, if we could pull up INQ0004235. So this is tab 14, my Lady, of the bundle.

This was 18 June, so right -- just shortly after the death of Child A, a meeting there and if we could go to page 3 of that. It records there that JCF, so that's and you -- your initials, sorry, yes, JCF, your initials and the Consultant obstetrician reviewed a twin death and that's referring to Child A.

If we go down:

"No issues with any element of care provided. Will be subject to neonatal review."

So that's as you were explaining to us --

A. Yes.

Q. -- recording that there would be an obstetric secondary review. There were no issues there, but there would be a neonatal review?

A. Yes.

Q. Was there a system for following up matters like that on the minutes to check that -- it says there's going to be a neonatal review --

A. Yes.

Q. -- that a neonatal review was done?

A. Yes. So at the next meeting they looked at the actions to make sure that they had been completed.

Q. That can come down then, please. We don't need to turn to this, but there was another meeting on 22 October and that referred, just very briefly, to

three unexpected neonatal deaths. There had in fact been four then, taking into account Child E, but it refers to three unexpected deaths, but there is no discussion in the agenda of unexpected deaths.

Was that something that on reflection should have been something that was discussed or would normally have been something that was discussed? It's the fact that they are unexpected deaths. Clearly on occasions there would be deaths, but the unexpected deaths, would that not be something that should have prompted discussion?

A. She would have expected the paediatricians to have said, to have brought some information regarding their reviews of those cases. But that was in the October when we were aware of the increase and that's why we then did our review in the November.

Q. So you say that it was for the neonatologist or the paediatrician to bring that. But as the deputy chair and as observing this from a critical standpoint, knowing that the role of the committee is to flag any issues, should you not have been asking your colleagues and saying: These are unexpected deaths. We don't have a solution, is there an explanation?

There seems a lack of curiosity.

A. With -- with hindsight then, yes there should have been more probing of the paediatric staff.

Q. If we can go -- thank you. If we can go to the meeting of 18 December and we can call this one up. It's INQ0004371, and page 2 of that.

Here we see -- so this is December. We know the Brigham report, the obstetric report we have seen was November, and we see this report came to the meeting here as one would expect?

A. Yes.

Q. And we see stillbirth and early neonatal death review and action plan:

"Panel set up to review each case individually. No themes identified. Overall the process showed we have a good record-keeping, good escalation. The outcomes would not have been any different."

Now, we know that these minutes then went up to QSPEC?

A. Yes.

Q. And reading that now, I know obviously you have the knowledge that this was an obstetric review but if one was reading that without that knowledge, that would appear to allay concerns about neonatal deaths because it's not clear from that that's just the obstetric care that's being looked at?

A. But I presented that report at QSPEC and was very clear in my verbal presentation that it was

a maternity and obstetric review of care.

Q. We will come to that in a moment. But from this minute, if one was reviewing the minutes, it's not clear from those minutes -- it would obviously have been clear to those at the meeting, but it wouldn't have been clear just on a paper review that there was a problem here?

A. Yes. Yes.

Q. Picking up on that point, did that provoke any discussion from Dr Brearey, who was in fact present at that meeting, about the situation on the neonatal unit?

A. Not that I recall.

Q. If we can just turn to some emails, this is tab 9, my Lady, in your bundle.

There were some -- there was an email exchange between Alison Kelly, and this rather just demonstrates the slight confusion, I think, possibly due to the titling of Brigham's report.

We see, and we could call this up, it's INQ0003220.

So if one starts at the bottom the page, this is from Alison Kelly:

"Hi, where are things up to re the thematic review? I am keen to get the paper to December QSPEC."

So she is referring there to the Brigham review, the obstetric review because Dr Brearey's review

hasn't -- was that your understanding anyway?

A. My understanding is she is referring to two reviews because she copied Ruth Millward in and Ruth Millward played no part in the obstetric, but would be looking for the neonatal one. And that's why I responded to say I had sent the papers in November ready for the next QSPEC meeting.

It was the paed update that was missing.

Q. Yes, and you then make it clear your understanding --

A. Yes.

Q. -- from your response is it is clear that there were two elements --

A. Yes.

Q. -- the midwifery element, which we have seen and looked at?

A. Yes.

Q. And then it's the paediatric --

A. Yes.

Q. -- update that's missing?

A. Yes.

Q. Then Ms Kelly replies:

"Sorry if I hadn't been clear. I mean the thematic review of neonatal deaths recently undertaken."

So you may not be able to assist but it seems to be

Alison Kelly's understanding that there was at that stage one review that combined the two. But that's not the case, is it?

A. No, no, and Alison Kelly knew that it wasn't one report that -- she knew that from my one to one and my, my verbal. She knew we were doing the thematic review in obstetrics before it had taken place because I had escalated that to her.

Q. Just looking at that, your discussions with Alison Kelly then about your review. Did you discuss the obstetric review with Alison Kelly --

A. Yes.

Q. -- and say we are waiting for the paediatric?

A. Yes. Yes, I had discussed that at my one to one with her.

Q. And can you recall what her view was about the fact that the paediatric -- the neonatal unit, you were awaiting that report, did she --

A. I think she said she would chase it up.

Q. So she was aware that there was -- that the neonatal review of the increased mortality hadn't taken place?

A. To my knowledge, yes.

Q. And if we can go now. Sorry, just to be clear then. You were aware that Dr Brearey had done

a thematic review and we know that was in February 2015 and re-issued in March 2015.

Did you, did you receive a copy of that, can you recall?

A. No.

Q. Would that be something that you would have expected him to have raised as soon as it was issued at the women and children's governance board?

A. I would have expected it to have come sooner than it did to the women and children's governance board, yes.

Q. I think we will look now at when it did come on 16 June. So if you go to INQ0003212. This is tab 18. If we could go to page 5, please.

So we've had the Brigham review back in December. We are now at June, mid-June, and the neonatal aspect of the same issue, increased mortality rates, is being reported here. It is entitled "NNU Thematic Review":

"There was a higher than expected mortality rate on the NNU in 2015."

And it goes on:

"An obstetric thematic review did not identify any common themes that might be responsible for the rise in mortality in 2015."

That's a reference to the Dr Brigham report?

A. Yes.
Q. And it said the aim of the neonatal meeting, that was the meeting that was held on 8 February was to:
"... review the cases as a multi-disciplinary team with an external reviewer to assess."
And it says there:
"There was no common theme identified in all the cases."
A. Yes.
Q. Do you recall any other discussion taking place at that meeting surrounding that report?
A. I -- due to the time lapse, I don't.
MS BROWN: My Lady, I don't know if that would be a convenient moment.
LADY JUSTICE THIRLWALL: Yes, certainly.
So we are going to adjourn now for lunch so if you will come back please and be ready to start again at 2 o'clock.
A. Right.
LADY JUSTICE THIRLWALL: Please don't talk about your evidence.
(1.00 pm)
(The luncheon adjournment)
(2.01 pm)
LADY JUSTICE THIRLWALL: Ms Brown.

MS BROWN: Ms Fogarty, we were just looking at the 8 February thematic report that had been presented to the Women's & Children's Care Governance Board on 16 June and the fact that on the entry for that it said there was no common theme identified in all the cases.
So having completed that, that review going through those board meetings of the Women's & Children's Care Governance Board, at no point between June 2015 and June 2016 did the Women's & Children's Care Governance Board have any minuted discussion about the cause of serious concerns of rising unexpected and unexplained neonatal deaths; that the case, isn't it?
A. It would be apparent from the minutes, yes.
Q. So it's not a case that it's not minuted, you would have recalled that discussion as well?
A. Yes.
Q. And consequently, no concerns about rising unexpected and unexplained deaths rose from there to QSPEC?
A. That's correct, yes.
Q. That follows as a matter of course.
And at paragraph 31 of your statement you address this frankly and you say that whilst, during your time as Head of Midwifery you felt that the WCCGB, the Women's & Children's Care Governance Board, was

effective in relation to maternity services, the fact that the issues relating to the NNU mortality was not presented at this board by the NNU Team demonstrates a gap in its overall effectiveness.
Just clarify what you mean by the gap in its overall effectiveness, please?
A. Well, the whole purpose the board is to, you know, receive information and where there is risk to then forward them on and obviously that didn't happen in this case.
So it was a gap that the increase in mortality wasn't flagged by the paediatric team for discussion, noting and escalating.
Q. And obviously you have had some time to reflect --
A. Yes.
Q. -- about this. And what is your explanation for that, why a meeting that was convened for that purpose with neonatal and midwifery and obstetric representatives, concerns that did exist, why was that not being debated in that forum?
A. I have no explanation as to why the paediatricians didn't bring that information forward or raise it for a topic of discussion.
Q. Do you feel that whilst, as you have made

clear, you weren't a paediatrician, you weren't from neonatal expertise, but did you think there was sufficient that you maybe should have raised it yourself as a concern?
A. I have no neonatology experience whatsoever. I have never ever reviewed a neonatal care case because it's not my area of clinical expertise. So I am not able to interrogate the data.
But certainly, you know, in hindsight then, just the fact that, you know, I was aware of the -- from our own review, our own obstetric review, there should have been some escalation at that time.
Q. And that's, in a sense, a question of hindsight. At the time you knew that there wasn't an obstetric cause and that's something you could have raised at the meeting.
A. Well, I knew that there wasn't an obstetric cause but I would -- I was being guided by the paediatricians who are the experts in neonatology.
Q. Thank you. And just on a related issue in terms of the reporting culture within the NNU. Again, you said in your Facere Melius interview that you felt there was a good reporting culture in midwifery, and that's the case, is it?
A. I would say yes.

Q. But you said that you considered that neonatal incidents were not always reported. What was the basis for that?

A. That was just a feeling I had of the fact that not all the incidents were Datixed so therefore weren't fed through, they were put in -- my understanding was some of the incidents were put in retrospectively.

Q. And that was a concern that you had at the time about neonatal --

A. Not at the time, no, because it wasn't something that I was looking for at the time because neonatal services didn't sit in my portfolio, so I therefore wasn't looking and challenging the data on a regular basis.

Q. So is that, that concern about neonatal reporting, was that something that occurred once you took on your new role as the Associate Director or when did that occur to you?

A. No, it was from when -- obviously when the execs started their investigation work. That was one of the things that I had heard.

Q. So it wasn't something that you considered at the time, at the time of these events, 2015 to 2016, June 2015 to June 2016, that you should have raised within the context of the Women's & Children's Care

Governance Board that you felt there was a reporting issue?

A. No, because at that time I didn't -- I wasn't aware of it.

Q. Just dealing briefly with QSPEC then. Before turning to the specific meetings, you say and this is paragraph 27 of your statement, that QSPEC had a role that included monitoring the implementation of recommendations from national reports such as Francis.

Can I just be clear there. You are referring there, are you, to the February 2015 Freedom to Speak Up report by Sir Robert Francis?

A. Yes.

Q. And in general terms -- you sat on QSPEC, can you recall what work was being done in 2015 into 2016 to implement recommendations from the Freedom to Speak Up reports?

A. So they were getting Freedom to Speak Up Guardians within the Trust and implementing those.

Q. And can you recall when those came in?

A. I couldn't be exact as to when they came in.

Q. And if you could turn then to a meeting -- we are going back in time now because we have looked through the Women's & Children's Care Governance string of minutes and we are going to go back in time now to

what QSPEC were doing and back to the meeting of 14 December 2015.

So that's INQ0003204.

This is, my Lady, tab 21 of your bundle. Sorry -- yes, 21.

If we can get, yes, page 5.

So this was very close in time to the meeting when you were presenting your report as well to the Women's & Children's Care Governance Board, you were reporting it also to QSPEC, and we see here at point 11, neonatal and stillbirth review:

"Ms Fogarty presented a review of neonatal deaths and stillbirths at the Trust during January to November 2015. It had been recognised that there had been an increase during the period and therefore a panel was set up to independently review all the cases again on an individual basis to identify any common themes or trends and lessons to be learned."

And then going down:

"The review team had also included an external reviewer who had felt the Trust review process was extremely robust, open and transparent."

And then going down:

"The report will now be received at the Women's & Children's Care Governance Board where the action plan

will be monitored."

So looking at that from the -- we will hear what you said about -- what you actually said to the meeting but from the notes of that meeting, that, from someone reading it, an outsider reading it who wasn't involved in that review, it wouldn't be apparent to them that that is purely an obstetric review?

A. No, no.

Q. And if we go over the page to the end of that entry, it says:

"Mrs Kelly thanked Ms Fogarty and the team for the report and the assurance it had provided to the committee."

Now, just dealing with Mrs Kelly first of all, the Director of Nursing. I think your evidence was before, but correct me if I am wrong, was that Mrs Kelly was aware that this was just -- you were presenting just an obstetric report?

A. Definitely, yes.

Q. And, of course, she was your line manager so she was very well aware of what your remit was?

A. Yes.

Q. But having accepted that that's misleading to the uninitiated reading that, what is your recollection of what you in fact presented at that meeting?

A. I mean, during the verbal report I was, I know I was clear that it was obstetric and maternity care that are being reviewed. The members of the meeting also knew that that was my remit.

Q. And did you consider raising at that meeting, or indeed subsequently, that there was a need for the neonatal care aspect to be brought back to QSPEC because they were just seeing half the picture, in effect?

A. I mean, it was my understanding that when they had done their review that it would go to QSPEC. So I didn't raise it at that meeting because I already knew that that's -- that's what would happen.

Q. And I think you have explained but did you review these minutes and have a concern at the time about how it was -- (overspeaking) --

A. Not at the time, no.

Q. Had you had a concern about the minutes or whether it was an accurate reporting, what was the process for approval of minutes and raising objections?

A. So at the start of each meeting you agreed the previous set of meeting minutes were correct and that if, if -- in hindsight I would have said no, we need further clarity that it was an obstetric and midwifery review not neonatal, but at the time --

Q. That wasn't something you raised --

A. But at the time I had verbalised that but I didn't appreciate the significance.

Q. And at paragraph 106, then, just moving on to a slightly different topic in your statement, you talk about yet a different type of meeting, this time the Cheshire and Merseyside Neonatal Network Steering Group.

Just very briefly, can you explain what that group was?

A. So I only attended one of those meetings. I don't know how I came to go to that meeting. Yet the minutes are clear that I was there. When I look at the contents, there was no other midwifery representative there and I didn't attend another meeting because the discussions at the meeting I couldn't contribute. It was all related to neonatal practice of which I had no information.

Q. You have answered my question. You don't recall why you were at this meeting?

A. No.

Q. Could it have been that you were asked to go along to this meeting because there was a thought that the issue of neonatal deaths or deaths of babies was going to be discussed and you would contribute in relation to the obstetric aspect?

A. No, because they wouldn't look at obstetric

care in a Neonatal Network meeting.

Q. And you say that the issue of neonatal deaths at the Countess of Chester, that's the increase in mortality, was not raised as far as you recall by Dr Brearey or Eirian Powell at that meeting?

A. No, and the notes confirm that.

Q. And did you, whether in the context of going to this meeting or at any other time, did you ever discuss with Dr Brearey or Eirian Powell the facts -- the topic of neonatal mortality --

A. No.

Q. -- and the need to flag that to this or any other committee?

A. No.

Q. If we could just look at the deaths of Child O, and Child P, which cover 23 and 24 June 2016. When were you informed of those deaths? Do you recall how you became aware of those?

A. I can remember being at a Consultant meeting, a Tuesday lunchtime meeting, and someone coming in and saying that, you know, another triplet had died.

Q. And I think that's the meeting that you look at in paragraph 115 of your statement and you say you -- that the obstetrician said "something's going on".

A. Yes.

Q. Do you know who that obstetrician was?

A. I can't remember who said it and then whoever chaired the meeting at the time came into the room and we then went -- proceeded to have the meeting. However, the person who had said about the triplets had also said that the paediatricians had gone to the executive team so I was aware that they had escalated to the executive team.

Q. So rather like the Consultant obstetrician, by the end of that meeting you certainly knew there was something going on?

A. Yes.

Q. Any more than that? What was your understanding of the situation at that point?

A. I, I didn't have any further explanation. All we knew was there had been an increase in deaths. But I didn't have any detail behind that.

Q. And was there either a suggestion that one member of staff was involved?

A. Not at that meeting, no.

Q. And mention of Letby wasn't made, I think it follows.

A. No.

Q. We come then to the 11 July, so just two weeks, just over two weeks after the death of

Child O and Child P, and you describe something that you say you have a clear recollection of and that's a recollection of you and Sian Williams undertaking an exercise to do a staffing matrix analysis.

Can you, first of all, explain who asked you to do this?

A. So it was at the executive meeting as a result of the, the increase in the mortality that had been escalated and so I can't remember which member of the executive team but it was a member of the executive team had asked, had -- a management request for myself and Sian Williams to work together to do this piece of work.

Q. So just going back to that meeting, what was the discussion at that meeting? What was the date of that meeting and what was the general discussion at that meeting?

A. I can't recall the exact date of that meeting because there were several meetings that were called. But it was, it was probably the day of, if not the day before this work was undertook.

Q. And the discussion about that meeting was -- well, explain what was being, what was the general topic of discussion? It may seem obvious to you but can you just explain to us what was being discussed at that meeting that led to this review?

A. Yes, yes, it was the increase in the mortality that had led to the need to undertake a series of pieces of work.

Q. And at that meeting and when you took this work at that point you understood that the Consultants had serious concerns about the --

A. Yes --

Q. -- cause of these deaths?

A. -- and that's why --

Q. And I think it is evident by the nature of the task we are going to go on to explaining but you understood there was at least concern that a member of staff may have been involved in --

A. I didn't at that time know it was a particular member of staff but we knew that they had concerns about the increase in mortality.

Q. And that that was, to go back to what we were discussing, on 2 July, that was an area of commonality they were looking at?

A. Yes.

Q. So having established that, you are set with Sian Williams to do this task. What exactly was the task?

A. So we were tasked with looking through the Meditech, which is the computer records of babies that

we were given the case number for, and we simultaneously went through a record and any time there was the word "sudden collapse", we would then look at who was caring for that baby, who was on duty, and who had been on duty the shift before.

So we didn't look at any clinical care because we are not trained to do that. We were simply looking at who was on duty and then we compiled a list of each of those -- for each baby a list of the carer and who was on duty before and during the actual shift of the collapse.

Q. So the product of your work was a number reference that would have related to a child?

A. Yes. So we used the cc number of the child, and then it was typed in, the name, so we cross-referenced it with the off-duty from the neonatal unit of the nursing staff.

Q. And in what format was that off-duty? Was that a paper register?

A. It was a paper copy.

Q. So you've got computer records which you are going through looking for the words "sudden collapse"?

A. Yes.

Q. When you find the words "sudden collapse" you are noting down the cc reference that could be -- would

identify the baby concerned?

A. Yes.

Q. And then you would be typing up which staff were on duty?

A. Which staff was looking after the baby.

Q. Right.

A. Because that would be derived from the Meditech note and then the off-duty would provide us with everybody on duty.

Q. And when you say who was looking after the baby, that's the designated nurse?

A. The designated nurse, yes.

Q. And staff on that shift or the shift before, the shift after, just to be precise?

A. So we did the shift before, including who was looking after the baby, and the actual shift of the collapse. Who was looking after, who was on duty.

Q. And when you say "the shift" we are talking about what periods there?

A. I can't -- I am not familiar with the neonatal shift pattern but it would state on the off-duty early, late, long day, so that's what we would write.

Q. And I think it's because you were providing a check to each other, but correct me if I am wrong, why were there two of you doing the task?

A. So that we didn't miss anything and to confirm that we both got the same numbers of collapses and the same staff looking after that person.

Q. And how long did this exercise take? Was it -- were you in the room for a day doing this or?

A. We did it over more than one day.

Q. And how did you -- how did you check your work? Did you produce one report? Did you confer at the end of the day?

A. When we -- after each baby we would confer, we wrote it down on some paper, and then we would confer. When we agreed we got identical information Sian then would type it up and send it, return it back to whoever she had been asked to return it to, because it was Sian who received the -- the case numbers for the baby, not myself.

Q. And did you have parity between you and Sian Williams about what you were picking up?

A. Yes.

Q. And at paragraph 124 -- you might want to turn that up -- what did your analysis show?

A. That Nurse Letby was a common denominator. So she wasn't present for all of the collapses, but a large proportion, disproportionate portion to everybody else.

Q. And did that lead you to suspecting that Letby

was involved or could have been causing harm to the babies?

A. Yes, and so that's why we escalated to the execs.

Q. And you say in fact at paragraph 125 that "a concern we both shared".

A. Yes.

Q. Is that a concern you are sharing with Sian Williams?

A. Yes.

Q. Were you sharing that concern with anyone else?

A. No, just myself and Sian, and then she escalated that to Ian Harvey on both our behalves and she confirmed that she had done that verbally to me.

Q. And escalated, what practically did she do? What did she do in terms of Ian Harvey? Did she go and see him?

A. So she went to see him and she escalated the fact that during our staffing check that the name Lucy Letby had come up as being a common denominator and that both myself and her were escalating our concerns to him.

Q. And you were aware that there were Consultants' concerns as well at this point having been

at the meetings?

A. We were aware of Consultants and we were also aware that there were Consultant paediatricians and children's nurses looking at the clinical aspect of care.

Q. And I suppose the added bit of the picture that you had was that you knew from Dr Brigham's report, certainly up to during 2015 anyway, that there were no obstetric concerns --

A. Yes.

Q. -- about these babies?

A. Yes.

Q. Did you make that connection?

A. And Sian was aware of that as well because she -- Sian Williams, because she sat on QSPEC, so she was aware of the obstetric report and work as well.

Q. So in addition to going to -- or Sian Williams going to Mr Harvey and you said she reported back to you that that had been done, did you discuss with Sian Williams, or indeed with anyone else, the idea of going to the police. We know you didn't, but did you discuss the idea of --

A. I personally didn't, no, because I was never fed back the outcome of the paediatric and neonatal nurse review of the care provided to the babies. That

information was never given to me.

Q. And at paragraph 126 you say that you accept now that you should have reported the findings to the police.

A. Yes.

Q. And we know in fact that Letby wasn't reported to the police for some time after this.

Looking back now, as you said, you were aware of the Consultants' concerns, you had drawn a concern that Letby may be causing harm, why do you think, doing the best you can, why do you think it was, having accepted now that's what you should have done, why did you not -- what was inhibiting you going to the police at that stage?

A. I think I had trust in the executive team that they were, were -- not -- when I say control, I don't mean stopping people from doing things but they had the range, so they were receiving all the information, so therefore they were making decisions based on information that was being fed back from all the different workstreams.

Q. And just considering the other steps, your answer may be similar, but did you, did you consider first of all whether internally you needed -- other than going to Mr Harvey, did you, for example, consider that

you needed to raise this on one of your committees, on the Women's & Children's Care Governance Board or on QSPEC, that you had to share what your concerns that were now heightened with either of these committees?

A. I felt that I had shared, you know, we'd shared it with the executive team which is the, you know, they are the most senior team in the Trust and, and at the time, you know, they appeared to be liaising with, with different bodies to take best advice.

Q. And you are a midwife but you are also a registered nurse. Did you consider referring Letby to the NMC? Did you think about restrictions on her practice? Was that a thought process you had?

A. Again, no, because I felt that that was -- I didn't at the time because I didn't have enough detail because I, whilst I knew she was a common denominator, I didn't have the clinical knowledge to know whether the collapses, even though they were sudden, whether they fitted within a picture of the baby's health, I didn't have that clinical insight.

Q. And I think we have addressed Safeguarding. That was something that didn't occur to you at the time?

A. Not at the time, no.

Q. And in terms of the obstetric secondary reviews, I think you carried out the obstetric secondary

reviews on 20 July for Child P and Child Q; is that correct?

A. Yes.

Q. And when we looked at Child A, Child C and Child D, they were done, those reviews, very shortly after the deaths -- in fact, I think in the case of Child D, within 24 hours.

This obviously is some time afterwards. Is there a reason for that?

A. Possibly annual leave because of the time of year. Also, I think that the Consultant obstetrician had had a brief look at the maternal care for the mum and didn't have any initial concerns. But I think it could have just purely been annual leave that there was a slight delay.

Q. When you say didn't have concerns, you are talking about the maternity -- (overspeaking) --

A. Maternity care, yes.

Q. Because we know there were very serious concerns --

A. Yes. No, no, this was purely the maternity and obstetric care.

Q. And if we could just go to the Women's & Children's Care Governance meeting, the last one we are going to look at, at INQ0003214, and that's

at tab 19, and just looking at, first of all, who was there, there's an awful lot of apologies for this meeting but we can see that you were present and Dr Jayaram was present at this meeting along with Sara Brigham, a Consultant -- the lead for obstetrics. So we had the lead for obstetrics and the lead for the paediatricians, the clinician for children's services.

If we go over to page 3, we see at the top there that Child O and Child P, it was being recorded there, it was unexpected neonatal deaths. And then turning over the page again -- actually, just, we don't need to go back but just dealing with the fact that those were reported.

You say, I think in relation to this meeting, that there wasn't any discussion, as far as you recall, about Letby's suspected involvement in the death of the babies. Clearly that was something that was present in your mind at this time. Are you able to give an insight as to why that wasn't discussed at this meeting?

A. So this meeting was in May and I didn't become aware -- was it May?

Q. No, this is 21 July.

A. Oh sorry, I thought it said May. So I think that the -- sorry, can you just ask me the question again?

Q. Yes. So we know that by 21 July concerns were in your mind --

A. Definitely yes.

Q. -- because we have discussed the exercise you did with Sian Williams, and we know that Dr Jayaram had concerns and we know that the topic of the death of Child O and Child P was at least referred to at the meeting.

Was there any discussion that you can recall about the issue of Letby, whether the police should be called, whether there should be restriction on her practice; any discussion about the issue that must have been at the forefront of, presumably, Dr Jayaram's and your mind at this meeting?

A. I don't recall there being a discussion about, about that at all because at that time the Trust Executive team were still, still had a working group, I was aware of that, that were looking at all the issues.

Q. So you, you didn't feel the need to minute it or raise it at this meeting?

A. No.

Q. And sorry, if we could go to a page where we have gone already, to page 4 of that document.

Sorry, that's why I am confused. It should be

3213. Sorry. I must have said 3214.
So if we could go to page 4 of 3213, page 4. Looking at page 4 of that. So maybe if we can just go back to page 3. So that's where we see the unexpected neonatal deaths that were raised -- can you see at the top of the page -- but no discussion underneath that?
A. No, because at that time it says it's an incident. I'm not sure if that is the receipt of a report or whether it's just the incident being logged.
Q. But --
A. It's not clear.
Q. But this is the meeting on the 21 July --
A. Yes.
Q. -- and the point is that there's no minuted discussion of Letby or steps that could be taken?
A. No. She was definitely never discussed in any Governance Board. I know that.
Q. Yes, that is the point --
A. I am very clear about that.
Q. Thank you very much.
If we could go then on to page 4, and we see there under "Risks", "New Risk for Escalation in the Month" and we see:
"Potential damage to reputation of neonatal service and wider Trust due to apparent increased mortality

within the neonatal unit."
So what seems surprising there is that the risk that is being identified is the potential risk to reputation. Wasn't the more important risk the risk to patients due to the increased mortality?
A. I mean, certainly. However, this risk was a plan, an Urgent Care risk so that, that division will have had the discussion and they have decided what they were going to include on their risk register.
It's -- it's come here for noting and escalation to QSPEC to follow a process.
Q. And did that discussion, the discussion about risk registers and the damage to reputation based on increased mortality, did that cause you to reflect as to whether the risk registers needed to be or should have been updated to reflect the risk to patients due to increased mortality? Because that doesn't appear to have been added to the risk registers at any time from June 2015 onwards.
A. I mean, certainly the risk registers, there should have been something in it far sooner within the Urgent Care Division.
Q. And was it something, because obviously there was the stillbirths and the identified increased neonatal deaths from the maternity aspect. Was that

something that was raised in the risk register in terms of the planned --
A. No, because the stillbirths, unfortunately in some cases people will present because in a lot and, you know, they have had a stillbirth. It doesn't actually mean that there is a problem with the care provided and that's why we did that review and it demonstrated that whilst we had an increase, it wasn't actually due to the care provided.
So therefore it didn't need to go on the Planned Care risk register. It wasn't relevant.
Q. Thank you.
And just before -- we are going to move now to your period as the Associate Director of Risk and Safety. But just to be clear, there was a CQC review in February 2016 and I think you didn't have any involvement in that.
A. No.
Q. And you weren't involved in the RCPCH review in September 2016.
A. Yes, that's correct, I wasn't involved in that either.
Q. And in relation to the grievance brought by Letby, you weren't involved or interviewed in relation to that?

A. No.
Q. So moving forward to April 2017. You took over a new role now as Associate Director of Risk and Safety. Who did you -- and you took over from Ruth Millward, I think you have told us.
A. Yes.
Q. Who did you report to in that role?
A. Alison Kelly, Director of Nursing.
Q. So you had the same reporting structure?
A. Yes.
Q. Was it a more senior role in fact?
A. No. It's probably -- parity, just a different remit.
Q. And you say -- and this is paragraph 137 of your statement -- that you first met Letby in April 2017 when you moved to the new role?
A. Yes.
Q. And what was Karen Rees' role in relation to Letby?
A. So she was her manager.
Q. And what was your role? You had, as I understand it, you were the, what's referred to as the day-to-day manager of -- (overspeaking) --
A. Yes.
Q. What's that?

A. When I moved down to the risk and safety team, Lucy was, was working within the patient experience team but their line manager post was -- the person hadn't commenced their post. So it was being, they didn't have clear supervision from somebody senior within the Trust.

So I was asked to provide some day-to-day, just support, whilst Karen Rees, who was the Head of Nursing for Urgent Care, so was responsible for neonatal unit, had kept the management of Letby insomuch of all the meetings with the executives, the unions, and any other meetings that Lucy attended, it was Karen who dealt with that.

I just dealt with her when she joined my team and I provided the day-to-day support of insomuch that she was working within risk and safety.

Q. And we know, because you have explained to us your thought process after doing your correlation exercise with Sian Williams. What did you think about the appropriateness of Letby being employed in that role at the time and the position that you were put into as being her day-to-day manager? How did you feel about that?

A. I mean, she was in a non-clinical role so she was not a risk to patients and at that time, we were still awaiting the next steps from the executive

management plan of their reviews of all of the care and what their next steps were going to be from external reviews, et cetera.

Q. And you say not a risk to patients. Were you aware of whether there were any restrictions on her movements within the hospital?

A. So when she worked for me in risk and safety, she was office-based, she didn't need to attend, but I had her working with nothing to do with women and children's services whatsoever because I didn't feel that was appropriate.

Q. But in relation to her physical access to other areas of the building, was that something you ensured that she --

A. I -- I wasn't responsible for that aspect of her, her work.

Q. But given your -- given the concerns --

A. Yes.

Q. -- that had occurred to you after your exercise with Sian Williams and given your post of Director of Risk and Safety, was it not a matter of concern to you that you had someone who was still working in the hospital who potentially could have gone back to the neonatal unit?

A. Well, she wouldn't be able to get in because

of swipe access. So you can't get into any areas of midwifery or neonatology without having swipe access and she didn't have access to get in.

Q. Was that something you checked or was it something --

A. She's had that access taken. I knew she had had that access taken away from her.

Q. So you knew that access had been taken away. Do you know who made that decision to take that access away?

A. No, I don't. But I checked when she joined my team because we had -- she needed access to join the office that one of my teams were based in where her desk was going to be, so I checked where her access was for and that's how come I know she did not have any access to --

Q. And related to that but on a rather wider scale, is, any restrictions on her practice by the NMC. Did you make any enquiries as to whether there were -- any restrictions had been placed on her practice, whether she would have been able to go and get a job somewhere else, for example?

A. Well, she wasn't -- when she was working for me she wasn't working clinically, she was in a non-clinical role.

Q. But did you think about making those checks or did you discuss whether those checks had been made with anybody else on restrictions on her practice?

A. Do you mean when she was in my team?

Q. Yes, so you became involved with her from April 2017. From that point, did you make any enquiries as to whether there were any restrictions on her practice or suggest that there should be restrictions on her?

A. Well, at that time she was just -- she was working in an administrative role. She wasn't working in a clinical role.

Q. So is the answer to the question you didn't check?

A. So I didn't check because I knew where she was working. She was office-based.

Q. And where was she physically working relative to you? Was it in the same room or just in the same --

A. Not as myself, but she was working in an office with the risk and safety leads.

Q. And were you aware then that she was leaving on occasions to go to visit Alder Hey hospital?

A. That was before I joined. So when that was happening I was still Head of Midwifery. That was prior to my movement to risk and safety. So I had no

knowledge of that until I was in my questioning for the Inquiry.

Q. And once -- did you come to learn of that?

A. Only when I received my pack --

Q. From the Inquiry?

A. -- to do with the Inquiry. I didn't have any knowledge of that prior.

Q. What would have been your view as her day-to-day manager had she expressed the fact that she was taking leave to visit another hospital?

A. Well, I wouldn't have -- I wouldn't have allowed -- I wouldn't have allowed that to happen. I would have had to escalate that to Alison Kelly.

Q. And why wouldn't you have allowed that to happen?

A. Well, because I had done a, you know, a staffing analysis where, you know, there was an index of suspicion and so therefore you don't want someone, if they have been removed from clinical practice in our neonatal unit, I don't want them to go into another clinical area.

So that's why I wouldn't have wanted that to have happened.

Q. And did you consider that from your perspective, while she was within your team sufficient,

consideration had been given to patient safety and safeguarding risks?

A. I felt that had been given prior, yes.

Q. You were then present at Tony Chambers' briefing on 16 May, and we see -- we don't need to turn to it, but we see that you are recorded as having attended that?

A. Yes.

Q. You recall that briefing, I imagine?

A. Yes, yes.

Q. And you understood from that point that there was a police inquiry?

A. Yes.

Q. And you understood that Letby was clearly going to be involved in that inquiry?

A. Yes.

Q. Can we just look at the issues you found when you came to the role of being the Associate Director of Risk and Safety. In paragraph 152, you set these out. I am not going to go through them all, but just to highlight some of those.

You say that:

"Hundreds of policies were out of date."

Can you just expand a little bit on that, that sounds quite a dramatic statement. What are you

referring to there?

A. Yes. So all policies within the Trust have an end date on them because practice changes and they have to be reviewed and even if they remain the same they get reviewed and should have a new date on them.

And I found that there were hundreds that were actually out of date. There were some policies that weren't even common practice, so it may be there had been a change and the policy had a new name but the old policy was still within the SharePoint document system.

Q. On the face of it that seems like too many policies. Was that also part of your conclusion?

A. Well, there wasn't a good housekeeping system when old policies that were no longer valid were removed from the system.

Q. And just working down, then we see a bit further down:

"Over 1,000 incidents in Datix that had not been reviewed."

A. Yes.

Q. How did you -- how did you come up with that figure? How did you know --

A. Because I pulled a report and it demonstrated that. So the -- because the serious incidents had been reviewed but there were a lot of low-graded incidents

that hadn't been reviewed.

Q. And you said before that it was only subsequently, but it wasn't that review that led you to your comment that you felt the neonatal unit weren't reporting things properly, this was a more general --

A. These were actual incidents that had been reported so they are in the Datix system but they had never been reviewed.

Q. And that was -- there was no one unit that stood out in that?

A. It was, it was -- it was across the --

Q. Across the board?

A. Yes, apart from within midwifery but then we only had small -- we had small numbers. So it was much easier for us to keep on top of things whereas some areas, just by the nature of the work, had more incidents.

Q. And then going down a bit further, you say:

"Inconsistent approach to risk across the Trust."

Can you just give a little bit more -- develop that a little bit.

A. Yes. So just in the make up of things like the governance boards, the items that went -- were received within Urgent Care and Planned Care, they weren't consistent. There were, were -- minutes were

received.
The way that the risk and safety leads maybe worked within the divisions wasn't consistent. Who attended what meetings. So someone from audit may attend one meeting but the -- the next division may not have somebody there.
Q. Underneath that, you refer to:
"Out of date mandatory training package."
A. Yes.
Q. Is that -- we looked at mandatory training used in the context of safeguarding before. Could that be a reference to that, is that --
A. So this was the risk and safety, so all staff had risk and safety training as part of their annual mandatory training and the data and the statistics and some of the information that was in there was out of date.
Q. So that's not a reference to safeguarding?
A. It is not safeguarding, no. It's the Trust.
Q. You say at the bottom:
"Poor management of the risk register."
A. Yes.
Q. Did that have any bearing specifically on not updating a risk register relating to neonatal deaths or is that not something you can recall?

A. It is -- across the board in the Trust there wasn't consistency when risks registers were reviewed.
Q. And I think you end your list by saying:
"This list is not all inclusive ..."
A. No.
Q. And if we could just see -- pull up INQ0006771.
My Lady, this is tab 12.
This rather shows that whilst you have put it in your witness statement what was happening at -- in real-time, so to speak, because this is a message from David Semple on 16 June 2017, so about a month or so, six weeks or so after you were in post; is that correct?
A. Yes, about that. Yes.
Q. It says:
"Please be assured that Julie Fogarty (Interim Associate Director of Risk and Safety), Mel Kynaston (Associate Director of Nursing ...) and I are acutely aware of ongoing concerns around clinical risk within the Trust. To put it mildly, we have inherited a mess and the issues include to name but a few ..."
So again, this is not an inclusive list, "previous poor leadership within the risk."
Who are you referring to as previous poor leadership?

A. Who's -- who is he referring to? He is referring to Ruth Millward.
Q. And it says risk and complaints team. This is obviously an email sent on behalf of you as well. Were there other people who were considered to be not performing?
A. No. No.
Q. And going down to the last bullet point, it says that:
"A plethora of committees and boards within the Trust with no clear reporting or escalation structure."
Now we have been through minutes and reflected, do you think it would be fair to put the Women's & Children's Care Governance Board and QSPEC within that description of boards where there was no clear reporting and escalation structure?
A. I think it could be improved upon definitely.
Q. Then if you just turn to paragraph 154 of your statement. You say there that you don't feel the issue with the risk processes across the Trust contributed to the failure to identify the risk Letby posed to babies.
Can that -- can that really be the case given what I have highlighted some of the risk that involves not escalating, risk registers, inconsistent approach, policies being out of date, Datix not being reviewed.

Surely that, in logic, must have contributed?
A. The reason I came to that conclusion was that it is obvious, though I didn't know it at the time, but it was obvious from the reports in the media and information within my pack, that the paediatricians had concerns for a long time and they had taken them to the Executive team to escalate their concerns and so even if you had all these processes, they had taken them to the Executive team.
So that's why I felt -- possibly that's why I felt that at the time when I wrote my statement.
Q. But having gone through the exercise we have gone through today, would you accept that these issues with risk were a contributory factor --
A. Oh certainly.
Q. -- to an environment where this was allowed to happen?
A. Yes, certainly as time has gone on and since I have produced my statement I've been aware of more facts. Then yes.
Q. And yes, yes, it was part of the environment that allowed these circumstances not to be investigated earlier?
A. Yes, yes.
Q. Is that a correct --

A. I would agree, yes.
Q. You talked very, very briefly and we may have covered this sufficiently but about your annual safeguarding. Can I just be clear that this was training that you were having in 2015 and 2016?
A. Yes.
Q. And you say, as well, when you are dealing with the safeguarding that you were trained in SUDiC, so that's Sudden Unexpected Death in Childhood.
Was it your understanding that that process, referring to the SUDiC process, would be used if there was a sudden unexpected death of a baby in hospital, so a baby that's born in hospital and has never gone home?
A. So my understanding is that the neonatal team would refer that baby to that, that person.
Q. So that would be your understanding that --
A. That would be my understanding.
Q. -- albeit it is not a death at home so there is no suggestion --
A. But because it was unexpected then I would still expect that that was the process they follow.
Q. And did you in your work ever have to refer a baby on --
A. No, because it wouldn't be in my, my sphere of practice.

Q. And then, finally, if we can just go to your reflections that you helpfully set out at the end of your statement, and at paragraph 169 you say:
"The ... steps I consider could have been taken to potentially identify earlier that Letby was harming babies on the NNU was a more comprehensive deep dive into the initial increase in mortality, including staffing analysis by an external team."
Is there anything you want to add to that by way of detail so that we can understand exactly what, as I understand it, where you feel a wrong turn was taken?
A. No, I think, I think I am fairly clear there. I felt that right at the very beginning the Trust should have engaged an external team to do a comprehensive review of the three cases involving in that review staffing involved, et cetera, to try and see if they could find a potential issue.
MS BROWN: Thank you very much, Mrs Fogarty, those are all my questions.
Mr Jamieson will now have some questions.
LADY JUSTICE THIRLWALL: Very well.
Questions by MR JAMIESON
MR JAMIESON: Is it Mrs Fogarty or would you prefer some other title?
A. Yes, that's fine.

Q. Mrs Fogarty, my name is Alex Jamieson. I ask you questions on behalf of some of the Families.
A. Right.
Q. All right? Can I start, please, by taking you back to something you dealt with at the start of Ms Brown's questioning. This Inquiry has received a deal of evidence about the impact of the change in the governance structure, three divisions to two, at the Countess and you gave a personal example of that in your Facere Melius interview which I think it would be useful for us to reflect on.
So please could we have on the screen INQ0012993.
So this is your interview on the -- in July of 2020, and can you see in the first entry ascribed to you, the top of the page, it says that what you are telling the interviewer is that at the point that the hospital had been reorganised, you had been a matron across women and children's services?
A. Yes.
Q. And so before it was reorganised, I'm sorry I am not looking at you, I am talking this way so the microphones pick me up.
A. Yes.
Q. You had had responsibility not just for maternity but also for neonatal services?

A. Yes.
Q. And so you very personally felt that reorganisation because after it had happened, your responsibility for neonatal services was taken away.
A. Well, the structure changed but my job -- my job role changed as well.
Q. Yes.
A. Yes.
Q. And so we have understood how generally it changed across the hospital but for you, in particular, that was a change in your responsibility and your approach, and you set out in the rest of that paragraph what that meant for the management and governance structures -- I don't need to take you to that.
But could we go on, please, to page 8 of this document.
There just in the middle of the page you have talked about something else and the interviewer has taken you back to this theme and he says:
"I'm just trying to put myself in that sort of time frame. You have been working for five years in this structure at this point."
And you go on to give a description of what it was like and you say these words:
"Silo working. It was true silo work."

And you go on to explain that on the staff -- on the shop floor, on the clinical floor, the neonatal staff and midwifery staff were doing well but as soon as you got above that into the governance structures it was complete silo working.

And I'm just wondering that phrase "silo working", what did that mean to you, why did you use that?

A. So instead of working jointly like we would do previously in the old -- when it was a women and children's services, we were working independently and feeding up through a different structure. So maternity services were feeding up through Planned Care and a Planned Care Board and the neonatal services sat on -- so it was a change in practice. Whereas we were used to all being sat round the table and reviewing and discussing, that's not how it was in the future. It was two completely separate divisions.

Q. And by this point, that is 2020, your job in the Trust has been this Director of Risk and so it's well known in the management of risk that silos of information are dangerous; am I correct?

A. They are not -- they are not beneficial.

Q. No.

A. They are not necessarily dangerous. But they are not beneficial.

Q. Well, if I am going to manage a risk I need all of the relevant information, wherever it may be, and if that information is in different silos I need to be able to get hold of it; is that accurate?

A. Yes.

Q. And so what you were reflecting here is that the arrangements that had been made in the Countess had led to the information being siloed?

A. Yes.

Q. I think what I and The Families would be grateful for your reflections upon is how that siloed approach was relevant to the risk that was presented by Letby in 2015 and 2016.

So I would just like to ask you some questions about that, if I may.

That can come down, thank you, Mrs Killingback.

Can we move, please, to the 2 July Serious Incident Panel.

A. Yes.

Q. I know you have answered quite a lot of questions about that already. Just before I ask you my questions, can I just contextualise that moment in time.

What has happened in the lead up to that meeting is that three children have died in two weeks in June, all of those deaths were sudden, all of those deaths were

unexpected. Those are Children A, C, and D.

Another child, Child B, the twin of Child A, has also seriously collapsed and required resuscitation within that period. The other fact that we need to build in is that the cause of death for each of those three children was at that stage uncertain. They had all been referred for post-mortem and indeed a Datix had been raised for each death.

Okay?

A. Yes.

Q. So that's the situation --

A. Yes.

Q. -- as you come to deal with the issue on 2 July 2015.

I wonder if next, please, we could have on the screen your notes of that meeting. Those are INQ0003530. Thank you. Please may we just zoom in on that top bit of the page. Thank you.

So we can see this is dated "SUI Review, 2 July '15" and to the right of that you have given the initials of the attendees. Yes?

A. Yes.

Q. Yes, okay. So we have got the right document.

Now, just before I ask my question, you have said a number of times to us in your evidence that you were

not a neonatologist, you didn't have any expertise in that area and what I am interested in, please, is your understanding of what your purpose and role was in this meeting.

Because what we can see when we look at the records that you have taken is a line or a section for each child, they are identified on the left as Child A, Child C, and Child D, a short description of some particulars and then on the right-hand side of the page, in relation to each one you have recorded the OSR -- is that the obstetric secondary review?

A. Yes.

Q. Is that what that is?

And that there were no M -- is that MW issues?

A. So this note, the bottom bit with -- it didn't have Child A, C, D.

Q. No.

A. It will have had the date -- it will have had a Datix number.

Q. Yes.

A. And that section underneath was written before I went to the meeting because I knew what I was going to discuss and I had to review the care from a midwifery aspect because that was my role at this meeting; was to take the midwifery aspect.

I obviously added who was there when I got there.
Q. Yes.
LADY JUSTICE THIRLWALL: So when you were asked what does "MW" stand for --
A. It's midwifery, no midwifery issues.
MR JAMIESON: Really it is that answer that you have just given that I am particularly interested in.
Your role at this meeting, as you understood it, was to take the midwifery information --
A. Yes.
Q. -- and to come back with any midwifery actions?
A. Yes.
Q. Right. So does that mean you did not understand it to be any part of your role to challenge professionally or evaluate the information that the other specialists were bringing?
A. Obviously if I had concerns then yes, but at this time I trusted the information, as did everyone else at the meeting, that was being provided by a neonatologist.
Q. Yes. I just, if I may, I would value your reflections on this issue because it's clear from what you have written that we have read that there were no midwifery issues identified or present in relation to

the tragic deaths of these three children, right?
Seen from the midwifery perspective, that is a reassuring fact, isn't it, because it means we haven't done anything wrong?
A. It means the care provided didn't -- yes.
Q. But if I am standing back and looking at it in the round, holistically, I have three deaths that have all been sudden and unexpected, no cause of death is identified, and there is nothing in the midwifery care that can have explained why these children died.
That's a concern, isn't it?
A. It is now but obviously, you know, nine years down the line when I am looking at this, my actions would be different than they were taken at that time.
Q. To be clear, this is not -- this questioning is not directed at you personally, I am trying to understand what is going on in the meeting.
A. Yes.
Q. All right? So that thought process that I have just set out for you, if there are no shortcomings in the midwifery care, that raises at least the possibility that there is something else that we are not seeing; was that thought process present in the meeting and, if so, who was it voiced by?
A. I would say that thought process wasn't

present in that meeting, I would say. Though it's nine years, it's a long time ago.
Q. Okay. There is one document that may help. That can come down, thank you very much.
It's the Datix report for Child D, that is INQ0002658.
Just while that's coming up, were those Datix reports available to you in the meeting? Were they considered by the attendees beforehand?
A. So the Datix were not brought up in that meeting.
Q. No. Had you seen them beforehand?
A. So I wouldn't have seen -- I hadn't seen the baby element but obviously the mother, yes, because we would have done the review that would have then gone into the Datix. But no, not the -- not the baby information.
Q. Okay. How does that work? So you log on to the system to see the Datix.
A. The risk and safety lead, they, they pull the incidents. So, for us, once there is an incident we look at all of the midwifery care.
Q. And so, going back to my question about your reflections on silos, even as you prepare for this meeting, even as you look at the Datixes, you are only

looking at the bit that relates to midwifery care?
A. Well, that's because you can't look at something you have not got the clinical expertise to interrogate data. So that isn't silo working, that is just a specialty reviewing care, that it's got the expertise to be able to interrogate and challenge.
Q. Okay. Well, let's, if we may please, look at page 2 of this document, and just zoom in on the top half of that page, please. Thank you.
Now, can you see -- this is a little involved, so bear with me. Under "Incident investigation" there are a number of entries that have been made by Debbie Peacock that are and then Dean Bennett that have been timestamped. Can you see the third one of those that's timestamped 23 July '15, if you look over on to the right-hand side there are in fact a number of earlier timestamps and it's the earliest one of those that I am interested in.
24 June 2015, 10:45:05 Debbie Peacock. So it is on that line just across to the right-hand side in the body of the text. And Debbie Peacock was an attendee of the SUI meeting, wasn't she?
A. Yes.
Q. What she's recorded is:
"Just to confirm that I have met with Eirian and

reviewed the case notes of Child D who died in the early hours of this morning. We have also discussed whether there are any other issues to address in the view of the two other recent sudden deaths on the NNU so all deaths are brought together. In regard to those three deaths, all deaths occurred in Room 1, our intensive care room but in a different cot space, all microbiology results have been negative to date, initial post-mortem result for Child A did not identify a definite cause of death."

A point that I have made with you already.

There is a bullet point about a TPN bag and why that makes a particular infection unlikely, but then the fourth bullet:

"There does not seem to be any staff, medical or nursing members present at all three episodes other than one nurse, who was not the nurse responsible for Child D on that shift."

Or putting that the other way round, there was a member of staff who was common to all of those three deaths and that entry, as I understand this record, is timestamped as having been made on 24 June '15, so a week or so before your meeting.

I take it from your answer that you didn't read that before the meeting?

A. No. No, because that is a neonatal entry so

I read the obstetric elements.

Q. But does one need to be a neonatologist to look at that and say: well, that is a common factor, we don't know if that's relevant or not. We had better think about it?

A. Well, I would have expected this level of information to have been -- to have been presented by either Debbie Peacock who wrote it or the paediatricians who were aware of this information. That was the purpose of the meeting. I was given the remit of looking at the obstetric, I wasn't asked to review neonatal records. I was asked to take the obstetric element and that's what I did.

Q. Just with your Director of Risk hat on, if I can use that vernacular, is that the right approach?

A. It obviously isn't now, but at the time I did the task I was given, so I was given the task of reviewing and bringing the obstetric information and that's what I took to the meeting. However, hindsight is a great thing.

Q. Yes. Okay. And the final question just to ask you to confirm this, please. We know from other evidence, I am not going to ask that it comes up on the screen, but for the record of the transcript, INQ0025743, it is the email from Dr Gibbs reflecting

Registrar concerns, that before this meeting Registrars had or a Registrar had visited a Consultant and said: we are concerned about these sudden collapses, we are concerned that there is a common and unusual rash that none of us have seen before but it's happened in three of these cases. We don't know what's happening here.

Was that information brought to your meeting?

A. This is the first time I have even heard of that.

Q. Okay, thank you. Those are the end of my questions then about that meeting.

Can I just please then move briefly to talk to you about QSPEC, the Quality, Safety and Patient Experience Committee.

Could we look very briefly at the 20 July 15-minute, so that's INQ0003211, and I am looking at page 2 to begin with, please.

So I'm just going to note in passing, again for the transcript and for my Lady's note, that Dr Brearey has attended this meeting -- it's at the bottom of this page -- particularly to talk about the Morecambe Bay Kirkup report and about the risks to neonatology that were presented by the current divisional structure, okay?

So that was a topic for discussion at that meeting.

I don't have a question for you about it. Thank you.

But may we go, please, to page 5 of this document. At item 11, the agenda item is "SUI update and other incidents" and there are a discussion of a number of incident reviews that have been raised to this meeting and taken place.

Now, the 2 July '15 meeting was a Serious Untoward Incident Review. That does not seem to have been discussed at this meeting, some three weeks later. Should it have been?

A. I mean, it obviously wasn't, but I can't, you know, I don't know why that wasn't tabled at that meeting.

Q. I didn't work in this hospital. Was that the sort of reports, the sort of meeting that should have been tabled here?

A. I mean, certainly it should, the, the concern should have been escalated further.

Q. I mean, in terms of escalation, Alison Kelly, the Director of Nursing, was in that meeting, so she would have had --

A. She called that meeting.

Q. She called the meeting?

A. Yes.

Q. She was aware of everything that was discussed. Could she have brought that to this meeting? She wouldn't have had to escalate it to anybody, she knew about it. Is that a fair inference?

A. Sorry, can you --

Q. Is that a fair inference, is that a fair comment that I have just made that she was aware of those --

A. Yes, she was aware. Yes, she called the meeting. She was fully aware.

Q. Okay. Thank you. That can come down.

In relation next to the Brigham report as it's been called.

A. Yes.

Q. You told us that there was an awareness that there had been an increase in the number of deaths from your perspective, stillbirths and neonatology deaths, and so the review had been commissioned. What I was interested in, please, is how did you capture that information that there had been an increased rate of mortality?

A. Data.

Q. What does that mean? What did you actually do or who did it?

A. So within data -- well, for a start the

Consultant obstetricians would be aware from being based on the labour ward, but from Datix.

Q. Okay. So who is it who is going into Datix on your side to notice those trends, to identify them and to action them with the review. Who's doing that work?

A. So not only the risk and safety leads but all of the ladies who have stillbirth, they have a Consultant review, they go to the Pregnancy Risk Clinic, and also the neonatal deaths were having an obstetric secondary review.

So because of an index of suspicion, we ran a Datix report.

Q. So but -- so you have identified I think the risk leads on the unit, they were the people who were actually doing this?

A. There is one risk lead for women and children's service, and they were asked to pull a report for us.

Q. Okay. And who made that request?

A. I can't remember.

Q. But it sounds like it was a matter of discussion between you and the clinicians?

A. It was -- it was myself and the Consultants but I couldn't tell you exactly who will have said pull, pull the list, due to the time lapse.

Q. Because do you see what -- the direction of my question? The data might be there on the Datix --

A. Yes.

Q. -- but somebody has to be prompted to go and draw it out. That hasn't happened in the NNU until later and so really I am trying to understand the process on your side, how that worked, and why it might not have worked on the other side.

A. I can't answer for why it didn't work in neonatology because I wasn't responsible for this area of practice.

But from a midwifery and obstetric point of view we were constantly looking at what was happening in our area and what our outcomes were.

Q. Okay. And there was that discussion between the senior clinicians --

A. Yes.

Q. -- and you that crystallised that understanding?

A. And we felt that the only way forward we could be assured that we didn't have a problem was to do a review and being open and transparent we invited an external Head of Midwifery from the Manchester network to join that review.

Q. Did you consider inviting neonatologists to

join your review?

A. No, because it was purely a review of obstetric care, so they wouldn't be able to contribute to reviewing whether people were on the right pathway or had the right drugs, et cetera.

We were also aware that they would be doing a review of their own.

Q. How did you have that awareness?

A. One of the -- one of the Consultants had said, "Well the paeds are doing a review as well." So it was a verbal -- that we had been told verbally.

Q. But the Brigham review, as I understand it, is finished in November?

A. Yes.

Q. It's presented --

A. In December.

Q. -- in December.

A. Yes.

Q. And there is nothing from the neonatology side in November, there is nothing in December.

A. I can't account for the practices within the neonatology unit.

Q. No. You have been asked -- you have already candidly conceded, and I am grateful, that on reflection looking at that Brigham report it is potentially

misleading.
A. Definitely, definitely.
Q. Right. And may we please just look at -- it is a document we have looked at before but we are going to look at it again briefly, if we may. It is the emails with Alison Kelly.
A. Yes.
Q. INQ0003220.
So we start at the bottom. So the question is coming to you on the 2 December by which time the Brigham report has been produced but it has not been presented.
A. Yes.
Q. "Hi, where are things up to with the thematic review? I am keen to get a paper to the December QSPEC."
Now -- and you reply:
"Hi, the updated midwifery element was received in November at QSPEC. It was the paed update that was missing."
Now, it may be suggested that Alison Kelly was one of those who received the report and was misled by it to begin with, thought it was a comprehensive document --
A. No, no.
Q. -- rather than just obstetrics?

A. No, because Alison Kelly emailed myself and Ruth Millward on 2 December. So myself, for the obstetric, and Ruth Millward, for the neonatal, because Ruth Millward played no part in our decision to review or our review.
And she's also copied Ian Harvey into the email. So that's why I said it was the paed element that was missing and so that's why Ruth was copied in because then she would be chasing up the neonatal element.
Q. Yes. So you have said that in terms, haven't you, on 2 December, the updated midwifery element was received in November, that document that I gave you in November was the midwifery element, it's the paed update that's missing.
A. Yes.
Q. But her reply at the top of that:
"Hi, sorry if I haven't been clear. I mean the thematic review of neonatal/deaths recently undertaken ..."
I don't, in fact, think I can put any particular -- it will be for her to explain what that meant.
A. So that, that is the neonatal review.
Q. Yes. Which you have said in the email below is midwifery element only, and just to bottom this topic out, please, can we go to the minutes.

A. Because Alison Kelly has written at the top:
"Despite terminology below this was an obs/maternity review."
That's Alison Kelly's handwriting.
Q. That's her handwriting? That's really helpful. Thank you. So that's the manuscript --
A. That's Alison Kelly's handwriting at the top, I recognise that.
Q. That's really helpful. Thank you.
Because I just -- in that light, I would just like to look at the minute of the December QSPEC, please.
That is INQ0003204, and can we start at page 11. It may be that I have given you the wrong --
LADY JUSTICE THIRLWALL: Do you mean page 11 or paragraph 11?
MR JAMIESON: I mean page 11 but that was not the document I was expecting.
LADY JUSTICE THIRLWALL: I think you might mean paragraph 11, 0005.
MR JAMIESON: So what I was hoping to see was the minutes of the QSPEC committee.
LADY JUSTICE THIRLWALL: Yes.
You have given the right reference.
MR JAMIESON: I have, okay, it is just not what has come up in front of me.

LADY JUSTICE THIRLWALL: I hadn't noticed that.
MR JAMIESON: And my Lady is quite right. It is paragraph 11, not page 11.
It is page 5, please.
Right. Now, my learned friend Ms Brown took you to this paragraph and I am not going to repeat what she's done already. It is the minute of your presentation of the neonatal and stillbirth review. What I would like to do, though, is having orientated us there, just go over the page to page 6, because the final sentence says:
"Mrs Kelly thanked Ms Fogarty and the team for the report and the assurance it had provided to the committee."
Now, as I understand your evidence, your explanation to QSPEC had been: this is our report, it only deals with maternity, we have not found any shortcomings with it, we have an action plan to pick up the items of improvement that we have identified.
A. That's correct, yes.
Q. That's accurate?
A. Yes.
Q. And so nobody listening to that should have taken assurance that it answered concerns on the neonatal side.

A. No, because they were aware of my remit. I made it clear it was obstetric and maternity only and Sian Williams in her statement makes reference to the fact that this report was an obstetric report only which confirms that that's what I verbally said at the meeting.

Q. Yes. There are no -- what you had also said in that email that we looked at a moment ago was that the neonatal review was still outstanding.

A. Yes.

Q. But there is nothing here in terms of an action or a plan taking forward that suggests the committee were awaiting that report or expecting that report.

A. No, it's not evident in that and I -- no, it's not evident in these minutes. But that would be something for Alison Kelly and Ruth Millward to chase outside of the meeting.

Q. That was your expectation?

A. That would be my expectation.

Q. But didn't QSPEC have a role in monitoring these issues, making sure that actions were completed?

A. Definitely, yes.

Q. So if, on this very serious issue an increase in neonatal deaths and stillbirths, half of the review

has been completed but the other half hasn't, shouldn't that have been formally on the agenda for future QSPECs?

A. Well, I don't know whether, aside from the meeting, whether there were any emails being sent to the relevant people asking where the reports were. Because I wouldn't be privy to that information.

Q. But as somebody who sat on this board, if I come to the next meeting of this committee and I am asked to review the minutes, I am not going to be looking, I am not going to be prompted to look for any additional review from the NNU in relation to these deaths. I am going to read that and it says, "Assurance has been provided, no further actions."

A. I suppose that Alison Kelly knew that there was a need for a neonatal review as did Ian Harvey, the Medical Director.

Q. Okay, thank you very much. That can come down.

The final topic is different to everything that we have talked about before and it comes from one of the Families that I represent and the concern that's raised is about the use of mobile telephones on the NNU.

Now, I know that you didn't work on the NNU --

A. Yes.

Q. -- and so I am asking you really from your

position of Director of Risk, okay?

So the risks that are or have been identified by Mother E/F in the evidence that she has heard, in the criminal trial and here, in staff using their mobile phones on the unit is principally a blurring of the lines between the personal and the professional because this Inquiry and indeed the criminal trial have received evidence of messages between clinicians, of friendly run-of-the-mill conversations, lighthearted social conversations, that then have interwoven an exchange of deeply personal and often tragic personal data that related to the children who died.

And the question is: was that a risk that the Trust was aware of at the time that you were Director of Risk Management?

A. So this is the first time I have heard that piece of information.

Q. Okay.

A. It wasn't something that I was familiar with.

Q. Okay. Were there any policies or rules that governed the use of personal mobile telephones on the NNU?

A. Not on the NNU, no. I would say that mobile personal phones were used not only in the Countess but widely throughout all of the NHS because staff are not

issued with a works telephone.

Q. But if that risk that I have identified is present, that measure that you have just mentioned, the issuing of a staff telephone, might be an effective one to reduce that risk?

A. I mean, it's very sad to hear what you have said about the, you know, the messages. I can say I had no personal knowledge of that until you have just raised it now.

MR JAMIESON: Thank you very much. Those are all my questions.

Thank you, my Lady.

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

I have no questions for this witness. We are finished now?

MS BROWN: Yes.

LADY JUSTICE THIRLWALL: Thank you very much indeed, Mrs Fogarty, you are free to go.

Are we going to take the break now?

MS BROWN: I think that's the suggestion and then there is going to be a summary of evidence after the break.

LADY JUSTICE THIRLWALL: Very good. We will recommence at quarter to 4.

(3.28 pm)

(A short break)

(3.46 pm)

LADY JUSTICE THIRLWALL: Yes, Ms Lyons.

MS LYONS: My Lady, this is the summary of the evidence of nurses and midwives.

LADY JUSTICE THIRLWALL: Thank you.

Summary of Evidence of NURSES AND MIDWIVES

MS LYONS: My Lady, the Inquiry local team sent Rule 9 requests to 30 nurses who were involved in the clinical care or management of babies on the indictment at around the time of collapse and/or death.

20 other nurses who worked on the neonatal unit and all 14 midwives who appeared in the hospital staff list were sent questionnaires. Any individual who worked there during 2015 and 2016 and who considers they might have relevant evidence to give the Inquiry should contact the Inquiry. It remains the case that the Inquiry remains open throughout the course of these oral hearings to receive such evidence.

This is a summary of the evidence of nurses who are not being called to give oral evidence. Collectively, they have provided 22 witness statements and completed 20 questionnaires. This summary also incorporates the evidence of the midwives. The nurses and midwives have

responded to specific questions in connection with the issues under investigation. We are grateful for their co-operation which is of assistance to the Inquiry's work.

This summary sets out their responses to questions about the culture and atmosphere on the NNU between 2015 and 2016, suspicions or concerns about Letby, the mortality rate, and what changes should be made to keep babies in the NNU safe from deliberate harm.

Culture and atmosphere on the NNU at the hospital from 2015 to 2016.

Many of the nurses concerned described June 2015 to June 2016 as a particularly busy period on the NNU. Christopher Booth, a Band 6 nurse, who had been working on the NNU since 1993 recalled it being:

"... an incredibly busy period with high acuity and it was a demanding time for all team members. As so much time has now passed my memory is somewhat sketchy but I do remember team members being asked to show greater flexibility with shifts worked and indeed even being asked to work extra shifts on a regular basis. I do remember grumblings of us needing more registered nurses to help cope with the increased workload but that did not seem to be forthcoming."

Lisa Walker, a Band 4 nursery nurse, had been

providing clinical care to special care babies since 2008. She described this period as:

"... very busy and stressful on the unit. We would sometimes miss breaks because it was that busy. Staff morale was low because everyone was tired. However, I always felt supported and valued."

Most of the nurses commented positively about the quality of management, supervision and/or support that they received during this period from the NNU ward manager Eirian Powell and the deputy ward manager Yvonne Griffiths.

Of the Band 6 nurses concerned, Laura Eagles described the ward manager and deputy ward manager as "very present, approachable and strong in their leadership".

Caroline Oakley also described Eirian Powell as "approachable, helpful and supportive", as did Ailsa Simpson who stated that Eirian Powell was "supportive and appreciated all our hard work as a team during an extremely difficult period."

Other Band 6 nurses such as Caroline Bennion described Eirian Powell and Yvonne Griffiths as "very supportive, approachable and proactive with personal development. Learning opportunities, study days, and courses were often recommended and encouraged".

Both Joanne Williams and Amy Davies said they felt supported within the nursing team and were encouraged to further their qualifications and training.

Nurse X noted that Eirian Powell was "open to general concerns or issues being raised". She also said:

"Eirian Powell could be defensive of nurses on the unit and would generally support nurses if issues were raised by doctors, for example. That said, she had obvious favourites amongst the staff as well as a couple of staff that she clearly did not like. This meant that her response to issues, incidents varied depending on who was involved."

Belinda Williamson described Eirian Powell as "generally very supportive and fair". She also stated:

"If I had a problem she was approachable and would generally work with me to solve the problem. She would often ask for the problem to be put in writing if she felt it was necessary to have a record of the issue. She encouraged the team to actively fill out Datix. Eirian supported us with trying to ensure we had adequate staffing levels and often asked us to enter a Datix if staffing levels were insufficient."

As regards the deputy ward manager Yvonne Griffiths Belinda Williamson commented that she worked well with

Eirian Powell:

"They balanced each other out and appeared to work well together."

She expressed the view that:

"At times it did feel that some staff were given opportunities based on who they were, not their abilities and/or experience. Staff were encouraged to improve their knowledge and skills through further training and education as well as secondments at tertiary centres. At times it felt staff were allocated infants above their capabilities due to the workloads occurring within the unit, relying on the nurse in charge or senior nurses to oversee their work."

Anne Murphy was the "matron of the women and children's ward", known in the Inquiry as the Lead Nurse for Children Services. Ailsa Simpson described Anne Murphy's management style as "very supportive".

Nurse Y gave similar evidence. She said that Anne Murphy was:

"Always contactable and supportive in the absence of management on the NNU".

Minna Lappalainen was less positive about the hospital's senior management who she felt "didn't support us or listen to staff or the NNU manager". She expressed the view that "our staffing levels remained

poor at times especially during busy periods. This period was stressful and exhausting at times."

Bernadette Butterworth, Mary Griffith, Sophie Ellis, and Samantha O'Brien were Band 5 neonatal nurses in 2015/2016. They all describe the management on the NNU as supportive.

As a junior Band 5 nurse working on the NNU between 2015 and 2016, Sophie Ellis found the nursing managers "supportive, approachable and knowledgeable". She felt able to talk about personal and professional matters with the nursing managers and felt "they listened to [her] with compassion".

Bernadette Butterworth recalled there being a good team spirit where the nurses would all support each other.

Of the Band 4 nursery nurses who had dealings with the NNU managers the majority reported feeling largely supported. Jean Peers said:

"I would describe the quality of management and supervision as supportive, close and caring, as were the nurses on the NNU."

However, Cherryl Cuthbertson-Taylor experience of the culture and atmosphere on the NNU differed. She said:

"My line manager between 2015 and 2016 was

supportive and did pass on any concerns I raised regarding staffing levels to her manager. I found the unit very stressful during this period due to increasing staff shortages and the increasing workload that was being expected of a Band 4. Even though I was an experienced Band 4 nurse I had not seen the staffing issues as bad as I had in 2015 to 2016. I was being asked to complete tasks that I was under qualified for, ie babies that required a Band 5/6 nurse. When I raised these concerns to fellow colleagues I felt very under supported."

In 2015 to 2016 Claire Bevan worked predominantly night shifts as a Band 6 bank nurse on the NNU. During these shifts she described either being in charge or second in charge of the NNU, co-ordinating staffing and care and allocating patients and staff for the shift as well as supporting staff. As to the quality of the management of the NNU between June 2015 and June 2016, she said:

"Some staff found management more approachable than others. The unit generally felt neglected by senior management as we were constantly short-staffed and it appeared they weren't listening to our requests for help. If we had sickness on shifts it was always very hard to get help from other areas of the hospital. We

felt like we were on our own. I think people were frightened to come and help because it was such a niche area of nursing."

Each of the nurses was asked to describe the relationship between (1) clinicians and managers, (2) nurses, midwives and managers, and (3) between medical professionals -- doctors, nurses, midwives and others -- at the hospital between June 2015 and June 2016.

Several of the Band 6 nurses gave evidence that there was a good relationship between the neonatal nurses and the doctors.

Laura Eagles recalled that the nurses worked well with the doctors, particularly the Registrars and senior house officers. She describe the Consultants as approachable. Joanne Williams also commented on the close working relationship the nurses had with the Registrars who she recalled were present on the NNU most of the time when acuity was high. She described the relationships across the different professions as professional.

Nurse Y described the Registrars who were allocated to the NNU as very experienced and appeared to have a good rapport with the nurses.

As regards the nature of the relationships with the Consultants she said she had "worked on the unit for

a long time" and that she felt she had "a good rapport with Consultants".

Ailsa Simpson recalled there being stressful periods at times. She stated:

"Sometimes when a baby required a review by a doctor they wouldn't always be available to attend straight away as they would be reviewing patients on the children's ward first. Overall, despite the [busyness] of the NNU, the doctors and nurses on the NNU collaborated well together as a team and the atmosphere was happy at times despite the stressful phases."

Belinda Williamson noted:

"There was frustration with the medical team at times due to lack of cover for neonates, especially overnight, or if the team became busy on A&E or on the paediatric unit."

Christopher Booth described the relationship between the medical professionals during this period as good. He also said:

"We were a strong, mutually supportive team and all worked well together for the well-being of our babies and their families. My only slight concern though, and it is a concern that I have held for some time, is that we at the Countess of Chester Hospital really could have benefited from the expertise of a neonatologist who

could offer more specific, focused and cutting-edge expertise in this very specialised field."

Abigail Lever, a Band 5 neonatal nurse stated that there has "always been a really good relationship between doctors and nurses."

In 2015 to 2016, Band 5 neonatal nurse Satasha Culshaw worked ad hoc shifts on the NNU that required cover. She cared for special care and high dependency care babies. She said:

"The staff I worked with all had a strong sense of teamwork ... I felt there was a good sense of teamwork between all members of staff that I worked alongside. I never got a feeling that there were any issues between colleagues."

Janet Cox, a Band 4 nursery nurse who had worked at the hospital from 1986 to 2022 stated that she did not have a clear memory of the relationships between clinicians and managers and medical professionals. She also stated that she did not wish to comment "as [her] view the Trust and various so-called medical 'professionals' is prejudiced by the horrendous way they treated Lucy, (Ms Letby)".

As to the relationship between neonatal nurses and midwives, Laura Eagles described this as:

"More complex. "We as nurses would directly liaise

with midwives. There was very little communication between us and the obstetricians. If we had challenging conversations to have, we would ask our Consultants to speak with them. We would sometimes face discord from some senior midwives and ourselves. This would be in relation to when we were heading to full capacity or already at it and the midwifery team not valuing our concerns. It could be quite a struggle sometimes when we were full and then wanting to deliver a baby that would need our care and us not having room. We would ask them for help and some appreciation of our situation but would not get it. I cannot say this was all the time but it was quite common to have a struggle when we were getting full and/or closed. If we as an NNU team felt the best thing for the pending admission was a transfer out, it would be very difficult to make this heard by the obstetric team."

In her evidence to the Inquiry, Caroline Oakley discussed the strain in the relationship between the NNU and obstetric teams when the midwives/obstetricians did not accept that the NNU was at full capacity and could not admit any more babies. She said that neonatal nurses would report such incidents via an online reporting system, Datix.

Susan Morton was employed by the hospital as a

Band 6 rotational midwife in 2015 to 2016. She worked on the central labour ward, antenatal/postnatal ward and within the maternity day unit. She described the extent to which she carried out work on or in connection with the neonatal unit between 2015 and 2016 as follows:

"If I was working on the labour ward and a baby required any care or observation on the neonatal unit immediately following birth, the baby may have been transferred to the unit by the neonatal team. I would complete a situation background assessment and recommendation handover to a member of the NNU team. This is a recognised tool we use in medicine to give a clear and concise handover and would detail any relevant risk factors from the mother's pregnancy, labour and delivery. When working on the postnatal ward a nursery nurse from the NNU would be allocated to the ward's transitional care room. This was a 3-bedded bay and may include, for example, babies who were slightly premature requiring additional observation, feeding, support, temperature monitoring, or phototherapy. As midwife I would be caring for the mother and the nursery nurse would be responsible for the care of the baby. In these situations I liaised with the neonatal nursery nurse who was caring for the baby. If a baby was being cared for on the NNU, mum may be staying in a single

room on the postnatal ward. If mum was unable to mobilise independently then a member of ward staff, on occasion a midwife, would transfer mum to the NNU in a wheelchair to feed and spend time with her baby. At that time any baby born on antibiotics had to be transferred from the ward to the NNU each time their medication was due as the drug and dose required checking by two of the registered nurses. On occasions that the parents or a member of the neonatal staff were unable to transfer the baby they sometimes asked a midwife or a midwifery assistant to take the baby to the unit. I cannot recall if I did this as during this time period I had completed six months' experience as a labour shift leader then went back to being a Band 6 midwife."

Susanne Boggan qualified as a registered midwife in 2014 and commenced work at the hospital between October 2014 and November 2015 as a Band 5 rotational midwife. She described the extent to which she carried out work on or in connection with the neonatal unit between 2015 and 2016 as follows:

"I would primarily have contact with the neonatal team if their attendance was required at a birth where it was anticipated the baby may need assistance or monitoring outside of midwifery scope of practice, for

example instrumental or operative births, premature babies, or babies who required resuscitation at birth. In such cases it was usually a neonatal doctor who would attend first and the team would include senior neonatal nurses if their assistance was required. I would also come into contact with the neonatal nurses if a baby in my care was receiving intravenous antibiotics as it was the neonatal nurses who would come to administer those. If a baby required admission to the NNU after birth, I would often accompany the parents to the NNU to see their baby once the mother was well enough. Occasionally, I would see the NNU shift leader when they would come to the labour ward to ask for updates on any anticipated birth that might require their presence. On one occasion I cared for a family in the bereavement suite after their baby had unexpectedly passed away and two neonatal nurses attended to help with bathing the baby and memory making, taking photos, hand and footprints."

Concerns or suspicions.

While few of the nurses could recall receiving specific training on how to report concerns about fellow members of staff, they were all aware of how to do so.

Laura Eagles:

"I do not recall ever having any training on

whistle-blowing formally. However, I am aware of how to raise concerns. The process would be to inform the manager, or higher, if necessary, and to complete a Datix incident form depending on the type of concerns."

Caroline Bennion:

"We had a good relationship with our immediate management team to feedback any concerns we may have had regarding colleagues, unsafe practices and not adhering to policies. The manager at the time Eirian Powell was very keen for staff to openly report incidents through Datix and log concerns with a no-blame culture. I was aware of the Freedom to Speak Up but at the time I would not have known who to approach or the process for doing so."

Bernadette Butterworth:

"With regards to any training we had been given regarding reporting concerns involving fellow members of staff I cannot recall what training we received at the time apart from discussing concerns with the manager. We now receive Speak Up core training for all workers which is mandatory for all staff."

Amy Davies:

"I cannot recall whether we had specific training on how to report concerns about members of staff at the

time. However, I know I knew about whistle-blowing and I felt confident that I could report any concerns to my line manager or higher management if I had concerns and I would have done so if I had any concerns."

Nurse Y:

"As a senior member of staff if I had concerns regarding another member of staff I would report this to my line manager in confidence or raise my concerns via email if they were not available at that time. As a registered nurse, it would be my responsibility to escalate any concerns about patient safety to the unit manager, or matron in her absence. This is the ethically correct course of action and follows the standard set by the NMC Code of Conduct."

Caroline Oakley:

"To the best of my knowledge I was not given any training on how to report concerns about fellow members of staff. As a senior member of the nursing team and depending on nature of my concerns, I would either speak to the member of staff or escalate the issue to my manager."

Sophie Ellis:

"I cannot remember whether we received any formal training about how to report concerns about another member of staff although if I did have any general

concerns, I know that I could speak to my line manager and escalate as appropriate if needed."

Mary Griffith:

"I would have been aware of how to report concerns about fellow members of staff. I knew that concerns should be reported to the unit manager."

Valerie Thomas:

"I cannot remember ever attending formal training on reporting concerns but I knew I could go and report at any time with my ward manager."

Claire Bevan:

"Annual training updates included whistle-blowing updates. I cannot remember the detail but throughout my training and career as a nurse, I was always taught that any concerns about staff, procedures, protocol not being followed, et cetera, should always be raised. There was lots of information on the intranet about how to do it. I believe that most senior staff on the neonatal unit were approachable. Even if a junior member of staff felt uncomfortable approaching management directly, the friendship groups within the neonatal unit were such that all staff, either directly or indirectly, had a route to raise concerns. I cannot think of any member of staff on the unit that if they felt for whatever reason they couldn't follow official channels didn't

have someone relatively senior to discuss concerns with, that then would have been formally reported."

The majority of the midwives had no recollection of having received any training on how to report concerns about a fellow member of staff. However, they all knew how to escalate concerns to their line management or any other manager that was felt appropriate.

Some midwives would have also reported any concerns regarding patient care via the Datix system. Those midwives who had received training said. Susan Morton:

"Training on how to escalate and report any concerns about fellow staff members was disseminated as part of mandatory study days via training modules, emails and campaigns, such as the 6 Cs which were the core values of the hospital at the time: care, compassion, commitment, courage, communication and competence."

Rachel Wright:

"I was given training on how to report concerns about fellow members of staff during midwifery training in university and at the start of my career within the mandatory study days that I attended. Any concerns were to be reported with the member of staff, shift leader or manager."

Deborah Moore:

"Yes, I have had training and am aware of processes such as Datix incident reporting and whistle-blowing. From what I can remember any concerns to be reported between 2015 onwards were to be reported, as always, through Datix incident reporting or, if this was not suitable or feasible to do so, there was the option to use the Freedom to Speak Up policy -- I'm not sure whether it was called this at the time -- and report to higher-ranking person."

Overwhelmingly none of the nurses had any concerns or suspicions about the conduct of Letby while she worked on the NNU.

Ailsa Simpson had no concerns but felt that Letby involved herself more -- with more babies than she needed to be involved in:

"For example, if a baby collapsed or required cardiopulmonary resuscitation but [Letby] wasn't caring for that baby she would involve herself anyway despite being told by a shift leader that she needed to look after her own babies."

Ailsa Simpson also recalled:

"After the death of the third or fourth baby it was generally noted that she (Lucy Letby) was involved in each case. This was the only point that the NNU staff observed. At that point, I did not consider that she

was the cause of the issues and I thought that her involvement might just have been a coincidence."

Vicky Blamire said:

"It wasn't until finding out about more and more fatalities that questions were asked about which members of staff were present at the time as this would have had a big impact on their mental health. Hearing Lucy's name with every occasion made me feel very uncomfortable as she didn't show any kind of emotion. I remember feeling very shocked and confused as to why she didn't seem to be upset. This was very unnerving."

Cherryl Cuthbertson-Taylor did not have any concerns or suspicions about Letby's care of the babies or as a nurse. She did, however, find Letby a little odd and said she was aware of several staff who felt the same way about her.

Nurse Y had no concerns about Letby and was not aware of any. She explained:

"As a full time Band 5 neonatal practitioner who also worked regular overtime shifts with the relevant qualifications to care for intensive and high dependency care patients, Letby was regularly allocated the sicker infants on shift. Band 5 nurses do not take charge of the NNU, I remember her being taken off night shifts to work only day shifts at some point. I had presumed this

was to protect her own well-being as she had been present for a number of deaths on the unit."

Janet Cox had no concerns or suspicions about Letby's conduct. In her view, Letby was "An exemplary nurse who is completely innocent of all the alleged crimes."

Ms Cox could not recall the precise dates when she became aware of the suspicions or concerns of others about Letby but she does recall "gradually becoming aware that certain Consultants, in particular Brearey, appeared to be trying to make Lucy a scapegoat for the increased number of deaths/collapses".

Joanne Williams did not have any concerns or suspicions that Letby was deliberately harming babies on the NNU. However, following the collapse of Child K on 17 February 2016, Dr Ravi Jayaram approached Joanne Williams wanting to know what had happened to Child K. She said:

"After this I thought he may have had concerns about Letby."

Other nurses were only aware of the concerns or suspicions of others regarding Letby's conduct after July 2016 when she was seconded to another department and the NNU was downgraded.

None of the midwives had any concerns or suspicions

about Letby's conduct. Most of the midwives did not know Letby or had not worked with her. They became aware of the increase in the number of deaths on the NNU as a result of the police investigation and/or from the media following Letby's arrest.

The nurses were asked whether discussions or debriefs, formal or otherwise, with or between nurses or between nurses and doctors, took place following the death of a baby. Most of the Band 4 nursery nurses said they did not participate in these types of discussions or debriefs. Vicky Blamire explained that this was not unusual because Band 4 nurses only cared for special care babies and babies who were getting ready to be discharged.

Caroline Oakley's evidence is that there was and still is no formal protocol for debriefs.

Laura Eagles described then as "informal and ad hoc".

There would be discussion led by a Consultant about the case and how everyone felt. Amy Davies explained that there was no formal process to discuss an unexpected event or unexpected response from a baby to treatment.

Caroline Bennion stated:

"There were always informal hot debriefs after

a death and collapse of a baby. All staff involved including the midwifery and obstetric staff, where appropriate, would be invited too. A formal meeting would be arranged and sent out by the Consultant to all staff involved later."

Christopher Booth gave similar evidence. He said:

"After the death of a baby formal debriefs did occur usually a few days after the event. I did not attend any formal debriefs as either I was working on a night shift or chose not to attend. I did, however, make use of informal debriefs with colleagues where we would talk, discuss, assimilate, and try to rationalise what had happened."

Belinda Williamson said:

"[Debriefs] depended on the circumstances of the death as to when or if a debrief occurred. It was voluntary for nursing staff to attend. If the ward manager or medical staff wanted us to attend it was generally arranged for a day when we were back on shift and available to attend. As a member of staff you could ask for a debrief with the medical team and raise any questions you had regarding the event even if the medical team did not necessarily know the answer. We could also ask verbally for the post-mortem results once they were completed. Nurses tended to discuss the

events amongst colleagues if we felt we needed to."

Susan Needham, who worked at the hospital as a midwife, said discussions with or between midwives after the death of a baby at the hospital would depend on how much input the midwives had had with the baby and their family and whether the labour and delivery were in some way significant to the demise of the baby.

She said:

"Midwives are always given the opportunity to discuss the demise of a baby that dies at or soon after birth. They will be given the opportunity to go through the labour, to try and pinpoint any problem with their care, and there was usually a multi-disciplinary meeting held for midwives and doctors to attend and this had been the process prior to, during, and after 2015 to 2016."

The mortality rate.

Most nurses described being aware of or worried about the increase in the number of deaths on the NNU. Laura Eagles:

"I was aware of the increase in mortality rate. Obviously all deaths are concerning and it is important to ensure that all clinical care has been reviewed to make sure that it was correct. As far as I can recall, the Coroner was informed of all the deaths. As I have

previously mentioned, there was an increase in activity on the unit and it felt there were more sick babies than is usual. This could then explain why perhaps that there were more deaths, in my opinion."

Christopher Booth:

"I was of course worried about the increased number of deaths on the NNU. It was extremely harrowing and emotionally exhausting. As I have outlined earlier, in my mind the collapses and deaths could all be rationally explained as we were experiencing an unprecedented level of acuity with the NNU being at capacity or close to capacity for such a long time. Water pressure was low, which was not ideal for hand washing. It took time for the issue to be resolved and it is only since the events were investigated that I reflected upon it and saw it as a potential factor in perhaps cases involving sepsis."

Caroline Bennion:

"I was personally alarmed or alerted to the number of child deaths when one of the triplets died on 21st(sic) June 2016. I can remember asking my colleague, although I can't recall who, about what had happened. It was completely unexpected. They were mature babies, born at 33 weeks, good weights, and although they were receiving respiratory support they were very stable. I wondered if there was a significant

infection on the unit that we were missing. This was a discussion with nursing staff although I cannot recall their names, given that infection is always a concern in relation to preterm babies. This was not a conversation I had with the medical staff or outside the unit but it was more of a speculation between the nursing staff."

Ailsa Simpson:

"The increase in the number of deaths on the NNU during the period 2015 to 2016 was very concerning. It is usually very rare for a baby to die and even if they do, it's usually in cases where the babies are extremely unwell, either with sepsis or if there is a congenital abnormality."

Joanne Williams:

"I was aware and concerned about the increase in the number of deaths on the NNU. I cannot recall specifically when I became aware of the increase or what I thought. At the time the acuity on the unit was always high and we were caring for vulnerable patients. It was very difficult for the team dealing with numerous deaths feeling overworked and at times under appreciated."

Mary Griffith:

"All staff on the NNU were concerned about the number of deaths on the unit but regarded this as being

the consequence of the gravity of the babies' conditions and the increased number of admissions."

Caroline Oakley:

"I was aware that 2015 to 2016 was a very busy year and we had more vulnerable babies coming in from the labour ward. I was aware of more deaths but due to the increase in the number of vulnerable babies we were caring for I did not think it was an unnatural result that there were more deaths.

Janet Cox:

"Obviously any death is a worry, but I did not think this at the time, nor do I think now, that there was anything sinister about the increase in the number of deaths/collapses. I do not see how you can set a figure on how many deaths are acceptable in one particular time frame. The very reason these babies required admission to an NNU was because they had a high chance of dying or collapsing."

Jennifer Jones-Key:

"I discussed with nursing staff about how busy we had been and how sad it was with the run of babies passing away. I was not concerned by the number of deaths as we had had a very busy time and had been full most of the time."

Claire Bevan:

"The increase was concerning but nobody to my knowledge expressed any concerns including doctors. As far as I am aware, although the deaths were unexpected and some apparently unexplainable, nobody voiced any concerns. In my recollection staff were discussing how odd it was but there was never any suggestion of anything untoward."

Nicola Dennison:

"I was not particularly worried about the increase of the deaths on the neonatal unit because we had lots of babies who were very poorly, some of which were born to very poorly mothers, and as such our statistics naturally increased. We also had a high instance of congenital abnormalities, which included heart conditions and gastroschisis, for example. We were at maximum capacity for the majority of the time. However, I do not feel that care was ever compromised."

Susan Morton:

"I remember being worried and concerned about the high number of deaths in 2016. This was when I was undertaking my developmental Band 7 labour ward shift leader role. I was the shift leader on a day shift when two of the three triplets died within a short period of time. I recall hearing that the transport transfer team were present when the second baby died and the parents

had requested that the third baby be transferred to another unit.

"I also recall that day that a decision was made to halt any elective inductions of labour and not commence any new inductions at that time. I don't however recall who this decision was made by. I remember feeling incredibly upset and shocked at the recent events and that morale was becoming increasingly low."

Recommendations.

The nurses were asked whether Letby's crimes could have been prevented if the babies had been monitored by CCTV. The majority doubted the efficacy of CCTV in preventing Letby's crimes.

Ailsa Simpson expressed the view that even if CCTV had been in place at the time Letby would have found a way:

"... as she had the intention to harm the babies."

Christopher Booth stated that CCTV:

"Would have little impact or effect. If a person is determined to commit any unlawful deed the CCTV camera system could be easily circumvented."

Amy Davies pointed out that babies are not always in full view due to the incubators and incubator covers and the position of staff.

She did not think CCTV would help.

Nurse Y, Minna Lappalainen, Joanne Williams, Mary Griffith, Lisa Walker and several other nurses expressed concern that the use of CCTV in clinical areas of the NNU was not appropriate and would interfere with the privacy rights of babies and their families.

Belinda Williamson felt it would inhibit mothers from breastfeeding or expressing milk or having skin-to-skin contact, which would be detrimental to both babies and their parents.

Nurse Y also considered it inappropriate to have CCTV monitoring of babies:

"... during procedures or examinations when their private areas may be visible."

It concerned her who might have access to these images. Nurse Y also stated:

"As a practitioner, I would strongly object to CCTV monitoring and I feel it is an intrusion. It is not used in general nursing wards or in paediatric care so I feel it would be unnecessary and inappropriate."

Satasha Culshaw pointed out the use of CCTV monitoring as a deterrent might be more effective in the drug dispensary where it might also be capable of capturing the commission of a crime.

Shelley Tomlins was employed as a Band 5 neonatal nurse on the NNU before moving abroad to work as

a nurse. On the issue of CCTV monitoring, she said:

"I am undecided whether having the babies monitored by CCTV could have prevented the crimes of Letby. On the one hand, it could have prevented any harm coming to any baby by deterring her entirely. It could also have prevented some of the later crimes as perhaps once the medical team started to suspect Letby she may have been either deterred by knowing she was being monitored or caught via the CCTV.

"Some of her crimes, such as injecting insulin into TPN bags and failing to act or request help when a baby was 'crashing', would have been detectable by CCTV. However, some of the ways in which she murdered or attempted to murder the babies were by using equipment that nurses handled all the time and by doing things which were very similar to routine tasks. What I am referring to here is when she used feeding tubes to overfeed the babies or insert air and intravenous lines to inject air.

"On camera these actions might be indistinguishable from routine and correct procedures. For instance, it might not be possible to tell from CCTV whether a syringe has air or clear fluid in it or whether a baby is receiving more milk than their usual feed amount. These crimes may have been detectable later on once the

CCTV was scrutinised closely and people had an idea what they were looking for. By that point, it would have been too late to catch her in the act and therefore too late to prevent harm happening to the babies.

"Overall though I do feel that perhaps the presence of CCTV might have been enough of a deterrent and therefore could have prevented Letby's crimes."

Other neonatal nurses and nursery nurses such as Pauline Fong, Abigail Lever, Adele McGarry, Cherryl Cuthbertson-Taylor and Faith Chidongo all considered that if the babies in the neonatal unit had been monitored by CCTV the crimes of Letby could have been prevented.

Janet Cox considers that if there had been CCTV monitoring, it would have proved Letby's innocence.

Finally, as to the recommendations which the nurses think my Lady should make to keep babies in NNU safe from any criminal actions of staff, they said as follows: Christopher Booth:

"I think using the utmost vigilance in the screening of potential staff members at the time of recruitment would be a good place to start. This could involve possibly conducting personality tests as part of the recruitment process to seek to identify any personality disorders which would mean such people would

probably be incompatible with working in such a stressful environment. That is not to say that I feel Letby necessarily suffered from such a disorder, but it seems to be a glaring oversight in the recruitment process.

"Improving staffing numbers would always have a positive effect on neonatal nursing teams' well-being as throughout this period between 2015 to 2016 we were almost constantly short-staffed with team members being asked to change shifts at short notice or work extra shifts. This is not good for staff mental health or morale."

Paula Baden:

"Parents should have more and better equipped facilities to enable a parent to stay at the bedside throughout their baby's stay. While I am unsure of the procedures around neonatal deaths and reporting, I feel that if there is more than one, regardless of reason, this should have a thorough investigation.

"Medication must always be kept securely and regular medication audits should also be carried out to identify any anomalies."

Joanne Williams:

"I do appreciate staffing is a main priority for all those in the NHS. Having safe staffing levels to

deliver high-quality care is paramount. General District Hospitals with NNUs should ensure they understand the challenges, difficulties in working in such a specialist area and provide appropriate support. Parents and primary carers should be able to be with their babies 24 hours, if they wish to be, with NNUs designed to facilitate this."

Minna Lappalainen:

"Appropriate professional staffing levels on neonatal units and open communication between all professional disciplines would improve the way concerns are addressed. Hospital executive management must respond promptly to concerns raised by nursing and medical managers."

Nurse X:

"Swipe card access to drug storage areas and CCTV would track access to these areas more accurately."

Ailsa Simpson:

"I believe a culture where members of staff can freely express their concerns without the fear of repercussions is necessary."

Shelley Tomlins:

"I think the Inquiry should make recommendations about the ways in which members of staff can voice concerns they have about staff members. The procedure

for doing this should be straightforward, dealt with much more quickly than it was for Letby, take the concerns of the whistleblower seriously and should put the safety of the babies as a priority rather than the feelings of staff members.

"I am sure there are ways to deal with serious concerns that are fair and sensitive to the staff member whilst also making patient safety the top priority. There should be no red tape to get through and never any hesitation or delay in contacting the police."

Sophie Ellis:

"There should be an open and honest culture with a freedom to speak up within all staff groups. Individuals who raise concerns should have guaranteed support from management and/or a dedicated team to support whistleblowers. A clear process of how to report concerns specifically about criminal actions of staff needs to be created and outlined. This should be streamlined within all Hospital Trusts.

"Staff may then be more likely to raise concerns without fear of negative judgment and instead be commended for their courage. This can be very difficult to do even with a positive culture. Some of these aspects may already be in place in some Hospital Trusts. If so, there needs to be consistency amongst all

hospitals."

Stephanie Terry:

"As a clinical educator for student midwives, I feel that the Inquiry should investigate the practical element of when students study to become nurses. In my experience, behavioural or personal attributes can be difficult to fail a student on. This, in my opinion, needs to change. We need to ensure that students are safe to be working with vulnerable babies and people going back to basics with recruitment and education."

My Lady, that concludes the summary of the evidence of the nurses and midwives.

This summary is intended to assist the oral hearings insofar as it provides some indication of the themes that run through the evidence from nurses and midwives who have provided written evidence to the Inquiry and will not be called to give oral evidence.

The witness statements and questionnaires summarised today will be published on the Inquiry's website in due course.

LADY JUSTICE THIRLWALL: Thank you.

Thank you very much indeed, Ms Lyons.

MS LYONS: Thank you.

LADY JUSTICE THIRLWALL: I think that concludes the proceedings for today. We will start again tomorrow

morning at 10 o'clock. Thank you all very much.

(4.37 pm)

(The Inquiry was adjourned until 10.00 am, on Wednesday, 16 October 2024)

I N D E X