Witness Statement of Stephen Paul Cross

Introduction

1. This statement is prepared in response to a Rule 9 request received from the Thirlwall Inquiry ("the Inquiry"). This statement aims to respond to the questions raised by the Inquiry in its Rule 9 request. The Inquiry has kindly provided me with two bundles of documents, each of which is labelled with an INQ number. Reference to those documents in this statement will be by reference to the same INQ number as the Inquiry has provided.

2. I fully support the Inquiry into these important matters and I where I am able to, I have set out below answers to the Inquiry's questions. It is difficult to comprehend what the families of the babies concerned must have been through, and my thoughts and condolences have always been and remain with them.

3. The questions raised by the Inquiry relate predominantly to the period of time between 2015 and 2018. I have reflected on the 272 questions posed by the Inquiry, and the supporting bundle of INQ documents and I have done my best to answer as many of the questions that I am able. I have used the same subheadings in this statement as in the Rule 9 letter where I am able. I have also had the opportunity to review my notebooks containing any notes that I made at the time of the various meetings that I attended. I took notes in most meetings that I attended in my time at the Trust, which would include meetings on a wide range of Trust matters. I left my original notebooks at the Trust when I left in 2019, so that they could be available to the Trust if required by the police or any other investigation. What I understand to be a complete set of those notes (from 2011 to 2018) has helpfully been provided to me by the Trust in recent weeks. Some of the notebooks I have been provided with by the Trust have coloured highlighting, I do not believe that the highlighting was done by me.

4. Whilst it has been helpful to have access to the Inquiry documents and my notebooks, I have still found it extremely difficult to recall the specifics of the meetings which took

place so long ago, due to the passage of time. I am being asked to remember detailed matters about this period of time now, eight years after the event, and I have tried to give as much detail and context as I can remember about these very important matters. However, there are a number of areas that I am unfortunately unable to assist the Inquiry with. In particular, it is difficult to recall what discussions may have been had outside of what can be ascertained from the minutes or notes of those meetings. I have also found it difficult to remember whether or not I received, saw or read a particular document eight years ago. As outlined below my role was very wide ranging and I received many documents about many different matters, however I wouldn't have always read or been expected to understand the detail of all of them.

5. I was interviewed by Facere Melius on 1 December 2020 [INQ0013006] and 2 December 2020 [INQ0013007] [Exhibit SC/1] as part of the independent review of the Countess of Chester Hospital NHS Foundation Trust ("the Trust") between 2015 and 2016. I can confirm that, to the best of my knowledge, the information I provided during those interviews was accurate and correct. The information within this statement is provided in addition to the records of my interviews with Facere Melius which were made nearer to the events at the time and therefore my memory of the events may have been clearer during those interviews, albeit they were still taken four years after the events.

Background

6. In 2007, I joined the Countess of Chester Hospital ("COCH") as Trust Secretary of the Countess of Chester Hospital NHS Foundation Trust ("the Trust") on a part-time basis, working three days per week. After approximately seven weeks in my role at the Trust, I was asked if I would undertake the role on a full-time basis, which I agreed to do. During my employment at the Trust, the Chief Executive of the Trust, suggested that because of the roles I was already carrying out for the Trust, it would be appropriate to change my job title to Director of Corporate and Legal Services. I had also been offered a similar role at the Liverpool Heart and Chest Hospital. As far as I can recall, there was not a formal application process and I did not receive a new job description, it was purely a title to reflect my role within the Trust. To the best of my recollection this became effective between 2012 and 2013. This was not a formal directorship, and I am aware that there were other Directors in addition to myself who

held the title of Director, such as the Director of Pharmacy and the Director of Estates, but who did not have the duties of an Executive Director.

7. During my employment at the Trust, I completed a Master's Degree in Health Care Governance at Loughborough University.

8. Irrelevant & Sensitive I&S following which I made the decision to retire. I handed my notice in to the Trust in March 2019, and formally retired from the Trust on 3 June 2019. I did not retain any role within the Trust following this date.

9. Prior to working at the Trust, I worked as a solicitor, having undertaken my law degree whilst studying part-time at Liverpool John Moores University between 1998 and 2001. I subsequently completed the Postgraduate Diploma in Legal Practice in September 2005 and was admitted to the Roll of Solicitors on 2 May 2006. Prior to being a solicitor I worked for Cheshire Police Constabulary ("CPC"), having joined at the age of 16 as a Police Cadet, and remained at CPC for 31 years. During my time within CPC, I undertook a number of roles, one of which was within the serious incidents investigation team. I retired from CPC at the age of 49, and subsequently worked with my brother as a Paralegal at his law firm in North Wales before deciding to undertake my law degree as mentioned above, qualifying as a solicitor at the age of 52/53.

10. Following my retirement from the Trust, I became a Governor of Blackpool Teaching Hospitals NHS Foundation Trust on an entirely voluntary basis, and remained in this role for two years during the Covid-19 pandemic.

11. I have been asked about current Directorships that I hold. I am currently a director of both the Chester Masonic Development, Freemason's Hall (Chester) Limited and the Masonic Hall, Cheshire View Limited, in an unpaid capacity. I am also a Trustee of the Cheshire Masonic Benevolent Association. I am also a Trustee of the Pause for Hope Cancer Charity based in Liverpool which is a support and prayer initiative for those suffering from cancer and their carers, and holds annual ecumenical services nationally. I am also a Trustee of the following organisations: the Chester Cathedral Development Fund, Irrelevant & Sensitive, the City of Chester Rotary Club and the Society of Friends of Chester Cathedral.

Role at COCH

12. Within my role at the Trust, I reported directly to the Chief Executive of the Trust and the Chair of the Trust. I had good working relationships with both individuals and they and others would sometimes come to me to discuss matters. This could include matters of which I was already aware, or new matters that I had no knowledge of, and they would use me as a sounding board for ideas and queries on occasion. As is evident from later in my statement, it was not the case that the Chief Executive, the Chair or any of the other Executives would run all issues past me, that would not have been practicable or necessary. The Chief Executive and the Chair were senior experienced decision makers at the Trust and whilst they may have asked for my thoughts, they did not need or seek my input on the majority of the decisions that they would have made in their role.

13. Within my role at the COCH, a number of teams reported to me, including Fundraising, Charitable Funds, Hospital Chaplaincy, Bereavement Services and Legal Services. Legal Services was a small department within the COCH. Legal Services was made up of three sub-teams, Inquests, Claims and Administration, and was managed by the Legal Services Manager.

14. I have been asked about my relationship with His Majesty's Coroner's Service. I had a good working relationship with the Coroner's Service which extended to joint seminars between the Coroner's Office and the COCH, and I also arranged mock Inquests to be carried out at the COCH for the purposes of staff training.

15. As I mentioned above, I did not have a job description for when my title changed, but my main responsibilities remained as per the Trust Secretary job description [Exhibit SC/2] which was as follows:

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- Establish and monitor procedures to ensure the Trust complies with the requirements of the National Health Service Act 2006, its Terms of Authorisation, its Constitution and Standing Orders;
- Ensure that amendments to the Constitution of Standing Orders are drafted and incorporated in line with correct procedures;
- Keep under review all corporate governance arrangements, legislation and codes of practice which might affect the Trust, and ensure the Boards are fully informed on these matters;

- Act as the initial point of contact between the Board of Directors and Board of Governors;
- Ensure that arrangements are in place for the appointment of the Trust's external auditors;
- Arrange for the Trust to access comprehensive legal services and liability insurance cover; and
- Provide adequate administrative resources for the effective working of both the Board of Directors and the Board of Governors.

16. My responsibilities to the Trust's Board of Directors were as follows:

- Provide advice to the Chair of the Trust and Board members on matters of governance and the conduct of meetings;
- Work with the Chair of the Trust and Chief Executive to plan, administer, record and communicate the outcomes of the meetings of the Board of Directors and Board of Governors and their sub-committees;
- Ensure that the sub-committees of the Board of Directors are properly constituted with clear terms of reference;
- Ensure that arrangements are in place for the selection of the Chair of the Trust and Non-Executive Directors and for their adoption by the Board of Governors;
- Ensure that a comprehensive induction programme is in place for new Directors and provide advice and support regarding the discharge of their duties;
- Ensure arrangements are in place to evaluate the effectiveness of the Board of Directors including appraisal of individual Directors; and
- Assist Directors with advice on ongoing development.

17. My responsibilities to the Trust's Board of Governors were as follows, and these responsibilities consumed the majority of my time throughout my role at the Trust:

- Be the first point of contact for Governors in communicating with the Trust;
- Provide advice to the Chair of the Trust and Governors on matters of governance and the conduct of meetings;
- Ensure that meetings of the Board of Governors are held in accordance with the Trust's Constitution;

- Work with the Chair of the Trust to plan, arrange and administer all meetings of the Board of Governors;
- Ensure that the sub-committees of the Board of Governors are properly constituted with clear terms of reference;
- Work with the Chair of the Trust to establish a suitable method to evaluate the performance of the Chair of Governors;
- Establish a suitable induction and ongoing training programme for Governors and provide advice to them in the discharge of their duties;
- Ensure effective communication channels are in place between the Boards particularly in situations where Directors' meetings are held in private ; and
- Agree with the relevant partner/stakeholder organisations the arrangements for the appointment of their representatives to the Board of Governors

18. My other responsibilities within my role at the Trust were as follows:

- Coordinate Annual Report and accounts;
- Attending Serious Untoward Incidents meetings as required;
- Freedom of Information requests;
- Maintain Registers of interests of the Board of Directors members and Board of Governors and Foundation Trust members and their constituencies; and
- Make available for public inspection a copy of the Terms of Authorisation and Constitution, the latest annual report and accounts and the annual plan.

19. During my time at the Trust I also completed a 12 month secondment working within the Trust's Finance department to lead the COCH's cost reduction strategy, assisted by one of the Assistant Directors of Finance.

20. I have been asked about the training that I received within my role as Director of Corporate and Legal Services. Specifically, I have been asked whether I received any training on patient safety (in particular the safeguarding of babies) or the process used and/or the organisations involved in reviewing a sudden, unexpected child death. I do not recall receiving training on either of those topics. I also have been asked whether I received any guidance or support from NHS England in my role and I do not recall any such guidance, nor do I recall any specific training on the culture within the NHS and how to improve it. I did go on training courses relevant to my role, such as the NHS Company Secretary's Development Programme. As I mentioned above,

I was awarded the title of Director of Corporate and Legal Services from the role of Trust Secretary and I did not receive any specific training when my title changed. I was not an Executive Director of the Trust and therefore I did not have any voting rights or formal decision making power, outside of the day to day decisions I was able to make within my own role.

Governance within the Trust

21. As part of my role within the Trust, I was asked to attend a number of meetings, including the Board Meetings, weekly Executive Directors Group ("EDG") (also referred to as Executive Team meetings), and Corporate Directors Group Committee ("CDG"). I also sat on a number of committees which reported up to the Board and CDG, and these included the Charitable Funds Committee, Risk Committee, Audit Committee, and the Finance and Integrated Governance Committee ("FIGC").

22. I cannot specifically recall from memory alone the exact functions and responsibilities of each group and how they differed from each other as it was too long ago. I have seen copies of the relevant Terms of Reference ("ToR") for the CDG and FIGC and have exhibited those ToR as Exhibit SC/3. **INQ0107706, page 55-59**

23. In respect of the purpose of the meetings, the Executive Team would discuss issues raised by each division, and decide which matters were required to be escalated and discussed at Board level at the Board meetings. I recall that the Chief Executive set the CDG meetings up in order to involve middle managers, between the Board and Executive Team meetings, and the attendees included a combination of Executives and middle managers (heads of departments). The purpose of the CDG was to enhance communication throughout COCH. I also recall that there was a process in place for escalating risks at the Trust at Divisional and Executive level which was set out within the Risk Management Strategy and Operational Policy [INQ0014962] and Executive Risk Register ("ERR") [INQ0050940]. The process provided a comparison of risk and incident reporting data. If the risk was elevated from the Divisional level, it would be discussed at the CDG, following which it would either remain as a Divisional risk or be escalated and placed on the ERR.

24. Part of my role at COCH required me to collate the Board Reports in advance of Board meetings. I attended every Board meeting provided I was available to do so, with the purpose of encouraging the Governors to have a voice, and ensuring that good governance was being practiced by the Board throughout COCH. I did not have a speaking role over and above that, and would not have made a routine presentation at those meetings.

25. I have been asked about the processes within the COCH for investigating concerns or complaints. There was a formal complaints department at COCH which was overseen by the Director of Nursing. I was aware that there was a process in place. From time to time the Head of Complaints would speak to me, and I was available to provide my input if anyone from the Complaints team needed to discuss a particular case. There was also a Speak Out Safely (Raising Concerns About Patient Care) and Whistle Blowing Policy in place [INQ0014171].

26. I was a member of the Speak out Safely Committee [INQ0098668], which met every other month to discuss any policy updates, updates on issues raised in the previous meeting, any new matters raised since the previous meeting, and matters of relevance to the Speak Out Safely framework such as Freedom to Speak up Guardians and the promotion of Speak out Safely. To the best of my recollection, the Freedom to Speak Up framework was a national framework across the NHS which was implemented at the COCH.

27. I was aware that processes were in place for notifying incidents, concerns or complaints to external bodies such as NHS England, the Care Quality Commission ("CQC") or Commissioning bodies. I don't think that I was specifically aware of the Child Death Overview Panel ("CDOP") prior to the neonatal deaths issue being raised. I did not sit on the CDOP or attend any CDOP meetings. To the best of my recollection the CDOP was not something which I had been made aware of prior to the Medical Director informing me of it in around March and April 2017 however, as outlined further below at paragraph 188, as soon as I became aware of the CDOP I identified it as an appropriate place within which to escalate the issue with neonatal deaths.

28. I have been asked about the circumstances in which the Coroner would be involved in respect of baby deaths on the Neonatal Unit ("NNU"). If a death occurred within the COCH, including a neonatal death, the clinicians would determine the cause of

death if they were able to do so, and the Coroner would be notified in the ordinary way if the death met the criteria for an Inquest.

29. I have been asked whether I ever referred any matters relating to complaints or allegations against members of staff to the Police. I do recall that there were matters at the COCH which would have been referred to the Police such as allegations of theft and I recall there was one of sexual assault. As far as I can recall, I personally never referred any staff member to the police and I was not responsible for security at COCH.

The culture and atmosphere of the neo-natal unit ("NNU") at the hospital in 2015 and subsequently

30. I have been asked how I would describe the relationships between i) clinicians and managers, ii) nurses, midwives and managers and iii) medical professionals (doctors, nurses, midwives and others) within the NNU at COCH in 2015 and subsequently. I did not spend time on the NNU and therefore I am unable to provide comments in respect of the relationships between clinical staff at the COCH. I have also been asked to comment on the effect of those relationships on the quality of care provided in the NNU at the COCH, however as I did not have knowledge of those relationships I am unable to comment.

Whether suspicions should have been raised earlier and whether Lucy Letby should have been suspended earlier

31. I have been asked how many deaths occurred on the NNU between 2015 and 2016 so far as I was aware at the time. As outlined below, I first became aware of the allegations about Lucy Letby and NNU deaths when it was raised with me by the Medical Director on 29 June 2016. Prior to that date, I had an awareness of some of the NNU deaths however I did not know how many had occurred or that there was any link between any of the deaths. There are a number of ways by which I would be made aware of deaths in the Trust (as outlined in paragraphs 39 and 40 below), however I would not be informed of every child death within COCH. I would become aware of information through communications such as Board Reports and Executive

Team meetings, however if particular information was not identified to me as being of relevance to my role within COCH then I may not be aware of it.

32. Prior to 29 June 2016 I understood that a review had been undertaken by Liverpool Women's Hospital into the deaths in the NNU. I have not been provided with this report as part of the Inquiry process, however to the best of my knowledge and recollection this review raised no concerns. I was also aware that there had been an independent review by an internal panel into the deaths in the NNU [INQ0003589]. Therefore, whilst I had the knowledge of the reviews above, it was only on 29 June 2016 when I became aware of the serious allegations made and the potential that a member of staff may be linked to the deaths. Prior to June 2016 I was also aware that the CQC had undertaken an inspection in February 2016 which had not highlighted any concerns in relation to the NNU.

33. On the 29 June 2016 we held four meetings with senior members of the Trust to discuss it further, and in the next two weeks there were seventeen meetings. The matter was taken extremely seriously by me and by the Executive Team, and I outline in more detail below the steps that were taken in stages to ascertain the circumstances of the deaths given the uncertainty of the circumstances at that time.

Freedom to Speak Up

34. I have been asked about the role of Freedom to Speak Up guardian, amongst a number of others. To the best of my recollection, I was asked by Alison Kelly to undertake the role however I cannot recall the specific date in relation to when this role was implemented. To my recollection, I received external training for the role at a national conference but I cannot now recall the specifics of the training. To my recollection I was never approached by any individual in my capacity as a Freedom to Speak Up guardian.

Chronology of events and meetings

35. In this part of my statement I will, as best as I am able, set out the chronology of events in so far as I can ascertain them from my notes and the documents provided

to me. As part of this process I have been asked to look at specific INQ documents and to comment on them in the order that the Inquiry has asked which I do in this section of my statement. I am unfortunately unable to provide comment in relation to matters to which I do not have knowledge of, for example if I was not a recipient of a document or if I was not present when a particular matter was discussed at a meeting, and as such I have not responded directly to every question within the Inquiry's Rule 9 request if I am unable to do so. I have been asked a number of questions relating to my thoughts in relation to coverage of the COCH which was published within the media however I do not feel able to provide comment in relation to such matters.

36. I have been asked whether formal records were made of a number of meetings, and whose responsibility it would have been to make the record, or to ensure that a formal record was made. Unless I have been provided with a copy of formal minutes, I cannot recall specifically and I have therefore not addressed each of those questions individually. I have been asked a number of questions about what documents were provided to me in advance of various meetings. Where I have been able to access documents in my archived emails I have set out in this statement responses to those questions. Where I have not responded, I have been unable to locate any evidence to be able to respond.

37. Due to the passage of time and the availability of documentation and information, I cannot now recall specifically how and when I was informed of the death of each child. There are a number of ways by which I would be made aware of child deaths (as outlined in the paragraphs below), however I would not be informed of every child death within COCH. I therefore cannot provide comment in respect of each individual child.

38. I have also been asked questions relating to my knowledge at the time of incidences in which children suddenly and unexpectedly deteriorated within the NNU at COCH. Unless I was specifically told about an incident such as this, I would not have known about it within the course of my day to day role. To the best of my recollection I was not informed of these incidents and am therefore unfortunately unable to assist in more detail. In relation to the sudden and unexpected deterioration of babies I have been referred to a number of documents that I have not seen before, including a number of documents which appear to be clinical notes [e.g. INQ000859] relating to a particular child. I confirm that I would not have had sight of clinical notes such as this within my role at the COCH.

39. As and when required, I would attend Serious Untoward Incident ("SUI") meetings within COCH and if a child death was discussed at such a meeting, I would become aware of it through those means. I would attend SUI meetings if the attendees felt that my attendance was appropriate, and/or when I was specifically asked to. An example of this would be if a complex inquest was due to take place and I would attend the SUI meeting in order to clarify the process. Alternatively I was sometimes required to attend SUI meetings if the Legal Services Manager, who would normally attend, was absent from the Trust or if there was an issue which the Legal Services Manager wanted me to speak to.

40. Separately, if a child death was reported to the Legal Services department within COCH, such as for the purposes of an Inquest, I would become aware of it. Outside of the processes I have identified, I would not generally be informed of a child death within COCH and to the best of my recollection prior to 29 June 2016, I had never been made aware of possible links between deaths during my time at the COCH.

41. I have been asked questions in relation to the decision taken in June 2015 to no longer record all neo-natal deaths as serious incidents [INQ0008157]. I was not involved in the decision to no longer record all neo-natal deaths as serious incidents and did not have input into this decision. I have been asked as to what impact I considered that this decision would have upon the safety of babies within the COCH. As I did not have a clinical role within the COCH, I am unable to provide comment as to whether this decision would have had an impact on the safety of babies within the COCH.

42. I have been asked questions relating to my memory in respect of specific children and reference to those children during meetings at COCH. Whilst I am keen to assist the Inquiry as far as I possibly can, if a particular child was not referenced within the minutes and is not referred to within the notes, I would not be able to recall now whether or not a particular child was mentioned and therefore unfortunately am unable to assist in more detail.

43. I have been asked a number of questions relating to various meetings prior to 29 June 2016. I am unable to provide additional comment in relation to a particular issue if it was not included within the notes.

44. Whilst as above I may have been aware of some of the deaths through discussions and Trust meetings between 2015 and 2016, I was unaware of any specific and significant concerns in relation to the NNU at COCH prior to 29 June 2016 and prior to this date I was not aware of the suspected link between the deaths or of the allegations against Lucy Letby. Once I became aware, I organised and attended a number of meetings specific to the matter however I had not attended any meetings that were specifically about this matter before that date.

45. I have been asked what documents I was provided with in advance of an EDG meeting which took place on 9 September 2015. On 8 September I received an email from the Chief Executive's Personal Assistant, which attached the papers for the EDG meeting on 9 September 2015. I have provided this email and the documents as [Exhibit SC/4], which included the Executive Team meeting notes of 2 September 2015, an agenda for the EDG meeting on 9 September 2015, and papers relating to Transformation/MCP Board Merger and Membership, stocktakes, NHS North West Leadership Recognition Awards 2015 and Notification of Trust Major Incident Exercise.

INQ0107706, page 60-75

46. I have been asked what documents I was provided with in advance of an EDG meeting which took place on 7 October 2015. On 6 October 2015 I received an email from the Chief Executive's Personal Assistant, which attached the papers for the EDG meeting on 7 October 2015. I have provided this email and the documents as [Exhibit SC/5], which included the Executive Team meeting notes of 30 September 2015, an options paper relating to the NNU, an agenda for the EDG meeting on 7 October 2015, and papers relating to Open Forum attendance, Blast Films filming, Women and Children's Services Partnership, NHS Sustainability Day event, Cost Recovery Services offered by third parties and the Relational Proximity Project.

INQ0107706, page 76-124

47. On 29 June 2016, the Medical Director came into my office and I can confirm that the handwritten note of the meeting timed at 08:15 [INQ0003360] is my note of that discussion. The conversation between myself and the Medical Director was a discussion just between the two of us, and so it would not be the usual course for any formal record of the meeting be made. The Medical Director informed me of emails he had received from the neonatal consultants escalating concerns regarding neonatal deaths within the NNU at COCH. He outlined the background to the matter, stating that whilst an earlier review had found no failings and no alarm bells in the neonatal unit, a common factor had arisen, 'this nurse', which was causing a sufficient

level of concern that there may have been illegal activity in the NNU. Based on what the Medical Director told me on 29 June 2016 in relation to the NNU, I noted my view in my notebook, which was that the Police should be involved "now", as reflected in my notes [INQ0003360]. This was not formal advice, as I did not have any of the detail or evidence that others may have been privy to, but rather a pragmatic view that if there was a serious allegation made within the Trust, that the Police should be informed. I do not recall a discussion relating to the need for a clinical forensic review of every death in the NNU during the conversation, however I recall that an Executive Team meeting was already arranged for later that day. The matter was taken very seriously within COCH and a number of meetings took place immediately to update the most senior positions, reflecting the urgency and severity of the matter.

48. I was not copied into subsequent emails between Murthy Saladi, Ravi Jayaram, the Medical Director and John Gibbs on 29 June 2016 [INQ003112] and therefore I am unable to comment in respect of the reasoning behind the views expressed within those emails.

49. I attended an Executive Team meeting at 10am on 29 June 2016 in accordance with the usual schedule of weekly meetings between the Executive Directors. Later that day, I attended a further meeting at 1pm and I confirm that the handwritten notes of both meetings are my own INQ0107706, page 125-127 Exhibit SC/6. The meeting at 1pm had been arranged by the Chief Executive, to discuss the concerns which had been raised. I recall that there was a discussion relating to the concern regarding the increase in mortalities on the NNU and from my notes I can see that I recorded "*Increase in mortalities. Arguably don't know why – unexpected but are they suspicious. No obvious causation. All clinical issues examined. Q of Nurse involvement – only evidence 'on shift'. Review or Police? David S, Ravi, Steve B, Murthy Saladi all say yes to Police. If Police, unit closed, forensic examination, i/v of all staff, arrest of Nurse. Reputational issues for Trust – link to CQC Report. Publicity/Press/TV.* During the meeting I re-iterated my view that if there were serious concerns, then the matter should be reported to the Police now, however I did not have any information or documents upon which to make an assessment of criminal activity. It was also clear to me at this stage that there was uncertainty around the cause of the neonatal deaths, which appears to be reflected in my notes which read *"no obvious causation*" and "*don't know why*".

50. I attended a further meeting at 5:10pm on 29 June 2016 and I confirm that the handwritten notes of the meeting are my own [INQ0003371]. Present at the meeting were the Chief Executive, Medical Director, Director of Nursing, Director of Operations, Consultants Dr Jayaram, Dr Brearey, Dr Semple, Dr Saladi and myself. I recall that a further discussion took place in relation to the concerns raised by the Consultants, and I have recorded a summary of the meeting: "*Concern – shut unit. Commission review. Then Police or Police and consequences. Balance needed. Support local hospitals. Consultants to agree way forward. Safety paramount. Unit closed tonight. Nurse cannot be excluded. Definition of restrictive unit. Definition of high-risk pregnancies. Definition of obstetric pathway. Go to level 1. 35 weeks & no intensive care. IH. Early review. Support for admin to achieve. Meet Eirion. Risk accepted. All agreed. Must not define our future. TY to clinicians*".

51. During the meeting I recall that there was serious consideration given to the most appropriate way to move forwards following the concerns being raised. There was a discussion in relation to the implications of what calling the Police would mean for the COCH during which I echoed my thoughts which I had expressed during the meeting at 1pm, in that the NNU would be closed, the Police would carry out an investigation, all staff would be interviewed and the nurse would likely be arrested. These were factual steps which I thought would occur based on my own experience.

52. I have been asked whether I agree with Stephen Brearey's statement that "*it was made clear to us that the police would not be involved*" [INQ0006890]. It is not my recollection that it was made clear during the meetings that the Police would not be involved. My recollection is that in this and other meetings there were discussions about the uncertainty of the information that the Trust had about the deaths, and there were discussions about whether the Police should be notified. When I was asked, I explained my understanding of what action the Police would take if the matter was to be reported to them. I do not recall the exact wording I used, but I explained the potential impact on staff, the NNU, patient safety and the families themselves. I was asked the same question on a number of occasions over the coming months and provided the same factual response. This did not mean that I was not in support of the concerns being reported to the Police. The decision as to whether to report this matter to the police was not mine to make. I did not have the clinical knowledge to be able to make any assessment about the cause of the deaths, nor did I have sight of any evidence on which to make any assessment at that stage. It was clear to me that

the concerns raised were treated by everybody present at those meetings as being very important.

53. I attended a meeting on 30 June 2016 of which I made handwritten notes [INQ0003361]. From my notes it appears that this meeting was attended by the Chair of the Trust, the Chief Executive, Medical Director, Director of Nursing, Director of HR and myself. To my recollection this was a meeting to discuss the current position and next steps at Director level, prior to attending further meetings later that day, which we arranged during our discussion. Due to the severity of the matter, it was important that we held regular meetings in order to discuss any updates and the next steps. Due to the uncertainty with regard to the cause of the deaths, the Trust's decision was to take a staged review process to rule all possible causes in or out. I was not a clinician however I respected their view as clinicians, and as such based on the information and views shared by the clinicians, I thought that instructing reviews into the circumstances was a sensible approach to take to try and ascertain the cause or causes, so that a decision could be made about what if any steps the Trust needed to take.

54. I have been asked specifically about my notes which record that the Medical Director said "*We cannot accept that the unit is safe despite their*", however I cannot recall specifically what the Medical Director said or what I understood him to mean.

55. I attended a further meeting at 2.45pm on 30 June 2016 [INQ003361]. Present at the meeting were the Chief Executive, Medical Director, Director of Nursing, Director of Operations and myself. To the best of my knowledge the handwritten note, which is mine, is an accurate record of the meeting. I have been asked to what the note 'Blood cultures issue' relates, however I cannot recall this specifically.

56. I later attended another meeting on 30 June 2016, of which I made handwritten notes [INQ00362]. At this meeting I was again asked what would happen if the COCH reported the matter to the Police. I again explained my understanding of what action the Police would take which would include a full investigation, the interview of staff, examination of any potential crime scene and if appropriate arrest any suspects. I was responding in a factual way to a question I was asked. I was asked the same question on a number of occasions. I am not a clinician and therefore was not responsible for making decisions in respect of the steps to be taken, this was the role of those with medical expertise and knowledge of the various processes. Due to the

passage of time, I am unable to provide further comment in relation to the comments of others during this meeting.

57. I have been asked about a meeting which took place on 1 July 2016 [INQ0014187]. I do not recall a meeting taking place on 1 July 2016 and I have not seen any notes which confirm that a meeting did take place.

58. I attended a meeting on 4 July 2016 and took handwritten notes [INQ0004314]. The focus of the meeting was safety of the mothers and babies, including the possibility of transporting mothers to different units and the need for communications with mothers. The following matters were also discussed at the meeting: special care, the role of the intensive care unit and high dependency unit when needed, the level of the NNU including discussions relating to the need to ensure communications in order to move the NNU to level 1, and working with the Trust's partners across the region and Wales. The Director of Nursing stated that the Medical Director had shared the draft ToR and the North-West region would be happy to assist the Review. I cannot now recall specifically which ToR this note referred to, although having reviewed the relevant documentation it appears that the ToR were in relation to the proposed Royal College of Paediatrics and Child Health Review ("RCPCH Review)". The meeting also discussed the importance of communication with families, stakeholders and staff. I was not in communication with the families at any time but recall that the Medical Director's comment and the discussion in general related to how to communicate with families, rather than there being any difficulty in doing so. To the best of my recollection the discussion was centred around how to communicate with them at the information gathering stage, whilst the cause was still uncertain.

59. I have been asked a number of times about the consideration given to the duty of candour and the families of the children. As above, I did not personally communicate with the families of the children however to the best of my recollection, the duty of candour and the families of the children were considered to be of the upmost importance within the Trust. As noted in the first meeting that I attended in relation to the NNU matters, to the best of my knowledge safety being paramount was always central [INQ0003371].

60. An Executive Team meeting was held at 9.30am on 6 July 2016, present at the meeting were the Chief Executive, Medical Director, Director of Nursing, Director of Operations, Director of Finance, Director of HR, Communication Manager and myself

[INQ0002682]. The notes of the meeting confirm that a paper relating to a 'Summary of NNU deaths' was presented and discussed, and an update was provided in respect of the current position. In view of the serious nature of the matter I suggested that an Incident Room was set up at the COCH with a dedicated Team to investigate the matter further. The notes confirm "*Incident Control. SPC to oversee it. Two responsibilities:*

• Data analysis & validation for neonatal with reviewing record of each baby transferred to the mortuary and other Trust's mortuaries (2013/14 to present). Questions to be agreed by close of play today with resource arrangements agreed.

• Managing operational consequences of decision.

Room to be operational by 9.00am tomorrow. Two teams to be supporting for that time. All comms work to be coordinated with major incident framework. Need to ensure clarity of use of room is capture communication / operational consequences of decision. Action: SPC to oversee clarity of investigation". This subsequently happened which enabled the matter to be strictly controlled, including receiving information and data, and the production of data analysis. The note of this meeting also states "*SPC to call extraordinary Board — 14/07/16*".

61. I have been asked what documents were provided to those invited to attend the Executive Team meeting on 6 July 2016. On 4 July 2016 I received an email from my Personal Assistant [Exhibit SC/7] which stated "*Following a number of apologies, Tony has suggested that those who are available, have an Exec catch up at 9.30am however there will be no formal agenda*".

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62. A further Executive Team meeting was held at 11.20am on 6 July 2016, with the same persons present [Exhibit SC/8]. The meeting discussed the setting up, resources and staffing of the Incident Room, together with its terms of reference, communication with stakeholders both internally and externally and a helpline for families. The Chief Executive informed the meeting that the Chair of the Trust had texted him "*re holding Ex-ord mtg of the Board if decision made to go to Police re neo-nates. Cd be held on Thursday 14 July 2016*". To the best of my recollection this note reflects the position that in order for any decision to report the matter to the Police to be taken by the Trust, this would need to be discussed at a Board meeting and approved by the Board.

INQ0107706, page 129-130

63. At 12.30pm on 6 July 2016 the Medical Director briefed Dr Brearey on all matters relating to the proposed Incident Room and it was agreed to ask Dr John Gibbs, a

senior neonatal Consultant, to represent the NNU Consultants within the Incident Room investigation team, a role he went on to undertake [Exhibit SC/8]. Although I have not seen any email to confirm it, to the best of my recollection, the Chair of the Trust and Non-Executive Directors were subsequently fully briefed by email.

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64. An Executive Team meeting was held at 5pm on 7 July 2016 which I attended [Exhibit SC/9]. The Director of Nursing confirmed that the Incident Room had been set up with the Director of Pharmacy appointed as Incident Room Manager. Staffing for the Incident Room included Consultant Dr Gibbs, senior nursing and management team members from the Women and Children's Division, senior nursing staff from the Risk Team and senior staff from HR. The Medical Director confirmed that following conversations with the neonatal clinicians, they were all in agreement to the actions being taken by the Trust.

INQ0107706, page 131-132

65. I have been asked questions about the RCPCH Review proposal. I do not recall being involved with the review of the RCPCH Review proposal, however I have reviewed the minutes of an Executive Team meeting on 6 July 2016 [INQ0002682] which state "*IH reviewed [RCPCH] proposal, alongside SPC and AK*". Whilst the notes refer to the RCPCH proposal, I did not have an active role in the development of the ToR and would have simply been present whilst the discussion in the meeting took place.

66. At 7.45am on 8 July 2016 in a telephone call I updated the Chair of the Trust with the position to date and advised him that there was to be a formal briefing of all Incident Room staff at 9am that morning, which he stated he would attend. At 8.30am the same day I briefed the Chief Executive regarding the Incident Room, and at 9am on the same day there was a briefing of all Incident Room staff. At 10.05am the same day in a telephone call I fully briefed the Deputy Coroner for Cheshire, who informed me that he would also brief the Coroner for Cheshire on his return to the office on 11 July 2016 [Exhibit SC/9].

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67. I then went on to inform in telephone calls, the Senior Coroner's Officer Chris Hurst, Patient and Liaison Services, fundraising regarding the Babygrow Appeal (which was the Appeal for raising money for the NNU), the Child Birth Trust, the internal Legal Services team, the Clinical Commissioning Group [Exhibit SC/9] and although I haven't seen a copy of any email as part of the Inquiry process, to the best of my recollection, an external communication was also sent to the Chair of the Safeguarding Group.

INQ0107706, page 131-132

68. I have been asked about the circumstances in which the internal review dated July 2016 v2 referred to by the Inquiry [INQ001888], prepared by the Director of Nursing, was commissioned. Although I would have likely seen a copy of the document at the time, I was not required to undertake any actions in relation to it and I am unable to provide comment in relation to the circumstances of its commissioning. It was my understanding that the Trust was organising for reviews to be undertaken to try to identify or rule out potential causes at the time. As I did not have a clinical background, I would not be able to comment as to whether the analysis provided a satisfactory explanation for the rise in mortalities on the NNU.

69. A meeting was held at 4.10pm on 12 July 2016, present at the meeting were the Chief Executive, Director of Nursing, Robert (surname unknown) of the Data Analysis team and myself, to brief Robert on the robust data required for analysis of the mortality level and rate of deaths within the NNU within the Incident Room [Exhibit SC/10] INQ0107706, page 133

70. An Executive Team meeting was held at 9.30am on 13 July 2016, present at the meeting were the Chief Executive, Medical Director, Director of Operations, Operations Manager, Director of HR, Matron Ruth Millward and myself [INQ0003365]. The meeting discussed in detail the neonatal deaths, staffing levels, unit level and regional network, security on the NNU and options for action to be taken with 'the Nurse'. It was agreed to brief the neonatal Consultants at 1pm on 13 July 2016.

71. A meeting was held at 1pm on 13 July 2016. Present at the meeting were the Chief Executive, Medical Director, Director of HR, Assistant Director of Nursing, Consultants Dr Jayaram, Dr Murty, Dr Gibb, Doctor ZA and myself. Dr Brearey had sent apologies [INQ0003365]. The Medical Director outlined the position to date and a discussion followed with particular reference to Lucy Letby (identified in the note as 'the Nurse') and supervision for her, security on the NNU and the use of CCTV and acuity levels. The Consultants stated that whilst they had concerns regarding the Nurse they were happy with the proposed actions which had been discussed during the meeting, including an independent review and supervision of the Nurse. [INQ0003365].

72. I have been asked about a record of a private Board meeting on 13 July 2016. It was not the case that this was a private Board meeting. It is my recollection that an update meeting was held at 2:30pm on 13 July 2016 [INQ0003365]. Present at the meeting

were the Chair of the Trust, the Chief Executive and myself. During this meeting, the Chair of the Trust was briefed regarding the meeting which had taken place at 1pm on 13 July 2016 as he had not been present, and I wanted to ensure that he was fully appraised of the position at all times. I added "*Private Board Apols. Ed & Andrew*" to my handwritten note, however upon review of the documents I note that both Mr A Higgins and Mr E Oliver are noted as providing their apologies to the Extra-Ordinary Board of Directors (Private) meeting on 14 July 2016 [INQ0004216], and therefore my handwritten note [INQ0003365] appears to relate to this matter [INQ0004216].

73. At 3.15pm on 13 July 2016 the Medical Director updated me regarding his meeting with Dr Brearey that afternoon. He reported that Dr Brearey '*is still concerned but is mindful to follow his colleagues in the decision not to report to Police. Trust are taking matter seriously. Nurse to be supervised and conversations with her & other nurses tmoro (14.7). SB will speak to his colleagues*' [INQ0003365].

74. I have been asked about a meeting with Lucy Letby on 14 July 2016. I was not part of any decision-making relating to Lucy Letby's employment or the associated grievance procedure and as such cannot comment on this matter.

75. An Executive Team meeting was held at 8.30am on 14 July 2016 which I attended [INQ0004327]. Present at the meeting were the Chief Executive, Director of Nursing, Director of Operations, Director of Finance, Director of HR and myself. The Medical Director gave his apologies as he was meeting the Obstetric Consultants regarding this matter. The Chief Executive gave an update following the meetings on the previous day, highlighting the decisions for enhanced security on the NNU, and supervision of 'the Nurse'. The update included that the Trust was to undertake the Independent Review and not go to the Police at present. The Chief Executive confirmed that a Board of Directors meeting was being held later that day. He also stated that he was informing Members of Parliament on the following day. The Director of Nursing confirmed that she had a telephone conference arranged with NHS England that afternoon. The Director of Operations highlighted the need to understand the vacancies in the NNU and stated that the culture in Obstetrics and Paediatrics was broken plus a breakdown between Doctors and Nurses. It was agreed to produce neonatal dashboard every week. To the best of my recollection, the neonatal dashboard was a document which included data from the NNU and was introduced to identify whether any incidents occurred week to week which caused concern.

76. At 12.30pm on 14 July 2016 I attended an Extra-Ordinary meeting of the Board of Directors INQ0004216]. Present were the Chair of the Trust, three Non-Executive Directors, the Chief Executive, the two Directors of Finance, Medical Director, Director of Nursing, two Consultants, the two Directors of Operations, myself and my PA to take the minutes of the meeting. I have reviewed the typed minutes of the meeting which confirm that the Medical Director provided an update regarding the NNU and a discussion followed. The minutes confirm that "*Mr Cross outlined his understanding of what action the police would take if they were called in to investigate this matter*". My recollection is that I explained my understanding of what action the police would take if the matter was reported to them and I also re-iterated my view "*that the Board will be informed as required*" [Exhibit SC/11]. I cannot recall any specific details in relation to the information provided in addition to the minutes of the meeting.

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77. An Executive Team meeting was held at 9am on 18 July 2016, which I attended [INQ0003368]. Present at the meeting were the Chief Executive, Medical Director, Director of Nursing, Director of Operations, Director of Finance, Director of HR and myself. The Director of Nursing confirmed that 'the Nurse' had been spoken to and was vulnerable. The Director of HR confirmed that the Royal College of Nursing ("RCN") would be briefed separately as they were a professional body. The Director of HR also highlighted the pressure on the neonatal unit, the low morale of staff, the increase in risk to mothers and babies and stated that 1-1 supervision of 'the Nurse' could not be guaranteed. The Chief Executive stated that 'the Nurse' would have to be moved from the NNU. Although I was present at the meeting, it was not my role to agree or disagree with decisions made as I do not have a clinical background or the medical expertise to be able to contribute to those decisions. I was also not present on the ward to understand the staffing levels and the impact on staff. Whilst I was happy to assist in any way that I could, at this meeting I was being told about decisions which had been or were to be made at meetings, but I was not involved in the making of those decisions.

78. My handwritten note of the meeting states "*SPC Police issue/ keep under review*" .To the best of my recollection, in respect of this note I reminded the meeting that my view was that the matter should be reported to the Police and that this should be kept under review [Exhibit SC/12]. I recall that although my view was that the Police should be called, as explained within my statement, as the meetings continued with

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colleagues who had professional knowledge in relation to clinical matters, it was decided that further reviews should be undertaken in order to rule in or rule out the other potential causes of the unexplained deaths and events within the NNU, which I respected.

79. I have been asked whether it is my understanding that following Lucy Letby being removed from clinical duties, the Medical Director led on all communications with families. I confirm that this was my understanding. I did not have any role in communicating with the families.

80. At 10:30am on 18 July 2016 in a telephone call I informed Non-Executive Director James Wilkie that that 'the Nurse' was to be moved from the NNU. To the best of my recollection the Chair of the Trust was initially informed of this by the Director of Nursing. At 2.55pm the same day in a telephone call from the Chair of the Trust I updated him in relation to what had been confirmed by the Director of Nursing during the Executive Team meeting earlier that day, which was that 'the Nurse' was being moved from the NNU because 1-1 supervision could not be provided [Exhibit SC/12]. INQ0107706, page 138-139

81. An Executive Team meeting was held on 20 July 2016 [INQ0007197_0132]. Present at the meeting were the Chief Executive, Medical Director, Director of Nursing, Directors of Operations, Directors of Finance, Director of HR and myself. The neonatal dashboard was presented as it had been agreed to review the dashboard during every Executive Team meeting. The Inquiry has noted that the handwritten note [INQ0004330] appears to be incomplete. I have provided a full copy of the handwritten note [Exhibit SC/13]. INQ0107706, page 140-142

82. I have been asked about an email which Stephen Brearey has stated that he sent to "IH" and "SC" on 6 July 2016 to say "*pathologist does not need TPN bags for triplets*" [INQ0003182]. I have not been provided with a copy of that email nor have I been able to locate any such email. I have also been asked about an email from the Medical Director to Stephen Brearey and the Director of Pharmacy dated 20 July 2016 [INQ0006890]. I was not a recipient of this email and therefore am unable to provide a comment. In any event, I do not have the medical expertise to be able to comment upon the storage of TPN bags.

83. At 8.30am on 27 July 2016 I had a meeting with the Lead Governor of the COCH, Michael Hemmerdinger, and fully briefed him on the current position regarding the neonatal matters [Exhibit SC/14]. INQ0107706, page 143-144

84. An Executive Team meeting was held at 9.30am on 27 July 2016 [INQ0050165] [INQ0007197_0137]. Present at the meeting were the Chief Executive, Medical Director, Director of Nursing, Director of Operations, Directors of Finance and myself. The meeting was informed that the RCPCH Review had been deferred to the 1st and 2nd September 2016. In respect of the neonatal and maternity dashboard, the typed minutes of the meeting recorded that:

- "*LB to speak to Julie Fogerty re: zero transfers for maternity.*
- *Neonatal report to go to SI panel*
- *Incidents subject to OSR to be included on dashboard.*
- *Include total births on dashboard.*
- *Concerns over antibiotic levels, AK to resolve pressures with the team*".

85. An Executive Team meeting was held on 3 August 2016. Present at the meeting were the Chief Executive, Medical Director, Director of Nursing, Director of Finance, Directors of Operations, Director of HR and myself. At this meeting it was confirmed that there was nothing significant to report in respect of the neonatal dashboard, and that the Medical Director and the Director of Nursing would need to review the statements in advance of an upcoming Inquest into the death of Child A [INQ0007197_0138].

86. At 9am on 9 August 2016 I had a meeting with the Lead Governor of the COCH and updated him on the neonatal matters.

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87. An Executive Team meeting was held on 12 August 2016 [Exhibit SC/15]. Present at the meeting were the Chief Executive, Director of Nursing, Director of Finance, Directors of Operations, Director of HR and myself. The meeting reviewed the neonatal dashboard and no issues were identified. I noted that the RCPCH Review was scheduled for 1st and 2nd September 2016.

88. I have been asked about an EDG Team meeting on 17 August 2016 [INQ0007197_0165]. The minutes of the meeting indicate that I did not attend this meeting and so I am unable to provide comment in relation to it.

89. An Executive Team meeting was held on 31 August 2016 [INQ0007197]. Present at the meeting were the Chief Executive, Medical Director, Director of Nursing, Directors of Operations, Director of Finance, Deputy Director of HR and myself. The typed notes of the meeting in respect of the neonatal dashboard state "*External review taking place this week (Thursday and Friday) with initial feedback late Friday PM and written feedback in 4 weeks. LB went through weekly dashboard. No issues to report*".

90. I have been asked about the RCPCH interview with Lucy Letby on 1 September 2016 [INQ0010121]. I was not involved in the RCPCH Review process and would not have made any comment or suggestion in relation to the procedure to be followed as it was not within my role.

91. I have been asked about the RCPCH Review recommendations provided to the Medical Director on 5 September 2016 [INQ0003120]. I recall that I would have seen this document at some point, although I cannot recall specifically when. I did not discuss what was required by a 'detailed forensic case note review', as the RCPCH recommendations would have been discussed by clinicians with the clinical and medical expertise required in order to take the recommendations forward.

92. An Executive Team meeting was held on 7 September 2016 at 9:30am [INQ0051885] [INQ0003369]. Present at the meeting were the Medical Director, Director of Nursing, Director of Finance, Directors of Operations, Director of HR and myself. I have reviewed the typed notes of the meeting in respect of the neonatal dashboard and note that the Director of Operations raised concerns following a review of the neonatal dashboard, particularly with regard to admissions, bed/cot capacity, welfare of staff on the NNU, and concern for 'the Nurse'. It was noted that the Medical Director would urgently meet with the neonatal clinicians, the Director of Nursing and Director of Operations will visit the NNU and meet the Senior Nursing Manager. In respect of the report to be provided to the Trust as a result of the RCPCH Review ("RCPCH Review Report"), the notes of the meeting also record the following: "*Open and frank discussions both internally and externally — team supportive of current situation. Feedback included a need for a process to manage staffing and secondly undertaking a further forensic review of case notes. Team confirmed that we have a safe unit and full report to be provided in 4-6 weeks. AK/SH raised the issue letter from the RCN. Agreed that recruitment of Neonatal Consultant to remain on hold*".

93. An EDG meeting was held at 11am on 8 September 2016 [INQ0006265]. Present at the meeting were the Chief Executive, Medical Director, Director of Nursing, Director of Finance, Director of HR, and the Senior Nursing Manager. My notes of the meeting record that the Director of HR gave an update on the position regarding Lucy Letby and reported on correspondence from the RCPCH and a grievance from Lucy Letby. The Director of HR referred to an options paper, recommending that option 4 as the preferred option. I cannot recall any additional detail in relation to this and I have not been provided with a copy of any formal minutes taken other than handwritten notes made by myself and the Director of Nursing.

94. At 11.40am on 8 September 2016 a further Executive Team meeting was held [Exhibit SC/16]. The Medical Director gave an update on the process for the RCPCH Review, and also discussed an email from Dr Brearey regarding the forensic review, the Nurse, and the behaviours on the NNU. The Medical Director said that he had responded to the email. The Medical Director stated that he had spoken to 'Ravi' and 'David Semple' regarding the behaviours on the NNU and 'Ravi' had raised the issue of neonatal recruitment and 'the Nurse'. The Medical Director also said that he had spoken to the Head of Nursing regarding recruitment and that the Deanery were undertaking a major reorganisation and that recruitment was to remain on hold.

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95. An Executive Team meeting was held on 14 September 2016 at 9.30am [INQ0004340]. Present at the meeting were the Chief Executive, Director of Nursing, Directors of Operations, Director of Finance, Director of HR and myself. The Chief Executive reviewed the Board meeting held on 14 July 2016. The Director of Nursing reported that she and the Director of HR had met the union representative for Lucy Letby, and the Head of Nursing to inform them that a decision had been made to maintain the "status quo" further to the grievance from Lucy Letby and the RCN. To the best of my recollection this related to not making any changes in relation to Lucy Letby's role within the NNU, however I cannot recall this specifically. My handwritten note [INQ0004340] states "*Neonates. Steady. No issues this wk*", however I cannot recall any additional detail behind this note.

96. I have been asked about a meeting with Lucy Letby on 15 November 2016. I was not present at the meeting and therefore I cannot provide comment in respect of it.

97. I have been asked a number of questions relating to Jane Hawdon and the RCPCH Review. I confirm that I was not involved with this process and am therefore unable to provide comment in respect of it.

98. On 6 October 2016 I attended a meeting prior to the inquest into the death of Child A. Present at the meeting were the Trust's external legal advisors, the COCH Legal Assistant, Dr Jayaram, Dr Harkness, Dr McCormick and Dr Saladi.

99. An Executive Team meeting was held on 12 October 2016 at 9.30am [INQ0007197_0228]. Present at the meeting were the Medical Director, Director of Nursing, Directors of Finance, Directors of Operations, Director of HR and myself. In relation to the NNU, the minutes of the meeting state "*Neonatal Dashboard. Update on current position and continual assurance required to ensure appropriate escalation. Action plan discussed and where up to on current actions and any outstanding. Action plan to be monitored weekly at EDG. All to review plan and feedback. SH and AK provide update on staff support being provided. IH noted the draft report from review expected towards the end of next week with required validation before final report*". My handwritten notes of the meeting [Exhibit SC/17] record that it was reported that Dr Brearey had challenged care given elsewhere, which I recall to mean at other neonatal units, however I cannot recall any additional detail. Matron Karen Rees had reported that a baby had been transferred out of the COCH NNU and an Executive Team member had not been informed, breaching the agreed process. The Director of HR and Director of Nursing gave an update on the actions put in place for the NNU following the RCPCH Review. They also gave an update on Lucy Letby who they had spoken to personally last Friday, who told them she was now aware of everything from her union representative, and asked when she could return to the NNU.

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100. It was also noted that the grievance hearing was scheduled for 15 November 2016 under the chairmanship of the Director of Pharmacy. The Medical Director reported that he was meeting Dr Brearey at 4pm on 12 October 2016 to update him on the position to date and that he was chasing the draft and final RCPCH Review Report.

101. I have been asked about an email dated 18 October 2016 within which RCPCH provided their draft report to the Medical Director [INQ0003403]. As mentioned above at paragraph 91, I recall that I would have seen this document at some point, although

I cannot recall specifically when and I do not recollect ever receiving a copy of the RCPCH Review Report in draft.

102. An Executive Team meeting was held on 19 October 2016 at 9.30am [INQ0003202]. I confirm that the handwritten note of the meeting is my own [INQ0003370]. Although I cannot remember specifically, it was usual for me to cross out my handwritten notes as the typed notes were being prepared and as such this may explain why these notes are crossed out within my notebooks. Present at the meeting were the Medical Director, Director of Nursing, Directors of Finance, Director of HR, Communications Manager and myself. In relation to the neonatal dashboard, the typed notes state "*AK gave update on neonatal dashboard- no specific issues arising from the dashboard however AK to discuss a more recent incident with IH outside of meeting*". In relation to the neonatal review, the typed notes state "*IH advised that the neonatal service review document had now been received by the Trust. A copy of which IH had shared with AK. IH highlighted aspects of the review. It was agreed that a copy would only be shared with Executive colleagues at this stage. It was noted that Nurse L was aware that the report had been received by the Trust. It was also noted that the Chairman and Board need to be updated regarding this matter. Agreed that once Executive colleagues have had chance to read the report a decision would be made on further distribution of the report- action IH*". My handwritten note of the meeting records that the Medical Director highlighted the RCPCH Review Report findings and recommendations [INQ0003370]. The Medical Director stated that the RCPCH Review Report was critical of both the governance in the NNU and of the neonatal network, and found that there was a lack of the following: Datix (which is an information analysis system within the Trust), appropriate escalation, lack of good transport arrangements when escalation needed and the lack of a Childrens' Champion for the NNU. The Medical Director also stated that in summary, the RCPCH Review Report stated that not calling the Police in was the "*right decision*" as there was "*unconvincing evidence*" at present to do so [INQ0003370].

103. I have been asked about a letter from Jane Hawdon to the Medical Director dated 29 October 2016 [INQ0003358]. Although I believe the letter was a response to questions asked by the Medical Director, I cannot recall this specifically and am unable to provide further comment.

104. I have been asked about a report entitled 'Advisory medical report' dated October 2016 [INQ0003172] (46 pages, dated "October 2016") [INQ0003357] (marked draft,

51 pages, dated "October 2016"), [INQ0006862] (56 pages, dated "October 2016"). I have also been asked to consider the transcript of my interview with Facere Melius on 1 December 2020. As above, although I will have seen a version of Jane Hawdon's report, I could not identify which version was shown to me. I do not have a clinical background and as such would be guided by my colleagues within the Trust with medical expertise as to the contents of the report. I am therefore unable to provide further comment in relation to Jane Hawdon's report.

105. An EDG meeting was held on 2 November 2016 [INQ0003215]. Present at the meeting were the Chief Executive, Medical Director, Director of Nursing, Director of Finance, Directors of Operations, Director of HR and myself. The typed notes record "*Neonates Review and Mortality Report. Findings of both reports discussed. IH to share redacted review with RJ, SB and Senior Nurse—in private. IH and SC to discuss re PMs to forward to JH. Plan secondary review by Jane Rennie of the unexplained cases. LL grievance scheduled for 15th Nov, might have to be delayed. Going generally well- Chris Green OK. Needs to speak to SB (who wants GMC support)*". The Medical Director gave an update on neonatal matters and reported in more detail the content of the RCPCH Review Report. My handwritten note of the meeting [INQ0003383] records that the Medical Director stated that that due to the confidential nature of the RCPCH Review Report there should be tight control of copies at present. He reported that the RCPCH Review Report was supportive of many aspects, however it was critical of the neonatal Team and network. I have noted that it was reported by the Medical Director "*right not going to police*". However, I cannot recall whether that was said directly because of the findings of the report. He also stated that he had received the Forensic Report which was a complex read.

106. I have been asked about an interview with the Medical Director by the Director of Pharmacy on 7 November 2016 [INQ0003156]. I was not present at the meeting, nor was I involved with the grievance procedure and therefore I am not able to comment in relation to the record of the meeting.

107. An EDG meeting was held on 9 November 2016 [INQ0004361]. Present at the meeting were the Chief Executive, Directors of Finance, Director of Operations, Deputy Director of HR and myself. The typed notes of the meeting in relation to the neonatal dashboard state "*Dashboard- review of cases as a couple of full term babies had recently been admitted to the NNU. SC meeting with Paeds team re Babygrow Fund and plans, some dissatisfaction from the team- feel they are not involved in*

decision making even though AK & IH had advised the team of the proposed plan to look at potential changes to the environment of the unit. Childbirth Trust- continuing to manage the comms around this with the Team. Grievance agreed for 1st December - DAC to check whether staff member is aware of this". To the best of my recollection, the notes relating to dissatisfaction relate to the decision to close the Comfort Zone shop and café within the COCH, and did not relate to the neonatal matters.

108. At 8am on 16 November 2016, the Director of Pharmacy came to see me. The handwritten note of the discussion is my own [INQ0003373]. This meeting was informal and as such was not pre-arranged and not formally recorded. The Director of Pharmacy came to see me and I felt that he wanted reassurance as he felt that he was in a difficult position and that I would be a listening ear. My notes of the meeting record "*Pressure on Execs. 'threatened' to go to Police (by Consultants not them). Consultants say 'no issue re Police being called. Denied any knowledge that they had wanted Police. 'Accusations that Lucy had harmed babies'/ Emails from Eirion-marked confidential- refer to foul play- 'harm'. Advice from Beechcrofts*". I cannot recall any additional detail in relation to this conversation. I expect that I would have suggested to the Director of Pharmacy that he await the advice from the external legal advisors, although I cannot recall exactly what I said as it isn't reflected in my note.

109. An Executive Team meeting was held on 16 November 2016 at 9.30am [INQ0004362]. I confirm that the handwritten note of the meeting was my own [INQ0003373]. Present at the meeting were the Medical Director, Director of HR, Director of Operations, Directors of Finance, Assistant Director of Nursing and myself. The typed notes of the meeting state "*Ian Harvey met with Dr Jayaram, Dr Brearey and Anne Murphy to discuss high level elements of the report into the NNU. Grievance is on-going and following the final report there needs to be a further Exec discussion on the outcomes and next steps. No issues within NNU this week. 1 lady transferred prenatally. Occupancy on the unit is low at the moment*". I have been asked to provide detail in relation to the typed entry "*Exec discussion on the outcomes and next steps* ". At this stage although I was not involved with the grievance process, it appeared that the procedure was ongoing and no conclusion had been reached. I have been asked questions about Part 2 of the meeting. My handwritten notes indicate that Part 2 of the meeting began at 10:30am and was attended by "*Debbie Bryce, Karen T, Linda, Ruby, Frankie, Steve B, Gill G, Chris B and Richard*" [INQ0003373]. From my notes it appears that the purpose of Part 2 of the meeting

was to discuss an Operational Plan relating to finance and the need to agree a model going forwards, although I cannot recall additional detail to that included within my notes.

110. I have been asked whether the paediatric Consultants had threatened to call the Police if Lucy Letby was not removed from the NNU. Whilst I was aware that it was the view of some Consultants that the Police should be called, there was a level of uncertainty between the Consultants as to whether they considered it appropriate for the Police to be called, or for a review to be undertaken. I cannot confirm as to whether any threat to call the Police was reliant on Lucy Letby being removed from the NNU.

111. I have been asked about a report by the Director of Pharmacy dated 22 November 2016. I do not recall receiving a copy of this report and I am therefore unable to provide comment as to its contents.

112. An Executive Team meeting was held on 23 November 2016 at 9.30am [INQ0007197_0288]. Present at the meeting were the Chief Executive, Medical Director, Director of Nursing, Directors of Finance, Directors of Operations, Director of HR and myself. The typed notes of the meeting in relation to neonatal matters recorded that:

- "*IH confirmed that he has met with the paediatric team to discuss the draft review report, which has now been returned to the review team.*
- *IH stated that updated PM reports had been sent to the reviewer undertaking the forensic investigation.*
- *Responses to both reports are expected in the near future.*
- *SHK gave an update re the grievance on the 1st December 2016.*
- *LB and IH meeting Julie Maddocks re network.*
- *SPC/CR to arrange a meeting in due course to update Board.*

  With reference to the neonatal dashboard, AK and LB to investigate recent incident regarding a transfer to another hospital. AK to speak to her opposite number at Arrowe Park regarding impact on changes. Agreed that the Exec Team will set aside protected time to discuss all these matters".

113. I have been asked about an email from Jane Hawdon to the Medical Director on 25 November 2016 [INQ0003102]. I was not a recipient of the email and therefore am unable to provide comment as to its contents.

114. I have been asked about two versions of the RCPCH Review Report provided to the Medical Director on 28 November 2016 [INQ0009617; INQ0009618; INQ0009619; INQ0009620]. To the best of my recollection I did read the reports, however it was not my role to take action as a result as I did not have a clinical role within COCH. Although I was aware of discussions surrounding the RCPCH Review Report being redacted, I was not involved with the redaction process in relation to the RCPCH Review Report and therefore I cannot provide comment as to the difference between the two versions.

115. I have been asked about Appendix 4 of the RCPCH Review Report. I do not recall this document specifically and am unable to comment on the contents of it.

116. I have been asked about a grievance hearing on 1 December 2016 [INQ0003155]. I was not present at the meeting, nor was I involved in the process and am unable to provide comment in relation to this. I have been asked about a statement made by Lucy Sementa that *"Stephen Cross advised that there was insufficient evidence to call the Police"*. The origin of this statement is unclear. Whilst I may have spoken to Lucy Sementa on other matters during my time at the COCH, to the best of my recollection I did not ever speak to her about the neonatal deaths. As I have explained, I did not have a view as to whether there was an evidential basis for calling the Police as this was a decision that needed to be made by the Trust Board, and those more senior than I had decided to await the outcome of the various clinical reviews that were being conducted as to the cause of the deaths.

117. I have been asked about communications between Annette Weatherly and Lucy Letby dated 1 December 2016 **[INQ0003611]** I believe that I would have been informed of the outcome, however I do not recall receiving a copy of the letter and I was not involved in the process as it was undertaken independently.

118. On 5 December 2016, the Deputy Director of HR informed me that a mediation meeting was taking place between the Consultants and Lucy Letby [Exhibit SC/18].

INQ0107706, page 150

119. I have been asked questions about a Board Meeting on 6 December 2016 [INQ0014820] which I attended. I do not recall the meeting specifically however if particular topics are not recorded within the minutes of the meeting then I would think that they were not discussed during the meeting.

120. An EDG meeting was held on 7 December 2016 at 9.30am [INQ0004366]. Present at the meeting were the Chief Executive, Medical Director, Director of Nursing, Directors of Operations, Director of HR and myself. The typed notes record that "*Neonates Dashboard —Agreed continued review and monitoring needed • Neonates Services Review. In depth conversation on current position. Actions agreed as follows: - Meeting with Board to be scheduled early new year — Proposal of 10th January 2017. Ian H and Gill Galt — to work on communications. Family meeting to be arranged. Develop plan to share review with Doctors plus thoughts on wider circulation*". I have been asked in relation to this meeting specifically, whether any incidents had occurred on the NNU. I cannot identify from my notes that an incident had occurred and therefore am unable to provide comment in relation to this.

121. At 8.30am on 9 December 2016 [INQ0003376], the Medical Director informed me that the final version of the RCPCH Review Report had been received. The Medical Director also informed me that as a result of advice received from the RCPCH, the Trust were to undertake some internal reviews which was to involve a secondary review of some of the neonatal cases. It was decided that an email would be sent to the Coroner for his permission to approach pathologists who had performed post mortem examinations so that we would be in a position to present a comprehensive review to the Coroner. I confirm that the handwritten note of the meeting is mine and that although it is dated 9 January 2016, I believe that this was an error and should read '9 December 2016'.

122. I have been asked about letters written by Sue Hodkinson to Lucy Letby and her parents on 16 December 2016 indicating a plan for Lucy Letby and her parents to meet with the Chief Executive and other members of the Executive Team on 22 December 2016 [INQ0002459] [INQ0002899]. I was not involved with this and therefore I am unable to provide comment in relation to it.

123. I have been asked about the Medical Director's request for Jo McPartland to carry out a review of four cases. I was not involved with this and as such am unable to provide comment in relation to it.

124. An Executive Team meeting was held on 21 December 2016 at 9.30am [INQ0007197_0308]. Present at the meeting were the Chief Executive, Medical Director, Director of Nursing, Directors of Finance, Directors of Operations and myself. The typed notes of the meeting record "*Further discussion to take place regarding communicating report, and meeting with clinicians. Final detail required regarding the external clinical case review. IH to meet with GG re communication stakeholder plan. TC, AK, SH, IH meeting with LL and her family on the 22 Dec*". My handwritten notes INQ0107706, page 151 [Exhibit SC/19] record that that Lucy Letby had requested a copy of the RCPCH Review Report and an apology from the neonatal Consultants. It was agreed not to release a copy to Lucy Letby at that time. The Medical Director reported that four cases were still to be reviewed and the Coroner had given consent to contact the pathologists. I refer in my notes to 'loose language by the Doctors' but I cannot recall now any additional detail in relation to the meaning of this. The Medical Director also reported on a letter received from NHS England regarding the RCPCH Review Report and he and the Director of Nursing would draft a response. I refer in my notes to financial consequences of losing £I&S, which to the best of my recollection referred to a loss of I&S if the NNU was placed within a lower level, but I cannot recall any additional detail. It was agreed that the RCPCH Review Report would go to the Board of Directors via the FIGC on the 10 January 2017.

125. I have been asked about a comment within my interview with Facere Melius on 1 December 2020 [INQ0003463] within which I said "*it wasn't the right place for her to go*". I had been asked within my interview whether I felt it was appropriate for Lucy Letby to be moved to the risk department and I responded that "*Well, I felt my personal view was that that perhaps wasn't the best place to go. And I remember I mentioned that to Alison Kelly. But as I say, I'm just one of it, you know, a co-opted member of the executive team. And at the end of the day, I could comment, but no, it wasn't the right place for her to go, in my view*". That remains my view.

126. At 10am on 29 December 2016 I met with the Chair of the Trust and briefed him on neonatal matters to date [INQ0004299]. He asked me to arrange a meeting for the following day (30 December 2016) with the Chief Executive, Medical Director, and Director of Operations. I confirm that the handwritten notes of the meeting are my own, however unfortunately I cannot recall any additional detail over and above the contents of the note.

127. At 10.15am on 30 December 2016 a meeting was held [INQ0004299]. Present at the meeting were the Chair of the Trust, the Chief Executive, Medical Director, Director of Operations and myself. The Medical Director gave an update on neonatal matters to date which included the redacted and unredacted copies of the RCPCH Review Report and the distribution of the RCPCH Review Report, the appropriate level of the NNU, communications with the press, Special Commissioners and NHS England and support from the neonatal regional network.

128. The Chief Executive reported on what he described as his difficult meeting with Lucy Letby and her family and highlighted the issues regarding Lucy Letby, particularly with regard to the outcome of the grievance hearing and the apology she had requested from the neonatal Consultants and the reason why. My note also confirms that Lucy Letby also wanted mediation to improve relationships.

129. The Chair of the Trust highlighted the need to finish the RCPCH Review as some of the deaths were 'unexplained but not unusual' with the need for clarity on any concerns and reference against standards, training requirements and investment needed to get the NNU back to Level 2. He stated the 'Board want to understand investment needed and network requirement and do we want it'. The Director of Operations stated the need for an overarching action plan following the recommendations in the RCPCH Review.

130. The Chair of the Trust and Chief Executive outlined the proposed meetings going forward; a meeting with Lucy Letby, an Extra-Ordinary Board of Directors (Private) meeting on the 10 January 2017 for formal acceptance of the RCPCH Review Report and Action Plan, and a meeting with the neonatal Consultants, with the Chair of the Trust representing the Non-Executive Directors, together with the relevant Executives. The Medical Director stated that a meeting for him and myself would be arranged with the Coroner by the end of January 2017. The Director of HR would check with the RCPCH on the position regarding the release of redacted and un-redacted copies of the RCPCH Review Report. To the best of my recollection and having reviewed the note of the meeting on 30 December 2016, the discussion reflects the fact that there was still some uncertainty within COCH at this time about the deaths, and I do not recall that a decision had been made in respect of Lucy Letby.

131. An EDG meeting was held on 4 January 2017 at 9.30am [INQ0004377]. Present at the meeting were the Chief Executive, Medical Director, Director of Nursing, Directors of Finance, Directors of Operations, Deputy Director of HR and myself. The Executive Team continued at 10:30 which I attended. The typed notes of the meeting confirm that in respect of the neonatal dashboard, "*Template has been modified for the maternity element within the dashboard and will be in operation from this week. AK & IH to produce a summary paper for private Board meeting on actions and recommendations following review and grievance process. Meeting with doctors to follow after final review*".

132. At 8.30am on 6 January 2017 the Director of Nursing informed me that the meeting with the Doctors was being arranged as soon as possible. My notes also state "*Lucy's s/ment. Gill's ext s/ment*" however I cannot recall any further detail in relation to these notes. [Exhibit SC/20]. INQ0107706, page 152

133. At 11am on 10 January 2017 an Extra-Ordinary meeting of the Board of Directors was held. Present at the meeting were the Chair of the Trust, Non-Executive Directors James Wilkie, Ed Oliver, Rachel Hopwood, Roz Fallon, the Chief Executive, Medical Director, Director of Nursing, Director of Finance, Director of HR, Director of Operations and myself. The Medical Director presented a paper to the Board 'Review of Neonatal Services at the Trust' [INQ0003237]. To the best of my knowledge the handwritten notes were taken by Claire Raggett INQ0003332. I cannot specifically recall which document or documents were provided to attendees of the meeting. I have been asked a number of questions in relation to the detail of the meeting, however I am unable to provide further comment over and above the information included within the minutes due to the passage of time. I am not recorded as having any input into the meeting and would not have had the clinical or medical expertise in order to have a view in relation to the particular reviews.

134. I have been asked about a document marked 'draft' by the Medical Director [INQ0003518]. I recall that I read the document at the time it was shared, however due to the passage of time I am not able to provide further comment in respect of it.

135. An EDG meeting was held on 11 January 2017 at 9.30am [INQ0004380]. Present at the meeting were the Chief Executive, Medical Director, Director of Nursing, Director of Finance, Director of Operations and myself. The Director of Nursing gave an update on neonatal matters, an update on outcomes from the Private Board meeting

held on 10 January 2017, and an update on a communications plan following her meeting with the Chief Executive and Lucy Letby on the previous day. My note records that she stated the next key step was in relation to the doctors and dealing with speak out safely issues. To the best of my recollection this related to ensuring that all employees had the opportunity to speak out as appropriate. During the meeting I was instructed to draft a letter of apology to Lucy Letby 'making explicit review exonerates Lucy', [INQ0004380] however this was subsequently taken out of my hands and drafted by HR. I do not know specifically who wrote the letter and I cannot comment on its contents. The Director of HR and Director of Nursing reported that they were meeting Lucy Letby later on the 11 January 2017 in order to discuss her meeting with a Non-Executive Director, the neonatal Consultants Dr Jayaram, Dr Brearey and the Executives, noting that the British Medical Association ("BMA") representative within the COCH, Dr Sean Tighe, should be involved in this meeting.

136. At 8.15am on 12 January 2017 the Medical Director gave me an update on the arrangements and the timescale for the meeting with the doctors. To the best of my recollection this refers to a meeting to be held with Lucy Letby [Exhibit SC/21] INQ0107706, page 153-154

137. At 9.45am on 12 January 2017 I briefed the Lead Governor on the neonatal matters. On the following day I met the Chair of the Trust for a briefing on the neonatal matters [Exhibit SC/21]. INQ0107706, page 153-154

138. I have been asked about letters sent from the Chief Executive to Lucy Letby and her parents dated 17 January 2017 [INQ0002785] [INQ0002919]. I was not involved with these letters and as such am unable to provide comment in respect of them.

139. According to my handwritten notes, an Executive Team meeting was held on 18 January 2017 [Exhibit SC/22]. Present at the meeting were the Chief Executive, Medical Director, Director of Nursing, Director of Finance, Director of HR and myself. The Director of HR reported on her challenging conversations with Lucy Letby's parents and stated that the meeting with a Non-Executive Director, Lucy Letby, Dr Jayaram, Dr Brearey and Executives was taking place on 26 January 2017 with the COCH's BMA representative in attendance. The Chair of the Trust was not available for the meeting and Non-Executive Director Rachel Hopwood would represent the Board of Directors. My notes record that the Chair of the Trust asked if the nature of the apology to the neonatal Consultants could be generic.

INQ0107706, page 155-156

140. An Executive Team meeting was held on 25 January 2017 at 8.30am [INQ0004386]. Present at the meeting were the Chief Executive, Medical Director, Director of Nursing, Director of HR, Director of Finance, Directors of Operations and myself. I have been asked as to whether a formal record of the meeting was made. I have been provided with typed minutes of the meeting by the Inquiry which appear to be the formal record [INQ0004386]. Neonatal matters were discussed in preparation for the meeting on the 26 January 2017 and the typed notes in relation to neonatal matters state "*Nothing to note from performance dashboard. Noted a review of a patient that had been transferred out is being reviewed. Discussion and agreement on next steps regarding the review. Meeting planned to take place with Paediatric Consultants tomorrow to share the recommendations accepted by the Board and inform on next steps and publication of the review to other stakeholders. Agenda agreed IH to finalise. Communication plans continue to be developed with a view for publication week commencing 6th Feb*". My handwritten note [INQ0003374] states "*Neonates Dashboard. Baby to Bolton transfer. Death. Out of process. Review to Coroner*". I cannot recall any further detail in respect of the meeting than is recorded within my handwritten note. I&S

141. I have been asked about an email sent from Jo McPartland to the Medical Director on 25 January 2017 which included her report [INQ0003135] [INQ0014373]. I was not a recipient of either the email or, the best of my recollection, the report and as such I am unable to comment in relation to the contents.

142. A meeting was held on 26 January 2017 at 12.30pm [INQ0003523]. Present at the meeting were Non-Executive Director Rachel Hopwood, Consultants Dr Jayaram, Dr V Dr V Dr Brearey, Dr Gibbs, Dr McGinn, Dr Salam, the COCH BMA representative, the Chief Executive, Medical Director, Director of Nursing, Director of HR, Matron Karen Rees and myself. The Chief Executive stated that the reason for the meeting was to discuss the RCPCH Review Report. The Medical Director outlined the RCPCH Review Report and recommendations, the HR process regarding the grievance and the element of triangulation.

143. The Chief Executive stated that the RCPCH Review Report would be published in the week commencing 6 February 2017 with a communications plan in place for the families, regional network, politicians, and the press. He stated that speak out safely was professionally managed with emotions running high at the time with things said and done below the value and standards of the Trust, which have been explored

through the grievance process and that an action plan would be developed from the RCPCH Review Report. He stated that he had met Lucy Letby and her family. The statement made by Lucy Letby was read to the meeting by Matron Karen Rees.

144. The Chief Executive reminded the meeting how the Trust had got in this position and that he encouraged all to speak out. The Medical Director stated that the RCPCH Review Report was "*not about raising concerns, as that is fine, but the review by a high powered team does not call out a criminal act but does raise other issues. There is a need to draw a line under the 'Lucy issue'*" [INQ0003523_0002]. The Chief Executive informed the meeting that the Board's decision on the 10 January 2017 was to accept the RCPCH Review Report and recommendations. He stated that the action to move Lucy Letby from the NNU was unfair but the decision to move her was right. An apology was requested from the neonatal Consultants and it was noted that mediation was necessary. He stated that the final recommendation as to level 1 or 2 for the NNU was contingent on the regional network review.

145. Dr Jayaram thanked the Chief Executive and said that '*they looked forward to working together and there is a need to understand each others position*'. He stated that we were '*not as good as we could have been*' and requested a copy of the RCPCH Review Report earlier as 'we need to group together and discuss what we have heard' [INQ0003523_0002]. The Medical Director stated that the RCPCH Review Report would be released to everyone at the same time, however some time could potentially be put aside for the Consultants to consider the report [INQ0003523_0002]. Dr Jayaram stated that consideration would have to be given to any '*poor consultant performance*' [INQ0003523_003].

146. The Chief Executive stated that doctors, nurses and managers must work together, noting his concern of the theme of difficult relationship between doctors and nurses. He stated that '*bringing Lucy Letby back to the unit will be tough, we cannot let emotions get in the way*'. The Chief Executive also stated that there is a *'need to develop an action plan for this to be achieved*' [INQ0003523_0003]. Dr Brearey stated that the '*consultants need time to reflect on what had been said. It is hard to have conversations between clinics. We need evidence of what has been said verbally*'. The Medical Director stated that there was '*no substantial difference as to what Dr Brearey and Dr Jayaram have already read in the draft report*' [INQ0003523_0003]. The meeting closed at 1.07pm. I have been asked as to whether the tone of the meeting, or any part of it, was aggressive, threatening and/or unprofessional. I recall

that the meeting was quite challenging, however to my recollection the phrase "draw a line" used by the Medical Director was in reference to drawing a line following the outcome of the grievance process as it was felt that the Trust could begin to move forward. My overall impression of the meeting was that the aim was to enable the Trust to move forwards positively.

147. Non-Executive Director, Rachel Hopwood instructed that an email be sent to the Chair and all Non-Executive Directors informing them that the meeting had been held, that it was an effective meeting, highlighting the communication from Lucy Letby and that the Consultants wanted time to reflect [Exhibit SC/23] INQ0107706, page 157-158

148. I have been asked to consider a joint letter written by the paediatricians which was sent to the Chief Executive on 30 January 2017 [INQ0003095]. To the best of my recollection I did not receive a copy of the letter.

149. I have been asked about an email from Sue Eardley to the Medical Director dated 31 January 2017 [INQ0003132]. I was not a recipient of this email and as such I cannot provide comment in this regard.

150. An EDG meeting was held on 1 February 2017 at 8.45am [INQ004392]. Present at the meeting were the Chief Executive, Director of Nursing, Director of HR, Director of Finance, Director of Operations, communications manager and myself. In respect of the NNU, the typed notes of the meeting record that "*No significant issues raised via the weekly spreadsheet. Discussion regarding feedback post Paediatrician meeting. Communications plan discussed in detail and timings of sharing the report with parents and key stakeholders etc*". My handwritten notes [Exhibit SC/24] record that the Director of Nursing reported that she had met with Lucy Letby and her union representative for them to read the RCPCH Review Report. Dr Jayaram requested a transcript of his interview with the RCPCH reviewer but was informed that no transcript available. The letter from the paediatric Consultants to the Chief Executive was also read to the meeting.

INQ0107706, page 159-160

151. An Executive Team meeting was held on 6 February 2017 at 9am [INQ0003375]. Present at the meeting were the Chief Executive, Medical Director, Director of Nursing, Director of HR, Communications Manager and myself. My notes of the meeting [INQ0003375] record that the matters discussed were the communications plan, an article in the Sunday Times newspaper, the Director of HR meeting Lucy

Letby and her parents today, the release of the RCPCH Review Report by the Coroner. My notes record '*Pursue Coroner angle re release of report*' and at the time, I understood that there was uncertainty as to whether the Coroner would release the redacted or un-redacted version of the RCPCH Review Report, however as I do not have clinical or medical expertise I was not involved in this discussion. My notes also record that the Medical Director raised Dr Jayaram's concern regarding comments in the RCPCH Review Report about the paediatric Consultants. The Director of Nursing and Medical Director gave an update on contact with the families.

152. I have been asked about a public statement made by the Medical Director on 6 February 2017 [INQ003100]. I was not involved in the preparation of the statement and as such cannot comment on its contents.

153. I have been asked about a letter dated 6 February 2017 from the Chief Executives to colleagues at COCH [INQ0003060]. I recall seeing the letter at the time however I did not have any input into the preparation of the letter, and as such am unable to comment on its contents.

154. I have been asked about a meeting with Lucy Letby on 6 February 2017 [INQ0003471] [INQ0014279]. My handwritten notes of an Executive Team meeting on 6 February 2017 state that the Director of HR was to meet with Lucy Letby on that date, however I was not aware of any additional information relating to the meeting [Exhibit SC/25] INQ0107706, page 161-162

155. At 4.45pm on 6 February 2017 the Executive Team met again [Exhibit SC/26]. The INQ0107706, page 163 Chief Executive reported on what he described as the difficult meeting with Lucy Letby and her parents, and the communications manager gave an update on press interest. The Medical Director reported that he was meeting with Dr Jayaram and Dr Brearey with regard to mediation, and the Director of Nursing advised on the need to draft a letter to the families.

156. I have been asked about Jane Hawdon's case note review which was released to NNU doctors on 7 February 2017 [INQ0003117]. I was not involved in this decision and am therefore unable to comment.

157. On 7 February 2017 at 11.30am a meeting recorded in my handwritten notes as a '*Private NEDS meeting*' was held [INQ0004393], however it appears from the list of attendees that this was an Extra-Ordinary Board Meeting (Private). Present at the meeting were the Chair of the Trust, three Non-Executive Directors and also in

attendance were the Chief Executive, Medical Director, Director of Nursing, Director of Operations, Director of HR, Director of Finance and myself. My handwritten note of the meeting records that a number of matters were discussed including an update from the Medical Director on the neonatal matter, however I cannot recall any additional detail in relation to the update given.

158. At 1pm on 7 February 2017 a Board of Directors meeting was held with ten Governors present. I have been referred to the minutes of the meeting which record that I was in attendance [INQ0014821] and asked questions in relation to the detail behind the minutes. I cannot recall specific discussions of that meeting over and above the notes as identified within the minutes.

159. I have been provided with the notes of a meeting of the EDG on 8 February 2017 from which it appears that I was in attendance at the meeting [INQ0004394]. Whilst I cannot specifically recall the meeting, it appears that it was confirmed that Medical Director and myself would be meeting with the Coroner regarding the neonatal matters.

160. On 8 February 2017 I attended a meeting with the Coroner and the Medical Director who fully briefed the Coroner on the neonatal matters to date [Exhibit SC/27]. The Coroner highlighted the need to share information with the families and the need for in-depth investigations. My notes states that the Coroner commented that the Trust had "*done the right thing*".

INQ0107706, page 164

161. On 9 February 2017 I briefed the Trust's legal advisors on the neonatal matters to date.

162. I have been asked about an email from Nim Subhedar to the Medical Director on 10 February 2017 [INQ0006890]. I was not a recipient of the email and cannot comment on its contents.

163. I have been asked about a letter from the consultant paediatricians to the Chief Executive on 10 February 2017 [INQ0003117]. I may have seen a copy of the letter, however I note that the Chief Executive reported on this letter at a meeting on 14 February 2017, as explained within paragraph 165.

164. An Executive Team meeting was held on 14 February 2017 at 9.30am [INQ003379]. Present at the meeting were the Chief Executive, Medical Director, Director of Nursing, Director of HR, Director of Operations and myself. I confirm that the handwritten note of the meeting is my note.

165. The Chief Executive informed the meeting that a letter had been hand-delivered from Dr Brearey. The Medical Director stated that he had met Dr Jayaram and Dr Brearey at the end of the previous week and there was no indication that this letter was coming. The Chief Executive outlined the paediatric Consultants and Coroner's position as he understood it, and an actions review was agreed upon. I have been asked to provide further detail relating to the handwritten notes, however I cannot recall details in addition to the notes.

166. I have been asked about emails between Jane Hawdon and the Medical Director on 14 February 2017 [INQ0014376]. I was not copied into these emails and therefore cannot provide comment as to my views on the issues discussed, nor the detail within the emails.

167. An EDG meeting was held on 15 February 2017 at 8.45am [INQ0004395]. Present at the meeting were the Chief Executive, Medical Director, Director of Finance, Directors of Operations, Assistant Director of Nursing, Head of Risk and myself. The typed minutes of the meeting record that "*IH talked about the recent letter received from Paediatric Consultants (x8) and his subsequent discussion with the Royal College. IH has now specifically reviewed 7 sets of notes, rather than just the previous cohort of 4 cases. Ruth Millward presented an analysis of 67 incidents which had previously occurred, and formally reported, with a view to extracting key themes. A discussion took place about these themes, and interpreting the information presented. TC outlined a perceived hypothesis which could be drawn from this data being:*

- *A culture of coping within the unit (due to external threats);*
- *Issue of delayed transfers (due to worries about robust transport arrangements);*
- *Leading to heroic endeavours; and*
- *Culminating in not actually recognising the risks being managed (by staff, management and executives)*

SC suggested the next stage is developing a coherent narrative, based upon the evidence presented. IH outlined the next steps about drilling down further on the key themes (including the 'coping mentality', which appeared to be an emergent theme). A discussion took place about short, and medium, term priorities (and also on how a

problem needs to be first recognised, before a change programme is owned by all involved). TC confirmed there is a scheduled Coroner's meeting later in the day with SC and IH, and recommended the sharing of the recent letter from the consultants at this meeting. TC summed up by saying that we should look to share all recommendations with the consultants, and also the full outcome of the Royal College report" . I have been asked to provide additional detail in relation to the handwritten notes of the meeting [INQ0006401]. I do not specifically recall the meeting over and above what is recorded within the notes.

168. On 15 February 2017 at 1.45pm I attended a meeting with the Coroner and Medical Director in order to discuss the concerns relating to the deaths within the NNU at COCH. I attended this meeting as it was within my role to contact the Coroner should such contact be required. The Medical Director passed to the Coroner a bundle regarding the neonatal matters and fully briefed the Coroner on all matters. I have been asked whether this included a letter dated 10 February 2017 [INQ0003117] .To the best of my recollection I was not responsible for preparing the bundle and I cannot recall specifically whether or not this was within the bundle. Inquests and the further investigations to be made were discussed. I have noted that the Coroner commented that '*absolutely right action by Trust*' which I understood to mean that he thought the action taken by the Trust with regard to the neonatal matters was correct. I have been asked whether I kept a note of the meeting. I confirm that I did keep a handwritten note which I understand has been provided to the Inquiry [Exhibit SC/28] INQ0107706, page 165-166

169. I have been asked about an EDG meeting which took place on 22 February 2017 and have been referred to the notes of the meeting [INQ0004397] which indicate that I attended. In respect of the neonatal dashboard, the notes of the meeting state "*IH and SC met Coroner last week. TC has sent letter to Paediatricians addressing their concerns, no single causal explanation, included College team observations re their specific concerns. No response as yet*". I am unable to recall any further specific detail in addition to that within the notes of the meeting.

170. I have been asked about a meeting between the Medical Director and consultant paediatricians which took place on 28 February 2017 [INQ0003096]. I was not present at this meeting and cannot provide comment in relation to it.

171. An EDG meeting was held on 1 March 2017, at 9am [INQ0006418]. Present at the meeting were the Chief Executive, Medical Director, Director of Nursing, Director of

Finance, Director of HR, Director of Operations and myself. In respect of the neonatal dashboard, the typed notes record *"Neonatal dashboard - noted IH confirmed that he had yesterday met the paediatric consultants and work was in progress regarding the review of some of the individual deaths. It was noted that arrangements were being made for the mediation meeting. SHK and AK meeting nurse L. IH to draft a holding letters to parents. SPC gave an update on the outstanding inquests*". Within my handwritten note [INQ0006421] I recorded that the Medical Director reported that he had met the paediatric Consultants on the previous day and had not yet come to an amicable solution. He confirmed that he was undertaking a case by case review of the neonatal deaths. The Director of Nursing and the Director of HR reported on the need for the availability of parties for the mediation process.

172. I have been asked about a letter from the consultant paediatricians to the Chief Executive on 1 March 2017 [INQ0006980], and a letter from the Medical Director to families on 3 March 2017 [INQ0003065]. I was not involved in the production of these letters and therefore am unable to provide comment in relation to them.

173. On 10 March 2017, the Legal Services Manager confirmed to me that the second review of Child D had been sent to the Trust's external legal advisors. On 13 March 2017 a pre-inquest meeting regarding Child D was held. Present at the meeting were the Trust's external solicitors, the Legal Services Manager, the Legal Services Assistant, Matron Julie Fogerty and Consultants Dr Newby and Dr Davies.

174. An Executive Team meeting was held on 15 March 2017 [INQ0006111]. The minutes of the meeting in relation to the NNU recorded *"LB noticed an increase in occupancy in the last week. Continual discussion is taking place with Specialist Commissioning regarding the model of care in the future. The Network are producing their action plans alongside us as a Trust. The finalised plan is due to be presented to QSPEC next week. Workshop with staff to be organised. Mediation meetings between staff are taking place as planned*". The minutes also record "*SC gave an update on current inquests taking place*".

175. An Executive Team meeting was held on 16 March 2017 at 9.15am [INQ0003344]. Present at the meeting were the Chief Executive, Director of Nursing, Director of HR, Director of Operations, Director of Finance and myself. The Director of HR gave a detailed update on her one and a half hours meeting with Dr Jayaram. I have been asked about a handwritten note [INQ0003344] which is my note and records "*TC*

Lucy cannot go back to the Unit". I have noted this as being said by the Chief Executive during the meeting. I was not involved in the decision regarding Lucy Letby's return to the NNU and cannot provide comment in relation to the decision-making process.

176. An Executive Team meeting was held on 21 March 2017 at 9.30am [Exhibit SC/29] INQ0107706, page 167 present at the meeting were the Chief Executive, Medical Director, Director of Nursing, Director of HR, Director of Finance and myself. Neonatal matters discussed were the circulation of the action plan, the CQC letter regarding engagement and the mediation process to date. To the best of my recollection, this was the first time the CQC were engaged in relation to the neonatal matters. It was agreed to arrange a meeting for the Chief Executive, Medical Director, Director of HR, Dr Jayaram, Dr Brearey and Nim Subhedar from the Regional Network. The Director of HR raised concerns regarding the mental health of Lucy Letby and the involvement of Occupational Health.

177. I have been asked about a meeting of the CDOP on 24 March 2017 [INQ0003338]. I did not attend this meeting, nor did I attend any other CDOP meetings and therefore I am unable to provide comments in relation to the meeting.

178. At 8.30am on 27 March 2017 I received a telephone call from the Chief Executive regarding what he described as developments on the neonatal matter following his meeting with the Medical Director, Dr Jayaram and Dr Brearey and he stated that there was '*no alternative but to report to Police*' [Exhibit SC/30]. INQ0107706, page 168

179. I have been asked questions in relation to a Paediatrics Meeting which was held on 27 March 2017, to discuss the neonatal matters, present at the meeting were the Chief Executive, Medical Director, Director of HR, Dr Jayaram, Dr Brearey, Nim Subhedar and Julie Maddocks. I was not present at this meeting and am therefore unable to provide comment in relation to the meeting.

180. On 28 March 2017 I noted within my notebooks [Exhibit SC/31] the following proposed action: "*Prepare 'Police' bundle bet. now & close of play Friday. Clarity on 'Steve B's and Ravi position on reporting matter to Police. Direct questions to them. Report to Police on Mon 3 April 2017. SPC to mt TC & other Execs Fri 31 March 2017*". To the best of my recollection the purpose of this meeting was to give an update in relation to reporting the matter to the Police. I recall that I was asked to

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prepare a bundle for the Police by the Chief Executive and the Medical Director. My notes state that the bundle to be provided to the Police was to be prepared in sections as follows: chronology and matrix of deaths; reviews- RCPCH Review Report, Hawdon report, in-house and network reports; grievance – relevant papers, correspondence, current position and mediation; correspondence between the Chief Executive and paediatric Consultants; Coroner – correspondence, meetings with the Coroner; and communications with the families and press.

181. At 10.20am on 28 March 2017 I was present at a meeting when the Chair of the Trust was fully briefed by the Chief Executive, Medical Director, Director of Nursing, and Director of HR. It was agreed that the bundle for the Police had to be prepared for 31 March 2017 and I was to contact the Police on this date with a view to making an appointment with the Police on 3 April 2017. The Director of Nursing and Director of HR reported that Lucy Letby was being returned to the NNU in the week commencing 3 April 2017 for one hour a day. I stated that in my view this could not happen in view of a Police investigation. To the best of my recollection I said this because due to the ongoing investigation, I thought it best for Lucy Letby not to return to the NNU whilst the investigation had not been completed, however I was not involved in this decision.

182. I have been asked about an EDG meeting on 29 March 2017. The notes confirm that I was in attendance at the meeting [INQ0004409] and in relation to the neonatal dashboard, the minutes record "*There was a brief discussion with regards to an additional external review being requested, which SC was currently co-ordinating. TC explained that he felt this to be a pragmatic option having met with the Neonatal Consultants but that he remained concerned for all the parents involved and hence my review needed to sensitively handled. TC asked that SH, AK & IH work to produce a single timeline as this would help explain the process and actions undertaken to my external review*". I cannot recall any additional detail over and above the notes of the meeting. I did not undertake or co-ordinate the external review referred to, or indeed any other.

183. I have been asked about a document entitled 'Rationale' [INQ0003226]. In this note I was recording a discussion that I was present at between the Chief Executive and Chair of the Trust and as such the document is a reflection of their views as at 3 April 2017. I was asked by them to prepare the document to note the discussion that was had. The document confirms that it had been decided at this point in time that the Police would be contacted in respect of the Trust's concerns. To the best of my

recollection the 'Rationale' document was produced to record the views of the Chair and Chief Executive, to then be presented to the Executive Team.

184. At 10.20am on 4 April 2017 I was present at a meeting of the Chair of the Trust, the Chief Executive, Medical Director and Simon Medland QC to discuss if it would be helpful for Counsel to meet the paediatric Consultants. It was agreed that it would be helpful. I have been asked a number of questions in relation to this matter, however I cannot recall additional details over and above the information recorded within my handwritten note [INQ0003351].

185. On 12 April 2017, Simon Medland QC met with the paediatric Consultants. I was not present at the meeting, however I was provided with a copy of the minutes from the meeting [INQ0006890]. I have been asked whether Mr Medland's statement that he had *"been instructed by the hospital to bring an independent objective view to present situation and see if formal report to the police was presently merited"* is correct. To the best of my recollection, this was the purpose of Mr Medland's instruction as the Trust continued to consider the most appropriate course of action due to the ongoing uncertainty as to the facts of the deaths, which included consideration as to whether the matter should be reported to the Police.

186. I have been asked about an email forwarded to me by the Director of HR on 4 April 2017 which contained legal advice provided to the Director of HR by an external legal advisor [INQ0003088]. I was unaware that the Director of HR had been in direct contact with the external legal advisor regarding the general advice relating to NNU matters and as such am unable to provide comment in relation to it.

187. An Executive Team meeting was held on 5 April 2017 at 9am [Exhibit SC/32]. The INQ0107706, page 170-171 Chief Executive reported on his meeting last week with Dr Jayaram and Dr Brearey when it was apparent they wanted a Police investigation. He gave an update on the NHS organisations to be informed; the regional network, special commissioners, and NHS England. The Director of Nursing and Director of HR confirmed that Lucy Letby would not return to the NNU. I informed the meeting that Counsel, Simon Medland QC, was to meet with the paediatric Consultants.

188. At 10.15am on 10 April 2017 I met Dr Rajiv Mittal, the COCH Designated Doctor on the CDOP, to understand the role of CDOP. He outlined the role of the CDOP Panel and informed me that it had considered the RCPCH Review Report at its last meeting

on the 21 March 2017 and had invited the Medical Director to its next meeting in 3 to 4 months' time. He stated that the Panel had taken no action on the investigations and CDOP was for wider over-arching learning.

189. At 11am on 11 April 2017 the Medical Director informed me that Justin Madders MP had forwarded an email from the Daily Telegraph and there had been contact from the Cheshire Police via CDOP [Exhibit SC/33]. **INQ0107706, page 172**

190. At 9.30am on 13 April 2017 an Extra-Ordinary meeting of the Board of Directors was held, present at the meeting were the Chair of the Trust, Non-Executive Directors Andrew Higgins, James Wilkie, Ed Oliver, Rachel Hopwood, Roz Fallon, the Chief Executive, Medical Director, Director of Nursing, Director of HR, Director of Operations and myself. Simon Medland QC was also in attendance. To the best of my knowledge the minutes of the meeting [INQ0003236] are an accurate reflection of what was said at the meeting.

191. I have a note of a meeting at 9.15am which is undated, but is recorded within my notes between the 13 April 2017 and 19 April 2017 when the Chair of the Trust was present [Exhibit SC/33]. I have noted that "*the strong view of the paediatric consultants is genuine, it is not going away, they are not pressing for Police but who for an investigation by who?. Noted that Royal College and Hawdon useful but not sufficient and to Police opens it all up. Hospital view that if evidence of crime – yes to Police but not sufficient evidence. Consultants want more and feeling by them not handled well by hospital. Moral and professional duty to report by consultants. The Chair of the Trust asked 'what did Jane Hawdon mean' by broader forensic review?*" It was suggested that a meeting should be held to include the Chief Executive, Medical Director, Chair of the Trust, Consultant David Semple, Coroner, Consultant Martin Sedgewick, Police, Network Special Commissioners instead, Consultant Paediatricians, Alison, myself, Jane Hawdon and Special Commissioner Medical Director.

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192. I have been asked about an email which was sent by Jane Hawdon to the Medical Director on 13 April 2017 [INQ0003124] and which was forwarded to me on 18 April 2017 by the Medical Director. I have been asked questions about the contents of the email, however as I have explained above, I did not have a clinical role within COCH, nor do I have medical experience, and therefore I would not have been aware of the particular processes in place and it would not have been my role to implement

suggestions made by Ms Hawdon in respect of the RCPCH Review. The email does, however, demonstrate that as of 18 April 2017 discussions were still ongoing within the Trust as to the most appropriate course of action to be taken. I do not recall discussions had with the Chief Executive and/or the Medical Director following receipt of the email, not do I recall discussing the email with anyone else.

193. An Executive Team meeting was held on 19 April 2017 at 9am [INQ0004414]. Present at the meeting were the Chief Executive, Medical Director, Director of HR, Director of Operations, Director of Finance and myself. In respect of the neonatal dashboard and next steps, the typed notes record that "*Neonatal Dashboard. The unit remains busy but no incidents reported. Next Steps. A discussion took place with regard to the broader forensic review recommended by Dr Jane Hawdon, which she had recently confirmed was for the Countess to define. It was agreed that the way forward was through the Child Death Overview Panel (CDOP) and IH agreed to arrange a meeting with representatives of CDOP as soon as possible. AK and SHK reported that they had met Nurse L yesterday and had advised her that there was no timescale set for her to return to the unit.*"

194. On 25 April 2017 at 9.50am at a meeting with the Legal Services Manager, I was informed that the Medical Director had sent a letter to all the families on the 24 April 2017 [Exhibit SC/34]. **INQ0107706, page 173**

195. An Executive Team meeting was held on 26 April 2017 at 9am [INQ0004418]. Present at the meeting was the Medical Director, Director of Nursing, Director of HR, Director of Finance and myself. In respect of the neonatal dashboard, the typed notes of the meeting record that "*TC received request to meet Mike Gregory, Margaret Kitching, Andrew Bibby, Lesley Patel to meet for update. IH responded and advised meet when completed processes. IH/SPC to meet with representatives from CDOP 27/04/17. A number of paediatricians to join the meeting. Communication to families has been distributed. LL/AK meeting with member of staff 27/04/17. Review of dashboard. Transport issues and not received information from the network. AK to check Datix in place for issues raised.*"

196. At 12.30pm on 27 April 2017 a meeting was held. Present at the meeting were the Medical Director, paediatric Consultants Dr Jayaram and Dr Holt, Lucy Letby's union representative, Dr Mittal (CDOP representative). Superintendent Nigel Wenham and myself [INQ0003337] [INQ0005461]. During this meeting Superintendent Wenham

noted the need for a further review and the resources it would need and confirmed that he would facilitate a further meeting in next few weeks. Superintendent Wenham also confirmed that he would clarify whether the Police would require a letter from the COCH to scope a forensic investigation. Dr Jayaram asked how the NNU would be affected if the Police were involved, to which Superintendent Wenham responded that terms of reference would determine investigation at a particular time with a proportionate response and will clearly need a strategy. He stated that a Senior Investigating Officer would be appointed from the Major Investigation Unit.

197. At 3pm on 27 April 2017 a meeting was held. Present at the meeting were the Medical Director, Regional Medical Director Vince Connolly, Regional Chief Nurse Margaret Kitching and myself. The Medical Director fully briefed them both on the neonatal matters. To the best of my knowledge, the notes of the meeting are accurate [INQ00003193].

198. At 8.40am on 28 April 2017 the Medical Director informed me that following the CDOP meeting he had contacted Sue Earley, Jane Hawdon, the RCPCH and was meeting Dr Jayaram later today. He also stated that the papers were to be sent to the Police that day [Exhibit SC/35] **INQ0107706, page 174**

199. At 3.05pm the Medical Director informed me that he had met Dr Jayaram who had informed the Medical Director that he felt for the first time that the paediatric Consultants were being listened to. They discussed the papers requested by Dr Jayaram [Exhibit SC/35 **INQ0107706, page 174**

200. At 9.15am on 2 May 2017 the Chair of the Trust was fully briefed by the Chief Executive and Medical Director on the position to date and I recall that he informed me that a meeting with the Police had been arranged for 5 May 2017 [Exhibit SC/35].

201. At 12 noon on 2 May 2017 an Extra-Ordinary meeting of the Board of Directors was held [INQ0004221]. Present at the meeting were the Chair of the Trust, Non-Executive Directors Andrew Higgins, James Wilkie, Ed Oliver, Rachel Hopwood, the Chief Executive, Medical Director, Director of Nursing, Director of Finance, Director of HR, Director of Operations and myself. To the best of my knowledge the minutes are an accurate reflection of the meeting [INQ0004221].

202. At 3.30pm on 5 May 2017 a meeting was held at the Police Headquarters, Winsford, Cheshire, present at the meeting were Assistant Chief Constable Darren Martland, Detective Superintendent Aaron [surname unclear], Acting Detective Chief Superintendent Nigel Wenham, the Chief Executive, Medical Director and myself. To the best of my knowledge the minutes are an accurate reflection of the meeting [INQ0003077], however I am unable to provide further comment in addition to the detail within the notes.

203. I have confirmed earlier within this statement that I was formerly a Police Officer. I do not agree that I told Claire Raggett not to inform the Police of this.

204. An Executive Team meeting was held on 8 May 2017 [INQ0014827]. Present at the meeting were the Chief Executive, Medical Director, Director of HR, Director of Operations, Director of Finance, communications manager, the Director of Nursing (by phone-in), Claire Raggett and myself. The Chief Executive gave an update following the meeting at the Police Headquarters on the 5 May 2017 and outlined the actions to be taken by COCH and stakeholders to be informed. I was subsequently appointed as the liaison between COCH and the Police during the Police investigation.

205. I have been asked about a meeting at Cheshire Constabulary HQ which I attended on 12 May 2017. To the best of my knowledge the minutes referred to by the Inquiry [INQ0003076] are an accurate reflection of the discussions during the meeting.

206. I have been asked about a call with Lucy Letby's father on 19 January 2018. I do not remember the call specifically, however I recall that it was a courtesy call which the Chief Executive had asked me to take. Due to the circumstances, I recall that I was trying to assist Lucy Letby's father with the queries he had whilst ensuring that I did not say anything which would have had an impact on the ongoing Police investigation. I cannot recall the specifics of the call in addition to the note [INQ0004456] and as such cannot provide any further comment.

207. I do recall that I met Lucy Letby's parents at the COCH as a courtesy at the request of the Chief Executive, but I am unable to recall any additional detail in relation to this meeting.

Reflections

208. I provided my initial reflections within my interview with Facere Melius on 2 December 2020 [INQ0013007]. I have also been asked a number of questions by the Inquiry relating to my reflections in relation to this matter. I have given a great deal of thought to these matters in producing my statement. I have been asked what I think happened to those who raised concerns about Lucy Letby. To my knowledge, those who raised concerns were taken seriously and their concerns were treated with importance within the Trust. To the best of my recollection, those who raised concerns were in constant communication with senior members of the Trust including conversations with the Medical Director and Chair of the Trust. I acknowledge that those who raised concerns may have felt frustrated during the process, but it was my understanding that those frustrations were due to the uncertainty surrounding the matter. Overall I recall that there was a constant dialogue between the Trust and those concerned in relation to the matters raised. I am aware that the Chair of the Trust attended a number of medical staffing meetings where the NNU matters were discussed.

209. I have been asked what I think were the failings of the HR processes which resulted in an apology being offered to Lucy Letby. As I have explained throughout my statement, I was not directly involved with the HR and grievance processes in relation to Lucy Letby and as such I would not have knowledge in relation to whether or not there were failings. My understanding at the time from the information provided to me was that HR followed due process and were being advised by external specialist solicitors.

210. I have been asked how I think I communicated with the parents of the babies murdered or injured by Lucy Letby, and whether the parents were given adequate information by me or anyone else representing the COCH. I personally did not have any communication with the parents as this was not within my responsibilities and I am aware that the Medical Director was in communication with the families. As such, I am unable to comment as to whether the parents were given adequate information.

211. I have been asked whether I think that if babies had been monitored by CCTV, the crimes of Lucy Letby could have been prevented. Whilst I do not know if the presence of CCTV would have prevented these incidents, it is my view that CCTV would always be of assistance if it were in use and I agree that it should be in place wherever possible within the COCH.

212. I have been asked whether I think systems, including security systems relating to the monitoring of access to drugs and babies in NNUs, would have prevented deliberate harm being caused to the babies named on the indictment. I have not been provided with a copy of the indictment referred to by the Inquiry, however I think that security systems would always be of assistance if they were in place. I had no personal knowledge of the details of the arrangements in place within the NNU and cannot comment as to their effectiveness or otherwise, but I think that if it is possible to enhance security systems to improve them then that would always be beneficial.

213. I have been asked what recommendations I think the Inquiry should make to keep babies in NNUs safe from any criminal actions of staff. Whilst I do not have experience of working within an NNU, it would seem sensible to me to ensure, so far as possible, that systems be in place within an NNU, for example enhanced security systems including CCTV, access to the NNU to include secure doors, the supervision of staff on the NNU and constant monitoring to ensure that the processes put in place on the NNU are working and effective.

Statement of Truth

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

Signed: Personal Data

Dated: 15 August. 2024 .