Monday, 11 November 2024

(10.00 am)

LADY JUSTICE THIRLWALL: Mr De La Poer.

MR DE LA POER: My Lady, thank you. Our first witness today is Ms Claire McLaughlan and I wonder if she might come forward, please.

MS CLAIRE McLAUGHLAN (affirmed)

Questions by MR DE LA POER

LADY JUSTICE THIRLWALL: Thank you, do sit down.

A. Thank you.

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

A. Claire-Louise McLaughlan.

Q. Ms McLaughlan, is it correct that you provided the Inquiry with a witness statement dated 23 May of this year?

A. Yes, that's correct.

Q. In terms of its content, I think you have identified that you made an error in relation to an interview which you were not present at but that you had thought you were --

A. Yes.

Q. -- when the phrase "gut feeling" was used?

A. That's correct.

Q. Does it come to this: you have realised that

you thought you were present because "CM" was used, but in fact that is a different CM to you and you were not present?

A. That's correct.

Q. Save for that correction, which I think applies in two places, is the content of your witness statement true to the best of your knowledge and belief?

A. Yes, it is.

Q. I am going to run through your background. Did you qualify as a nurse in 1983?

A. That's correct.

Q. Did you gain qualifications in intensive care and teaching in 1998?

A. That's correct.

Q. Between 2002 and 2008, were you an associate lecturer with the Open University?

A. Yes.

Q. What subject did you lecture in?

A. It was a foundation course in healthcare.

Q. During that period, that is to say in 2004, did you cease practising as a nurse?

A. Yes.

Q. I believe you stayed on the NMC register until 2016?

A. I think that's correct, yes.

Q. Now, broadly concurrent with the period that you were an associate lecturer at the Open University, so here I am talking about 2001 to 2005, did you complete a law degree?

A. Yes.

Q. Did you complete the Bar Vocational Course?

A. Yes.

Q. Were you called to the Bar in 2005?

A. That's correct.

Q. We will come back to that topic in more detail in a moment. But just in terms of qualifications, is it right that you never undertook pupillage?

A. That's correct.

Q. And that you never practised as a barrister?

A. Correct.

Q. In your witness statement, you describe yourself as an unregistered barrister?

A. (Nods)

Q. At the time, looking at the CVs that were circulated, did you describe yourself as a non-practising barrister?

A. That's correct. Yes.

Q. Just tell us briefly, please, why the change in description?

A. I understand that "non-practising" wasn't

being used any more, and that the term was "unregistered".

Q. Returning to your background. Did you become the Head of Fitness to Practise at the NMC in 2005?

A. I think so, yes.

Q. And did you undertake that role for two years?

A. That's right.

Q. Did you then move to the National Clinical Assessment Service?

A. Yes.

Q. So that we understand what that organisation is, is that a service that provides impartial advice to healthcare organisations?

A. It does.

Q. And whilst there, did you rise to the position of Associate Director?

A. I did.

Q. So does that account for the period approximately 2007 to 2014?

A. It does. Could I just add that it only provides advice about doctors, dentists and pharmacists.

Q. Yes. Thank you. In 2014, were you made redundant and did you start work as an independent consultant?

A. I did.

Q. So that I describe this accurately, I am just going to read out from your statement what you say about yourself, as a consultant:

"[You] provided bespoke holistic services and access to resources relating to performance management including investigations and reviews, revalidation remediation, reskilling and rehabilitation for individual and teams of health professionals and organisations that they work in"?

A. That's correct.

Q. In as succinct a summary as you can give, what did that mean in practice?

A. I was contracted by a number of organisations to look at the dynamics within a team, perhaps, or an individual's performance within a team, so it could be the whole team or within a team and help them, the organisation, to better -- better work with the team or the individual and vice versa.

I did some investigations around complaints about doctors and dentists and pharmacists and sometimes nurses, mainly about their behaviours and attitudes.

Q. So not competence?

A. No.

Q. What you say in your witness statement is you've worked with over 300 NHS and private healthcare

organisations and people?

A. That included my time with the National Clinical Assessment Service which did look at competence and as well as behaviours.

Q. Whilst holding yourself out as an independent consultant, did you begin work with the RCPCH --

A. Yes.

Q. -- as lay reviewer?

A. Yes.

Q. And did you begin in that role in 2014?

A. I think so, yes.

Q. Again we will come back to the RCPCH but just to complete what you tell us about yourself. Did you also work for NHS England as a lay panel member for the Performance Advisory Group?

A. Yes.

Q. And as a lay chair of the Performance List Decision-Making Panel?

A. Yes.

Q. And finally as a lay member of the Royal College of Veterinary Surgeons?

A. Correct.

Q. Now, before we go further, I just want to ask you a little bit more about what you say about yourself as a barrister.

Now, to set the scene, and it's not important that you have seen this but Dr Gibbs when he read your CV said in an email that he noted that you had trained as a barrister and that was one of the features of your CV that he pointed out, no doubt that will be because you included what you told us in your CV that was sent by the Royal College?

A. Okay. Sorry, I don't know who Dr Gibbs is.

Q. Dr Gibbs is one of the Consultants that you spoke to upon the visit?

A. Okay.

Q. So far as Ms Eardley is concerned, it would appear that she attributed some significance to that qualification. On Thursday, I asked her about what she thought about your experience of legal process was and the first part of her answer was to describe you as a qualified barrister?

A. (Nods)

Q. And in her statement, she says this about you as a lay reviewer, that you had:

"... vast experience in objective investigations from her barrister training and career at NCAS"?

A. (Nods)

Q. Do you recognise that it's important that everybody that you interacted with understood what your

qualification as a barrister meant and what it didn't mean?

A. (Nods)

Q. Do you agree with that?

A. Yes.

Q. At the time, did you identify that there may be a risk that people would read too much into the fact that you had been called to the Bar or was that not something that you considered at the time?

A. I was always very careful to make sure that everybody knew, at the time, that I was non-practising.

It's only in the last, I don't know, year or so that I came to understand that I should -- should now say I am unregistered to make it clear to people that I am not a practising barrister, but right -- right from the very beginning I always made it very clear I was non-practising.

Q. Now, in terms of that phrase and I am not -- do not understand that I am criticising you for using that phrase in and of itself, but by saying that you are non-practising may leave open the question that you practised in the past, do you see by saying "I am non-practising today" might allow for the possibility in somebody's mind that you had practised in the past; do you see that that's a possibility?

A. I -- yes, yes.
Q. To what extent was that in your mind at the time; that people might think: oh she is not practising now but she has practised?
A. If anybody ever asked me about it, I would say that I had never practised and people did ask me. So it was in my mind, I suppose, that that's -- I -- I never tried to hide that I had never practised and I was very clear about it if people asked me. Otherwise I wouldn't have thought about it.
Q. If we just think about what Ms Eardley's perception, and this is very much in her mind but she interacted with you. She appears to have ascribed some considerable significance, bearing in mind it was the first part of her answer, to the fact that you were a qualified barrister when being asked about your experience of legal process.
In fact, is this fair: your experience as a barrister would not have involved you engaging in any legal process, you have academic training as law degree --
A. (Nods)
Q. -- and you undertook the Bar Vocational Course which is an academic qualification --
A. Yes.

Q. -- not even involving placements --
A. Sure.
Q. -- albeit that you may occasionally go to court as part of that course?
A. Sure.
Q. So to what degree do you think the fact that you were a qualified barrister was relevant to your experience of legal process?
A. That's not how I would have described it.
Q. Similarly, Ms Eardley says that you had vast experience in objective investigations from your barrister training and career at NCAS. NCAS aside, plainly that did give you very considerable experience, but did you in fact gain experience of objective investigations from your barrister training?
A. No.
Q. So again would you say that's not a way that you would have described it?
A. I wouldn't have described it.
Q. So again acknowledging that this is Ms Eardley's perception and her words, but she's somebody that you had interactions with and spoke to, are you able to shed any light on how it may be that she placed that level of emphasis on something that you yourself wouldn't say it justifies?

A. No, I cannot answer that.
Q. And do you think there's any possibility that you overstated or overemphasised the relevance and significance of your barrister training?
A. No.
Q. We are going to move now to your role with the RCPCH and you have told us that it was as a lay reviewer and you had approximately two years' experience before the Countess of Chester inspection?
A. I think that's right.
Q. Or review, rather.
You describe that role as having a number of functions: to represent patient and public interest is one part of it?
A. (Nods)
Q. We will come back to that. It's also to stop there being too much jargon being used, is that right, particularly in the final report, to make it more accessible?
A. Yes.
Q. To stop the tendency of professionals who all know each other to talk in a cosy way but to recognise that there needs to be proper boundaries; is that another part of it?
A. Yes, I think I call it critical -- being

a critical friend.
Q. Yes.
A. Yes.
Q. Yes, and if it was just as a friend, you would sit there passively and let them get on with it. Being a critical friend involves you needing to challenge people and say: hang on a minute, I am sitting here as a layperson, this doesn't feel right to me, can you explain it?
A. Yes.
Q. Now, in terms of representing patient and public interest, does that mean that in the context of the Countess of Chester review, you were there representing the interests of the Families of the children who died?
A. I can't, I don't, I don't -- it was broader than that. It was -- I think is also the patients who were still there.
Q. So I have drawn it too narrowly. It includes the category that I have spoken about, but you say it --
A. Wider.
Q. -- is wider than that.
In terms of your conduct of that role representing the bereaved families and patients who are still alive and on the unit, how do you say you discharged that

particular function of your role as lay reviewer when it came to the Countess of Chester inspection?

A. I was there as part of the panel to try to decipher. So to go into -- into the final report what was going on and how -- how it was going on.

I was involved in a number of interviews separately from the main group. I can't answer any more than that.

Q. Speaking generally, is there, in your experience, a risk that sometimes in an NHS setting, people become very focused upon internal disputes, internal politics, internal relationships and that sometimes they are not thinking about the patient first?

A. I think that can happen.

Q. Yes. So would your role be to, when that is happening in front of you, say: hang on a minute, everybody, this is about the patients. That's who we should be thinking about first?

A. It could be. Yes.

Q. Do you think that in the course of the Countess of Chester inspection -- or review, forgive me, my mistake, in the course of the Countess of Chester review, you ever said: I know we have got this two sides of this issue, but don't we need to take a step back, everybody, and think about the patients?

A. I don't remember.

Q. You don't remember?

A. No.

Q. By saying that, are you allowing for the possibility that you did say it?

A. (Nods)

Q. You are?

A. Yes. Either I did or I didn't, I don't recall.

Q. Well, have you seen any note or record of you having said that or anything to that effect?

A. No.

Q. Does that indicate to you that that is unlikely to have happened then, or would you not draw that conclusion?

A. I -- I couldn't draw that conclusion. I -- I haven't got a note of it.

Q. You haven't got a note?

A. I haven't seen anybody else's note of it either but that doesn't mean it didn't happen but, but it may not have done. I just don't know.

Q. No. Well, just examining that for a moment. You didn't make a note of you saying that, nobody else has made a note of you saying that --

A. That I have seen.

Q. -- that you have seen, of the notes that you

have seen, you have no recollection of having said it?

It would be quite a significant moment in any meeting, wouldn't it, it is a big challenge to people participating to say: everyone, just stop for a moment, let's think about the patients. Do you agree?

A. It's hard to say because it was such a long time ago. There are -- having looked through all of the information that I was given in preparation for this, there were lots of things I didn't recall.

So ...

Q. Well, in terms of your recollection, and granting that we are now 2024 and it was 2016, in fact this was a unique experience for you in all of the reviews that you had conducted; is that fair?

A. In retrospect, yes.

Q. But at the time it's the only time you tell us that they had any issue raised about the possibility of criminality being committed by a member of staff?

A. Yes.

Q. There are other reasons for it to be unique which is that you thought it was going to be one kind of inspection?

A. Yes.

Q. When you turned up, you found it was rather different?

A. It was a review.

Q. A review, forgive me, thank you, I welcome that correction, please ensure that I get that right?

A. Yes, you are right.

Q. But, yes. It was: you thought it was going to be one kind of review and it turned out to be another?

A. Yes.

Q. So there were reasons at the time for it to be memorable, do you agree?

A. Yes.

Q. Then it's not just that we are looking back from 2024, because presumably you will have heard about the arrest or charge or trial of Letby?

A. Yes.

Q. All of which were some time ago now. Presumably that would have caused you to bring to mind your involvement in this review?

A. Of course.

Q. Your thoughts at the time, so we aren't just looking back over eight years, in fact there have been opportunities in the past for you to think about it. So again just doing the best that you can, with those opportunities and the fact that it was memorable in the way it was, do you think that you did give that challenge at any point about thinking about patients or

do you think it is likely that you didn't?
A. I can't recall.
Q. In terms of your overall experience of the RCPCH inspections, I think you believe that you did 14 in total over the time?
A. I -- I think so.
Q. That this was number 6; is that right?
A. I think that's what I said, yes.
Q. In terms of the RCPCH training, did the RCPCH give you any safeguarding training?
A. I don't think it was done directly through the RCPCH. No.
Q. Did they have any requirement of you that you had a minimum level of safeguarding training in order to participate?
A. I don't recall. But I was always in date for the required level of training that I would -- that I needed for the other jobs that I was doing so I will always have been in date as I am now.
Q. Did the training that you had received give you a familiarity with Working Together?
A. No, it didn't, I don't think.
Q. In terms of what amounts to a safeguarding allegation; in other words, an allegation that should trigger safeguarding concerns. We will just bring up

what Working Together says about it and see whether it accorded with your definition at the time.
INQ0013235, and we are going to go to page 54.
So the third bullet, although it's the widest indented bullet towards the top, talks about clear policies being required and then it says this:
"An allegation may relate to a person who works with children who has behaved in a way that has harmed a child or may have harmed a child, possibly committed a criminal offence against or related to a child, or behaved towards a child or children in a way that indicates they may pose a risk of harm to children."
So before I ask you to agree or disagree with this as being consistent with your understanding at the time, just to pick out some things, we are here framing things in terms of possibilities. So "may pose a risk" or "possibly committed a criminal offence". So that is what Working Together in 2015, which was the current version of the statutory guidance, said.
Was that consistent or inconsistent with your understanding of the threshold for safeguarding?
A. At the time?
Q. At the time.
A. I can't recall but the training was provided by, I think, the NHS at the time so I am sure that it

will have included that.
Q. So your expectation is that that you would have been operating on --
A. Under this.
Q. -- the basis that we see there?
A. (Nods)
Q. Thank you. We can take that down.
Now, the Invited Review guidance published by the RCPCH talks about when a review may not be appropriate. We can bring it up, INQ0010214 and it's page 8 and we are looking at paragraph 7.5.
We can see that the College will not take on cases where the expected scope, the third one down:
"Includes behaviour or misconduct, bullying, harassment or possible mental health concerns."
Does that accord with your understanding at the time that that's not what the College would be investigating as part of its review?
A. Yes, yes.
Q. Do you agree that the suggestion that somebody may, a member of staff may be murdering babies falls four square within behavioural or misconduct issues?
A. Yes.
Q. If we go over the page to 7.7, we can see that:

"If any of the issues listed in 7.5 come to light, the Review should be completed in relation to its original remit, unless advised to the contrary, in order to avoid prejudicing other investigations by public authority or regulator."
Now, you had experience working for a regulator, the NMC, in their Fitness To Practise Directorate?
A. Yes.
Q. No doubt as part of your legal training you gained some understanding of the powers of police and investigating, it is a standard part of law degrees and Bar Vocational Course?
A. Sure.
Q. So just drawing upon that experience, do you recognise that there is a risk to both regulatory and police investigations if the Royal College continues to investigate in a space which is rarely their remit?
A. Yes.
Q. What would you say the risk of prejudice is to those investigations if the College carries on?
A. That it's going to slow things down, it's going to put -- give false assurance to people.
Q. In fact the very process of interviewing people can muddy the waters, can't it?
A. Yes.

Q. It can involve for example getting lots of people into a room as you would without a problem in an Invited Review and have them all share their perspectives?

A. Sure, of course.

Q. But in principle, that's not a good way of conducting a regulatory or police investigation, is it --

A. No.

Q. -- when taking accounts?

So, again, that exists as a possible prejudice?

A. Yes.

Q. Do you think that in 2016, based on your experience with the NMC and the training you got on your law degree and in the BBC, that you understood those risks?

A. I did. However, if I may --

Q. Of course.

A. -- could we go back to 7.5?, please.

Q. Yes, of course. It's the page preceding.

A. The preceding. In taking on the review, I had personally believed that we would not have been taking on the review if this was the case. So I -- I assumed that this work had been done before --

Q. Absolutely.

A. -- we got there.

Q. If I can give you this reassurance: Ms Eardley has accepted that she did know that the issues in relation to Letby, although her position was that that was not going to be part of what was going to be considered and she has suggested that she doesn't think she told any of the rest of you --

A. No.

Q. -- about that. So that is not a disputed fact; it accords with your recollection as well. Absolutely, 7.5 is about taking on a review. What 7.7 is about the situation you found yourself in which is that once it has started, if we go back over the page --

A. Thank you.

Q. -- if it comes to light, is how it's framed, during an Invited Review, then it should be completed; is what the language says?

A. (Nods)

Q. Unless it's advised to the contrary in order to avoid prejudicing, so it's understanding that?

A. And we weren't advised to the contrary.

Q. Well, did you offer any advice based upon your experience?

A. That was not my place. I was not there in a legal capacity.

Q. No, but you had an understanding unique to the team about the particular potential damage to a regulatory or police proceeding, you had that in your mind. You have told us that; that you knew that?

A. Okay.

Q. Would it not be the right thing to do, to draw that to people's attention so that they could consider that as part of whether the review should continue?

A. I think in the -- in the moment, we were under the impression that no red flags had been raised by a number of different organisations in relation to the allegations that had been made and I suppose we were given a -- a false assurance that that had been considered and dealt with, I suppose.

Q. We are going to get to the detail of when that assurance was given and what you recollect. But at any point in this process, did you contemplate the police might need to get involved?

A. As I say, we were given -- we were on a -- you know, given false assurance, I think, so --

Q. If I can just ask you to focus on my question.

A. Sure.

Q. At any point in this process, did you anticipate that the police might need to get involved?

A. I don't recall the conversations.

Q. Well, we can go to it in your witness statement. But what you tell us is, jumping all the way to the end, that you thought that by recommending an HR investigation, a disciplinary investigation, that the police would quickly get involved after that. So that's what you tell us in your witness statement?

A. Well, if, if -- if they then found that they needed to get involved.

Q. Yes. So does it follow that the answer is that you did anticipate that the police may need to get involved during this process?

A. Yes.

Q. Understanding as you did at the time about the potential risk to the police investigation, do you think that you should have said, "I think we should all consider the possibility here of stopping because this might damage a police investigation that may happen"?

A. No, I didn't.

Q. Do you think you should have?

A. I think I probably should have, in retrospect. But it didn't occur to me at the time.

Q. Well, you have added two caveats to that "probably" and "retrospect".

Just thinking about the question. At the time, with the information you had, bearing in mind you

foresaw the police might get involved and you knew from your previous experience about the potential prejudice, do you think you should have spoken up and said, "I think we should stop because of that risk"?

A. I wish I had. But, again it's a different -- you are -- I am answering a different question. I understand that, but In --

Q. You --

A. Yes, I should.

Q. We will turn now please to the beginning of your involvement. You have looked at your records and you think the first contact you had was at the end of June of 2016?

A. I think so.

Q. Is this how it worked, that effectively you told the RCPCH you were willing to act as a reviewer but that was subject to your diary and other commitments so it would be entirely unremarkable for them to reach out to you and say: are you free to agent as a lay reviewer?

A. That is how it worked.

Q. That is essentially what happened here?

A. (Nods)

Q. What you say in your witness statement about your understanding at the start of this process was:

"It was my understanding that ahead of the Countess

of Chester Invited Review taking place there were no known circumstances or allegations highlighted to the Review Team."

A. That's correct.

Q. That's your very clear understanding, is it?

A. Yes.

Q. Could you turn up paragraph 36, because it should be in the witness statement in front of you. Do you have that?

A. Yes.

Q. What you say in paragraph 36 is:

"Had I been aware of the concerns about Ms Letby prior to the visit during the preparatory stage, or even the evening before, I would not have participated in the review."

Then you go on to say:

"I would have advised the RCPCH that in the circumstances the Terms of Reference, especially the fourth bullet point [and you go on to quote it] were misleading and that it was inappropriate to start a service review until these matters had been dealt with and the situation clarified."

We will just pause there for a moment. Why do you describe the term of reference as "misleading", what was it that caused you to describe it in that way?

A. Because they had already identified something that linked the death, or they thought they had identified something that had linked the deaths.

Q. Yes, and so you read that fourth term of reference as implying that no link had been identified yet?

A. Yet. Yes.

Q. You say:

"I would have advised the Countess of Chester to follow its own internal processes for dealing with such serious allegations made, I believe, in good faith such as clarifying the concerns, taking them seriously, seeking HR legal advice, considering a formal restriction of practice or exclusion from practice was required and following that process. That would have included beginning a conduct or capability investigation and appointing an independent investigator as well as discussing the matter with the police and with the NMC."

A. (Nods)

Q. So if we understand what you are saying here is, if the night before you had been told "the Consultants have identified that there is a nurse who is on duty for most of these deaths" and we will just limit it to that, "and they are concerned that she may be deliberately harming babies", if that was said to you,

you would have said number one, we mustn't do this review?

A. (Nods)

Q. Is that right?

A. Yes.

Q. Number two, we need to tell the Countess of Chester that they need to engage some kind of HR process and/or take legal advice; is that right?

A. Yes, yes.

Q. Three, that they should consider whether or not it is necessary for that nurse to be excluded from practice?

A. Yes.

Q. And four, that they should discuss the matter with the police and the Nursing and Midwifery Council?

A. Yes.

Q. That's the night before.

A. Or previous.

Q. Or earlier than that?

A. Yes.

Q. 12 hours or so later, you were given that information, weren't you?

A. Yes.

Q. At that stage, did you say: we should stop?

A. No.

Q. At that stage, did you say: you should consider some formal restriction or exclusion from practice?

A. No.

Q. At that stage, did you say that they should undertake an HR process and/or take legal advice?

A. No.

Q. At that stage, did you say: you need to discuss this with the police and the NMC?

A. No.

Q. So I suppose the question really is --

A. Why.

Q. -- what changed over those 12 hours that you were -- you are so clear, if I may say so, about the precise steps that would have been taken the night before, you accept you didn't take any of those steps 12 or so hours later when you were possessed of that information.

Why not?

A. Again we were given a false level of assurance and we were hearing about -- it was sort of dropped into the conversation as a "by the way" ... it wasn't given any level of importance or credence and it was given to us as part of almost a breakdown in relations.

Q. But what -- that was what the Executives were

saying?

A. Yes.

Q. But you immediately went to speak at some length with Dr Brearey and Dr Jayaram who gave you their perspective?

A. Sure.

Q. What was being said was an allegation of the very most serious type?

A. (Nods)

Q. Do you agree with that?

A. Yes.

Q. I would just like to -- I asked Ms Eardley this same question, I would just like to reflect on it. If it had been, to use your phrase, just dropped into the conversation, that doctors were worried about a member of staff sexually assaulting a patient, and if you then went to see the doctors and they said, "Yes, that is what we are worried about", do you think you would have reacted any differently?

A. I don't know. I don't know.

Q. I am just trying to unpick what you say here because you have accepted that --

A. Yes.

Q. -- it is an allegation of the most extreme type, albeit played down or whatever phrase, "false

assurance" given by the Executives. But the doctors weren't giving you that assurance, were they?

A. Well, they gave us a mixed picture because they told us in one breath about their concerns and the allegations they were making.

But in the next breath they were telling us what a good nurse she was.

Q. Well, it's possible to be a good nurse and a murderer?

A. I am not saying it isn't and I am not downplaying this.

Q. They weren't suggesting to you that their worry was that through incompetence she was killing the babies?

A. But they found it hard to believe as well.

Q. Well, but they still entertained in good faith, to use your phrase, that suspicion?

A. They did.

Q. That is that --

A. But they hadn't called the police either.

Q. Well, they can answer for that.

A. Sure. But that was -- that was part of the false assurance that we were given. The whole picture of the false assurance.

Q. But they -- on the subject of the police they

had told the Executives in the expectations the Executives would call the police and so in the doctors' minds, do you agree, the police should be called, but they were following a process, tell the Executives, and at that point what they had thought would happen didn't happen.

So it wasn't as if they were telling you: we don't think the police need to be involved. They told you they thought the police should be involved but the people they thought should call the police were the Executives and the Executives weren't doing it.

So again is it fair to describe that as a false reassurance?

A. Yes, I think so because they had -- they had the ability to call the police themselves individually. So this was all a pattern of -- of having looked at the information, this one piece of information that we were given which was uncorroborated against all the other information that we had been given as a package that looked at the Coroner's reports and the CDOP reports and the network review, looking in, in the whole of the context that there were no red flags, that this was the only piece of evidence that we were -- well, the only piece of information, I wouldn't at that stage even have called it evidence, that there was something else going

on.
Q. Well, you have described it as uncorroborated and that is a phrase you use a number of times in your witness statement?
A. Yes.
Q. So let's just see if we can understand what you mean by that. So if we go to paragraph 108, that is an occasion where you use that phrase. Do you have paragraph 108?
A. I do, yes.
Q. What you say:
"In my opinion I cannot speak for the whole team. This was the personal view, feelings, interpretation of one person regarding Ms Letby, it was not based on fact and was uncorroborated. Even now I would not consider his view as objective or impartial as he was too involved, too close to the situation and had a conflict of interest."
I just want to look at some of the language you have used there to try and understand it.
You start by using the word "personal". You don't say it was his view or his professional view or his expert view or his view as a Consultant. You say "personal". Why did you choose the word "personal" there?

A. My understanding was that that the -- it was one person who I -- it was one person who had put the information together.
Q. We will come on to the one in a moment.
Why personal?
A. Because he -- that, that's how it was presented; this is what I have done ...
Q. Can I invite you to reflect on this. Within a professional setting, it's quite common to distinguish between personal views and professional views. A professional view is somebody offering their opinion, which is just their opinion, based upon their professional knowledge and expertise. A personal view is usually understood to mean a view that they are giving outside of the parameters of their professional expertise or outside of their job.
Are you familiar with the distinction?
A. I can understand where you are coming from, yes.
Q. Now, you have used the word "personal" here?
A. Sure.
Q. Do you not think that giving that opinion the appropriate respect that it was entitled to, that actually it was a professional or expert view?
A. The information we were given was of --of the

duty rosters and --and an interpretation of the duty rosters for the doctors and nurses that were present during the period that the babies died.
It's not normally the role of somebody of that doctor's status and experience to have any involvement, is my understanding, in the rostering of staff. And therefore I would not have -- I wouldn't have called it his professional role for him to take on the analysis that he apparently did of those rosters.
Q. Wasn't what you in fact were told rather more complicated than that; that what you had was a Consultant, the head of the neonatal unit if we just talk about the one individual you are referring to, who using his professional expertise looked at the deaths and could not understand, applying all of that medical knowledge, why there had been an increase in the deaths. So that is absolutely 100%, would you agree, his professional expertise being exercised?
A. Absolutely.
Q. That he as any reasonable person would start from the fact there could be any number of possibilities for this, but I need to work my way through to exclude the ones which it definitely isn't? And that he had undertaken that process and that he had using that expertise excluded lots of common explanations, again

all exercising his professional judgment, would you agree?
A. Yes.
Q. And it was absolutely part of that exercise of his professional judgment to consider whether staffing may have been responsible for the increase in the deaths, do you agree?
A. I agree.
Q. When he came to look at that area, he found what he thought was a surprising state of affairs in the first instance which was that there was one person, unexpectedly in his mind, associated with every single one of the deaths bar one?
A. Yes.
Q. In addition, the cohort of babies he was considering he knew, based upon his professional expertise, were not expected to die and so we weren't just talking about an increase in the deaths. He was looking at babies who he expected to survive and so he was dealing with an unexpected cohort and he didn't have an explanation beyond the commonality that he had identified.
Is that all fair about the information you were told?
A. That's fair.

Q. So do you see that or do you think that in fact it might in fact be absolutely his provisional judgment that is being involved here?

A. I -- yes.

Q. The fact that you used the word "personal", do you think that that is a reflection of the fact that perhaps even until this very moment, you had not seen what you were being told in those terms?

A. Yes.

Q. Again, do you think that's a reason why you might have used for example the word "feeling" in your list of three personal attributes where you said this was the "personal view/feeling/interpretation"?

A. Yes.

Q. Because if we are going to be real about it, describing something as a personal feeling is not terribly persuasive; describing something as a professional interpretation is rather more persuasive? Do you agree?

A. I agree.

Q. But you were -- when you wrote this, which was in fact I think only in May of this year, your take on it was that this was capable of being described as a personal feeling?

A. Yes.

LADY JUSTICE THIRLWALL: Now, Mr De La Poer, is that a convenient moment?

MR DE LA POER: It absolutely is, my Lady. Thank you very much.

LADY JUSTICE THIRLWALL: I should have mentioned earlier, I hope you have been told. We are going to take the break now. There is a service going on outside and obviously we will be observing the two minutes' silence and it seemed to me more appropriate that if we break now and we will come back in at 10 past 11.

(10.49 am)

(A short break)

(11.10 am)

LADY JUSTICE THIRLWALL: Yes, Mr De La Poer.

MR DE LA POER: Ms McLaughlan, we are looking at paragraph 108 and we have dealt with personal and feelings and we are I think agreed that the correct analysis is "professional opinion", and then we read on, "of one person".

Now, in fact, Dr Brearey who I think is the one person you are referring to sat in a meeting with you and other reviewers together with Dr Jayaram; is that correct?

A. I believe so, yes.

Q. The two of them were speaking effectively with

one voice about their concerns, weren't they?

A. In the meeting, yes.

Q. Yes. So the starting point is that bearing in mind that, do you think it is fair and accurate to suggest that this is the professional opinion of one person or do you think that in fact one person is not the correct description?

A. My understanding was that the tables, the -- the Excel spreadsheet had been done by one person and that's what I mean by that.

Q. But as we have discussed already, it's not just about that table, it's about the expertise that was brought to bear to understand how common causes were not an explanation and the fact that the deaths were unexpected, so you were dealing with a particular cohort of deaths?

A. I am, in this paragraph I am talking about that one piece of information, that one Excel spreadsheet.

Q. But you are here summarising, aren't you, your overall view of the information that you were provided with?

A. I believe I am talking about that one piece of information, which was the Excel spreadsheet.

Q. I understand that that is what you are

referring to. But are you not offering that characterisation as being the overall -- your overall assessment?

A. No, no, my -- that, that is about that -- the uncorroborated evidence I am talking about is that Excel spreadsheet.

Q. Well, let's read the whole paragraph. At paragraph 3.12 it is stated that:

"The paediatric lead and all the Consultant paediatricians had become convinced by the link between Letby and the deaths but it is stated this was a subjective view with no other evidence or reports of clinical concerns about the nurse beyond this simple correlation. In section 4 it is stated there was no other evidence or history to link Nurse L to the deaths"?

A. Yes.

Q. Then you give "in my opinion", so ...

A. Yes. That is what I am referring to. That is the link to Nurse L is that spreadsheet.

Q. But --

A. That's exactly what I am referring to there.

Q. But the link to Nurse L, Letby, is in the context of the wider information that you are being provided with?

A. I am talking here about that one piece of evidence which was the Excel spreadsheet. I am very clear about that, that's what I am talking about.

Q. Well, I invite you to consider an alternative interpretation, because if we look on to what you say:

"There had been no independent review or oversight of the allegations and the information provided in support of the allegations."

A. Yes, that's that one piece of evidence which was the Excel spreadsheet.

Q. It was -- I'm sorry, I don't want to stop you saying something you want to say.

A. Nobody else had looked at that spreadsheet. We were just given the spreadsheet with the analysis undertaken. We didn't even get to see the underpinning rosters and rotas on which that was based. That's what I am talking about there.

Q. So --

A. That's what --

Q. The spreadsheet that Dr Brearey created was attached as appendix 1 to the thematic review, that was a meeting at which a number of people visited. It was based on the work of the nursing manager of the unit, Eirian Powell, who had created that spreadsheet earlier. It was reviewed by the Executives and nobody ever

suggested that its content was wrong. The dispute was about its interpretation?

A. I am not aware of the thematic review that you are talking about other than in -- in the broadest terms. I was presented with the Excel spreadsheet in isolation.

Q. So the thematic review was a document that was provided to all reviewers beforehand and it was the document that the lead reviewer commented upon in that email which you say you didn't see?

A. Yes.

Q. So that is --

A. Yes.

Q. So that is Dr Brearey's work in February that you were told about and the document that you received?

A. I only remember seeing the Excel spreadsheet. That's what I am talking about there, I am not talking about the thematic review.

Q. Well, did you think that there was in fact any dispute of fact over whether or not Letby had been correctly identified at nine out of the ten deaths?

A. The -- sorry, can you say that again?

Q. Yes, of course. Did you think that there was any dispute of fact about the contention that Letby was present at nine out of the ten deaths, or associated

with them?

A. Not later. But at that time, which is what I am talking about here, that's all I was aware of --

Q. So --

A. -- was that Excel spreadsheet.

Q. The Executives told you that a nurse had been identified by a Consultant, that is what they told you?

A. Yes, a nurse had been identified by a Consultant.

Q. Yes, yes. And they also told you in that first meeting that they had conducted their own investigation, Ian Harvey is noted as recalling "it's all been investigated".

We can look at that note if you would like to?

A. I would like to, please, yes, just to remind myself.

Q. Yes, of course.

A. Thank you.

Q. Of course. INQ0014604. We will look at the first page. Just four lines up you see against Ian Harvey's name:

"Been through all the evidence."

And he then starts talking about another aspect of the evidence.

It's just the first part that's the important bit;

that, do you agree, Ms McLaughlan, that at no time did the Executives suggest to you that the analysis which suggested an association was wrong?

A. I don't know that he's referring to the Excel spreadsheet or --

Q. I will just ask my question again. Do you agree that at no time the Executives suggested to you that the analysis indicating that Letby was associated with nine out of ten deaths was wrong?

A. No.

Q. They are here saying that they had been through all the evidence, that's what the note records. So do you agree it would be quite a surprising state of affairs if there was actually any dispute about something which could be so readily checked if you hadn't been told about it?

A. Sorry, say that again, please?

Q. Of course. It would be quite a surprising state of affairs, given how easy it would be to check that, if the Executives had checked it, found that it was wrong, and then didn't tell you?

A. That's right. But we hadn't seen it for ourselves.

Q. But --

A. That's what I am talking about in that -- in

that paragraph 108; that it was at that point it was uncorroborated, it's that simple.

Q. But uncorroborated by whom?

A. Anybody.

Q. Well, it had been corroborated by the Executives.

A. But I don't know that that's what he's referring to four lines up on that page.

Q. Well, if you were uncertain about whether that underlying very simple analysis was correct or not, did you ever ask?

A. We didn't get that at that point.

Q. Well, you --

A. We didn't have it at that point.

Q. You had received the thematic review which said the same thing?

A. I don't recall seeing that Excel spreadsheet before we received it -- I believe I received it on that first day of the review.

Q. When the Executives told you that the doctors had or the doctor had identified this association, did you say to them, "Have you checked to see whether that's right?"

A. I don't recall.

Q. Well, is there any record of you having said

so?

A. No.

Q. Do you have any recollection of having said so?

A. I just said I don't recall.

Q. Well, I think -- so you don't have a recollection of saying so?

A. No.

Q. So does it seem likely that you didn't say that?

A. I didn't ask.

Q. Could the explanation for that be because everybody at all of the meetings that you had were proceeding on the basis that underlying facts were correct, that it was a dispute about the interpretation of those facts that represented the difference between the different sides?

A. Yes.

Q. So if that is the basis on which the entire review was conducted, just help us with why in your reflection in May of 2024 you are talking about that particular chart as not being based on fact and being uncorroborated?

A. Because we hadn't seen -- I hadn't seen the evidence on which it was based. It was that moment in

time when we were given that document -- that I was given that document to see that that's all we had.

Q. On what basis could you assert that it wasn't based on fact?

A. So the -- the doctor that I understand completed that was one person who may, who could have and -- manipulated the data without seeing the underlying rotas. We had seen the doctors' rotas, I understand, but not the nursing rotas.

Q. I'm afraid I am going to have to ask you to look at your assertion: you weren't saying maybe it wasn't based on fact, you have asserted in terms it was not based on fact. How were you in a position to hold that view in circumstances, particularly as this is a doctor who's done the analysis, and that analysis has been available for everybody to check at the hospital and nobody in the 48 hours you conducted this inspection suggested it was wrong, so how is it that you come to be asserting it was not based on fact?

A. I was wrong to do that.

Q. Well, just taking a step back. Do you think until this moment, in this hearing, you had rather underestimated the significance of the information you were provided with by the doctors?

A. That --

Q. The overall significance of it, do you think that at the time you ascribed too little significance to it?

A. Yes.

Q. Why do you think it has taken until now for you to see that?

A. I can't answer that specifically. I -- I can't -- I -- I don't know.

Q. Well, what additional factors were you, incorrectly as it must be, weighing in the balance to -- to cause you to think less of that information at the time?

A. The circumstances in which I was given that information were that there was a lot of assertions at the time that Ms Letby was being scapegoated.

Q. Do you think that you placed too great an emphasis upon that?

A. In retrospect, yes.

Q. Did you have enough information at the time to make the balanced judgment that you are now making?

A. No.

Q. Why not?

A. Because a lot has happened since then.

Q. But on the one hand of course you are mindful of the individual employee and the possibility of being

scapegoated. On the other hand you have got two doctors, as we will come to in a moment, sitting in front of you telling you that they are, having exercised their professional expertise, dealing with an unusual cohort of patients and they cannot see any other explanation and they are worried.

Why is that not enough to weigh in the balance and say; well, obviously it's not for me to determine which is right, but we need to act on the basis that the frankly more serious of those risks is right?

A. In the context we were at the time we also had had -- we had knowledge that the cases had been through a Coroner's investigations who had, they had been through network reviews. So I don't think we were in a place at that time to think the unthinkable.

Q. Well, you presumably -- and in fact you tell us in your witness statement, you are aware of the case of Beverley Allitt?

A. But not -- we weren't in that context at the time.

Q. Well, the context is that somebody was saying a nurse may be killing babies.

A. That wasn't until afterwards, I think.

Q. Wasn't that exactly what Dr Brearey and Dr Jayaram were saying that that was their worry;

somebody may be killing babies?

A. Yes. But I think that -- I can't speak for everybody else but I think at that time we thought that had been excluded because of all of the other work that had gone on around before the College was involved.

Q. What did you think that had been done to exclude that possibility?

A. That there had been no red flags raised by the organisations I had already talked about, so the Coroners had been involved and the CDOP and the network review had all looked at those babies' deaths.

Q. The network review had concluded that they couldn't identify a common theme, that was in the thematic review --

A. (Nods)

Q. -- that was sent to you.

But what organisation is capable of determining whether or not murder has been committed?

A. So the -- well, of course that would be the police.

Q. You knew the police hadn't been involved?

A. Yes.

Q. Although the doctors wanted the police to be involved?

A. Yes.

Q. Well, look, let's have a look at some of what you were told in more detail. We can deal with the preparation fairly briefly. You saw both sets of Terms of Reference but I think that not knowing the information that Ian Harvey provided to Sue Eardley you didn't perceive a difference between the two of them?

A. There was a slight difference in one of the Terms of Reference about the common themes I think, but --

Q. You also tell us that you didn't see the lead reviewer's email in which he identified the commonality of Letby?

A. Yes.

Q. I mean, if we just pause to think about that. The lead reviewer on the information that you had all been sent had identified that for himself?

A. I'm not sure that that was in ...

Q. He saw the thematic review --

A. Okay.

Q. -- which identified Letby as being present at nine out of the ten deaths which is?

A. I don't recall seeing that.

Q. Was it your practice to read every document that you were sent?

A. Not every single document, no.

Q. If a document was identified as thematic review, would that be the sort of document that you would think may be important?

A. I am surprised that I didn't look at it, yes.

Q. Are you able to take it from me because I know that you read Ms Eardley's evidence from Thursday or we can look at the references, that in her email circulating it to you all access to the material, she specifically drew attention to the thematic review as being one the documents that should be considered?

A. Could I see that, please?

Q. Yes, of course. INQ0012846. This is 12 August and what she says here, it is the third paragraph:

"Key things to look at but probably the Mortality Reviews. There are some concerns coming out of Transport Service. Please keep the Terms of Reference in mind."

A. That is, is that I -- I thought you said it was entitled "Thematic Review"?

Q. "Of Neonatal Mortality" is the full title of the document?

A. Okay. Okay. I -- I don't remember seeing the email. I obviously received it. I don't recall.

Q. Well, let's move forward to day one and it's

in your first meeting with Ian Harvey and Alison Kelly that you are told about the doctors' concerns.

A. Yes.

Q. What was your overall impression of Mr Harvey's attitude towards the seriousness of the allegations and the calling of the police?

A. I don't recall the conversation specifically and the detail of the conversation. I think the feeling that I got was that he didn't want to do that.

Q. Are you able to give us any more detail about where that feeling might have come from? Is that just an impression of the overall conversation?

A. Yes.

Q. And so far as Alison Kelly was concerned, the other person present at that first meeting, what was your overall impression of her attitude towards the seriousness of the allegations and calling the police?

A. I don't recall. I recall her being supportive of Ms Letby.

Q. Now, one of the notes, and we will bring it up on screen, we are not going to look at all of it, INQ0014604, this is a note by Ms Eardley who was acting as notetaker, and this is really just to prompt your collection, I hope.

We can see halfway down the text, so it's about

two-thirds of the way down:

"Director of Corporate Affairs was DCI before he" and then "huge nettle to grasp, need to unpick things around", then "rely on him".

So these are handwritten notes transcribed so they are not always easy to interpret. But do you have a recollection of being told that the Director of Corporate Affairs was a former Detective Chief Inspector?

A. I don't recall that. However, could it -- is it possible to see the handwritten note because I looked at this again last night and I think the -- this transcript is not quite accurate?

Q. If you just bear with me a moment.

A. Thank you, sorry.

Q. Not at all. INQ0010124. So you will just have to help us to navigate where it was that you --

A. It's down further down the notes where there is an indent.

Q. So if we go to the next page.

A. And further down, sorry. And further down again. Oh, where was it?

Sorry. Further down. No, it must be --

Q. I think we are going to need to go back because we are moving off that meeting?

A. Yes, go back to the top.

Q. Go back to the first page, I have got up in front of me --

A. It must be.

Q. -- the transcription.

A. Yes. Sorry, it's halfway down on that first page.

Q. Yes.

A. So it says £the Director of Corporate Affairs was DCI before" and then there is the bit that is redacted.

LADY JUSTICE THIRLWALL: Before he retired.

MR DE LA POER: He retired.

A. Yes, and then the arrow down below that is "rely on him reference police" I think that says, rather than "not police". So it would appear to me that they took advice from the Director of Corporate Affairs about going to the police.

Q. At that time what did you understand Ian Harvey and Alison Kelly's attitude towards going to the police was?

A. Not to do that because they had taken advice from the DCI. But this is my -- the previous DCI. This was my interpretation now as I don't recall that from the time.

Q. Thank you. I wonder if we can go back to the typed notes, INQ0014604.

We are going to need to go to page 2. This is something that your colleague Ms Mancini says. In the middle of the page, "Alex", do you see that that reference, "Can we see PM reports?"

A. Yes.

Q. Now, would it be normal for an Invited Service Review to be reviewing the postmortem reports for individual patients?

A. I don't know. I don't think so but I don't know.

Q. Well, just -- I appreciate this is what the nursing member of the panel is saying, but you have an understanding of what the purpose of such reviews is for?

A. (Nods)

Q. Do you think that was an opportunity for you to say: I just think we all need to take stock here?

A. Yes.

Q. That we are not here to look at the postmortem reports for individual children, we are here to do a service review?

A. I think we were all a bit shocked about what we had heard. Yes, it was a missed opportunity.

Q. So that's a wrong turn, isn't it, for the whole review process?

A. Okay.

Q. If we go to page 3, just above "CM's process" which I think we will come to in a moment, which is a reference to you, we see what it says is:

"Need details of nurses who looked after the babies at the time."

Again this appears to be the reviewer's, and it is not ascribed to any particular individual, asking for the details of individual nurses who were looking after the babies?

A. (Nods)

Q. Again is that something that you would expect at an Invited Service Review?

A. Given the information -- it goes back to what I said before about not having had the information until this point.

It's getting a bit muddied.

Q. Well, it rather looks like you are suggesting to the Executives that you will carry out some kind of investigation of which nurses were on duty or associated with the deaths and when I say "you", I mean you collectively, not you personally?

A. Yes, yes.

Q. So again would you say that is another wrong turn that the review is taking in that first meeting?

A. It could be seen like that, yes.

Q. Well, do you see it that way?

A. Yes.

Q. We then see "CM's process", and was this you with your background and experience trying to understand for yourself what had been done so far as the nurse who you had been told about was the subject of suspicion?

A. Yes. I believe I was asking about what process had been undertaken.

Q. Yes. And if we go over to page 4, we can see again it is not attributed to anybody but what seems to be said is:

"Just taken out of duties. How to get her back in again."

A. Yes.

Q. That seems perhaps more likely that that's the Executives speaking --

A. Yes.

Q. -- rather than the reviewer. But on the basis of that note, what seems to be being said to you, the reviewers, on 1 September by the Executives is that they have taken her out of the duties, but what they are looking to do is get her back?

A. Yes.

Q. Is that what they were telling you at that time?

A. I think that was the impression we got which gave us the impression that they hadn't given any credence to the allegations.

Q. Page 5. We can see right at the bottom:

"CMC parents complaints", which appears to be you asking whether the parents had complained, and then what appears to be an answer from the Executives:

"Contacted as many parents as possible before it went to the paper. No extra complaints."

Then over the page:

"Accepted we are doing the right thing. Nobody had raised concerns."

And no -- and there is a triangle signalling no draining, presumably, before that in terms of complaints or no warning."

Did you think that the views of the parents were important to your review?

A. Sorry, could we go back down to the previous page?

Q. Yes, of course.

A. Because I think this was about the unit being downgraded.

Q. I think the preceding topic is discussion about Occupational Health as recorded in these notes.

A. I don't -- I don't know, I can't recall the context that I would have asked about that.

Q. Bearing in mind that Ms Mancini appears to have asked to see the postmortem results in relation to those babies, what was the ethical position so far as the RCPCH were concerned and consent? Would you have regarded yourself as needing to get the parents' consent before you could see a postmortem on their baby or would you have regarded that as something, I mean, I saw your expression there and quizzical perhaps is the right way of describing it?

A. Yes.

Q. I mean, you were there representing the interests of patients and parents --

A. Yes.

Q. -- and so on, so invading their privacy is something that you would have an eye on presumably as part of that function to make sure that their confidentiality was respected. What did you understand the position about whether they needed to consent to postmortem reports about their babies being given to the reviewers?

A. I can't say I gave it thought at the time.

Q. Do you think that's something you should have been thinking about?
A. I should have done.
Q. Do you think that there's a possibility at least that you were for whatever reason perhaps not putting the parents of those babies at the centre of your thinking as you were conducting this review?
A. I can't, I can't, I can't say. Perhaps they weren't at the centre.
Q. Is it fair to say that of all the people who were there, and everybody should have that in mind, but it was your role to be the check and balance on that and ensure that that happened?
A. But -- yes.
Q. The next discussion -- thank you, we can take that down and again I am certainly not trying to rush you, but we have been over some of this already in terms of what you were told. You had a discussion with Dr Brearey and Dr Jayaram and in summary, they told you that things had been fine until June 2015 when they had had three deaths?
A. (Nods)
Q. And that at that stage, the fact that there was a common nurse was noted but not thought to be significant?

A. Yes.
Q. Dr Jayaram told you how it was the way in which the babies collapsed which was the concern to him?
A. (Nods)
Q. And they told you about the thematic review that had been conducted and said that the deaths -- increase in the mortality rate was still unexplained?
A. Yes.
Q. They told you about the fact that the nurse that they were concerned about had been on shift at all the times and that that had been something that they had told the Executives; is that right?
A. Yes.
Q. And they told you that Letby had been moved from night shifts to day shifts and that the pattern had then changed?
A. Yes.
Q. Now, Dr Stewart's note of that meeting includes this:
"Paeds worried about foul play."
And that is something that you looked in your statement to reflect upon. Do you recall the phrase "foul play" being used?
A. I don't think so.
Q. But they were worried about murder, weren't

they?
A. Yes.
Q. So whatever --
A. Yes, yes.
Q. Well, they also told you that they conducted research into how Letby might have killed the babies because they told you that they had looked up air embolism, didn't they?
A. Yes.
Q. And the notes record the word "chilling" against Dr Jayaram as he described the process of him conducting that research. Do you remember him using the word "chilling"?
A. No.
Q. Do you have an impression of the emotion or lack of emotion that he spoke about this with?
A. No.
Q. The note also makes it absolutely clear "injecting air into babies", that's the handwritten note of what was being said.
A. (Nods)
Q. So is it fair to say that at the end of that meeting, you had had communicated to you very clearly that they at that moment in time suspected -- no more than that, suspected -- that Letby may have murdered

babies?
A. Could you take me to that note, please?
Q. Yes, of course.
A. Sorry.
Q. INQ0014604. Which particular part of it? Is it the embolism?
A. Yes.
Q. Yes, of course. So we will go to page 10 for this. So we see at the bottom:
"When thinking forensic what happens with air embolism? Looked at case studies and last [query] observation: chilling. Just like what happened. Babies [and then if we go over the page] unresponsive to any inputs."
And lists them:
"Odd skin discolouration, blue with eyelids of pink in the ..."
And then this:
"Injecting air into the babies" with "??" against it.
So that is what I was suggesting the notes record?
A. Sure.
Q. My question was whether you agree that at the end of that meeting, they had communicated to you and the other reviewers that they were suspicious of whether

Letby had murdered babies?
A. I'm not sure. I don't remember those words being said. So I'm not sure whether they those words were said or whether that is Ms Eardley's interpretation of what was being said.
Q. Well --
A. I'm sorry, I just don't remember that and I don't remember the word "chilling" being used.
Q. Well, there are a number of possibilities that arise, if you don't remember.
One of them is that it wasn't said, although we do know what Ms Eardley has recorded?
A. Yes.
Q. Another is that you didn't really in light of what the Executives had told you, perhaps, think that what they were saying was important or significant?
A. I don't recall it. That's the problem.
Q. But if somebody had told you that they thought somebody else was murdering babies, that's quite a memorable thing to be told, isn't it?
A. It is, which is --
Q. So can you help us at all?
A. I am trying to help. I don't recall.
Q. We know that the meeting -- thank you, we can take that down -- which followed was with the other

Consultants and they were all concerned, weren't they, between them, about the deaths, that was the impression they were giving, and did they appear to you to be supportive of Dr Brearey and Dr Jayaram?
A. Yes.
Q. So now we are up to seven Consultants who appear to be crediting this possibility; do you agree?
A. Yes.
Q. Then there is a discussion at lunchtime. Do you know what the phrase "war gaming" means?
A. I -- I know what I think.
Q. Yes, well, I want to make sure we are on the same page, so an unusual phrase --
A. Would you explain it from your perspective?
Q. Yes, of course it is the notion, and it's often used in the context of military medicine because of the overlap, of where doctors -- military doctors -- come together and they come up with scenarios as to how you might treat a patient or how a particular piece of surgery might happen, they just talk about it in terms of "war gaming" that, so it is the idea that you talk about multiple scenarios in a constructive way?
A. Okay.
Q. You are familiar at least with the idea of doing that

What I suggest is that effectively what happened at lunchtime based upon the notes of what Ms Eardley told us was that the doctors war gamed how Letby may have been murdering the babies.
Do you remember such a conversation?
A. No.
Q. Well, let's have a look at the note INQ0010124, page 23. This is the typed note and I am going to make a correction based upon what we know to be right and can I say that you will see that two words are redacted, we are not going to mention those words?
A. Okay.
Q. If you need to see them to remind yourself, then I will find a way for you to do that?
A. Okay, thank you.
Q. But it may very well be that we don't need to in order for you to understand the flavour of what we are talking about.
So page 23, please. So right at the bottom under the line, the word is "team" that is what we understand from Ms Eardley, it actually in the typed notes says "Tom" but it is team?
A. Thank you.
Q. She told us these are her notes of the lunchtime meeting and that's where they fit in the

sequence and she told us this was the first opportunity that the team had had to sit in private and discuss everything that they had been told, much of which was new to many of them. And that there are two words that you can simply take it from me that those are chemicals.
A. Okay.
Q. Okay so two different types of chemical:
"... or insulin injection or air embolism but all had different presentation."
That is what her note records. This was a conversation she told us at which the team was together at lunchtime and at which the doctor members of the team were having a discussion about how it could be that there were different presentations for each of these babies if somebody was murdering them and they were war gaming how that might have occurred by making suggestions about embolism, insulin injection, and those two other matters that we are not going to publicise.
Do you remember that conversation?
A. No.
Q. Do you know why you wouldn't remember that conversation, is it because that's not something that you would have paid attention to or do you think that you were not present, or what -- what explanation might that be --

A. I do not recall that at all.
Q. Because would you agree that's quite an extraordinary conversation for the Review Team to be having at lunchtime on day one of the RCPCH visit?
A. I don't recall. I -- I -- I may not have been there, I may have been doing something else but I do not recall. I was not participating in that conversation.
Q. Forgive me. My question was: do you agree that that is an extraordinary conversation?
A. Yes.
Q. Do you agree that the very fact of that conversation, whether or not you were present, the very fact of that conversation is itself the clearest indication that at that stage the reviewers should have said --
A. Yes.
Q. -- if we are getting into a conversation about how you might murder babies, we just need to walk away from this and the police need to be involved?
A. Yes.
Q. So would you say that anybody involved in that conversation ought to have been saying that?
A. Yes.
Q. We can take that down, thank you very much.
After that lunchtime break, the next meeting was

with the safeguarders. Do you remember meeting some of the safeguarding team, Dr Mittal --
A. If I was there then I was.
Q. -- and Dr Isaac. So I believe this isn't one of the meetings you suggested you weren't present at.
Now, one of the functions of your Invited Review was to look at how well policies and procedures were implemented and how robust things were around process. Is that right?
A. Yes.
Q. One of the policies and areas that was being investigated was what was the approach to safeguarding; is that right?
A. Yes.
Q. No doubt that explains why the safeguarders were spoken to.
We will circle back to the start of my questions.
What the doctors told you, the Consultants told you, do you agree fits into the definition of a safeguarding allegation?
A. Yes, it would.
Q. A meeting took place with the safeguarders and one way to test how robust procedures would be would be to say: are you aware of this concern?
A. Yes.

Q. Would that have been an appropriate question to ask?
A. Yes.
Q. Now, there is no record, you can take from me, that that question was asked. Do you think it should have been?
A. Yes.
Q. Although it's a collective responsibility, do you accept that you had some responsibility in that?
A. Of course.
Q. Now, Alison Kelly was the Executive Lead for safeguarding and we know that because that's within the material that was provided to the reviewers. Do you have any recollection of her being asked in the context of this allegation; you are the safeguarding lead, how is that being dealt with from a safeguarding perspective?
A. I don't recall that question being asked.
Q. Well, do you think that the reason for that is because it wasn't asked?
A. Yes.
Q. And do you think it should have been?
A. Yes.
Q. Letby was spoken to by you and Ms Mancini?
A. Yes.

Q. She wasn't originally scheduled to be spoken to. It has been suggested by Ms Eardley that it was your idea, that is her recollection, and she says it was to give Letby an opportunity to give her perspective, that is Ms Eardley's recollection.
Do you know whose idea it was?
A. I cannot recall how the idea materialised, I don't know.
Q. Do you agree it was a wrong turn?
A. I do now.
Q. Well, did you have enough information at the time to realise that that was a wrong turn?
A. No.
Q. You didn't?
A. No.
Q. Well, you had a couple of hours earlier spoken to some Consultants who told you they thought she was a murderer, or she may be.
Was that not sufficient reason to think: probably shouldn't be going to speak to her?
A. No.
Q. Why not?
A. Because of all the other information that we had that muddied the waters around her as a person.
Q. But you were conducting a service review. Why

were you investigating an individual case?
A. We weren't investigating her. We were interviewing her as part of the -- the nursing cohort.
Q. Well, my question was to suggest that you were investigating her. It was her case, I was suggesting, putting it as broadly as that, whether from an HR perspective or any other perspective; you weren't there to look at individual situations, were you?
A. No, but we didn't ask her about the case, her case.
Q. Well, you were asking her about how she had been treated?
A. And relationships on the unit and those type of questions. It was much broader than that.
Q. But you had already identified all the people that you needed to speak to for that purpose, hadn't you, they were already rostered?
A. Yes.
Q. So presumably the only reason that you wanted to speak to her was because of what you had been told about her in the morning?
A. She would have been in with the other group otherwise, with the other group of nurses otherwise.
Q. So you think that Letby would have been spoken to the following day?

A. Had -- had she not been moved from the unit and she wasn't allowed to contact people on the unit.
Q. How do you know that she would have been spoken to the following day; you didn't speak to all of the neonatal nurses?
A. Well, she, she -- okay, she could have been spoken to the next day as part of the group of nurses that we spoke to.
Q. But the only reason that you would need to speak to her as opposed to whichever nurses were available to speak to you was because of what you had been told in that morning?
A. It felt like the right thing to do at the time.
Q. Well, I am not disputing that. But did you not have sufficient information to realise that you were now moving in a direction that you ought not to have been moving?
A. We didn't think that at the time.
Q. Again, but did you have enough information to realise that as a reasonable conclusion?
A. Clearly not, otherwise we wouldn't have done it.
Q. Now, in terms of the discussion we have a record of that, I don't want to ask you any questions

about that and you made notes so we can refer to those.
I want to ask you about what may not have been recorded in the notes, certainly what is suggested by Letby, who we must not lose sight of the fact is a convicted murderer, but she sent contemporaneous messages to Dr U which I think you have seen and had a chance to refresh your memory from.
INQ0000569 and it's page 34. Page 34. Can I just give the reference INQ0000569. Well, can we just take that down from the screen for the moment. I am going to need just to read this out to you. I know you have had a chance to, but I don't want to create any unfairness but I am not going to have that entire document up on the screen so can we take it down, please.
The first message sent at 18:14. She says to Dr U:
"Thank you for your help. The two members were nice."
Presumably a reference to you and Ms Mancini:
"They didn't ask much about the babies, it was more about the unit as a whole, et cetera."
In brief it looks as though there is potential for this to go further over a long period of time. H [presumably Hayley Cooper who was her RCN representative] thinks we need to look at taking out a grievance case."

That is her first message to Dr U.
About 15 minutes later she sends another one:
"The report will take a minimum of six weeks with the preliminary tomorrow. They 'off the record' told me they think an investigation into the deaths will be a recommendation and I need to prepare myself that as I would play a big part in that over due to being a common factor and it could take several months."
All right, so I know you have seen those messages before and you weren't in fact a party to them at the time.
A. Yes.
Q. I just want to ask about that. Was there an off-the-record conversation involving you, Ms Mancini and Letby?
A. Not that I recall, no.
Q. Did you discuss whether she should take a grievance?
A. I believe her Union representative mentioned that in our conversation.
Q. I mean, it was in your mind at the end of that day one that there would be a recommendation for an investigation, wasn't it?
A. Yes, I -- I guess, yes.
Q. And what she seems to be saying is there was

some discussion about the impact upon her because she said "I need to prepare myself". So that is what she's reporting that she's being told. So that is a discussion about how she should cope with it. That is her characterisation of it?

A. Sure.

Q. Do you have any recollection at all?

A. No.

Q. Now, it appears that Letby ended up with your telephone number. Do you know how that happened?

A. No.

Q. Did you give her your telephone number?

A. No.

Q. You suggest in your witness statement:

"It appears that if my number was given to them it was by the Invited Review manager."

Who do you mean by the Invited Review manager?

A. Ms Eardley.

Q. Ms Eardley. What do you base that upon?

A. The way the -- the one of the notes was written the next day, I think.

Q. Well, let's have a look at that.

A. Gave -- I think it said "Gave Claire's number".

Q. INQ0014605, page 6. We will just come back to

that issue in a moment. We will take it in order that it appears. Somebody appears to say:

"Not sure if the review will give you the answers you are looking for. Considered aborting and starting again but Terms of Reference to be important to get the background."

Do you see that at the top?

A. Yes, sorry.

Q. Do you recollect a discussion in which the team considered aborting?

A. I think there was a discussion, yes.

Q. What -- who was in favour, who was against?

A. I -- I don't recall.

Q. What consideration, if any, was given to the possible impact upon a regulatory or police investigation if you carried on?

A. I don't recall the conversation so I couldn't say.

Q. Well, do you have any reason to think that that was mentioned by anybody?

A. I -- it would be speculation to say so.

Q. We can see that it continues:

"Need independent Casenote Review of all the deaths by two independent people. Big concerns about Lucy plus need formal process to be started so she knows where she

is."

So by that stage, that conclusion had been reached that there needed effectively two processes, one Casenote Review and one formal process for Letby?

A. Yes.

Q. Then if we see further down, about two-thirds of the way down:

"We were worried to let her go home."

That is just picking up:

"Hayley to take her home, gave Claire's number to Hayley plus Lucy worried about her mental health as feels that everyone has turned their backs on her."

A. Yes.

Q. That is the reference in the notes to your number?

A. Yes.

Q. So you were present at this meeting?

A. (Nods)

Q. Did you have any concerns about the fact that your number had been given to Letby?

A. I don't -- I don't recall that, the only reason I know about this is from the note, not from giving my number. I -- I didn't give her my number.

Q. But what appears to be occurring is that at a meeting that you are present at, somebody is talking

about having given your telephone number to Letby?

A. I don't recall it being said. I only know about it from the note.

Q. Then we can see last paragraph:

"Needs to be put into a process for her protection and yours. Disciplinary process to get to the bottom."

This appears to be that she is going to be disciplined on the basis of the allegations of the Consultants; is that right?

A. Well a process to be put in place to --

Q. Well, a disciplinary process?

A. I don't remember saying "disciplinary process" so a process needed to be put in place because she had been moved from her place of work to another place of work, within the -- within the Trust without any process being put in place to do that.

And then something needed to be done in order to investigate the allegations that were made about her.

Q. Do you agree that a disciplinary process to investigate the Consultants' allegations would be completely inappropriate?

A. But this is the type of process that needed to be put into -- in place that the Invited Guide Review I believe it is that we looked at earlier talks about for misconduct.

Q. They weren't just talking about misconduct?
A. No, no.
Q. Murder is a form of misconduct, they are talking about murder so --
A. I appreciate --
Q. I'm sorry, I don't want to talk across you but can I just ask my question: do you agree that a disciplinary process to get to the bottom of the Consultants' allegations would be inappropriate?
A. Yes. But something had to be started in order to put a formal process in place.
Q. Well, would calling the police be enough to start it?
A. Not without other things happening. So she should in my view have been put through a process that would have suspended her from practice, referred to the NMC, referred to the police, and the processes allowed to take their course.
Q. Why don't you phone the police first?
A. The order in which it happened wouldn't -- just -- it's hard to explain that this all should have been done way before the College was involved in this process. By just moving Ms Letby to another place of work without doing anything, without inform -- putting any formal process in place, left everybody at risk

including other patients in the hospital, her access to records, all sorts of things.
Q. My question was: why not call the police first?
A. I agree.
Q. So we then read on. There's reference to a grievance which you tell us you knew about.
"If nothing happens good case for constructive dismissal. She knows it will be horrid."
So that appears to be somebody at this meeting telling the Executives that they have, that inferentially Letby must know about the fact that there is a process to come and that it's not going to be very pleasant for her which is very much the tenor of her message to Dr U the night before about how she needed to prepare herself for it.
Just seeing --
A. Yes, I can see that.
Q. Just seeing this note now, bearing in mind this is something either said by you or said by Ms Mancini because you were the only two people who could speak to Letby's state of mind, does it look in fact as if there was this off-the-record conversation in which you and Ms Mancini told Letby that there was going to be an investigation that she needed to prepare

herself for?
A. I don't know who said that. I can't answer the --
Q. Well, what other explanation can you offer for why it was said either by you or in your presence "she knows it will be horrid"?
A. But without knowing whether those were the actual words that were said, I -- I don't know.
Q. We are going to move away from the content the review, there were obviously other meetings that you had including with senior nurse, we have the notes for that.
I would just like to move to the letter of 5 September. But before we do, we just need to go, while we still have this on screen, to page 34. So this is the feedback session which -- we can go up if you need to, but I hope you will be able to take from me that this is the feedback session involving Mr Chambers right at the very end of the process?
A. Thank you.
Q. We can see "Tony, were these unexpected" is right in the middle of the page there just to anchor you where we are?
A. Yes, thank you.
Q. Immediately above that "CM", so presumably you:

"... will list some areas of point to check in the detailed review what needs looking at."
So ascribed to you in this note that's not your note, it is Ms Eardley's note, in the context of a more in-depth review of cases, you appear to be recorded to be saying:
"Will list some areas of point to check in detailed review."
A. I don't recall. I don't know what that means.
Q. Well, let's see if we can have a look and see the recommendation. INQ0009611, this is the letter of 5 September, where the detailed Casenote Review is recommended.
If we go to page 2. We can see that there are some points to check to use the language of that note. This investigation should include as a minimum the following elements ..."
Then there are four listed.
A. Yes.
Q. So what we appear to have is a meeting three days earlier in which the record indicates that you said: we are going to give you some points to check for the forensic Casenote Review and then we have a letter which provides that. My question will come as no surprise. What contribution did you make to those

items?
A. I don't recall making any contribution to those items.
Q. If we look at (d), for example:
"Details of staff with access to the unit from four hours before the death of each infant."
Are you able to recognise that that is an inappropriate recommendation for the RCPCH to be making?
A. Yes.
Q. Because that's a matter for the police, isn't it?
A. Yes.
Q. Now, you were involved in the drafting of the report in that you made some comments, but presumably you read it through thoroughly and were signed up to the finished product?
A. Yes.
Q. INQ0010131. What we are just going to have a look at now is page 6, please. Are we able to crop in towards the right-hand side? So just the centre middle, please, thank you.
This is a part about the deaths in the report and you have added a comment:
"I think we should mention here that some of these were actually congenital abnormalities which were

counted as unexplained and unexpected."
Now, first of all, that's very much a medical issue, isn't it, that is under discussion there?
A. Yes.
Q. And your function wasn't to make a medical contribution --
A. No.
Q. -- to this report; is that right?
A. That's correct.
Q. One interpretation of what you are doing there is to diminish the potential significance of the apparently unexplained and unexpected by implying that some of them may be a result of congenital abnormalities. That is one interpretation. Do you recognise that at least --
A. Yes, yes.
Q. -- as an interpretation?
A. Yes.
Q. What you say in your witness statement is:
"I thought it would be appropriate to provide some balance ..."
A. Yes.
Q. "... in connection with this."
Were you seeking to diminish the significance of those factors by implying that perhaps the deaths were

as a result of congenital abnormalities?
A. No.
Q. What explanation do you offer for proposing that change, bearing in mind it's a medical issue?
A. As I explained in my witness statement, it was to provide balance.
Q. What do you mean by balance?
A. We had been told by some of the senior nurses, I think, that the cluster of babies included some of those with congenital ...
Q. Is that something the doctors had told you?
A. Abnormalities.
Q. Or that they thought were significant?
A. No.
Q. Well, let's imagine the balance that you have described. On the one hand you have got the fact that these are unexplained and unexpected. Are you suggesting that there is a countervailing factor to somehow balance out that fact?
A. Well, yes, because if some of them were as a result or some had congenital abnormalities then it would be remiss not to add that balance in.
Q. Well --
A. As I understand it, my comment was removed so it didn't happen.

Q. Well, it is about your state of mind that we are looking at, not what was ultimately in the report because an interpretation of this proposal was that you were trying to minimise the seriousness of what the doctors were suggesting --
A. No.
Q. -- by suggesting that there was a natural explanation for the increase in neonatal mortality?
A. No. I was just trying to provide some balance.
Q. The overall report did not provide an answer to the question at term of reference 4, did it?
A. No.
Q. Finally, you say in your witness statement that the fact that there were two reports was inappropriate --
A. Yes.
Q. -- or not appropriate. Why do you say that?
A. It lacks transparency.
Q. Is that something that you said at the time?
A. I think I spoke to Sue Eardley about it.
Q. Before the report was released?
A. I can't remember when. But yes, I think, yes at some point during that process.
Q. What did you say to Sue Eardley?

A. I don't recall. But I have had a conversation with her about being -- there being more than one report.

Q. Was the thrust of the conversation as you have told us that you thought that was inappropriate because it lacked transparency?

A. Yes, and it's confusing around version control and who sees what.

MR DE LA POER: Ms McLaughlan, those are my questions.

LADY JUSTICE THIRLWALL: Just wait there.

Mr Sharghy, you have some questions.

Questions by MR SHARGHY

MR SHARGHY: Ms McLaughlan, good afternoon, I represent one of the Families whose child was murdered by Lucy Letby and I also ask questions on behalf of six other Families as well.

I am not going to go over, you will be glad to hear, a lot of the issues.

A. Sorry I am having real trouble hearing you.

Q. I am so sorry.

Is that better?

A. That's much better, thank you.

Q. Thank you, I am not going to go over a lot of the issues that you have already been asked questions

about but there are a couple of matters that I do want to just press further, if I may.

As lay member of the Review Team it is fair to say, isn't it, that you are not just there to make up the numbers?

A. Yes.

Q. That your role would be integral to any discussions or indeed meetings that take place either before the review starts or indeed during the review process?

A. Yes.

Q. Are you comfortable that you were involved in all discussions between the Review Team or indeed any meetings that took place?

A. I was, but I understand from looking at this information that there were discussions between the lead reviewer or email exchanges between the lead reviewer and Ms Eardley that I believe the rest of us weren't party to.

Q. The reason I am asking you this is because Mrs Mancini is going to give oral evidence just after you, but she has said in her written witness statement to the Inquiry that there was a discussion before the review actually began in relation to additional evidence that the Review Team believed would be of assistance but

the feeling amongst the team was that there was some limitations in gathering the detailed information from the Trust within the remit of the Terms of Reference.

Does that ring true to your knowledge as to that discussion?

A. I don't recall a discussion like that.

Q. Do you recall any discussions at all whether with the entire Review Team, or indeed with one or two members, where the concept of additional documents was raised?

A. Not specifically, no.

Q. Did you believe when you received the information from the Trust that was placed on the Huddle system --

A. Yes.

Q. -- that it contained all of the relevant information for you and your colleagues to undertake the review?

A. I assumed it did but then again looking through the pack, the bundle that we received, afterwards there was obviously additions later on that I don't recall seeing.

Q. In relation to the process as it unfolds from the morning of 1 September, when the review begins, you say in your witness statement it became quite clear

early on in the interviews -- and I think there you are referring to those with the Consultants Dr Brearey and Dr Jayaram -- that there are these concerns raised in particular regarding a connection between increase in neonatal deaths on the unit and a particular individual on the unit; is that fair?

A. I think that was raised actually in the very first meeting with the Medical Director, but then again with the Consultants, yes.

Q. I am just going to press you a little bit further in relation to the decision thereafter made to interview Lucy Letby, knowing what you then knew, on that morning.

Given that there were other nurses who you could have interviewed as a team, whether on that day or the day after, and putting aside that the service review was not going to consider any allegations against Lucy Letby, why was she so integral to the interview process that she was interviewed on that first day?

A. I think it was about availability, but I -- I don't know. I didn't arrange the -- the interview so whether it was about availability, timing, I -- I can't answer that.

Q. But specifically given what you were aware of by that stage, as a patient and public interest

representative on this panel, did you not even begin to imagine that there could be a conflict here?

A. I clearly didn't.

Q. We heard from Hayley Griffiths, you may have known her as Hayley Cooper at the time, who was the RCN rep that accompanied Lucy Letby to that meeting. It was a fairly short meeting she indicated?

A. (Nods)

Q. Fairly shortly after the questioning had started Lucy Letby becomes very emotional and she leaves the room. What Mrs Griffiths said to this Inquiry is that one of the members, either yourself or Mrs Mancini said something along the lines of: does she realise the gravity or the severity of the allegations that are being made against her?

Was that you who said that?

A. I don't recall that happening at all. I don't recall Ms Letby leaving the meeting.

Q. You don't recall --

A. No.

Q. -- Lucy Letby becoming very emotional, leaving the room and being followed by her representative?

A. No.

Q. And you have no recollection that one of the two interviewers had said anything along the lines of:

do you realise how severe that those allegations are?

A. No. She was very upset in the meeting which was why I was concerned for her mental health at that time. But I don't recall her leaving the meeting at all.

Q. Final question.

At paragraph 81 of your witness statement, you say that although you weren't involved in this discussion you did look at the transcript of what Andrew Higgins, who was a non-executive director, had said in relation to issues about why the police were not being called and why an independent review, effectively your review, is the most appropriate concept.

The words that are ascribed there is that:

"He indicated that: it's important to keep the shutters down and contain the situation."

Do you now understanding not just what you knew at the time, but also on reflection, appreciate that that is precisely what the review that you were part of did?

A. I wouldn't put it like that.

Q. How would you put it?

A. We were doing our best to help the Countess of Chester Hospital to discover what was going on. We were in a long line of organisations who were asked to look at those problems that they had got.

I can see why you would say that, but from the inside it didn't feel like that.

Q. On reflection, you don't believe that that is exactly what happened, the shutters were kept down and the situation was contained, ie the police weren't called?

A. That is your interpretation of that.

MR SHARGHY: Okay, my Lady, thank you those are my questions?

LADY JUSTICE THIRLWALL: Thank you, Mr Sharghy. Ms Scolding?

MS SCOLDING: I have no questions of this witness, thank you very much.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Thank you very much indeed.

Just one matter from me just in relation to the end of the meeting with Ms Letby. I just want to check my own note.

Do you have any memory of speaking to Ms Cooper --

A. Not.

LADY JUSTICE THIRLWALL: She has a memory of thinking she had forgotten her coat and so went back in to the room and spoke to you without Ms Letby being there.

A. No, I have no recollection of them being separate at all.

LADY JUSTICE THIRLWALL: No, all right.

One final thing. When you were talking much earlier in your evidence about the evidence of the rota which you were attributing to Dr Brearey, although we note its genesis was with Eirian Powell, you said the doctor was one person who may or could have manipulated that information.

What was your basis for saying that?

A. Well, I was hesitant in saying it but I couldn't think of another word but we hadn't seen -- we had seen I think we had seen the doctors' rotas on Huddle.

LADY JUSTICE THIRLWALL: Yes, and you told us about that. I just want to know what you meant, or whether on reflection you don't want to repeat it, that he was one person who may or could have manipulated it and I was puzzled about that. What do you mean?

A. We -- because we didn't see the original data we had only got the interpretation of the data which can be, it can be manipulated is what I meant.

LADY JUSTICE THIRLWALL: So that you didn't have a basis for saying it had been manipulated?

A. No, no it wasn't a -- it was -- it, the --

it's easy to even make a mistake in putting data into an Excel spreadsheet to get that information back out again.

LADY JUSTICE THIRLWALL: So he may have made an error would have been another way to put it?

A. I wasn't suggesting that he had, but we didn't -- because we only had that Excel spreadsheet that had already been -- the data had already been entered to, we hadn't seen the source data.

LADY JUSTICE THIRLWALL: Thank you. Anything you want to ask, Mr De La Poer?

MR DE LA POER: My Lady, no, thank you very much.

LADY JUSTICE THIRLWALL: Thank you very much indeed, Ms McLaughlan. You are free to go.

A. Thank you.

MR DE LA POER: My Lady the next witness is Ms Mancini and subject to my Lady's better view we were proposing to move on with her evidence now.

LADY JUSTICE THIRLWALL: Yes.

MR DE LA POER: Albeit that I think Mr Carr will be asking for a shortened lunch break today when we get to it.

LADY JUSTICE THIRLWALL: Yes. Thank you, Mr De La Poer. So if you would like to re-organise the front bench. If you would like to come straight up to

the desk.

MS ALEXANDRA MANCINI (sworn)

Questions by MR CARR

LADY JUSTICE THIRLWALL: Do sit down.

A. Thank you.

MR CARR: Can we start with your full name, please.

A. Alexandra Mancini.

Q. You have prepared two statements for the purposes of this Inquiry, the first dated 26 June 2024 and that deals with your involvement in the RCPCH review?

A. Yes.

Q. A second more recent statement dated 6 November 2024, addressing recent work you have carried out, developing a framework for BAPM?

A. Yes.

Q. Now, in respect of your first witness statement, and that's the one that I am going to be asking you questions about, I understand there is a correction you want to make?

A. Yes.

Q. It's at paragraph 87 of that statement. where you deal with discussions about police involvement and I think it's the last two sentences that you want to correct?

A. Yes.

Q. So do you want to read those sentences and tell us what the correction is?

A. Yes, read them first as they are?

Q. Read the final two sentences first and then tell us what the correction is.

A. Okay:

"I wasn't actively involved in discussions with Ian Harvey about involving the police. The Review Team recommended that the Medical Director and senior management contact the police directly."

Q. Yes, that is what it says at present. What is the correction?

A. Okay, the correction is that:

"The Review Team had a discussion about recommending that the Medical Director and senior management contact the police directly. We had that discussion and we made a decision that we wouldn't recommend that in the recommendations of the report."

I think that this is an absolute oversight on my part as I was preparing my witness statement, that this is one of the questions that was put to me and I haven't taken it out of the witness statement.

Q. Subject to that correction, are the two statements true, to the best of your best knowledge and

belief?

A. Yes.

Q. Before I start asking questions, I think there is something that you wish to say.

A. Thank you. I would like to speak directly to the parents and offer my deepest and sincerest condolences that your babies have died and this -- I can only imagine how distressing this must be for you, so I am very, very sorry for what's happened.

Thank you.

Q. By profession you are a neonatal nurse?

A. Yes.

Q. You tell us in your statement that you qualified in New Zealand. There were two dates of qualification in your statement. Paragraph 1 suggests 1991; paragraph 2, 1990.

A. Okay. I do apologise. It should read 1990 for both.

Q. In 1993 you started working as a paediatric nurse?

A. Yes.

Q. Since 1998, you've worked as a neonatal nurse?

A. Yes.

Q. You have held -- and this is set out in your witness statement -- a number of senior leadership

positions?
A. Yes.
Q. You spent around six years working as a matron on a neonatal intensive care unit?
A. Yes.
Q. You explain at paragraph 4 of your statement that at the time of the RCPCH review, in 2016, you were the Pan London Regional Lead Nurse for national palliative care?
A. For Neonatal Palliative Care.
Q. You weren't a member of the RCPCH, were you?
A. No.
Q. Your Royal College was?
A. The Royal College of Nursing.
Q. You were nominated by the RCN --
A. Yes.
Q. -- to serve on this review and you say, it is paragraph 4 again, that was due to your nursing experience, clinical governance experience as matron and expertise as Pan London Lead Nurse for Neonatal Palliative Care?
A. Yes.
Q. What did you understand to be the nursing perspective or the reason for a nursing perspective being required for this review?

A. I understood it to be I was part of a team, I was being asked to be part of an expert team to bring expertise and experience to a review process and so the nursing perspective will always consider the nurse staffing, the nursing culture and really ensure that there's a multi-disciplinary approach within that team.
Q. If we can turn to safeguarding, knowledge and training, please. You say at paragraph 6 of your statement that you have not received specific safeguarding training in respect of what to do where abuse on the part or a member of staff towards babies or children in hospital is suspected.
Do you recognise as a broad principle of safeguarding that concerns relating to the harm of children should be escalated?
A. Yes.
Q. That is something that you would have appreciated at the time?
A. Yes.
Q. Did you consider there was any reason that that broad principle wouldn't apply to staff members in hospital?
A. No.
Q. Were you aware at the time of the review of the statutory guidance contained in Working Together to

Safeguard Children?
A. Yes.
Q. It was a 2015 edition that would have applied at the time of the review and it was a requirement, wasn't it, of that guidance that it was read and applied by healthcare workers?
A. Yes.
Q. If we can have up on screen, please, INQ0013235, page 54. We are going to look at a part of the statutory guidance.
The guidance sets out, doesn't it, the process to be followed in respect of allegations made against people who work with children and if we look at the top of the page, page 54, the third paragraph down, that starts:
"Clear policies ..."
Then if you go to the final sentence of that paragraph, it reads, it has been highlighted:
"An allegation may relate to a person who works with children who has ..."
Then there are a number of subparagraphs:
"Behave in a way that has harmed a child or may have harmed a child, possibly committed a criminal offence against or related to a child or behaved towards a child or children in a way that indicates they may

pose a risk of harm to children."
In respect of those definitions, the explanation of an allegation, each of them sets a relatively low bar, doesn't it, it's "possibly", "may" ...
A. (Nods)
Q. The requirement, and we will see this at the bottom of the page, paragraph 7, is for any allegation to be reported immediately to a senior manager?
A. (Nods)
Q. Do you have that, where it's highlighted:
"Any allegation against people who work with children should be reported immediately to senior manager within the organisation"?
A. (Nods)
Q. Then the next sentence:
"A designated officer or team of officers [going on to the next page, please] should also be informed within one working day of all allegations."
The reference there to the designated officer, that is the Local Authority Designated Officer, isn't it?
A. Yes.
Q. So taking all of that together, where there is allegation of possible criminal offending, involving somebody who works with children, it must immediately be reported within the organisation and within 24 hours

escalated to the local authority?
A. (Nods)
Q. Did you understand that process --
A. Yes.
Q. -- at the time of this review?
Turning, please, to your recruitment for the review and your experience and training. Paragraph 29 of your statement.
A. Sorry, did you say 79?
Q. 29.
A. Sorry. Yes.
Q. You state there:
"Prior to the Countess of Chester Hospital Invited Review I had not participated as a member of a Review Team."
A. Yes.
Q. To be clear, you are referring to not having participated in a Review Team for any College, so not simply the RCPCH, also the RCN or anybody else?
A. Yes.
Q. So this was your very first --
A. First time.
Q. -- Invited Review.
At paragraph 33, you note that in your wider practice, you had experience of reviewing individual

deaths but not of reviewing a cohort of unexpected or unexplained deaths?
A. Yes.
Q. Did you raise with either the RCN or the RCPCH your lack of experience in assessing or reviewing a cohort of cases?
A. Yes. From a perspective that I said this was the first time that I had participated in a review of this kind, so I said that both to Fiona Smith at the RCN and to Sue Eardley.
Q. Reflecting on your own practice, your own experience as a neonatal nurse, how common -- if it was common -- were unexpected and unexplained deaths of neonates?
A. In my experience --
Q. Yes.
A. -- it wasn't common.
Q. Would you agree that it was extremely unusual for newborns to die unexpectedly and without a clear diagnosis or explanation?
A. Yes.
Q. So would the fact that there was a cohort of unexpected and unexplained deaths by itself be a cause for concern?
A. Yes.

Q. Had you had experience within your practice -- I know you hadn't reviewed a cohort but had you had experience within your practice of a cohort of unexpected and unexplained deaths, is that something that you had seen before?
A. Not a cohort; individual cases.
Q. Do you consider -- you explain that you raised with both Fiona Smith and Sue Eardley your lack of experience. Do you consider that your lack of experience both in undertaking reviews and your limited experience of unexpected and unexplained deaths meant that this was an unsuitable first review for you to undertake?
A. We didn't discuss that.
Q. Do you think it may have been beyond your competence and experience, too complex to undertake as a first review?
A. I think that the experience that I brought to the Review Team was as a senior neonatal nurse thinking about culture of the unit, thinking about staffing, about how neonatal units are run and those were the other Terms of Reference.
But I agree that I didn't have the experience of reviewing a cohort of babies with unexplained or unexpected deaths.

However, within the team we all bring different experiences and expertise to it and there were two very experienced paediatricians within that team as well.
Q. In preparing for the review, you were sent -- you deal with this in your statement -- by Sue Eardley written guidance, so a copy of the guide on Invited Reviews and you have set out a number of the provisions in there in your statement.
You note at paragraph 12 that according to the guidance:
"Invited Review reviewers must undertake RCPCH approved training when they are selected for role."
A. Yes.
Q. The position is, as you explain later in your statement, you didn't receive any training, did you?
A. No.
Q. You didn't receive any induction?
A. No.
Q. Why didn't you undergo training or induction as required?
A. Because I was signposted to the Handbook For Reviewers, which I thought was the training, an element of training to read through what was expected of me as part of the Review Team.
Q. So you consider that you did undergo the

relevant training by reading the guidance?
A. Yes, I wasn't aware there was any other type of training.
Q. If you look at paragraph 133 of your statement, it's there you deal with the lack of training for the role and you say:
"I didn't receive [second sentence] specific training and induction for reviewers by the RCN or RCPCH I was sent the link to the Handbook For Reviewers For Invited Reviews."
Indeed it's within that handbook, isn't it, that your reference from paragraph 12 comes which suggests that RCPCH approved training must be undertaken when joining a Review Team?
A. I'm sorry, could you repeat the question?
Q. Yes. So at paragraph 133 you make the point that you didn't receive any specific training or undergo an induction for reviewers?
A. Yes.
Q. I think when I put this point to you a few moments ago you said: Well, I was sent the handbook and I thought that amounted to undergoing training.
But the handbook itself has a provision which sets out that reviewers must undergo RCPCH approved training?
A. Yes.

Q. So it would have been clear from receiving the handbook and seeing that provision which requires reviewers to undergo training that reading the book alone didn't amount to training?
A. I have to say that when I read that I took it as the RCPCH reviewers. There is a process for applying to the RCPCH to be a recognised reviewer. I wasn't that person, I was a person that had been asked. I think there is a paragraph within the handbook or the guide that does say at times there will be the need for a nursing perspective and so the Royal College of Nursing will provide that.
So I wouldn't -- I am not a recognised reviewer on the RCPCH team as such. I have been called in as needed.
Q. So because you were a nominee --
A. Yes.
Q. -- by the RCN you thought specific training wasn't required for you?
A. Yes.
Q. If we can consider some of the guidance, please, it's INQ0010214 and if we can turn to page 7.
I want to consider with you the paragraphs under the heading "Where Serious Concerns Are Raised".
Dealing first with paragraph 6.1. It reads:

"If issues of patient safety are raised at any time the reviewers will advise the client immediately and discuss what urgent action should be taken if any."
Then the final sentence of that paragraph:
"For concerns about safety service beyond the scope of the review, the regulatory authority should be advised with consideration as to whether temporary suspension of a service is appropriate."
So do you agree that this paragraph is setting out two levels of concern: firstly dealing with a concern which can be managed with the client, so a discussion with the client to determine what action should be taken, if action is required, but then that final sentence is addressing a more serious concern and where that more serious concern arises, on this guidance, it provides for the regulatory authority to be told of that concern?
A. (Nods)
Q. Looking at that paragraph, do you consider that this enabled the Review Team to escalate sufficiently serious categories of safety concern?
A. (Nods)
Q. Did you appreciate that at the time of this review?
A. I didn't.

MR CARR: I am going to deal with one more point, if I may, my Lady.
LADY JUSTICE THIRLWALL: Very well, yes.
MR CARR: Staying in the guidance before breaking, I do want to keep that up, sorry.
So it's back to page -- we were at page 7, if we go to page 8, please. The section is dealing with process.
At paragraph 7.5 you will see the section dealing with the circumstances in which the College would not take on cases.
Now, it's right that by the time you became involved with the review, the case had already been taken on?
A. Sorry, can you repeat the question?
Q. By the time you were recruited to the review --
A. Yes.
Q. -- the case had already been taken on?
A. Yes.
Q. This section however is useful in indicating the limits of a service review?
A. (Nods)
Q. Do you agree?
A. Yes.
Q. If we go to page 9, please. At paragraph 7.7,

it sets out that:

"If any of the issues raised in 7.5 [which we just looked at] come to light during an Invited Review, the review should be completed in relation to its original remit unless advised to the contrary in order to avoid prejudicing other investigations by a public authority or regulator."

Now, included amongst the issues listed at paragraph 7.5 are where the expected scope includes behavioural misconduct, bullying, harassment or possible mental health concerns.

Now, do you agree that allegations or concerns that a member of staff is murdering babies would be a very extreme example of that sort of conduct?

A. Yes.

Q. At paragraph 7.5, so those cases that the College will not take on, includes cases where the police or counter fraud service are involved and that's another indication, isn't it, that matters of criminality go beyond the scope of an Invited Review?

A. Yes, but I didn't know this information at the time.

Q. Forgive me, you were sent a copy of this?

A. I was sent a copy, yes, but I didn't know the information about the allegations.

Q. No, I understand but just in terms of understanding the process, because you didn't undergo formal training but you have indicated that --

A. Yes.

Q. -- reading this guidance.

If we stick with 7.7 and before we break, I want to understand your interpretation of this. Did you consider this section either before the review or whilst you were at the review?

A. I read it before the review in preparation. I didn't refer to it during the review.

Q. It contains a number of elements, doesn't it? So the first sentence which I have already read suggests that the review should be completed unless advised to the contrary. Who do you understand would be giving that advice?

A. I would see that the person that is the most senior within the review would be the lead reviewer and the invited head of reviews.

Q. The circumstances in which the advice may be given to stop the review is in order to avoid prejudicing other investigations. So that would appear to call for an assessment, wouldn't it, of whether carrying on when such issues arise will or won't prejudice other investigations?

A. Yes.

Q. What did you understand might be the circumstances in which other investigations may be prejudiced by continuing an investigation where the issues set out at 7.5 have arisen?

A. Are you asking what I think now or what I thought at the time?

Q. At the time?

A. Okay.

Q. We will come on to the issues that arose.

A. So at the time, I would have thought it would prejudice possibly an investigation into safeguarding concerns or possibly the police.

Q. Did you understand why that is something that it was desirable to avoid?

A. Yes.

Q. And why there needed to be an assessment if those issues arose to ensure that such prejudice would be avoided?

A. Yes.

Q. Finally this: if the review was going to continue, then this section makes clear, doesn't it, that the reviewers firstly can't investigate those sorts of issues of concern set out at paragraph 7.5?

A. Sorry, where are you reading from?

Q. Four lines down, "but the reviewers cannot investigator suggest solutions for any of the above"?

A. (Nods) Yes.

Q. So the point that appears to be being made in the guidance is that if you are going to continue with an investigation, you cannot investigate those issues of concern that have arisen, first point, you cannot suggest solutions for them, and then the following sentence:

"Clear scope boundaries should be agreed before further work takes place."

A. Yes.

Q. Again that would appear to be for the purposes of ensuring that other investigations won't be prejudiced?

A. Yes.

MR CARR: My Lady, thank you, that is a convenient time.

LADY JUSTICE THIRLWALL: Thank you, Mr Carr.

We will adjourn now and we will start again at a quarter to 2.

(1.05 pm)

(The luncheon adjournment)

(1.45 pm)

LADY JUSTICE THIRLWALL: Mr Carr.

MR CARR: I want to turn now to the steps that you took to prepare for the review visit. Your evidence in your statement is that prior to arriving at the hospital, you were not aware of the submissions that the doctors had there about Letby; is that correct?

A. Yes, that's correct.

Q. You were not told of those suspicions by Sue Eardley?

A. No.

Q. You don't remember any discussion amongst the team or with any members of the team about Letby?

A. Before we met?

Q. Before, yes?

A. No.

Q. You have seen in the RCPCH chronology document, that is the document prepared by Sue Eardley, it contains an email from David Milligan, the lead reviewer, dated 26 August 2016 in which he identifies there are a number of questions arising from the data, including the fact that one individual appears to have been present for all but one of them. You know the email that I am referring to?

A. I know the email you are talking about, referring to.

Q. But you say you didn't receive that --

A. I didn't receive it.

Q. -- prior to --

A. No.

Q. But what you do explain in your statement, it's paragraph 50, at page 10, that in your own preparation ahead of the review, you had identified yourself that Letby was present for a number of the deaths?

A. Yes.

Q. The document that you refer to is -- and can we have it up please, INQ0001072, that's not correct. So we can take that down, the reference is INQ0010072. It's a spreadsheet, yes.

There we go. It's a spreadsheet with -- we can see at the bottom a number of tabs analysing nurse staff on duty, medical staff on duty and marking whether individuals were on shift at the time of unexpected deaths and whether they were on shift before.

A. Yes.

Q. In your statement you cite this as being the document you saw, as I understand it, prior to the review?

A. Yes.

Q. It deals with 11 deaths in total, doesn't it, 11 deaths?

A. Yes.

Q. It shows that Letby was on duty or on the shift before for 10 of the 11, all but one, as you say in your statement?

A. (Nods)

Q. What view did you form about that correlation? We can take it down now, please, thank you.

A. I think this -- this is one element of all the numerous documents we were looking at. I didn't form a view at that time that there was anything particularly unusual.

Q. Did you turn your mind as to why somebody had carried out that analysis?

A. I think there was a problem with -- we know that there was a problem with an increased number of deaths and people were trying to get to the bottom of it, so looking at various processes, looking at various information that was available and this was one element of a document that might give some information.

But at that stage I was looking at it I wasn't thinking that it might be what we now know: somebody causing harm to babies.

Q. Did you think there might be a connection between that correlation and the number of deaths, so did you consider that the fact somebody had carried out

that analysis and what it revealed there may be a connection between the individual and --

A. Okay, so what I would see as a nurse with my experience is looking at the members of staff that are on any shift and looking at skill mix. I would also take that view when you are looking at a spreadsheet of members of staff to look at might that have contributed to some of the elements of babies dying more -- more than they were used to having on their unit.

Q. You have explained that you weren't told that the doctors had any suspicions about Letby prior to arriving at the hospital?

A. No.

Q. Was that a possibility that occurred to you in your analysis, a possible explanation for the unexpected and unexplained deaths?

A. Do you mean by looking at this spreadsheet?

Q. Looking either at this spreadsheet or any of the other documents --

A. No.

Q. -- that you looked at, did you consider that one explanation for the increase in deaths might be deliberate harm?

A. No.

Q. If we can look, please, at INQ0012846, what's

about to come on screen is an email from Sue Eardley to you and the other members of the team dated 12 August 2016.

Now, the third paragraph of that email, reads:

"Key things to look at are probably the Mortality Reviews and there are some concerns coming out over the transport service."

It's the first part of this email that I -- of that paragraph, sorry, of this email that I want to deal with. What did you understand to be key about the Mortality Reviews?

A. Well, I think the information that was included in the Mortality Reviews and if there was anything that we were having to look through this methodically, there were so many documents we had to look at, but to draw our attention to look at the Mortality Reviews and as one of the Terms of Reference was looking at any commonalities seeing if there was anything within those reviews that looked immediately obvious to us.

Q. Did you look at the thematic review from 2016? February 2016 -- sorry, Mortality Review February 2016, it's the one that involved, Dr Subhedar from Liverpool Women's Hospital?

A. Okay, I can't remember that document exactly

without seeing it. But if it was included in these I would have looked at it in detail.

Q. When dealing with the Mortality Reviews in your statement, it's paragraph 44, the fourth sentence?

A. Sorry.

Q. Paragraph 44?

A. 44, thank you.

Q. It's on page 9.

A. Yes.

Q. Your fourth sentence reads:

"I recall that it was important to consider any Mortality Reviews to ensure that appropriate processes were being followed in conducting Mortality Reviews".

Can you explain what you mean by that sentence?

A. What I mean is that they followed a robust process. So when a Mortality Review is conducted, and again sometimes the terminology may be used quite loosely, but when a baby dies, there is -- there's the postmortem, there is a whole process that happens. There are multi-disciplinary meetings that we have together called Mortality and Morbidity Meetings where they would be discussed in detail within obstetrics, the maternity teams and neonatal with the postmortem results.

So that's one way of looking at the reviews to do

with mortality. Then I understand again because of really not understanding why these babies were collapsing and there were these unexpected and unexplained deaths, these Mortality Reviews were taken a step further to look at in further detail and to look at them together.

Q. So is this a fair summary: the importance of the Mortality Reviews, one, was to ensure that processes were being followed properly?

A. Yes.

Q. Two, to consider the content of the reviews --

A. Yes.

Q. -- and what they told you about the deaths?

Finally, so far as the preparation is concerned, before we turn to the review itself, if you look at your paragraph 48, please. You describe there a meeting prior to the review visit and you describe a discussion with Sue Eardley and the final couple of sentences of that paragraph read:

"I think we identified that the Review Team would be limited in gathering this detailed information within the remit and the Terms of Reference provided. I have no contemporaneous notes of this given the passage of time."

You say that in the context of a discussion as to

whether or not the team did have enough information.

A. Sorry, could you repeat that last sentence, I couldn't hear very well?

Q. Yes, I am trying to summarise your paragraph for you.

A. Thank you.

Q. As I understand it, you are describing here a discussion amongst the team with Sue Eardley where the team is considering whether there is sufficient documentation or not?

A. Yes.

Q. The final part of the paragraph that I'll read to you says:

"I think we identified that the Review Team would be limited in gathering this detailed information within the remit and the Terms of Reference provided."

Now, the suggestion appears to be that the team thought further detailed information was required but you wouldn't be able to get it?

A. So I think what I mean by that sentence, yes, is that gathering further information would be difficult within the time that we had within the remit and the Terms of Reference provided that there were significant number of elements that we had to consider within the Terms of Reference in a short space of time.

Q. There are three different factors there, so time, remit, Terms of Reference?
A. Yes.
Q. Firstly, before we look at those, what was the further detailed information that you and the team considered was required?
A. I think when -- when you are reviewing as, as we have already discovered this was my first review but I have experience of being a clinical adviser for the ombudsman, so when there are those situations you gather the information that you have, you read it, you check it, and then new questions will come up and then you need to have -- you will request further information on that basis.
But if you are limited for time, that's very difficult to do that.
Q. So was time the reason that the Review Team felt they couldn't request the further documentation required?
A. Yes. Well, we put in the request and it took time for the Trust to share that information.
Q. Did you feel a sense of pressure or did you feel hurried to start the review?
A. I think the pressure was felt because this was very, very serious. There was -- babies were dying, this was

very, very serious and we had been in discussions since July about organising the team and the dates that we could meet in person and because of work commitments that did add to a delay of us starting on 1 and 2 September.
So I don't think the pressure felt so much so that we didn't have the right information at the time that we needed it.
Q. So you would say you were content to proceed with --
A. Yes.
Q. -- the review, notwithstanding the missing information?
A. Yes.
Q. Are you able to help us with the nature of the information that was missing, what was it that you felt or the team felt they didn't have?
A. I think that there was certain elements that were missing and I am -- I can't remember exactly but it was thinking about details from the Child Death Overview Panel and information about the babies that were discussed within those meetings.
Q. We are about to turn to the review visit. I want to ask you a question about the rest of the team. You have made mention already to Sue Eardley and we have

heard evidence from her?
A. Yes.
Q. She was the Review Team manager. There were two neonatal doctors, one of those was the lead reviewer, that's right, isn't it, David Milligan and Graham Stewart?
A. Yes.
Q. Then the final member of the team in addition to yourself was Ms Claire McLaughlan?
A. Yes.
Q. She was a lay reviewer and had you ever worked with her or met her prior to this review?
A. No.
Q. What was your understanding of her professional background?
A. Claire's?
Q. Yes.
A. That she had -- she had a nursing background, she was a qualified barrister and I can't remember without looking at my notes exactly the nature of her work at that time but I think that she was supporting doctors when there had been difficult situations at work, I think, so I am not 100% certain about that.
Q. So far as her being a qualified barrister, was your understanding of that based on a discussion with

her or was it based on documentation you had seen?
A. Documentation.
Q. Did you understand from that that she had worked as a barrister at some point?
A. No. I think, no. I -- because she hadn't written it, I am, I am talking, I am making reference to our biographies that were shared with us via email.
So a qualified barrister, I didn't take that as she was currently working as a barrister or had done.
Q. Turning to the review visit, which is made up for the most part of interviews of different members of staff--
A. Yes.
Q. -- over the course of two days, 1 and 2 September.
I am not going to go through every single interview but there are some I am going to look at --
A. Yes.
Q. In detail --
In terms of the structure of day one, my understanding is that you had a first meeting with Ian Harvey and Alison Kelly --
A. Yes.
Q. -- followed then by a meeting with Dr Brearey and Dr Jayaram?

A. Yes.
Q. Then there was a morning break.
A. Yes.
Q. It was that initial meeting -- and you deal with this in paragraph 60 of your statement -- that concerns amongst the paediatricians in relation to Letby were raised with the Review Team?
A. Yes.
Q. Do you have that? If I understand the sequence of events as you describe them in your statement, that was the first time you became aware --
A. Yes.
Q. -- of those concerns.
There is a suggestion in the evidence that there would have been a pre-meeting amongst the Review Team the evening before --
A. Yes.
Q. -- the review started but you don't have any recollection of the team discussing Letby or the nurse at that meeting?
A. No.
Q. If we can look it is INQ0014604, we are going to start here, so this is the first page of Sue Eardley's handwritten notes. This is a transcript of her handwritten notes?

A. Okay.
Q. This is the start of the review visit. And the meeting commences with DM, that appears to be a reference to David Milligan, doesn't it, lead reviewer:
"... said that we may not be able to explore the detail of the deaths."
So right from the start, that fourth term of reference which required the Review Team to consider factors or failings which may have caused the death and any common factors or failings, that was something that David Milligan was saying was essentially off the table, you weren't going to explore the deaths?
A. Yes.
Q. And then after "deaths", in the transcript it says "IA", the written note looks more like "IH", Ian Harvey, what he said:
"Correlation of one nurse paediatricians see as elephant in the room. Lucy Letby."
You agree, don't you and you make this point in your statement, that that note by Sue Eardley reflects what you were told by --
A. Yes.
Q. -- Ian Harvey.
A. (Nods)

Q. The next sentence:
"Pattern of babies' collapse don't seem to follow normal pattern and respond to resuscitation in normal way."
Now, there are two points to make. Firstly, this report of the elephant in the room, the paediatricians' concern, it appears right at the start of the meeting, isn't it, it is what Ian Harvey is opening the discussion with?
A. Yes.
Q. Did that primacy indicate or signal to you a level of significance or importance of that issue for the Trust?
A. Sorry, can you repeat the question, please?
Q. Yes. So the point that I am making is that this is the first issue, first topic raised by Ian Harvey?
A. Yes.
Q. Did the fact that you have gone to this meeting, you say you weren't aware of the concerns, did the fact that this was what Ian Harvey was opening with, did that indicate that it was a significant and important point?
A. Yes.
Q. The second observation to make is that the

note refers to paediatricians in the plural, doesn't it?
A. Yes.
Q. It does not suggest that it is just a single doctor who has that view?
A. Yes, I agree.
Q. In fact the reference appears to be to the paediatricians as a body, doesn't it, it seems to be referring to the collection of paediatricians?
A. Yes.
Q. If we can go to page 2, please, and about two-thirds of the way down the section underlined, we see it is recorded:
"Clinicians threatened to go to the police."
A. (Nods)
Q. Now, what did that indicate to you as to the degree of seriousness with which the paediatricians held their concerns?
A. Very serious.
Q. If we can go forward, please, to page 4 and we are still within the interview with Ian Harvey and Alison Kelly. Third line down:
"IH [that is Ian Harvey] had to intervene with the neonatal lead as junior doctors had been referring to her as "Nurse Death". Ripples through the team and trying to function. Can't see how it is concluded

without calling the police. Unless there is something to satisfy the medical staff, they can call the police."

Now, what I want to ask is, what did you understand by that final reference:

"Unless there is something to satisfy the medical staff ..."

A. I would -- thinking about this now, I would think that suggests that unless there is another cause for this increased number of deaths, then the medical staff may follow their concerns in contacting the police.

Q. Was the suggestion that unless you as a Review Team came up with something, the police would be called?

A. No. I didn't -- from what I understand from your question is that unless we found something and we were being urged to find something, then the medical staff would call the police.

I -- I don't agree with that. I --

Q. Forgive me, sorry.

A. No. I think that may be interpreted in that way but I didn't feel that at the time. We would find what we found.

Q. Yes.

A. Which was the truth.

Q. Put aside the suggestion then of being urged

to find something. But did you or did the team understand that whether or not the police were to be called depended on whether or not you as a team deliver something to satisfy the medical staff?

A. So if I can repeat back to understand it.

Do you mean that unless -- it was dependent on what we found in the report, and what we wrote in the report was dependent on whether they went to the police or not?

Q. What I am trying to understand is what you, what impression you had and what you understood from the suggestion that unless there is something to satisfy the medical staff, they can call the police, what is the something as you understood it, that would satisfy the medical staff?

A. I don't know.

Q. What was your impression of the attitude of Ian Harvey and Alison Kelly to the doctors' concerns and their suspicions?

A. I think his attitude was disbelieving.

Q. You said "his attitude", is that a reference to Ian Harvey?

A. Also I believe that Alison Kelly felt that as well.

Q. So you got the impression that they didn't believe the allegations?

A. (Nods)

Q. Did you get the impression that they were treating the allegations seriously and recognised the seriousness?

A. No.

Q. The next meeting, and I think it followed immediately afterwards, was with Dr Brearey and Dr Jayaram. We are staying in the same document but going forward to page 7, please.

The entry roughly in the middle of the page, next to the name "Steve", that is a reference to Dr Brearey. You see there that he reports:

"Things okay until last June, were comparable to other units et cetera" and "didn't feel they were much of an outlier.

"Three neonatal deaths in June. Reviewed in detail. Met Alison and SI Panel to discuss them.

"Learning from every case but no overarching deficiency in practice. Identified one nurse present at all collapses."

Just pausing there, you knew at this stage that that nurse was Letby?

A. Yes.

Q. "Didn't think it was significant. Agreed to keep an eye on things. As the year progressed each

subsequent mortality not a huge concern but by end of 2015 numbers stacked up a little."

So what Dr Brearey is describing there is a realisation as mortality increased of the connection, correlation between Letby and that increase in mortality?

A. Yes.

Q. Now, that is something that you had already identified in your own preparation?

A. (Nods)

Q. If you go forward, please, to page 9, and the first entry by the name "Steve" and the final couple of lines:

"Even after PM [postmortem] unexplained."

So do you have that?

A. Yes.

Q. It's a little bit further down, so it's that entry that has the red arrow but it but yes, the final section "even after [postmortem] unexplained".

So did you understand from this that in addition to the increase in mortality, in addition to the correlation with Lucy Letby, you had Dr Brearey explaining that even after postmortem examination there was no explanation for --

A. Yes.

Q. -- the deaths.
You explained at the beginning that unexplained unexpected deaths is something that is rare in neonatal practice and to have a cluster in itself would be a concern?
A. (Nods)
Q. Then the penultimate entry from Dr Jayaram, do you see that:
"Nurse on shift at all times. Spoke to Ian and Alison."
That is a reference to Ian Harvey and Alison Kelly, isn't it?
A. (Nods)
Q. What you would have understood from that is that there were -- there was a concern which had been escalated to senior --
A. Yes.
Q. -- managers.
The next page, page 10, at the top of the page there is reference to Letby's changing of shift patterns. So if you look five lines down, the sentence that starts: "no U/E collapses", do you have that?
A. Yes.
Q. "No [unexpected] collapses at night when she was on days but collapses happened in daytime. All

never individually realise they had thought the same thing."
What the doctors were explaining to you is that the unexpected collapses had been happening during the night shift when Letby was working during nights?
A. (Nods)
Q. She had been moved to day shifts and unexpected collapses stopped at night and started occurring at the daytime?
A. Yes.
Q. Then in the bottom third of the page, just two lines above the redaction box that contains Child A it says:
"Thinking about it, what could she be doing? Postmortems gave no cause. Not checked for electrolytes, levels OK beforehand."
Then there's a reference to "inject".
The bottom two lines:
"When thinking forensic, what happens with air embolism? Looked at case studies and last observations. Chilling."
Over on to page 11, please:
"What had happened? Babies unresponsive to any inputs, odd skin discolouration. Blue with eyelids of pink, [query] injecting air into the babies."

So what is clear from this discussion that you had with Dr Jayaram is the level of their concern was such that they had been looking up medical literature --
A. (Nods).
Q. -- for methods of deliberate harm to babies.
And upon doing so, they had found consistency between what was reported in the medical literature and what they had being seeing on their ward?
A. Mm-hm.
Q. The final point, it's dealt with later in the interview but you were aware, weren't you, that since Letby had been moved off the shift, no more unexpected collapses had occurred, so since she had been moved off the unit --
A. Yes.
Q. -- no further unexpected collapses had occurred.
Now, in light of your discussions with Dr Brearey and Dr Jayaram, and in light of the matters that they were raising, did you have any reason to doubt the sincerity of their views?
A. No.
Q. Did you consider that their concerns were genuine?
A. Yes.

Q. Did you have any reason to doubt their expertise as Consultants?
A. No.
Q. Did you have any concern as to the factual accuracy of their analysis, whether that's to do with rotas, the correlation, their consideration of the medical literature?
A. No.
Q. Now, there was a discussion amongst the Review Team at which consideration was given as to whether or not the review should be aborted?
A. Mm-hm.
Q. It was at some point following this interview?
A. Yes.
Q. I think your statement says you can't recall exactly when it was. Graham Stewart in his statement suggests that the discussion happened during the first morning break, morning coffee break, so it would have been shortly after the interview with Brearey and Jayaram?
A. Yes.
Q. Now, I know you weren't responsible for taking any notes during the review visit, but that discussion to abort is not documented in the notes, is it?
A. No.

Q. None of the notes that we have seen. It is something that should have been recorded in the notes?
A. Yes.
Q. Was this a discussion involving the whole team?
A. As far as I can remember, yes.
Q. And the conclusion was that the review should continue?
A. Yes.
Q. The conclusion of the team and in particular, this is dealt with at paragraph 86 of your statement, you say:
"I didn't think the review should be aborted and I shared this view with the others. I can't remember any other member saying we should abort the review."
Now, what I want to ask you about is your view that the review should continue --
A. Yes.
Q. -- notwithstanding the matters that you had heard in your first two interviews. Why in your view was the information that you had received which amounted to criminal activity of a serious kind, why was that an insufficient reason to stop the review?
A. Whilst we had a discussion amongst ourselves and I can remember why I thought that we should continue

because it was still a very valuable fact finding review/exercise. We were there, we had our Terms of Reference and I have to say being guided by the two most senior people which was the head of the Invited Reviews and the lead reviewer, that it was the right thing to continue finding further information.
I do feel that if I disagreed it would not be a problem. I felt able to speak up if I disagreed with them, so I wasn't blindly guided, but I took their expertise and their experience as part of the decision-making process.
Q. When you say the two senior members of the team, who are you referring to?
A. The lead reviewer, David Milligan and the invited head of review, Sue Eardley.
Q. Graham Stewart, in his statement, and you will have seen this, he suggests that he raised the view that the review should be aborted. Do you remember there being discussion or anybody being of the opinion that the review ought to end?
A. I don't remember that.
Q. Can we go through the factors that were present during this discussion? So following the interviews of Kelly and Harvey and then Brearey and Jayaram, you knew as a team there was a pattern of

unexpected and unexplained deaths.
You identified in your evidence earlier that a cohort of such -- because unexplained deaths are so rare in neonatal practice, that in itself would be a concern?
A. (Nods)
Q. You knew that there had been a correlation with Letby and that persisted when she changed shifts, it followed her when she changed shifts from night to days?
A. (Nods)
Q. Then the unexpected deaths stopped --
A. (Nods)
Q. -- when she was moved off the unit?
A. (Nods)
Q. You knew that experienced doctors you described as being sincere and genuine in their views were concerned that she was responsible for murdering babies?
A. (Nods)
Q. You had been told of threats to call the police?
A. (Nods)
Q. You had been told that the doctors had gone so far as researching medical literature and had found

consistency with what they had seen?
A. (Nods)
Q. In light of all those factors, didn't you think this: this really is well beyond the scope of an Invited Review, this needs the police?
A. I didn't think that at the time.
Q. Why did you think a police investigation was not warranted in light of all of those factors?
A. It wasn't something we had considered as a team or individually at that time.
Q. Do you agree that in light of all those factors we have just gone through, that the serious nature of the alleged offending, the fact that the views were genuinely and sincerely held by expert doctors, that the police ought to have been involved and that the review should have been aborted?
A. I think on reflection, I think on reflection the review could have been stopped at that time and aborted and further advice taken from the RCPCH, that's where I think the advice should have been taken from.
Q. The question is: do you think it should have been stopped at that point in light of the serious nature of the concerns that had been raised?
A. I think I would still maintain that we were trying to find information and gathering information for

the other Terms of Reference at that point and that's why we decided collectively that we should continue.

Q. The notes of the team meeting at lunch on day one, it's INQ0014604 and it's page 25 -- which should be the redacted version before we put it up.

The note is about to come up but, as I understand it, the discussion to abort the review occurred in the morning and then at lunchtime there was a further team discussion?

A. I genuinely don't remember that.

Q. In the middle of this page, we see reference, it starts "Tom" underlined, but in the handwritten version of the notes that reads "team", and this appears to be a note of a team discussion:

"Were RMs ..."

That should be "PM".

"Were [postmortems] done by perinatal pathologists?"

Then the next line has two matters which have been redacted or where it says "no" that should say "insulin"

"... or insulin injection or air embolism."

It appears, and we have heard evidence from Sue Eardley on this point, that the team were discussing at lunchtime various different methods by which deliberate harm could be caused to babies by members of

staff. Do you recall that discussion?

A. I don't.

Q. Were you present at --

A. I can't remember.

Q. Do you agree that if the team had got to the position where they are discussing amongst themselves different potential methods of murdering babies, it is a clear signal that the review has to stop and it's inappropriate?

A. I agree.

LADY JUSTICE THIRLWALL: Mr Carr, I think we probably should take this page off I think there is some information on there that should have been redacted?

MR CARR: Please remove.

LADY JUSTICE THIRLWALL: So it shouldn't be reported, not the passages that you have taken us to, but that which follows, so if we can just --

MR CARR: If we can take that down, please.

Towards the end of your statement in your reflections, it's your paragraph 135, you say:

"I do not consider ..."

Sorry, are you there, it is page 31?

Do you have it?

A. Yes.

Q. It reads:

"I do not consider an Invited Service Review to be an appropriate means of investigating an increase in unexpected, unexplained death in circumstances where clinicians suspected a nurse of criminality."

That is the position that emerged on the morning of the first day of the review, isn't it?

A. Yes.

Q. In those circumstances, the review should have been stopped, shouldn't it?

A. On reflection, yes.

Q. The advice should have been given to the Trust to call the police, who were the appropriate agency to investigate the concerns that emerged?

A. An appropriate agency, yes.

Q. In deciding as a team to continue, and just before the lunch break we looked at the Invited Reviews guidance, was any advice sought, did you seek any advice from the RCN, did any of your colleagues on your team seek advice from the RCPCH?

A. I didn't physically see that, no.

Q. In your discussions as to whether or not to abort the review, was consideration given as to whether continuing might prejudice other investigations?

A. I don't remember discussing that.

Q. When we were looking at the guidance, one of

the provisos was that if an Invited Review is to continue when serious concerns emerge, clear scope boundaries should be agreed before further work is undertaken.

Were any clear scope boundaries agreed?

A. I don't remember that there was a different scope than the one that we started off with with the Terms of Reference and our plan to interview the members of staff that we did and speak with different departments.

Q. Yes, but the fact of the guidance that we looked at which dealt with circumstances -- and I can get it back up if you would like to see it again -- circumstances in which the College would not take on a review, so it is those categories of cases listed at 7.5. Then it gives guidance on what to do if those sorts of issues arise during a review?

A. (Nods)

Q. Okay, we will get it up. It's INQ0010214. If we go, please, to page 8. 7.5 lists those categories of cases that the College would not take on.

The first subparagraph includes:

"Where the expected scope includes behavioural misconduct, bullying, harassment or possible mental health concerns."

At the penultimate paragraph:
"The police or counter fraud service are involved."
It's clear, isn't it, that an Invited Review or a request for an Invited Review looking into allegations of attempted murder would not be taken on under this terms of this guidance?
A. I agree, they wouldn't be taken on.
Q. Then if we go to the next page, page 9, paragraph 7.7, that deals with the situation where a case has been taken on and during a review, the sort of issues we see at paragraph 7.5 emerge so this is a situation that you and the team found yourselves in?
A. Yes.
Q. Paragraph 7.7.
Now, you decide as a team to continue. What this paragraph of the guidance provides is:
"The reviewers cannot investigate or suggest solutions for any of the above."
Okay, so that is the issues that we looked at just at the previous paragraph.
A. Yes.
Q. The next sentence:
"Clear scope boundaries should be agreed before further work takes place in order to avoid prejudicing other investigations."

So what this paragraph seems to be envisaging is in circumstances where a serious concern emerges mid-review, firstly you need to consider whether you are going to continue at all --
A. Yes.
Q. -- in light of the possibility of prejudicing other investigations. If you are going to continue, don't investigate or suggest solutions for the serious conduct issues that may arise and agree clear scope boundaries?
A. Yes.
Q. Now, do you understand the reason why it's suggesting or advising clear scope boundaries?
A. Absolutely, yes.
Q. What I am asking you is what clear scope boundaries, if any, in accordance with that paragraph did the Review Team agree?
A. When -- when we had our discussion, our focus was on continuing to fact-find and gather information that we thought would be helpful even --
Q. Forgive me, sorry.
A. Even in light of the information that we had been given.
Q. I am asking very specifically about clear scope boundaries.

A. We -- we didn't agree any.
Q. If the Review Team had considered this paragraph and there had been discussion of clear scope boundaries, would one very obvious clear scope boundary be: well, we mustn't interview Letby, the person against whom these allegations are being made?
A. I agree with you.
Q. Do you consider looking at that paragraph it was a mistake for the Review Team to decide following the interviews that morning on the first day of the review visit, it was a mistake to decide to interview Letby?
A. In relation to this paragraph, yes.
Q. If you look, please, at your paragraph 54 in your statement.
A. 54?
Q. Yes, 5-4. It's a long paragraph but what you set out there is that upon hearing that Letby had been removed from practice, during the morning of the first day of the review visit, you wanted to know what reasons were given for removing her from clinical practice, what HR process had been followed, what support had been given and you go on to identify in that paragraph the HR considerations that you had in mind.
Why was your immediate concern in respect to

Letby's removal, HR processes and not safeguarding processes?
A. I haven't included safeguarding processes within my statement but I agree it should be safeguarding primarily.
Q. What consideration did you give to safeguarding processes?
A. Thinking that when there are allegations and the safeguarding policy and a safeguarding process is when the allegations are made there's a very clear framework to follow in the first instance contacting your manager or designated doctor or nurse for safeguarding within the institution and then a whole process follows about fact finding and information finding.
So primarily from this aspect as well, as much as the safeguarding process wasn't followed, neither was an HR process of removing somebody from clinical practice which is a very intentional move and what I was concerned about was in not having an HR process, disciplinary process or other similar, is that it might interfere with future investigations or fact-finding reviews.
My experience is that following HR processes are absolutely vital to ensuring patient safety. But you

have to follow those processes rigidly, so that it protects the patients and there's no room for, as I said, influencing future investigations.

Q. Did you ask anybody at the Trust during the review whether a referral to the Local Authority Designated Officer had been made?

A. I think I did when we first -- I think I did see it when we first met when Ian Harvey told us that she had been removed from practice. I think I asked then.

Q. What was your understanding as to whether a referral had been made?

A. None.

Q. Did you advise that a referral should have been made?

A. No.

Q. Why not?

A. I had just heard that information, I was processing the information about Letby and we were gathering information there as a team and it's something that I thought we would discuss at a later point.

Q. Can we turn please to the actual interview of Letby, it was conducted by you and Ms Claire McLaughlan?

A. Is it coming up on the screen?

Q. It will do in a moment.

A. Okay.

Q. What I want to ask you first is in respect of your own witness statement, paragraph 70, you say:

"As a Review Team we discussed topics to put to Lucy Letby and decided that they should be the same as everyone else we interviewed."

Do you see that?

A. (Nods)

Q. But you interviewed a number of different people with a number of different specialisms?

A. Yes.

Q. So you discussed different issues with different people?

A. Yes.

Q. So in respect of Letby, can you be more specific in explaining what it was decided that you would be discussing with her?

A. Well, along the Terms of Reference of thinking about staffing, relationships within the team, the culture of the unit, anything that they wanted to share with us and that was very much our approach with all the interviews and of course as you say there is different specialisms and people chose to share different things with us, different information with us, so that did change.

But what I mean by paragraph 70 is we didn't change -- ask anything specific or we weren't investigating.

Q. One of the Terms of Reference required the team to consider whether there were common factors or failings contributing to the increase death rate?

A. We didn't -- we didn't ask that directly.

Q. Did you determine before speaking to Letby that you wouldn't ask her about that?

A. No.

Q. The document is INQ0014602. This is again a transcript of the notes made by Claire McLauglan, as I understand it, you will have seen her handwritten notes, of your interview with Lucy Letby and also we can see at the top there that in attendance was Hayley Cooper, or Hayley Griffiths as you may have known her.

Now, on the basis of this note, and we will go to page 3, please, we can see there in the first paragraph that you discussed with Letby or there is a note indicating a discussion with Letby, her redeployment and the reasons for it.

A. Yes.

Q. We can see in the second paragraph on the page a reference to her being scapegoated.

A. Yes.

Q. Again, you have indicated that if the team had turned their mind to clear scope boundaries, Letby wouldn't have been interviewed at all.

If you and Ms Claire McLaughlan had clear scope boundaries in your mind going into this interview, you would have stayed well away from --

A. Yes.

Q. -- issues concerning her redeployment and issues connected to the increase in unexpected deaths?

A. So we didn't ask her about her redeployment. She offered that information. Because how the -- I haven't unfortunately got a list of the questions that we asked but you can see from how the interview has gone, tell us a little bit about yourself, about your nursing background, and then she offered up that she was, she exactly this on this page, about having been removed clinically for a period of 10 weeks, not knowing why.

But also --

Q. Does that -- forgive me, sorry, I thought you had finished.

A. I was going to say but Claire and I didn't explore further when she offered this information, that wasn't our purpose.

Q. Does that perhaps underline the reason why --
A. Yes.
Q. -- she shouldn't have been interviewed because of the danger of trespassing into areas of discussion you would or should not have been ...
A. (Nods)
Q. Now, Hayley Griffiths, or Hayley Cooper, the RCN representative, she describes -- has described that Lucy Letby left the meeting with you in a distressed state. Do you remember Lucy Letby getting into a distressed state?
A. No.
Q. Do you remember her leaving the meeting?
A. I can't remember her exactly leaving the meeting.
Q. Do you recall having a discussion with Hayley Griffiths following your meeting with Letby?
A. No.
Q. Do you remember having any discussion with Hayley Griffiths?
A. Not alone, no.
Q. No.
A. No.
LADY JUSTICE THIRLWALL: By "alone", you mean without?

A. Without Lucy Letby.
LADY JUSTICE THIRLWALL: Yes, thank you.
MR CARR: The evidence from Hayley Griffiths is that she was told words along the lines after Letby had left the room -- she was told words along the lines of: Does she know what is going on here and what she's potentially being accused of?
A. I don't remember that at all.
Q. Do you remember hearing Claire McLaughlan say that --
A. No.
Q. -- to Hayley?
Can we get up please, INQ0000569, it's the same document from before but it's the restricted, the one-page version, please, thank you.
We might need to zoom in so that we can see that. These are text messages sent by Letby to Dr U the evening of 1 September, so shortly following your interview with her.
Do you see in the first one it says:
"The team members were nice. They didn't ask much about the babies. It was more about the unit as a whole, et cetera. In brief it looks as though there is a potential for this to go further over a long period of time. H thinks we need to look at taking out

a grievance case."
Then the second entry further down on that page:
"The report will take a minimum of six weeks with a preliminary tomorrow. They 'off the record' told me they think an investigation into the deaths will be a recommendation and I need to prepare myself that as I would play a big part in that over due to being a common factor and it could take several months."
Now, just going through the substance of that. The report will take a minimum of six weeks. Did you tell --
A. No.
Q. -- Letby that's how long it would take? Did you hear Ms McLaughlan tell her that's how long it will take?
A. No.
Q. A turnaround time of six weeks for the report is about right, isn't it?
A. Yes. According to the Review Handbook, but I didn't say that.
Q. So she is accurate in her understanding of how long?
A. Sorry?
Q. She is accurate in her understanding of how long the report will take?

A. Yes.
Q. But you say she didn't get that from you?
A. No.
Q. And she didn't get it from Claire McLaughlan?
A. No.
Q. As to the reference of the "off the record" discussion, did you have an off the record discussion with her?
A. No.
Q. Did you have an off the record discussion with Hayley Griffiths?
A. No.
Q. Did you advise her there was going to be an investigation?
A. No.
Q. Did Claire McLaughlan advise her?
A. No.
Q. It is correct, isn't it, and we can look at the other notes from that day, that the plan was for a recommendation for further investigation by the Review Team to the hospital?
A. Yes.
Q. That is ultimately what was advised?
A. Sorry, what do you mean advised? To Letby?
Q. No, to the hospital.

A. Yes.
Q. So Letby is accurate in her description of there being an investigation into the deaths because that's what you as a team were proposing?
A. Yes, but we hadn't made that decision until the next day.
Q. We can take the messages down.
No, I understand that. Yet we have the text messages and I understand you say -- well, you didn't tell Letby that there was going to be an investigation into the deaths, but that was your plan, so she has accurately reflected?
A. She -- she has but I haven't -- I haven't told her that.
Q. Did you tell her that she had been identified as a common factor --
A. No.
Q. -- in the deaths?
Is that an accurate description of your understanding of the evidence?
A. Sorry, what do you mean?
Q. Did you consider that she was going to play a big part in the investigation, that the RCPCH was recommended because of the correlation that you had identified?

A. I -- I wouldn't have said that. I didn't say that.
Q. Did Claire McLaughlan have a discussion with her as to --
A. No.
Q. Did you advise her to prepare herself?
A. No, they are also words that I just wouldn't use.
Q. (Pause) Forgive me, I needed to find a reference. The next document I want to take you to is INQ0014605. These are the transcripts of Sue Eardley's note for the second day of the visit and it is page 6 that I want to take you to, please.
This appears to be notes from a discussion that morning with Ian Harvey and Alison Kelly. Do you recall being present at this meeting, so it is the day two meeting with Ian Harvey and Alison Kelly, it's not the feedback session at the end of the day?
A. Is that the end of the day, yes?
Q. Sorry?
A. The end of the day?
Q. No, it is not the feedback session at the end of the day, it is earlier in the day.
A. Okay.
Q. So it is not the meeting with Tony Chambers,

Ian Harvey and Alison Kelly; it is a meeting earlier with Ian Harvey and Alison Kelly?
A. Okay.
Q. There is discussion of your interview with Letby the previous day. I am looking at the bottom of the page about six lines up where it says:
"Needs to be put into a process for her protection and yours. Disciplinary process to get to the bottom. Can't understand why RCN have let this go on. Suspect there will be a grievance. If nothing happens good case for constructive dismissal. She knows it will be horrid."
The reference there to "she knows it will be horrid", that is a reference to Letby, isn't it?
A. I -- yes, I assume so. But I didn't say that.
Q. No, but what did you understand or can you help us to understand what it is that Letby would know or knows is going to be horrid?
A. I don't remember having a conversation that this would have been mentioned, certainly not with Letby.
Q. Well, looking, we have looked at the text messages and there was actually one interpretation of those text messages is that Letby has been tipped off about the fact that the RCPCH are going to recommend an

investigation into the deaths and she's going to be a part of it and the reference here to "She knows it'll be horrid"?
A. I don't know where she got that information from. But also she was under the impression and I can't remember where it's written she was under the impression that following the review, she would be reinstated.
Q. So you don't know where she got the information from. She didn't speak to anybody else from the RCPCH Review Team, did she?
A. Not that I can remember.
Q. So the possibilities appear to be either she was told directly by you, she was told directly by Claire McLaughlan, she was told directly by both of you, Hayley Griffiths has told her, or it's just a lucky guess?
A. I don't know the answer to that. I know that I didn't have that conversation with her.
Q. I am going to deal more briefly now with some of the other discussions that you had over the course of the review visit. You spoke to the other Consultants, Dr V, Dr Gibbs, Dr Saladi, Dr Holt and Dr ZA on 1 September. During that meeting with those doctors, again, you were told about the unexplained nature of the deaths?

A. Yes.
Q. It's right to say that those doctors expressed concern --
A. Yes.
Q. -- about the situation on the unit.
Dr Saladi is noted in Sue Eardley's notes to describe mottling of some of the babies?
A. Yes.
Q. So that is further evidence of what you had been told by Dr Jayaram. The Inquiry has already heard evidence from Dr Saladi and Dr ZA. Both of those doctors describe informing your team that they had concerns with Letby, so Dr Saladi's evidence was that he and the other Consultants told you they were worried about a nurse on the unit potentially causing deliberate harm?
A. Yes.
Q. Do you remember that?
A. Yes.
Q. Dr ZA's evidence was:
"We were very open from the beginning of our meeting that our concern was that Lucy Letby was doing something deliberate to harm babies".
Do you recall Dr ZA disclosing that?
A. I can't remember that it was him or her. But

I do remember that being said.
Q. You spoke to Dr Mittal, the designated safeguarding doctor?
A. Yes.
Q. I can bring the notes up if necessary but I can't see in the notes of that discussion that there was any exploration with him as to whether he was aware of the concerns that the doctors on the neonatal unit had, the suspicions that they had in respect of Letby?
A. From what I can remember, without looking at documents, he wasn't aware of their concerns.
Q. Did it ring any alarm bells for you that the safeguarding doctor was not alert to the suspicions that several doctors on the neonatal --
A. Yes.
Q. -- unit had shared with you?
A. Yes, it did -- it did cause alarm.
Q. Was there any discussion or advice to him as to his need to engage with the doctors on the neonatal unit as to their concerns?
A. Sorry, can you repeat that please?
Q. Did you tell Dr Mittal that he needed to speak to the neonatal doctors about their suspicions?
A. I don't think I said that directly, more that it was assumed because we had had that discussion that

he would then contact the doctors on the unit.
Q. Let's look at the note. It is INQ0014604 and it's page 28. This is notes from the discussion with Dr Mittal and it is a point at which he's talking about the increased deaths and can you see five lines down:
"None of these deaths raised concern for Rajiv or the panel, accepted as natural death even though some had PMs but nothing found."
Then further down the page there is a line that reads:
"Have discussed deaths with Steve et cetera didn't find any patterns."
You will have known by the time of being in this interview that that wasn't correct because there were patterns and there were patterns that were concerning the doctors on the neonatal unit?
A. Yes.
Q. Now, given your familiarity that you described at the beginning of your evidence with Working Together to Safeguard Children, you would know that the matters that had been described to you are matters that it was mandatory to escalate within the hospital and then to the local authority?
A. Yes.
Q. That hadn't been done?

A. No.
Q. That is something that should have been explored with Dr Mittal?
A. Yes.
Q. It does not appear from the notes that it was explored with him?
A. No.
Q. The final interview in the notes that I want to go to, please, it is the interview with Andrew Higgins, it is a different document the following day, INQ0014605. It's page 22. And the second line down, the sentence that begins "Long debates ..." and Andrew Higgins, he was a member of the board, wasn't he, and he was telling you about what had gone on at board level in respect of these concerns?
A. Yes.
Q. The note reads:
"Long debates about how to deal with it for that point, eg, involvement of police after internal briefings from Exec. PAV and board needed to get an external view. View came from doctors' team itself so needed an external opinion."
Something is crossed out:
"I know what it was based on. Took a bit of time then about [a word that's hard to decipher] and whether

to involve the police. Wanted to try and unpick this as best we could. Exec recommendation, independent review is the best way to challenge, corroborate, need to keep shutters down and contain situation."

Firstly, the reference to an independent review being the best way to challenge and corroborate, was the independent review being referred to the RCPCH review that you were engaged in?

A. I'm not sure but I think so.

Q. What was your understanding of the reference "to challenge and corroborate"?

A. I think the "corroborate" is to find proof and I make -- I am making assumptions here because I am interpreting this -- "corroborate" is to corroborate with the doctors' view that there is Letby causing harm to the babies. "Challenge" I would assume means that there's something completely different that's found, another reason why babies were dying.

Q. Were you concerned that a member of the board saw the independent review as an alternative to police involvement?

A. I can't comment what the board's views were.

Q. Were you concerned that a member of the board was reporting that the shutters need to be kept down and the situation contained?

A. I was concerned. I don't know what is meant by "keep the shutters down", but "contain the situation" I think is clear.

Q. Well, again, did that ring any alarm bells for you from a safeguarding point of view?

A. Yes. But we didn't explore it further.

Q. Now, at the end of the second day there was a feedback session with Tony Chambers, Ian Harvey and Alison Kelly and the advice given was in respect of the investigation I have asked you questions about and an HR process.

I am not going to take you to the notes of that meeting. The advice is contained in the letter that followed the review visit. It's INQ0009611.

It's already dated 5 September, written by Sue Eardley. You have seen this --this letter in the preparation --

A. (Nods)

Q. -- of your evidence?

It's three days after the review visit. Fourth paragraph deals with Letby being moved off the neonatal unit. The final sentence reads:

"These steps appear to have been taken on the basis of an allegation made by one member of medical staff supported by his medical colleagues."

To be clear, the allegations I have asked you several questions about is that Letby is murdering babies and it's clear from the evidence that you have given that one member of staff is not an accurate description of the level of concern you received, was it?

A. I agree.

Q. Now, it's the second page of this letter that contains the two action points, one the HR investigation, secondly a case review and the paragraph under the heading "Action by HR investigation", second sentence:

"Our understanding is that an allegation has been made and therefore a process of investigation needs to be put in place which sets out nature of the allegation and the process you will follow to investigate it."

Now, as somebody with experience in HR matters, did you consider an HR investigation an appropriate mechanism for investigating the allegations that had been made by the doctors?

A. No, I think in the context of this it's a safeguarding investigation.

Q. Are you saying it should be a safeguarding investigation?

A. Yes.

Q. Because it says "HR investigation" doesn't it?

A. But the HR investigation is specifically about her being removed and redeployed, removed from clinical practice and redeployed for 10 weeks without a process in place. But that -- that sentence, that paragraph is that specifically safeguarding, that is a safeguarding process that should be followed.

Q. It doesn't say that, does it, in the letter?

A. It doesn't.

Q. It ought to have --

A. Yes.

Q. -- made recommendations to safeguarding and in light of the evidence that we have already dealt with, in fact the Review Team had heard enough to be recommending in strong terms contact the police?

A. Yes.

Q. Can I deal with the clarification you made in your witness statement right at the beginning of your evidence. It's paragraph 87 and you have corrected your statement so it no longer states that the Review Team recommended that the Medical Director and senior management contact the police directly.

As I understand it from your corrections, tell me if I am wrong, the sentence before that remains in that your evidence is there was some discussion amongst the

team as to whether or not --
A. Yes.
Q. -- to recommend the police be contacted but that recommendation wasn't made.
However, you weren't involved in those discussions?
A. No, both of those are incorrect. That sentence and that starts "I wasn't actively involved ..."
Q. Yes.
A. And "The Review Team ... "
Those two sentences are incorrect.
Q. So you were involved in the discussions and the conclusion of those discussions was not to contact the police.
A. I was, yes.
Q. What was the justification for not contacting the police?
A. There needed to be the safeguarding process followed first and the HR process and those were the recommendations that were made.
Q. Why was the HR process or a safeguarding process required before the police were contacted?
A. From what I can remember, the safeguarding process had been followed with those allegations was the correct first course, first point to follow. The HR

process was separate, that was because she had been removed from clinical practice and there needed to be a robust process in place.
Q. You say it was a correct process to follow but what process are you referring to?
A. HR or the safeguarding?
Q. Either.
A. Safeguarding is when you make a referral.
Q. No, I understand the two processes that you are referring to. My question is about contacting the police --
A. Yes.
Q. -- and why it wasn't done and your answer is: well, there needed to be an HR process, there needed to be a safeguarding process. I am asking you on what basis why couldn't there be?
A. The safeguarding process is the correct way to -- when there is an allegation of harm to babies or patients, other patients, is that's the first step.
Q. Do you or did the team consider it would have been inappropriate to contact the police in light of the lack of a safeguarding process?
A. I can't speak for the rest of the team but following the discussion that we had, it was deemed appropriate to recommend the safeguarding process as the

first point because of the allegations. We had only -- as far as I was aware we had only heard those -- I had only heard those allegations that morning. And it was throughout the morning and the two days that I had found out that this had been going on for a while.
Q. The final point I want to deal with with you is the preparation of the report and I am not going to take you to the final report, I want to take you to the comments that you made in the drafting process.
A. Sure.
Q. There are two points. Firstly quite early in the process your recommendation was that all deaths at the hospital should be subject to further investigation, not just those which had been classified as unexpected?
A. Yes.
Q. The reason that you give for that is you were concerned that the classification may have been wrong or inconsistent, so you wanted to cast the net quite wide?
A. Yes.
Q. Then secondly, if we can look please at INQ0010147, and if you turn to page 7, please, we may need to zoom in, it is the comment box, the fourth one down which is slightly orange. Thank you.
This comment on the right is a comment made by you, isn't it, on the report?

A. Yes.
Q. You have added in a section of the report dealing with the allegations against Letby.
"The significance of this one nurse being rostered on shift at the time of each of the deaths had not been investigated via a thorough process and is only individual senior Consultant's subjective view".
Now, just on that point, individual senior Consultant's subjective view, that is not accurate, is it?
A. Not with all the other information that became evident within those two days that we were interviewing other people and a range of people. But what I mean by that, and when I say "individual senior Consultant", I do mean the -- the Consultant Dr Jayaram who was possibly more forthcoming in his views and when I say "subjective" is because again we weren't there to investigate this nurse but on the surface it very much appeared that it was from the commonality rather than from proof or evidence but that was also not our role to investigate that.
So that's why I have put "subjective" and then I go on further to say ...
Q. It's not accurate firstly because it wasn't just one individual, it wasn't an individual senior

Consultant?
A. No.
Q. Dr Brearey, Dr Jayaram, the other Consultants, all of them raise their concerns. You had been told by Ian Harvey that the paediatricians as a body had those concerns?
A. (Nods)
Q. So it was wrong to diminish the concerns as if it was just one individual, do you agree?
A. It wasn't my intention to diminish his concerns.
Q. It wasn't a subjective view. You considered and heard a lot of evidence over the course of the two days and although we have not gone through it, there were a number of comments made about Letby from her nursing colleagues which were quite supportive?
A. Yes.
Q. But so far as the doctors were concerned, what they were referring to was what they had experienced, their medical expertise, the fact that the deaths were unexpected and unexplained, and consistency with medical literature.
None of that was subjective, was it?
A. No, but in relation to this particular nurse there wasn't any definitive proof other than the

commonality that she was present for the majority of the collapses and deaths.
Q. You commenced your evidence with an apology to the -- thank you that can come down -- parents for the deaths of their babies.
Is there anything in respect of your own role that you would wish to say sorry for?
A. I think the -- being part of the Review Team and for the enormity of the Terms of Reference I was possibly quite naive in thinking it was possible to address all of those Terms of Reference and the significance of them within two days. And on reflection, it's thinking about having a different thought process and really listening to what people were saying.
MR CARR: My Lady, I have no further questions, thank you.
LADY JUSTICE THIRLWALL: Thank you. Mr Sharghy.
Questions by MR SHARGHY
MR SHARGHY: Mrs Mancini, I ask questions on behalf of the Families of seven babies who Lucy Letby either murdered or attempted to murder. I will ask you questions on about three specific areas, if I may.
You said to counsel to the Inquiry that not only had you not been provided with any induction training by

the RCPCH but you had actually not undertaken in fact any refresher process at all?
A. No.
Q. At paragraph 33 of your witness statement, you specifically say that at that time, ie in 2016, you lacked the experience of reviewing a cohort of unexpected or unexplained deaths or indeed where concerns of criminal conduct are raised; is that fair?
A. Yes.
Q. So not only had you not received any specific training from the Royal College or indeed had an opportunity of speaking to people who had previously carried out reviews, but your own professional experience meant that even on a cursory glance of the Terms of Reference you were not the right individual to be part of this Review Team; is that fair?
A. I think it's fair to say that, yes.
Q. Thank you.
Can I move on now to looking at views or conclusions that you reached as part of the review process. For this can I take you to paragraph 47 of your witness statement, please. It's on page 9. In the preceding paragraph you deal with a number of documents, tables of documents that you had reviewed and in paragraph 47 you say:

"Following consideration of the documents you reached a view that although the number of deaths were higher than in previous years, I [that is you] did not identify evidence of unexpected, unexplained deaths or collapses or any common factors in increased mortality."
Given what you have just accepted, that you had no experience previously in looking into a cohort or as we have referred to it --
A. Yes.
Q. -- previously as clusters in this Inquiry, how were you able to come to that view simply by reviewing documents?
A. I couldn't. But what I would say is that exploring and reviewing unexplained and unexpected deaths requires the time and the expertise to be able to do that over a period of time and that was just not possible within the Terms of Reference of the review.
Q. Yes. Mrs Mancini, isn't there a danger that if you do come to a view just based on documentation then you fall into the trap of confirmatory bias? In other words, the more you learn about a process and a review and an inquiry, the more you look for evidence that tends to support your initial view?
A. Yes, that's correct.
Q. Thank you. And matters in terms of the

process, your thought process in particular, didn't just stop there because can I take you to paragraph 102 of your witness statement as well, please. This is a description of what you did having read the draft?

A. Yes.

Q. Then you provided a comment. You specifically wanted a comment put in or some form of wording that indicated that:

"It was important that we as the group recognise that these allegations are only hearsay and have no substance."

A. (Nods)

Q. Did you truly believe that at the time you made this suggestion?

A. No, I think that I should have reworded it, worded it differently and what I meant was as I have previously said that we weren't given any proof that this had in fact been happening by this member of staff. That's what I meant by that comment and I haven't written it in correct language.

Q. But you can see the danger that it influences what the final report ends up suggesting --

A. I can see that.

Q. -- and the false reassurance it provides to the reader, ie in this case the Trust?

Final issue is in relation to the discussion that took place with the team and you have helpfully clarified you were part of that discussion as regards whether the police should be called based on, for some, the new information that had been discovered?

A. (Nods)

Q. Can you just take us into that room for a moment. Were all the members of the Review Team present for this discussion?

A. I think so. But I can't remember exactly.

Q. Can you assist with how and which side of the fence the various professionals fell in; other words, the nurses on one side and the doctors on the other? Or was it a mixture?

A. I think it was a mixture. I can't remember clearly, I have to say that, but I think it was a mixture. It wasn't an obvious divide as far as I can remember.

Q. How finely balanced was that divide?

A. I don't remember -- as I said earlier, I didn't remember that there was one of the doctors that had suggested we should abort the review. And I can't remember that conversation in detail, honestly. So I don't think I can give you any further information on that.

Q. The final question: when Counsel to the Inquiry asked why the team decided to continue with a review even though there was outstanding information you said: well, there were serious allegations. It was quite urgent that the work started.

But in fact didn't it become even more urgent and more concerning at the end of the pre-session when you were having this discussion that rather than suggesting there should be a further review and potentially further delay, that the police needed to be called or at least the Trust told, "We have got serious concerns here you need to contact the police"?

A. I understand what you are saying but our decision was that we would advise that the safeguarding process should be the first point of call.

Q. Did you at any point think about the repercussions of that to patient safety, these very vulnerable babies who could be exposed to further harm?

A. We, we had the babies absolutely uppermost in our mind and patient safety. We knew that that member of staff had been removed from clinical practice. I know that there's lots of other elements about that not being done appropriately.

But we felt that that was -- we discussed it and we thought consensus that that was right thing to do.

Q. Okay. Did you ever consider that having received your review, that the Trust might reintegrate Lucy Letby back on to the neonatal unit?

A. No, not for a minute.

MR SHARGHY: Thank you, my Lady.

LADY JUSTICE THIRLWALL: Thank you, Mr Sharghy. Ms Scolding.

Questions by MS SCOLDING

MS SCOLDING: I only have one question, my Lady, to Ms Mancini.

Good afternoon, Ms Mancini, I obviously ask questions on behalf of the Royal College of Paediatrics and Child Health. I just have one question in the light of everything that has been discussed today: what would you do differently if you were faced with a similar situation to the situation you were faced with in 2016?

A. I would gain advice myself about processing -- sorry, continuing with the process of the review and if that was the correct thing to do, I would get that advice directly.

Q. Who would you have got that advice from, which body or organisation?

A. The first point, I would have gone to the Royal College of Nursing and I know that they would have then directed me to the Royal College of Paediatrics and

Child Health.

MS SCOLDING: Thank you very much, I have no further questions.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Thank you, Ms Scolding. I just have one question and it is in relation to the letter that went to Mr Harvey on 5 September. I will get it up so that you can see it. It is 0009611 and then it's page 2.

We have looked at it already.

A. Thank you.

LADY JUSTICE THIRLWALL: It's in relation to the first heading because I just want to make sure that I have understood your evidence correctly. It's -- this is the first action point and it's headed "HR Investigation".

Now, that might be thought --

A. Yes.

LADY JUSTICE THIRLWALL: -- to connote an HR investigation but, as I understand it, your evidence is that this meant safeguarding.

A. Safeguarding plus HR investigation for the redeployment of Letby.

LADY JUSTICE THIRLWALL: Where's the clue in this paragraph that it's --

A. It's not there, I'm sorry.

LADY JUSTICE THIRLWALL: No. And in fact if we look at it, second sentence. First of all you have got to formalise the actions you are taking with the nurse?

A. Yes.

LADY JUSTICE THIRLWALL: So it's about her.

A. Yes.

LADY JUSTICE THIRLWALL: Then:

"An allegation has been made and a process needs to be put in place which sets out nature of the allegation and the process you will follow to investigate it" and that is what you were saying in your evidence earlier.

A. The safeguarding.

LADY JUSTICE THIRLWALL: No, I'm sorry, no.

A. Sorry.

LADY JUSTICE THIRLWALL: The allegation made, process of investigation to be put in place which sets out nature of the allegation and the process you will follow to investigate it.

So that is a different thing from investigating the nurse, is it?

A. No, that's starting the safeguarding process. That's specifically for the safeguarding process. The first sentence alludes to the HR process for her having been redeployed.

LADY JUSTICE THIRLWALL: I see. Then the next sentence:

"No doubt you have your own policies for this ..."

So that is not a safeguarding policy?

A. Yes.

LADY JUSTICE THIRLWALL: "... but the MHPS process used for doctors provides a helpful framework."

That is not a safeguarding policy?

A. No.

LADY JUSTICE THIRLWALL: So we have this one sentence in the middle of a paragraph which the hospital were to understand was a reference to safeguarding rather than an HR investigation?

A. Yes, it's unclear.

LADY JUSTICE THIRLWALL: Well, it's either unclear or it means something different from what appears on the page, isn't it? I just wonder how you think someone would know that was safeguarding in that middle section.

A. I think it's open for interpretation but it should have a heading of "Safeguarding", we should have a process of safeguarding investigation.

LADY JUSTICE THIRLWALL: Thank you very much. Mr Carr, have you any questions arising out of my questions?

MR CARR: No, I don't, thank you.

LADY JUSTICE THIRLWALL: All right. Thank you very much indeed, Ms Mancini, you are free to go.

Now, Mr Carr, is that a good time to take a short break?

MR CARR: It is, yes.

LADY JUSTICE THIRLWALL: There isn't any pressure because we can come back to evidence, but have you any idea how long the next two witnesses are likely to take?

MR CARR: They will be much shorter. I am going to try and keep to less than half an hour per witness.

LADY JUSTICE THIRLWALL: Very good, okay. In that case shall we take 15 minutes and start again at 5 to 4.

(3.41 pm)

(A short break)

(3.55 pm)

LADY JUSTICE THIRLWALL: Mr Carr.

MR CARR: My Lady, may I call Dr David Shortland, please.

LADY JUSTICE THIRLWALL: Dr Shortland, would you like to come forward.

DR DAVID SHORTLAND (sworn)

Questions by MR CARR

LADY JUSTICE THIRLWALL: Thank you, Dr Shortland. Do sit down.

MR CARR: Can we start with your full name, please?

A. Dr David Shortland.
Q. You have prepared a statement for this Inquiry dated 20 May 2024, haven't you?
A. Yes.
Q. Are the contents of that statement true to your best knowledge and belief
A. They are, yes.
Q. I am going to summarise your professional background, but tell me if I have got anything wrong. You qualified as a doctor in 1979, you became a Consultant in 1989?
A. (Nods)
Q. And you retired from NHS practice in 2021; is that correct?
A. Yes.
Q. You have held a number of leadership roles including being clinical lead of a neonatal unit for a decade and clinical director for 12 years in the course of your career?
A. Yes.
Q. At the time of the RCPCH review of the Countess of Chester Hospital, you were the clinical adviser for the Invited Review Board?
A. (Nods)
Q. I have also seen reference in your statement

to you being the clinical lead, those two roles are the same, aren't they?
A. Same, yes.
Q. Two interchangeable terms?
A. Yes, they are.
Q. That is one of several roles that you have had at the RCPCH?
A. (Nods)
Q. For the purposes of your evidence today I am going to be asking you about that review. Before I do, in respect of safeguarding training you make the point that you undertook regular mandatory safeguarding training as part of your NHS practice?
A. Yes, it was a standard part of the mandatory training.
Q. There was no specific safeguarding training as part of the Invited Review programme?
A. Yes, that's correct, yes.
Q. Your statement states paragraph 8, you have never had safeguarding training about abuse suspected by a member of staff but is there any reason to think that different principles would apply?
A. No, I think if you look at the documentation I think -- excuse me, I think if there are safeguarding concerns you would follow the same principles whether it

was a member of staff or family or whoever, really.
Q. You were very experienced in Invited Reviews, you have undertaken approximately 50 Invited Reviews each time as lead reviewer?
A. Yes. Yes.
Q. But you had never done a review involving unexpected or unexplained deaths --
A. Yes, that's correct.
Q. -- had you?
A. Yes.
Q. Never been involved in a review where the Terms of Reference looked at mortality of individual cases?
A. That's correct, yes.
Q. Is an overview of your involvement of the Countess of Chester Hospital Invited Review as follows: you had no involvement in devising or agreeing the Terms of Reference or the arrangements or preparation for the review?
A. Not quite correct. I think I said in my statement that a few days before the review, I had an email from Sue telling me that the review was about to take place and mentioning that one of the issues was increase in unexpected deaths in the unit.
So it was on a Saturday morning and I telephoned

Sue which would be quite unusual for me to do that, so I had slight further information about the review before it took place but I wasn't -- I didn't see the formal Terms of Reference but I recognise one of the Terms of Reference, the fourth Terms of Reference which we discussed.
Q. You are slightly getting away from my question, I was just giving an overview of your involvement?
A. Sorry.
Q. The second point I was going to come to was that there was a telephone conversation with Sue Eardley a few days before the review, but the first point I was making is that you had no involvement, as I understand it, from your evidence, in devising the Terms of Reference or arrangements or preparations for the review?
A. Yes, that's correct, yes.
Q. The telephone call with Sue Eardley you've alluded to.
You were not approached for advice during the course of the Invited Review?
A. (Nods)
Q. Following the review visit, you read the final draft of the report before it was sent to the hospital

and you made a brief comment on it which we will come to?

A. Yes, that's correct.

Q. That is the extent of your involvement.

The first topic of questions is whether your involvement should have been greater. You have described in your statement, it's paragraph 29, you describe your role as clinical adviser for the Invited Review programme was "to Chair the programme board meeting at which, from memory, occurred every four months".

So you are describing quite a limited role?

A. Yes.

Q. You have seen and you will be familiar with the guide to Invited Reviews and you were sent a copy of it to prepare your evidence and I am not going to put it up on screen but you were asked questions about it.

It's right, isn't it, that the guide to Invited Reviews suggests that it is for the clinical adviser to agree Terms of Reference?

A. (Nods)

Q. Where there is to be a pre-visit review, that is something that would be carried out by the clinical adviser or the lead reviewer; is that right?

A. Yes, that's correct, yes.

Q. So far as defining the issues and determining the methodology of a review, again the guide suggests that that should be done by either the clinical lead or the lead reviewer?

A. Yes, that's correct according to the guide. Yes.

Q. So for all the important preparatory steps for an Invited Review the guidance is clear, isn't it, that there needs to be a clinical person taking those steps; it should not be left to the Invited Review manager alone?

A. Yes.

Q. In circumstances where a lead reviewer hasn't been appointed, then it would fall to you to take those steps?

A. Yes, I think that's correct, yes.

Q. In terms of the Countess of Chester Hospital review, the Terms of Reference were agreed and were discussed before a lead reviewer was appointed, weren't they; you would have seen that from the chronology?

A. Yes. So could you just repeat the question, Mr Carr, was it the Terms of Reference were agreed before the --

Q. Lead reviewer was appointed?

A. I'm not sure I can answer that because I don't

know exactly when David Milligan was approached about being the lead reviewer.

Q. The point is this: you will have seen from the documents you have considered that the Terms of Reference were discussed and agreed on behalf of the RCPCH solely by Sue Eardley weren't they?

A. Yes, that's correct, yes.

Q. It's clear on the guidance that shouldn't have occurred?

A. Yes.

Q. There should have been input either from the lead reviewer and until he was appointed it should have been you?

A. Yes, yes. Yes.

Q. So far as your discussion with Sue Eardley in the days prior to the Invited Review visit, you have described that she told you that a nurse had been suspended and part of the reason for the Invited Review was increased deaths?

A. Yes, the -- the three things that I do definitely remember was the cluster of unexplained deaths. I knew that the police hadn't been involved and I knew that one of the Terms of Reference was trying to look for clinical explanations for the cluster of deaths.

I -- I think I am right in saying that I knew a nurse had been suspended. But that is from my memory and it would depend I think on when Sue Eardley knew that because obviously if she didn't know, I couldn't have known that, so it's possible that part is -- is faulty recollection.

Q. Yes, you make the point in your statement, don't you, that you don't have a note of this telephone discussion and you are recalling it as best as you can?

A. Yes.

Q. But your best recollection, it's paragraph 49 if you want to look at it, paragraph 49 in your statement.

A. Yes, I have got it, yes.

Q. Four lines down you describe there your recollection that a few days before the review you received an email from the College that the review was about to take place and then over the page you describe in the rest of the paragraph the discussion you had by telephone?

A. Yes.

Q. Five lines down:

"A nurse had been suspended by the hospital and the primary purpose of this review was to look at other factors on the neonatal unit which would have led to

an increase in mortality?"
A. (Nods)
Q. And another three lines down:
"It was not clear that the presence of this nurse had been linked to the increase in mortality."
Did Ms Eardley tell you that there was a potential link between the suspended nurse and the increased mortality?
A. Sorry?
Q. Did Ms Eardley tell you that there was a potential link between the suspended nurse and the increase in mortality?
A. No. I think all we knew at that time, if I am remembering this correctly is a nurse had been taken away taken off clinical duties. But we didn't know why she was taken off clinical duties.
Q. Just specifically about what you recall that you knew. You knew that she had been moved. Did you understand that that was completely unrelated to the increase in deaths or did you understand that there was or there might be a connection?
A. I -- I think my recollection of this was that the -- or my assumption was that the nurse had been moved because it was linked because a conversation followed that the -- the Trust Management Team were

looking for potential clinical explanations for the change in mortality.
So I don't think Sue ever said explicitly to me that the nurse had been excluded because of, you know, clearly we had no ideas of the concerns at the time and I think I have mentioned it could have been a competence issue or a training issue. But I -- I inferred from that that there was some relationship between the nurse and the -- and the events, yes.
Q. And the possibility if there was a relationship would be either an issue with her competence, so errors in competence leading to increased deaths, something malevolent, a deliberate harm causing increased deaths or just a statistical anomaly and there being no causative link between increased correlation.
A. Yes.
Q. It's right to say, isn't it, that an Invited Review was not designed to carry out investigations into those sorts of links, or to exclude --
A. Yes, exactly.
Q. -- those sorts of links?
A. Yes.
Q. If there were any concerns about criminality or potential criminality you are clear in your evidence, aren't you, that the answer is to contact the police?

A. Yes, yes.
Q. During the review we have heard evidence from some of the reviewers and we have got written statements from others, we know that there was a discussion amongst some members of the Review Team as to whether or not the review should be aborted when details emerged on the morning of the first day of the review visit of the suspicions that the doctors had and the reasons for those suspicions.
Your advice was not sought. In your view should it have been, given the complexity and unusual nature of the review and the matters that emerged?
A. I think it should, I think I am probably clear about that having seen the -- you know, the witness statements. In fact, Helen Crisp interviewed the reviewers and it struck me that there was a clear high level anxiety amongst reviewers even down to the, you know, professional qualifications in terms of taking on the review.
So I -- I think it my view is yes, they should have escalated it. I think in mitigation, the 2016 guidance was actually put much more emphasis on to the Review Team themselves about decisions. I mean, clearly the new guidance is very different, but I do understand these are an incredibly senior Review Team and they made

a decision amongst themselves which was the normal as part of a review, we did that all the time but it was just in this particular case I think the level of anxiety probably would have been to -- or should have been to escalate it, yes.
Q. At paragraph 61 you set out the advice that you would have been given -- sorry, you set out the advice that you would have given if the Review Team had raised concerns with you. You say four lines down:
"My response would be to have explained that the allegations were so concerning that the police should be involved given that this had been the request of the paediatric team. In my professional experience it would have been very unusual for any paediatric team to make such a suggestion and so I would have taken it seriously."
A. (Nods)
Q. And so if you had been contacted and if you had been told and you have seen the notes of the interviews with the paediatricians, if you had been told that the concerns that they had, then you are clear in your mind the police ought to be contacted?
A. Yes, I mean I think the guidance at the time was they would have continued with the non-contentious issues of the review. So I think had I been involved

I think the question of should the police be involved at that point and you see from my evidence that I felt they should have been involved at probably -- well, at an earlier stage than the review took place actually. But I think that the escalation process now is very much tighter than it was at the time this review took place.

Q. Yes, I am asking only about -- only about the policies and approach at the time the review took place.

But even on the guidance that was in place at the time, and we have looked at it in the course of the evidence today, it certainly doesn't mandate a Review Team to continue, does it, it provides circumstances in which a review may continue?

A. Yes, exactly.

Q. But there will be circumstances where the safety concerns are such or the risk of prejudice to further investigations are such that it shouldn't continue?

A. Yes, I agree with that actually. Yes. I mean, I think it's a safeguarding issue, isn't it, really, you know, what the -- the Review Team were told.

So it should have been really escalated along safeguarding concerns but, I mean, there are some other factors you may ask me in due course. But I think the -- you know, this would have been pursued in

a safeguarding approach, you know, if the Review Team had severe concerns that babies were being harmed.

Q. On a connected but more general point. At paragraph 39 earlier in your statement, when dealing with the question of the policy in place at 2016, you make two points that I am going to read out. On the third line you make the point:

"We are not a criminal investigatory body and would not have wished to have interfered in any such allegations."

Four further lines down:

"If I had been asked about situations where there may be criminality, my advice would have been not to undertake any review where there may be criminal allegations."

So there is a clear dividing line for you in terms of when to undertake reviews and when to stop any review that was in progress?

A. Yes, that's true, yes. Yes.

Q. As to the decision to interview Letby during the Invited Review, you have addressed this in your statement and the position is you think it was wrong to interview her?

A. Yes, that's correct.

Q. Is that for the very same reason that we have

just considered, in light of the allegations that were being raised, in light of the fact that the RCPCH is not a criminal investigatory body and the guidance that was in place at the time, do you consider that there was a risk of prejudicing any future investigation by interviewing her?

A. Well, I think there definitely was the risk and I think the other issue was there would have been the HR issues I would have thought involved in one of the nurses being suspended from clinical duties, I would have thought that we shouldn't be interviewing somebody in that situation because of the HR processes.

So I think for both reasons I think it was probably in retrospect something that we shouldn't have done.

Q. The final versions of the report -- I say versions, you know that there were two different versions?

A. Yes.

Q. There was the full version the confidential copy and the dissemination copy?

A. Yes.

Q. They were sent out under a letter in your name, weren't they --

A. (Nods)

Q. -- in your role as clinical lead?

A. (Nods)

Q. You have explained that before it was sent you would have received a copy, a final version of the report and you would have read it?

A. Mmm.

Q. We have the comments that you made having read the report. They are contained in the RCPCH chronology. It's reference 0012748 and it's page 4, please. It's the entry in the middle of the page, 28 November. David S -- thank you -- QA of final report.

Now before I read it, to be clear, you didn't conduct quality assurance of the report?

A. No, I didn't. It was Dr Dorling and Dr Wilson that did it, it wasn't me.

Q. It was Dr Wilson. As for Dr Dorling, Dr Dorling was instructed to make quality assurance, did he in fact undertake quality assurance?

A. I think I have seen that actually, because there was some suggestion that I QA it, but I didn't --

Q. Forgive me, carry on?

A. No, I was going to say I have seen somewhere in the papers that was it was Dr Wilson and Dr Dorling, I may be wrong but my memory is I -- I saw the report but I didn't QA it because I think at the -- it would have been QAd before that date, so I think my email

wouldn't have been on the same date as I had seen it.
Q. So you were looking at the final version of the report as it was about to be sent out?
A. Yes. I can't be clear which version I saw because I think there were two. There was the October and the November version. So I can't be sure whether I saw the redacted or the unredacted one. I am guessing I saw the unredacted one.
Q. The confidential dissemination versions are both the same date, so they are both sent in October. There are subsequent editions dated November but the versions, as I understand it, sent under copy of your letter were the October versions, a full and a redacted.
What you say or what you are noted to say in this chronology is as follows:
"Quite an interesting and complex review. Good to have David M [that is a reference to David Milligan] leading that one. Almost felt a bit like the Grantham situation 30 years ago and my only question is why they didn't involve the police if they had those suspicions, otherwise looks like a good report with very clear recommendations."
Now, firstly to put this into context. You have explained in your statement that you were a Senior Registrar working in Nottingham in 1988 to 89, weren't

you?
A. I was, yes.
Q. You retrieved sick babies from the Grantham unit?
A. (Nods)
Q. That is the unit where Beverley Allitt worked?
A. Yes.
Q. Now, looking at that comment, Dr Shortland, the first point to make and you said a few moments ago you are not sure if you saw the redacted report or the full report, isn't the fact that you are referring to the Grantham situation here, doesn't that indicate it was probably the full report?
A. Yes, I think yes, I think --
Q. With reference to Letby and you must have seen --
A. Exactly right, yes. My assumption as well.
Q. It was the version of the report that was about to be sent to the Trust so it was the final version of the report, you hadn't seen the earlier iterations and drafts with track changes?
A. That's correct, yes.
Q. So by the time you see the report, references to police involvement, threats to call the police; they are not contained in that final version are they?

A. They are not in the version I have as the November version. But they were in the October version.
Q. Despite those references having been removed for the final draft, based on what you read, you saw similarities in what was being described in that report to another incident of a nurse killing and harming children?
A. (Nods)
Q. You make the point when explaining this comment in your statement, it's paragraph 77, that can come down now, thank you:
"In my experience as a paediatrician and neonatologist, it is extremely unusual for newborn infants to die without a clear diagnosis or evidence of a clinical deterioration and I can understand why I would have written that comment in relation to a review of unexplained neonatal deaths."
The point that you are making there is it seems -- but correct me if I am wrong -- is that the cluster or the cohort of deaths in itself because they were unexpected and unexplained, that would have been a matter for concern?
A. Yes, yes, that's correct. Yes.
Q. But there is the additional factor here and it is dealt with to some extent in the final full version

of the report, is the allegations against a nurse?
A. (Nods)
Q. Now, in light of the concern that you would have had because of the cluster of deaths, and in light of the parallel that you draw with Beverley Allitt, why didn't you ensure that there was a positive recommendation to call the police in the report? Or going to the Trust?
A. Yes, yes, okay. I mean, the comment that I made actually was it was -- the email was to Sue and it was actually referenced to the conversation that I had had with her two months previously where I had made the comment because the conversation we had had is that they had thought about calling the police but had decided not to wait for the College review and I felt that was really counterintuitive at the time, that if you think about calling the police you probably should call them and that -- that reference was really directing back to the -- to conversations I had with Sue.
I think the answer to your broader question is I think when you look at this review it was a really complicated one because you had the doctors, this was my view at the time, based on my recollection. You had the doctors concerned that a nurse was harming babies, you

had the nursing staff really vehemently denying that. You had a management structure that wasn't probably fully engaged, you had a governance system that wasn't fully engaged and you had some issues around the clinical service which probably was a risk too in terms of the shared rotas and the lack of, you know, the concerns around escalation.

So I think my thought at the time was I had this anecdotal thing in my mind from something that happened 30 years ago and actually you had had a review from five very senior reviewers who had come to a different conclusion and I think the proviso within that of course is that as far as I am aware, the paediatricians did suggest that the police were involved, I don't think they followed that through though as they perhaps could have done and they asked for another review.

So I think my recollection of seeing this review was that there was still potential explanations for why the mortality was higher.

But it clearly is -- and, you know, perhaps on reflection there's different ways of looking at this. But I think it was just a review that -- I had had no involvement after the conversation with Sue, so it just --

Q. Dr Shortland, can I just stop you there. You

might be moving slightly away from my question.

The first point of clarification, when explaining this email that you refer to a conversation that you had had with Ms Eardley, if I heard you correctly about police involvement, do I understand that? Was there a previous conversation?

A. There was a first conversation I had with Sue a few days before the review.

Q. Before the review visit?

A. Yes, it was when I received the email from Sue it was I think the Saturday, the review was on a Thursday, wasn't it? So about five days before the review I had an email from Sue.

Q. Was there a discussion as to police involvement at that stage?

A. I had a telephone -- I telephoned Sue which would be unusual for me at the weekend and my recollection of that was the things that I definitely knew was there was a cluster of unexplained deaths, the police weren't involved and the main purpose of the review, or one of the purposes of the review was to look at, you know, I suppose what you might call clinical explanations for the high -- the apparent increase in mortality.

Q. Dr Shortland, just to be clear, prior to this

entry in the chronology dated 28 November, had you had a discussion with Sue Eardley or anybody else on the Review Team relating to the police being contacted about matters at the Countess of Chester Hospital?

A. No. What I knew was the police hadn't been contacted.

Q. You raise your only question was why they didn't involve the police, did you receive an answer to that question?

A. Sorry, when you say I raised the question, do you mean in that email?

Q. Yes, forgive me, it has been taken down but we can put it back up, it is INQ0012748.

Forgive me, page 4.

A. Yes. Yes, I think my interpretation of my email would be that it was a complicated review; that for the reasons I have explained I think it was a very complex review to actually, you know, read and I think I just came back to the comment I had said to Sue at the initial conversation before the review took place was: basically, if you think about involving the police, you probably need to do it and I think that's what the referral is back to.

So it wasn't having read the review itself I thought the police should be involved because I think

the review, a lot of it is generic and there was so many complicated factors that I don't think the review made me make that comment. It was the fact that I had made the comment relating to a conversation I had had two months previously.

Q. Dr Shortland, thank you, but I'm not sure if there was an answer to my question in that.

You say my only question was why they didn't involve the police if they had those suspicions. So it appears you are raising as a query why haven't the police been contacted?

A. Yes, yes.

Q. My question is: did you receive an answer to that?

A. No, no --

Q. Were you told --

A. Sorry, I misunderstood the question.

As far as I know that email wasn't circulated and as -- I don't remember receiving a -- I think if I had probably the College would have, I am assuming, found the email.

Q. Nobody replied? Nobody replied?

A. No, as far as I know, no.

Q. The question went unanswered.

A. Exactly, yes.

Q. The report was sent out without making that recommendation.

A. (Nods)

MR CARR: My Lady, thank you. I have nothing further for this witness.

LADY JUSTICE THIRLWALL: Thank you. Mr Sharghy?

Questions by MR SHARGHY

MR SHARGHY: I know you have been sitting, Dr Shortland, in the hearing room so I will skip the introductions because you have already heard it and I just want to ask you questions in relation to two specific areas.

The first is looking at your experience, and you spent I think 10, 12 years as clinical lead on a neonatal unit and at the time of this review you were working as a Consultant paediatrician at Poole Hospital, it is quite rare, isn't it, in a neonatal setting to actually catch someone who's causing a form of harm --

A. (Nods)

Q. -- in the act?

A. Oh, yes, yes. Definitely.

Q. So the only thing that as clinicians one is left with is trying to piece together information and evidence in order to create a picture; is that fair?

A. Mmm (Nods)

Q. And one of the ways in which one does that from a clinician's point of view is you look at common factors between them to see if there's a cluster cohort or theme --

A. (Nods)

Q. -- you look at idiosyncratic issues between babies, you exclude environmental factors, is that all right so far?

A. (Nods)

Q. And once you have done that and perhaps you can tell me any more, you start to see a trend, don't you?

A. Mmm.

Q. You start to see some element of commonality to explain the unexplainable and the unexpected events; is that fair?

A. Yes, it is fair, yes.

Q. Given what you reviewed before you actually attended the hospital on 1 September and what you learned over the period of the 1 and 2 September, isn't that precisely what these Consultants, in particular Dr Brearey as the clinical lead, had done?

A. Yes. Just to be clear I didn't -- I didn't do the review.

Q. I am so sorry. But you are aware of the

information and the evidence that had been gathered?

A. Yes, I am yes.

Q. Is that not precisely what these Consultants had done?

A. Yes. Yes, I mean -- I think -- yes, the problem I think is that if someone's harming babies I think it's highly likely that the medical staff that detect that because they will see idiosyncrasies within what's happening and I don't mean that disrespectfully to any other health professional, but doctors tend to approach things diagnostically. So I think if your consultants are of the view that someone is harming babies -- and I don't say that lightly -- but I think what I mean is that they have looked at other possibilities which I think your question's leading. I think, you know, maybe this is an anecdotal comment, but it is very rare as I mentioned in my witness report, for babies to die or children to die without an explanation. I mean, it is quite unusual. You know, they might become ill and they might deteriorate but the doctors usually know. So I think if your clinicians cannot find an alternative explanation, it's probably at that point that you have to take those comments very seriously.

Q. They are suspicions of crimes, aren't they,

they are not simply medical factors that need further exploration?

A. Yes. I mean, I think, you know, these babies are monitored massively, extensively when they are in a neonatal unit. I mean, they are going to be covered in monitors and I think to have very sudden collapses is very unusual not to be able to resuscitate a baby if they have collapsed and if they have deteriorated massively, clinically that is usually evident why they have done it. So I think this pattern is actually unusual, yes.

Q. So undertaking a service review of the type that we know was undertaken would never have actually got to answer the concerns of the Consultants would it?

A. No, no I think -- I think that's right. I think if your Consultants as a group have considered harm and, you know, your Consultants are respected by the, you know, the hospital and their opinions are taken seriously, it's almost difficult in my opinion to know how you can approach that other than with a forensic inquiry. Because I don't think a clinical -- I mean, the Terms of Reference of this review, as you appreciate, as I have mentioned to Mr Carr, was very much about is there a clinical explanation for this and in itself that is a sensible question.

But the other question may be more important.
Q. Final question: you have carried out a large number of these reviews?
A. Yes.
Q. The Inquiry has heard from the other members and will hear from one more later this afternoon.
What would it take to stop a review either shortly before it starts or once it's started. How significant does the concern have to be to stop a Invited Service Review?
A. I mean, the current guidance would put that threshold very low actually, because the --
Q. Back in 2016?
A. Yes, the guidance in 2016 was -- I mean, I have to be honest, I was involved in writing these documents. I don't think we ever considered this scenario. But, you know, the level I think at that point, the advice was: you carry on with the non-contentious issues but I think with something like, you know, had the Review Team considered that a criminal act was highly likely, I think the review would have stopped.
Q. So the judgement call is very much dependent on the quality and the experience of a Review Team as a whole in order to make that call to stop it back in

2016?
A. I think it is. I mean, when you do reviews, you probably talk to a hundred people with a hundred different views and sometimes something crystallises at that review and it might be a person or group of people that review and that changes your perspective and I think it's that that happens in a review. Because College reviews are not fact-finding reviews, they are assimilation of information that you are being given, so you are assimilating -- you are not really genuinely looking at original facts, you are hearing what people say and there is a great strength in that. But there would have to be something about I think if a Review Team from the masses of information they are receiving suddenly taking a piece of information so seriously that they actually felt that that was the crystallisation of the review. In which case, you know, the action in my opinion in this situation would have been to stop the review, yes.
Q. Would one of the reasons back in 2016 to have stopped a review have been if the team or indeed individuals within that team realised this was too complex?
A. Yes.
Q. Outwith their experience, would that have been

sufficient in your view to have stopped?
A. I mean definitely on their judgement. I mean arguably if you escalate the review, you sort of take that decision more as a College-wide decision, I guess, really. So I think it was perfectly -- you know perfectly reasonable for a Review Team to decide to stop a review. I don't think there is any question about that.
MR SHARGHY: Thank you. My Lady, thank you very much. Those are my questions.
LADY JUSTICE THIRLWALL: Thank you very much Mr Sharghy. Ms Scolding.

Questions by MS SCOLDING

MS SCOLDING: My Lady, I just have two clarificatory questions arising.
Good afternoon, Dr Shortland. I am Fiona Scolding, I represent the Royal College of Paediatrics and Child Health.
I just have two clarificatory questions arising from the questions that have just been posed by you by Mr Sharghy.
Firstly, did you see any notes of interview or any of the background information in respect of the review when you were looking at the report in November 2016?
A. Sorry, do you mean did I see anything as well

as the review?
Q. Yes.
A. No, no, I just saw the review, yes, yes.
Q. Okay. So you would not have seen the conversation that took place between Dr Brearey and Jayaram?
A. No.
Q. The reviewers on the morning of the 1 September?
A. No, no definitely not, yes.
MS SCOLDING: Those are the only questions I have, my Lady.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Thank you very much, Ms Scolding.
Dr Shortland, is it a fair summary heading of your evidence that this review could never deal with the issues that the doctors had raised?
A. Yes, I think that's --
LADY JUSTICE THIRLWALL: This was a service review?
A. Yes.
LADY JUSTICE THIRLWALL: It wasn't a fact-finding review.
A. (Nods)
LADY JUSTICE THIRLWALL: And it didn't produce any

answers to the questions raised by the doctors?
A. Yes. I think that's a fair -- you know, I agree.
LADY JUSTICE THIRLWALL: Yes. Then I was just looking at the summary right at the end of the report before the recommendations at page 25, INQ0009618, page 25.
We have looked at this before with other witnesses, I think Ms Eardley. But there are a number of recommendations included which are summarised there.
So the first is staffing levels --
A. Yes.
LADY JUSTICE THIRLWALL: -- being inadequate, which was a common problem, frankly, wasn't it? That's not an explanation and, secondly, escalation of concerns to tertiary units but again that wasn't an answer to the problems and then there are two recommendations about postmortems, but again they wouldn't -- they wouldn't address the questions that had been raised in respect of what was causing the deaths of these babies?
A. Yes, yes, that does -- that's correct, yes.
LADY JUSTICE THIRLWALL: Yes. Thank you very much indeed, Dr Shortland. Does anybody else want to ask anything else?
No. Thank you for coming. We are very grateful.

It is Dr Wilson next, isn't it?
MR CARR: My Lady, may I call our final witness for today, Dr Nicholas Wilson.

DR NICHOLAS WILSON (sworn)

Questions by MR CARR

LADY JUSTICE THIRLWALL: Thank you. Do sit down, Dr Wilson.
A. Yes.
LADY JUSTICE THIRLWALL: Mr Carr.
MR CARR: Tell us your full name, please.
A. Nicholas Robert Wilson.
Q. You have prepared a statement, haven't you, dated 29 May 2024 for this Inquiry?
A. Yes.
Q. Are the contents of that statement true to your best knowledge and belief?
A. They are.
Q. You are a Consultant paediatrician and neonatologist and have held that position since 1998, haven't you?
A. This is true.
Q. And you have also been named doctor for safeguarding children since 2003?
A. Yes.
Q. Did you, at the time that we are concerned

with, which is when you undertook quality assurance of the service review report of the Countess of Chester Hospital, were you familiar with the statutory guidance contained in Working Together to Safeguard Children in 2015?
A. I was.
Q. Did you understand when a referral to the Local Authority Designated Officer was required?
A. I was.
Q. Turning to the Invited Review. Your role was to undertake quality assurance of the report?
A. Yes.
Q. The guidance in place at the time required quality assurance to be undertaken by two people, didn't it?
A. Yes.
Q. Another doctor, a Dr Dorling was instructed to undertake quality assurance. Do you know if he did undertake that?
A. I don't, no.
Q. Is the quality assurance process independent so there is no working between two quality assurers?
A. That's true. We don't contact each other.
Q. So far as your experience at the time, in your witness statement, it's your paragraph 12, you state

that the Countess of Chester Hospital review was one of the earliest roles of this kind that you undertook?
A. This is true.
Q. And further in your statement, paragraph 14, you state you had perhaps been involved in one review as quality assurance reviewer prior to the Countess of Chester?
A. This is true.
Q. So the Countess of Chester review was either your first or second as quality assurance reviewer. Had you done other reviews before that as part of a Review Team?
A. Yes, I had been a reviewer and visited other hospitals before that.
Q. As for preparation and training for the role of quality assurance, you state in paragraph 17 of your statement, the final sentence, that you do not believe you received any specific training with regards to carrying out a quality assurance review?
A. That is correct.
Q. You have described in your statement the process for raising and escalating concerns as part of the Invited Review process?
A. Yes.
Q. And there's categorisations of concern up

to immediate risk and you deal with that in your witness statement.

It's right to say, isn't it, that what you are describing there is an escalation process which postdates the Countess of Chester review?

A. I'm sorry, I don't fully understand the --

Q. Forgive me. If you look at your statement.

A. Yes.

Q. Paragraph 18, final sentence. When dealing with --

A. Yes.

Q. -- escalation process, you say:

"We would grade our response as a concern ..."

A. Yes.

Q. "... a serious concern or as evidence of an immediate risk."

A. That's right, yes.

Q. And what you are referring to, we can look at it, INQ0012813, I will get the section up in the guidance --

A. Yes.

Q. -- but the point is it comes from the 2023 guidance?

A. Yes.

Q. And that categorisation didn't exist in 2016?

A. Yes, that's different, no, that's right.

Q. Forgive me. We can take that down.

So far as the role of quality assurance particularly where there are no -- there's no training for the role, what was your understanding of what was required of a quality assurer?

A. So in a conversation, I was told that the main role was to read the report and make sure it was easy to understand, that there were not too many technical terms which might be confusing for a wider audience, because it's being looked at by managers as well as clinicians, to make sure that it met the requirements of the Terms of Reference.

I think that was it: readability and making sure -- and also if there were recommendations within the report that they were justified on the evidence presented within the report. So if conclusions were arrived at that there was evidence supporting that conclusion.

Q. Okay. So readable, coherent and substantiated?

A. Yes, yes.

Q. Two references. First INQ0010214. I am going to take you to the guidance from August 2016 on Invited Reviews, so this is the guidance that would have been in place at the time of your quality assurance. It's

page 6, please. If you look at paragraph 4.3, there is a summary of the different individuals involved in the review process and do you see the final subparagraph of 4.3 states:

"There is a clear quality assurance process to challenge the report, content and conclusions."

Were you familiar with that provision?

A. Yes, I have seen that.

Q. And what did you understand by "to challenge the report, content and conclusions."

A. Well, again, if conclusions had been arrived at which I did not think were fitting with the statutory guidance we have from our professional organisations like the -- like BAPM, then I would suggest that it wasn't appropriate for the College to be making those recommendations.

Q. And then looking at the letter of instruction to you, it's INQ0009631. This is the letter from Sue Eardley to you of 7 October 2016, and you will see at the bottom of the letter under the heading "Your role" a description of a quality assurance reviewer.

A. (Nods)

Q. The second sentence:

"You are not expected to have visited the site or conducted interviews and the role is as an objective

external critical friend both to the reviewers and to the RCPCH Review Team."

Now, that term or phrase "critical friend", what did you understand by that?

A. Well, whilst one is looking at work made by a -- by a colleague who is -- we may or may not know each other, but we are all colleagues within the same field, we, we have respect for each other. So we would not want to be I think excessively critical. We would understand how our comments might affect our colleagues.

Notwithstanding that, if we thought something in the report was, you know, factually inaccurate or clearly wrong then we would still bring that up.

So I think as a -- it would be a critical friend, a critical colleague I guess is how I interpreted that.

Q. And both to the reviewers and to the RCPCH Review Team. What's the difference or the distinction that's being drawn there?

A. Yes, I think the -- the problem as a quality assurance person is that I wasn't sure where my -- what route my comments were actually taking. So I would make my comments, I wasn't sure who was seeing those comments. So it is here saying it's going to the College and to the team. I wasn't actually aware how that was taking place, whether my comments would go

directly to the leader of the team or to somebody within the College itself. So that wasn't clear to me.

Q. I see. So when there is a reference to being a critical friend both to the reviewers and to the RCPCH Review Team, is the distinction there that the reviewers are the people conducting the review?

A. Yes.

Q. So the Review Team for an individual review and the RCPCH Review Team are the people at the RCPCH --

A. Yes.

Q. -- who oversee the service.

So far as your quality assurance, there are three sources, aren't there? There is a quality assurance form that you completed, there is a version/iteration of the draft report, which you added some comments to, and then there is an email containing some additional commentary?

A. Yes.

Q. We will consider each of those. Please can we deal first with the comments added to the draft report, the reference INQ0010145 and the page we want is page 18.

If we can zoom in on the text at the bottom, which is in orange and, Dr Wilson, this is the commentary that you added to the report --

A. Yes, I believe so.

Q. -- that you reviewed?

You make a number of points in that first paragraph:

"All deaths should be raised as a Serious Incident."

You make reference to investigations internally or externally and the decision to step down. Can you explain why you added this, why you identified this as a point that needed to be put into the report?

A. From my interpretation, when I read the report I did not think that certainly early on the Trust was -- was doing this. I think the Trust was -- if they felt that a death was not -- was explicable and they did not think that there been any failure of their service they were not raising it as a possible Serious Incident.

And the organisation I work within, the -- I think it's the management team really want quality assurance, want assurance about our practice. So they would expect us always to bring each death to a specific risk assessment meeting so we could go over the death and discuss it with colleagues, with management colleagues, with other professionals, so there was more openness and people could challenge our -- our practice.

Q. And you go on to observe that unexpected

deaths must be referred to the Child Death Overview Panel.

A. Yes.

Q. And you query the role of the CCG and you think five times a year is too infrequent for lessons to be learnt and you are describing there five times a year. What's that a reference to?

A. Yes.

Q. What is it a reference to?

A. Oh, I think the -- I think the panel was meeting five times a year, that's ... I'm used to it happening maybe monthly in my experience, but ...

Q. And over the page, page 19, yes, the top of the page, in orange your final comment there:

"The ODN could have an annual death meeting (if not already)."

A. Yes.

Q. So those are observations that you made so far as the systems in place particularly as they related to deaths --

A. Yes.

Q. -- at the hospital.

Can I ask you within the same document, if we go back to page 7, please. There are a number of changes or added text to the document in orange. It looks like

a similar colour to the colour that you use and so my query: is are these your additions?

A. I think -- I commented that I thought most of the references towards child death I had added to the report. I'm not sure if these were my comments.

Q. But at the bottom of the --

A. Yes.

Q. -- page, we see a reference:

"Circumstances in the unit were not materially different..."

And then it goes over the page to the next page to say:

"... from those which might be found in many other neonatal units within the UK."

Now, is that a observation that you made and do you think you added this to the --

A. Yes, I remember that reference. That was the -- the unit prior to its change in designation was a unit which was looking after an excessive number of very small, sick babies with staffing levels not at a safe point. That was what my reference was. I was making that reference, yes.

Q. And the point that you were making is those lower staffing levels were not atypical --

A. That's right.

Q. -- it was something that was -- would be a feature of similar units?

A. Certainly at that point, of the development of the neonatal networks, yes.

Q. So those were the comments on the report. But it would appear, and again we go to the RCPCH chronology, that there were some additional comments made. It's INQ0012748, sorry, page 3.

The entry, the penultimate entry dated 15 October.

A. Yes.

Q. And what you write is:

"I hope my contribution was useful. I felt only that you might tone down your justifiable high dudgeon about how badly the Trust had dealt with the exclusion and the supine behaviour of the Union rep. Your conclusions were entirely sound. Their governance is flawed. Green for Danger, before your time of course, in neonatal medicine death is one of the few clearly definable outcome measures and should be closely monitored not just by the doctors. As has been well said if you want to drain the pond don't ask the frogs."

Now, I want to ask you about different elements of that commentary. Firstly, the reference to toning down justifiable high dudgeon and how badly the Trust had dealt with the exclusion; is this a reference to the

allegations relating to Letby in the reports, the green text in the version of the report you reviewed?

A. The report had sections which were redacted and I think it's a reference to parts of those redacted texts where there was a comment from the Review Team and I knew that and it was difficult to understand those sections, not having visited the unit.

But, yes, it was referring to that and the Review Team were unhappy about the way the HR process had been followed within the Trust and I thought and I --

Q. To be clear, when you say the report had redactions, you saw a version that wasn't redacted?

A. Although they were -- those sections were highlighted differently.

Q. Yes.

A. And it was pointed out to me, when I took on the report, that those sections would not be necessarily clear to understand not having visited the Trust.

Q. Was it your understanding that those comments were going to be removed altogether from the report or did you appreciate there were going to be two different versions of the report?

A. My impression was there were going to be two different versions of the report.

Q. Yes. So back to my question. This comment

refers to those green sections --

A. Yes.

Q. -- so to the Letby sections?

A. Yes.

Q. Supine behaviour of the Union rep. What do you mean by that?

A. I think there was a criticism of the way that this had been dealt with by -- the individual's Union representative had not been supportive, sufficiently supportive, I think or -- or something about that Union rep had been inappropriate in terms of dealing with the process.

Q. And justifiable high dudgeon?

A. I got the impression that the Review Team -- well, there was some emotion coming across that they were unhappy about the situation they found themselves in and I think in a College report we wouldn't want that emotion to be expressed in that way. It wasn't appropriate for these emotive terms to be used in the report.

Q. In light of what was contained in the green text, what consideration did you give, particularly in light of your safeguarding roles, to the safeguarding implications of the allegations?

A. I wasn't clear that there were allegations

that any individual had wilfully done anything harmful. I thought it was more issues of competence rather than any high level of concern.

There's nothing explicit in the report which made me think that that was what they were referring to.

Q. Within the version of the report that you considered in the green text, it states, doesn't it, that this was removed from the final version but -- or it was amended in the final version:

"The Consultants apparently threatened to call the police unless the nurse was removed from the unit."

A. Mmm.

Q. So that would convey a seriousness of their concern and that their concern was of criminal behaviour?

A. Yes, this would.

Q. And so I return to my question about what consideration you gave to the safeguarding implications?

A. Yes. I think as the reviewer, I was looking at other people who had been there and if that hadn't been their conclusion, I didn't feel I was going to contradict their opinion. They did know more about the situation than I did. So if they had not raised their concerns, I must admit I did not feel I would do that myself.

Q. Thinking about the letter that you received from Sue Eardley defining the role, the suggestion of being a critical friend, if you were being a critical friend then this is the sort of topic that you could be critical on?

A. Yes.

Q. You could depart from those who were visiting?

A. I think it was also partly because I wasn't clear how my comment -- what direction my comments would take, this is quite true.

I think it did -- we did all have opportunities to say in a way whatever we felt was important to say. So we could have said anything if we felt that was necessary.

Q. Do you consider that as part of the quality assurance, and you only looked at the report as I understand it, you didn't look at all the notes, but from you had seen should -- in the same way you flagged issues about the Child Death Overview Panel and Serious Incident investigations, shouldn't you have flagged the need to ensure that the hospital was complying with its safeguard obligations when serious allegations of deliberate harm against children were made?

A. Yes. I was aware of that process, certainly as a named doctor for safeguarding and it would have

been appropriate for me to bring that to their attention at the time -- at that time.

Q. "Your conclusions were entirely sound. Their governance is flawed."

The reference to their governance being flawed, does that arise from the text that you added to the draft report?

A. Around the death process and investigating deaths.

Q. Are there any other additional points in respect of which you considered their governance flawed?

A. That was what I was most concerned about, yes.

Q. "Green for Danger, before your time."

You explain in your statement Green for Danger is a film where a patient is killed by a doctor using surreptitious means swapping an oxygen cylinder for something --

A. Yes.

Q. -- presumably noxious.

We are just going to get it back up it is page, yes. Now, you explain in your statement that the reason that you refer to this film is because of what was contained in that green text and the suggestion that --

A. Yes.

Q. -- a member of staff was responsible for the

deaths. And on reading, on reading the draft report, did it create a parallel in your mind with this film?

A. So reading the redacted sections it -- I got the impression that something unusual, unexplained, inexplicable was going on in this hospital; this is true. And the film is more about it's not clear whether anything has -- whether there's a crime been committed or not but it's -- no -- it's a situation, yes, where a member of staff is suspicious, is suspected of having harmed a patient.

So, yes, I thought that from the redacted text that was -- that was, to some extent that conclusion was mentioned within the -- within those sections, yes.

That was a worry.

Q. And in light of safeguarding practice and safeguarding principles in place at the time, the fact that there is a low bar to -- there's a low bar before there needs to be escalation and referral where there are those suspicions, there needs to be onward escalation?

A. Yes, if that suspicion exists then escalation should take place.

Q. And then the final point about neonatal medicine and "... death being one of our few clearly definable outcome measures" and the reference to

draining the pond, what you explain in your statement is that you were referring here to the fact that sometimes local neonatal units can be resistant to reconfiguration because they are protective of their own interests?

A. Yes.

Q. But the situation here wasn't that the doctors were resisting reconfiguration. In fact, the reconfiguration had occurred because of the increase in deaths?

A. Yes.

Q. So what was the relevance of the draining the pond?

A. Having thought about that, I think it's also a general point about people sometimes very close to a problem not necessarily being the best people to understand the problem, well, the -- what is actually going on in, in that problem.

So it's true sometimes neonatal doctors want to protect their patches, but also people close to a problem aren't the ones who are able to see what what's going on most clearly. That could be the doctors, that could be other people within the unit.

Q. Finally this, Dr Wilson, it's a form that you filled out for the purposes of quality assurance. It is INQ0009628. There's a series of questions that you have

responded to?
A. Yes.
Q. And the two that I want to take you to are 2 and 8 -- sorry, 4 and 8. Number 4:
"Are the elements of the Terms of Reference clearly addressed?"
You have answered yes. One of the Terms of Reference, term of reference 4, asked whether or not there were identifiable factors or failings which were common and causative of the death and the report doesn't address that one way or the other, does it?
A. It doesn't directly, but it makes the recommendation that a further investigation should take place, which is why I felt that was a reasonable conclusion to come to.
Q. A connected question. Second page, number 8:
"Are the recommendations achievable and realistic?"
What did you understand the main recommendations to be of the report?
A. Yes. That was -- my concern was around the increased activity on the unit and inadequate staffing. So the recommendations were about, you know, the redesignation of the unit, which had already taken place as you say, and also improving the management structure, making the clinicians have closer connection with their

senior managers. I think it was around those areas.
Q. On your review and your reading of the report, did you consider that it made any recommendation to commence a safeguarding process?
A. No.
MR CARR: Thank you, my Lady. I have no further questions.

Questions by MR SHARGHY

MR SHARGHY: Just two questions, my Lady.
Dr Wilson, I think you have also been sitting in the room as well, so you will know I will ask questions on behalf of seven Families who Lucy Letby harmed the babies of.
Green for Danger. I have just done a very quick Google search; a 1946 movie. The police were called in that move, weren't they --
A. They were.
Q. -- to investigate?
A. Yes.
Q. And in relation to making the reference in your comments as you did, do you think you could and perhaps should have been more explicit about the police potentially being called?
A. Now it seems, yes. Something about when I read the report I was concerned, yes. So clearly

I had made that reference because I was concerned and I didn't take it further and that, it may well have been some --
Well, it was something I should have taken further, yes.
MR SHARGHY: Thank you very much. My Lady, thank you.
LADY JUSTICE THIRLWALL: Thank you, Mr Sharghy. Ms Scolding.
MS SCOLDING: I have no further questions, my Lady.
LADY JUSTICE THIRLWALL: Thank you very much.
You have nothing else? Thank you very much.
Thank you, doctor, you are free to go.
A. Thank you very much.
LADY JUSTICE THIRLWALL: Now, we've got two witnesses tomorrow, I think, Dr Hawdon and Dr McPartland?
MR CARR: Yes, my Lady.
LADY JUSTICE THIRLWALL: Yes, and we will start at 10 o'clock. Thank you, all.
(5.12 pm)
(The Inquiry adjourned until 10.00 am
on Tuesday, 12 November 2024)

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