Tuesday, 1 October 2024

(10.00 am)

LADY JUSTICE THIRLWALL: Good morning, Mr De La Poer.

MR DE LA POER: My Lady, can I ask Dr John Gibbs to come forward, please.

LADY JUSTICE THIRLWALL: Dr Gibbs, would you like to come forward?

DR JOHN GIBBS (sworn)

Questioned by MR DE LA POER

LADY JUSTICE THIRLWALL: Do sit down.

MR DE LA POER: Can we begin, please, with your full name?

A. I am John Gibbs.

Q. So far as your contribution in writing to this Inquiry is concerned, can I confirm, please, with you that you have given a witness statement dated 1 July 2024?

A. Yes.

Q. And a witness statement dated 6 September 2024?

A. Yes.

Q. Are the contents of both of those statements true to the best of your knowledge and belief?

A. Yes, they are.

Q. Dr Gibbs, we are going to begin by introducing you briefly. Is it right that in 1983, you graduated MBBS?

A. Yes.

Q. Meaning that you completed the academic part of the training to be a doctor?

A. Yes, it was the basic medical degrees.

Q. Did you become a Fellow of the Royal College of Paediatrics and Child Health in 1996?

A. Yes.

Q. Insofar as your career is concerned, did you begin in Cornwall?

A. Yes.

Q. You subsequently worked at Guys, Great Ormond Street and Alder Hey?

A. Yes.

Q. That for a period of time you conducted research at University College London?

A. Yes, I did.

Q. And that you took up the role of Consultant paediatrician at the Countess of Chester Hospital in 1994?

A. Yes.

Q. And that so far as paediatrics is concerned, do you have a special interest in epilepsy and childhood

disability?

A. Yes, I did. But all of us paediatricians in Chester were general paediatricians who covered paediatrics in general at a district general hospital level and neonates.

Could I just add at the beginning, please, that I do deeply regret and I am ashamed that I failed to protect the babies from harm by Letby, but I do understand that the parents concerned probably now would prefer explanations rather than belated apologies.

Q. Returning to your career. Did you become the Paediatric Lead Clinician between the period 2000 and 2004?

A. Yes.

Q. Then Paediatric Clinical Director between 2004 and 2009?

A. Yes, that is right.

Q. Did you retire from medicine in 2019?

A. Yes, five years ago.

Q. Albeit that you worked, including supporting the response to the pandemic in 2020?

A. Yes.

Q. Thank you, Dr Gibbs.

We are going to move to the next topic, which is your awareness of deliberate harm cases.

Firstly, in 2015, were you aware of the case of Beverley Allitt?

A. Of who?

Q. Beverley Allitt?

A. Yes, I was, yes.

Q. Was that something that just formed part of your general awareness or had you received any particular training or warning about it that you can recall?

A. I can't recall any particular training. I was just aware, as most paediatricians at that time and before that time would have been aware, because of such media interest and such importance to paediatrics. But time, memories fade over time. So Beverley Allitt was not at the front of my mind most of the time I was practising.

Q. To take a case closer in time to the summer of 2015, were you aware of the situation of two nurses at the Stepping Hill Hospital?

A. Yes, I wasn't quite sure how many nurses were involved but I was aware of the insulin problem at that hospital.

Q. Insulin problem. When I said two, and you mentioned this in your statement, one nurse falsely accused?

A. Yes.
Q. One nurse convicted?
A. Yes.
Q. And we know that in the late spring of 2015, the nurse who was convicted was sentenced in the Crown Court. Was that sentence something that you were aware of, do you think, back in the summer of 2015?
A. I can't remember whether I was but I was aware of the situation over those years that had happened at Stepping Hill Hospital.
Q. So were you aware in the summer of 2015 that insulin had in the past been used as a weapon?
A. Yes.
Q. To move to my third topic, which is just for you as our first witness of fact working at the Countess of Chester Hospital, to introduce the neonatal unit. Can I just say this to you, Dr Gibbs and for the benefit of everybody else: paragraphs 5-35 of your witness statement will be published on the Inquiry website where you deal in some detail with setting the scene.
You and I are just going to go through some of those matters. We don't need to go through all of them.
So we begin with this: the neonatal unit formed part of the paediatric department; is that correct?
A. Yes, it did and that's a typical set-up in

a district general hospital.
Q. And the paediatric department at that time sat in the Urgent Care Division of the hospital?
A. Yes.
Q. Obstetrics sat in the Planned Care part of the hospital?
A. Yes, it did.
Q. Just pausing there for a moment. In your view, bearing in mind the very close relationship between those two specialties, did the fact that they sat in separate divisions within the hospital cause any difficulties relevant to the matters that we are considering?
A. To some extent but I don't think to a significant extent. The reason being that aware of how closely we needed to work with our obstetric colleagues particularly from the neonatal side of our department, governance -- clinical governance structures were maintained between paediatrics and obstetrics even though we were in separate divisions.
The problem with us, we had been downgraded really from -- there used to be three divisions, one was women and children's and then there was medicine and surgery. Because we had been split, the women and children's, to the two divisions that were then created, that meant we

didn't have a direct line to the senior managers.
When I was Lead Clinician back in -- and Clinical Director up to 2009, I sat on the Management Board and liaised more closely with the senior Executives. My colleague, Dr Jayaram, who was Lead Clinician in 2015/16, didn't have that position. He had to liaise through the Urgent Care Clinical Director. So from that point of view, being slightly more separated from the managers was a bit of a problem. But we knew, and Dr Jayaram knew, how to contact the managers which is why I think it wasn't such a big problem.
Interestingly, the women and children's departments had been joined back together again now at the Countess of Chester Hospital.
Q. Just to reflect back what you have just said to make sure I have understood it. When you were Clinical Director, you had regular meetings with the senior management and built up relationships at those meetings; is that right?
A. Yes, yes.
Q. But by contrast, in the ordinary run of things, Dr Jayaram would be expected to contact a layer of management below the senior management for his concerns?
A. Yes.

Q. Meaning that he didn't have the same sort of relationships that you would have had because he simply wasn't sitting round the table as frequently?
A. That's correct.
Q. Now, as far as the Consultant body was concerned, you have mentioned Dr Jayaram who was the Clinical Lead for paediatrics which was the equivalent relevant, albeit in a different structure, to the one that you had held?
A. (Nods)
Q. Dr Stephen Brearey was the neonatal lead; is that right?
A. Yes.
Q. And that was an additional clinical role for him, not a management role?
A. That's correct.
Q. There were then three other consultants who were present throughout the entire period we will be looking at: Dr ZA, Dr V and Dr Saladi; is that right?
A. Yes.
Q. At the start of the period we will be looking at Dr Liz Newby was part of the Consultant body; is that right?
A. Yes, she was.
Q. And she left around March 2016, I believe?

A. Right, yes.
Q. And was she replaced by Dr Suzy Holt?
A. Yes, she was.
Q. Who was then part of the Consultant body up until past May 2017?
A. Yes.
Q. Now, at the start of the period that we are going to be looking at in detail, and I will just date-stamp it for you, June 2015, what was your view about whether there were enough Consultants?
A. Sorry, could you repeat?
Q. What was your view about whether there were enough Consultants in the paediatric department?
A. We knew, we -- we felt we needed more Consultants and we were planning to have two extra Consultants so that we could provide enough regular cover for both sides of our department, that's the paediatric ward and the neonatal unit.
Q. So enough Consultants for the whole paediatric department of which the neonatal unit was part?
A. Yes.
Q. And was a business case created for two more Consultants?
A. Yes. I can't remember exactly when it was created, it was created around 2016 onwards.

Q. Yes, well --
A. And well before June 2016.
Q. You will take it from me that records indicate that at some point in 2016 it was agreed that those two extra Consultants would be appointed and those appointments were made in 2017; does that sound about right?
A. Yes, yes.
Q. So that's the Consultant body. Let's just turn to deal with the senior nurses. Sister Ann Murphy was the lead nurse for children's services; is that right?
A. That's correct.
Q. And there were two ward managers, the paediatric ward was run by nurse Anne Martyn, as she was then?
A. Yes.
Q. Now McGlade. The neonatal unit was run by Nurse Eirian Powell?
A. Yes.
Q. Now, in your witness statement, Dr Gibbs, you run through a number of different types of meetings which took place and it is not necessary, given that's going to be published, for us to go through all of them. But let's just mark some of them. There were monthly

neonatal unit risk management meetings; is that right?
A. Yes.
Q. There would be -- my word -- ad hoc, meaning arising as required, mortality review meetings; is that right?
A. For neonates.
Q. For neonates.
A. Yes.
Q. There would also be a monthly meeting which Consultants could attend; is that right?
A. Yes, just going back to the mortality meetings~--
Q. Yes.
A. There was an ad hoc one for neonates which I think in 2015/16 probably took place two or three times. But there was also a two monthly meeting where we met with our obstetric colleagues and neonatal deaths or other problems were discussed at that meeting as well. I don't know if you are going to come on to that.
Q. I was. It was this -- what you say in your statement is every one to two months there is a maternal and neonatal mortality and morbidity meeting?
A. Yes.
Q. Sometimes I think referred to as the perinatal meeting?

A. Yes.
Q. There was also a Monday meeting between paediatricians and nurse managers?
A. Yes. Each week.
Q. With one formal one a month?
A. Yes, once a month it was -- we had more people attending from finance, IT to look at the general activity of our department, yes.
Q. It was at those monthly ones that minutes would be kept?
A. Yes.
Q. Less formally, as a group of Consultants, were there also informal discussions between you in twos and more in each of your offices?
A. Yes, which were generally unminuted.
Q. And was it at some of those meetings, as we will come to in a while, that Letby was first discussed?
A. Yes.
Q. So far as the staffing levels on the NNU were concerned, and you deal with this at paragraph 38 if you want to turn it up, we have already heard from Sir Robert Francis Kings Counsel about the BAPM guidelines as to minimum safe staffing?
A. Yes.
Q. In your view, were there adequate nursing

staff on the NNU during the period 2015/16?
A. There is two answers to that. Yes, I felt so and there was similar nursing staffing to that that we had in prevent years, it hadn't suddenly changed in 2015/16. But no in that it was below the BAPM guidelines. But it was my understanding at the time that many hospitals -- many -- failed to meet the BAPM standards for nurse staffing on the neonatal unit.
Q. So three points then, yes? Firstly, lower than the guidelines suggest?
A. Yes.
Q. Secondly, that that had been a longstanding problem?
A. Yes.
Q. Thirdly, in your understanding, that was comparable to many other hospitals?
A. Yes, and if I could just add a figure there that might come up later. When we had the College review -- I am not going to talk much about that yet -- in September 2016, the reviewers pointed out that the nursing staffing levels on our neonatal unit were 21% below the BAPM recommendation.
But that compared to within the region all the other units, the average was 27% below the BAPM recommendations, which just hopefully confirms what

I said: most other hospitals did not meet the guidelines and we are actually slightly better off staffing wise than other neonatal units in the Cheshire and Merseyside region.
Q. Is what you have said about nurses also true of the doctors in terms of the adequacy and number?
A. In theory we had enough doctors. But because of the busy paediatric ward as well, we Consultants weren't spending enough time on the neonatal unit, although we had the numbers, but we needed more to satisfy enough time on the neonatal unit and although we had adequate numbers of registrars, there were often gaps in the rota. People had dropped out of training for different reasons, maternity leave, doing research, going abroad and those gaps in the rota did cause a problem for us and all the other hospitals I was aware of in our region.
LADY JUSTICE THIRLWALL: Can I just ask you, so although you had enough registrars, in theory --
A. Yes.
LADY JUSTICE THIRLWALL: -- I think gaps in the rota, does that mean they just weren't there?
A. Yes, we should have had seven registrars and often we only had six and that was the case during 2015/16.

LADY JUSTICE THIRLWALL: Thank you.
MR DE LA POER: Dr Gibbs, I am now going to move on to a subtopic of relationships. We will start here. In summary what is your view about the relationship between the Consultant body during the period 2015-2017?
A. Relationship between Consultants?
Q. Consultant paediatricians, yes?
A. Oh, it was good. It became strained only from the fact that we felt under considerable stress as events unfolded during that two-year period.
Q. As between all of the doctors, how was the relationship?
A. With ourselves and our junior doctors?
Q. Indeed.
A. I understood it to be very good. Of course the view of the Consultant, how you feel you relate to your junior doctors may be different from a junior doctor perspective, but I am sure you will be hearing from some of the doctors who were in training at the time later on.
Q. How about between the doctors and the nurses?
A. I felt it was very good. Until we started -- Consultants started developing concerns about what was happening on the neonatal unit and that caused a strain between ourselves and the senior nurses on the neonatal

unit.
Q. Well, speaking of senior --
A. Sorry, that was a consequence of what was happening on the unit, it wasn't the cause of what was happening on the unit; it came afterwards.
Q. Speaking of senior nurses, I just want to invite you to consider an opinion, so you have an opportunity to comment upon it, from Eirian Powell. She suggests that Consultants thought all staff members worked cohesively because staff did exactly what they were told to do by the Consultants without challenging them. Does that accord with your experience of that period?
A. No, it doesn't. But sometimes what I might feel is the case a relationship with -- with nurses may be slightly different from their point of view. I am disappointed and surprised to hear that Eirian Powell has said that. If she had said it towards the mid to end of -- well, any time from the end of 2015 beginning of 2016 onwards, tensions were building up at that time between us Consultants and senior nurses, so I can understand it. I would be very surprised and disappointed if that was the case earlier on in 2015 and in preceding years.
Q. Another observation for your comment, please,

from Eirian Powell, she suggests that Consultant communication with nurse managers and midwives was sometimes poor and they didn't listen to the views of others?

A. Sorry, I didn't hear that last word didn't listen to?

Q. The views of others.

A. Again I am disappointed and rather surprised to hear that. I do understand and it came out when the nurses spoke to the Royal College reviewers in September 2016, that they felt at times -- and I thought this wasn't frequently, but at times when nurses felt that we ought to escalate and that doesn't just mean the Consultants, it means the Registrars as well, escalate problems, that's Registrar up to Consultant and Consultant to the regional neonatal centres, sometimes the nurses felt that should have happened quicker than it did and they -- it appears that they felt they were not empowered to say anything.

I always thought the nurses could say whatever they liked at any time to me and I hoped I listened. But I do think there came a strong and unpleasant difference of opinion about what was happening on the neonatal unit that maybe has coloured all those comments that you just read out from Eirian Powell.

Q. In terms of the relationship between the Consultants and managers outside of the paediatric department but below the Executives, so here I am thinking about people in the role such as Head of Risk, did you or your colleagues have relationships with that tier of management?

A. Yes. We had an associate or assistant business manager to assist us in the paediatric department and we had good relationships with her. But she had to answer to the business manager in the urgent care, so we are several -- you know, one layer below that and we didn't have a good relationship with the urgent care management, not because there was anything wrong with them but we were removed from them. We had a good relationship with our assistant business manager.

As far as clinical risk is concerned, it's a complicated network of different committees and groups that were supposed to look at risk and I must confess I was confused by that even though I worked at that hospital, even though I had been a Clinical Director in the past, and I think at times it was difficult to know how risk was being managed.

Q. Finally on the topic of relationship, and we are going to come back to risk in a little bit more detail, the relationship at the start of the period, so

June 2015, between the Consultants and the Executive Directors?

A. I wasn't aware of any problems. As has been discussed previously the way our management structure was set up within the hospital, we were quite removed from them. We knew who they were, we saw them occasionally, and we didn't have a close relationship with them.

You might say just that because I had been Clinical Director in the past and I said I sat on the management board like all the clinical directors do and I knew the Chief Executive Medical Director, Nursing Director, met them at different meetings, that I might have known them a bit better but all those personnel had changed over by 2015/16.

Q. So your pre-existing relationships were no longer relevant?

A. Yes, those people had retired or left or moved to other jobs.

Q. Dealing with what is quite a big topic but in summary form for now, during the period 2015 through to June 2016, so here we are talking about the period before the deaths of Child O and Child P towards the end of June 2016, did you have any hesitation or reason to think that you wouldn't be listened to by those

Executive Directors if you went to them with a problem?

A. No.

Q. So although you didn't know them well, you didn't regard them as hostile to your position or unwilling to listen?

A. No, I didn't, no.

Q. So I said I would come back to the topic of risk and here I would just like to look at Datix reporting?

A. Yes.

Q. It may be that was what you were referring to a moment ago. Let's see.

A. That's part of the risk management, yes.

Q. So firstly, because you are here to help us by way of introduction to some matters, just tell us in a nutshell what is a Datix form?

A. Well, a Datix form is just an electronic form for recording clinical incidents and clinical incidents are just events that may cause concern, either did cause concern or potentially might cause concern.

That's when there's been problems with care of patients. And you are supposed to fill in a Datix form when you are aware of such an event and that will then go through the clinical risk system within the Trust.

Q. Now, I just want to focus on your answer

there. You gave the first half of the answer which was when there is an incident which may be of concern or was of concern?

A. Yes.

Q. And then you added "to do with the care", or words to that effect. Would it only be when there were concerns about arising from care that you would fill out the Datix or could you just fill out a Datix if you were generally concerned without really being able to put your finger on what it was you were concerned about?

A. I am not sure and I never filled a Datix form in to do with a general concern, it was always a specific concern about a particular patient and a particular event with a particular patient.

Q. So if we just test that with an example. If a baby suddenly and unexpectedly collapsed and recovered, and you didn't understand at the time the reason for that sudden and unexpected collapse, is that the sort of thing that you would fill out a Datix for or would you not fill it out because you didn't identify any issue with care?

A. Generally would not fill it out, no, because you had to identify what was the problem, a medication error, a lack of equipment, a staffing problem that led to that episode.

Q. So as far as you were concerned, a Datix form presupposed that you were able to identify something that had gone wrong?

A. That's correct. I might have been wrong in that understanding, but that was my understanding.

Q. But if you simply couldn't figure out why a particularly serious event was happening that wouldn't necessarily lead to a Datix?

A. No and I ought to add that, myself included, I think in general clinicians are not good at filling in Datix forms when they should and I believe -- but I only have experienced of the Countess of Chester as a Consultant, I believe that's a widespread problem and it is said that a department in a hospital is very risk aware and good from that sense by filling in lots of Datix forms but also you get criticised by having so many events in your hospital there is a disincentive to fill them in.

Q. Just doing your best to get to the bottom of why you think that phenomenon is, ie doctors not as good as some of their colleagues at filling out Datix forms, what do you think the reason for that is?

A. That not being aware one should have been filled in, not having the time to fill them in sometimes, and in my experience, nurses are much better

at filling in Datix forms than doctors.

Q. Well, you have mentioned nurses there. Often with a clinical event there will be a number of members of staff present?

A. Yes.

Q. If there are, if there is more than one person there, whose responsibility is it to fill out a Datix form?

A. Anyone's.

Q. And how is the situation avoided where if there are six people present, all six of them put in a Datix form? Is there to be any communication between people about who will do it?

A. That would be a slightly embarrassing situation. I think the risk managers would tell you they would much rather receive six forms than no form on the same incident and I think probably more often they receive no form.

Q. But was there, for example, a line of communication with perhaps one of your nursing colleagues where you could say as a Consultant: this needs a Datix form, would you mind filling it in? Is that the sort of dialogue that you had or would that not be an appropriate request?

A. Yes, you could have that dialogue. I think by

and large the nurses just took it upon themselves correctly to form a fill in when it needed to be done, the doctors didn't and in part mitigation for that is that doctors tend to be responsible for a large number of patients, say a paediatrician if you are on-call, all the babies on the neonatal unit, all the children on the paediatric ward. The nurses look after, and it depends the medical needs of the patient, maybe just one patient or maybe just a small group of patients. So although we all have responsibility for Datix forms, the nurse who is with the patient most the time for the whole of her or his shift is more likely to fill the Datix form in than a doctor that's hurrying from one patient to another.

Q. Do you think there was any possibility that doctors were, or you were -- speaking for yourself -- assuming that the nurse would do it if one was required?

A. Sometimes. But I admit that is not a good excuse for not filling one in.

Q. In the event that such an assumption is made, can you see that there may be a risk around that and I will explain what I mean by that, that it may be that the doctor in that particular situation has a better understanding of what has gone wrong and the nurse may not have identified it and that therefore if the nurse

is to be relied upon unless the doctor speaks to the nurse about filling in the Datix, something the doctor thinks is significant may not be recorded?

A. That is true. I think generally, though, the more significant a doctor or I might have felt an event was that needed a Datix form, that is more likely to encourage me or another doctor to fill the Datix form in but it doesn't guarantee it would happen.

Q. I want to deal briefly with safeguarding.

Have you as part of your preparation for your evidence had an opportunity to have a look at Working Together 2015?

A. Yes.

Q. Had you received any training about Working Together and there was a previous iteration in 2013 and one before that in 2010, had you received any training about that document by June of 2015?

A. Yes, I had received general training to do with safeguarding that at times related to parts of Working Together.

I never received training where you sat down or discussed or went to a presentation on Working Together. Parts of Working Together came into general safeguarding training. I would add, though, that I cannot recall -- it doesn't mean it didn't happen, I can't recall ever

being given any training on the 2015 guidelines that had come into force whether there were any changes compared to the previous guidelines.

Q. Had your safeguarding training included as any part of it how you might go about reporting a concern related to a colleague?

A. I am hesitating because I can't remember if that ever came under safeguard training although generally it is under that area. I was aware and I did know the -- I thought I knew the rough steps you should take if you were concerned about a colleague, yes. I can't remember if that was covered in safeguarding training, but we did have specific safeguarding training each year.

Q. Well, what in 2015/16 was your understanding about the steps you should take if you had a concern about a risk from a colleague?

A. It depended on the colleague. For a junior doctor or so-called doctor in training, and these are qualified doctors but they are still counted as in training until they get to Consultant level, that each doctor in training had an educational supervisor who was a Consultant. If you had concerns about a training doctor's performance, you would discuss that with the educational supervisor and that would then be fed back

and discussed with the doctor. If there were serious concerns, it could be fed back to the training school which in each region of the country there is a training school for doctors in every specialty and for us in Chester it would have been the Mersey Deanery for training doctors. If you had a concern about a doctor and if there were serious concerns, that doctor would be supervised or even removed from the training rota. That's a junior doctor.

Q. How about nurses?

A. Can I come on to --

Q. Of course, no, I don't want to interrupt.

A. Because that's the most difficult part of the answer.

Q. Yes.

A. If you had a concern about a Consultant colleague, that's more difficult because you are at the same sort of level, the same level of seniority, but you would discuss it with the Lead Clinician or Clinical Director. But it would be a difficult if the concern was with the Lead Clinician and Clinical Director. So you would go one higher and if necessary you would go to the Medical Director to discuss concerns about a Consultant colleague's performance.

Q. And for nurses?

A. More difficult because they are sort of a separate structure. And so I felt I knew well how to handle concerns about another doctor, either a training doctor or a Consultant. When it came to concerns about nurses you would mention those to the ward manager usually, unless it was the ward manager his or herself that you were concerned about, and you would go to a higher nurse then, and then leave them to deal with it. I felt, but I don't know for sure, that the nurses had a similar way of dealing with problems that we doctors would have; that for a nurse in training it's her training supervisors that would look at her, the concern about that.

For a nurse who's qualified, a more senior nurse would look at the problem and if necessary escalate it up, up to the divisional nurse manager and if necessary to the nursing director and of course we all know we knew that ultimately concerns about a doctor can be fed back to the General Medical Council but you wouldn't do that without usually involving senior doctors like the Medical Director.

Similarly on the nursing side they could report a nurse to the Nursing Midwifery Council, but we would not go to those bodies straight away; we would try to deal with it within the hospital structure initially.

Q. Obviously there are concerns and there are concerns. The vast majority no doubt are of a clinical nature: somebody isn't safe in what they are doing, making mistakes.

What did you understand to be the correct way of dealing with a situation where you had a nurse and the concern included the possibility of deliberate harm or criminal activity?

A. I don't recall that ever being discussed in my training as a junior doctor or in the mandatory training we did each year as a Consultant. But I assumed, and I think it is a reasonable way to assume, that you would deal with them initially in the way you dealt with a performance problem. If it was the nurse, you would discuss it with the nurse manager and if the nurse manager was concerned it would go to the next level up, ultimately to the Director of Nursing in the hospital.

Q. Why wouldn't you in those circumstances go to the safeguarding department?

A. Because I regarded the safeguarding department, particularly in paediatrics, as being there to help manage a concern about a particular child or family, not a concern about other members of staff.

Q. Do you think it's wrong to characterise situations where there is concern about a nurse

potentially causing deliberate harm as a safeguarding issue?

A. It is a safeguarding issue but it wasn't one that I would have envisaged going to the safeguarding team who we involved regularly with concerns about individual patients or the patient's family.

LADY JUSTICE THIRLWALL: So that would be in relation to parents?

A. Parents or other caregivers.

LADY JUSTICE THIRLWALL: Or other caregivers.

A. Yes.

LADY JUSTICE THIRLWALL: Sorry, Mr De La Poer.

MR DE LA POER: Not at all. So you tell me if I have got this wrong but is what you are saying that it just wasn't in the way you thought about how to solve this problem that the safeguarding unit may be part of the solution.

A. That's correct. Yes. If a member of staff was suspected of harming patients, for example, I would go to their -- their line managers and if you were worried, as you would do with something like that, you would want to escalate it quite quickly to the most senior line managers in the hospital. I wouldn't have thought of involving the safeguarding team who were there generally to sort of -- and in paediatrics my

whole experience had been are there to help manage an individual child or family.

Q. Just exploring the idea of going to their line manager. Is a potential challenge of going to their line manager with such a potentially serious allegation or even if it does not amount to an allegation, a concern that human relationships may get in the way of dealing with it as quickly as it needs to be dealt with?

A. Yes, that is true. But in that situation you would look to escalate it to higher managers who were slightly further removed from the person in question. We all develop good working relationships within our own teams at ward level and it probably ought to be easier -- but not easy -- for someone outside the ward level to deal with a concern like that than a fellow colleague at ward level.

Q. We will come back to the local safeguarding policy in just a moment. But if we move to the topic of the external reporting of child death. You have had a chance to look at Working Together 2015. Did you note the part which deals with Sudden Unexpected Death in Infancy and Childhood?

A. Have I noted it now?

Q. Yes, now?

A. Yes.

Q. Now, as part of your preparation?

A. Yes, I don't remember my attention being drawn to that back in 2015 but it is my responsibility to try and keep up to date with the enormous number of guidelines in all different aspects of our specialty.

Q. Having had a chance to read that now --

A. Yes.

Q. -- do you agree or doing with the proposition that those guidelines, the SUDiC guidelines, applied to babies who died in hospital?

A. I am still actually not certain now and I was -- I just did not realise it did. That's now. Back in 2015/16 I did not realise it applied to babies in hospital. I had very sadly intermittently throughout my career had to deal with SUDiC cases and usually SUDI, the infant rather than the child, and I felt I knew how to deal with those in a multi-agency manner, including the police.

That was -- the scenario was always a cot death type situation of a baby at home and then dealing with the police. Why in that situation? Because the police look at the home circumstances, the behaviour of the caregivers, parents or others, whether they have drug or alcohol problems, whether there could have been child abuse or neglect and in most cases there won't be for

a cot death.

I didn't have that same understanding -- I didn't have the understanding that same approach was supposed to apply to children in hospital, but most specifically a neonate who had never been home from hospital back in 2015/16. I think a lot of other clinicians -- but I can only talk for myself -- had that same understanding.

I did -- I have read Dr Garstang's expert view and as she admitted, her very well-resourced child review programme in Birmingham probably would have handled it differently to us, but she has an academic interest in it and I didn't realise that's the way she would have managed it at that time.

Q. You were also invited to consider the Pan Cheshire guidelines, so these are the more local guidelines?

A. Yes.

Q. Again, having read those now, do you agree or disagree that they, like Working Together, indicate that the SUDiC process applies to hospital deaths as well?

A. Probably, probably it does. I didn't realise back in 2015 and the reason I say "probably", it is not at all clear that it does. Is it possible to have a look at -- I don't mind either guideline, they have got the same flowchart in them, if we have got the Pan

Cheshire guidelines for SUDiC?

Q. Yes, we can certainly bring that up.

A. It would be page 9 for that -- actually no, no, I think it is page 91 for the Pan Cheshire guidelines.

Q. So the Pan Cheshire guidance is INQ0013225, I believe. My Lady, you have that in hard copy at tab 5 of your Consultant core bundle, so that's the double bundle.

A. Thank you, and this is page 91, I think we are all looking at, and this is the flowchart.

Q. Yes.

A. Now, there is a lot of text as well but flowcharts are designed as a visual aid to help you follow a process. If we look at the child death and so on, when it starts and expected death, we are not talking about expected deaths, we are talking about the left-hand column which at the top is headed "Sudden and Unexpected Death of an Infant or Child".

If you work your way down that flowchart, at the top is "Ambulance and Police immediate response". Then the next box it starts with "Where appropriate, child and carer transferred to hospital".

That's what this flowchart shows. That was my understanding of how SUDiC is managed. This is the 2015

guideline. It just shows it must be a child in the community because you don't call an ambulance to a child on the neonatal unit. This is a child in the community and the ambulance and police get involved. The child comes to hospital. Sadly, the baby -- and it is often a baby, it is a cot death type problem often, not always, the baby may not actually be alive at home but often the ambulance -- or the parents first and then the ambulance staff start resuscitation, bring the child to hospital and sadly we have to declare the child dead in hospital and then follow the process shown here.

I wouldn't have from this flowchart realised this applies to a neonate who has not come from home.

Q. Could we just scroll to the top just to see -- the heading is "Child Death in Hospital/Community"?

A. Yes.

Q. So obviously you have drawn attention to parts lower down but in the heading is included "hospital".

A. Yes, because most children who are found collapsed at home, as this flowchart shows, are brought to the A&E department where we continue resuscitation until we realise it is hopeless.

Q. So dying in hospital having been transferred there in a state of distress?

A. Yes, yes.

Q. I understand.

A. If you want to look at page 85 I think on this guideline --

Q. I think that's one that our technology is just letting us down with. I wonder if we might come back to that?

A. Okay.

Q. That's not to -- yes, it has just been pointed out that that document has 67 pages so the reference you have given --

A. The document we are just looking at?

Q. The Pan Cheshire.

A. I thought we were looking at page 91 there, weren't we? 9, the other one is 91. Sorry, okay, well we can leave that for the moment.

Q. I am sure we can come back to it.

A. Well, I can just point out this is the Pan Cheshire guideline, the other was the Working Together guideline, sorry. We don't have to look it, it's got the same flowchart in it and honestly someone can check that it is the same flowchart. It starts with the top bit: ambulance and police called, child brought to hospital. And the child may be declared dead at home because ambulance I think and police can declare a child dead or a baby dead at home but often they will try to

resuscitate the baby, bring to hospital. Which is why the SUDiC could occur in the community or be declared the death in the hospital. That's why I said when you said "But does that only apply in that situation, could it apply in hospital?" I said possibly it could, but it's unclear.

Q. One more policy to have a look at which is the hospital safeguarding policy.

A. Yes.

Q. That's INQ0003250. This is a document you have had a chance to have a look before coming here today. Can we just go to page 11 -- sorry, forgive me, page 33.

This is the hospital's own policy. Here it defines it as:

"The sudden unexpected death, unexpected in 24 hours prior to death of a child under the age of 24 months, irrespective of the place of death at home or in the community, in the hospital emergency department or ward."

A. Yes.

Q. Again from your point of view, does that enlighten the position any further or does it maintain the ambiguity?

A. It could be taken either way and my

understanding back in 2015, most of these SUDiCs are babies in the first year of life, cot death type problems. A child -- an older child can die suddenly in hospital and that's why an older child dying in hospital, the SUDiC procedures do apply. Why get the police, for example, involved in those? Because the child had lived at home and all the home circumstances, the parents or caregivers' behaviours and problems and possibilities of neglect exists. I didn't take that as happening on the neonatal unit.

Q. Thank you very much indeed, can we take that down?

A. Could I also add, these are the documents to do with SUDiC?

Q. I beg your pardon?

A. Is this the end of the documents to do with SUDiC?

Q. Well, I was going to just acknowledge that you had, before I moved on to the next topic, provided a document dated 2011 --

A. Yes.

Q. -- which you have drawn to the Inquiry's attention. I wasn't going to ask you any questions about it but if there is any part of it you want to draw attention to?

A. Yes, that that document from the BAPM again, that same organisation, from 2011 that applied in 2015/16, it wasn't updated until 2022 so it did apply at the time of the incidents we are going to be considering, that relates to babies who die within the first week of life either at home or still in the hospital.

It only applied to term babies and admittedly it was -- it is designed to address the investigation, the medical investigation of those babies. But because these are babies who suddenly unexpectedly die in the first week of life, it does overlap with SUDiC and it says in the introduction to that particular document that SUDiC guidelines tend to emphasise death in the community. But they do mention police in that BAPM document and the only mention of the police is that if the family of a child dying in the first week of life suddenly, if the family are already known to Social Services or to the police, then information should be obtained from those agencies. It doesn't give the impression those agencies are automatically involved in SUDiC but that was not a SUDiC document.

The other document just to mention, if you don't mind, please, is the SUDiC document from the Royal College of Paediatrics and Child Health.

Q. Yes.

A. It is a joint document with our paediatric college and the College of Pathologists, and the one that applied in 2015/16, Dr Garstang -- I mean, that's what our SUDiC policy is based on in managing these babies. Dr Garstang admitted in her evidence on the transcript that that doesn't mention death in hospital at all. She felt that was well out of date at that time because she would have done it differently in Birmingham, but that document that our SUDiC policy is based on doesn't mention death in hospital and Dr Garstang said that a revision of that at the end of 2016 which is still in force now is wholly inadequate and needs updating.

Q. Thank you very much indeed, Dr Gibbs. We are going to move now to start our review of the period beginning in June 2015 and you know, because I have already told you this, that to help us we are going to just mark between us a number of events, some of which you weren't a direct party to but we can just make sure that they are not disputed fact and everybody can therefore follow what the context of it is.

So if we begin with the death of Child A, the date was 8 June 2015. Now, that wasn't a child that you were involved in the care of, is that right?

A. That's correct, yes.
Q. We will come to Child C which I think begins at paragraph 104 in your statement but just --
A. What paragraph was that again?
Q. Paragraph 104, page 30 if you want to turn to it.
A. Sorry, it might be my hearing but the echo I sometimes miss the number.
Q. Not at all.
LADY JUSTICE THIRLWALL: You are not alone.
MR DE LA POER: So the next date is the sudden and unexpected deterioration of Child B, the date for that for those deteriorations 9 and 10 June 2015. Again not a child who you provided any care for?
A. That's correct. But I did hear about those children, there was concern in the department about them.
Q. We are going to come and have a look at some of the documentation about that.
So we come to Child C which, as I say, is dealt with in your statement from paragraph 104 on page 30 and Child C died on 14 June of 2015?
A. Yes.
Q. If we just run through some of your involvement, and I am not going to rehearse all the

medical detail that you provide, it is extremely helpful and we are very grateful, but we just need to understand your involvement as you would have understood it at the time.
Do we see from your paragraphs 108 and 109 that you were at home and you received a call to attend?
A. Yes, it was at night, yes.
Q. The request was for your presence urgently and you arrived within just a few minutes?
A. Yes, fairly quickly, yes.
Q. And when you arrived full resuscitation was in progress of Child C?
A. Yes.
Q. It was not successful and was stopped after 30 minutes?
A. Yes.
Q. Now, what you say at paragraph 118 is that you learned from Dr Davis in her police statement that there was no response from Child C to the resuscitation which you comment is unusual.
A. I note -- I think she said in her statement it is unusual.
Q. Yes?
A. But I would agree with that.
Q. You would agree with that?

A. It is unusual in a child who has suddenly deteriorated. Sadly, resuscitations after cardio respiratory arrest, that's a combined failure of circulation and breathing, sometimes the patient of any age, including neonates, does not respond, but particularly if they have been ill for some time and steadily deteriorating, they have no reserve left. When a baby suddenly collapses you would hope to get some response, even if it is not sustained you would -- and you would sometimes hope you would get a good response and save the baby.
So it is unusual from a sudden collapse in the baby that was managing well beforehand not to get a response to resuscitation.
Q. I think what Dr Davis has said in her police statement wasn't something that you were aware of at the time; is that right?
A. I wasn't aware of what at the time, sorry?
Q. That there had been no response to resuscitation or was that something that --
A. No, I was yes.
Q. You knew that at the time?
A. Well, yes, I attended 10 minutes into the resuscitation, yes, and there was no response from that point onwards. I think I was told there was no response

beforehand. But I wasn't there at the very beginning, if that's what you mean, but I knew there was no response to the resuscitation, yes.
Q. Child C was referred to the Coroner?
A. Yes.
Q. And was your reasoning for that that you weren't able to sign the death certificate?
A. Yes, I didn't know why Child C had collapsed and died.
Q. And in terms of your concerns and suspicions at the time that something unnatural may have happened or something very wildly out of the ordinary, you didn't have any such concerns at the time; is that right?
A. Yes, not at all.
Q. We will come to the point at which your concerns come to the forefront of your mind but we will move on from Child C to Child D and again, Child D died on 22 June 2015. But I don't think that that was a child that you were closely involved in the care of?
A. That's correct, I was not involved.
Q. If I can just pause here. You have had an opportunity, and we can bring it on screen, if you want to see an extract from Ruth Millward, the head of risk and safety's opinion, do you recall reading that it was just an extract from her witness statement?

A. Yes. I think, along the lines that she wasn't aware of these problems, is that correct?

Q. Well, let's just go to page 56. Paragraph 260.

What she says, and here she is talking about the three deaths that had occurred in relatively quick succession:

"I now recognise it would have been appropriate for the hospital to have reported the overall increase in neonatal deaths that occurred in June 2015 as a serious incident. This would have then triggered a comprehensive investigation into the increased mortality rate at a much earlier stage. However, given the small number of cases reviewed this may not have resulted in Letby's earlier suspension."

So we don't need to worry about the second part of it but the first part, identifying cluster of three deaths as a serious incident, is that something that you agree with Ruth Millward about that or disagree or is that not for you as a Consultant paediatrician to be getting involved in?

A. I will -- I am prepared to comment on that.

Q. Yes.

A. This partly relates to my confusion about how risk management works. I don't understand what

Mrs Millward means by "would have been appropriate for the hospital to have reported the increase in deaths as a serious incident".

I thought they were, I thought there was a Serious Incident Review of the first three deaths, I thought it had happened.

Now, whether it had been reported to the right channel and gone to the right committee and been reported from the hospital to someone outside the hospital, I don't understand that part of the working of clinical risk management.

I thought these deaths were reported as a serious incident and I thought they were reviewed including the Director of Nursing being involved in that review.

Q. I think, although she will speak for herself, what she is saying is that whilst each of them may have separately been identified as a serious incident, it is identifying a serious incident in relation to all three. So the cluster is the incident, not the individual occasion of each death, I think that's what she is saying, but she will tell us because she is coming to give evidence later?

A. Yes.

Q. But if that's what she is saying, is that a process that you understand or can comment upon?

A. The cluster was dealt with as a serious, unexpected or untoward incident, the cluster of the first three deaths and the Director of Nursing was involved in that review, I understood.

Now, whether we have reported it as a hospital to the right authority or classified that serious incident in the right way I don't know but it was -- I thought it was dealt with as a serious incident and all three deaths were looked at together.

Q. Well, I am sure we can ask her about it when she comes. Thank you very much, Dr Gibbs.

A. Well, also the people involved in that, because it would be Dr Brearey, one of the risk managers and the Director of Nursing were involved in that Serious Incident Review. Maybe it didn't get to Mrs Millward but other senior people were involved in it to my understanding.

Q. We can take that document down. We are going to --

A. It is possible that the right Datix form wasn't filled in for that but it was reviewed as a serious incident.

Q. We are going to just move forward in time to the 23 June and here we have INQ0025743.

Again, my Lady, the hard copy of that is in your

core bundle which is two lever-arch folders, so I am not sure --

LADY JUSTICE THIRLWALL: That doesn't matter, I can look at it on the screen, thank you.

MR DE LA POER: Thank you. Can we please go to the final email. So let's just scroll to the bottom of the thread. This is an email from you dated 23 June 2015, 10.04 to your Consultant colleagues.

I will just read the first part out and you can then speak to the generality of it.

"Rachel Lambie ..."

That's Dr Lambie?

A. (Nods)

Q. "... came to see me this morning, I think because I was the only person in the office when she came, to say the Registrars are very concerned about the recent neonatal deaths and collapses where [Child B is identified] all the infants showed a strange purpuric looking rash that probably wasn't true purpura. However, I pointed out that Child C who also died did not have this rash but it's true that Child A Child B and the recent death, Child D, did show similar strange colour on collapsing. Rachel also said that all the neonatal nurses are very worried. They feel we ought to do something and also what else different the Registrars

can do".
So if we just pause there. You had had a conversation with Dr Lambie?
A. Yes.
Q. And have you summarised in that email everything that we need to know about the content of that conversation. Does that capture the nature of it?
A. As far as I can remember from eight years ago, yes, that's the essence of it. And the reason I said that sort of slightly facetious remark probably because I was the only one in the office, I had been involved with Child C but not Child A, Child B and Child D. It is absolutely fine for a Registrar to come and talk to any Consultant about a concern, but my colleagues had been involved and I think one or two of them had been involved in three of those four. So I was passing this message on because they had more experience, particularly I didn't feel Child C had the same rash that I was told the other three babies had, but I had never seen that rash because I wasn't involved with those three babies.
Q. The final paragraph you said:
"Although I have mentioned we are looking into this I am not exactly sure how this is being done."
You then go on to speak directly to Dr Brearey and

Dr Jayaram and propose a meeting just to allow people to air concerns?
A. Yes.
Q. Do you know if that meeting ever took place?
A. I don't think so. I can't remember now whether it did or not. Unless the Inquiry Team have the document from that meeting I can't remember if it ever took place. I think -- from the email correspondence above, I think my colleagues were going to talk to different Registrars rather than have a meeting of everyone together, I think that's what the emails say about --
Q. Let's just scroll up, please.
A. That was in lieu of the meeting, I think. Our worry at this stage was that we had some medical problem on the unit like some -- and you do get superbugs or some nasty infection or, as has happened on some units, contamination of the feeding fluid for babies, there was something that was affecting all these babies. But they seemed to have different problems and Baby C to me seemed different to what I was told about the other children.
Q. If we can just scroll down a little, please. Are we able to scroll? It is buffering. I think we have jumped to the bottom of the thread again.

A. But even at the top that we just saw, my colleague Dr Brearey is suggesting how to deal with it and not a presentation -- well, they are going to be presented at the morbidity and mortality meetings, exactly how we fed back to the Registrars at the time I can't remember.
Q. Well, let's see. I think if we put it in -- we can just see that Dr Newby in a reply says:
"I agree. I have just been grilled by Dave Harkness. This is causing a lot of concern and upset."
Dave Harkness being Dr Harkness who again was one of the Registrars I think on --
A. Yes, he was, a colleague of Dr Lambie, another Registrar, yes.
Q. The email threads goes on, we don't need to look at the detail of it, but in short, we can see that Dr Brearey mentions the PMM tomorrow afternoon:
"Please encourage all juniors and nurses to attend and discuss in this forum rather than privately"?
A. Yes, that was one of the morbidity and mortality meetings. And also I might be wrong here, so as I say I am sure you will look into this.
I thought the three other babies yes, the -- yes, the three babies Child A, Child C and Child D were

looked at as a serious incident together as well. But that wasn't with the Registrars that was with the Director of Nursing, Dr Brearey and one of the team from the risk management department.
Q. So we are going to move forward from 23 June to 29 June and here we will look at INQ0036166. This is a senior clinicians meeting that you attended on 29 June.
We don't need to look at all of the detail of it, I know you have had a chance to see this before. We can go to the second page, please, the fourth paragraph. We can see where it.
Says: "There was also an issue raised round the fact that with the three recent neonatal deaths the Registrar had been quite worried and feel that nothing is being done. Behind the scenes reviews are going on but it was felt that formal debriefs should probably take place rather than any specific meeting to discuss all three."
So again at that time would you agree, Dr Gibbs, it seems that the Registrars are making known their particular concerns to the Consultant body?
A. Yes. And I was only involved with Child C and there a debrief was held on Child C, I think a few days before 29 June, that involved the Registrar and some of

the nurses who were concerned with Child C's sad death.
It was actually Dr Davis that was mentioned before, another one of the Registrars, it wasn't Dr Lambie or Dr Harkness. So at least for one of those babies a debrief had taken place with the Registrar and nurses who had been involved in the resuscitation of Child C. I am not sure what debriefs took place for Children A,B and D.
Q. Now you have mentioned second -- forgive me, you have mentioned a serious incident meeting. We may be able to bring that up now, INQ0003530. This is 2 July and if you want a reference for yourself, Dr Gibbs, I think if you look at paragraph 72 on page 22.
I'm sorry to make you move around, you might want to keep a finger in where you are but page 22, paragraph 72.
INQ0003530. Now, this may have been what you were referring to earlier. SUI, serious untoward review, 2 July of 2015. Now was this a meeting that you had attended or did --
A. No, I didn't attend that but I knew it had taken place and Ruth Millward was at that meeting because she -- at the top line there "RM" I presume is her. There might have been someone else who has those

initials. "SB" is my colleague Dr Brearey, "AK" I assume is Alison Kelly, the Director of Nursing.
Q. We will ask them about the detail of it. We can take it down, that's to mark that moment. But you comment upon that meeting in your paragraph 72, just saying that:
"There were informal discussions between Consultants around July 2015, several had been involved with the death on the NNU. It was recognised that Letby had been present on each occasion."
A. Yes.
Q. So Letby's name had come up as a common factor in July of 2015?
A. Yes. Yes, I can't remember how, obviously it had obtained greater significance as time went on and that association persisted, but I can't remember if we looked closely or considered in our informal discussions, and being informal unminuted discussions, there is nothing to go back to check, which is a problem.
I am not sure how closely we considered other members of staff as well because some of them might have been involved in several of those and obviously Letby wasn't the only nurse involved in all of those. I don't know if she was the only common factor but she was noted

because she was involved in the resuscitation for all four babies.
Q. Just help us to understand the terms in which her name came up. At this time, you had no suspicions of any deliberate harm being caused to babies?
A. No, and in fact, felt sympathy for Letby at that time because felt she had been unlucky to have been involved in a number of incidents. It can happen to any of us, and it's happened to me during my career, that you have a bad run where when you are on-call or on duty; in a short space of time, a number of unfortunate incidents, cot deaths and other deaths may happen. But then that stops happening if it is just an unfortunate coincidence.
Q. Now, if we can just complete the 2 July because that meeting, the serious untoward incident meeting wasn't the only meeting that took place. Also taking place, and we will bring it up INQ0000108 -- forgive me, I can see you are indicating, Dr Gibbs.
A. Sorry. But that's a Serious Incident Review meeting and I don't understand -- and it involved those babies. I don't understand why Ms Millward said it wasn't reported as a serious incident and those deaths together weren't reported. What were they having that meeting on all those deaths together for with the

Director of Nursing and Ruth Millward herself if it wasn't reported? Does it only mean the right form wasn't submitted through Datix? I don't understand.
Q. Well, you can rest assured she will be asked.
We are going to go to page 178, please, and here we can see within Child C's notes that on 2 July there was a Sudden Unexpected Death in Infancy Childhood additional strategy meeting and you are one of those identified as being present?
A. Yes.
Q. We don't need to go into the detail of the discussion then. You have told us in clear terms you weren't suspicious at that time of any deliberate harm being caused but just help us with this.
You didn't, as I have understood your evidence, think that SUDI applied to deaths in hospital, but this meeting appears to be a SUDI meeting. So just help us to understand that?
A. Right. Maybe I should qualify what I meant about SUDI not applying in hospital. Of course sudden unexpected deaths can occur in hospital and can occur on a neonatal unit, but if you are talking about the guidelines on the procedures for managing a SUDI, which includes what is known as the Joint Agency Response, the JAR, I didn't think that applied in hospitals to a baby

that's never been home. I thought that applies to cot deaths that occur in the home.

So the actual: can a baby die suddenly in hospital? Yes, and that's a sudden unexpected death. I didn't think the procedure that involved the JAR applied to babies who had never been home.

Q. And so just in summary form, what was the purpose of an initial strategy meeting then?

A. Because all child deaths have to be reported through the CDOP procedure, Child Death Overview Panel, and most -- most of the babies on our neonatal unit came from the West Cheshire area. A few come from the Wirral area and a few come from North Wales and they have different CDOP or CDOP related processes in those areas.

I was a little surprised to come to this meeting because I wasn't normally expected to come to CDOP meetings for the majority of our babies who come from the West Cheshire area and I thought *(redacted)*.

Q. Thank you. We can take that document down and then finally --

A. Even on this document, you have not shown it, which might have been embarrassed me but I saw this and I realised: on that document there, it does say "no police involved" and you might say why did I think that should be there if we don't normally involve the police

for a baby who dies on a neonatal unit? This is a generic form and it is the same sort of form that would happen with a review meeting for a typical cot death baby and that's why I thought there was a little box there for saying are the police involved or not.

Q. I understand.

The last event on 2 July was, as I am sure you will take from me but we can look at the document, a debrief in relation to Child C. Does that accord with your recollection?

A. On 2 July, wasn't it?

Q. Yes.

A. Right, fine, I was wrong then. That meeting on the 29th when we talked about having debriefs was just before the debrief we had on Child C. Sorry, I thought it was the other way round in time.

Q. That's fine. Unless you want to, there is no need to go to the document, but that's date we have got?

A. Fine, fine.

MR DE LA POER: So I think that that concludes 2 July 2015 and, my Lady, I note the time. Would now be a convenient moment?

LADY JUSTICE THIRLWALL: Yes, indeed. So, Dr Gibbs, we are going to take a 15-minute break so would you be back, please, at 25 to 12.

(11.18 am)

(A short break)

(11.35am)

LADY JUSTICE THIRLWALL: Yes, Mr De La Poer.

MR DE LA POER: Dr Gibbs, we will move forward to Child E which, if you want a reference so you have your statement in front of you, is paragraph 140 at page 43. I will try and summarise just a couple of points from what you say in your evidence.

You examined Child E on 2 August. There was a deterioration on 3 August which was unexpected and Child E died on 4 August, is that your understanding?

A. Sadly that's my understanding, yes.

Q. What you say at paragraph 142 is that it was surprising that Child E rapidly deteriorated and died?

A. Yes. That's after I had found him well the previous day. Others who were looking after him the day he died will be able to report how well he seemed before he suddenly collapsed.

Q. What you tell us at paragraph 144 is you were not at that time suspicious?

A. No.

Q. We move forward to Child F and the 5 August and again we are just continuing in your witness statement. I will try and give a summary. Child F had

persistently high glucose and was given insulin?

A. Yes, very early in life.

Q. Very early on. You had a discussion with Dr Harkness, you tell us in paragraph 147, about the management of Child F?

A. Yes, and just to set it into context the fact he required -- Child F required insulin in the first day or two of life for a short period, he had been off insulin for quite a few days before the incident we are now going to talk about.

Q. Yes. You examined Child F at about 8.30 in the morning of 5 August; is that right?

A. Yes, yes.

Q. But what you tell us in paragraph 156 is that although you can't say exactly when the blood results were required, you were not -- you yourself didn't see the results of the blood result?

A. That's correct. I had been on-call over that night and that's why 8.30 in the morning I had a look at -- examined Child F. I knew he had a low blood sugar at that time I thought the most common problem which is not unusual in neonates -- newborn babies -- is that he probably had an infection and when babies have infections they can drop their blood sugars.

During the rest of the day when a colleague was

looking after Child F, he continued to have low blood sugars despite needing quite a lot of extra sugar given in the intravenous fluids he is receiving and that's why in that unusual context he had some special blood tests done.

Q. What you say at paragraph 157 is that -- and we will have a look at the insulin result in a moment:

"I believe it was a collective failure on the part of our paediatric team to not have recognised the significance of the insulin and C-peptide result in Child F in mid-August 2015. With hindsight this was a serious failure because we realised that Child F had been administered insulin and this was not indicated and had not been prescribed for him and this should have raised immediate and serious concerns either about possible deliberate harm on the NNU or that there were seriously deficient procedures and practices on the NNU that led to insulin being given to a patient accidentally."

A. That is correct. Those insulin results came back a week after they had been taken from Baby F, Child F. So it was a week later and looking at Child F's notes, certain junior doctors, training doctors, and a Consultant did look at those results. It is recorded in the notes and it seems to me they didn't

understand the significance of those results.

I wasn't aware of those results at the time. Now it's easy for me to say I wasn't aware of those results, I wasn't on the ward on that day therefore I don't -- it has no effect on me. I did look after Child F when I was on-call on subsequent days a few days later, so did some of my colleagues. We all had the opportunity to look back at those results although we would normally do so if we were still concerned about the baby and Child F's blood sugars came back to normal quite a few days before those insulin results came back. But any of us could have seen those results. So I don't think it is fair to say just those few doctors who saw the results didn't respond appropriately to them. We all had a chance to look at those results.

Q. If we can bring up INQ0000861. We have got two documents just to bring up. Now, is this the form that you would expect to see the results on your system?

A. No.

Q. No. So we can ask somebody else about that. We can then go to INQ --

A. I did -- I assume this is a lab not a ward based result, but I am not sure but as I say, others can confirm that.

Q. INQ0000862. Is this a more familiar view or

not something that you would see when accessing the notes?

A. No, this isn't a view I would expect to see. No. And I wasn't aware of the comment on the middle right-hand side.

Q. There is a query there about exogenous, meaning externally administered as opposed to generated by the body?

A. That's correct, yes. Now, I have assumed -- and again others can confirm this -- this is a screen that was used in the laboratory. If it was a screen that we should have seen at ward level I didn't know how to access this particular screen, which is a problem, but I think it's a screen that the lab used rather than we would see at the ward level when looking at patient results.

Q. That was exactly why I wanted you to have a look at it and give us your comments on it.

Thank you, that can be taken down.

The phrase that I read out to you at 157, the second sentence, you say:

"With hindsight this was a serious failure ..."

Can I just ask why you have applied the words "with hindsight" to this?

A. Because I didn't know this result until about

two years or so later when I was preparing a statement for the police and then I came across this result. I suppose for those that knew the insulin results on the day or the day after they came back a week after the bloods had been taken, then maybe that's not -- they might not say with hindsight, they will have to explain why they interpreted them in the way they did.

But with hindsight I didn't even know -- I didn't know these results until a few years later. Looking at those results -- and I have to admit as well, I had to check what is a significance of a C-peptide as opposed to the insulin level so you would need to look that up. I am not sure most paediatricians would have that in their head immediately, it is an uncommon blood test to request that realising it meant this was likely to be insulin that had been injected into the baby.

Q. We are going to continue to move forward in our timeline. We need to return to Child C. You deal with this at paragraph 120 of your statement, page 36. This is your discussion with Dr -- now you will help me with the pronunciation?

A. Kokai.

Q. Thank you, who is a pathologist?

A. Yes.

Q. About the postmortem results?

A. Yes.
Q. For Child C?
A. Yes.
Q. We don't need to go into the science of it or the medicine of it. But following your conversation with Dr Kokai, were you satisfied at that time that Child C's death had been adequately explained or did you still have concerns?
A. I was satisfied that the death had been partly explained. When requesting a postmortem on a child who's died, particularly when it was a sudden or unexpected death and when the cause is unclear to myself at the ward level, you are hoping that the postmortem will find a cause so that you can explain to the parents why their child died. It will not compensate for the tragedy of losing the child but it is logical to help a bit to have an explanation for the child's death and some causes of death will have an influence or possible consequences for future children or pregnancies and so on.
So in a way it was a relief to find a cause for death. But without going into the detail again, because of the unusual nature of the resuscitation and then *(redacted)*, I wasn't sure whether the damage to the heart that was noticed on this postmortem would have all

happened at and after the resuscitation or whether it happened before. It was Dr Kokai's view that the damage to the heart had happened before the resuscitation and therefore caused the collapse but it didn't fully explain it because I then asked "but why did the damage occur to the heart?" So you keep going back one more step. But with Baby C being an at-risk baby, very small, growth retarded, difficulties with perfusion from the placenta, the afterbirth, before the baby was born possibly that might have explained why the heart was -- had suffered this insult. But it didn't quite fit together.
Q. In terms of your state of mind in August 2015, does it follow that whilst you weren't entirely satisfied with the explanation that you had been given, you didn't think that there was any more investigation that was required --
A. Yes.
Q. -- by you?
A. Yes.
Q. At that time you were not suspicious of any deliberate harm being caused by anyone?
A. Yes, because sadly it had been my experience even after postmortem it is not always possible to explain a death and that is occasional. When that

situation keeps arising, something very strange is happening.
Q. Just to bookmark 21 August 2015. We understand that you had a discussion with Child C's parents, I am not going to ask you about that but it may be you will be asked some questions about it later, so we will move forward to September 2015 and Child G which you deal with at paragraph 159 on page 48 and following.
Again, as before hopefully, Dr Gibbs, I can be efficient about this, just pick out from the following paragraphs that Child G was transferred to the Countess of Chester at 11 weeks of age, they experienced a rapid collapse on 7 September 2015, something that you weren't involved with, transferred back to Arrowe Park.
A. That was a severe collapse requiring ventilation.
Q. Yes. There was -- they then came back to the Countess and there was a collapse on 21 September 2015 which you tell us about at paragraph 163.
A. Yes.
Q. And you were involved in the care of Child G following that deterioration and you describe at paragraph 172 that you were slightly surprised at the time of the deterioration but not too surprised?
A. Yes. I have a problem with -- and I think

there is a problem with -- what we mean by a collapse in a baby and I do mention this in my statement and maybe we don't want to go into it in too much detail now.
We recognise when a death has occurred and we can monitor those events. I am not sure that we know exactly what a collapse is in a child. Different people will mean different things.
I wouldn't have said that Child G collapsed in the morning of 21 September, had a vomit, dropped the oxygen level but actually didn't need any resuscitation. Later on that same day, Child G dropped her oxygen levels again and did need some resuscitation so that second one was more of a collapse. But in the literature different definitions are used for "collapse", why does that matter, if you want to monitor collapse, there is a warning that collapses may be recurring too often in a unit and might indicate a problem on that unit. You need to be able to define what a collapse is and I wouldn't say Baby G had a collapse in the morning of 21st but she did have a collapse later on.
"Collapse" normally means in everyday language a fall to the ground often with loss of consciousness. That obviously doesn't apply to babies, but whether you mean the heart or the breathing is compromised what level of support that requires is all dependent on how

you define a collapse. That's not so relevant to Baby G just now, it is relevant if you want to monitor collapses as a warning sign on a unit that there is too many collapses going on.

Q. And in terms of your overall reflection following your involvement with Child G, your position was that you had some concern about the vomiting that you had been told about, but you weren't otherwise concerned or suspicious about the circumstances that you had been involved in?

A. Yes, and could I just add with Child G, I feel I was misleading myself, I felt Child G was a very vulnerable baby, extremely premature baby. She had a number of collapses. I now know that some of those collapses were induced by Letby. I didn't realise that at the time. So I felt this is a baby who is prone to collapses so I wasn't too surprised when that baby had a few difficult spells on that day and I must say when we come to it, the same applies to Child I.

Q. If we move forward, please, to Child H, this is paragraph 181 on page 54. Again, just summarising, I hope I am using the word "collapse", maybe I will use the word "deterioration". There was deterioration in Child H due to oxygen desaturation; is that right?

A. Yes.

Q. You conducted an assessment of Child H and Child H subsequently responded well; is that right?

A. Yes.

Q. That's your paragraph 188, I think.

A. Yes, before then other doctors -- the Registrar had intervened and given treatment and at that time, the baby responded well to the treatment.

Q. There were further collapses on 26 and 27 September 2015?

A. Yes.

Q. As you say you told the police that the number of sudden deteriorations were unusual in such a short period of time?

A. Yes, and most of them at night, yes.

Q. What you say at paragraph 193 is that both you and Dr Jayaram noticed that Letby had been the nurse caring for Child H?

A. Yes.

Q. So just to help us to understand that, was that a conversation between the two of you at around this time in September or was that a subsequent conversation where you referred back to Child H?

A. I can't clearly remember now. I think it's -- it was a looking back at it when we were trying to make sense of the number of collapses and deaths that were

happening and then realising that Letby was around for many of the ones. Not all of them.

Q. So not at the time?

A. No, I knew she had been involved at the time because I was there helping baby -- Child H and Letby, amongst many other nurses, was around helping. But trying to work out was she always there for each of those and had she been there for previous collapses or deaths, that was looking back at them when I started to get more concerned and I can't remember exactly when. I would say towards the end of 2015 but more so at the beginning of 2016.

Q. I am just going to look briefly at an email that you sent to Dr Mittal, or Dr Mittal, if I have pronounced that. INQ0103110. This is on 28 September. I make clear this isn't a reference to an indictment baby. Your email is at the bottom and over the page. What I just wanted to ask you about is on page 1, please.

At the bottom, firstly if we just scroll up a tiny bit we will see Dr Mittal's sign-off. He is a Consultant paediatrician in the community and designated doctor for safeguarding; is that right?

A. Yes.

Q. You said in this email "we have had another

neonatal death"?

A. Yes.

Q. My question really was to what degree insofar as you were aware had Dr Mittal been kept informed of the neonatal deaths that had taken place in 2015?

A. As designated doctor for safeguarding, we sent the CDOP, Child Death Overview Panel, forms to Dr Mittal for each the deaths.

Q. So you would have expected that Dr Mittal had received such a form in respect of every death --

A. Yes.

Q. -- on the neonatal unit?

A. Yes, but depending on where the child lived. He would have received forms for every baby on the neonatal unit whose parents lived in West Cheshire. There were a few from the Wirral, *(redacted)*.

Q. Can I just stop you there. We are not going to go into the other areas, you haven't said anything wrong, but were there other areas that would not have been sent to Dr Mittal?

A. I am not sure. I thought they all went to Dr Mittal or his secretary and those babies whose parents didn't live in West Cheshire, those forms would be sent to the other areas.

But the babies who lived in West Cheshire would

stay with Dr Mittal. Whether he was aware of the babies whose forms had gone off to the other areas or not I don't know.

Q. Well, you can rest assured he will be asked.

We are going to move forward to Child I who died on 23 October -- we can take that down, thank you very much indeed, on 23 October 2005. You deal with Child I at paragraph 196, page 58. Again, I will just do as I did before, try to summarise what you say. That Child I was born at the Liverpool Women's Hospital, transferred to Chester, transferred back to Liverpool and then transferred back to Chester. That's your 196. Is that right?

A. Yes.

Q. There were significant breathing problems over three nights, you deal with that at 198?

A. Yes.

Q. Transferred back to Arrowe Park with suspected necrotising enterocolitis, (NEC)?

A. Yes.

Q. Back to Chester two days later?

A. Yes.

Q. And then five days after return to Chester, the sudden drop in oxygen saturation which resulted in you being called in?

A. Yes.

Q. Upon arrival you found that Child I had improved remarkably, that's your paragraph 201; is that right?

A. Yes.

Q. You were then called back in just an hour later following the same pattern of deterioration as you say at paragraph 203?

A. That's correct.

Q. Child I did not recover from that second deterioration that you attended?

A. Yes, tragically not, yes.

Q. Was, so far as you were concerned, Child I's death sudden and unexpected?

A. To an extent. And the reason I say that it was a sudden collapse and Child I did it twice that same night. But as you already recounted a few weeks earlier over consecutive nights Child I had had serious collapses and Consultants had been called in each time so a little like Child G, I had gained the impression that Child I was quite a vulnerable, very premature baby -- had been a very premature baby and was prone to these collapses. I didn't realise then that the earlier collapses have now been attributed to harm by Letby. So I thought this was a baby who was quite precarious who

decompensated quickly.

Q. You tell us at paragraph 4 that you were unsettled by Child I's death?

A. Yes.

Q. Now, you have mentioned that the collapses the period before, one of the matters the Inquiry is investigating is whether Letby was moved off the care of Child I on one shift because of concern with her association with those collapses, so that's a matter that we are investigating. My question for you is: is that something that you were aware of?

A. No.

Q. If that had occurred, is that something that you would have expected to be told about?

A. It -- no, depending on the reason for moving a nurse off a particular -- was it off particular shifts or off care of that particular patient?

Q. Off care of that particular baby is our present understanding, we are investigating.

A. Oh, right. If it was thought that nurse was harming the baby then we should have -- well, probably we should have all known. When I say "we", Consultants and senior nurses, not everyone in the department.

If it was a concern that -- which I had understood later on was the reason for moving Nurse Letby off

different shifts, if it was a concern a nurse had been unfortunate in experiencing a series of stressful conditions and therefore like we felt early on it was unfair on her, then to move her out of that situation is not an unreasonable thing to do. So it depends on the reason she was moved from that patient.

Q. If it was that first reason, ie somebody was sufficiently concerned that she might be causing harm to the babies, so not for her emotional welfare --

A. Yes.

Q. -- is that a situation that you would expect that if somebody is taking that step, that they would also take other steps as well, such as notifying senior management?

A. Yes. But she should be removed from all patient care in that situation, as happened much later on.

Q. Yes.

A. Rather belatedly in June or July 2016.

Q. I am just going to read you part of the transcript from Mother I and just ask for your comment on it, please.

She says:

"Dr Gibbs said that our baby was basically a full term baby and these collapses shouldn't have kept

happening. He mentioned about our baby having a postmortem examination. I said I didn't want her to have one as I wanted her leaving alone but he informed me that I didn't have a say and that she needed to have one as her death had been unexpected and the results would be needed to clear the hospital."

Is that a conversation that you can recall and if so, what were the terms of it?

A. I can't recall that exact conversation. I can't imagine why or how I would ever have used that final phrase. The reason for doing a postmortem in a baby who's just died is to try -- if you need a post-mortem because you don't know the cause of death, is to find the cause of death for reasons I have already mentioned in associated with Child C.

It had nothing to do with clearing the hospital or anyone else and I can't imagine -- I don't think -- well, it is difficult, I am sure Mother thinks I said that, so I am not going to argue with her in her -- at the time in her grief. I would never have said something like that.

Now, she also said I forced her into having a postmortem. I can understand why she felt like that. In the circumstances where a death is unexplained and you need to refer the death to the Coroner, you don't --

parental consent doesn't come into it as far as I understand and postmortem has to take place if the Coroner agrees and that's what I was trying to tell the Mother.

It's -- one of the worst things as a paediatrician is those occasions when you have to deal with a parent who's just lost their baby or child and they are in utter despair and it is very difficult to talk about the child or baby having a postmortem in those circumstances. I think most parents or some parents would hate me for bringing that subject up.

Q. I just want to bring up another document to ask you a very focused question about it. INQ003288.

A. Can I just make one comment about Mother I. I thought it was really kind of her in her statement and in the transcript that although she said she didn't like me, I think something like that, and that I had forced her into the postmortem, she did make the comment I think and it is in her statement, that maybe it was the mood I was in or something like that, at the time, and that her mother thought that I was fine who was there. That's very kind of her to add that, she didn't need to add that because I am glad that at least to the Grandmother of Child I, I didn't appear quite so horrible as Mum perceived me, but I can understand

asking a parent -- well, telling a parent their baby has to have a postmortem would be received very badly by some parents.

Q. Thank you very much indeed. This is on 26 November 2015. It is a meeting that you attended neonatal mortality meeting. You deal with this in your witness statement. It is indicated at the top the period of assessment is August to October 2015, but Child E, as you observe in your statement, is not included in this review. Do you know why?

A. No.

Q. Bearing in mind that that was the period of assessment, do you think Child E should have been included in this review?

A. Yes, if Child E hadn't been reviewed in another meeting and as we say, this is the neonatal mortality meeting. There are also perinatal obstetric and paediatric morbidity mortality meetings that run at other times and Baby E might have been discussed then. Do I know that Baby E definitely was discussed? No. I don't have a record of that, but I am not trying to put all the responsibility on Dr Brearey as our lead for neonatology, if anyone has a record of that when Baby E was discussed at a morbidity meeting, Dr Brearey will hopefully have a record of that.

Q. Thank you. We will move forward to the back end of 2015. Child J. You deal with Child J at paragraph 213, page 63. Again, in summary, there were a number of desaturations and seizures and your position as you set out at 224 was there was an explanation for the seizures but not the desaturations.

A. I think a possible explanation for the seizures.

Q. Yes, possible explanation, but not for the desaturations?

A. No.

Q. Now --

A. But Baby J was a complicated baby with -- it is all there, so I won't go through it, with a problem we didn't often deal with, seldom dealt with on the neonatal unit related to her bowel and the surgery she had undergone and the need to manage her stomas.

So that increased the number of unusual conditions that might have caused the problem to Baby J.

Q. But we are now, according to your statement and the evidence you have given, in the general vicinity of when your concerns were starting to come to --

A. Yes.

Q. -- coalesce, if you like?

A. Yes, and I have to admit and I don't know how

poor Baby J's parents might take it, Baby J didn't feature in my concern.

Q. Are you able to identify, and I know you have given this a lot of thought, whether it was a particular incident that caused that or was it simply a thought that crossed your mind that you began to focus on and think about more deeply?

A. Thinking of Baby I's death and then thinking back to Baby C's death, the two babies I have been involved with, by the -- and it is not that I don't want to give a date, I can't remember exactly when I became concerned something unusual, not natural, might be happening on the unit, maybe the end of 2015 or early 2016 and when we come to it, the thematic review helped to sort of concentrate the concern.

Q. At that stage when the concern first came to your mind, was Letby among the thoughts connected?

A. I don't think so, when it first came to mind. But it -- looking back at them, talking to colleagues realising the only common factor that we could identify was Letby, that became a concern, yes.

Q. Do you think that was before the thematic review in February 2016 or after?

A. I am not sure. Maybe a bit before. The thematic view helped to confirm it.

Q. Can you recall which of your colleagues you were speaking to?

A. No.

Q. Are we talking Consultant colleagues --

A. Yes, yes.

Q. -- though? When Letby was first identified as being connected in your mind to the concerns you had about something being wrong on the unit, and you were speaking to others, were you speaking in terms of the possibility that she was causing deliberate harm?

A. I am not sure, which isn't -- doesn't mean I am saying no, I am not sure when I first had those concerns that we were talking about deliberate harm but that did come later. It is something that came up from time to time. I was aware of what had happened at Stepping Hill Hospital and I was aware not only that patients had been harmed and some killed with insulin, that the wrong nurse was accused because she happened to be on duty every time and someone else had done it but managed to conceal their activities and so on.

So thinking about might Letby have done it, I was also aware that Letby might be completely innocent and it was just a coincidence as it was at Stepping Hill for the nurse falsely accused.

Q. Although in the Stepping Hill case, there was

still a perpetrator?

A. Yes.

Q. Just not the person who was first identified?

A. Yes.

Q. So we will move forward to the thematic review of neonatal mortality, that's 8 February 2016.

A. Sorry, can I -- you are absolutely right about Stepping Hill. I was just trying to think. But I had been aware and I have mentioned it earlier and we were talking about the earlier deaths that I had been in a situation where I have had two cot deaths in one week and they happened in the community and then another child from an accident dying. So within a short space of time expecting just one death every year or two, there were three.

So you don't have to have a perpetrator to be unfortunate and be on duty when sad events keep happening. I did know that Staff Nurse Letby tended to be around on the neonatal unit a bit more than other nurses because she did extra shifts.

Q. As these thoughts start to come to your mind, and I think as best we can we have date-stamped them end of 2015/beginning of 2016 and at least the possibility that somebody might be causing harm to babies, came to your mind, did it occur to you that bearing in mind

Stepping Hill, bearing in mind Beverley Allitt and insulin, that one useful investigation that might have been done as 2015/2016 came about was to look back at insulin results, was that something that you thought about as something that you could do at that stage in conjunction with your Consultant colleagues?

A. No, it didn't. At that stage there was one insulin result by that stage.

Q. Well, quite. Do you agree that had you thought in those terms there was a result to be found that would have immediately raised a very large red flag?

A. Yes. But I had been involved with Baby F early in the morning, about 8, 8.30 in the morning on the neonatal unit when his blood sugars were low and at that time I thought it was possibly due to infection. I can't remember whether I knew he went on to have insulin blood tests after that.

Q. The thematic review of neonatal mortality was -- just so that everybody understands it -- arranged to look back at the deaths that had occurred over the course of 2015 and a doctor from the Network was invited to join?

A. Yes. From the Neonatal Network.

Q. Yes, again I hope I pronounce this quickly,

Dr Subhedar?
A. Subhedar.
Q. Thank you very much for the correction.
You didn't attend yourself the meeting which took place on 8 February?
A. That's correct.
Q. Before the meeting, did you have any discussion with Dr Brearey or Dr V who also attended about Letby or any particular concerns you wanted them to take into that meeting?
A. I can't remember. I was -- and as far as I knew from informal discussions, I think all my Consultant paediatric colleagues, so the other six, were concerned about the number of deaths and I think around this time, by 2016, definitely the realisation that Letby was being involved with most of them there were some deaths and collapses that I knew she wasn't around at the time but that -- that association was causing concern, yes.
That is -- not particularly to look at Letby to look at the deaths and try and find out why we had more than usual was the reason to have that thematic review.
Q. Now, I don't need to show you it because you have seen it already, but we know that there was a chart or spreadsheet produced by Eirian Powell at which

Letby's name was highlighted in red. Was this a document that you saw at the time?
A. I don't remember her name being highlighted in red. I did see the document with all the nurses who had been on duty for those deaths entered into it. I don't recall Letby being highlighted in red. I have seen several different versions of that document that were circulated between some time after the 8 February and up to about beginning of March. I am not saying I never did. I can't remember seeing one that highlighted anyone's name.
Q. We don't need to --
A. And you would have to look closely at it. You can see Letby's name for each of those, amongst many other nurses. The association wouldn't be immediately obvious if you didn't spend a lot of time trying to work out who is the common person.
Q. But it would be, do you agree, immediately obvious to you looking at it because by the time that chart was produced, you had Letby's name in your mind?
A. Yes.
Q. So from your point of view, an informed reader, you could look at that chart and note the frequency of the occurrence of her name?
A. Yes. Just a slight concern, as I say in my

statement. For some of those babies there were very few nurses's names and I find it difficult to believe that all the nurses who are around on the unit at that time was recorded on that chart for all of the babies and that just means just in case there is someone else that's been missed off.
Q. We will look at the thematic review document briefly in a moment when we get to the finalised version in March, but there was a CQC visit on 16 to 18 February and some of your Consultant colleagues were spoken to. I was just wondering, were you among the Consultants that were spoken to by the CQC?
A. I don't remember being one of them. If I was, it obviously didn't stick in my mind, I don't remember though. I knew there was a CQC visit going on.
Q. Would that meeting have been an appropriate forum, or indeed privately afterwards, to raise with the CQC concerns about the neonatal mortality that existed at that time?
A. Yes, but I wouldn't have thought it's appropriate to talk about a particular member of staff. There are other ways to deal with that rather than asking the CQC who happen to be visiting the hospital about that.
Q. So not specifics in terms of members of staff

but that is an appropriate forum, whether publicly or privately, immediately after the meeting for any Consultant who is speaking to an inspector to say: are you aware of the increasing mortality?
A. Yes, or to indicate in some -- that we are struggling on the neonatal unit, yes.
Q. At the same time as the CQC visit, Child K collapsed. Forgive me?
A. Sorry, just to go back to that CQC visit. It is a bit inappropriate though -- and I don't remember meeting the CQC inspectors, it is a bit inappropriate to just tell the CQC inspectors when they happen to be visiting if you haven't tried to sort that out within your own Trust management structure. It's almost like telling OFSTED you have got a problem with a teacher and you have never told anyone in the school, it would have to be an OFSTED inspection, you have never tried to deal with that problem within the school.
Q. But wasn't the position in -- on 17 February 2016 that the internal investigation at the ward level had been conducted with input from the Network and there still wasn't a clear explanation for the increase in deaths?
A. Yes, that's correct. The thematic review did identify some sub optimal care issues, none of them

thought to be very significant as in none of them thought to have caused any of the deaths. But that thematic review did highlight, as will be obvious if you look at the review point number 1, that there had been several -- it doesn't mention how many -- unexpected, unexplained deaths. That's the worry.

Q. Yes, I am just wondering, bearing in mind that that had been identified by the CQC visit, whether it wasn't time to tell the CQC about that and what your thought is on that subject?

A. I would have thought you deal with that within the hospital first and then go to the CQC if it's not been dealt with.

Q. So far as Child K was concerned, you don't mention Child K's collapse in your statement. That's not a criticism. Is that not something that you were involved in at the time?

A. That's correct. I don't think I ever saw Child K who was only on the unit for a relatively short time.

Q. We then come to the revised thematic review of neonatal mortality and we can go straight to the review and just look at a couple of parts of it. INQ0003251.

So this is the updated version although the date remains the same there, but you can take it from me that

this is the updated version. Page 7, the point that you have just made, that the first theme that was added to this as against the original draft was:

"Some of the babies suddenly and unexpectedly deteriorated and there was no clear cause for the deterioration and death identified at postmortem."?

A. Yes.

Q. The other matter to draw your attention to on this page is that it's been identified that six babies from 9 had arrested between midnight and 4 in the morning?

A. Yes.

Q. Was that something that you were aware of at the time, that that trend had been identified?

A. Not precisely, but I had been called in for some of those collapses -- these are all death babies. Some of the deaths and indeed collapses, babies who didn't die, like the earlier collapses of Child I, the week or two before Child I died, and they were all seen to be occurring in the early hours of the morning but I hadn't been involved in most of those.

So I wasn't aware that I knew that some of them had occurred at that time. I didn't realise 6 out of 9 had occurred then.

Q. Thank you. We can take that document down.

A. But I was aware of that once I saw this thematic review document.

Q. Of course. So that's 2 March.

Now, on 7 April, around that time Letby was moved on to day shifts. We know that now. What I would like to know from you, Dr Gibbs, is whether that's something that you knew at the time?

A. I don't think I did. Some time later or maybe -- not at the time, no. Some time later, like weeks later, I think I was aware and this I think, and I can't remember, it's trying to think back to eight years ago. I did not know at the time she was moved off nights, no, I think I knew some weeks later.

Q. If we move forward to Child L on 9 April 2016. Just going into the care that you were involved in for Child L. By this stage in April of 2016, your suspicions had begun to coalesce, is that right, that something was wrong on the unit?

A. Yes, and one aspect that made it more difficult to be not even sure, to try to help confirm those suspicions, was that there was a very strong argument being put forward from the senior nurse on the unit that this suspicion was totally wrong and that we were maligning Nurse Letby and that she was a very competent, safe nurse.

Q. So just to be clear about that. The conversation that you are aware of that involved the ward manager Eirian Powell saying that, did that occur before 9 April, was that?

A. Oh, I am not sure and my colleague Dr Brearey would probably know that because he met every month to do the clinical incident review with Eirian Powell, the ward manager, and someone from the risk management department. I think some of those meetings or in between those meetings Dr Brearey had had discussions and email correspondence with those people, but he will have to confirm when he had those meetings or discussions and what was said at those. I knew from Dr Brearey that there was a very firm push-back from the senior nursing level that this was utterly wrong and we were being unfair on Nurse Letby and I worried that were we being unfair, knowing about the nurse who was wrongly accused in Stockport.

Q. But you still had a suspicion?

A. Yes.

Q. And so if matters had reached that point where you had a suspicion about Letby, would say it appropriate at that time for you to do something?

A. Yes. But I knew efforts were being made by Dr Brearey to address that, not just with the ward

manager, but with the Medical Director and Director of Nursing. Exactly what he said and how he conveyed that concern to those Senior Executives, he would have to explain.

Q. But if your suspicion was right -- and it is only a suspicion as you have told us -- then Letby might pose a very serious danger, wasn't that the natural consequence of your suspicion?

A. Yes.

Q. If that is your reasoning at the time, doesn't that risk require immediate action?

A. Yes, it should have done. But perhaps I was and maybe we were -- but my colleagues have to answer from themselves, the other paediatricians -- influenced by the conviction that we were wrong from the nursing side. And I regret that we or I didn't go to the police at this time after the thematic review.

Why didn't I go straight to the police? Why didn't we paediatricians go straight to the police? And I know that the parents of the later babies will not thank us for this, the suspicion was that there might be something that had affected a number of babies, children on the unit, and it would be best managed through the Senior Executives in the Trust and this is a similar problem for why -- what do we do later on as well, why

didn't we go straight to the police and not keep trying to involve the senior managers?

When you have a major problem in a hospital, for example, that a whole serious of tests have been done wrongly and people have been wrongly reassured that they didn't have cancer at screening tests, it is a major incident, many patients, not just those affected, every one who has ever used that service in that year, or due to use the service over the next year, is going to be very concerned and that's why the Trust has communication teams and set up helplines and that's how you deal a problem like that.

Was I wrong to have waited for that to happen? The way things turned out, yes.

Q. There was of course an alternative route and we have discussed it already, to going straight to the police, and that would be to involve the safeguarding department but that is just not within the way you thought about things at the time; is that right?

A. Yes. The safeguarding department, from the paediatric point of view, is the appropriate department to go to when you have concerns about a particular child or baby and how -- and I know it's difficult saying this now we know what Letby was doing, it is if you have concerns about the way the carers are managing the child

or baby. We did do that for babies on the neonatal unit, it is occasional, whose parents either behaved in quite an irresponsible manner or didn't turn up to visit their baby, we would contact the safeguarding team and social services and look at what support was needed for that family.

Q. We will move forward --

A. But it seemed more appropriate if you are worried about a series of problems going on over a period of time, and where there is a member of staff, to involve Senior Executives than going to the safeguarding team that I would normally -- and I might have been wrong -- expect to involve when you have concerns about management of a particular child.

Q. Child L, we know from the results that were taken that there was an indication that insulin had been externally administered.

A. Yes.

Q. Was that something that you saw at the time?

A. No. I had dealt with Child L when his blood sugars were low. The blood tests were done -- had been done the day before, actually, but the results weren't back for -- it wasn't quite a week, a few days later, as far as I can tell looking at the notes now in retrospect. I didn't know those results at the time.

Q. You have accepted at 268 of your statement that your view is that this is a collective failure on the part of the pediatricians, the page reference is 77.

A. Yes, for the same reasons as Child F.

Q. Again you have used that phrase for with the benefit of hindsight. Are you there indicating that is because you didn't know about it at the time?

A. Yes, I found out the results two years later whilst doing a police statement and reviewing the records.

Q. But that is something that you could have known at the time?

A. Possibly. Consultant colleagues who were looking after the baby when the results came back are more likely to have known at the time, and indeed if looking at the medical notes for Baby L, some of the junior doctors did record those results in the notes but I wasn't around on the ward at that time, I wasn't on duty, I wasn't the Consultant of the week for that baby when the results came back.

But Baby L and M were followed up in my baby clinic and I only saw them briefly because a new Consultant who started then, one of the new nine Consultants took over that clinic. But it just shows that these babies were being seen by other people afterwards and the result was

sitting in their notes. But when you are seeing a baby in clinic a year or two later, monitoring their development, you don't always look back at all the results they had done whilst they were on the neonatal unit. But I think we all collectively have responsibility for missing that.

Q. Child M, 9 April 2016. Child M is the twin of Child L. Child M collapsed. Were you aware of that collapse at the time?

A. Not at the time. I knew the following day when I saw Child M on the ward and he was doing very well then. He had made a good recovery, complete recovery.

Q. At the time did you put that collapse of Child M in the category of the sudden and unexpected deteriorations that are spoken about in the thematic review or did you not regard that as suspicious at the time?

A. That added to concern, not because I saw Child M looking very well in the neonatal unit the following day, which is fantastic he made such a good recovery, it is because my colleague Dr Jayaram, who had been there at the time of the collapse and came in to help resuscitate Baby M, he was concerned that there had been a sudden collapse. So I gained the concern from

what he had said.

Q. So again just help us with this in your thought process at the time. Before Child M's collapse you had reached a point where you thought there is a possibility that deliberate harm may be being caused. Then there is another incident of potential further deliberate harm. Again, just help us to understand why when you have that conversation with Dr Jayaram you are not saying: we need to do something straight away about this?

A. Because it still wasn't clear that harm was happening to the babies. And why, despite that thematic review, most of the babies had an explanation for their deaths from the ones that had had the postmortem. That doesn't include all the babies. One of the babies who didn't have a postmortem the clinician, my colleague at the time, felt that the doctor knew what had caused that baby's death, not realising, as we now know, it was Letby.

So because we had explanations for all the deaths we -- I wasn't sure that harm had happened to these babies. Just because it's -- it's I think an important concept that's going to come back when we talk about how we related to the managers later on, we now classify those many of those deaths as unexpected, unexplained

and unusual. They were relatively unexpected but some of the babies did have lots of risk factors. They were not completely unexplained; some of them had postmortems that seemed to explain the death but they didn't explain it adequately when we looked back at it. But some of them had unusual features like strange rashes.

But because of all that, it wasn't clear that these were unexplained deaths, they were deaths that had explanations that were not entirely satisfactory, especially when we looked back at them.

Q. If we use the language of safeguarding which we see in Working Together, and we can look at the page if we need to, but I am sure you don't, is safeguarding principles are engaged if you think someone may have harmed a child?

A. Yes.

Q. Does that reflect your state of mind at the time?

A. Yes. But there was uncertainty about whether harm had happened to these babies. But because there was the possibility we should have involved the police earlier some time in 2016 and I feel I was at fault, and my colleagues have to speak for themselves, in not involving the police earlier and trying to do that through the managers and that to get the communication

system and the helpline set up for parents and the general public who might be concerned.

Q. There was a meeting on 11 May of 2016, which you didn't attend. It was Dr Brearey meeting with Mr Harvey and Ms Kelly, also present Nurse Powell.

Going into that meeting, presumably firstly you knew that that meeting was happening?

A. Yes.

Q. Was it your expectation that Dr Brearey would say in terms that there was a concern of the possibility of deliberate harm?

A. Yes, and more than that, to actually say the suspicion had fallen on Nurse Letby: exactly what he said to those two Senior Executives he will be able to tell you.

Q. Absolutely.

A. Also how he had asked him to go to that meeting and what level of concern had been expressed when requesting that meeting and when he requested that, I am sure he will be able to tell you.

Q. But your expectation in terms of here he is going into speak for the group of you, certainly speak for you, about the collective concern was not just that there is a concern about the nurse, but even more than that, that there is a concern that she may be

deliberately harming babies?
A. Yes.
Q. And did you speak to him after the meeting?
A. Yes. I can't remember exactly where and when. He fed back to us that no decision had been made but the senior managers were considering the problem and hopefully we would come to a decision. That could have been a trigger, should have been a trigger that we bypass managers and went to the police. And we failed to do that.
Q. We will just have a look at an email that Dr Brearey sent following that meeting, INQ0005721. You deal with this at paragraphs 270 and following on page 78, but it is the email of 16 May that he sent. The first paragraph is a short summary from Dr Brearley to his Consultant colleagues about the meeting.
He describes it as a helpful meeting, sometimes Dr Gibbs there is a difference between what people put in writing and what they say privately. What was your understanding from having spoken to Dr Brearey about whether it was a good meeting or not?
A. I understood it wasn't a helpful meeting. Who's been copied into this?
Q. Eirian Powell has been copied in as has Ann Murphy?

A. Not the two Executives. I wondered whether the phrasing was representing who had got the email but not -- yes.
Q. From your understanding from him, that wasn't what he was saying privately about the meeting?
A. In some sense it had been helpful because I understood that Dr Brearey felt the Senior Executives were becoming were understanding the issues. The unhelpful bit is nothing had been done about it so it was partly helpful but the outcome was disappointing.
Q. You have told us that that outcome should have been a trigger for further action from the Consultant paediatricians or certainly from you?
A. Yes.
Q. The second part speaks about coming across a baby who deteriorates suddenly or unexpectedly or needs resuscitation to notify both Dr Brearey and Ms Powell and you were aware -- thank you, we can take that down -- that Child N suddenly and unexpectedly deteriorated, 3 June and 15 June?
A. (Nods) I am not sure I knew about 3 June. It might have been mentioned at handover, we have a handover when we are on-call. But I knew the deterioration on 15 June, yes.
Q. Bearing in mind what Dr Brearey had said

there, was that a collapse that you were directly aware of in Child N on 15 June something that you spoke to him and Nurse Powell about?
A. No, I didn't, because he was involved in the collapse. It depends which collapse. Baby N on that day, Child N on that day had a number of deteriorations and created a lot of difficulties needing a specialist team from Alder Hey to come over and assist and Dr Brearey was involved in that. I was the only involved later on in the evening but I knew Dr Brearey and I am fairly sure, but I can't remember now, Mrs Powell knew about those collapses on that day.
Q. So although you had received that email, in your mind Dr Brearey already knew about it, didn't need to be told twice?
A. Yes, he was involved in it.
Q. We then move forward to Child O on 23 June of 2016. You deal with Child O's care at page 84 starting at paragraph 295 of your statement, and what you tell us at 297 is that you were uncomfortable arriving on the neonatal unit to find Child O undergoing a resuscitation; is that right?
A. Yes, yes. Can I just mention for Child N, to go back for a moment?
Q. Of course.

A. Again, Child N's parents might not be happy to hear this, but I wasn't that concerned that his collapses were unexplained. They were strange. Eventually -- they haven't been properly explained. He was a complicated little boy that had a blood disorder, it was thought he suffered a bleed into his lung on the day he had these problems, on that 15 June, and there was a great deal of difficulty from four -- two Consultants, two Consultant paediatricians, Consultant anaesthetist and some of the Registrars at viewing his windpipe, trying to put a tube into his lungs to help him breathe, because of a swelling and that could have been related to his bleeding disorder.
So just Baby N, I didn't -- it wasn't apparent to me that he had been harmed in any way, it was more his complicated medical problems. As things turned out later on, and once he had gone to Alder Hey and the specialist doctors there for the blood disorder looked on things, they felt it was probably unlikely his blood disorder accounted for his problems but at the time and including when the sad events happened to Baby O and P, I felt Child N's problems could have a medical explanation.
Q. As you come into the NNU to find Child O undergoing resuscitation, was one of the thoughts that

you had that this was a further example of the sort of events that had been troubling you and giving rise to your suspicion?

A. Yes, but not directly that it's Letby again. It was because, as I said, knowing what happened, looking back on it, it sounds foolish to think just wasn't sure harm really was happening on the unit, but my main concern is this is just yet another collapse on our unit, we have had far too many. I didn't immediately think therefore this baby has been harmed and did Letby do it? So I was just concerned there had been another sudden collapse.

Q. Do you think that the mental approach you were taking to the index of certainty that you needed was perhaps wrong; in other words that you didn't need to conclude that you were sure that deliberate harm was being caused before doing something, in fact -- and that was the way you were thinking about it at the time but that in fact your approach should have been to apply a different threshold?

A. It should have been a lower threshold, yes. I -- I don't -- I wasn't at the time thinking I have got to be convinced that harm is happening, that I wasn't sure was harm happening at all, but there was that suspicion and I didn't expect to be convinced because

it's -- it was only after a further detailed assessment over a long period of time that the fact that harm had happened became more clear.

Q. Following the death of Child O, did you have any discussions with those who were present about the suspicions that had previously been in your mind?

A. Immediately after Child O's death, no, I don't think I did. Again, I don't think I did. There is nothing recorded in the notes that I know of in O or Brother P and I had come on to the unit to -- I was on-call that evening. The resuscitation of Child O was already in progress when I arrived on the unit.

I turned my attention to the two other triplets, siblings and to check -- and particularly to check for medical problems in them because when you have multiple births if one baby has got a problem like an infection all of the babies in that group could be developing the same problem or about to. And really there wasn't time to talk to other colleagues about it because I had to deal with the other two babies and the colleagues who had been involved in the resuscitation their focus was on the grieving parents.

Q. Child P died the following day, 24 June. Between the two deaths, were you aware of any steps that your Consultant colleagues were taking to raise their

concern outside of the neonatal unit?

A. I am not sure that day. I can answer I was aware by Monday the 27th and as I mention in my statement I can't remember the discussions that might have taken place on the 25th, I think -- no, 24th.

Q. 23rd for Child O.

A. Yes.

Q. 24th for Child P.

A. Yes. But the discussion was on -- that was a Friday, the 24th. I was in clinic that day. I think I had found out that Child P had died after the clinic, but I can't remember exactly what the discussions were because I muddled them between discussions we had, might have had that evening and the discussions we definitely had about our concerns on the following Monday.

Q. We will --

A. But to answer your question, I was -- I did -- I was aware of what my colleagues, how my colleagues had tried to raise the issue with concern specifically about Nurse Letby but I think it was by Monday the 27th I was aware of that.

Q. That's when you became aware?

A. Yes. But I might have known in the evening of the 24th, I can't remember now.

Q. Child Q deteriorated on 25 June 2016. Were

you aware of that at the time?

A. Yes and we come to what we mean by collapse and deterioration. It happened in several stages. I was aware he had had a deterioration in the morning of that day, the 25th, and then I was aware that he had slowly deteriorated and needing ventilation that evening.

It looked like a more medical problem, a baby that's slowly got worse whose breathing reduced and then had to go on a ventilator and we were covering him for infection at the time and it seemed to be more consistent with that sort of medical problem.

Q. So does it come to this: going into the meeting on 27 June 2016, in your mind Child O and Child P had been weighed into the balance in terms of the concerns you had but Child Q hadn't?

A. Absolutely, yes. I was enough concerned about Child Q in the morning just to -- I mean, it's in my statement so maybe we don't need to go there too much, just to ask some of the nurses on the unit who had been looking after Child Q at the time. And I don't -- when a child collapses your attention is why did they collapse, what had been wrong, what were the observations beforehand, what were the indicators they were about to collapse. I never asked who was looking

after them. So it was unusual to ask that question.
Q. So in terms of marking a moment in time --
A. Yes.
Q. -- was that the first time that you were making investigations outside of the Consultant body to ask others --
A. Yes.
Q. -- to give you information --
A. Yes.
Q. -- pertinent to your concerns?
A. Yes, and it was perhaps my rather feeble attempt to try and offer some protection, if some harm was going on, that it was known on the unit that I was on-call that day, I was watching who was doing what on the unit.
Q. So were you expecting that it would get back to all the nursing staff that Dr Gibbs wanted to know who had care of Child Q?
A. Yes. Because I never normally ask that.
When -- when -- and I didn't think Child Q's deterioration that morning was that significant. He wasn't that unwell, but I just -- any deterioration was worrying us after Baby O and P.
Q. So we come to the senior paediatrician meeting on 27 June of 2016. You probably don't need to look it

up because you will recall it. But what you say in your statement is that:
"All Consultants expressed serious concerns about the number of deaths and the persistent association with Letby."
A. Yes.
Q. Persistent association is one thing. In that meeting with your Consultant colleagues, was the fact that she may be causing deliberate harm to babies spoken out loud?
A. I would be surprised if it wasn't. I can't recall exactly. I don't think there is any recorded notes from that meeting, it was an unminuted meeting, and I would be surprised if we didn't discuss it then.
What might have inhibited us, the senior nurses were there as well and relationships were proving difficult, becoming a bit difficult whenever we broached the subject -- well, I knew from Dr Brearey when he broached the subject of Nurse Letby it created problems with the nursing staff, senior nursing staff.
I am not sure of the more junior, the below ward manager staff, I don't know if they knew anything about this at all at that time.
Q. What you say in your statement is that following the meeting, your understanding was that

Dr Brearey telephoned the Medical Director Mr Harvey?
A. Yes.
Q. Do you know what he said to Mr Harvey in that conversation?
A. No, but I assumed he conveyed those concerns, including Nurse Letby to Mr Harvey, but he will be able to confirm. Mr Harvey hopefully will be able to confirm.
Q. There is something of a record of that meeting, INQ0003116. If we go to page 2 and scroll down. This is Dr Brearey's email, which you are copied into as is Mr Harvey. If you just scroll down, please. It may be easiest just to leave the whole document on the screen. It begins:
"I thought it might be helpful to put down in an email what was discussed at the senior paediatricians meeting yesterday."
So this is the 28th, referring back:
"~... significant concerns about the increased mortality, the sudden deterioration of apparently well babies, no cause identified and the presence of one member of nursing staff at these episodes. There has been a watchful waiting approach since our last meeting with Ian and Alison in March."
That may or may not be an incorrect date, we will

investigate that. It may be a reference to May.
"However ~..."
A. I would have thought so, yes.
Q. "~... since the episodes and deaths last week there was a consensus at the senior paediatricians meeting that we felt on the basis of ensuring patient safety on the NNU this member of staff should not have any further patient contact on the NNU."
A. Yes.
Q. It goes on to refer to the external peer review, which is clearly a reference to a conversation he has had with Mr Harvey. But in terms of capturing what the position of the senior paediatricians was at lunchtime on 27 June, does that accord with your recollection?
A. Yes, it is.
Q. And if we scroll up to the top, so back to page 1. Again you can leave it on the full screen. We can see a response from Karen Townsend just to Dr Brearey. So you weren't on copy for this but we are going to look at the email at the top because it speaks about you.
Dr Brearey replies to Karen Townsend's email saying:
"Just to confirm then Ian and Alison are happy for

LL to work on NNU in the same capacity as last week despite the Paediatric Consultant Body expressing our concerns this may not be safe and that we prefer her not to have any further patient contact."

Largely saying the same thing as below, but in very direct terms. Did that represent your view at the time?

A. Yes. I mean --

Q. Thank you. We can take that down. Now, the Inquiry understands, and again this is a matter we will be investigating, that Letby worked day shifts on the 28th, so the day that that email was sent the day after the paediatric Consultant meeting, the 29th, so the Wednesday of that week and the 30th.

Now, were you aware that she continued to be on the ward after that Consultant paediatric meeting?

A. I must have been, I suppose, is the only honest way I can answer it.

I am trying to think of the meetings we had and yes, I think the determined efforts from us paediatricians to ensure that Nurse Letby wasn't on the ward I can remember that at the meeting on 13 July. So I must have been aware she was still around on the unit before then. I thought she was going on annual leave at that time. So I don't know quite when she went on annual leave and how many days she was on the ward

before she went on annual leave.

Q. 1 July is our understanding and it is important that you don't guess here. So is it fair, being fair to you that if she did continue on the ward that will have been something you were aware of at the time?

A. Probably, yes.

Q. Well, bearing in mind that you are uncertain I don't want to ask you an unfair question about that I will just move on.

A. I mean, should she have? No.

Q. Should she have? No?

A. Yes.

Q. And obviously at that time, the managers, senior managers were being consulted about the next steps. As a Consultant paediatrician in that very difficult situation, if something is unsafe is happening in your view and that you have raised it with senior managers and they say we are comfortable with this level of risk, what is it that you should do?

A. Well, disagree with them. Is that what you're saying?

Q. Well, that's words. Does it require any action or do you simply engage with them verbally?

A. I thought at this time -- I am just getting

the dates muddled. I am fairly sure at this time steps were being taken early July to downgrade the unit.

Q. We haven't got to July yet. We are talking about the period 28, 29 and 30 June so whilst, we understand, Letby was still on the ward --

A. Yes.

Q. -- post the assertions that have been made on the 27th and in writing on the 28th, that the Consultant paediatric body feel that that's unsafe.

I am just trying to understand how, as a Consultant paediatrician, you manage that situation where that is your view.

A. Yes.

Q. The senior managers are not acting immediately upon it. What is it that --

A. Well, I should have done and we should have done something more definitive. But as I am struggling to remember, I am not sure if I was aware she was still on the ward for those -- I thought she was going off on annual leave but as you say that wasn't until 1 July.

But in answer to your question if we knew she was still on the ward and thought she might be harming patients, we should have got her off the word or got the police involved then. But I can't remember if I was aware she was still working on the ward.

Q. We have time, I think just before lunch, to look at an email thread on 29 June which you were involved in starting with an email from Dr Saladi. INQ0003112. If we go to page 3, which is the bottom of the thread, you I am sure will be very familiar seeing this again with Dr Saladi's email.

I would like if I can just to summarise it for you.

What it comes to is -- and if you need to remind yourself, I don't want to rush you, but what it comes to is Dr Saladi saying we need to contact the police. Do you recollect --

A. Yes.

Q. -- and agree that that's a summary.

If we just go over the page, so to page 4, the substance of Dr Saladi's reasoning is there. I just wanted to ask you about the first sentence at the top of the page:

"We have moved this particular staff member from night shifts to day shifts and from ITU care to HDU/SCBU care."

You have told us that there came a point when you realised that Letby had been moved from night shifts. Do you think that when you received Dr Saladi's email that was news to you, the first time you heard about it, or do you think you had heard about that earlier?

A. I knew she had been moved off night shifts earlier than that, we discussed it a bit earlier, and it was because she had been unlucky and had difficult experiences and to give her more support during the daytime.

But it was -- you say that happened in April and I have seen it said I think in the documents it said it happened in April. It was some time after that I became aware. I think I knew she had been moved off night shifts before this particular email. I didn't know about her being moved off ITU care to lower-level care.

Q. That was exactly what I was going to ask you about.

A. I didn't know.

Q. We obviously can ask Dr Saladi about that --

A. Yes.

Q. -- but that must have been the first time that you learned of that then?

A. Yes, and I mean Dr Saladi must have got that from somewhere. I wasn't aware that was true actually.

Q. Thank you. If we go up to page 3, so to the next page again. We can leave it on the whole page view. We can see that Dr Jayaram responds thanking Dr Saladi saying:

"Steve and I are trying to meet with senior execs

ASAP to discuss exactly this issue. However they do not seem to see the same degree of urgency as we do. Until we meet them I am reluctant to go to external non-medical agency ie the police off my own back. I am going to speak to the MDU today to find out where I stand as lead for the service with regards to these concerns and I will share their thoughts with you all."

So that was what Dr Jayaram was saying at the time.

If we then go to page 2, please. In fact, Mr Harvey was on copy to those previous emails and replies:

"Ravi - this is absolutely being treated with the same degree of urgency. It has already been discussed and action is being taken. All emails cease forthwith.

"We will share with you what action we are taking."

I just wanted to ask you Dr Gibbs whether you have a recollection of receiving that email on 29 June and what your reaction to it was. We are going to see the email that you sent in a moment, but what was your reaction to that email?

A. Well, partly pleased that the Senior Executives were treating this urgently. Yes, it was a bit uncomfortable that we were told to cease all emails forthwith and as you can see from my email we weren't going to do that. If you have serious concerns

we would carry on discussing them.

Q. Page 1. We see that you do exactly that. Starting your email:

"Despite Ian asking us to cease emails on the issue we are entitled to discuss our concerns with one another."

You say:

"We are all agreed that something has to be done fairly quickly to try and ensure our neonatal patients are protected. It is exactly what should be done and what if any information should be released concerning this action that is difficult to decide and which no doubt is exercising our Senior Executives minds."

Now, you, Dr Gibbs, have mentioned a number of times the helpline and using the communication department of the hospital, which is clearly a very important part of reassuring the public. But should deciding on such things which may be complicated in terms of exactly what you are saying to the outside world hold up taking immediate action to ensure safety?

A. No, but I am -- no, it shouldn't.

The reason I made this comment is -- I might be wrong and they will answer for themselves -- it was my understanding that they, that those sort of concerns: how do we communicate this generally to

parents concerned, to the public would be exercised, they would be thinking about that.

Q. So you were effectively trying to walk in their shoes saying: I think that these are the relevant factors that they will be considering?

A. Yes.

Q. Rather than you endorsing them as in fact being the right way of thinking about them?

A. That's right and that's why they are not going to give us an immediate answer, that's why Dr Jayaram was frustrated that he thought they weren't treating it urgently. Mr Harvey assured him that he was treating it urgently; that it's not just shall we go to the police. It's shall we go to the police and then what communication strategy do we put out because calling the police into to look at the whole unit, as we know in the end, has to be managed through what you tell all the parents.

Q. Absolutely. But has going straight to that calling the police perhaps skipped a stage, which is that patient safety is addressed internally in the first instance and that doesn't require a communication strategy and I am just seeking your comment on whether that is being perhaps overlooked in all of this; that there is -- immediate action needs to be taken

internally, then a big decision like the police can follow?

A. Yes, of course that has to happen. But hopefully that was what the managers were thinking about. I don't think the Medical Director can go marching onto the ward and pull a nurse off the ward. There has to be discussions with her line manager and presumably with the senior nurses and so on to remove a person from their duties.

Q. And is that the position even if the entire Consultant body are saying that nurse is unsafe?

A. That has -- that ought -- that action I just described ought to be done fairly quickly and I think, I know we have looked at what Dr Brearey wrote.

From my point of view it was not "This nurse is unsafe", "This nurse might be unsafe." But you should treat that "might be" and "is" unsafe with a similar degree of urgency, yes.

Q. We will just conclude this email by indicating that Dr Jayaram said on 29 June, 10:24 at the top of the email thread:

"The Trust are contacting the police soon once some information gathering has taken place which is why Ian has asked for the chit-chat to stop for now."

And then he makes a reference to a matter which is

in your lower email where you raise the possibility of air in the skull, which we don't need to look at now.

So was it your understanding at that time that the police would be involved imminently.

A. Yes, from that email. Yes, and it had taken us a long time and we delayed too long but at last it looked like the right action was being taken.

MR DE LA POER: My Lady, would that be a convenient moment?

LADY JUSTICE THIRLWALL: Yes, thank you very much indeed. So we will rise now until 5 past 2. If you could be back by then, please, Dr Gibbs.

(1.04 pm)

(The lunch break)

(2.05 pm)

LADY JUSTICE THIRLWALL: Yes, Mr De La Poer.

MR DE LA POER: Dr Gibbs we have reached a stage in my questioning where we are going to start to focus more on what you were understanding the senior managers were doing, and of course --

A. But would you mind, Mr De La Poer, if -- I was finding it a bit difficult to answer some of your questions just before lunch when you were rightly pointing out that I and perhaps my colleagues should have acted more decisively earlier and I would just like

to try and offer a few explanations, none of which are adequate, that I was extremely concerned of putting parents -- bereaved parents through the agony of a murder investigation if we got it completely wrong and no one had harmed patients. Also, contrary to what Eirian Powells seems to have put in her statement, I did listen to nurses, I valued their contribution although I might not always agree with it and therefore the strong assertion from the nursing side that we got it completely wrong and Letby had done nothing influenced me but did not convince me.

Finally, I suppose, just wrongly looking for some stronger indication there had been harm because no one on the unit throughout that time seemed to have seen anyone harm a patient and also the postmortems that had been done didn't seem to reveal any harm having been caused to patients.

So all of those contributed to me and maybe my colleagues, but they will have to let you know -- contributed to me dithering at that time which is why I said at the beginning I am ashamed for not having protected babies from harm, particularly the babies later on in 2016.

Q. Thank you very much indeed for that clarification, Dr Gibbs.

Before I move on to the next phase, it has been drawn my attention that I just need to ask you a few more questions about the moment of that crystallisation, that's my word, not yours, of when things moved to the front of your mind and you were thinking: I have concerns possibly about Letby. I think that your evidence this morning was that that was some time before the end of 2015; have I got that right?

A. Yes, I think I said and if I didn't, I am saying it now, I can't remember when I first -- I mean if you say certainly after Baby I died I didn't feel then that harm was being done to these babies but I was feeling very uneasy that it was strange that we had had -- I had been involved with two babies with such unusual deaths that I felt, and then after that and maybe late 2015 or early 2016, begun to worry that harm may have been happening on the unit, yes.

Q. So you have described a two-stage process there and you very much focused upon your own internal thoughts. What I just wanted to clarify with you is whether it was around the time of Child I that you voiced those thoughts, as they were at that time, to any of your colleagues or whether you heard your colleagues voice any such thoughts at around that time?

A. Yes, after Child I -- after I had been

involved with Child I's death, so not at the time of Child I, and yes, I was beginning to talk about concerns there might be harm but I think that was more early 2016.

Now, I can't remember the dates and I am not trying to conceal anything. I just do not remember. Some of my colleagues were concerned about harm I think earlier and I didn't agree at that time that we are talking about when -- just because Letby had been around when a few unfortunate -- a few worrying incidents happened that didn't mean she had done anything and just because you have worrying incidents by themselves doesn't mean that someone is harming patients. So maybe some of my colleagues -- and one in particular and he will be here to answer, to give his evidence later, I think maybe Dr Brearley might have got worried a bit earlier than I did and maybe that's because he was involved so closely in reviewing all the incidents in the monthly clinical incident meetings. That doesn't mean he kept it secret from himself; he did discuss it with us. But perhaps he developed concerns earlier than I did.

Q. And raised those concerns with you in some form or other and at the time of first hearing them your instinct was to think: well, I am not sure I agree that this is a problem?

A. Yes, yes.

Q. So that the point when things start to become of concern for you, you had already heard at least Dr Brearey voicing concerns and presumably that fed into your own concern --

A. Yes.

Q. -- at that time?

A. Yes.

Q. Again I appreciate it is a long time ago but doing your best to give us as close a date as you can, Child I died in October 2015?

A. Yes.

Q. I think you have indicated your concerns arose after that, although not immediately after that?

A. Yes, but that was a concern about strange deaths, not fully explaining Child C and Child I.

Q. Absolutely. In terms of Dr Brearey firstly raising with you that he was concerned about strange deaths, did he discuss that with you before Child I?

A. I can't remember.

Q. In terms of when --

A. People were talking about strange events. The rashes in Baby A&B were very strange and worried my colleagues and some of the Registrars, as you have seen in that email. But as far as I remember, no one at that

time was any suggestion that someone has deliberately harmed patients. So concern about strange events had happened from June 2015.

Q. But for your part in terms of unexplained or strange deaths, that was following Child I?

A. We have accepted Baby A and B had strange rashes and Baby A's death didn't appear to be properly explained.

Q. And Baby C you have told us you weren't entirely satisfied --

A. Yes.

Q. -- following the postmortem --

A. Yes.

Q. -- and before the postmortem you considered it even less explicable?

A. Yes.

Q. So let's just, rather than focusing upon the moment --

A. But with Baby C, I had accepted the postmortem gave a cause for his death. As I said earlier it didn't quite explain why that heart damage had happened but I assumed it might have been from the poor blood flow before he was born and so on. So I am not saying I had no explanation at all for his death and I think -- I don't know Baby C's parents would know otherwise,

I think that uncertainty we had discussed it together, but I had no inclination at that time any harm had been done to Baby C.

Q. Just focusing on the moment when somebody other than you voiced out loud their concern that perhaps deliberate harm was being caused, we know because you have told us that was before you reached that point yourself. Are you able to help us with whether that was before or after Child I?

A. I can't remember. Sorry.

Q. And just to complete this piece, the moment when you thought for the first time perhaps deliberate harm is being caused, was that within 2015?

A. I am not sure. It could have been towards the end of 15 or early 16. I think the big worry was after the thematic review.

Q. That's in February?

A. Yes, February.

Q. 2016.

A. One of the surprises, and maybe it shouldn't have been a surprise to me as a Consultant working on the unit, I didn't realise there had been quite so many deaths either. So just the full enormity of it started to hit me when I saw that thematic review.

Q. Thank you. I apologise to you that we didn't

deal with that as a piece at the time.
So let's return, please, to late June of 2016. There were according to records two meetings on 29 and 30 June with Senior Executives attended by Dr Brearey, Dr Saladi and Dr Jayaram?
A. (Nods)
Q. I will come back to what they were told as you understood it in a moment, but before we get to that, if we could please bring up INQ01002065.
If we go to page 2, please, a document exhibited by Dr Saladi, but which I think you have seen. We can see that on 30 June at 8.25 in the morning at the bottom the thread Dr Jayaram circulates an article which you then comment upon and I hope I capture the medicine correctly but fundamentally it is about air embolus?
A. Sorry, I am just reading it. I don't remember seeing this before, sorry. Maybe --
Q. If you haven't that's a failing of our process and I apologise. So take your time reading it.
A. Maybe I have seen this. I can't remember amongst all the documents. But ...
Q. At all events, having taken a moment just to refresh your memory and it being an e-mail that you were on copy to --
A. It is fine, it makes sense. Thank you, yes.

Q. Yes. Is it right that on Thursday, 30 June and following that there was a discussion, whether in writing or in person, about the possibility of air embolus --
A. Yes.
Q. -- as between you and so that we are clear about it, what was being discussed was the possibility of murder or attempted murder being caused by air embolus; in other words, the deliberate application of it?
A. Yes.
Q. That was the context of this discussion?
A. Yes.
Q. So although not reaching any conclusions, the Consultants at this time are saying between themselves: I wonder if Letby has murdered or attempted to murder children using air embolus?
A. Yes, and that starts to answer a question, this is just speculation, that why did the postmortem show no evidence of harm? It is a devious and subtle way of trying to harm patients which tends to leave nothing behind afterwards for a postmortem to find, tends to. Some people, as was argued at the Letby trial, there are some subtle indications that you can sometimes see postmortem, difficult to distinguish the

air embolus changes from natural gas changes in a body postmortem.
Q. So that's your state of mind. It has reached that?
A. Yes.
Q. I am not suggesting everybody was sure that was what was the case, but it had crystallised to: might Letby have killed and attempted to kill babies?
A. Yes, this is one way it might have been done and that no one noticed and there was nothing to find in the babies.
All of these concerns, including the concerns without knowing about the air embolus, were without knowing about the insulin results. We didn't have to have the insulin results to eventually come to the conclusion harm might have been occurring on the unit.
Q. And was this an important or unimportant step forward in your thinking at that time? I mean what significance did you ascribe to this article and formulating the possibility in that way?
A. I don't feel it helped much. It was useful in just realising silent ways, hidden ways of killing that leave nothing at postmortem could have happened. As I have mentioned in this email, I wasn't involved in the babies that had the rash that might have been due to air

embolus. That rash only occurred in very few babies in the paper that Dr Jayaram is quoting here and those babies had different problems related to the nature of their ventilation from back in the 1970s and 80s so I wasn't sure that that paper really explained what we had seen in our babies but it was interesting that the possibility of air embolus in a more subtle way might have explained some of the collapses.
Q. Was that something that you ever yourself raised in a meeting as a potential explanation for what might have happened?
A. Well, I am sure you are not trying to catch me out here, I --
Q. I am not. Your recollection?
A. Well, I did not raise air embolus at this stage, it was Dr Jayaram who found this paper. I thought I had raised the possibility of air embolus after seeing this paper but I now think one of the emails on 29 June, I talk about air inside the skull of one of the babies on a skeletal survey X-ray done at postmortem and I wondered was that significant and that would have been air embolus as well. That was -- I thought it was after seeing this paper. From the timeline of these emails, I had suggested that before.
The reason that didn't seem to take us anywhere is

when I quickly looked into: can you get air inside the body after death naturally, the answer is yes, so I thought that didn't help.

Q. So you are absolutely right you did raise air inside the skull. In fact we didn't focus on it but those emails where Mr Harvey said "all email traffic should cease", you then sent a message to Dr Brearey and Dr Jayaram?

A. Yes.

Q. In fact that's on 29th. Your recollection is exactly correct?

A. Yes.

Q. My question was more directed --

LADY JUSTICE THIRLWALL: Didn't we look at that earlier?

MR DE LA POER: We did, yes, that was the one just before lunch.

LADY JUSTICE THIRLWALL: Yes, thank you.

MR DE LA POER: Absolutely. So far as my question was really going to whether or not you raised with outside of your paediatric group -- obviously the paediatric group is talking about, whether you raised with any of the managers in any of the meetings or anything like that, saying: look we have been discussing air embolus, we are wondering whether that's something

that should be investigated?

A. I don't remember that. But I have seen in the various documents one of these meetings with the managers around the end of June/beginning of July Dr Jayaram -- I have seen it written in the handwritten notes -- raised that possibility.

Q. Yes.

A. I don't remember that.

Q. No.

A. But -- but likely to have been one of the meetings after he saw this paper and sent this email round.

Q. Yes.

A. So yes, it was raised and I think it was with managers. But I can't remember which meeting that was.

Q. Well, we will be asking Dr Jayaram about it and you are right about your recollection, it does appear in minutes I was asking specifically about you?

A. No.

Q. But we will deal with -- you didn't?

A. I don't remember raising that, no, it was only in that email about the air in the skull which I now know is a day before. I don't know that precipitated Dr Jayaram to start looking at this but he found this paper the day after I raised the issue about the air in

the skull.

Q. 1 July, the day after this, we can bring that down. You deal with this in your witness statement although I am sure I can remind you without inviting you to turn it up but I can give you the reference. This is a meeting which you attended together with Dr Brearey and Dr Jayaram and Stephen Cross?

A. Yes.

Q. Was present at that meeting?

A. Yes. Well, I will just qualify that sorry.

I thought it was on 1 July. It was some time around end of June/beginning of July and do you know where that meeting took place, have you got that down anywhere?

Q. I'm afraid I can't answer that question confidently --

A. I thought Mr Cross had come to speak to us in what we call the conference room, the paediatric seminar room, and I think that meeting on the 1st, looking at those documents, was in the boardroom in which case I am not sure if that was the time I heard Mr Cross say that. But at some stage, one of those meetings, and I can't give you the day around the end of June/beginning of July, Mr Cross -- I was at a meeting where Mr Cross talked about the difficulties that might be caused by

the police coming to investigate.

Q. Do you want to just tell us best as you can recall what it is that he was saying?

A. That it would just be disruptive for the neonatal unit.

Q. And --

A. I also said in my statement I think he said it again the following year in June but I might have -- and I qualified it in the statement, we met a then QC called Mr Medland and looking at what he had said from his notes it almost mirrors what I thought Mr Cross has said to us around that time in 2017.

So I might -- it might not have been Mr Cross back in 2017. But it was around this time in 2016.

Q. And Mr Cross is saying it is disruptive?

A. Yes.

Q. I mean, was that just a statement to be weighed into the balance or was that a decisive factor as to why the police shouldn't be called? What was the context for that assertion?

A. I took it to be that's one of the consequences of involving the police.

Q. Was there any discussion at that stage when the comment was made about well, yes, it will be very disruptive but this is more important, or is that not

how the conversation developed?
A. Not that I recall. But to me it made no difference whether it be disruptive or not; involving the police to investigate possible murders is going to have a massive impact particularly on the parents concerned.
Q. Moving to 4 July. You say in your statement there was a meeting with the Chief Executive. Again I can give you the reference but all that I wish to remind you is what you say in the statement is you were told in that meeting there would be a review while Letby was on holiday?
A. Yes, an internal hospital review and we knew at that time, and I don't remember exactly which date, we knew there was going to be a Royal College review as well.
Q. Yes, we have seen that may have been one of the first things that Mr Harvey said to Stephen Brearey, but we will hear about that --
A. But this is the hospital's own internal rapid, rapid inquiry to get done before Letby came back from leave.
Q. What you say in your statement about this is that:
"The Consultants agreed with the senior managers to

delay calling the police and undertaking internal investigation as not aware anyone had witnessed harm being caused."
Would you like to turn that up or does that just accord with --
A. No, I accept that, yes. But at this stage, we knew Letby was off the unit and we hadn't decided definitively what else we would do. But having Letby not on the unit was the right thing and that did give us time to then consider other investigations. The problem was she going to come back and that -- that cropped up later.
Q. Yes. Well, we will just have a look, spend a few moments looking at the review process. Before we do, we just need to bring up an email dated 5 and 6 July INQ0002693. I am going to bring it up on screen and then I am hoping I will be able to deal with it by way of summary, but it will be here if you need to check.
This is an e-mail thread, which you can see at the bottom of the first page, is about the comms message and if I can summarise what we will see if we looked at it, there was concern within the Consultant body about the way in which the hospital was characterising what was happening at the Countess of Chester; is that right?
A. Yes.

Q. We can scroll?
A. Maybe minimising it a bit.
Q. Minimising it?
A. But I don't know -- personally I can understand trying to be careful how you put out a message not to cause panic and unnecessary alarm.
Q. So if we just scroll down so that we --
A. That's different from misleading people.
Q. Absolutely. So if we just pause it there. The discussion which precedes this as I am sure you can confirm was about the accuracy of that message and in particular the suggestion that this wasn't outside expected statistical variation. That's the focus?
A. Yes.
Q. This is Dr Holt drawing specific attention to Regulation 20, the duty of candour. Was the duty of candour something that you thought was engaged by the situation that was under discussion?
A. I can't remember seeing this particular email. But it's fine, I mean, I knew of the doubt of candour, so -- sorry, your question was?
Q. The question was: At this time were you thinking in terms of the duty of candour or ...
A. I find it difficult to know if -- and it came up much later as well when the police were getting

involved and we knew we were moving towards the police getting involved, how much the duty of candour might be compromised -- the answer could be never at all, might be compromised if you are going through police and criminal investigations, how much you tell everyone about that?
Q. That of course is arising at the point at which the police are involved?
A. Yes, yes.
Q. So if we --
A. But without -- just the statistical bit because that's come up quite a lot, not just from what the hospital said about these rises.
Statistics are complicated and can easily use the wrong statistics and come to the wrong conclusion. In these emails I was saying I wasn't sure -- we are not saying they weren't, but actually increased -- the fairly substantial increased rate we had would be statistically significant. Why on earth 13 deaths in that year period compared to 1-3 normally, why wouldn't that be significant? It is because you have to compare it to the 3,000 deliveries a year and the 400 babies that go through the neonatal unit and it is not so much the numbers of deaths that was the concern. It was the nature of the deaths that was the worry.

You could have lots of reasons, genuine reasons, why you have an increased death rate and you would expect the same sorts of death to happen but just more of them. These were unusual deaths. That was the clue. So by saying there is not a statistical increase, I felt that wasn't -- I wasn't sure, I felt it wasn't necessarily untrue to say that.

Q. If we just scroll to page 2, please. We will see that you --

A. Yes, I am sort of saying that, yes.

Q. You are saying exactly that in the final paragraph, I am not saying that we don't need to take action. You are just querying whether factually the press release is incorrect?

A. Yes.

Q. And then you say this:

"Even if the increase in neonatal mortality is actually not statistically significant, and I am suggesting this might be the case, we should still be very worried about it"?

A. Yes. It is almost like saying: we have a couple of extra deaths this year, that is not that many above the normal. But they were both murders. We shouldn't worry about it because it is not statistically above the normal death rate. It is nature of the deaths

that worried us, not just the fact there were more of them.

Q. Thank you very much indeed. We can take that down.

I am going to just consider now the review that you and Nurse Anne Martyn, as she was, conducted, and I am sure you will agree, having looked at it all it, is quite involved and quite complicated?

A. Yes.

Q. Fortunately for us, you gave an explanation at the time, or certainly in early 2017 as to how we should all understand it and we will just bring up that email as a way, I hope, of shortcutting this. So we will go to INQ0005336 and to pages 6 and 7, please.

6 and 7, please. So does that look familiar to you, that email?

A. Yes.

Q. Again we don't need to go through it, it can be looked over in greater detail. But is that your best explanation for what that document means and does it represent your best recollection of how that document was created?

A. Yes.

Q. Well, as I say --

A. But could I add? You mentioned I had

submitted a main statement and then a second statement --

Q. Yes.

A. -- on 6/9. I did submit a third statement on 20/9, I don't know if it got through, I can't see it on the list here, and that is a re-analysis of this particular review.

Q. Well, I haven't seen that but that may well be my fault so please don't feel --

A. Right. It just changes things slightly. Most of what it says here is true. I realised, having looked at the image of the handwritten notes that Anne Martyn had taken that the red text in the transcript, which Anne Martyn and I hadn't done, the transcript had been made from Anne's written notes, the red text does not indicate all the patients in whom we had concerns. I had to go back to the original handwritten notes and there were six patients that we had concerns about. They were not quite the six I am talking about here, four of them were the same, there were two others. It is explained in my second supplementary statement I'm afraid.

Q. Well, can I thank you very much indeed for that statement and I am sure that it can be considered in due course.

LADY JUSTICE THIRLWALL: Did you say it was 20 September?

A. 20 September.

LADY JUSTICE THIRLWALL: Of this year?

A. Yes, yes.

LADY JUSTICE THIRLWALL: Thank you.

A. It wasn't that long ago, sorry.

LADY JUSTICE THIRLWALL: No, that's all right. That may explain where it is. We will have a look for it.

MR DE LA POER: We can take that document down.

Let's just, if we can, headline this review. You and Anne Martyn were asked to investigate babies who had been transferred out of the unit?

A. Yes.

Q. My phrase, not yours, but that was a proxy for unexpected collapse or potential unexpected collapse. Wasn't it?

A. Yes, a proxy for a limited type of unexpected collapse.

Q. A subset of unexpected collapses and the thinking went, if I have understood it correctly, that it is very difficult to work out unless you go through line by line of every note and you were acting under pressure when there were unexpected collapses?

A. Yes.
Q. But one way of identifying some of the unexpected collapses was to identify those who had been transferred out of the Countess?
A. Yes.
Q. You could then examine those.
A. Yes, and find which of those had had unexpected collapses, they weren't all unexpected collapses leading to transfer.
Q. No, but it was as I say a proxy --
A. Yes.
Q. -- as a way -- a shorthand way of trying to look at least some of the unexpected collapses?
A. Yes, that is right.
Q. As you have made clear, there were limitations to this exercise because unexpected collapses for babies who weren't transferred out wouldn't be captured by the work that you did?
A. Yes.
Q. You deliberately didn't look at the staffing for those babies; is that right?
A. That's correct. I was told a staffing analysis would be done afterwards.
Q. And the upshot --
A. I was looking at the -- I was looking at the

medical notes so I could see which doctors had written the notes. So to be fair I knew the doctors, I didn't know anything about which nurses had been involved.
Q. You, with the support of Ms Martyn, who was helping you with the exercise but it was your clinical judgment that counted, identified six unexpected collapses which you regarded as being of concern?
A. I would say unusual collapses. Probably I have to go back to all six, probably some of them unexpected, others were unusual in some way.
But that was a quick review of the notes. I didn't examine all the notes in any detail and I have to mistake one admission: Baby F was one the babies transferred out and Baby F is the one that had the abnormal insulin results and I said any of us could have seen it at any time, including during this review. But Baby F was transferred out when he was entirely well because the Family lived outside West Cheshire and he was going back home. So as soon as we saw that, we stopped looking at him in the review.
Q. So I am sure you will be the first to agree, not a forensic analysis?
A. Certainly not.
Q. And in fact not an analysis that resulted in any kind of formal report from you in writing?

A. No, because the notes -- Anne gave the notes to another colleague and I mention in my statement who I think it was, but that's who I think it was, so I don't know it was that person and it went off for -- to be further analysed.
Q. Your expectation was that a staffing analysis would then be done based upon the work that you had done?
A. At least a staffing analysis, yes.
Q. In paragraph 93 of your statement, you state that you presented the findings to the Medical Director and other Consultants in mid-July?
A. Sorry?
Q. Presented the findings to the Medical Director and other Consultants in mid-July, would you like to look at the reference?
A. No, I never presented the findings. The findings were presented in mid-July.
Q. They were presented, forgive me.
A. The findings of the hospital's internal review was presented on 13 July. Now, I was part of that review doing this particular review of patients transferred out of the unit. That didn't actually feature in the presentation. I thought it was going to.
Q. When you handed over the notes, which

certainly to a layperson are not the easiest to follow because they are your working notes, did you say in terms: look, there are six children here that we think need a closer look?
A. No. We said, as far as I remember handing it over, we have identified some of the babies in whom we think there are unusual reasons for transferring them out.
Q. Then left it to others to read your notes?
A. Yes.
Q. Work out which ones those were?
A. Yes.
Q. And to go from there?
A. Yes.
Q. A meeting took place on 13 July of 2016 and you deal with this at paragraph 388 of your statement. You give the date there as 13/6/2016 but it may be that's a typo?
A. Sorry, where is that?
Q. 388 on page 110.
A. Where's the typo, sorry?
Q. The date is 13 June 2016, I am suggesting?
A. July.
Q. It is 13 July?
A. That's a typo, sorry, I thought I got the year

wrong. No, the month is wrong, sorry.
Q. Month. Yes, and you have had a chance to see the handwritten notes of that meeting and, broadly speaking, do they accord with your recollection of what occurred at that meeting?
A. Yes.
Q. And you deal in your statement with some of the discussion. One of the things that Mr Chambers is recorded as saying you deal with this at the end of the paragraph:
"There is a correlation with nurse but [recorded in block capitals in the notes] we know a change in acuity and activity plus staffing levels were challenged"?
A. Yes.
Q. I just wanted to ask you there about a position paper that was written which has a number of graphs and so on in it because you talk about a presentation being made in terms of the activity and acuity. We don't need to look at the whole position paper, we just need to identify it. INQ0003492. Unfortunately it is on its side.
LADY JUSTICE THIRLWALL: Do you know how to rotate it?
MR DE LA POER: It may be, because this can form part of the Inquiry record, it doesn't matter. If we

could just go to page 11, and I apologise, Dr Gibbs, this is hardly the ideal circumstances, but this is a document that has been sent to you before, I believe?
A. Yes.
Q. We can see some findings presented there about acuity and activity and on the preceding pages there are a number of graphs?
A. This position paper is useful and quite helpful and I only saw it when it came through with the Inquiry documents.
Q. That was really my question, whether or not this position paper itself was presented to you or whether the PowerPoint presentation that you speak about was something different?
A. Just the PowerPoint presentation.
Q. Just the PowerPoint?
A. Yes, I saw this particular paper for the first team when the Inquiry Team sent it through.
Q. I understand, thank you very much indeed. We can take that down.
A. The emphasis of that presentation was, as we have just seen there, there was some increased activity, numbers of babies, there was some increase in illness on average with those babies and what we knew already, we were not up to the normal staffing levels like most of

the other units weren't.
But that that was 2015/16. Those graphs also show those same problems in 2014 where there had been very few deaths.
Q. So were you unpersuaded by what was being suggested was the correct interpretation?
A. Yes, yes.
Q. You were?
A. Yes, but I did accept that because -- because of those reasons, that could cause a few more deaths but if you had a few more deaths because you were very busy, didn't have enough staff and so on, by and large those would be the same sorts of deaths you would normally see but a few more of them unfortunately. And if you are busier, you might just get the extra death because you had more patients.
Q. What you say in your witness statements is that the Consultant paediatricians pointed to the fact it wasn't just the increase but the fact that deteriorations were unexpected and sudden?
A. Yes, and from the handwritten notes of that meeting on the 13th, you can see some comments that say exactly that.
Q. Now, in terms of what the Executives' view at that meeting was, can it be summarised in this way that

it was wait for the Royal College's visit and report?
A. Yes, it seemed to be accepted that those graphs, with the changes we have mentioned, could explain the increased death rate and yes, they could explain an increase in the death rate. I don't want to get stuck in the statistics, which are always difficult. I am not sure it would have explained quite such an increase in the death rate. It did not explain the unusual nature of the deaths and that was mentioned at the meeting. But even so, we had agreed, we Consultants -- and I was one of them who agreed -- we would look at the Royal College's review of our service.
Q. What you say at paragraph 403 is:
"Several of us, including myself, considered that since our concerns about Letby were purely circumstantial and the hospital's investigation had indicated an appreciable increase in workload pressure that might explain the higher rate of adverse outcomes, that it would be best to wait for the RCPCH review of our neonatal service to see whether it supported the findings of the hospital's hurried investigation and then to decide on police involvement"?
A. Yes.
Q. Now, just help us to understand how on the one hand your view was that the charts that you were being

presented with didn't provide an adequate explanation?
A. Didn't seem to.
Q. Didn't seem to?
A. Couldn't say absolutely not.
Q. No, but that was your impression at the time, and that they failed to capture the thing that was uppermost in your mind which was the sudden and unexpected unusual cases that you were dealing with. Why in those circumstances were you content to wait until the RCPCH had reported rather than saying: this data is not what you think it is, we need to go to the police now?
A. Two reasons: we were hopeful the RCPCH review would clarify whether the deaths were unusual and could be explained by what they were going to examine as stresses and pressures in our unit. And secondly, as came up in this meeting, what we hadn't ensured before, which we should have done, that we did not want Letby back on the unit until this had been sorted out.
Now, that delayed getting answers for the parents whose babies had been harmed, it prevented any more babies being harmed while these further assessments were ongoing. We had hoped we would have an answer by mid/end of September after the College review at the beginning of September.

Q. What you say at paragraph 404:
"All of us Consultant paediatricians were adamant that if the police were not to be involved at this stage and if Letby was to continue on the NNU, she had to be closely monitored in case she had harmed babies"?
A. Yes.
Q. So is this right, that at least your position and the position you understood of others, was that Letby could return to the unit but only under close supervision as opposed to requiring that she be excluded altogether?
A. Yes, at that time. But close supervision was CCTV cameras and/or she had to be supervised by another nurse all the time. I didn't think that was likely to be possible. They would not get -- CCTV cameras are an issue that the Inquiry is looking at. We would never have got them up by the time she was back from holiday in a few days' time even if they would rush in a set of CCTV cameras. So in a way it was a slightly convoluted way of just trying to make it rather difficult for her to come back.
Q. We know, in the event, no supervision could be found and she did not in fact return --
A. Yes.
Q. -- to the unit as a practising nurse when she

came back from holiday.
If we just keep moving through.
On 19 July, Dr Jayaram sent an email. We can bring it up if you need to, but if I summarise its content for you. He suggested that the paediatricians thought the Neonatal Network should be involved in what was occurring --
A. Yes.
Q. -- at the Countess?
A. Yes.
Q. Did that accord with your view at the time?
A. Yes, we had hoped the College review that was due in September might help to clarify matters. But particularly for the hospital's own internal review it would be useful if outside the hospital but still within the region, neonatologists could offer some advice on the graphs that we had seen.
Q. And when did you learn that the Network would not be involved?
A. I didn't find out whether they would or wouldn't afterwards, no. But Dr Subhedar, who had been involved back in February 2016, did get involved later.
Q. Absolutely, when we come to February/March.
A. He represents part of the Network but I don't think he was involved at this time. But that was either

him or the whole Network, I think as Dr Jayaram mentions in his email it was the intention of trying to get those people involved again to offer advice to the Trust.
Q. If we then move forward to 1 September and the interview with the RCPCH. You deal with this at paragraph 411 having -- and we thank you for this -- gone through all the notes of the discussion which took place. What you say is:
"The main issue discussed as needing fixing was the concern that we expressed over the number of deaths in 2015 and the first half of 2016. Many were unexpected and frequent poor response to the resuscitation was unusual and few babies exhibited strange mottling of the skin."
Then you go on:
"Babies who deteriorated several times on our NNU seemed to be stable once transferred elsewhere. The cause of death was uncertain in some cases even after a postmortem. The increased number of deaths and non-fatal collapses had caused significant distress among the medical and nursing staff.
"Finally we mentioned that we hoped we could again move back to being a Level 2 NNU and that we all like working with neonates."
A. Yes.

Q. Just pausing, just a footnote to that. In July the unit had been downgraded --

A. Yes.

Q. -- to a Level 1?

A. Yes.

Q. This is a reference to the fact you wished to return to Level 2?

A. Yes, by "downgraded", less beds and not the most intensive babies; so lower risk babies, less of them.

Q. Now you then go on to say:

"Neither the handwritten notes of this interview nor the typed transcript record concerns about Letby"?

A. Yes.

Q. "I cannot remember if we mentioned her by name but I thought we had told the review team that we were worried about a particular nurse being associated with most the deaths and also non-fatal collapses. Perhaps we mentioned this to the review team outside of our interview session."

A. Yes, there was a comment I mention there. It is hard to decipher and understand what was meant but Dr Saladi, one of my colleagues, might be able to add to that. He made a comment that is recorded in his handwritten notes that may allude to a problem with

a member of staff. But the Royal College paediatrician and neonatologist and specialist nurse weren't there to do a staffing analysis or look at individual staff. So if we didn't mention her, that wouldn't have bothered me. We wanted their opinion on the nature of the deaths and whether it could be accounted for by pressures on our unit.

Q. Now, at paragraph 411 you were asked to comment upon what you had said to Facere Melius in terms of the RCPCH review feeling like a bit of a waste of time?

A. Yes.

Q. Do you want to just tell us what you did in fact think the value or otherwise of the RCPCH visit was?

A. Right. The main value was that it did not -- the reviewers did not find any clear explanation for why we had an increased death rate and the unusual nature of the deaths and they felt that the -- that those questions could not be properly answered until a detailed external expert had reviewed the deaths. And the bit about -- I am sort of rude to the Royal College of which I am a member or a Fellow. We were hoping they would pass some sort of judgement on that.

But they did say when they came that they weren't

going to look at individual deaths but I think they did see an overview of the deaths which might have been something like that thematic review but I am not sure. We knew they were not going to look at staffing -- well, they looked at staffing levels. They were not going to look at individual members of staff and say who did what, or anything like that. But it is just disappointing that they didn't pass opinion on whether they felt the deaths were explained by pressures on my unit.

Q. You do say, however, you found it reassuring they recommended an external review?

A. Yes.

Q. That being a reference --

A. Yes.

Q. -- as it turned out to be to Dr Jane Hawdon?

A. That was good. But the disadvantage was that it prolonged the whole assessment, but that's a necessary thing to do.

Q. When you learned that there was going to be further delay having hoped that there would be a response or a conclusion by September did you return at any point as far as the Executives were concerned to the idea that the police needed to be called at that stage or were you content to let it run its course?

A. Content to let it run its course because Staff Nurse Letby was not on the unit. As I say a bit earlier, as you pointed out, we had decided if she did come back we would have to take dramatic action, which would probably mean going to the police, but we didn't have a definite plan of when and how we would do that.

Q. Just help me with that. At what point best you can say was there an agreement between some or all of the Consultants that if she did come back on the ward, you would go directly to the police?

A. I don't think we had a formal agreement about that, that was just a discussion between us because what comes up later is when after these reviews were looked at and presented to us by Senior Executives there was a plan to bring her back and we had some discussion about what would happen then.

Q. If we come forward to October 2016 and in particular to the grievance process that we know that Letby had commenced, you deal at paragraph 418 and make comment upon matters that have been drawn to your attention in relation to what Eirian Powell had said?

A. Sorry, which paragraph was this?

Q. 418 unless?

A. 18 -- 18, right.

Q. Yes.

A. 417 onwards.
Q. 417 onwards, yes, forgive me. That's the context.
I am less interested in what Eirian Powell was saying about you in that, more about what you say you were doing at 418. You say this:
"However, I advised that we should be cautious in necessarily attributing a causal relationship with Letby and mentioned the case of a nurse accused of patient harm at Stepping Hill Hospital in Stockport?"
A. Yes.
Q. And you say that in the context of Eirian Powell's comments about you in October. Can you just help us with when you were advising that caution?
A. Oh right, I don't remember and I thought that was relatively early on.
Q. So this isn't now --
A. No.
Q. -- after the Executives had been contacted?
A. No, no. Well, I have no idea. I don't know why Eirian Powell made that comment given that Consultants never listen to nurses and so on. I don't know why she made that comment about me. But I am only speculating why she might have made that.
Q. You give us a bit more detail in 419 so

I think you should see that.
Although you say you don't remember, you say that in terms of your own approach:
"As suspicions about Letby increased in late 2015 and into 2016 I avoided discussing this concern openly on the NNU with the neonatal nurses because I felt this was inappropriate and unprofessional."
A. Yes.
Q. You go on to say that you may have discussed Stepping Hill Hospital with Eirian Powell?
A. Yes, or amongst the Consultants, but obviously Eirian, if she is saying -- if that's why she said I was a voice of reason she must have heard that. So it might have been one the meetings when she was there that we had on the Monday lunchtimes.
Q. Again your focus there when talking about Stepping Hill is about the nurse who hadn't --
A. Yes.
Q. -- killed anyone rather than the nurse who had poisoned patients?
A. Yes.
Q. Why do you think that was your focus from that incident?
A. Well, it's simply saying there is a correlation between a nurse and being present at

certain incidents, that's what led to the wrong nurse being arrested initially in Stockport.
Q. So it was the parallel what was being said about Letby specifically in terms of association --
A. Yes.
Q. -- that brought --
A. Yes.
Q. -- the innocent nurse at Stepping Hill to mind as opposed to the guilty nurse?
A. Yes, yes, and I think we don't want to go there too much because of what's been said about the Letby trials, but there are other nurses who have been accused of harming children because they seem to be around at the wrong times that then there's been doubt cast afterwards.
Q. Well, in terms of what you were saying --
A. But this was the Stepping Hill.
Q. You were talking about Stepping Hill?
A. Yes.
Q. Now, 10 November 2016 is the date on which Dr Brearey tells us that he reviewed the RCPCH report and he described circumstances where he was given an hour and he says that you were present at that. Is he right about that, that you in November reviewed the RCPCH report for an hour?

A. I don't remember being there. No. And actually when these reports were presented to us by the Senior Executives on 26 January 17, there is a comment in the handwritten notes from Mr Harvey saying that Dr Jayaram and Dr Brearey had reviewed the notes in his office, he didn't say me, I don't remember it being me. If you say am I absolutely certain I didn't see them there, no, I don't remember it though.
Q. Certainly we are going to come now to that meeting on 26 January and you deal with this at paragraph 423 at page 121 onwards. There are notes of the meeting which I think you have had an opportunity recently to consider although you didn't see at the time and there is no part of those notes that you think is wrong?
A. That's correct, yes.
Q. Whether or not they capture the full tone and content of the meeting is really what I want to ask you about. Can you just give us a summary of that meeting and your experience of it?
A. Yes. I -- many of the -- some of the notes of meetings I was at including that one, when I look back at the notes, although I am trying to think back seven years or something, they don't seem to capture everything and I think some were just writing notes

down, not by shorthand, we will never get everything down that's said in a meeting unless you have someone as in the Inquiry doing it word by word.

But I suppose they don't convey the emotion of that meeting and I found it quite an emotional stern meeting. You don't get that from just the notes written down. Do you want me to run through the meeting?

Q. Absolutely. In terms of, firstly, was it a discussion sort of meeting or was it the paediatricians making a presentation or was it the Executive Directors making a presentation?

A. It is Executives making a presentation telling us the findings and then telling us the action that needed to be taken without any discussion. I think there was a chance for discussion at the end. I think Dr Brearey and Dr Jayaram just managed to ask: can we see these reports? I was too stunned to ask anything at the end of that meeting. My head was swirling. I didn't quite understand what had happened.

Q. What stunned you?

A. The nature of the meeting because I thought we were going to that meeting for the first time, because I don't think I had seen those the College report briefly in Mr Harvey's office, although maybe I did, but we were going to see the two reports, the College report

and Dr Hawdon's external expert review of the deaths and a few of the collapses and we would have a discussion about it.

I didn't realise we were going just for a brief presentation summary of those reports and then to be told what needed to be done.

Q. Now, one of the matters recorded in the notes of the meeting is words to the effect were said: "review by a high power team didn't call out any criminality, draw a line".

A. Yes.

Q. Does that capture the sort of thing that you were being told by the Executive Director?

A. Yes. What we were told initially by the Medical Director was that the College report had shown poor leadership on the unit, poor communication, and it just sounded so negative. And I felt so bad that that's how our unit was perceived, but perceived by eminent peers who had come in to review our unit. Then Dr Hawdon's report hadn't shown any concerns, I think it was no common factor to account for the deaths. I don't think Dr Hawdon had any staffing analysis or anything, but no common factor from the medical side.

And then we were -- I say it was emotional, a letter was read out from Letby by one of the senior

nurses in a quite emotional tone and then we were told how much we had upset Letby by the Chief Executive and told firmly that the board had accepted the findings that there had been no evidence of any wrongdoing and that Letby was exonerated -- I don't know if he used the word "exonerated" -- but no evidence against her and that a line was being drawn under this and that was said quite firmly. I thought the Chief Executive finished by saying, "Is that clear?" as he looked round the room at each of us. I think some of my colleagues thought he said something slightly differently but they can report on that.

Q. We are interested of course in your recollection --

A. But it was clear that was the end of it. The board had accepted these reports had shown no wrongdoing and we were to apologise to Letby.

Q. You used the word "shocked" in your witness statement.

A. Yes.

Q. Particularly by reference to the fact that you hadn't reviewed at that time either the RCPCH or the Dr Hawdon report?

A. Yes.

Q. I mean, in the ordinary course of things --

and I do recognise in my question that this wasn't the ordinary course of things -- but are management generally open with Consultants in relation to the content of expert reports before they discuss that content with the Consultants?

A. I am not sure because I hadn't had experience of this situation with those managers. It had been my experience as a Clinical Director some years earlier that the managers then were more consultative and for example would have probably shown us the reports and had a discussion about it?

Q. So you were told a line had to be drawn under it?

A. (Nods)

Q. Under the Letby issue, as sometimes it is characterised.

But you and your colleagues wrote a letter to Mr Chambers four days later and we will just bring it up, INQ0003095. Signed by you all. You asked specifically what the board's understanding of the reason for the increased number of unexpected and unexplained deaths on the neonatal unit between June 2015 and July 2016 and "the actions that you and the board now expect us paediatricians to take". And go on to say that you want to read the RCPCH report and the

Casenote Review and give an assurance that it will be kept confidential?

A. Yes.

Q. What was your thinking behind asking specifically for the board's understanding of the reason for the increase, what were you trying to achieve by asking that very direct and specific question?

A. Well, we paediatricians couldn't understand the increase. Interestingly, the board could, and we wanted to know their reasons for accepting why there had been an increase. Obviously it would help us to have read the actual reports to try and understand it.

MR DE LA POER: Thank you. My Lady, would that be a convenient moment?

LADY JUSTICE THIRLWALL: Yes, thank you very much indeed, Mr De La Poer. 20 past 3.

(3.04 pm)

(A short break)

(3.20 pm)

MR DE LA POER: We had reached 30 January of 2017 and is this right, there were two issues confronting the Consultant paediatric body: on the one hand you hadn't at that time read the reports which had only been summarised to you in a particular way?

A. (Nods)

Q. But also was it your understanding at that time that Letby would be returning to the ward?

A. Yes.

Q. And how imminent was it did you have the impression that that was going to happen?

A. I wasn't sure. Within the next week or two I presumed, not that day.

Q. So I am going to come now to a WhatsApp chat which I think you have been asked to consider as part of your preparation. We can deal with it in summary. It is a discussion between you and your Consultant colleagues between 5 and 7 February in which you are effectively discussing between yourselves why it is only some of you will be permitted to view the report and others would not be able to?

A. Yes, which dates again, 5 February onwards?

Q. 5 February onwards.

A. I think that's probably referring to the Hawdon report. I think we were all given the Royal College report.

Q. Well, we know on 7 February you were in fact all given access to the RCPCH report.

A. Okay, right.

Q. Perhaps it doesn't matter terrible.

A. One or both reports only a few of us were

going to see originally.

Q. Yes, and did you also at about that time get access to Dr Jane Hawdon's report?

A. Around that time, yes. I thought we had the Royal College report a day or two report before the other report, but a few days apart. It didn't really make any difference.

Q. You obviously had the opportunity to consider both reports?

A. Yes.

Q. What you say? Your statement is once you got access to both, you realised that deliberate harm had not been excluded?

A. Yes.

Q. When you read them, how obvious to you was that conclusion?

A. Fairly obvious from -- I mean, deliberate harm hadn't been confirmed either. From Dr Hawdon, the expert review that four were unexplained deaths, sort of similar to what -- not necessarily four, similar to we felt these were unusual deaths, it wasn't just the number, it was the nature.

Q. Those being category 2?

A. Yes, four patients.

Q. Which she recommended for broad forensic

review --

A. Yes.

Q. -- or local forensic review depending on which part of the report we are looking at?

A. Yes.

Q. Again just bookmarking an event without going to the detail, records indicate that you contacted the British Medical Association on 7 February?

A. (Nods)

Q. Why did you do that?

A. Because I realised I could be in conflict with senior managers and potentially I might be disciplined or suspended or lose my job and that's also why I contacted the MDU.

Q. What was it that you thought you might do at that time that was going to put you in conflict with the managers?

A. Go against what the managers had clearly advised; that that's the end of the discussion about Letby.

Q. So in other words that you wouldn't accept that a line had been drawn under it?

A. Absolutely, that's why we sent the letter a few days later to the Chief Executive knowing it might get us into trouble.

Q. That was the letter of 10 February 2017?
A. We sent one a few days earlier, the one at the end of January.
Q. 30 January we looked at?
A. Yes.
Q. That's where you asked specifically for the board's understanding of the explanation?
A. But even at that stage we had not drawn a line under it and we defied what we were told and we were starting to ask questions, and again on the 10th.
Q. If we bring up the 10 February letter, INQ0003117. So this letter written following --
A. Having read the reports.
Q. Exactly so. You give the dates 3 and 7 February?
A. (Nods)
Q. The substance of the letter goes on to urge a Coronial investigation?
A. Yes.
Q. Why did you think that the Coroner was the right person in these circumstances?
A. Because the Coroner is supposed to examine deaths to try and ascertain why they occurred and we thought if he had access to Dr Hawdon's report and knew of our concerns, that that would ring major alarm bells

for the Coroner.
Q. So --
A. And in a very loose way -- and I might have got this wrong, I am not a legal person -- I thought going to the Coroner is not the same as going to the police, but I thought they were closely linked. If you had deaths you could not explain and that we were raising the sort of concerns we paediatricians were raising.
Q. At the end of the second paragraph:
"The reports have not reassured us that all these deaths and collapses are explicable by natural causes"?
A. Yes.
Q. What isn't said in terms in this letter is: we remain suspicious of Letby.
A. Yes.
Q. Is there any particular reason why that express statement of the sort of the concern was not included in this letter?
A. Well, maybe we were being a little bit cowardly. We didn't want to ask to be sacked so we had been told this was the end of the matter and the board decided it was the end of the matter. We were clearly pushing it and without -- we didn't feel we had to explicitly say we still had the same concerns that

patients had been harmed and that it may be Letby doing it because we had been told to leave it. But we felt this sort of letter implied the same thing without stating it.
Q. Of course to the informed reader the Executives who had heard your concerns articulated that would be implicit when reading it?
A. Yes.
Q. But as we will get to, this letter was -- it was a request that the letter be given to the Coroner?
A. (Nods)
Q. The Coroner, do you agree, wouldn't, reading just this letter, understand the specific nature of your concern?
A. Yes, but we hoped, did we say just the letter to be given to the Coroner?
Q. No --
A. I think we wanted the Coroner to do a full investigation so maybe this letter but also the thematic review and other things. We didn't think the Coroner would be given one letter and be expected to do a full investigation.
Q. That's what I was coming to: were you expecting this letter would be a broader explanation to the Coroner?

A. Yes, yes, and I suppose we should have made it clear and there is a lot of things we didn't make clear, it would have been quite useful if we had all gone to speak to the Coroner but you may ask: why didn't we do that anyway? We were trying to do it through the managers and we knew at this stage Letby was not on the unit and we suspected, but did not know, that by sending letters like this one and the following one at the beginning of March, that would probably stop her coming back until this had been sorted out.
Q. 12 February, an email that we don't need to look at, we can take it down. You deal with it in some detail in your statement. You will know the one I mean, it is a reference to Howie?
A. Yes.
Q. Who is Dr Howayda Isaac?
A. Howie Isaac, I think.
Q. And Dr Issac is a Consultant Community paediatrician and the named doctor for safeguarding in the paediatric department?
A. Yes.
Q. And you raise in that email, I am sure you can recall the fact that Dr Isaac was considering intervening in what was going on?
A. Yes.

Q. And you were discussing with your colleagues whether that was a good idea or not?
A. I am not sure a good idea whether we could show her the reports because we had been given the reports and told to keep them highly confidential. I thought we could give them to her because she was a fellow paediatrician, albeit a community rather than a hospital. Some of my colleagues felt it better that she go via the Executives which in normal practice I would have given the report to a colleague who is another paediatrician.
Q. Was one of the attractions of Dr Isaac having the reports because Dr Isaac had a safeguarding role?
A. Yes, and she may raise concerns as well, it is up to her once she has seen the reports.
Q. So does it follow from that that at this time you were seeing safeguarding as a possible way of ensuring the concerns were properly investigated?
A. No. I think Dr Isaac felt she ought to be involved and we thought she should be involved. We thought we would raise safeguarding issues quite clearly to the senior managers who have a responsibility for safeguarding in the Trust. It didn't necessarily need Dr Isaac as well, but it was fine if she wanted to join in. We weren't expecting her to raise the issues for

us. We thought we had raised them clearly enough already.
Q. When you raised them, and here we are talking about with the Executive Directors, had you so far as you can recall expressly referred to them as a safeguarding concern?
A. I can't remember if we did. I thought it's fairly obvious they were.
Q. Continuing with our chronology, 16 February 2017, a letter from Mr Chambers confirming that the letter had been sent to the Coroner, do you recall that letter, or shall we --
A. Yes -- no, I recall it, yes.
Q. What was your reaction to the actions that you were being informed the Executives were taking at that time?
A. Pleased the letter had been sent to the Coroner, weren't clear if that meant the Coroner would investigate all the deaths but at least some action had been taken. I think it fair to say I can say for myself and I think my colleagues will express their own opinions, trust between ourselves as Consultant body and the Senior Executives was breaking down at this stage.
Q. There was mention in that letter about the fact that there had been a meeting and there was to be

a meeting with the Coroner?
A. Yes.
Q. So trust was breaking down. Is that a polite way of saying you didn't believe that your concerns would be fairly represented?
A. I wasn't sure that our concerns would be slanted in the correct way. It was clear from previous meetings going right back to July 13 2016 when we were given the results of the Trust's internal investigation that the Senior Executives' interpretation of data was different to our paediatric interpretation of data. We didn't know quite what view had been given to the Coroner.
Q. On 24 February, you had a meeting with Mr Harvey?
A. Yes.
Q. Am I right in suggesting that that meeting was because Mr Harvey contacted you saying he wanted to talk to you about your July 2016 report?
A. Yes, and we had asked to see that report in our earlier letter to the Chief Executive. When we sent letters to the Chief Executive, we assumed, but maybe we shouldn't have done, probably the Medical Director and nursing director would have been shown those by the Chief Executive.

Q. Were you told by Mr Harvey anything of what he had done so far as the Coroner was concerned in that meeting on the 24th?
A. Yes, he mentioned he had seen the Coroner with Mr Cross, the corporate and legal advisor for the Trust, and that they had shared our concerns with the Coroner, they had copies of our letters to the Chief Executive and the Chief Executive had mentioned the letter going to the Coroner in his letter which at that time reassured me that hopefully a resolution may be coming for our concerns, that the Coroner would consider these concerns in the forthcoming inquests which were on three babies.
I know two of them were Child O and Child P. I am not sure who the third one was, possibly a child not in the indictment.
Q. So at that moment in time when Mr Harvey told you that, did you consider that you had taken the matter as far as you needed to and it was now in the hands of someone else, or did you think more needed to be done?
A. I thought the Coroner must take some action once he has been told all of this.
Q. Did you suggest to your colleagues that the ball was now in the Coroner's court?
A. Yes, yes because we had said in our letter to

the Chief Executive of 10 February that we wanted the Coroner to investigate all the deaths.

Q. Were your colleagues as satisfied as you were that it was appropriate to take a step back at that point?

A. No, they weren't and I quickly realised the error that I had made. I think my colleagues fed back Dr Jayaram was on holiday at the time which prevented us getting together for a few days. I think it was yet another of these informal meetings in our office and I don't think it is minuted.

It's just that my colleagues felt that we did not know exactly what had been sent to the Coroner and, as I said before, what sort of slant had been put on it and also it was discussed and I realised this is probably true and I was wrong to think we are wrong to get a resolution, get a proper investigation, if the Coroner is just considering at an inquest for individual children, and it can take many months for those inquests to take place, would the Coroner really look at all the deaths or consider all the deaths in that, and we couldn't be sure what would happen and it could take a long time. My colleagues were adamant then that we ought to go to the police, not just leave it to the Coroner although we had earlier said we wanted

a Coroner's investigation.

I think my colleagues were quite clear that trust has broken down between us and the Senior Executives at that stage and in that discussion, I agreed they were right, I was wrong; we had to go to the police.

Q. 28 February, you met together with some of your colleagues with Mr Harvey?

A. Yes.

Q. I am not going to go into the detail of it but you will recall that Dr Brearey sent an email following it setting out his version of what happened, Mr Harvey replied effectively saying that he had matters to add to that?

A. (Nods)

Q. Having considered those two emails, do you agree with either of them or both of them, what's your view?

A. I can't remember all the details now.

Q. No.

A. But the meeting we had with Mr Harvey and Dr Subhedar again from the Neonatal Network was looking at the review of all the babies and instead of just the four that had been highlighted as unexpected, with Dr Subhedar's input and our Consultants' input, we decided there were eight babies with unexplained deaths

and I think at that stage Mr Harvey was going to look at how they could be further investigated and get hold of Dr Hawdon to find out what she meant by forensic review but we felt we were getting somewhere slowly at this stage.

Q. The same day -- we will just bring it up -- 28 February 2017, INQ0003187 -- the seven of you Consultants wrote a letter of apology to Letby?

A. Yes.

Q. Let's just be clear about this. You I am sure have been over the text of this many times both before it was sent and afterwards. Were you accepting when you sent that letter that you didn't think Letby had done anything wrong?

A. Sorry, can you pose that question again?

Q. Do you want to just read it and then ...

(Pause)

A. Sorry, yes. We were not saying she had done no wrong here, we were just apologising for the stress that has been caused. In fact, did we say to her or not? "You", it says, yes. We were sorry for the stress we had caused all the other nurses on the unit as well. So we are apologising for the stress, we weren't apologising for the -- I think from my colleagues saying we never accused her of anything, I think we implied

quite strongly what we were accusing her of. But we didn't apologise for having raised concerns that she may have harmed patients.

Q. Thank you, we can take that down.

1 March another letter to Mr Chambers, INQ0006816.

A. This in a way is emphasising the fact we have reviewed Dr Hawdon's report with Dr Subhedar and there were now eight unexplained deaths, we felt. We were pointing that out to Mr Chambers.

Q. We will just bring it up but you have got there without needing to see it.

Was that the purpose of this letter, just to say: look, we have got to a particular position. It is not four, it's at least eight?

A. Yes, do we say that in this letter? I thought we had, but ...

Q. I think you will see it over the page.

A. Right.

Q. If my recollection is ... The second bullet point.

A. Yes. So we are saying there are eight cases altogether.

Q. Exactly so.

A. And saying this needs to be investigated.

Q. Thank you very much indeed.

Now, there is an email chain which ends with you sending an email on 19 March 2017 which I can bring up if you need to, but if I give you the context.

It appears to be a discussion about a draft letter that is going to be sent to Mr Harvey identifying specific cases of concern. Do you know the --

A. Yes.

Q. One of the matters under discussion was Child K.

A. (Nods)

Q. I am not looking to go into the detail of this with you, but you will know that Dr Jayaram has spoken about an occasion in relation to Child K that he was concerned about.

A. Yes.

Q. Had Dr Jayaram told you that there was an incident connected with Child K and Letby that he was concerned about?

A. I think he had at that stage, yes. When I say I think he had a bit evasive -- I mean, I was very well aware later on that he had and I knew about the two trials for that baby. I can't remember exactly when it was Dr Jayaram raised that, but I thought he had raised that not long after he had been involved in that incident back in January 2016.

Q. So you think that's something that he mentioned to you?

A. I think it was back that early. But my memory is a bit confused because it's been mentioned so many times since.

Q. Well, certainly in this email chain -- we can look at it but I am sure you will take it from me that one of the things you say about Child K is I know you are concerned about this case, Ravi?

A. Yes, yes --

Q. So at least at 19 March?

A. Absolutely, I knew it by then, yes.

Q. Was that a case or an event that you encouraged him to tell the managers about?

A. I can't remember that because as I say, I can't remember exactly when I heard about it. But from this email I did know by this time. But this is 2017.

Q. This is 2017?

A. It happened in February 16 so I can't remember between February 16 when it happened and this email at what point I learned about it. All I can say is I knew about it by the time of this email.

Q. You don't --

A. I don't think in particular -- there were

quite a few cases that concerned us. I don't think Child K -- just pause for a second. I was going to say I don't think Child K was a major case, except of course it's the only one where anyone might have seen Letby doing something but rather it was not doing something, so I suppose that's important.

But I don't remember talking to Dr Jayaram about raising it with the managers, no.

Q. We will move forward to the meeting with Simon Medland QC, as he was then. This was on 12 April 2017 and you have had a chance to see now His Honour Judge Medland's note of that meeting.

A. Yes.

Q. All that I really need to ask you about that was going into that meeting, what was your expectation about its purpose?

A. Mr Medland was to help us to decide how to present our case to the police.

Q. So implicit in that is a decision had been made to contact the police?

A. The police were going to be called in, how were we to do that?

Q. Who had you got that impression from?

A. I think it was Dr Brearey, it is a chain of events, Dr Brearley got it from someone else. So you

would have to talk -- I know who he got it from but he can tell you that.

Q. When you got into the meeting with Mr Medland, what were you told he thought the purpose of the meeting was?

A. To decide whether there was enough reason to go to the police. We made it clear to him, because we were getting a bit fed up the way things were just not going the way we thought, we thought we had been told one thing and something else was happening. We made it very clear to him at the beginning of the meeting it doesn't quite come across in his notes which are otherwise a very good summary of the meeting, very clear that we felt he had been misled and we had been misled. And he apologised for that, then we carried on as it says in his record of that meeting.

Q. One of the suggestions that Mr Medland makes in that meeting as recorded in the notes is that you make a list of your best points?

A. Yes.

Q. Now, on the face of it, that would be a good way to bring together all of your concerns on paper in one place?

A. (Nods)

Q. That hadn't been -- correct me if I am

wrong -- a thought that had occurred to any the Consultant paediatricians before that point, other than that email that was being drafted to Mr Harvey a couple of weeks earlier; is that correct?

A. That's true. But I thought in various discussions we had had over the previous year that we had covered most the points that we would put to the police.

Q. So is it the position that if not in writing, you had communicated the best points already to the Executives?

A. Yes, we hadn't hidden anything from the Executives that we revealed to the police and not to them.

Q. Could you at the time see the benefit in setting everything out in writing?

A. Yes, it is obviously very good to have some documentation of what went on, yes.

Q. And --

A. In a way, we had set -- we hadn't identified each patient, we had set out our concerns in writing in these letters to the Chief Executive to the last two letters we sent. But maybe yes, we should have set it out in writing like that much earlier. But we had hoped by talking to people, by telling someone they might take

action even though we didn't send a letter saying the same thing. But maybe we were wrong to have assumed that.

Q. We know that in fact on 10 May, to use Mr Medland's language, a document containing your best points was sent to the Cheshire Police?

A. Yes.

Q. Was that a direct result of Mr Medland's advice or was that something that you had all reached the conclusion by then you would need to do in any event?

A. We thought we were heading very close to doing that anyway, as we were indicating in our letter to the Chief Executive.

But Mr Medland also suggested maybe if you wanted to talk to the police, we talk to the police officer as part of the local Child Death Overview Panel and that had happened before the 15 May.

Q. 10 May --

A. It happened -- it wasn't myself, I wasn't there. Some of my colleagues met with the police officer from the Child Death Overview Panel and as a result of that, the police were very interested and that letter documenting concerns about individual patients went to the police.

Q. We can just bring that up. INQ0006136, 13 April 2017 so the day after the meeting with Mr Medland?

A. (Nods)

Q. And if you look at the third paragraph of Dr Jayaram's email:

"We feel that his suggestion of speaking informally with Detective Superintendent Wenham from the CDOP would be very helpful and would like this to be facilitated as soon as practically possible."

A. Yes, and that meeting was arranged.

Q. Yes, we know that meeting -- I hope I get this right, 27 April is when it occurred?

A. Was it? I would have to check. It was around then, yes.

Q. Two more matters from me, Dr Gibbs.

Thank you, that can come down.

The first is to move outside of our time period that we have been focused on and just draw your attention to the spring of 2018 and in the spring of 2018, a table was sent to Mr Chambers providing a list of the Consultants' concerns --

A. Yes.

Q. -- one after another in terms of how the whole situation had been dealt with. Were you a party to the

creation of that table?

A. Yes. We -- it was circulated amongst all the Consultants -- paediatricians.

Q. And we know that Mr Chambers replied also in tabular form, it would seem?

A. (Nods)

Q. And that there was a further column setting out what the response to the reply was?

A. Yes.

Q. So far as you were concerned, do you stand behind the concerns that -- as they ultimately landed within that document?

A. As far as I can remember, generally yes. I did feel by the time we had this to and fro of letters that we probably weren't getting anywhere and we had said enough at that stage. The police were currently investigating and I felt our focus should be on what the police found. This wasn't part of the attempt and the Chair of the Trust was getting -- Sir Duncan Nichol was getting involved at around this time, of trying to repair the relationship between us Consultant paediatricians and senior managers.

Q. And in terms of your response to Mr Chambers's reply to your concerns, did you think that moved the relationship closer together or further apart?

A. No, I felt it just -- it angered people really and that's why I felt we weren't gaining much from continuing this process. Every letter that he wrote to us we could criticise it line by line and I felt that wasn't constructive, although I was part of reviewing the letters.

Q. Thank you. The final topic is just in isolation, if you like, and that's certainly how it appears in your statement. I am looking here at paragraph 474 on page 137 of your statement.

You were asked specifically about interactions with the Cheshire Coroner?

A. Yes.

Q. We can just move through it. Before June 2015, you had only had direct contact with the Coroner on a couple of occasions, is that right?

A. Yes.

Q. You contacted the Coroner's office regarding two babies because you didn't know why they had died and one of those babies was Child C?

A. Yes.

Q. You set out in your --

A. Most of my contact with the Coroner's office -- sorry, was through the Coroner's officer not the Coroner himself.

Q. Yes. And you set out at 475 that you think having -- you pass on the information the Coroner's officer discussed the case with the Coroner and phoned you back to tell you that Child C would be a Coroner's case?

A. Yes.

Q. As a result you completed a form?

A. Yes. I mean, the fact the form was completed and sent off and a copy should have been in Child C's notes -- I think it was -- indicates that that process had taken place.

Q. But as you have told us, at the time that you are doing this, there were no concerns that you had -- or suspicions is perhaps a better way of putting it -- about Child C's death?

A. Yes, my concern was trying to find the cause of Child C's death and that was a concern, not only suspicions of harm at that stage.

Q. Child I you deal with at 476 and you say you believe you were Consultant of the week at that time who reported Child I's death to the Coroner?

A. Yes.

Q. And although you considered Child I's deterioration to be unusual in the hours prior to death, Child I had suffered previous multiple deteriorations

and required several interhospital transfers and that caused you at the time to suspect an underlying medical problem rather than deliberate harm?

A. Yes, and as I mentioned a little earlier Child I, like Child G, I didn't realise some of those deteriorations had been caused by Letby but that led me to believe this was a vulnerable child who was prone to deteriorating because they decompensated quickly, which some babies can if they have multiple problems and have been trying to deal with them for some time.

Q. Now, you say at 477, effectively summarising the position, that you don't think additional information should have been provided by the babies who died in 2015 because there was not sufficient suspicion that the deaths were not natural?

A. Yes.

Q. That at least being a reflection of your view at the time of both of those deaths?

A. Yes.

Q. If we look at 478, however:

"At the time of the deaths of Child O and Child P in June 2016, there was concern about the possibility of deliberate harm. I do not think this concern was mentioned with when a colleague reported those deaths to the Coroner possibly because we paediatricians were

seeking agreement from the senior managers on how to deal with our concerns and we knew the NNU nurse manager was adamant that our suspicions about Letby were misplaced. Furthermore, since we were uncertain how to proceed as a group at that time, it was difficult for the individual reporting a death to the Coroner to take sole responsibility for raising this concern outside of the hospital."

A. Yes.

Q. It is really just to help us to understand in terms of your responsibilities as a paediatrician, I appreciate this is not you being the final arbiter of the decision because you are not the one in contact with the Coroner but you appear to be speaking for the view that you took at the time?

A. Yes.

Q. Just help us to understand a little bit more about your reasoning there about why because of uncertainties how to manage a situation, and I am obviously summarising what you are saying there, you didn't think it was appropriate that the Coroner be told at the time of notification of O and P that there were suspicions?

A. I suppose I wasn't sure if my colleague had conveyed those suspicions and I was trying to explain

why I thought they might not have done. I think that colleague is one of the Consultants who will be giving evidence here and may be able to answer that.

Q. So --

A. And I think in the end, because just from documents I have seen from the Inquiry Team, I think when those forms to the Coroner or to the pathologists doing the PM on behalf of the Coroner were sent, I think -- but my colleague could answer this, I think there might have been some mention of unusual unexpected deaths having occurred several times on the unit. I think that was the case.

Q. Well, given, as you have explained to us, that that isn't a representation of your view but rather an attempt at explanation at somebody else's thought process, I won't take that any further.

Can I just say this as far as my questioning is concerned. Dr Gibbs, you devote a substantial part of your statement, if I may say so, to part 4, your reflections. That is going to be published on the Inquiry website rather than us taking you through it now.

I wouldn't want you or anyone else to think that we were not enormously grateful to you for the time and care you have taken over those reflections, but they

will stand as part of the Inquiry record and can be considered and referred to in the future. So thank you very much indeed.

A. If I could briefly add, because I know time is against us -- I quite accept I wouldn't want any of those recommendations implemented unless other people feel likewise so it's -- and it is up to the Inquiry to decide which to decide which of those get implemented.

MR DE LA POER: Dr Gibbs, that concludes the questions that I have for you. As you know there are some further questions to come on behalf of one of the Core Participant groups.

LADY JUSTICE THIRLWALL: Mr Baker.

Questioned by DR BAKER

MR BAKER: Good afternoon, Dr Gibbs. I ask questions on behalf of a number of the Families, in particular Mother C, so I am going to ask you some questions about the history of Child C and your interactions with Mother C.

Now, I appreciate in doing so that involves quite a substantial change in track to the questions you have just been answering?

A. (Nods)

Q. I am also conscious of the fact that your witness statement was written a number of years after

the event, so your witness statement for this Inquiry is written in 2024, describing events that took place in 2015. So where I think seek to draw out differences between your recollection and Mother C's recollection, please don't see that as being anything other than a question about recollection rather than probity.

A. Okay.

Q. I want you to go, if you can, please, to paragraph 104 of your witness statement on page 30. This may help orientate you in relation to the background for Child C. You see here you say Child C was born prematurely at 30 weeks.

Just to put a marker down there, 30 weeks in 2015 was by no means the extremes of prematurity, was it?

A. No, it wasn't.

Q. I can take you to the entry in the medical records, but it is also correct to say that Child C was born in a good condition?

A. Yes.

Q. Required very little resuscitation, if any?

A. Yes.

Q. In a general sense, would you expect a baby born in good condition at 30 weeks to survive?

A. Yes. Slight qualification for Baby C is that he was particularly small for a 30 weeker. He should

have been one and a half kilos roughly and he was around half that size.

Q. So he was around the second percentile?

A. Yes, half the average size for his age.

Q. Yes.

A. So that does increase risks a bit.

Q. Yes. I mean, I think the advice you gave to Mother C at least insofar as her recollection is concerned that you would have expected Child C to survive?

A. Yes.

Q. And the risks of prematurity in general, I don't mean the risks of being attacked by a nurse, but the risks of prematurity in general, would they centre around problems with the bowel, the risk of infection, respiratory difficulties?

A. Yes, and sometimes problems with bleeds in the brain.

Q. Yes. So, I mean, at 30 weeks in a baby who had had I think antenatal steroids, you would not ordinarily expect the risk of a germinal matrix haemorrhage?

A. No, that's correct.

Q. So the risks would be Respiratory Distress Syndrome, sepsis and Necrotising Enterocolitis.

A. Yes, and particularly for Child C, necrotising enterocolitis because of the problems with poor growth in utero and poor umbilical placental blood flow. That does significantly in increase the chance of NEC.

Q. I am going to look at his condition in respect of each of those pathologies, if you will, but from a respiratory point of view in the days leading up to Child C's collapse, he was improving?

A. Yes.

Q. His oxygen requirements had gone down substantially?

A. Yes, I wouldn't have thought he would experience any significant problem at that stage from his breathing.

Q. No. And insofar as sepsis was concerned he had had, I think, a raised C reactive protein which is a marker of infection or inflammation, should I say. But he had no other signs or symptoms of infection?

A. No. He did have a high blood lactate level which is a sign of poor perfusion which can be related to infection. But his blood cultures didn't show any infection. But sometimes babies have infection with all the clinical signs but a negative blood culture.

Q. Yes, because they may be colonised by a particularly fastidious bacteria?

A. Yes, and the small sample of the blood we can get out of the baby doesn't always identify the organism even when it is there.

Q. Yes, but cultures taken before and after his death didn't reveal any signs of bacteria?

A. No, it didn't look like he died from infection, neither did his postmortem.

Q. His respiratory rate and temperature were normal?

A. I thought they were and Dr Hawdon points out he had a slightly fast respiratory rate, but that wouldn't bother me knowing he is a 30-weeker prone to Respiratory Distress Syndrome. We knew he needed support for his breathing that was gradually reducing so that would explain the slightly raised respiratory rate.

Q. If I put it this way. Given the signs of infection that were present, raised inflammatory marker, would you expect that to result in a sudden collapse and death of a baby in and of itself?

A. I just missed the very last bit.

Q. Just a raised C-reactive protein?

A. Yes.

Q. In and of itself, you would not expect that to be the thing that caused a baby to collapse and suddenly die, would you?

A. No. It depends. The raised C-reactor protein is an indication of possible, not always infection, possible infection. It would depend on whether the baby showed signs of severe infection with poor circulation and gradual deterioration. He didn't show those signs, so I would not expect him to die from infection just because of the raised CRP.

Q. Indeed the CRP was mildly raised?

A. Yes.

Q. I think it was a little over 20?

A. Yes.

Q. In severe infection, it can get up to over 300, cant it?

A. Yes. But not -- unlikely in a little baby but nearer 100, yes.

Q. So necrotising enterocolitis.

A. Yes.

Q. There was no evidence of that prior to the collapse?

A. I didn't think so and this was discussed a little bit at his trial. One of his x-rays the day before he died did show slight distinction in his abdomen which I think the radiologist reported as possible bowel obstruction.

I felt it was quite consistent with a baby that had

been having respiratory support that blows air and oxygen down the nose and mouth and actually fills up the tummy a bit. But you could say that -- you just worry a little bit, could that slightly unusual bowel pattern be the very beginning of NEC.

Q. Yes.

A. The postmortem didn't show NEC at all.

Q. No, there was no sign of it on the postmortem and also NEC doesn't appear out of nowhere and cause a death, does it, it evolves?

A. Usually.

Q. Usually?

A. Sometimes babies can deteriorate within a few hours with overwhelming NEC and they perforate the bowel. But usually it's a few days of being ill and some babies do die of NEC usually after a few days of being very ill and not improving.

Q. And bowel perforation presents in a typical way which wasn't present here?

A. Well, a bowel, a bowel perforation which can happen for various reasons, and affected one of the other babies in the indictment, can happen suddenly and cause a sudden quick deterioration. But Baby C did not have a bowel perforation at postmortem.

We didn't suspect it in life and he didn't have it.

Because the reason for doing a postmortem -- sorry to rush, but I can see the time -- sometimes you find conditions that you did not diagnose in life and it explains the problem. We didn't have a -- we had no explanation from the bowel at postmortem for Baby C's collapse.

Q. And looking at the raised lactate at the time of his birth, one of the things that was raised at postmortem was myocardial ischaemia.

A. Yes.

Q. Now, lactate can raise in the presence of heart failure?

A. Yes, any -- any poor perfusions and heart failure is one of those causes, yes.

Q. Yes, but in Child C's case the lactate was elevated at the start?

A. Yes.

Q. And then improved to normal --

A. Yes.

Q. -- by the time he collapsed?

A. Yes and we know from the antenatal scans of the baby -- and that's why the baby was delivered -- that perfusion was poor from the placenta to the baby and that could well explain the raised lactate which then improved in the early days of life.

Q. But looking at heart failure as a potential cause of the collapse, would you say that improving a normal lactate is inconsistent with heart failure as a cause of collapse?

A. Probably. It's not that common to encounter heart failure in little premature babies. It does occur obviously, so I don't have a good understanding of the relationship between lactate and heart failure.

Q. It's extraordinarily unusual for a baby to --

A. Yes, yes --

Q. -- die of myocardial ischaemia?

A. -- so I am not confident with answering that, you know, improving lactate means you can't have heart failure because we don't see heart failure that much -- I don't see heart failure, I haven't recognised heart failure that often in babies.

Q. I mean, that may in and of itself tell us a great deal.

A. Yes. Well, heart failure does happen in babies when they have got overwhelming problems like generalised septicaemia, which affects all the organs including the heart, and then you will have a raised lactate but that's because the baby is very ill with very poor perfusion due to the sepsis.

Q. Yes.

A. But that is not the scenario in Baby C.

Q. I mean, the reality with Child C is that his collapse came completely out of the blue.

A. Not completely. Well, yes is the short answer. The slightly longer answer: we knew Baby C was at risk of NEC. We know afterwards with the postmortem he didn't have it.

Baby C was having a few regurgitations and a few bar stain regurgitations earlier on the day that he died and there was a worry that one of the nurses had just given a small milk feed just before he collapsed and you wondered whether the milk had gone the wrong way. But it was such a small feed it shouldn't have caused a problem even if had gone into the lungs. So that's why I am qualifying it a bit. It wasn't completely out of the blue; it was largely out of the blue.

Q. Yes, so a potentially vulnerable baby but in terms of his observations they were all stable or improving prior to the collapse?

A. Yes.

Q. And a collapse may occur suddenly and unexpectedly, but you would ordinarily in the neonatal context expect to be able to resuscitate that baby or reverse the collapse?

A. Yes, well, particularly in a baby where it

happens suddenly because they haven't been compromised for some time.

Q. Yes. So children or babies who are stable or improving who suffer collapses in the neonatal setting it's generally reversible with resuscitation?

A. It's generally reversed?

Q. Reversible.

A. Generally, yes.

Q. So two factors here that were unusual about Child C. First of all, his observations were stable or improving and, secondly, he couldn't be resuscitated?

A. Yes.

Q. These were two unusual features.

A. Yes, but the unusual feature of not being resuscitated might have been explained by his postmortem report because Dr Kokai felt that myocardial ischaemia, the heart damage, had predated his collapse.

Q. Yes.

A. In which case that could have caused the collapse.

Q. I will come on to that in a moment. Were deaths due to sudden unexpected collapses common in the neonatal unit before June 2015?

A. No.

Q. And how long had you worked there?

A. 21 years.
Q. When you say they were uncommon, bordering on never happening at all?
A. Sudden unexpected deaths? No, no. Occasional, every few years.
Q. Yes.
A. I mean, some babies, like adults, can die suddenly and nothing is found at postmortem and increasingly as genetics is improving a gene is discovered, sometimes found in the family years later, that causes cardiac dysrhythmia.
So there can be rare causes of collapse which aren't explained at postmortem which do cause sudden -- cause sudden death.
Q. So I am going to come on then to -- first of all you had a conversation with Mother C where you said there would need to be a postmortem --
A. Yes.
Q. -- because the death had been sudden and unexpected and also you couldn't explain the death --
A. Yes.
Q. -- so a postmortem was necessary?
A. Yes.
Q. And you had a meeting with Mother C on 21 August 2015 by which time a postmortem examination

had been carried out, but the report hadn't been published?
A. Yes.
Q. So you had a conversation with Dr Kokai, who was a pathologist, before you spoke with Mother C?
A. Yes.
Q. Which I think you concede in a letter was a slightly irregular thing to do, but you wanted to be able to explain this to her?
A. Yes, yes, and Dr Kokai, like the other pathologist, was quite helpful in giving preliminary results of postmortems. But I think strictly they are not supposed to do that until the Coroner gives permission -- I hope I'm not getting Dr Kokai into trouble -- and that can be weeks or months afterwards.
Q. Yes.
A. Many months afterwards.
Q. It was something done so that Mother C might have answers?
A. Yes, but I think it was *(redacted)*. I don't know what -- I don't think the Coroner would have objected, but I don't know if the Coroner knew.
Q. Let us not worry too much about that.
But I would say that Mother C's recollection of the meeting is that you said the following: that Child C was

not expected to die, his collapse at the time and in the way that it happened was not expected, that you found it unusual that Child C had not responded at all to vigorous resuscitation but had later shown signs of life, that the postmortem had not revealed an obvious cause of death, but that there was an unusual finding of patchy myocardial ischaemia, which you thought was more likely to have been the consequence of the collapse but not the cause of it, and that Mother and Father C were left with an uncertainty about what had happened.
They felt you had their best interests at heart and were open about your sense of uncertainty also as to the cause of death.
A. Yes, and I think, maybe I didn't, I thought I had indicated the pathologist felt that myocardial ischaemia explained the collapse and death.
Q. Yes.
A. He thought it was likely to have occurred six to eight hours before the death, which would have been an hour or two before the collapse.
Q. Yes. What you say in your witness statement, and if I can go back to paragraph 71, you refer here to the postmortem results and you say that it was shown that:
"~... Child C had died of myocardial ischaemia,

damage to heart muscle from a lack of blood and oxygen. This provided a reasonable explanation for Child C's death, although later as I became concerned about deliberate harm on the NNU in 2016 I wondered if the PM had revealed the true cause of death."
I appreciate it's semantics, but I want to be clear about whether you thought that the myocardial ischaemia provided an explanation for the collapse, a reasonable one, rather than the death?
A. For the collapse, I wasn't sure that it did. But I knew it might, if Dr Kokai was right, and knowing that Child C had had a raised lactate and very poor perfusion before birth, that might have damaged the heart.
Q. So I --
A. But I did tell the parents I didn't think that was the likely explanation, but I wasn't sure and when we have all the mortality reviews the results of the postmortem are given there and the death certificate quotes myocardial ischaemia as the cause of death.
Q. So I accept that you may have felt that perhaps the pathologist knows better. But what you said to the parents, and I suggest it's what also you felt at the time, was that this explanation didn't seem to make sense as a cause for the collapse to you that the --

A. Yes, I wasn't sure that it did explain the collapse.

Q. And if we look back --

A. I don't think I was explicit -- I don't think I was adamant it does not explain the collapse. I wasn't sure it did explain it.

Q. So if we look, please, at INQ0008978, this is to refresh your memory. This is a letter, if we go on to page 3, this is a letter from you to Mother and Father C on 24 September, dictated on 21 October -- sorry, 21 August and it follows on, you can see in the first sentence, from a meeting on 21 August 2015.

If we look on to page 2 and if you begin reading down, please, from -- thank you -- the second paragraph or the first substantial paragraph on this page, you can see:

"Although there were several risk factors in Child C that would increase the probability of death following his delivery, it still was not expected that he would die ..."

If you could just read it to yourself in its entirety. (Pause) Then if you could let us know when you have finished.

A. I've finished that paragraph, yes.

Q. Yes. If you could read then the following

paragraph and it may help if I read a bit of it out:

"The pathologist was impressed by the patchy myocardial ischaemia in Child C's heart and until I have discussed the PM with him by phone, he had felt this could have caused Child C's collapse. He based this assumption on the fact that there was a sudden cardiorespiratory collapse. This would lead to myocardial ischaemia but it takes some hours for the cellular changes (histological changes) to become apparent. Therefore because Child C had clear signs of patchy myocardial ischaemia the pathologist had assumed this problem must have developed during the few hours before he suddenly collapsed because if he died at or shortly after the resuscitation this would not have allowed time for the ischemic changes as a result of that collapse to become obvious when later examining the heart.

"However, when I pointed out to the pathologist that because of the slightly unusual, prolonged nature of Child C's resuscitation even though the latter part of the resuscitation was only intended to be a relatively token effort pending the baptism, some signs of life had returned and it was some hours later that Child C died. This would probably have allowed the myocardial ischaemia that would have been expected at

the time of Child C's collapse and during his resuscitation to have become established histologically since Child C's death did not occur for some hours after his collapse and resuscitation."

Then on to the following page again, you are setting out there more of the same. But you go on to say:

"I am sorry to have gone over in some detail over the finding of patchy myocardial ischaemia in Child C and it is entirely understandable why the pathologist thought this might have been the cause of Child C's collapse. But on taking his history into careful consideration, particularly the fact that he died some time after the resuscitation, raises the distinct possibility that those ischemic changes followed the sudden collapse rather than preceded it."

So again, I mean you are expressing scepticism in this letter as to whether the myocardial ischaemia was the cause of the collapse --

A. Yes.

Q. -- rather than a product of the collapse?

A. Yes.

Q. And that's also something you had said to Mother C and Father C in the meeting --

A. Yes.

Q. -- that followed --

A. Yes.

Q. And also, and I appreciate this may be conflating things we later find out, but if we look at INQ0001993, on to page 14, paragraph 54.

We can see here this is a section of your police statement. If we look at that paragraph again, it's saying the same thing. If we look to the bottom, please, that would be particularly helpful. So you can see a sentence that begins:

"Nevertheless these residual signs of life for several hours prior to the eventual death would have been associated with extremely poor blood supply to Child C's heart muscle ..."

And then finally:

"~... taking Child C's unusual circumstances into account related to prolonged but mild resuscitative efforts pending his christening in my opinion it is more likely that the ischemic changes noted at postmortem were a consequence of rather than the cause of his collapse ..."

And that's a position you had reached in 2017?

A. Did I, in this -- just if we go on a little bit. Did I then explain that Dr Kokai disagreed or was it not in this statement?

Q. It's not in this statement certainly in this section.
A. Oh.
Q. It's perfectly reasonable. I mean, what I am suggesting to you is that when you were discussing with Mother and Father C you explained to them what Dr Kokai had said but expressed scepticism as to whether --
A. Yes.
Q. -- that was the cause of death, do you agree?
A. Yes.
Q. Thank you. That scepticism I would say persisted and we come on to or you came on to have a neonatal perinatal morbidity and mortality meeting on 11 February 2016. It is described as a thematic review meeting elsewhere, I think.
A. The thematic review when -- when 10 babies altogether were included, is that the one?
Q. Yes.
A. Yes, I wasn't at that meeting.
Q. But you also have a meeting.
If we can go mean to INQ0005449. So this is the neonatal perinatal morbidity and mortality meeting record and we can see that your name is fifth in the list of attendees. Can you see that?
A. Yes.

Q. The first child who is discussed within that list is Child C and we can see the third line down in the middle box discussion and learning from the case. It says, "Sudden collapse ? cause."
A. Yes.
Q. And, again, would you have been presenting the circumstances of Child C's death to this meeting given that you were his treating neonatologist or paediatrician?
A. I might have been. I can't remember. It's not necessarily always the Consultant who presents. Sometimes as a learning exercise one of our training doctors presents but we consultants add in comments.
Q. Yes. Is it fair it say given what you have just said about Dr Kokai's cause of death that "sudden collapse ? cause" probably came from you?
A. It's likely, yes.
Q. And --
A. But sometimes in this discussion and learning from the case, we are just summarising what the case was and Baby C died of a unknown cause on the day of his death.
Q. Yes, but if you were in a position by 11 February 2016 of accepting that the cause of death was, one, a widespread hypoxic ischemic damage to the

heart and that that had also been the cause of the collapse, we wouldn't see "sudden collapse ? cause" here, would we?
A. Well, Dr Kokai felt the ischemic heart problems caused the collapse, I wasn't sure. So there is a difference of opinion there so those two come together.
Q. Yes. So the actual cause of death is recorded and it has "PM" for postmortem before it, so indicating where the source is --
A. Yes, yes.
Q. -- but the narrative section to the right of that puts "sudden collapse ? cause", which suggests a degree of scepticism as to the cause of the collapse?
A. Yes.
Q. And --
A. Can I add also, sorry, there was a letter I sent to the parents in December, I can't remember the date in December, once the final postmortem report had come through and that was after my discussion with Dr Kokai, who was going away to discuss with colleagues, and knowing what I told him about my scepticism, well, the question to him about: did the ischaemia really start before the collapse? And I don't know what discussion he had with which colleagues, but that's what

he was going to do.
His subsequent formal death certificate, well, I'm sorry, his subsequent postmortem report then said -- he presumably discussed it or thought about it -- myocardial ischaemia was the cause of death.
Q. Yes, I don't think there is any doubt that that's what Dr Kokai felt. But you I think you have agreed were sceptical about that as the cause of collapse?
A. Yes.
Q. Dr Brearey in his evidence says that at this meeting, and he says it in a police interview, he says that you presented the circumstances of Child C's death to the group.
A. All right, okay.
Q. And that you put up a slide, or at least otherwise showed the group Child C's observation charts preceding the collapse, which were all stable and normal.
A. Yes and that's why it surprises me Dr Hawdon in her report says his observations weren't normal, but...
Q. But certainly, can I suggest this; that by 11 February 2016, there were audible noises being made within the group of Consultants that somebody may be

deliberately harming patients?
A. Yes.
Q. At this meeting, you held up a slide of Child C's observation charts to show the sudden and unexpected nature of the collapse because of a concern that Child C may be one of the children who was deliberately harmed?
A. It wasn't expressed like that at the meeting as far as I remember. Sorry, I held up a chart saying that he was one the children that we were concerned about deliberate...?
Because I didn't think we discussed deliberate harm to patients in a forum with the junior doctors. That had been discussed with the ward manager by Dr Brearey as the neonatal lead and then with more senior managers.
Q. But here we have a meeting occurring after a point where I think you would accept that you had been concerned about deliberate harm whether or not you could identify the individual?
A. Yes, at this point I was wondering could Baby C have been harmed, that's correct.
Q. Yes.
A. I don't remember expressing that in the meeting. I wouldn't normally do it in a meeting with junior doctors and midwifery team and the obstetric

people that are mentioned in the attendee list.
Q. Okay, so --
A. I would discuss that with the other consultants. Dr Brearey was discussing it with the neonatal ward manager and then shortly after this date in February he was escalating it to senior managers in the hospital.
Q. But certainly by this time, you were concerned that the sudden collapse against a background of stable or improving observations --
A. Yes, we were concerned about that from when he -- yes, right from his death.
Q. But to be precise, had been caused by somebody rather than being some unknown natural process. That was what was concerning you as of certainly by February 2016?
A. Yes. Baby C and Baby I I started to worry about were those natural deaths, that's correct, yes.
Q. Just a final point in relation to Mother C, sorry, Mother F who I also represent.
A. I know you didn't ask this question, but just when I mentioned earlier that I might be guilty of not following a duty of candour.
When one starts suspecting could criminal activity have taken place, I wouldn't normally share that with

the parents at that stage. Now, that -- maybe I am at fault for not being candid -- I think has to go through other channels and then later on, if the police get involved, the parents need to know.
Q. Thank you.
A. So I am not quite sure what the concern is at this stage; that I had said it or hadn't said it?
Q. No, the concern is just identifying what your state of understanding was in relation to Child C.
A. Yes, I was wondering by February 2016 whether Child C might have been harmed, but I didn't feed that back to the parents, no, and that's -- and it can be accepted as a failure of duty of candour. But I had mentioned a bit earlier that I'm not sure whether you can be completely candid with parents when you are thinking you might be heading towards police investigations until those police investigations start and their child is involved.
Q. Thank you. Mother and Father E F had a conversation with you about Child F and the cause of Child F's collapse and their recollection is that you told them that he had collapsed because of an infection in his lung line and they never found out about hypoglycaemia.
Is that a fair observation for them to make?

A. When did I have that discussion with them? On the morning, on the morning when he had collapsed?
Q. Well, he was transferred out, so it was before he was transferred to Arrowe Park.
A. Right. My recollection, and in my statement my involvement with Child F was on the morning he'd started to become unwell in the early hours of the morning. One of the registrars was involved, phoned me at home, I saw him at 8.30 in the morning.
If that, just after that was the time I spoke to his parents. I indeed thought that he was suffering from an infection at that time and I think later on, when his lung line was taken out, it did have -- it had a bacteria on it and it was thought that could have been causing him an infection.
I think that was the -- I think it's Baby C, yes.
So at that time I did think he was suffering from an infection and hypoglycaemia is a common consequence of infection in premature -- well, in babies.
Q. But in fact I appreciate the insulin results were never seen by you. You were taken to some versions and I just wanted to make sure you saw the correct version of how it was published. It's at INQ0000844.
A. But is this blood insulin and blood c-peptide result, is it? Yes.

Q. It shows, it's a printout within Child F's records of the issue?
A. Yes.
Q. But it is a printout. It shows an insulin of 4657.
A. Yes.
Q. And c-peptide of less than 169?
A. Yes.
Q. I think -- I mean, that's a very, very high level of insulin, isn't it?
A. Yes, it is.
Q. I think you said that you would have needed to work out why somebody might have high insulin levels and low c-peptide levels. But as a paediatrician if you had seen 4657 as the insulin level and a c-peptide of less than 169, you would have known that that was highly abnormal?
A. Yes, and if I wasn't sure, which I think I wasn't because I knew when I saw that result two years later doing the police statement, I had to check what would the normal level of c-protein be because premature babies sometimes have different levels and we are not always given the correct level for a premature baby when the result comes back. That would have confirmed this is likely to be exogenous insulin, yes, that's correct.

Q. But you would have known that the c-peptide should have risen alongside the insulin --
A. Yes, those results suggest injected insulin, yes.
Q. Yes. And, again, if you had seen that you would have investigated why the high insulin and low c-peptide in the way that you did subsequently?
A. Well, those results came back a week later. I didn't see those results when they came back and Baby F's blood sugars had returned to normal about 24 hours later, roughly, maybe slightly longer. So there was no further investigation really to do in the baby at that time. But that was a decision from one of my colleagues that saw the results.
Q. All I am saying is if you had seen that result, and I know you didn't, but if you had seen the result, you would have regarded it as highly abnormal and warranting further investigation?
A. I think I would have done. The reason I say I think I would have done, I did not see those results and I have admitted I had to check the significance of the low c-peptide when I saw the results two years later.
Q. Yes, but you realised that the c-peptide shouldn't be low and the insulin shouldn't be high?

A. Yes, yes. And if you see any results in a baby that you don't fully understand, you look up, you check, double check and that would indicate this is likely to be injected insulin, that's true.
Q. Yes, thank you, my Lady.
A. But I didn't see those results.
Q. No.
A. But I accept it's a collective failure, as I said in my statement, of all of us on the unit particularly the Consultants who are meant to have the most experience not to have recognised that abnormal result in Baby F.
MR BAKER: I am grateful, thank you.
Thank you, my Lady, I have no more questions.
LADY JUSTICE THIRLWALL: Thank you very much, Mr Baker. Does that conclude the evidence of Dr Gibbs?
MR DE LA POER: It does unless you have any questions, my Lady.
LADY JUSTICE THIRLWALL: No thank you.
Dr Gibbs, thank you very much indeed for being so patient and careful in the way you have given your evidence today. It has been a long session and we are very grateful to you.
A. Thank you.
LADY JUSTICE THIRLWALL: You are free to go now, as

is everyone else, and we will meet again tomorrow morning at 10 o'clock.
(4.34 pm)
(The hearing was adjourned until 10 o'clock **on Wednesday, 2 October 2024)**

I N D E X