

Tuesday, 15 October 2024

1
2 (10.00 am)
3 **LADY JUSTICE THIRLWALL:** Good morning.
4 Ms Langdale.
5 **MS LANGDALE:** Good morning. May I call, please,
6 Nicola Lightfoot.
7 MS NICOLA LIGHTFOOT (affirmed)
8 Questions by MS LANGDALE
9 **LADY JUSTICE THIRLWALL:** Do sit down.
10 **A.** Thank you.
11 **MS LANGDALE:** Ms Lightfoot, you have prepared
12 a statement for the Inquiry dated 31 March 2024.
13 Can you confirm the contents are true and accurate
14 as far as you are concerned?
15 **A.** Yes, that's correct.
16 **Q.** Have you got it with you?
17 **A.** I have, yes.
18 **Q.** So if I refer you to paragraphs you have it
19 there?
20 **A.** Yes.
21 **Q.** You tell us that you worked as a Band 6 deputy
22 ward manager during 2011 to 2015 on the children's unit.
23 Can you tell us what that role entailed and also set
24 out, as much as you would like to, your experience
25 before taking that role; how long you had been a nurse

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1 **Q.** So in 2011 how long had you been working as
2 a nurse or practising?
3 **A.** So I qualified in -- the end of '96 and
4 started, sort of, '97', so nearly 20 years is that? Get
5 my fingers you out.
6 **Q.** A considerable time.
7 **A.** Yes, yes.
8 **Q.** So you have a lot of experience.
9 Did you overlap in your role as a deputy manager on
10 the children's unit with the managers on the neonatal
11 unit?
12 **A.** No. We have always worked quite
13 independently. Although we are logistically next to
14 each other, they have always run very separately,
15 separate areas and specialties.
16 So I may have been involved in some of the contact
17 with managers during meetings and such but the
18 day-to-day runnings of the neonatal unit, we had no
19 involvement of. Very little awareness even in
20 a management role, even as deputy manager, as to any
21 day-to-day issues or things that are happening within
22 the neonatal unit.
23 **Q.** What about the managers there, which ones did
24 you overlap with in management meetings?
25 **A.** So I might have been to meetings with

3

1 and your experience?
2 **A.** Okay. So I completed my nurse training '93 to
3 '96. It was specific in paediatrics. I started my role
4 on the children's ward at Chester in January '97 as
5 a junior staff nurse at that point.
6 After a few years I took on a role as senior staff
7 nurse and then after that, I also took on the deputy
8 ward manager role which was classed as a sort of Sister
9 role.
10 I have been an acting manager on the unit for
11 a short period of time as well. I have worked on that
12 unit ever since.
13 My role involves day-to-day clinical management of
14 my own patient workload at times. I am responsible for
15 running the unit which is across three areas. I have
16 management responsibilities on day-to-day runnings of
17 the ward, managing patient flow from the admissions that
18 we have in, supporting my colleagues and junior staff.
19 Part of my deputy ward manager role is also
20 completing appraisals, sickness reviews, any
21 disciplinarys with any staff, dealing with parent
22 complaints.
23 So it's two-fold really. There is some management
24 of the staff and then the day-to-day runnings of
25 clinical duties as well.

2

1 Eirian Powell. Usually, if I was representing the
2 manager -- the manager would usually go to these
3 meetings; obviously I would stand in as deputy manager
4 in their absence.
5 **Q.** Right.
6 **A.** So it wasn't a regular thing but that's where
7 I might have come across --
8 **Q.** Her.
9 **A.** -- the management.
10 **Q.** And what about Yvonne Griffiths or
11 Yvonne Farmer, dealings with any of them?
12 **A.** Similar. I might have just sat, sat in the
13 same meeting but no other interaction other than sort of
14 friendly "hellos", you know, when passing. If we had
15 gone to the unit to borrow equipment or vice versa if
16 they'd have come over.
17 **Q.** We know, and I am going to come on to the
18 specifics, that you were Letby's mentor during her final
19 placement in 2011. But can you tell us first of all, as
20 you do at paragraph 5 onwards, what the Mentorship
21 Module (Teaching and Assessment Module) was about
22 in 2011? How did the scheme work? What was it supposed
23 to achieve?
24 **A.** Okay. So, so my mentorship training was,
25 actually, a module. I had to complete a piece of work

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1 and a number of assessments. It was an official
 2 qualification at that time.
 3 It's since changed since. There isn't actually the
 4 formal training and qualification now.
 5 So I completed that. That was something that was
 6 routine for senior nurses at a certain point into their
 7 career. It was a sort of natural progression as you
 8 became a senior staff nurse that you would complete that
 9 course to enable you to support and mentor students.
 10 **Q.** And support and mentor students, was that
 11 their way of achieving qualification, you were helping
 12 them to achieve their qualification and develop into
 13 independent nurse practitioners?
 14 **A.** Absolutely. So throughout, obviously, the
 15 nurse training at that point was a three-year course and
 16 students would have various placements across different
 17 specialties, some community placements, some hospital
 18 placements.
 19 Towards the end of their third year we expected
 20 a bit more autonomy, them to be able to work a little
 21 bit more independently, and in the placement that I was
 22 mentor to Lucy, and it was her final placement, so that
 23 is the placement prior to becoming a qualified nurse.
 24 So it's quite pivotal and particularly important to
 25 ensure that that student is ready to qualify because as

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1 then, under support, completing that task yourself.
 2 By the time they are in the third year, we would
 3 allocate our third year students their own patient
 4 workload of two or three patients. They would
 5 independently plan that care, with your supervision,
 6 based on their nursing assessments, the condition of the
 7 child, you are observing their interaction with the
 8 family and other members of the multi-disciplinary team.
 9 But we are expecting them, as I said before, to
 10 work more autonomously, come back, touching base every
 11 so often, but I would expect a third year to be able to
 12 go and plan their own care for their patients,
 13 recognising their priorities, delivering that care and
 14 assessing and evaluating how that care has impacted on
 15 the condition the child.
 16 **Q.** And what kind of mentor were you, certainly in
 17 final placements? Had you mentored many third year
 18 students?
 19 **A.** Yes, so at that point, I -- I had been
 20 qualified sort of almost 15 years. We have -- we all
 21 have had a number of students over, over every year.
 22 I had mentored an awful lot of students, first years,
 23 second years, third years.
 24 I think I personally in the first year perhaps the
 25 expectations I would have are not quite so high because

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1 a student, you do obviously have your own
 2 responsibility, however you are supported and the main
 3 responsibility lies with your mentor and the qualified
 4 staff you are working with.
 5 Obviously that transition to go from that to
 6 an independent worker although albeit under still
 7 supervision we have a sort of preceptorship programme
 8 that we support newly-qualified staff in is really quite
 9 a change.
 10 So you have to be absolutely sure that that person
 11 is at that point ready to qualify and take on that
 12 responsibility.
 13 **Q.** So in the first year, then, so first year
 14 students you say need basic orientation to the role and
 15 you teach basic skills like ward routeing, observations,
 16 and completing documentation but by the time of the
 17 third year, they are about to qualify so expectations
 18 are different, as you have just said.
 19 **A.** Absolutely, absolutely, and you work almost
 20 more remotely, you allow that independence.
 21 They -- in the first and second year often they are
 22 on your shoulder, they are behind you, they are
 23 observing a lot. Obviously we would try and encourage
 24 participation in those skills and that is how you learn,
 25 you know, often, you know, watching what is done and

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1 they have got time to develop. By the time they get to
 2 third year, my professional responsibility and my duty
 3 of care as a nurse is to ensure that that student
 4 qualifies and is safe, can deliver effective care; that
 5 I am happy that that protects them as a practitioner.
 6 I am happy that that protects their colleagues as
 7 a safe practitioner and, more importantly, the children
 8 and the families that they are looking after and that's
 9 is my primary focus.
 10 It doesn't always make you very popular especially
 11 I have found in my experience that students that have
 12 been weaker or I have felt were lacking in some areas
 13 are often quite defensive. Often may have said, "Oh,
 14 I find, I find you difficult" or "I find you
 15 intimidating", but my primary responsibility is to
 16 ensure that that person is safe for all of those reasons
 17 I have just, I have just said.
 18 **Q.** And how many had you failed? When you are
 19 asked about this with the police in 2018, how many third
 20 year students had you failed at that time, would you
 21 say, roughly?
 22 **A.** Yes, I couldn't, I couldn't put a number on it
 23 but I have, I have failed a few. And as you probably
 24 have seen and for anybody that isn't aware, any student
 25 that is failed in that final placement has the

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

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

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

14 **A.** Yes.

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

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

25 So there is right and wrong ways of completing it;
9

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

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

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

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

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

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

25 Sorry, could you just repeat the question again?
11

1 that's not a subjective assessment.

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

6 **Q.** You tell us at paragraph 15 that you were
7 Letby's mentor during her final placement 23 May to
8 31 July and you say:

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

12 What did you mean by that?

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

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

25 This is a position of trust. It is an honoured
10

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

2 **A.** Okay.

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

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

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

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

25 **Q.** If we go to your final report, we see what you
12

1 said at the time. So it's INQ0014042, page 163. So
2 0014042_0163?

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

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

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

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

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

14 Had you failed her at the midpoint of the
15 placement?

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

18 **Q.** Right.

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

21 **Q.** Right.

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

13

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

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

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

8 **A.** Yes.

9 **Q.** Page 165, we are still not there.

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

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

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

15

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

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

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

8 **A.** Yes.

9 **Q.** -- you say she:

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

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

19 Non-verbal signs are absolutely crucial as a nurse.

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

14

1 administering drugs.

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

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

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

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1 medication guidance that that is the correct dose for
 2 that child as well.
 3 When we are then administering that, so we are
 4 independently checking even though we are alongside each
 5 other, we are independently checking all of those
 6 things. We are then ascertaining that we are giving it
 7 to the correct patient, so we are checking their name
 8 band, we are confirming verbally with the parents,
 9 asking them to confirm the name and the date of birth
 10 and any allergies, we would confirm with the child, if
 11 appropriate, and then only if we were happy with all of
 12 those things we would administer that medication and the
 13 two registered nurses would sign the drug chart which
 14 was paper at that time.

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

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

17

1 **Q.** Can we go over the page, please, to 166.
 2 You in that second paragraph highlight the -- what
 3 you said already, I don't need you to go back on that
 4 about the non-verbal cues. We heard from Nurse T
 5 yesterday, who had Lucy for the first period in that
 6 third year, that she felt her communication skills were
 7 very positive, and something that was raised by Letby
 8 was that at the midpoint she found it -- was anxious --
 9 you made her feel anxious.

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

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

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

19

1 struggled to retain the information about side-effects
 2 and drug usage for common drugs given.
 3 Is that a different struggling to retention rather
 4 than calculations; do you see how you have set it out
 5 there that's what you say -- (overspeaking) --
 6 **A.** So calculations -- so we have a certain drug
 7 calculation to work out the volume and that is based on
 8 how many milligrams or micrograms of that drug there are
 9 in a certain volume. So that is one part of it.

10 So there is a calculation to ascertain the correct
 11 volume that you are going to give and that the strength
 12 of the drug you are giving is correct because many drugs
 13 come in various strengths, so you have to ascertain
 14 because 5 millilitres of one drug would be a different
 15 strength than 5 millilitres of another drug.
 16 As I say, there are, there are a number of very
 17 basic medications we give all the time in paediatrics,
 18 such as paracetamol, ibuprofen, basic antibiotics, stuff
 19 that, actually, after you have given a couple of times
 20 I would expect you to remember the side-effects because
 21 actually they are fairly generic and the same and
 22 actually when we would ask Lucy to verbalise during any
 23 practices, and including her official OSCE practice, to
 24 clarify some of those side-effects she couldn't
 25 verbalise them.

18

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

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

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

16 **Q.** Look at the last paragraph. You say:
 17 "At the moment Lucy is requiring much more support,
 18 prompting and supervision than I would expect at this
 19 stage to allow her to qualify as a competent
 20 practitioner. However, I strongly feel if Lucy
 21 continues to take on board feedback and continues to
 22 work on her weaker areas and develop her practice
 23 accordingly then this is achievable in the future."

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

20

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

6 **A.** Yes.

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

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

16 **A.** Yes.

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

19 **A.** Absolutely.

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

23 **A.** Yes.

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

21

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

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

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

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

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

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

23

1 and decisions. There we are.

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

7 What are AI, DI, and JI?

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

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

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

22

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

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

11 **A.** No.

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

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

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

24

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

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

9 **A.** Absolutely.

10 **Q.** But she went to different nurses and different
11 experiences?

12 **A.** Okay.

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

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

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

25

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

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

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

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

27

1 enough experience in working that neonatal unit to know
2 that.

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

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

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

25 Did you take that up with anyone at the time or

26

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

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

7 **Q.** Do you have safety briefs in there sometimes?

8 **A.** Yes, yes, we do.

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

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

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

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

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

28

1 escalate that concern appropriately.

2 At that point, I thought it was nothing more,
3 still, than a member of staff that disliked Lucy making
4 ongoing unprofessional comments and judgments and
5 supposition.

6 I am aware that there was also a separate complaint
7 about Nurse ZC.

8 **Q.** Well, let's just pause there. I am focusing
9 on Letby. We know that you said, for example,
10 Dr Barrett and Nurse ZC had used a derogatory term about
11 Letby, both of them say that conversation didn't happen
12 although Dr Barrett accepts she did say "Nurse Death",
13 she said, "I didn't have that conversation with Dr ZC".

14 So who else, apart from Dr ZC, when you say you
15 were aware of people --

16 **LADY JUSTICE THIRLWALL:** Nurse ZC.

17 **MS LANGDALE:** Nurse ZC, sorry.

18 Who else, apart from her, were you aware was
19 talking about Letby when you say you were aware and
20 thought people were gossiping or it was malicious?

21 **A.** May I just clarify. In my statement I didn't
22 hear a conversation between Nurse ZC --

23 **Q.** Right.

24 **A.** -- and Dr Barrett talking about Nurse Death.

25 The comment was made after the second triplet passed
29

1 **A.** I don't recall saying that to him. I didn't
2 have that kind of relationship with him.

3 **Q.** Nurse ZC tells us that there were briefings at
4 this point that staff were told they shouldn't be
5 discussing deaths on the neonatal unit, infant deaths,
6 or Letby, or disciplinary measures might be considered.
7 Was that the case because there was concern that this
8 was malicious gossip --

9 **A.** So the malicious gossip, as I said, was
10 witnessed by a number of colleagues, as well as myself,
11 and it was --

12 **Q.** Which colleagues?

13 **A.** So there were colleagues that I am aware of
14 made a formal complaint.

15 **Q.** Yes, who were they? Tell us who they were.

16 **A.** (Redacted).

17 **Q.** (Redacted)?

18 **A.** (Redacted).

19 **Q.** Yes, about -- in support of Letby, malicious
20 comments about Letby?

21 **A.** Yes, part of the complaint was about
22 Nurse ZC's general professional behaviour.

23 **Q.** I'm not asking about her, I want to move on
24 and ask about --

25 **A.** But part of it was about Lucy Letby and
31

1 away by Dr Barrett on the corridor to myself --

2 **Q.** Right.

3 **A.** -- when she passed me and she said, "I see
4 Nurse Death's on again."

5 **Q.** Right.

6 **A.** So I didn't hear a conversation per se.

7 **Q.** So you had had Dr Barrett say to you
8 "Nurse Death" and you had had Nurse ZC saying the
9 comment "Isn't it concerning she's involved and she's
10 always there?", or something similar. So you had had
11 two people raise with you concerns about Letby at that
12 point.

13 But you thought they may still be gossip or
14 malicious or what is your evidence? I don't know what
15 you thought.

16 **A.** I did, I did, because Nurse ZC and Dr Barrett
17 and Dr Mayberry, who I had also mentioned in my
18 statement, were very friendly, they were often together,
19 they were often sending text messages between each
20 other. So the conversations that I am aware other staff
21 had also witnessed were between those three. So
22 I didn't feel they were independent concerns.

23 **Q.** Did you speak to Dr Mayberry about them at
24 all? Did you tell him that she didn't seem engaged as
25 a student or anything like that, or not?
30

1 allegations that they had heard her make that she would
2 be -- she would be involved.

3 **Q.** So would you have been part of the briefings
4 to staff to say: do not discuss her otherwise
5 disciplinary measures would follow?

6 **A.** Absolutely, because at that point it was, it
7 was -- there was nothing substantiated from our
8 perspective on the children's unit that we had awareness
9 of.

10 **Q.** But you had concerns yourself about her
11 communication and you had heard something that you
12 thought was inappropriate, didn't that ring --

13 **A.** Absolutely.

14 **Q.** Didn't that ring bells for you that it might
15 be concerning?

16 **A.** No, I didn't have any other evidence other
17 than concern about an inappropriate response. The
18 briefings were not to silence anybody, the briefings
19 were: this is damaging unsubstantiated, from our
20 perspective, discussions about a neonatal colleague that
21 were very damaging. So please do not gossip and discuss
22 anything that we have no involvement in, that we know
23 nothing about.

24 **Q.** Were you curious after hearing the comment
25 about the triplets to know more about it? Did you have
32

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

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

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

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

16 **Q.** When she went to the risk department?

17 **A.** Absolutely.

18 **Q.** What did you think was going on then?

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

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

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

33

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

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

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

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

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

35

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

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

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

13 **A.** Sorry, could you repeat.

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

16 **A.** Not that I recall.

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

23 **A.** (Nods).

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

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1 it, take it forwards through a process.

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

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

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

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

19 **Q.** I'm not asking for comments --

20 **A.** I thought you asked me --

21 **Q.** No, no --

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

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

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1 A. Okay.

2 Q. -- freedom to speak up generally. How does it
3 work for you that someone might tell you in an informal
4 setting, not just that one? You indeed tell us you went
5 back to the children's unit and would have probably said
6 to somebody what you'd heard Letby say because it
7 shocked you.

8 A. (Nods).

9 Q. Again, that would be natural for you to go
10 back and say, "I have just heard someone say this." Do
11 you think if you said it in an informal way like that,
12 there wouldn't be a responsibility on the receiver of
13 that comment to take it forward if they thought
14 "Actually, that's really troubling"?

15 A. Yes.

16 Q. If they knew something else, another piece?

17 A. I think obviously, as you said before, this
18 was a small piece of a puzzle that in hindsight --

19 Q. Yes.

20 A. -- perhaps I -- I could have escalated it.
21 But with the limited information I had at that point,
22 I didn't feel professionally I had a need to raise it
23 further.

24 We have -- we encourage all of our staff to speak
25 out, to bring any concerns, as you say, professionally

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1 other units if it was an internal issue.

2 Q. And so by the time she had moved to the risk
3 patient safety unit, did you think that was a matter
4 that shouldn't be discussed because it obviously
5 affected an employee and she was moved to another unit;
6 is that broadly where you were at with that?

7 A. Absolutely. Absolutely. Obviously, you know,
8 personal thoughts aside, you know, it's my job to try
9 and maintain professionalism and set an example of as
10 a role model, as a deputy manager, so we would
11 discourage as much as we could general gossip about
12 a colleague that, as I say, at that point was
13 unsubstantiated.

14 Q. We know that nurses on the neonatal unit were
15 all e-mailed with information about secondments or being
16 able to move around the hospital for secondments. Was
17 there any conversation like that on the children's unit
18 about people wondering about those opportunities or
19 generally talking about secondments at that time?

20 A. Not that I can recall.

21 MS LANGDALE: Just give me one moment.
22 Thank you, I have got no further questions.

23 A. Okay. Thank you.

24 MS LANGDALE: My Lady, there are no further
25 questions from the Bar.

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1 or personally to us as managers. I felt I had a good
2 relationship with all of our members of staff and that
3 they could do that and I, as I say, it is my
4 professional practice to raise concerns if I feel it
5 appropriate. But at that point, I didn't have all of
6 the information that I am now aware of.

7 Q. Understood.

8 You also refer to an internal investigation being
9 conducted, I think. Do you know what investigations
10 were being done? Whether it was the RCPCH or
11 internally, what did you think was happening?

12 A. I didn't really have much information about
13 that. I knew that the Trust was looking at the
14 mortality rate and the collapses on the neonatal unit.
15 I really knew very little about it as I say, because we
16 are a separate unit.

17 Q. Do you think you should have known? Someone
18 should have told you, you are working in a children's
19 unit.

20 A. I suppose we -- we are separate units. We are
21 separate teams of nursing staff. Again, I imagine if it
22 was our unit that it would be dealt with within our unit
23 and escalated appropriately within our management
24 hierarchy. I wouldn't necessarily expect it to be
25 shared with the neonatal unit or midwifery or any of the

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1 **LADY JUSTICE THIRLWALL:** Thank you very much
2 indeed.

3 No, I have no questions either. Thank you very
4 much indeed, Nurse Lightfoot, you are free to go.

5 **MS LANGDALE:** My Lady, I am going to ask Ms Bennett
6 to read in sections of Sarah Jayne Murphy's statement to
7 complete the mentoring.

8 **LADY JUSTICE THIRLWALL:** Thank you very much.
9 Ms Bennett.

10 Statement of SARAH JAYNE MURPHY

11 **MS BENNETT:** My Lady, the Inquiry has received
12 a statement from Sarah Jayne Murphy, nurse practitioner,
13 which reads as follows:

14 My full name is Sarah Jayne Murphy. After studying
15 at Chester University for a diploma in higher
16 educational nursing studies, I qualified as a registered
17 children's nurse in February 2004. A few weeks after
18 I qualified, I went to work on the Children's Unit at
19 the Countess of Chester Hospital where I worked
20 until September 2013.

21 Whilst working at the Trust I completed the
22 Teaching and Assessing in Practice module enabling me to
23 become a mentor and an assessor for student nurses.

24 As part of the mentoring and assessing role,
25 I became a sign-off mentor, meaning that I could work

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1 with students during their final placement and their
 2 OSCEs, the Observed Structured Clinical Examination.
 3 My day-to-day duties on the ward included managing
 4 the care of a small group of patients, assessment of
 5 patients' needs, planning, implementing, and evaluating
 6 care delivery according to changing health needs.
 7 I worked collaboratively with the wider
 8 multi-disciplinary team to ensure health needs were met
 9 and contributed to the development of services for
 10 children and young people, supervision of others
 11 including being a shift leader, development and
 12 education of student nurses.

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

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

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

25 Currently, I am a Band 7 children's epilepsy

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

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

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

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

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

25 As registered nurses and mentors, we had support

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

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

10 Mentorship of nursing students.

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

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

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

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

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

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

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

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

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

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

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

21 Mentorship of Letby.

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

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1 families.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 This was at the end of her first year. However, I do
 2 not have the documentation in my possession now.
 3 There would have been documents in relation to
 4 Letby's final assessment as well but, again, I do not
 5 have access to these documents.

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

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

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

25 I have set out the relevant proficiencies and what
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1 personalities between them. I felt awful as I had been
 2 approached due to Lucy requesting me to be her mentor
 3 for her final placement and she felt that we had a good
 4 relationship during her first year placement."

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

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

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

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

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

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

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

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

24 "I believe that Lucy appealed Nicky's decision to
 25 fail her reasoning that there was a clash of
 50

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

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

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

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

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

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

24 I do not remember conversations with
 25 Nurse Lightfoot and/or Ruth Sadik with regards to
 52

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

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

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

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

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

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

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

13 Friendship.

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

22 Concerns or suspicions.

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

55

1 It would be usual for the retrieval placement to be
2 documented but I cannot remember exactly where or how.
3 I would imagine the school of nursing would have a
4 record of the documentation.

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

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

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

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

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1 My Lady, that concludes the statement.

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

5 **MS LANGDALE:** It is, my Lady, 11.30?

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

8 (11.13 am)

9 (A short break)

10 (11.30 am)

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

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

13 JULIE CAROLE FOGARTY (sworn)

14 Questions by MS BROWN

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

16 **A.** Thank you.

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

18 **A.** I am Julie Carole Fogarty.

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

22 **A.** Yes, it is.

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

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1 and as a supervisor of midwives in 1996?
 2 **A.** That's correct.
 3 **Q.** And you also have a degree in midwifery and
 4 a postgraduate certificate in leadership behaviours.
 5 **A.** That's correct.
 6 **Q.** And turning to your career history, when did
 7 you first start working at the Countess of Chester
 8 Hospital?
 9 **A.** So in 1987 I commenced my midwifery training
 10 as a student midwife.
 11 **Q.** And when was your first role as a midwife?
 12 **A.** So that would be in 1988, upon qualification
 13 as midwife.
 14 **Q.** And that was at the Countess of Chester?
 15 **A.** Yes.
 16 **Q.** And I think approximately 12 years later, you
 17 were appointed Head of Midwifery in July 2010?
 18 **A.** Yes, that's correct.
 19 **Q.** And in that intervening period you worked
 20 solely at the Countess of Chester Hospital, did you?
 21 **A.** Yes.
 22 **Q.** And you moved, I think, from your role of Head
 23 of Midwifery to that of Associate Director of Risk and
 24 Safety in April 2017, is that correct?
 25 **A.** That's correct, yes.

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

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

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

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1 Q. And how often would you be asked to be on that
2 call rota?

3 A. Probably a couple of times a month.

4 Q. And in terms of your physical presence on the
5 ward, how often would you, you said you didn't have
6 a clinical role, but how often would you be physically
7 present on the maternity ward, walking around?

8 A. Probably three, four times a week.

9 Q. And where was your office in relation to the
10 maternity ward?

11 A. It was in the Long House Building, which was
12 the building virtually next door to the maternity unit.

13 Q. So did you have to leave one building and go
14 into another or did you just --

15 A. There was a corridor, so it, it was just
16 a corridor but I did have to leave one building, so
17 I was based in what was known as the Long House, but it
18 was literally next door.

19 Q. And in terms of the neonatal ward, would you
20 ever have cause to visit the neonatal ward to actually
21 walk on to that ward?

22 A. No, no, it wasn't in my remit, so no.

23 Q. And just looking at where the Head of
24 Midwifery fitted into the divisional structure.

25 Midwifery was part of the Planned Care Division?

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1 Q. And did you feel that this management
2 structure, with those three -- well with your -- four
3 posts sitting at the top of the Planned Care Division
4 was that a management structure that worked effectively?

5 A. It appeared to work for me because the -- the
6 divisional directorate, that was more the business
7 planning side and the Director of Nursing that was the
8 professional aspects.

9 Q. And to understand how it worked in practice,
10 if you had concerns, for example with mortality rates,
11 would you be raising those issues with the divisional
12 director, the Medical Director of Planned Care or would
13 you be going straight to Alison Kelly with those sort of
14 issues?

15 A. I would raise them with both people.

16 Q. And just staying with the divisional structure
17 for a moment. Midwifery, as you have explained, was
18 part of the Planned Care Division, but the neonatal unit
19 was part of the Urgent Care Division.

20 A. That's correct, yes.

21 Q. And you say in your statement at paragraph 21
22 that you felt that it was not good practice to have the
23 mother in one division and her baby in another, so you
24 are referring there to the fact that the mother when on
25 a maternity unit would obviously be in the Planned Care

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1 A. Yes.

2 Q. And then at the top of the Planned Care
3 Division there was a divisional director of Planned
4 Care, who was that?

5 A. Linda Fellowes.

6 Q. And then again, looking at Planned Care, there
7 would be a Head of Nursing for Planned Care and that was
8 Carmel Healey?

9 A. That's correct, yes.

10 Q. There was your role, obviously, as Head of
11 Midwifery, and then there would be a Medical Director
12 for Planned Care and that was David Semple, I believe?

13 A. Yes.

14 Q. And what was his specialty as a doctor?

15 A. So he was an obstetrician.

16 Q. And in terms of that management structure of
17 the Planned Care Division, David Semple and Carmel
18 Healey, did they continue in practice or were those
19 full-time management roles?

20 A. So Mr Semple continued clinical practice.
21 Carmel Healey was like myself; it was a management role.

22 Q. And who did you report to?

23 A. So I reported directly to Alison Kelly, the
24 Director of Nursing, and Linda Fellowes, the divisional
25 director.

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1 and if her baby had cause to be admitted to the neonatal
2 unit, the baby would then be under the Urgent Care
3 Division?

4 A. Yes.

5 Q. And what were the problems that you saw with
6 that structure?

7 A. I just felt that if the two areas of care had
8 been within the same division, there would have been
9 more joint working, there would have been better
10 communication and we would have been on the same journey
11 together at the start of projects.

12 Q. And Dr Brearey raised this issue and you refer
13 in fact to 20 July 2015 in your statement, at
14 paragraph 21 as well, that the divisional structure with
15 Urgent and Planned Care split, obstetrics, gynaecology
16 and midwifery on one side, paediatrics and neonatal
17 within Urgent, and that was discussed at the Quality,
18 Safety, and patient Experience Committee that you sat
19 on, I think, as well?

20 A. Yes, I did.

21 Q. And Dr Brearey said at that meeting that he
22 considered the split would hinder the improvement of
23 maternity, neonatal and paediatric services. Did you
24 agree with that view?

25 A. I did, yes.

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

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

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

16 A. More as --

17 Q. Nursing and midwives, I should say.

18 A. More as the management structure.

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

22 A. Yes.

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

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

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

7 A. No.

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

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

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

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

19 Q. I see, thank you.

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

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

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

3 A. Yes.

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

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

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

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

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

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

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

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

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

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

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

15 A. Nurses.

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

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

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

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

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1 agreed on a plan going forward.

2 **Q.** And in practice, how would that take place,
3 would you walk to her office, call her on the phone,
4 just a feel of how often you would be in communication
5 with Eirian Powell?

6 **A.** So it would be very, very infrequent. But
7 normally I would email her to see if she's free.

8 **Q.** And in relation to Dr Brearey who was the
9 clinical lead of the neonatal unit, what was the extent
10 of your contact with him?

11 **A.** So, again, I would see him very infrequently
12 because he wasn't working in the same sphere of practice
13 as myself.

14 **Q.** And how would you describe your working
15 relationship with Dr Brearey, or was it minimal?

16 **A.** Very -- if ever I needed to engage with him
17 there was no issues whatsoever.

18 **Q.** And presumably you would have a great deal
19 more contact with the Consultant obstetricians?

20 **A.** Daily.

21 **Q.** Just staying with the culture of the hospital
22 for a moment. Generally the relationship with doctors
23 and nurses, how would you have observed that, how would
24 you characterise that?

25 **A.** I can only comment on the relationship between
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1 on the corridor if I went to the execs' office to
2 escalate or to drop a report off, then I may see her
3 there.

4 **Q.** And what could you or -- could you comment
5 about Alison Kelly's level of engagement with the issues
6 on the maternity ward and the issues that you were
7 dealing with?

8 **A.** So she was always engaging, if ever I had
9 anything I need today escalate I always had access and
10 she listened.

11 **Q.** And in relation to Tony Chambers and
12 Ian Harvey would you have cause to have much contact
13 with either of those?

14 **A.** I didn't see them on a regular basis but there
15 would be meetings that they would be present at that
16 I would also be present at.

17 **Q.** And members of the board, Sir Duncan Nichol
18 would you come into contact with him?

19 **A.** So again, I didn't see him on a regular basis,
20 but he may be there in the execs' office. He came to
21 visit maternity unit when we won an award. So he was
22 aware of what was happening but I didn't see him on
23 a regular basis at all.

24 **Q.** And the non-executive board members, would you
25 have known who they were?
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1 doctors and midwives.

2 **Q.** Of course.

3 **A.** And I felt there was excellent teamworking.

4 **Q.** And relationships between staff and senior
5 management, again, you will be dealing with staff within
6 your unit, but what were the relationships like between
7 staff and senior management?

8 **A.** I mean, I can -- again, I can only really
9 comment for within maternity services and there didn't
10 appear to be a problem. It wasn't anything that was
11 ever escalated to me or anything that came out through
12 any incident reporting or -- there were lots of
13 different channels that people could go to if they
14 needed to and they were never, they were never used.

15 **Q.** Why was that? Why were these channels never
16 used?

17 **A.** Because obviously people didn't feel there was
18 a need to escalate. They felt that if they wanted to
19 speak to managers they had access.

20 **Q.** And in relation to access to managers, your
21 relationship with Alison Kelly as the person who you
22 reported to, or one of the people you reported to, how
23 often would you see her?

24 **A.** So I had a monthly one-to-one with her but
25 I would also see her at meetings and I may bump into her
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1 **A.** Yes.

2 **Q.** Did they ever visit?

3 **A.** Yes, I mean, some of them were -- some of them
4 were on QSPEC and there were a number of meetings that
5 I attended that they represented -- you know,
6 represented the non-execs on.

7 **Q.** Just one final point looking at the divisional
8 structure, you gave an interview, I think you'll recall,
9 to Facere Melius in -- on 14 July 2020. You recall that
10 interview?

11 **A.** Pardon? Sorry?

12 **Q.** You had an interview --

13 **A.** Yes, yes.

14 **Q.** -- on 14 July? And one of the points you made
15 in that interview was you felt the fact that neonatal
16 unit being in Urgent Care and the fact that A&E also
17 clearly was part of Urgent Care with the four-hour
18 target that they work to, meant that the neonatal unit
19 was swamped, what did you mean by that?

20 **A.** Well, the fact that that was a big division
21 with a lot of competing priorities.

22 **Q.** And you also say --

23 **LADY JUSTICE THIRLWALL:** Sorry, I wonder, could you
24 just -- I am sorry, Ms Brown.

25 But the neonatal unit was swamped, do you mean sort
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1 of overlooked or do you mean too much to do? I wasn't

2 ...

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

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

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

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

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

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

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

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

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

7 **Q.** And you were the deputy chair?

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

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

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

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

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

17 **Q.** Would you discuss the agenda with
18 Mr McCormack?

19 **A.** Not before the meeting, no.

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

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

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1 are you referring to there, are you talking about the

2 issues of increased mortality or --

3 **A.** Yes.

4 **Q.** -- more generally?

5 **A.** Yes, because obviously I was interviewed in
6 2020 and I was aware then of the mortality issues.

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

11 My Lady, this is tab 13 of your bundle.

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

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

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

20 **A.** Yes.

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

24 **A.** Yes.

25 **Q.** And we can see there in terms of the

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

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

12 **A.** Yes.

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

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

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

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1 position on the committee, as with everyone on the
 2 committee, was to see that this looked at things
 3 holistically, that the committee looked at both
 4 midwifery and the neonatal care?
 5 **A.** Yes.
 6 **Q.** That was the purpose of the board presumably?
 7 **A.** So we were responsible so the -- everybody who
 8 was a member was responsible for bringing documents to
 9 the meeting and at that meeting, we all would review and
 10 challenge. However, we were aware that because it is
 11 such specialised work, we were dependent on the
 12 specialist to provide the overview.
 13 **Q.** And I think if we could go over the page to
 14 page 2, we will just see the duties and responsibilities
 15 there. And we see the second bullet point down, that
 16 one of those was to:
 17 "Provide assurance to the board lead executive of
 18 effective risk management".
 19 Again, what does that mean in practice?
 20 **A.** So if we had any concerns that were identified
 21 or any gaps or risks that we then made sure that we
 22 escalated them through this meeting.
 23 **Q.** So if you had a concern, for example, about
 24 increased mortality rates, this would -- that would be
 25 the sort of thing that should be escalated through this

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1 **Q.** When you say you are looking at the data, what
 2 data would you be looking at on a regular basis?
 3 **A.** So, so every month we would be looking at any
 4 new Level 1, 2 or 3 investigations, progress of action
 5 plans and any trends that were being identified that
 6 were being flagged up to us.
 7 **Q.** And then just the last one that has particular
 8 relevance, three from the bottom:
 9 "Also duties and responsibilities to ensure that
 10 clinical performance, quality monitoring and reporting
 11 mechanisms are working effectively".
 12 So that would be one of the responsibilities of
 13 this board.
 14 **A.** Yes. Yes.
 15 **Q.** So in terms of -- I think you have accepted
 16 that this would be an appropriate forum to discuss
 17 concerns about increased rates in mortality, more babies
 18 dying; this would be something that would fall --
 19 **A.** Yes.
 20 **Q.** If there were concerns about this, this would
 21 be the place to discuss it?
 22 **A.** Yes.
 23 **Q.** And this would be the place that you would
 24 bring, you would expect people to bring those concerns
 25 to you?

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1 meeting?
 2 **A.** If, if that information was brought to the
 3 meeting, yes.
 4 **Q.** And going down the next bullet point, so the
 5 third bullet point:
 6 "Review and monitor the risk registers, escalate
 7 risks to the divisional and organisational risk
 8 registers".
 9 Again, just can you explain in simple terms what
 10 that actually in practice meant?
 11 **A.** So every area had a risk register and if a new
 12 risk was identified, they would be discussed at
 13 a divisional level and then brought to this meeting for
 14 noting and escalating further.
 15 **Q.** And then finally, not quite finally, the next
 16 but one down says:
 17 "Review and monitoring ..."
 18 And one of the things you were reviewing and
 19 monitoring was incident trends.
 20 **A.** Yes.
 21 **Q.** And obviously the trend that this Inquiry is
 22 concerned with is the trend of increased mortality, so
 23 that would fall -- should that be the trend that would
 24 fall within the remit of this?
 25 **A.** Yes, we would be looking at the data.

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1 **A.** You would expect them to bring those concerns,
 2 yes.
 3 **Q.** And what about concerns about some commonality
 4 in terms of a member of staff being connected to deaths
 5 or collapses, would that be something that you would
 6 consider could be raised in this forum?
 7 **A.** It could be, yes.
 8 **Q.** So turning now to another committee that you
 9 sat on, and if I could go to INQ0002639.
 10 So this is the Quality, Safety & Patient Experience
 11 Committee and this, we can see there at the top, was
 12 a committee that reported to the Board of Directors?
 13 **A.** Yes.
 14 **Q.** So there was a hierarchy here, correct me if
 15 I have this wrong, Mrs Fogarty, where the
 16 Women's & Children's Care Governance Board would take
 17 the views from the neonatal and the midwifery and look
 18 at things from the perspective of women and children and
 19 babies and then their concerns would be escalated to
 20 QSPEC?
 21 **A.** Yes.
 22 **Q.** And we see, just picking out some of what they
 23 say the purpose was in the Terms of Reference there,
 24 four bullet points down:
 25 "To monitor serious untoward incidents".

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

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

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

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

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

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

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

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

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

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

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1 why that was?

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

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

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

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

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

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

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

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

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

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

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

10 **Q.** So as far as you were aware --

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

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

16 **A.** Sorry, can you repeat?

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

20 **A.** No, it is who has completed.

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

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

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

9 **A.** That is correct.

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

14 **A.** So I wasn't Lucy's direct line manager until
15 2018 when the police were already involved.

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

19 **A.** No.

20 **Q.** Did you --

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

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

25 **A.** Because I didn't have any further information

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1 to back up.

2 **Q.** And you are aware, were you, Mrs Fogarty, that
3 the guidance on Working Together is that Safeguarding is
4 everybody's responsibility?

5 **A.** Yes.

6 **LADY JUSTICE THIRLWALL:** Sorry, Ms Brown.

7 So did you think of raising it?

8 **A.** No, because --

9 **LADY JUSTICE THIRLWALL:** You have given a lot of
10 reasons why you might not have done it. But I just want
11 to see whether you actually thought of it in the first
12 place.

13 **A.** I didn't think of it in the first place.

14 **LADY JUSTICE THIRLWALL:** And I just wonder if you
15 might reflect now and think I wonder why that was that
16 you didn't think of it as a Safeguarding issue.

17 **A.** I think at the time I felt that the Executive
18 Board had initiated actions to try and review the whole
19 situation and I didn't have the clinical component.

20 So my work with Sian Williams had demonstrated that
21 Lucy was a common denominator though not involved in
22 every collapse, but I didn't have the clinical situation
23 because I have not got the clinical expertise to
24 interrogate neonatal data.

25 **LADY JUSTICE THIRLWALL:** No, you have explained
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1 from the first point of contact with maternity services
2 to delivery or to the postnatal period, if there's
3 a complication with the mum.

4 So what we are trying to do is make sure that the
5 correct pathways were followed, the correct escalation,
6 correct documentation, and that care met our pathways
7 and what was expected.

8 **Q.** And in what circumstances would there be
9 a OSR, obstetric secondary review, what would trigger
10 one?

11 **A.** Anything where there was a poor outcome or
12 concerns about care.

13 **Q.** And when you say poor outcome, that would be
14 poor maternal outcome or maternal complications?

15 **A.** Maternal or neonatal outcome.

16 **Q.** And what was the procedure that you followed
17 to conduct an obstetric secondary review? So one
18 assumes you would examine the notes, but what else would
19 go on? In terms of speaking to the midwives or doctors,
20 what was the process of the review?

21 **A.** So it was purely a review of the, the case
22 notes and the handheld record that the mum and
23 electronic notes, if required, for the obstetric, for
24 the OSR, the obstetric secondary review.

25 If we decided that it needed a further deeper
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1 that. I just wondered why you didn't think it was
2 a Safeguarding issue. You didn't get as far as thinking
3 of the other things, I understand that.

4 **A.** Yes.

5 **LADY JUSTICE THIRLWALL:** But it just didn't occur
6 to you.

7 **A.** It didn't occur to me.

8 **LADY JUSTICE THIRLWALL:** Do you think, on
9 reflection, that this is something that ought to be
10 considered a Safeguarding issue?

11 **A.** Definitely, definitely, on reflection it is
12 something that I would have done.

13 **MS BROWN:** And turning now, then, Mrs Fogarty to
14 the involvement that you had with reviewing the deaths
15 of some of the babies on the indictment from a maternity
16 aspect, you were involved in obstetric secondary
17 reviews, and I think you confirm in your statement that
18 you were involved in a number of the indictment babies,
19 certainly you were involved in the obstetric secondary
20 reviews of Child A, Child C and Child D.

21 Can you just explain, assist with what an obstetric
22 secondary review was?

23 **A.** So it is a review purely of the obstetric and
24 midwifery care provided to a mother and it involves
25 a comprehensive critical analysis of all care provided
90

1 comprehensive review then obviously that would be then
2 notifiable and it would be a root cause analysis and
3 that would involve interviewing staff.

4 **Q.** So this was an initial paper exercise?

5 **A.** Definitely, yes.

6 **Q.** And who would generally make up the review
7 panel?

8 **A.** So there would always be an obstetrician,
9 a senior midwife and a risk and safety lead as
10 a minimum.

11 **Q.** And how would you reach conclusions about
12 whether the standards of care had been set?

13 **A.** Benchmark it against practice and get clinical
14 guidelines.

15 **Q.** And what was the system to ensure that any
16 issues you did identify were followed up, followed up?

17 **A.** So if we found an issue with an individual
18 they would be spoken to. If we found a theme that would
19 be included in the mandatory training, it would be
20 escalated at handover so that all staff received that
21 information.

22 Also we had a resource room on the labour ward
23 where anything that we had identified from reviews,
24 there was a poster presentation and the staff used to go
25 in there and read those so that they were familiar with
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1 the findings. But the most important things was that if
2 an individual had not followed policy or their
3 documentation wasn't accurate, that they were informed,
4 because otherwise you are never going to improve
5 practice if the individual wasn't aware.

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

10 **A.** In maternity, yes.

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

13 **A.** No.

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

19 **A.** No.

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

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

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

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

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

12 **A.** No, no.

13 **Q.** Why was that?

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

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

23 **A.** Yes, that's correct.

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

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

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

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

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

14 **A.** Yes, providing we were aware.

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

17 **A.** Yes.

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

21 **A.** Yes.

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

25 **A.** Yes.

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

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

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

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

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

14 **A.** Yes.

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

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

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

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

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

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

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

21 **Q.** Thank you.

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

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

3 **A.** (Nods).

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

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

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

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

19 **Q.** Yes, I think --

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

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

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

4 And it says:

5 "... the Executive Serious Incident Panel on
6 2 July 2015; there had been three neonatal deaths in
7 a short period of time and the circumstances were
8 discussed to identify if there was any commonality which
9 linked the deaths ..."

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

13 **A.** Yes, that's correct.

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

16 **A.** No.

17 **Q.** -- were you just asked to attend?

18 **A.** No, I was just asked to attend.

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

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1 **A.** Yes.

2 **Q.** -- listing who was there.

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

6 **A.** Never.

7 **Q.** -- or was this a --

8 **A.** No.

9 **Q.** So this was a unique experience?

10 **A.** This was, yes.

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

15 **A.** No.

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

20 **A.** Yes.

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

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1 babies and were present at the -- failed in this case --
 2 resuscitations of Child A, Child C, and Child D?
 3 **A.** The paediatricians had elected to send
 4 Stephen Brearey to represent them so there was no
 5 discussion about other paediatricians. They didn't go
 6 in great detail about each individual case, you know,
 7 Dr Brearey, you know, provided a summary report, verbal
 8 report, and he didn't identify, as far as I recall, any
 9 issues that he felt warranted any further action at that
 10 time.

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

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

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

24 **A.** I agree, yes.

25 **Q.** And in addition to the issue of whether the
 101

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

5 **A.** That decision was made by the Director of
 6 Nursing.

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

10 **A.** Yes.

11 **Q.** Did anyone dissent from that at the meeting?

12 **A.** Not at the meeting, no.

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

18 **A.** No.

19 **Q.** -- at the meeting?

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

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

24 "The common factor of Letby as a nurse on duty was
 25 not discussed at this meeting."
 103

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

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

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

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

14 **Q.** Child B survived, fortunately, but the
 15 collapse --

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

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

20 **A.** Definitely. Definitely.

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

24 **A.** There was no clinical, no detailed clinical
 25 information given.
 102

1 Are you clear in your recollection about that?

2 **A.** I am very clear that that, that that was not
 3 discussed.

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

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

10 **Q.** So you are confident in that recollection?

11 **A.** I am confident in that recollection, yes.

12 **Q.** And just again to clarify as well, before we
 13 move on, you say at paragraph 36 about this meeting:
 14 "The paediatricians did not raise any concern at
 15 that meeting ..."

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

18 **A.** Yes.

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

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

23 **Q.** If we can turn on now, you say in paragraph 52
 24 of your statement, that it was also at that meeting, the
 25 meeting of 2 July that was looking at the commonality,
 104

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

6 **A.** Yes.

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

12 **A.** With hindsight definitely, that, that should
13 have been done.

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

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

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

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

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

7 **Q.** Didn't happen?

8 **A.** Didn't happen.

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

14 **A.** Yes.

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

17 **A.** That was an actual physical meeting, yes.

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

20 **A.** Yes.

21 **Q.** -- of both obstetricians and a paediatrician?

22 **A.** Yes.

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

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1 Child D because this really makes the point clearly that
2 this is a review and we can see just by the
3 investigation team that we have got present there, the
4 obstetric secondary review team, including you and
5 a Consultant, Dr Davis, and then we've got the neonatal
6 review team, Dr Brearey, and Ms Powell, the neonatal
7 unit manager, and there is -- we won't go through it but
8 what follows is an 18-page report with appendices, an
9 11-page report.

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

12 **Q.** So that's my next question.

13 **A.** Yes.

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

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

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

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

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

4 **A.** No.

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

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

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

11 **A.** It wasn't escalated to me.

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

18 **A.** Yes.

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

21 **A.** Definitely.

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

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

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

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

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

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

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

8 **A.** Yes.

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

12 **A.** Yes.

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

15 **A.** Yes.

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

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

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

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

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

4 **Q.** Thank you, Mrs Fogarty.

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

9 **A.** Yes.

10 **Q.** -- examine their side?

11 **A.** Yes.

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

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

23 **A.** So they were already planning their review
24 which they did in the beginning -- at the beginning of
25 2016.

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

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

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

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

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

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

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

2 **A.** Yes.

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

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

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

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

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

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

24 **A.** Yes.

25 **Q.** -- department?

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1 A. And it actually states that on the email, that
 2 it's -- it's up, it's already up as a poster
 3 presentation which was our format.
 4 **LADY JUSTICE THIRLWALL:** Sorry. Does that mean
 5 that it was, the report was in the resource room?
 6 A. Yes. Visible, visible for staff to look at.
 7 **LADY JUSTICE THIRLWALL:** So every page was there?
 8 A. Yes, yes.
 9 **LADY JUSTICE THIRLWALL:** Thank you.
 10 A. And staff also knew to go to the resource room
 11 every week because that's where we -- that was our
 12 training method that we used. It was very effective.
 13 **MS BROWN:** So if we can just look now and go
 14 through and see what was being discussed at the
 15 Women's & Children's Care Governance Board.
 16 So if we could put up, please -- that report can go
 17 down and just maybe one more question regarding that
 18 report, Mrs Fogarty, before we take it down.
 19 That report didn't highlight within the report
 20 itself that a neonatal review was needed and my
 21 understanding is that's because you understood that that
 22 was going ahead in any event?
 23 A. Yes.
 24 Q. So, yes, if we could pull up INQ0004235. So
 25 this is tab 14, my Lady, of the bundle.

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1 three unexpected neonatal deaths. There had in fact
 2 been four then, taking into account Child E, but it
 3 refers to three unexpected deaths, but there is no
 4 discussion in the agenda of unexpected deaths.
 5 Was that something that on reflection should have
 6 been something that was discussed or would normally have
 7 been something that was discussed? It's the fact that
 8 they are unexpected deaths. Clearly on occasions there
 9 would be deaths, but the unexpected deaths, would that
 10 not be something that should have prompted discussion?
 11 A. She would have expected the paediatricians to
 12 have said, to have brought some information regarding
 13 their reviews of those cases. But that was in
 14 the October when we were aware of the increase and
 15 that's why we then did our review in the November.
 16 Q. So you say that it was for the neonatologist
 17 or the paediatrician to bring that. But as the deputy
 18 chair and as observing this from a critical standpoint,
 19 knowing that the role of the committee is to flag any
 20 issues, should you not have been asking your colleagues
 21 and saying: These are unexpected deaths. We don't have
 22 a solution, is there an explanation?
 23 There seems a lack of curiosity.
 24 A. With -- with hindsight then, yes there should
 25 have been more probing of the paediatric staff.

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1 This was 18 June, so right -- just shortly after
 2 the death of Child A, a meeting there and if we could go
 3 to page 3 of that. It records there that JCF, so that's
 4 and you -- your initials, sorry, yes, JCF, your initials
 5 and the Consultant obstetrician reviewed a twin death
 6 and that's referring to Child A.
 7 If we go down:
 8 "No issues with any element of care provided. Will
 9 be subject to neonatal review."
 10 So that's as you were explaining to us --
 11 A. Yes.
 12 Q. -- recording that there would be an obstetric
 13 secondary review. There were no issues there, but there
 14 would be a neonatal review?
 15 A. Yes.
 16 Q. Was there a system for following up matters
 17 like that on the minutes to check that -- it says
 18 there's going to be a neonatal review --
 19 A. Yes.
 20 Q. -- that a neonatal review was done?
 21 A. Yes. So at the next meeting they looked at
 22 the actions to make sure that they had been completed.
 23 Q. That can come down then, please. We don't
 24 need to turn to this, but there was another meeting on
 25 22 October and that referred, just very briefly, to

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1 Q. If we can go -- thank you. If we can go to
 2 the meeting of 18 December and we can call this one up.
 3 It's INQ0004371, and page 2 of that.
 4 Here we see -- so this is December. We know the
 5 Brigham report, the obstetric report we have seen
 6 was November, and we see this report came to the meeting
 7 here as one would expect?
 8 A. Yes.
 9 Q. And we see stillbirth and early neonatal death
 10 review and action plan:
 11 "Panel set up to review each case individually. No
 12 themes identified. Overall the process showed we have
 13 a good record-keeping, good escalation. The outcomes
 14 would not have been any different."
 15 Now, we know that these minutes then went up
 16 to QSPEC?
 17 A. Yes.
 18 Q. And reading that now, I know obviously you
 19 have the knowledge that this was an obstetric review but
 20 if one was reading that without that knowledge, that
 21 would appear to allay concerns about neonatal deaths
 22 because it's not clear from that that's just the
 23 obstetric care that's being looked at?
 24 A. But I presented that report at QSPEC and was
 25 very clear in my verbal presentation that it was

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1 a maternity and obstetric review of care.
 2 **Q.** We will come to that in a moment. But from
 3 this minute, if one was reviewing the minutes, it's not
 4 clear from those minutes -- it would obviously have been
 5 clear to those at the meeting, but it wouldn't have been
 6 clear just on a paper review that there was a problem
 7 here?

8 **A.** Yes. Yes.

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

12 **A.** Not that I recall.

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

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

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

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

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

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

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

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

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

12 **A.** Yes.

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

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

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

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

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

23 **A.** To my knowledge, yes.

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

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1 hasn't -- was that your understanding anyway?

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

8 It was the paed update that was missing.

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

11 **A.** Yes.

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

14 **A.** Yes.

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

17 **A.** Yes.

18 **Q.** And then it's the paediatric --

19 **A.** Yes.

20 **Q.** -- update that's missing?

21 **A.** Yes.

22 **Q.** Then Ms Kelly replies:

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

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

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

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

5 **A.** No.

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

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

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

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

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

21 And it goes on:

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

25 That's a reference to the Dr Brigham report?

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1 A. Yes.
 2 Q. And it said the aim of the neonatal meeting,
 3 that was the meeting that was held on 8 February was to:
 4 "... review the cases as a multi-disciplinary team
 5 with an external reviewer to assess."

6 And it says there:
 7 "There was no common theme identified in all the
 8 cases."

9 A. Yes.

10 Q. Do you recall any other discussion taking
 11 place at that meeting surrounding that report?

12 A. I -- due to the time lapse, I don't.

13 MS BROWN: My Lady, I don't know if that would be
 14 a convenient moment.

15 LADY JUSTICE THIRLWALL: Yes, certainly.

16 So we are going to adjourn now for lunch so if you
 17 will come back please and be ready to start again at
 18 2 o'clock.

19 A. Right.

20 LADY JUSTICE THIRLWALL: Please don't talk about
 21 your evidence.

22 (1.00 pm)

(The luncheon adjournment)

24 (2.01 pm)

25 LADY JUSTICE THIRLWALL: Ms Brown.
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1 effective in relation to maternity services, the fact
 2 that the issues relating to the NNU mortality was not
 3 presented at this board by the NNU Team demonstrates
 4 a gap in its overall effectiveness.

5 Just clarify what you mean by the gap in its
 6 overall effectiveness, please?

7 A. Well, the whole purpose the board is to, you
 8 know, receive information and where there is risk to
 9 then forward them on and obviously that didn't happen in
 10 this case.

11 So it was a gap that the increase in mortality
 12 wasn't flagged by the paediatric team for discussion,
 13 noting and escalating.

14 Q. And obviously you have had some time to
 15 reflect --

16 A. Yes.

17 Q. -- about this. And what is your explanation
 18 for that, why a meeting that was convened for that
 19 purpose with neonatal and midwifery and obstetric
 20 representatives, concerns that did exist, why was that
 21 not being debated in that forum?

22 A. I have no explanation as to why the
 23 paediatricians didn't bring that information forward or
 24 raise it for a topic of discussion.

25 Q. Do you feel that whilst, as you have made
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1 MS BROWN: Ms Fogarty, we were just looking at the
 2 8 February thematic report that had been presented to
 3 the Women's & Children's Care Governance Board on
 4 16 June and the fact that on the entry for that it said
 5 there was no common theme identified in all the cases.

6 So having completed that, that review going through
 7 those board meetings of the Women's & Children's Care
 8 Governance Board, at no point between June 2015
 9 and June 2016 did the Women's & Children's Care
 10 Governance Board have any minuted discussion about the
 11 cause of serious concerns of rising unexpected and
 12 unexplained neonatal deaths; that the case, isn't it?

13 A. It would be apparent from the minutes, yes.

14 Q. So it's not a case that it's not minuted, you
 15 would have recalled that discussion as well?

16 A. Yes.

17 Q. And consequently, no concerns about rising
 18 unexpected and unexplained deaths rose from there to
 19 QSPEC?

20 A. That's correct, yes.

21 Q. That follows as a matter of course.

22 And at paragraph 31 of your statement you address
 23 this frankly and you say that whilst, during your time
 24 as Head of Midwifery you felt that the WCCGB, the
 25 Women's & Children's Care Governance Board, was
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1 clear, you weren't a paediatrician, you weren't from
 2 neonatal expertise, but did you think there was
 3 sufficient that you maybe should have raised it yourself
 4 as a concern?

5 A. I have no neonatology experience whatsoever.
 6 I have never ever reviewed a neonatal care case because
 7 it's not my area of clinical expertise. So I am not
 8 able to interrogate the data.

9 But certainly, you know, in hindsight then, just
 10 the fact that, you know, I was aware of the -- from our
 11 own review, our own obstetric review, there should have
 12 been some escalation at that time.

13 Q. And that's, in a sense, a question of
 14 hindsight. At the time you knew that there wasn't an
 15 obstetric cause and that's something you could have
 16 raised at the meeting.

17 A. Well, I knew that there wasn't an obstetric
 18 cause but I would -- I was being guided by the
 19 paediatricians who are the experts in neonatology.

20 Q. Thank you. And just on a related issue in
 21 terms of the reporting culture within the NNU. Again,
 22 you said in your Facere Melius interview that you felt
 23 there was a good reporting culture in midwifery, and
 24 that's the case, is it?

25 A. I would say yes.
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1 Q. But you said that you considered that neonatal
2 incidents were not always reported. What was the basis
3 for that?

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

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

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

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

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

22 Q. So it wasn't something that you considered at
23 the time, at the time of these events, 2015 to 2016,
24 June 2015 to June 2016, that you should have raised
25 within the context of the Women's & Children's Care
129

1 what QSPEC were doing and back to the meeting of
2 14 December 2015.

3 So that's INQ0003204.

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

6 If we can get, yes, page 5.

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

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

19 And then going down:

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

23 And then going down:

24 "The report will now be received at the Women's &
25 Children's Care Governance Board where the action plan
131

1 Governance Board that you felt there was a reporting
2 issue?

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

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

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

13 A. Yes.

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

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

20 Q. And can you recall when those came in?

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

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

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

8 A. No, no.

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

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

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

19 A. Definitely, yes.

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

22 A. Yes.

23 Q. But having accepted that that's misleading to
24 the uninitiated reading that, what is your recollection
25 of what you in fact presented at that meeting?
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1 A. I mean, during the verbal report I was, I know
2 I was clear that it was obstetric and maternity care
3 that are being reviewed. The members of the meeting
4 also knew that that was my remit.

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

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

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

16 A. Not at the time, no.

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

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

25 Q. That wasn't something you raised --
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1 care in a Neonatal Network meeting.

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

6 A. No, and the notes confirm that.

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

11 A. No.

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

14 A. No.

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

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

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

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

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

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

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

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

19 A. No.

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

25 A. No, because they wouldn't look at obstetric
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1 Q. Do you know who that obstetrician was?

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

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

12 A. Yes.

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

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

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

20 A. Not at that meeting, no.

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

23 A. No.

24 Q. We come then to the 11 July, so just
25 two weeks, just over two weeks after the death of
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1 Child O and Child P, and you describe something that you
2 say you have a clear recollection of and that's
3 a recollection of you and Sian Williams undertaking an
4 exercise to do a staffing matrix analysis.

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

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

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

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

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

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

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

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

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

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

20 **A.** It was a paper copy.

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

23 **A.** Yes.

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

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

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

7 **A.** Yes --

8 **Q.** -- cause of these deaths?

9 **A.** -- and that's why --

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

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

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

20 **A.** Yes.

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

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

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1 identify the baby concerned?

2 **A.** Yes.

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

5 **A.** Which staff was looking after the baby.

6 **Q.** Right.

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

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

12 **A.** The designated nurse, yes.

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

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

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

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

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

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

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

6 A. We did it over more than one day.

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

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

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

19 A. Yes.

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

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

25 Q. And did that lead you to suspecting that Letby
141

1 at the meetings?

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

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

10 A. Yes.

11 Q. -- about these babies?

12 A. Yes.

13 Q. Did you make that connection?

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

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

23 A. I personally didn't, no, because I was never
24 fed back the outcome of the paediatric and neonatal
25 nurse review of the care provided to the babies. That
143

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

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

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

7 A. Yes.

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

10 A. Yes.

11 Q. Were you sharing that concern with anyone
12 else?

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

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

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

24 Q. And you were aware that there were
25 Consultants' concerns as well at this point having been
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1 information was never given to me.

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

5 A. Yes.

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

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

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

22 Q. And just considering the other steps, your
23 answer may be similar, but did you, did you consider
24 first of all whether internally you needed -- other than
25 going to Mr Harvey, did you, for example, consider that
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1 you needed to raise this on one of your committees, on
2 the Women's & Children's Care Governance Board or on
3 QSPEC, that you had to share what your concerns that
4 were now heightened with either of these committees?

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

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

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

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

23 **A.** Not at the time, no.

24 **Q.** And in terms of the obstetric secondary
25 reviews, I think you carried out the obstetric secondary
145

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

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

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

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

22 **Q.** No, this is 21 July.

23 **A.** Oh sorry, I thought it said May. So I think
24 that the -- sorry, can you just ask me the question
25 again?
147

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

3 **A.** Yes.

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

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

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

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

18 **A.** Maternity care, yes.

19 **Q.** Because we know there were very serious
20 concerns --

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

23 **Q.** And if we could just go to the
24 Women's & Children's Care Governance meeting, the last
25 one we are going to look at, at INQ0003214, and that's
146

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

3 **A.** Definitely yes.

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

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

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

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

22 **A.** No.

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

25 Sorry, that's why I am confused. It should be
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1 3213. Sorry. I must have said 3214.

2 So if we could go to page 4 of 3213, page 4.
3 Looking at page 4 of that. So maybe if we can just go
4 back to page 3. So that's where we see the unexpected
5 neonatal deaths that were raised -- can you see at the
6 top of the page -- but no discussion underneath that?

7 **A.** No, because at that time it says it's an
8 incident. I'm not sure if that is the receipt of
9 a report or whether it's just the incident being logged.

10 **Q.** But --

11 **A.** It's not clear.

12 **Q.** But this is the meeting on the 21 July --

13 **A.** Yes.

14 **Q.** -- and the point is that there's no minuted
15 discussion of Letby or steps that could be taken?

16 **A.** No. She was definitely never discussed in any
17 Governance Board. I know that.

18 **Q.** Yes, that is the point --

19 **A.** I am very clear about that.

20 **Q.** Thank you very much.

21 If we could go then on to page 4, and we see there
22 under "Risks", "New Risk for Escalation in the Month"
23 and we see:

24 "Potential damage to reputation of neonatal service
25 and wider Trust due to apparent increased mortality

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1 something that was raised in the risk register in terms
2 of the planned --

3 **A.** No, because the stillbirths, unfortunately in
4 some cases people will present because in a lot and, you
5 know, they have had a stillbirth. It doesn't actually
6 mean that there is a problem with the care provided and
7 that's why we did that review and it demonstrated that
8 whilst we had an increase, it wasn't actually due to the
9 care provided.

10 So therefore it didn't need to go on the Planned
11 Care risk register. It wasn't relevant.

12 **Q.** Thank you.

13 And just before -- we are going to move now to your
14 period as the Associate Director of Risk and Safety.
15 But just to be clear, there was a CQC review
16 in February 2016 and I think you didn't have any
17 involvement in that.

18 **A.** No.

19 **Q.** And you weren't involved in the RCPCH review
20 in September 2016.

21 **A.** Yes, that's correct, I wasn't involved in that
22 either.

23 **Q.** And in relation to the grievance brought by
24 Letby, you weren't involved or interviewed in relation
25 to that?

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1 within the neonatal unit."

2 So what seems surprising there is that the risk
3 that is being identified is the potential risk to
4 reputation. Wasn't the more important risk the risk to
5 patients due to the increased mortality?

6 **A.** I mean, certainly. However, this risk was
7 a plan, an Urgent Care risk so that, that division will
8 have had the discussion and they have decided what they
9 were going to include on their risk register.

10 It's -- it's come here for noting and escalation to
11 QSPEC to follow a process.

12 **Q.** And did that discussion, the discussion about
13 risk registers and the damage to reputation based on
14 increased mortality, did that cause you to reflect as to
15 whether the risk registers needed to be or should have
16 been updated to reflect the risk to patients due to
17 increased mortality? Because that doesn't appear to
18 have been added to the risk registers at any time
19 from June 2015 onwards.

20 **A.** I mean, certainly the risk registers, there
21 should have been something in it far sooner within the
22 Urgent Care Division.

23 **Q.** And was it something, because obviously there
24 was the stillbirths and the identified increased
25 neonatal deaths from the maternity aspect. Was that

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1 **A.** No.

2 **Q.** So moving forward to April 2017. You took
3 over a new role now as Associate Director of Risk and
4 Safety. Who did you -- and you took over from
5 Ruth Millward, I think you have told us.

6 **A.** Yes.

7 **Q.** Who did you report to in that role?

8 **A.** Alison Kelly, Director of Nursing.

9 **Q.** So you had the same reporting structure?

10 **A.** Yes.

11 **Q.** Was it a more senior role in fact?

12 **A.** No. It's probably -- parity, just a different
13 remit.

14 **Q.** And you say -- and this is paragraph 137 of
15 your statement -- that you first met Letby in April 2017
16 when you moved to the new role?

17 **A.** Yes.

18 **Q.** And what was Karen Rees' role in relation to
19 Letby?

20 **A.** So she was her manager.

21 **Q.** And what was your role? You had, as
22 I understand it, you were the, what's referred to as the
23 day-to-day manager of -- (overspeaking) --

24 **A.** Yes.

25 **Q.** What's that?

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

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

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

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

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

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

4 **Q.** Was that something you checked or was it
5 something --

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

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

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

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

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

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

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

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

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

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

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

18 **A.** Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 **A.** Only when I received my pack --

5 **Q.** From the Inquiry?

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

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

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

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

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

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

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

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1 referring to there?

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

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

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

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

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

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

20 **A.** Yes.

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

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

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1 consideration had been given to patient safety and
2 safeguarding risks?

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

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

8 **A.** Yes.

9 **Q.** You recall that briefing, I imagine?

10 **A.** Yes, yes.

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

13 **A.** Yes.

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

16 **A.** Yes.

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

22 You say that:

23 "Hundreds of policies were out of date."

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

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1 that hadn't been reviewed.

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

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

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

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

12 **Q.** Across the board?

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

18 **Q.** And then going down a bit further, you say:
19 "Inconsistent approach to risk across the Trust."

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

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

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1 received.

2 The way that the risk and safety leads maybe worked
3 within the divisions wasn't consistent. Who attended
4 what meetings. So someone from audit may attend one
5 meeting but the -- the next division may not have
6 somebody there.

7 **Q.** Underneath that, you refer to:

8 "Out of date mandatory training package."

9 **A.** Yes.

10 **Q.** Is that -- we looked at mandatory training
11 used in the context of safeguarding before. Could that
12 be a reference to that, is that --

13 **A.** So this was the risk and safety, so all staff
14 had risk and safety training as part of their annual
15 mandatory training and the data and the statistics and
16 some of the information that was in there was out of
17 date.

18 **Q.** So that's not a reference to safeguarding?

19 **A.** It is not safeguarding, no. It's the Trust.

20 **Q.** You say at the bottom:

21 "Poor management of the risk register."

22 **A.** Yes.

23 **Q.** Did that have any bearing specifically on not
24 updating a risk register relating to neonatal deaths or
25 is that not something you can recall?

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1 **A.** Who's -- who is he referring to? He is
2 referring to Ruth Millward.

3 **Q.** And it says risk and complaints team. This is
4 obviously an email sent on behalf of you as well. Were
5 there other people who were considered to be not
6 performing?

7 **A.** No. No.

8 **Q.** And going down to the last bullet point, it
9 says that:

10 "A plethora of committees and boards within the
11 Trust with no clear reporting or escalation structure."

12 Now we have been through minutes and reflected, do
13 you think it would be fair to put the
14 Women's & Children's Care Governance Board and QSPEC
15 within that description of boards where there was no
16 clear reporting and escalation structure?

17 **A.** I think it could be improved upon definitely.

18 **Q.** Then if you just turn to paragraph 154 of your
19 statement. You say there that you don't feel the issue
20 with the risk processes across the Trust contributed to
21 the failure to identify the risk Letby posed to babies.

22 Can that -- can that really be the case given what
23 I have highlighted some of the risk that involves not
24 escalating, risk registers, inconsistent approach,
25 policies being out of date, Datix not being reviewed.

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1 **A.** It is -- across the board in the Trust there
2 wasn't consistency when risks registers were reviewed.

3 **Q.** And I think you end your list by saying:

4 "This list is not all inclusive ..."

5 **A.** No.

6 **Q.** And if we could just see -- pull up

7 INQ0006771.

8 My Lady, this is tab 12.

9 This rather shows that whilst you have put it in
10 your witness statement what was happening at -- in
11 real-time, so to speak, because this is a message from
12 David Semple on 16 June 2017, so about a month or so,
13 six weeks or so after you were in post; is that correct?

14 **A.** Yes, about that. Yes.

15 **Q.** It says:

16 "Please be assured that Julie Fogarty (Interim
17 Associate Director of Risk and Safety), Mel Kynaston
18 (Associate Director of Nursing ...) and I are acutely
19 aware of ongoing concerns around clinical risk within
20 the Trust. To put it mildly, we have inherited a mess
21 and the issues include to name but a few ..."

22 So again, this is not an inclusive list, "previous
23 poor leadership within the risk."

24 Who are you referring to as previous poor
25 leadership?

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1 Surely that, in logic, must have contributed?

2 **A.** The reason I came to that conclusion was that
3 it is obvious, though I didn't know it at the time, but
4 it was obvious from the reports in the media and
5 information within my pack, that the paediatricians had
6 concerns for a long time and they had taken them to the
7 Executive team to escalate their concerns and so even if
8 you had all these processes, they had taken them to the
9 Executive team.

10 So that's why I felt -- possibly that's why I felt
11 that at the time when I wrote my statement.

12 **Q.** But having gone through the exercise we have
13 gone through today, would you accept that these issues
14 with risk were a contributory factor --

15 **A.** Oh certainly.

16 **Q.** -- to an environment where this was allowed to
17 happen?

18 **A.** Yes, certainly as time has gone on and since
19 I have produced my statement I've been aware of more
20 facts. Then yes.

21 **Q.** And yes, yes, it was part of the environment
22 that allowed these circumstances not to be investigated
23 earlier?

24 **A.** Yes, yes.

25 **Q.** Is that a correct --

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

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1 **Q.** Mrs Fogarty, my name is Alex Jamieson. I ask
 2 you questions on behalf of some of the Families.
 3 **A.** Right.
 4 **Q.** All right? Can I start, please, by taking you
 5 back to something you dealt with at the start of
 6 Ms Brown's questioning. This Inquiry has received
 7 a deal of evidence about the impact of the change in the
 8 governance structure, three divisions to two, at the
 9 Countess and you gave a personal example of that in your
 10 Facere Melius interview which I think it would be useful
 11 for us to reflect on.
 12 So please could we have on the screen INQ0012993.
 13 So this is your interview on the -- in July of
 14 2020, and can you see in the first entry ascribed to
 15 you, the top of the page, it says that what you are
 16 telling the interviewer is that at the point that the
 17 hospital had been reorganised, you had been a matron
 18 across women and children's services?
 19 **A.** Yes.
 20 **Q.** And so before it was reorganised, I'm sorry
 21 I am not looking at you, I am talking this way so the
 22 microphones pick me up.
 23 **A.** Yes.
 24 **Q.** You had had responsibility not just for
 25 maternity but also for neonatal services?

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

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

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

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

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

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

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

23 **Q.** No.

24 **A.** They are not necessarily dangerous. But they
25 are not beneficial.

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1 unexpected. Those are Children A, C, and D.

2 Another child, Child B, the twin of Child A, has
3 also seriously collapsed and required resuscitation
4 within that period. The other fact that we need to
5 build in is that the cause of death for each of those
6 three children was at that stage uncertain. They had
7 all been referred for post-mortem and indeed a Datix had
8 been raised for each death.

9 Okay?

10 **A.** Yes.

11 **Q.** So that's the situation --

12 **A.** Yes.

13 **Q.** -- as you come to deal with the issue on

14 2 July 2015.

15 I wonder if next, please, we could have on the
16 screen your notes of that meeting. Those are
17 INQ0003530. Thank you. Please may we just zoom in on
18 that top bit of the page. Thank you.

19 So we can see this is dated "SUI Review,
20 2 July '15" and to the right of that you have given the
21 initials of the attendees. Yes?

22 **A.** Yes.

23 **Q.** Yes, okay. So we have got the right document.

24 Now, just before I ask my question, you have said
25 a number of times to us in your evidence that you were

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1 **Q.** Well, if I am going to manage a risk I need
2 all of the relevant information, wherever it may be, and
3 if that information is in different silos I need to be
4 able to get hold of it; is that accurate?

5 **A.** Yes.

6 **Q.** And so what you were reflecting here is that
7 the arrangements that had been made in the Countess had
8 led to the information being siloed?

9 **A.** Yes.

10 **Q.** I think what I and The Families would be
11 grateful for your reflections upon is how that siloed
12 approach was relevant to the risk that was presented by
13 Letby in 2015 and 2016.

14 So I would just like to ask you some questions
15 about that, if I may.

16 That can come down, thank you, Mrs Killingback.

17 Can we move, please, to the 2 July Serious Incident
18 Panel.

19 **A.** Yes.

20 **Q.** I know you have answered quite a lot of
21 questions about that already. Just before I ask you my
22 questions, can I just contextualise that moment in time.

23 What has happened in the lead up to that meeting is
24 that three children have died in two weeks in June, all
25 of those deaths were sudden, all of those deaths were

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1 not a neonatologist, you didn't have any expertise in
2 that area and what I am interested in, please, is your
3 understanding of what your purpose and role was in this
4 meeting.

5 Because what we can see when we look at the records
6 that you have taken is a line or a section for each
7 child, they are identified on the left as Child A,
8 Child C, and Child D, a short description of some
9 particulars and then on the right-hand side of the page,
10 in relation to each one you have recorded the OSR -- is
11 that the obstetric secondary review?

12 **A.** Yes.

13 **Q.** Is that what that is?

14 And that there were no M -- is that MW issues?

15 **A.** So this note, the bottom bit with -- it didn't
16 have Child A, C, D.

17 **Q.** No.

18 **A.** It will have had the date -- it will have had
19 a Datix number.

20 **Q.** Yes.

21 **A.** And that section underneath was written before
22 I went to the meeting because I knew what I was going to
23 discuss and I had to review the care from a midwifery
24 aspect because that was my role at this meeting; was to
25 take the midwifery aspect.

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1 I obviously added who was there when I got there.
 2 **Q.** Yes.
 3 **LADY JUSTICE THIRLWALL:** So when you were asked
 4 what does "MW" stand for --
 5 **A.** It's midwifery, no midwifery issues.
 6 **MR JAMIESON:** Really it is that answer that you
 7 have just given that I am particularly interested in.
 8 Your role at this meeting, as you understood it,
 9 was to take the midwifery information --
 10 **A.** Yes.
 11 **Q.** -- and to come back with any midwifery
 12 actions?
 13 **A.** Yes.
 14 **Q.** Right. So does that mean you did not
 15 understand it to be any part of your role to challenge
 16 professionally or evaluate the information that the
 17 other specialists were bringing?
 18 **A.** Obviously if I had concerns then yes, but at
 19 this time I trusted the information, as did everyone
 20 else at the meeting, that was being provided by
 21 a neonatologist.
 22 **Q.** Yes. I just, if I may, I would value your
 23 reflections on this issue because it's clear from what
 24 you have written that we have read that there were no
 25 midwifery issues identified or present in relation to
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1 present in that meeting, I would say. Though it's
 2 nine years, it's a long time ago.
 3 **Q.** Okay. There is one document that may help.
 4 That can come down, thank you very much.
 5 It's the Datix report for Child D, that is
 6 INQ0002658.
 7 Just while that's coming up, were those Datix
 8 reports available to you in the meeting? Were they
 9 considered by the attendees beforehand?
 10 **A.** So the Datix were not brought up in that
 11 meeting.
 12 **Q.** No. Had you seen them beforehand?
 13 **A.** So I wouldn't have seen -- I hadn't seen the
 14 baby element but obviously the mother, yes, because we
 15 would have done the review that would have then gone
 16 into the Datix. But no, not the -- not the baby
 17 information.
 18 **Q.** Okay. How does that work? So you log on to
 19 the system to see the Datix.
 20 **A.** The risk and safety lead, they, they pull the
 21 incidents. So, for us, once there is an incident we
 22 look at all of the midwifery care.
 23 **Q.** And so, going back to my question about your
 24 reflections on silos, even as you prepare for this
 25 meeting, even as you look at the Datixes, you are only
 175

1 the tragic deaths of these three children, right?
 2 Seen from the midwifery perspective, that is
 3 a reassuring fact, isn't it, because it means we haven't
 4 done anything wrong?
 5 **A.** It means the care provided didn't -- yes.
 6 **Q.** But if I am standing back and looking at it in
 7 the round, holistically, I have three deaths that have
 8 all been sudden and unexpected, no cause of death is
 9 identified, and there is nothing in the midwifery care
 10 that can have explained why these children died.
 11 That's a concern, isn't it?
 12 **A.** It is now but obviously, you know, nine years
 13 down the line when I am looking at this, my actions
 14 would be different than they were taken at that time.
 15 **Q.** To be clear, this is not -- this questioning
 16 is not directed at you personally, I am trying to
 17 understand what is going on in the meeting.
 18 **A.** Yes.
 19 **Q.** All right? So that thought process that
 20 I have just set out for you, if there are no
 21 shortcomings in the midwifery care, that raises at least
 22 the possibility that there is something else that we are
 23 not seeing; was that thought process present in the
 24 meeting and, if so, who was it voiced by?
 25 **A.** I would say that thought process wasn't
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1 looking at the bit that relates to midwifery care?
 2 **A.** Well, that's because you can't look at
 3 something you have not got the clinical expertise to
 4 interrogate data. So that isn't silo working, that is
 5 just a specialty reviewing care, that it's got the
 6 expertise to be able to interrogate and challenge.
 7 **Q.** Okay. Well, let's, if we may please, look at
 8 page 2 of this document, and just zoom in on the top
 9 half of that page, please. Thank you.
 10 Now, can you see -- this is a little involved, so
 11 bear with me. Under "Incident investigation" there are
 12 a number of entries that have been made by Debbie
 13 Peacock that are and then Dean Bennett that have been
 14 timestamped. Can you see the third one of those that's
 15 timestamped 23 July '15, if you look over on to the
 16 right-hand side there are in fact a number of earlier
 17 timestamps and it's the earliest one of those that I am
 18 interested in.
 19 24 June 2015, 10:45:05 Debbie Peacock. So it is on
 20 that line just across to the right-hand side in the body
 21 of the text. And Debbie Peacock was an attendee of the
 22 SUI meeting, wasn't she?
 23 **A.** Yes.
 24 **Q.** What she's recorded is:
 25 "Just to confirm that I have met with Eirian and
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1 reviewed the case notes of Child D who died in the early
2 hours of this morning. We have also discussed whether
3 there are any other issues to address in the view of the
4 two other recent sudden deaths on the NNU so all deaths
5 are brought together. In regard to those three deaths,
6 all deaths occurred in Room 1, our intensive care room
7 but in a different cot space, all microbiology results
8 have been negative to date, initial post-mortem result
9 for Child A did not identify a definite cause of death."

10 A point that I have made with you already.

11 There is a bullet point about a TPN bag and why
12 that makes a particular infection unlikely, but then the
13 fourth bullet:

14 "There does not seem to be any staff, medical or
15 nursing members present at all three episodes other than
16 one nurse, who was not the nurse responsible for Child D
17 on that shift."

18 Or putting that the other way round, there was
19 a member of staff who was common to all of those three
20 deaths and that entry, as I understand this record, is
21 timestamped as having been made on 24 June '15, so
22 a week or so before your meeting.

23 I take it from your answer that you didn't read
24 that before the meeting?

25 A. No. No, because that is a neonatal entry so
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1 Registrar concerns, that before this meeting Registrars
2 had or a Registrar had visited a Consultant and said: we
3 are concerned about these sudden collapses, we are
4 concerned that there is a common and unusual rash that
5 none of us have seen before but it's happened in three
6 of these cases. We don't know what's happening here.

7 Was that information brought to your meeting?

8 A. This is the first time I have even heard of
9 that.

10 Q. Okay, thank you. Those are the end of my
11 questions then about that meeting.

12 Can I just please then move briefly to talk to you
13 about QSPEC, the Quality, Safety and Patient Experience
14 Committee.

15 Could we look very briefly at the
16 20 July 15-minute, so that's INQ0003211, and I am
17 looking at page 2 to begin with, please.

18 So I'm just going to note in passing, again for the
19 transcript and for my Lady's note, that Dr Brearey has
20 attended this meeting -- it's at the bottom of this
21 page -- particularly to talk about the Morecambe Bay
22 Kirkup report and about the risks to neonatology that
23 were presented by the current divisional structure,
24 okay?

25 So that was a topic for discussion at that meeting.
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1 I read the obstetric elements.

2 Q. But does one need to be a neonatologist to
3 look at that and say: well, that is a common factor, we
4 don't know if that's relevant or not. We had better
5 think about it?

6 A. Well, I would have expected this level of
7 information to have been -- to have been presented by
8 either Debbie Peacock who wrote it or the paediatricians
9 who were aware of this information. That was the
10 purpose of the meeting. I was given the remit of
11 looking at the obstetric, I wasn't asked to review
12 neonatal records. I was asked to take the obstetric
13 element and that's what I did.

14 Q. Just with your Director of Risk hat on, if
15 I can use that vernacular, is that the right approach?

16 A. It obviously isn't now, but at the time I did
17 the task I was given, so I was given the task of
18 reviewing and bringing the obstetric information and
19 that's what I took to the meeting. However, hindsight
20 is a great thing.

21 Q. Yes. Okay. And the final question just to
22 ask you to confirm this, please. We know from other
23 evidence, I am not going to ask that it comes up on the
24 screen, but for the record of the transcript,
25 INQ0025743, it is the email from Dr Gibbs reflecting
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1 I don't have a question for you about it. Thank
2 you.

3 But may we go, please, to page 5 of this document.
4 At item 11, the agenda item is "SUI update and other
5 incidents" and there are a discussion of a number of
6 incident reviews that have been raised to this meeting
7 and taken place.

8 Now, the 2 July '15 meeting was a Serious Untoward
9 Incident Review. That does not seem to have been
10 discussed at this meeting, some three weeks later.
11 Should it have been?

12 A. I mean, it obviously wasn't, but I can't, you
13 know, I don't know why that wasn't tabled at that
14 meeting.

15 Q. I didn't work in this hospital. Was that the
16 sort of reports, the sort of meeting that should have
17 been tabled here?

18 A. I mean, certainly it should, the, the concern
19 should have been escalated further.

20 Q. I mean, in terms of escalation, Alison Kelly,
21 the Director of Nursing, was in that meeting, so she
22 would have had --

23 A. She called that meeting.

24 Q. She called the meeting?

25 A. Yes.
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1 Q. She was aware of everything that was
 2 discussed. Could she have brought that to this meeting?
 3 She wouldn't have had to escalate it to anybody, she
 4 knew about it. Is that a fair inference?
 5 A. Sorry, can you --
 6 Q. Is that a fair inference, is that a fair
 7 comment that I have just made that she was aware of
 8 those --
 9 A. Yes, she was aware. Yes, she called the
 10 meeting. She was fully aware.
 11 Q. Okay. Thank you. That can come down.
 12 In relation next to the Brigham report as it's been
 13 called.
 14 A. Yes.
 15 Q. You told us that there was an awareness that
 16 there had been an increase in the number of deaths from
 17 your perspective, stillbirths and neonatology deaths,
 18 and so the review had been commissioned. What I was
 19 interested in, please, is how did you capture that
 20 information that there had been an increased rate of
 21 mortality?
 22 A. Data.
 23 Q. What does that mean? What did you actually do
 24 or who did it?
 25 A. So within data -- well, for a start the
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1 Q. Because do you see what -- the direction of my
 2 question? The data might be there on the Datix --
 3 A. Yes.
 4 Q. -- but somebody has to be prompted to go and
 5 draw it out. That hasn't happened in the NNU until
 6 later and so really I am trying to understand the
 7 process on your side, how that worked, and why it might
 8 not have worked on the other side.
 9 A. I can't answer for why it didn't work in
 10 neonatology because I wasn't responsible for this area
 11 of practice.
 12 But from a midwifery and obstetric point of view we
 13 were constantly looking at what was happening in our
 14 area and what our outcomes were.
 15 Q. Okay. And there was that discussion between
 16 the senior clinicians --
 17 A. Yes.
 18 Q. -- and you that crystallised that
 19 understanding?
 20 A. And we felt that the only way forward we could
 21 be assured that we didn't have a problem was to do
 22 a review and being open and transparent we invited an
 23 external Head of Midwifery from the Manchester network
 24 to join that review.
 25 Q. Did you consider inviting neonatologists to
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1 Consultant obstetricians would be aware from being based
 2 on the labour ward, but from Datix.
 3 Q. Okay. So who is it who is going into Datix on
 4 your side to notice those trends, to identify them and
 5 to action them with the review. Who's doing that work?
 6 A. So not only the risk and safety leads but all
 7 of the ladies who have stillbirth, they have
 8 a Consultant review, they go to the Pregnancy Risk
 9 Clinic, and also the neonatal deaths were having
 10 an obstetric secondary review.
 11 So because of an index of suspicion, we ran a Datix
 12 report.
 13 Q. So but -- so you have identified I think the
 14 risk leads on the unit, they were the people who were
 15 actually doing this?
 16 A. There is one risk lead for women and
 17 children's service, and they were asked to pull a report
 18 for us.
 19 Q. Okay. And who made that request?
 20 A. I can't remember.
 21 Q. But it sounds like it was a matter of
 22 discussion between you and the clinicians?
 23 A. It was -- it was myself and the Consultants
 24 but I couldn't tell you exactly who will have said pull,
 25 pull the list, due to the time lapse.
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1 join your review?
 2 A. No, because it was purely a review of
 3 obstetric care, so they wouldn't be able to contribute
 4 to reviewing whether people were on the right pathway or
 5 had the right drugs, et cetera.
 6 We were also aware that they would be doing
 7 a review of their own.
 8 Q. How did you have that awareness?
 9 A. One of the -- one of the Consultants had said,
 10 "Well the paed's are doing a review as well." So it was
 11 a verbal -- that we had been told verbally.
 12 Q. But the Brigham review, as I understand it, is
 13 finished in November?
 14 A. Yes.
 15 Q. It's presented --
 16 A. In December.
 17 Q. -- in December.
 18 A. Yes.
 19 Q. And there is nothing from the neonatology side
 20 in November, there is nothing in December.
 21 A. I can't account for the practices within the
 22 neonatology unit.
 23 Q. No. You have been asked -- you have already
 24 candidly conceded, and I am grateful, that on reflection
 25 looking at that Brigham report it is potentially
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1 misleading.

2 **A.** Definitely, definitely.

3 **Q.** Right. And may we please just look at -- it
4 is a document we have looked at before but we are going
5 to look at it again briefly, if we may. It is the
6 emails with Alison Kelly.

7 **A.** Yes.

8 **Q.** INQ0003220.

9 So we start at the bottom. So the question is
10 coming to you on the 2 December by which time the
11 Bringham report has been produced but it has not been
12 presented.

13 **A.** Yes.

14 **Q.** "Hi, where are things up to with the thematic
15 review? I am keen to get a paper to the
16 December QSPEC."

17 Now -- and you reply:

18 "Hi, the updated midwifery element was received
19 in November at QSPEC. It was the paed update that was
20 missing."

21 Now, it may be suggested that Alison Kelly was one
22 of those who received the report and was misled by it to
23 begin with, thought it was a comprehensive document --

24 **A.** No, no.

25 **Q.** -- rather than just obstetrics?

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1 **A.** Because Alison Kelly has written at the top:
2 "Despite terminology below this was an
3 obs/maternity review."

4 That's Alison Kelly's handwriting.

5 **Q.** That's her handwriting? That's really
6 helpful. Thank you. So that's the manuscript --

7 **A.** That's Alison Kelly's handwriting at the top,
8 I recognise that.

9 **Q.** That's really helpful. Thank you.

10 Because I just -- in that light, I would just like
11 to look at the minute of the December QSPEC, please.

12 That is INQ0003204, and can we start at page 11.
13 It may be that I have given you the wrong --

14 **LADY JUSTICE THIRLWALL:** Do you mean page 11 or
15 paragraph 11?

16 **MR JAMIESON:** I mean page 11 but that was not the
17 document I was expecting.

18 **LADY JUSTICE THIRLWALL:** I think you might mean
19 paragraph 11, 0005.

20 **MR JAMIESON:** So what I was hoping to see was the
21 minutes of the QSPEC committee.

22 **LADY JUSTICE THIRLWALL:** Yes.

23 You have given the right reference.

24 **MR JAMIESON:** I have, okay, it is just not what has
25 come up in front of me.

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1 **A.** No, because Alison Kelly emailed myself and
2 Ruth Millward on 2 December. So myself, for the
3 obstetric, and Ruth Millward, for the neonatal, because
4 Ruth Millward played no part in our decision to review
5 or our review.

6 And she's also copied Ian Harvey into the email.
7 So that's why I said it was the paed element that was
8 missing and so that's why Ruth was copied in because
9 then she would be chasing up the neonatal element.

10 **Q.** Yes. So you have said that in terms, haven't
11 you, on 2 December, the updated midwifery element was
12 received in November, that document that I gave you
13 in November was the midwifery element, it's the paed
14 update that's missing.

15 **A.** Yes.

16 **Q.** But her reply at the top of that:

17 "Hi, sorry if I haven't been clear. I mean the
18 thematic review of neonatal/deaths recently undertaken
19 ..."

20 I don't, in fact, think I can put any particular --
21 it will be for her to explain what that meant.

22 **A.** So that, that is the neonatal review.

23 **Q.** Yes. Which you have said in the email below
24 is midwifery element only, and just to bottom this topic
25 out, please, can we go to the minutes.

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1 **LADY JUSTICE THIRLWALL:** I hadn't noticed that.

2 **MR JAMIESON:** And my Lady is quite right. It is
3 paragraph 11, not page 11.

4 It is page 5, please.

5 Right. Now, my learned friend Ms Brown took you to
6 this paragraph and I am not going to repeat what she's
7 done already. It is the minute of your presentation of
8 the neonatal and stillbirth review. What I would like
9 to do, though, is having orientated us there, just go
10 over the page to page 6, because the final sentence
11 says:

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

15 Now, as I understand your evidence, your
16 explanation to QSPEC had been: this is our report, it
17 only deals with maternity, we have not found any
18 shortcomings with it, we have an action plan to pick up
19 the items of improvement that we have identified.

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

21 **Q.** That's accurate?

22 **A.** Yes.

23 **Q.** And so nobody listening to that should have
24 taken assurance that it answered concerns on the
25 neonatal side.

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1 A. No, because they were aware of my remit.
2 I made it clear it was obstetric and maternity only and
3 Sian Williams in her statement makes reference to the
4 fact that this report was an obstetric report only which
5 confirms that that's what I verbally said at the
6 meeting.

7 Q. Yes. There are no -- what you had also said
8 in that email that we looked at a moment ago was that
9 the neonatal review was still outstanding.

10 A. Yes.

11 Q. But there is nothing here in terms of an
12 action or a plan taking forward that suggests the
13 committee were awaiting that report or expecting that
14 report.

15 A. No, it's not evident in that and I -- no, it's
16 not evident in these minutes. But that would be
17 something for Alison Kelly and Ruth Millward to chase
18 outside of the meeting.

19 Q. That was your expectation?

20 A. That would be my expectation.

21 Q. But didn't QSPEC have a role in monitoring
22 these issues, making sure that actions were completed?

23 A. Definitely, yes.

24 Q. So if, on this very serious issue an increase
25 in neonatal deaths and stillbirths, half of the review

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1 position of Director of Risk, okay?

2 So the risks that are or have been identified by
3 Mother E/F in the evidence that she has heard, in the
4 criminal trial and here, in staff using their mobile
5 phones on the unit is principally a blurring of the
6 lines between the personal and the professional because
7 this Inquiry and indeed the criminal trial have received
8 evidence of messages between clinicians, of friendly
9 run-of-the-mill conversations, lighthearted social
10 conversations, that then have interwoven an exchange of
11 deeply personal and often tragic personal data that
12 related to the children who died.

13 And the question is: was that a risk that the Trust
14 was aware of at the time that you were Director of Risk
15 Management?

16 A. So this is the first time I have heard that
17 piece of information.

18 Q. Okay.

19 A. It wasn't something that I was familiar with.

20 Q. Okay. Were there any policies or rules that
21 governed the use of personal mobile telephones on the
22 NNU?

23 A. Not on the NNU, no. I would say that mobile
24 personal phones were used not only in the Countess but
25 widely throughout all of the NHS because staff are not

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1 has been completed but the other half hasn't, shouldn't
2 that have been formally on the agenda for future QSPECs?

3 A. Well, I don't know whether, aside from the
4 meeting, whether there were any emails being sent to the
5 relevant people asking where the reports were. Because
6 I wouldn't be privy to that information.

7 Q. But as somebody who sat on this board, if
8 I come to the next meeting of this committee and I am
9 asked to review the minutes, I am not going to be
10 looking, I am not going to be prompted to look for any
11 additional review from the NNU in relation to these
12 deaths. I am going to read that and it says, "Assurance
13 has been provided, no further actions."

14 A. I suppose that Alison Kelly knew that there
15 was a need for a neonatal review as did Ian Harvey, the
16 Medical Director.

17 Q. Okay, thank you very much. That can come
18 down.

19 The final topic is different to everything that we
20 have talked about before and it comes from one of the
21 Families that I represent and the concern that's raised
22 is about the use of mobile telephones on the NNU.

23 Now, I know that you didn't work on the NNU --

24 A. Yes.

25 Q. -- and so I am asking you really from your

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1 issued with a works telephone.

2 Q. But if that risk that I have identified is
3 present, that measure that you have just mentioned, the
4 issuing of a staff telephone, might be an effective one
5 to reduce that risk?

6 A. I mean, it's very sad to hear what you have
7 said about the, you know, the messages. I can say I had
8 no personal knowledge of that until you have just raised
9 it now.

10 MR JAMIESON: Thank you very much. Those are all
11 my questions.

12 Thank you, my Lady.

13 LADY JUSTICE THIRLWALL: Thank you very much,
14 Mr Jamieson.

15 I have no questions for this witness. We are
16 finished now?

17 MS BROWN: Yes.

18 LADY JUSTICE THIRLWALL: Thank you very much
19 indeed, Mrs Fogarty, you are free to go.

20 Are we going to take the break now?

21 MS BROWN: I think that's the suggestion and then
22 there is going to be a summary of evidence after the
23 break.

24 LADY JUSTICE THIRLWALL: Very good. We will
25 recommence at quarter to 4.

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1 (3.28 pm)

2 (A short break)

3 (3.46 pm)

4 **LADY JUSTICE THIRLWALL:** Yes, Ms Lyons.

5 **MS LYONS:** My Lady, this is the summary of the
6 evidence of nurses and midwives.

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

8 Summary of Evidence of NURSES AND MIDWIVES

9 **MS LYONS:** My Lady, the Inquiry local team sent
10 Rule 9 requests to 30 nurses who were involved in the
11 clinical care or management of babies on the indictment
12 at around the time of collapse and/or death.

13 20 other nurses who worked on the neonatal unit and
14 all 14 midwives who appeared in the hospital staff list
15 were sent questionnaires. Any individual who worked
16 there during 2015 and 2016 and who considers they might
17 have relevant evidence to give the Inquiry should
18 contact the Inquiry. It remains the case that the
19 Inquiry remains open throughout the course of these oral
20 hearings to receive such evidence.

21 This is a summary of the evidence of nurses who are
22 not being called to give oral evidence. Collectively,
23 they have provided 22 witness statements and completed
24 20 questionnaires. This summary also incorporates the
25 evidence of the midwives. The nurses and midwives have
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1 providing clinical care to special care babies since
2 2008. She described this period as:

3 "... very busy and stressful on the unit. We would
4 sometimes miss breaks because it was that busy. Staff
5 morale was low because everyone was tired. However,
6 I always felt supported and valued."

7 Most of the nurses commented positively about the
8 quality of management, supervision and/or support that
9 they received during this period from the NNU ward
10 manager Eirian Powell and the deputy ward manager
11 Yvonne Griffiths.

12 Of the Band 6 nurses concerned, Laura Eagles
13 described the ward manager and deputy ward manager as
14 "very present, approachable and strong in their
15 leadership".

16 Caroline Oakley also described Eirian Powell as
17 "approachable, helpful and supportive", as did Ailsa
18 Simpson who stated that Eirian Powell was "supportive
19 and appreciated all our hard work as a team during an
20 extremely difficult period."

21 Other Band 6 nurses such as Caroline Bennion
22 described Eirian Powell and Yvonne Griffiths as "very
23 supportive, approachable and proactive with personal
24 development. Learning opportunities, study days, and
25 courses were often recommended and encouraged".
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1 responded to specific questions in connection with the
2 issues under investigation. We are grateful for their
3 co-operation which is of assistance to the Inquiry's
4 work.

5 This summary sets out their responses to questions
6 about the culture and atmosphere on the NNU between 2015
7 and 2016, suspicions or concerns about Letby, the
8 mortality rate, and what changes should be made to keep
9 babies in the NNU safe from deliberate harm.

10 Culture and atmosphere on the NNU at the hospital
11 from 2015 to 2016.

12 Many of the nurses concerned described June 2015 to
13 June 2016 as a particularly busy period on the NNU.

14 Christopher Booth, a Band 6 nurse, who had been working
15 on the NNU since 1993 recalled it being:

16 "... an incredibly busy period with high acuity and
17 it was a demanding time for all team members. As so
18 much time has now passed my memory is somewhat sketchy
19 but I do remember team members being asked to show
20 greater flexibility with shifts worked and indeed even
21 being asked to work extra shifts on a regular basis.
22 I do remember grumbings of us needing more registered
23 nurses to help cope with the increased workload but that
24 did not seem to be forthcoming."

25 Lisa Walker, a Band 4 nursery nurse, had been
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1 Both Joanne Williams and Amy Davies said they felt
2 supported within the nursing team and were encouraged to
3 further their qualifications and training.

4 Nurse X noted that Eirian Powell was "open to
5 general concerns or issues being raised". She also
6 said:

7 "Eirian Powell could be defensive of nurses on the
8 unit and would generally support nurses if issues were
9 raised by doctors, for example. That said, she had
10 obvious favourites amongst the staff as well as a couple
11 of staff that she clearly did not like. This meant that
12 her response to issues, incidents varied depending on
13 who was involved."

14 Belinda Williamson described Eirian Powell as
15 "generally very supportive and fair". She also stated:

16 "If I had a problem she was approachable and would
17 generally work with me to solve the problem. She would
18 often ask for the problem to be put in writing if she
19 felt it was necessary to have a record of the issue.
20 She encouraged the team to actively fill out Datix.
21 Eirian supported us with trying to ensure we had
22 adequate staffing levels and often asked us to enter
23 a Datix if staffing levels were insufficient."

24 As regards the deputy ward manager Yvonne Griffiths
25 Belinda Williamson commented that she worked well with
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1 Eirian Powell:

2 "They balanced each other out and appeared to work
3 well together."

4 She expressed the view that:

5 "At times it did feel that some staff were given
6 opportunities based on who they were, not their
7 abilities and/or experience. Staff were encouraged to
8 improve their knowledge and skills through further
9 training and education as well as secondments at
10 tertiary centres. At times it felt staff were allocated
11 infants above their capabilities due to the workloads
12 occurring within the unit, relying on the nurse in
13 charge or senior nurses to oversee their work."

14 Anne Murphy was the "matron of the women and
15 children's ward", known in the Inquiry as the Lead Nurse
16 for Children Services. Ailsa Simpson described
17 Anne Murphy's management style as "very supportive".

18 Nurse Y gave similar evidence. She said that
19 Anne Murphy was:

20 "Always contactable and supportive in the absence
21 of management on the NNU".

22 Minna Lappalainen was less positive about the
23 hospital's senior management who she felt "didn't
24 support us or listen to staff or the NNU manager". She
25 expressed the view that "our staffing levels remained

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1 supportive and did pass on any concerns I raised
2 regarding staffing levels to her manager. I found the
3 unit very stressful during this period due to increasing
4 staff shortages and the increasing workload that was
5 being expected of a Band 4. Even though I was
6 an experienced Band 4 nurse I had not seen the staffing
7 issues as bad as I had in 2015 to 2016. I was being
8 asked to complete tasks that I was under qualified for,
9 ie babies that required a Band 5/6 nurse. When I raised
10 these concerns to fellow colleagues I felt very under
11 supported."

12 In 2015 to 2016 Claire Bevan worked predominantly
13 night shifts as a Band 6 bank nurse on the NNU. During
14 these shifts she described either being in charge or
15 second in charge of the NNU, co-ordinating staffing and
16 care and allocating patients and staff for the shift as
17 well as supporting staff. As to the quality of the
18 management of the NNU between June 2015 and June 2016,
19 she said:

20 "Some staff found management more approachable than
21 others. The unit generally felt neglected by senior
22 management as we were constantly short-staffed and it
23 appeared they weren't listening to our requests for
24 help. If we had sickness on shifts it was always very
25 hard to get help from other areas of the hospital. We

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1 poor at times especially during busy periods. This
2 period was stressful and exhausting at times."

3 Bernadette Butterworth, Mary Griffith,
4 Sophie Ellis, and Samantha O'Brien were Band 5 neonatal
5 nurses in 2015/2016. They all describe the management
6 on the NNU as supportive.

7 As a junior Band 5 nurse working on the NNU between
8 2015 and 2016, Sophie Ellis found the nursing managers
9 "supportive, approachable and knowledgeable". She felt
10 able to talk about personal and professional matters
11 with the nursing managers and felt "they listened to
12 [her] with compassion".

13 Bernadette Butterworth recalled there being a good
14 team spirit where the nurses would all support each
15 other.

16 Of the Band 4 nursery nurses who had dealings with
17 the NNU managers the majority reported feeling largely
18 supported. Jean Peers said:

19 "I would describe the quality of management and
20 supervision as supportive, close and caring, as were the
21 nurses on the NNU."

22 However, Cheryl Cuthbertson-Taylor experience of
23 the culture and atmosphere on the NNU differed. She
24 said:

25 "My line manager between 2015 and 2016 was

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1 felt like we were on our own. I think people were
2 frightened to come and help because it was such a niche
3 area of nursing."

4 Each of the nurses was asked to describe the
5 relationship between (1) clinicians and managers, (2)
6 nurses, midwives and managers, and (3) between medical
7 professionals -- doctors, nurses, midwives and others --
8 at the hospital between June 2015 and June 2016.

9 Several of the Band 6 nurses gave evidence that
10 there was a good relationship between the neonatal
11 nurses and the doctors.

12 Laura Eagles recalled that the nurses worked well
13 with the doctors, particularly the Registrars and senior
14 house officers. She describe the Consultants as
15 approachable. Joanne Williams also commented on the
16 close working relationship the nurses had with the
17 Registrars who she recalled were present on the NNU most
18 of the time when acuity was high. She described the
19 relationships across the different professions as
20 professional.

21 Nurse Y described the Registrars who were allocated
22 to the NNU as very experienced and appeared to have
23 a good rapport with the nurses.

24 As regards the nature of the relationships with the
25 Consultants she said she had "worked on the unit for

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1 a long time" and that she felt she had "a good rapport
2 with Consultants".

3 Ailsa Simpson recalled there being stressful
4 periods at times. She stated:
5 "Sometimes when a baby required a review by
6 a doctor they wouldn't always be available to attend
7 straight away as they would be reviewing patients on the
8 children's ward first. Overall, despite the [busyness]
9 of the NNU, the doctors and nurses on the NNU
10 collaborated well together as a team and the atmosphere
11 was happy at times despite the stressful phases."

12 Belinda Williamson noted:
13 "There was frustration with the medical team at
14 times due to lack of cover for neonates, especially
15 overnight, or if the team became busy on A&E or on the
16 paediatric unit."

17 Christopher Booth described the relationship
18 between the medical professionals during this period as
19 good. He also said:

20 "We were a strong, mutually supportive team and all
21 worked well together for the well-being of our babies
22 and their families. My only slight concern though, and
23 it is a concern that I have held for some time, is that
24 we at the Countess of Chester Hospital really could have
25 benefited from the expertise of a neonatologist who

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1 with midwives. There was very little communication
2 between us and the obstetricians. If we had challenging
3 conversations to have, we would ask our Consultants to
4 speak with them. We would sometimes face discord from
5 some senior midwives and ourselves. This would be in
6 relation to when we were heading to full capacity or
7 already at it and the midwifery team not valuing our
8 concerns. It could be quite a struggle sometimes when
9 we were full and then wanting to deliver a baby that
10 would need our care and us not having room. We would
11 ask them for help and some appreciation of our situation
12 but would not get it. I cannot say this was all the
13 time but it was quite common to have a struggle when we
14 were getting full and/or closed. If we as an NNU team
15 felt the best thing for the pending admission was
16 a transfer out, it would be very difficult to make this
17 heard by the obstetric team."

18 In her evidence to the Inquiry, Caroline Oakley
19 discussed the strain in the relationship between the NNU
20 and obstetric teams when the midwives/obstetricians did
21 not accept that the NNU was at full capacity and could
22 not admit any more babies. She said that neonatal
23 nurses would report such incidents via an online
24 reporting system, Datix.

25 Susan Morton was employed by the hospital as a

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1 could offer more specific, focused and cutting-edge
2 expertise in this very specialised field."

3 Abigail Lever, a Band 5 neonatal nurse stated that
4 there has "always been a really good relationship
5 between doctors and nurses."

6 In 2015 to 2016, Band 5 neonatal nurse Satasha
7 Culshaw worked ad hoc shifts on the NNU that required
8 cover. She cared for special care and high dependency
9 care babies. She said:

10 "The staff I worked with all had a strong sense of
11 teamwork ... I felt there was a good sense of teamwork
12 between all members of staff that I worked alongside.
13 I never got a feeling that there were any issues between
14 colleagues."

15 Janet Cox, a Band 4 nursery nurse who had worked at
16 the hospital from 1986 to 2022 stated that she did not
17 have a clear memory of the relationships between
18 clinicians and managers and medical professionals. She
19 also stated that she did not wish to comment "as [her]
20 view the Trust and various so-called medical
21 'professionals' is prejudiced by the horrendous way they
22 treated Lucy, (Ms Letby)".

23 As to the relationship between neonatal nurses and
24 midwives, Laura Eagles described this as:

25 "More complex. "We as nurses would directly liaise

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1 Band 6 rotational midwife in 2015 to 2016. She worked
2 on the central labour ward, antenatal/postnatal ward and
3 within the maternity day unit. She described the extent
4 to which she carried out work on or in connection with
5 the neonatal unit between 2015 and 2016 as follows:
6 "If I was working on the labour ward and a baby
7 required any care or observation on the neonatal unit
8 immediately following birth, the baby may have been
9 transferred to the unit by the neonatal team. I would
10 complete a situation background assessment and
11 recommendation handover to a member of the NNU team.
12 This is a recognised tool we use in medicine to give
13 a clear and concise handover and would detail any
14 relevant risk factors from the mother's pregnancy,
15 labour and delivery. When working on the postnatal ward
16 a nursery nurse from the NNU would be allocated to the
17 ward's transitional care room. This was a 3-bedded bay
18 and may include, for example, babies who were slightly
19 premature requiring additional observation, feeding,
20 support, temperature monitoring, or phototherapy. As
21 midwife I would be caring for the mother and the nursery
22 nurse would be responsible for the care of the baby. In
23 these situations I liaised with the neonatal nursery
24 nurse who was caring for the baby. If a baby was being
25 cared for on the NNU, mum may be staying in a single

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1 room on the postnatal ward. If mum was unable to
 2 mobilise independently then a member of ward staff, on
 3 occasion a midwife, would transfer mum to the NNU in
 4 a wheelchair to feed and spend time with her baby. At
 5 that time any baby born on antibiotics had to be
 6 transferred from the ward to the NNU each time their
 7 medication was due as the drug and dose required
 8 checking by two of the registered nurses. On occasions
 9 that the parents or a member of the neonatal staff were
 10 unable to transfer the baby they sometimes asked
 11 a midwife or a midwifery assistant to take the baby to
 12 the unit. I cannot recall if I did this as during this
 13 time period I had completed six months' experience as
 14 a labour shift leader then went back to being a Band 6
 15 midwife."

16 Susanne Boggan qualified as a registered midwife in
 17 2014 and commenced work at the hospital between
 18 October 2014 and November 2015 as a Band 5 rotational
 19 midwife. She described the extent to which she carried
 20 out work on or in connection with the neonatal unit
 21 between 2015 and 2016 as follows:

22 "I would primarily have contact with the neonatal
 23 team if their attendance was required at a birth where
 24 it was anticipated the baby may need assistance or
 25 monitoring outside of midwifery scope of practice, for
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1 whistle-blowing formally. However, I am aware of how to
 2 raise concerns. The process would be to inform the
 3 manager, or higher, if necessary, and to complete
 4 a Datix incident form depending on the type of
 5 concerns."

6 Caroline Bennion:
 7 "We had a good relationship with our immediate
 8 management team to feedback any concerns we may have had
 9 regarding colleagues, unsafe practices and not adhering
 10 to policies. The manager at the time Eirian Powell was
 11 very keen for staff to openly report incidents through
 12 Datix and log concerns with a no-blame culture. I was
 13 aware of the Freedom to Speak Up but at the time I would
 14 not have known who to approach or the process for
 15 doing so."

16 Bernadette Butterworth:
 17 "With regards to any training we had been given
 18 regarding reporting concerns involving fellow members of
 19 staff I cannot recall what training we received at the
 20 time apart from discussing concerns with the manager.
 21 We now receive Speak Up core training for all workers
 22 which is mandatory for all staff."

23 Amy Davies:
 24 "I cannot recall whether we had specific training
 25 on how to report concerns about members of staff at the
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1 example instrumental or operative births, premature
 2 babies, or babies who required resuscitation at birth.
 3 In such cases it was usually a neonatal doctor who would
 4 attend first and the team would include senior neonatal
 5 nurses if their assistance was required. I would also
 6 come into contact with the neonatal nurses if a baby in
 7 my care was receiving intravenous antibiotics as it was
 8 the neonatal nurses who would come to administer those.
 9 If a baby required admission to the NNU after birth,
 10 I would often accompany the parents to the NNU to see
 11 their baby once the mother was well enough.
 12 Occasionally, I would see the NNU shift leader when they
 13 would come to the labour ward to ask for updates on any
 14 anticipated birth that might require their presence. On
 15 one occasion I cared for a family in the bereavement
 16 suite after their baby had unexpectedly passed away and
 17 two neonatal nurses attended to help with bathing the
 18 baby and memory making, taking photos, hand and
 19 footprints."

20 Concerns or suspicions.

21 While few of the nurses could recall receiving
 22 specific training on how to report concerns about fellow
 23 members of staff, they were all aware of how to do so.

24 Laura Eagles:

25 "I do not recall ever having any training on
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1 time. However, I know I knew about whistle-blowing and
 2 I felt confident that I could report any concerns to my
 3 line manager or higher management if I had concerns and
 4 I would have done so if I had any concerns."

5 Nurse Y:

6 "As a senior member of staff if I had concerns
 7 regarding another member of staff I would report this to
 8 my line manager in confidence or raise my concerns via
 9 email if they were not available at that time. As
 10 a registered nurse, it would be my responsibility to
 11 escalate any concerns about patient safety to the unit
 12 manager, or matron in her absence. This is the
 13 ethically correct course of action and follows the
 14 standard set by the NMC Code of Conduct."

15 Caroline Oakley:

16 "To the best of my knowledge I was not given any
 17 training on how to report concerns about fellow members
 18 of staff. As a senior member of the nursing team and
 19 depending on nature of my concerns, I would either speak
 20 to the member of staff or escalate the issue to my
 21 manager."

22 Sophie Ellis:

23 "I cannot remember whether we received any formal
 24 training about how to report concerns about another
 25 member of staff although if I did have any general
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1 concerns, I know that I could speak to my line manager
2 and escalate as appropriate if needed."

3 Mary Griffith:

4 "I would have been aware of how to report concerns
5 about fellow members of staff. I knew that concerns
6 should be reported to the unit manager."

7 Valerie Thomas:

8 "I cannot remember ever attending formal training
9 on reporting concerns but I knew I could go and report
10 at any time with my ward manager."

11 Claire Bevan:

12 "Annual training updates included whistle-blowing
13 updates. I cannot remember the detail but throughout my
14 training and career as a nurse, I was always taught that
15 any concerns about staff, procedures, protocol not being
16 followed, et cetera, should always be raised. There was
17 lots of information on the intranet about how to do it.
18 I believe that most senior staff on the neonatal unit
19 were approachable. Even if a junior member of staff
20 felt uncomfortable approaching management directly, the
21 friendship groups within the neonatal unit were such
22 that all staff, either directly or indirectly, had
23 a route to raise concerns. I cannot think of any member
24 of staff on the unit that if they felt for whatever
25 reason they couldn't follow official channels didn't

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1 "Yes, I have had training and am aware of processes
2 such as Datix incident reporting and whistle-blowing.
3 From what I can remember any concerns to be reported
4 between 2015 onwards were to be reported, as always,
5 through Datix incident reporting or, if this was not
6 suitable or feasible to do so, there was the option to
7 use the Freedom to Speak Up policy -- I'm not sure
8 whether it was called this at the time -- and report to
9 higher-ranking person."

10 Overwhelmingly none of the nurses had any concerns
11 or suspicions about the conduct of Letby while she
12 worked on the NNU.

13 Ailsa Simpson had no concerns but felt that Letby
14 involved herself more -- with more babies than she
15 needed to be involved in:

16 "For example, if a baby collapsed or required
17 cardiopulmonary resuscitation but [Letby] wasn't caring
18 for that baby she would involve herself anyway despite
19 being told by a shift leader that she needed to look
20 after her own babies."

21 Ailsa Simpson also recalled:

22 "After the death of the third or fourth baby it was
23 generally noted that she (Lucy Letby) was involved in
24 each case. This was the only point that the NNU staff
25 observed. At that point, I did not consider that she

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1 have someone relatively senior to discuss concerns with,
2 that then would have been formally reported."

3 The majority of the midwives had no recollection of
4 having received any training on how to report concerns
5 about a fellow member of staff. However, they all knew
6 how to escalate concerns to their line management or any
7 other manager that was felt appropriate.

8 Some midwives would have also reported any concerns
9 regarding patient care via the Datix system. Those
10 midwives who had received training said. Susan Morton:

11 "Training on how to escalate and report any
12 concerns about fellow staff members was disseminated as
13 part of mandatory study days via training modules,
14 emails and campaigns, such as the 6 Cs which were the
15 core values of the hospital at the time: care,
16 compassion, commitment, courage, communication and
17 competence."

18 Rachel Wright:

19 "I was given training on how to report concerns
20 about fellow members of staff during midwifery training
21 in university and at the start of my career within the
22 mandatory study days that I attended. Any concerns were
23 to be reported with the member of staff, shift leader or
24 manager."

25 Deborah Moore:

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1 was the cause of the issues and I thought that her
2 involvement might just have been a coincidence."

3 Vicky Blamire said:

4 "It wasn't until finding out about more and more
5 fatalities that questions were asked about which members
6 of staff were present at the time as this would have had
7 a big impact on their mental health. Hearing Lucy's
8 name with every occasion made me feel very uncomfortable
9 as she didn't show any kind of emotion. I remember
10 feeling very shocked and confused as to why she didn't
11 seem to be upset. This was very unnerving."

12 Cheryl Cuthbertson-Taylor did not have any
13 concerns or suspicions about Letby's care of the babies
14 or as a nurse. She did, however, find Letby a little
15 odd and said she was aware of several staff who felt the
16 same way about her.

17 Nurse Y had no concerns about Letby and was not
18 aware of any. She explained:

19 "As a full time Band 5 neonatal practitioner who
20 also worked regular overtime shifts with the relevant
21 qualifications to care for intensive and high dependency
22 care patients, Letby was regularly allocated the sicker
23 infants on shift. Band 5 nurses do not take charge of
24 the NNU, I remember her being taken off night shifts to
25 work only day shifts at some point. I had presumed this

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1 was to protect her own well-being as she had been
2 present for a number of deaths on the unit."

3 Janet Cox had no concerns or suspicions about
4 Letby's conduct. In her view, Letby was "An exemplary
5 nurse who is completely innocent of all the alleged
6 crimes."

7 Ms Cox could not recall the precise dates when she
8 became aware of the suspicions or concerns of others
9 about Letby but she does recall "gradually becoming
10 aware that certain Consultants, in particular Brearey,
11 appeared to be trying to make Lucy a scapegoat for the
12 increased number of deaths/collapses".

13 Joanne Williams did not have any concerns or
14 suspicions that Letby was deliberately harming babies on
15 the NNU. However, following the collapse of Child K on
16 17 February 2016, Dr Ravi Jayaram approached
17 Joanne Williams wanting to know what had happened to
18 Child K. She said:

19 "After this I thought he may have had concerns
20 about Letby."

21 Other nurses were only aware of the concerns or
22 suspicions of others regarding Letby's conduct after
23 July 2016 when she was seconded to another department
24 and the NNU was downgraded.

25 None of the midwives had any concerns or suspicions
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1 a death and collapse of a baby. All staff involved
2 including the midwifery and obstetric staff, where
3 appropriate, would be invited too. A formal meeting
4 would be arranged and sent out by the Consultant to all
5 staff involved later."

6 Christopher Booth gave similar evidence. He said:

7 "After the death of a baby formal debriefs did
8 occur usually a few days after the event. I did not
9 attend any formal debriefs as either I was working on
10 a night shift or chose not to attend. I did, however,
11 make use of informal debriefs with colleagues where we
12 would talk, discuss, assimilate, and try to rationalise
13 what had happened."

14 Belinda Williamson said:

15 "[Debriefs] depended on the circumstances of the
16 death as to when or if a debrief occurred. It was
17 voluntary for nursing staff to attend. If the ward
18 manager or medical staff wanted us to attend it was
19 generally arranged for a day when we were back on shift
20 and available to attend. As a member of staff you could
21 ask for a debrief with the medical team and raise any
22 questions you had regarding the event even if the
23 medical team did not necessarily know the answer. We
24 could also ask verbally for the post-mortem results once
25 they were completed. Nurses tended to discuss the
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1 about Letby's conduct. Most of the midwives did not
2 know Letby or had not worked with her. They became
3 aware of the increase in the number of deaths on the NNU
4 as a result of the police investigation and/or from the
5 media following Letby's arrest.

6 The nurses were asked whether discussions or
7 debriefs, formal or otherwise, with or between nurses or
8 between nurses and doctors, took place following the
9 death of a baby. Most of the Band 4 nursery nurses said
10 they did not participate in these types of discussions
11 or debriefs. Vicky Blamire explained that this was not
12 unusual because Band 4 nurses only cared for special
13 care babies and babies who were getting ready to be
14 discharged.

15 Caroline Oakley's evidence is that there was and
16 still is no formal protocol for debriefs.

17 Laura Eagles described then as "informal and
18 ad hoc".

19 There would be discussion led by a Consultant about
20 the case and how everyone felt. Amy Davies explained
21 that there was no formal process to discuss an
22 unexpected event or unexpected response from a baby to
23 treatment.

24 Caroline Bennion stated:

25 "There were always informal hot debriefs after
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1 events amongst colleagues if we felt we needed to."

2 Susan Needham, who worked at the hospital as
3 a midwife, said discussions with or between midwives
4 after the death of a baby at the hospital would depend
5 on how much input the midwives had had with the baby and
6 their family and whether the labour and delivery were in
7 some way significant to the demise of the baby.

8 She said:

9 "Midwives are always given the opportunity to
10 discuss the demise of a baby that dies at or soon after
11 birth. They will be given the opportunity to go through
12 the labour, to try and pinpoint any problem with their
13 care, and there was usually a multi-disciplinary meeting
14 held for midwives and doctors to attend and this had
15 been the process prior to, during, and after 2015 to
16 2016."

17 The mortality rate.

18 Most nurses described being aware of or worried
19 about the increase in the number of deaths on the NNU.
20 Laura Eagles:

21 "I was aware of the increase in mortality rate.
22 Obviously all deaths are concerning and it is important
23 to ensure that all clinical care has been reviewed to
24 make sure that it was correct. As far as I can recall,
25 the Coroner was informed of all the deaths. As I have
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1 previously mentioned, there was an increase in activity
2 on the unit and it felt there were more sick babies than
3 is usual. This could then explain why perhaps that
4 there were more deaths, in my opinion."

5 Christopher Booth:

6 "I was of course worried about the increased number
7 of deaths on the NNU. It was extremely harrowing and
8 emotionally exhausting. As I have outlined earlier, in
9 my mind the collapses and deaths could all be rationally
10 explained as we were experiencing an unprecedented level
11 of acuity with the NNU being at capacity or close to
12 capacity for such a long time. Water pressure was low,
13 which was not ideal for hand washing. It took time for
14 the issue to be resolved and it is only since the events
15 were investigated that I reflected upon it and saw it as
16 a potential factor in perhaps cases involving sepsis."

17 Caroline Bennion:

18 "I was personally alarmed or alerted to the number
19 of child deaths when one of the triplets died on
20 21st(sic) June 2016. I can remember asking my
21 colleague, although I can't recall who, about what had
22 happened. It was completely unexpected. They were
23 mature babies, born at 33 weeks, good weights, and
24 although they were receiving respiratory support they
25 were very stable. I wondered if there was a significant

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1 the consequence of the gravity of the babies' conditions
2 and the increased number of admissions."

3 Caroline Oakley:

4 "I was aware that 2015 to 2016 was a very busy year
5 and we had more vulnerable babies coming in from the
6 labour ward. I was aware of more deaths but due to the
7 increase in the number of vulnerable babies we were
8 caring for I did not think it was an unnatural result
9 that there were more deaths.

10 Janet Cox:

11 "Obviously any death is a worry, but I did not
12 think this at the time, nor do I think now, that there
13 was anything sinister about the increase in the number
14 of deaths/collapses. I do not see how you can set
15 a figure on how many deaths are acceptable in one
16 particular time frame. The very reason these babies
17 required admission to an NNU was because they had a high
18 chance of dying or collapsing."

19 Jennifer Jones-Key:

20 "I discussed with nursing staff about how busy we
21 had been and how sad it was with the run of babies
22 passing away. I was not concerned by the number of
23 deaths as we had had a very busy time and had been full
24 most of the time."

25 Claire Bevan:

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1 infection on the unit that we were missing. This was
2 a discussion with nursing staff although I cannot recall
3 their names, given that infection is always a concern in
4 relation to preterm babies. This was not a conversation
5 I had with the medical staff or outside the unit but it
6 was more of a speculation between the nursing staff."

7 Ailsa Simpson:

8 "The increase in the number of deaths on the NNU
9 during the period 2015 to 2016 was very concerning. It
10 is usually very rare for a baby to die and even if they
11 do, it's usually in cases where the babies are extremely
12 unwell, either with sepsis or if there is a congenital
13 abnormality."

14 Joanne Williams:

15 "I was aware and concerned about the increase in
16 the number of deaths on the NNU. I cannot recall
17 specifically when I became aware of the increase or what
18 I thought. At the time the acuity on the unit was
19 always high and we were caring for vulnerable patients.
20 It was very difficult for the team dealing with numerous
21 deaths feeling overworked and at times under
22 appreciated."

23 Mary Griffith:

24 "All staff on the NNU were concerned about the
25 number of deaths on the unit but regarded this as being

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1 "The increase was concerning but nobody to my
2 knowledge expressed any concerns including doctors. As
3 far as I am aware, although the deaths were unexpected
4 and some apparently unexplainable, nobody voiced any
5 concerns. In my recollection staff were discussing how
6 odd it was but there was never any suggestion of
7 anything untoward."

8 Nicola Dennison:

9 "I was not particularly worried about the increase
10 of the deaths on the neonatal unit because we had lots
11 of babies who were very poorly, some of which were born
12 to very poorly mothers, and as such our statistics
13 naturally increased. We also had a high instance of
14 congenital abnormalities, which included heart
15 conditions and gastroschisis, for example. We were at
16 maximum capacity for the majority of the time. However,
17 I do not feel that care was ever compromised."

18 Susan Morton:

19 "I remember being worried and concerned about the
20 high number of deaths in 2016. This was when I was
21 undertaking my developmental Band 7 labour ward shift
22 leader role. I was the shift leader on a day shift when
23 two of the three triplets died within a short period of
24 time. I recall hearing that the transport transfer team
25 were present when the second baby died and the parents

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1 had requested that the third baby be transferred to
 2 another unit.
 3 "I also recall that day that a decision was made to
 4 halt any elective inductions of labour and not commence
 5 any new inductions at that time. I don't however recall
 6 who this decision was made by. I remember feeling
 7 incredibly upset and shocked at the recent events and
 8 that morale was becoming increasingly low."
 9 Recommendations.
 10 The nurses were asked whether Letby's crimes could
 11 have been prevented if the babies had been monitored by
 12 CCTV. The majority doubted the efficacy of CCTV in
 13 preventing Letby's crimes.
 14 Ailsa Simpson expressed the view that even if CCTV
 15 had been in place at the time Letby would have found
 16 a way:
 17 "... as she had the intention to harm the babies."
 18 Christopher Booth stated that CCTV:
 19 "Would have little impact or effect. If a person
 20 is determined to commit any unlawful deed the CCTV
 21 camera system could be easily circumvented."
 22 Amy Davies pointed out that babies are not always
 23 in full view due to the incubators and incubator covers
 24 and the position of staff.
 25 She did not think CCTV would help.

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1 a nurse. On the issue of CCTV monitoring, she said:
 2 "I am undecided whether having the babies monitored
 3 by CCTV could have prevented the crimes of Letby. On
 4 the one hand, it could have prevented any harm coming to
 5 any baby by deterring her entirely. It could also have
 6 prevented some of the later crimes as perhaps once the
 7 medical team started to suspect Letby she may have been
 8 either deterred by knowing she was being monitored or
 9 caught via the CCTV.
 10 "Some of her crimes, such as injecting insulin into
 11 TPN bags and failing to act or request help when a baby
 12 was 'crashing', would have been detectable by CCTV.
 13 However, some of the ways in which she murdered or
 14 attempted to murder the babies were by using equipment
 15 that nurses handled all the time and by doing things
 16 which were very similar to routine tasks. What I am
 17 referring to here is when she used feeding tubes to
 18 overfeed the babies or insert air and intravenous lines
 19 to inject air.
 20 "On camera these actions might be indistinguishable
 21 from routine and correct procedures. For instance, it
 22 might not be possible to tell from CCTV whether
 23 a syringe has air or clear fluid in it or whether a baby
 24 is receiving more milk than their usual feed amount.
 25 These crimes may have been detectable later on once the

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1 Nurse Y, Minna Lappalainen, Joanne Williams,
 2 Mary Griffith, Lisa Walker and several other nurses
 3 expressed concern that the use of CCTV in clinical areas
 4 of the NNU was not appropriate and would interfere with
 5 the privacy rights of babies and their families.
 6 Belinda Williamson felt it would inhibit mothers
 7 from breastfeeding or expressing milk or having
 8 skin-to-skin contact, which would be detrimental to both
 9 babies and their parents.
 10 Nurse Y also considered it inappropriate to have
 11 CCTV monitoring of babies:
 12 "... during procedures or examinations when their
 13 private areas may be visible."
 14 It concerned her who might have access to these
 15 images. Nurse Y also stated:
 16 "As a practitioner, I would strongly object to CCTV
 17 monitoring and I feel it is an intrusion. It is not
 18 used in general nursing wards or in paediatric care so
 19 I feel it would be unnecessary and inappropriate."
 20 Satasha Culshaw pointed out the use of CCTV
 21 monitoring as a deterrent might be more effective in the
 22 drug dispensary where it might also be capable of
 23 capturing the commission of a crime.
 24 Shelley Tomlins was employed as a Band 5 neonatal
 25 nurse on the NNU before moving abroad to work as

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1 CCTV was scrutinised closely and people had an idea what
 2 they were looking for. By that point, it would have
 3 been too late to catch her in the act and therefore too
 4 late to prevent harm happening to the babies.
 5 "Overall though I do feel that perhaps the presence
 6 of CCTV might have been enough of a deterrent and
 7 therefore could have prevented Letby's crimes."
 8 Other neonatal nurses and nursery nurses such as
 9 Pauline Fong, Abigail Lever, Adele McGarry,
 10 Cherryl Cuthbertson-Taylor and Faith Chidongo all
 11 considered that if the babies in the neonatal unit had
 12 been monitored by CCTV the crimes of Letby could have
 13 been prevented.
 14 Janet Cox considers that if there had been CCTV
 15 monitoring, it would have proved Letby's innocence.
 16 Finally, as to the recommendations which the nurses
 17 think my Lady should make to keep babies in NNU safe
 18 from any criminal actions of staff, they said as
 19 follows: Christopher Booth:
 20 "I think using the utmost vigilance in the
 21 screening of potential staff members at the time of
 22 recruitment would be a good place to start. This could
 23 involve possibly conducting personality tests as part of
 24 the recruitment process to seek to identify any
 25 personality disorders which would mean such people would

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1 probably be incompatible with working in such
2 a stressful environment. That is not to say that I feel
3 Letby necessarily suffered from such a disorder, but it
4 seems to be a glaring oversight in the recruitment
5 process.

6 "Improving staffing numbers would always have
7 a positive effect on neonatal nursing teams' well-being
8 as throughout this period between 2015 to 2016 we were
9 almost constantly short-staffed with team members being
10 asked to change shifts at short notice or work extra
11 shifts. This is not good for staff mental health or
12 morale."

13 Paula Baden:

14 "Parents should have more and better equipped
15 facilities to enable a parent to stay at the bedside
16 throughout their baby's stay. While I am unsure of the
17 procedures around neonatal deaths and reporting, I feel
18 that if there is more than one, regardless of reason,
19 this should have a thorough investigation.

20 "Medication must always be kept securely and
21 regular medication audits should also be carried out to
22 identify any anomalies."

23 Joanne Williams:

24 "I do appreciate staffing is a main priority for
25 all those in the NHS. Having safe staffing levels to

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1 for doing this should be straightforward, dealt with
2 much more quickly than it was for Letby, take the
3 concerns of the whistleblower seriously and should put
4 the safety of the babies as a priority rather than the
5 feelings of staff members.

6 "I am sure there are ways to deal with serious
7 concerns that are fair and sensitive to the staff member
8 whilst also making patient safety the top priority.
9 There should be no red tape to get through and never any
10 hesitation or delay in contacting the police."

11 Sophie Ellis:

12 "There should be an open and honest culture with
13 a freedom to speak up within all staff groups.
14 Individuals who raise concerns should have guaranteed
15 support from management and/or a dedicated team to
16 support whistleblowers. A clear process of how to
17 report concerns specifically about criminal actions of
18 staff needs to be created and outlined. This should be
19 streamlined within all Hospital Trusts.

20 "Staff may then be more likely to raise concerns
21 without fear of negative judgment and instead be
22 commended for their courage. This can be very difficult
23 to do even with a positive culture. Some of these
24 aspects may already be in place in some Hospital Trusts.
25 If so, there needs to be consistency amongst all

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1 deliver high-quality care is paramount. General
2 District Hospitals with NNUs should ensure they
3 understand the challenges, difficulties in working in
4 such a specialist area and provide appropriate support.
5 Parents and primary carers should be able to be with
6 their babies 24 hours, if they wish to be, with NNUs
7 designed to facilitate this."

8 Minna Lappalainen:

9 "Appropriate professional staffing levels on
10 neonatal units and open communication between all
11 professional disciplines would improve the way concerns
12 are addressed. Hospital executive management must
13 respond promptly to concerns raised by nursing and
14 medical managers."

15 Nurse X:

16 "Swipe card access to drug storage areas and CCTV
17 would track access to these areas more accurately."

18 Ailsa Simpson:

19 "I believe a culture where members of staff can
20 freely express their concerns without the fear of
21 repercussions is necessary."

22 Shelley Tomlins:

23 "I think the Inquiry should make recommendations
24 about the ways in which members of staff can voice
25 concerns they have about staff members. The procedure

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1 hospitals."

2 Stephanie Terry:

3 "As a clinical educator for student midwives,
4 I feel that the Inquiry should investigate the practical
5 element of when students study to become nurses. In my
6 experience, behavioural or personal attributes can be
7 difficult to fail a student on. This, in my opinion,
8 needs to change. We need to ensure that students are
9 safe to be working with vulnerable babies and people
10 going back to basics with recruitment and education."

11 My Lady, that concludes the summary of the evidence
12 of the nurses and midwives.

13 This summary is intended to assist the oral
14 hearings insofar as it provides some indication of the
15 themes that run through the evidence from nurses and
16 midwives who have provided written evidence to the
17 Inquiry and will not be called to give oral evidence.

18 The witness statements and questionnaires
19 summarised today will be published on the Inquiry's
20 website in due course.

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

22 Thank you very much indeed, Ms Lyons.

23 **MS LYONS:** Thank you.

24 **LADY JUSTICE THIRLWALL:** I think that concludes the
25 proceedings for today. We will start again tomorrow

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1 morning at 10 o'clock. Thank you all very much.
 2 (4.37 pm)
 3 (The Inquiry was adjourned until 10.00 am,
 4 on Wednesday, 16 October 2024)

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