

1 Tuesday, 1 October 2024

2 (10.00 am)

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

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

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

9 **DR JOHN GIBBS (sworn)**

10 **Questioned by MR DE LA POER**

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

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

14 **A.** I am John Gibbs.

15 **Q.** So far as your contribution in writing to this
16 Inquiry is concerned, can I confirm, please, with you
17 that you have given a witness statement dated
18 1 July 2024?

19 **A.** Yes.

20 **Q.** And a witness statement dated
21 6 September 2024?

22 **A.** Yes.

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

25 **A.** Yes, they are.

1

1 disability?

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

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

11 **Q.** Returning to your career. Did you become the
12 Paediatric Lead Clinician between the period 2000 and
13 2004?

14 **A.** Yes.

15 **Q.** Then Paediatric Clinical Director between 2004
16 and 2009?

17 **A.** Yes, that is right.

18 **Q.** Did you retire from medicine in 2019?

19 **A.** Yes, five years ago.

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

22 **A.** Yes.

23 **Q.** Thank you, Dr Gibbs.

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

3

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

4 **A.** Yes.

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

7 **A.** Yes, it was the basic medical degrees.

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

10 **A.** Yes.

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

13 **A.** Yes.

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

16 **A.** Yes.

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

19 **A.** Yes, I did.

20 **Q.** And that you took up the role of Consultant
21 paediatrician at the Countess of Chester Hospital in
22 1994?

23 **A.** Yes.

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

2

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

3 **A.** Of who?

4 **Q.** Beverley Allitt?

5 **A.** Yes, I was, yes.

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

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

17 **Q.** To take a case closer in time to the summer of
18 2015, were you aware of the situation of two nurses at
19 the Stepping Hill Hospital?

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

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

4

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

5

1 didn't have a direct line to the senior managers.
 2 When I was Lead Clinician back in -- and Clinical
 3 Director up to 2009, I sat on the Management Board and
 4 liaised more closely with the senior Executives. My
 5 colleague, Dr Jayaram, who was Lead Clinician in
 6 2015/16, didn't have that position. He had to liaise
 7 through the Urgent Care Clinical Director. So from that
 8 point of view, being slightly more separated from the
 9 managers was a bit of a problem. But we knew, and
 10 Dr Jayaram knew, how to contact the managers which is
 11 why I think it wasn't such a big problem.
 12 Interestingly, the women and children's departments
 13 had been joined back together again now at the Countess
 14 of Chester Hospital.
 15 Q. Just to reflect back what you have just said
 16 to make sure I have understood it. When you were
 17 Clinical Director, you had regular meetings with the
 18 senior management and built up relationships at those
 19 meetings; is that right?
 20 A. Yes, yes.
 21 Q. But by contrast, in the ordinary run of
 22 things, Dr Jayaram would be expected to contact a layer
 23 of management below the senior management for his
 24 concerns?
 25 A. Yes.

7

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

6

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

8

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

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

11

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

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

12

1 staff on the NNU during the period 2015/16?

2 **A.** There is two answers to that. Yes, I felt so
3 and there was similar nursing staffing to that that we
4 had in prevent years, it hadn't suddenly changed in
5 2015/16. But no in that it was below the BAPM
6 guidelines. But it was my understanding at the time
7 that many hospitals -- many -- failed to meet the BAPM
8 standards for nurse staffing on the neonatal unit.

9 **Q.** So three points then, yes? Firstly, lower
10 than the guidelines suggest?

11 **A.** Yes.

12 **Q.** Secondly, that that had been a longstanding
13 problem?

14 **A.** Yes.

15 **Q.** Thirdly, in your understanding, that was
16 comparable to many other hospitals?

17 **A.** Yes, and if I could just add a figure there
18 that might come up later. When we had the College
19 review -- I am not going to talk much about that yet --
20 in September 2016, the reviewers pointed out that the
21 nursing staffing levels on our neonatal unit were 21%
22 below the BAPM recommendation.

23 But that compared to within the region all the
24 other units, the average was 27% below the BAPM
25 recommendations, which just hopefully confirms what

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

2 **MR DE LA POER:** Dr Gibbs, I am now going to move on
3 to a subtopic of relationships. We will start here. In
4 summary what is your view about the relationship between
5 the Consultant body during the period 2015-2017?

6 **A.** Relationship between Consultants?

7 **Q.** Consultant paediatricians, yes?

8 **A.** Oh, it was good. It became strained only from
9 the fact that we felt under considerable stress as
10 events unfolded during that two-year period.

11 **Q.** As between all of the doctors, how was the
12 relationship?

13 **A.** With ourselves and our junior doctors?

14 **Q.** Indeed.

15 **A.** I understood it to be very good. Of course
16 the view of the Consultant, how you feel you relate to
17 your junior doctors may be different from a junior
18 doctor perspective, but I am sure you will be hearing
19 from some of the doctors who were in training at the
20 time later on.

21 **Q.** How about between the doctors and the nurses?

22 **A.** I felt it was very good. Until we started --
23 Consultants started developing concerns about what was
24 happening on the neonatal unit and that caused a strain
25 between ourselves and the senior nurses on the neonatal

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1 I said: most other hospitals did not meet the guidelines
2 and we are actually slightly better off staffing wise
3 than other neonatal units in the Cheshire and Merseyside
4 region.

5 **Q.** Is what you have said about nurses also true
6 of the doctors in terms of the adequacy and number?

7 **A.** In theory we had enough doctors. But because
8 of the busy paediatric ward as well, we Consultants
9 weren't spending enough time on the neonatal unit,
10 although we had the numbers, but we needed more to
11 satisfy enough time on the neonatal unit and although we
12 had adequate numbers of registrars, there were often
13 gaps in the rota. People had dropped out of training
14 for different reasons, maternity leave, doing research,
15 going abroad and those gaps in the rota did cause
16 a problem for us and all the other hospitals I was aware
17 of in our region.

18 **LADY JUSTICE THIRLWALL:** Can I just ask you, so
19 although you had enough registrars, in theory --

20 **A.** Yes.

21 **LADY JUSTICE THIRLWALL:** -- I think gaps in the
22 rota, does that mean they just weren't there?

23 **A.** Yes, we should have had seven registrars and
24 often we only had six and that was the case during
25 2015/16.

14

1 unit.

2 **Q.** Well, speaking of senior --

3 **A.** Sorry, that was a consequence of what was
4 happening on the unit, it wasn't the cause of what was
5 happening on the unit; it came afterwards.

6 **Q.** Speaking of senior nurses, I just want to
7 invite you to consider an opinion, so you have
8 an opportunity to comment upon it, from Eirian Powell.
9 She suggests that Consultants thought all staff members
10 worked cohesively because staff did exactly what they
11 were told to do by the Consultants without challenging
12 them. Does that accord with your experience of that
13 period?

14 **A.** No, it doesn't. But sometimes what I might
15 feel is the case a relationship with -- with nurses may
16 be slightly different from their point of view. I am
17 disappointed and surprised to hear that Eirian Powell
18 has said that. If she had said it towards the mid to
19 end of -- well, any time from the end of 2015 beginning
20 of 2016 onwards, tensions were building up at that time
21 between us Consultants and senior nurses, so I can
22 understand it. I would be very surprised and
23 disappointed if that was the case earlier on in 2015 and
24 in preceding years.

25 **Q.** Another observation for your comment, please,

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

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

7 **Q.** The views of others.

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

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

17

1 June 2015, between the Consultants and the Executive
2 Directors?

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

9 You might say just that because I had been Clinical
10 Director in the past and I said I sat on the management
11 board like all the clinical directors do and I knew the
12 Chief Executive Medical Director, Nursing Director, met
13 them at different meetings, that I might have known them
14 a bit better but all those personnel had changed over by
15 2015/16.

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

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

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

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

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

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

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

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1 Executive Directors if you went to them with a problem?

2 **A.** No.

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

6 **A.** No, I didn't, no.

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

10 **A.** Yes.

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

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

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

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

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

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

20

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

4 **A.** Yes.

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

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

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

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

21

1 at filling in Datix forms than doctors.

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

5 **A.** Yes.

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

9 **A.** Anyone's.

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

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

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

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

23

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

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

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

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

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

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

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

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

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

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

24

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

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

9 **Q.** I want to deal briefly with safeguarding.
10 Have you as part of your preparation for your
11 evidence had an opportunity to have a look at Working
12 Together 2015?

13 **A.** Yes.

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

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

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

25

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

9 That's a junior doctor.

10 **Q.** How about nurses?

11 **A.** Can I come on to --

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

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

15 **Q.** Yes.

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

25 **Q.** And for nurses?

27

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

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

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

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

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

26

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

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

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

28

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

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

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

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

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

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

29

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

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

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

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

23 **A.** Have I noted it now?

24 **Q.** Yes, now?

25 **A.** Yes.

31

1 potentially causing deliberate harm as a safeguarding
2 issue?

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

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

9 **A.** Parents or other caregivers.

10 **LADY JUSTICE THIRLWALL:** Or other caregivers.

11 **A.** Yes.

12 **LADY JUSTICE THIRLWALL:** Sorry, Mr De La Poer.

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

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

30

1 **Q.** Now, as part of your preparation?

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

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

7 **A.** Yes.

8 **Q.** -- do you agree or doing with the proposition
9 that those guidelines, the SUDIc guidelines, applied to
10 babies who died in hospital?

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

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

32

1 a cot death.

2 I didn't have that same understanding -- I didn't
3 have the understanding that same approach was supposed
4 to apply to children in hospital, but most specifically
5 a neonate who had never been home from hospital back in
6 2015/16. I think a lot of other clinicians -- but I can
7 only talk for myself -- had that same understanding.

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

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

17 **A.** Yes.

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

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

33

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

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

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

16 **A.** Yes.

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

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

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

25 **A.** Yes, yes.

35

1 Cheshire guidelines for SUDiC?

2 **Q.** Yes, we can certainly bring that up.

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

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

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

12 **Q.** Yes.

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

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

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

34

1 **Q.** I understand.

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

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

7 **A.** Okay.

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

11 **A.** The document we are just looking at?

12 **Q.** The Pan Cheshire.

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

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

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

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

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

9 **A.** Yes.

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

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

16 "The sudden unexpected death, unexpected in
17 24 hours prior to death of a child under the age of
18 24 months, irrespective of the place of death at home or
19 in the community, in the hospital emergency department
20 or ward."

21 **A.** Yes.

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

25 **A.** It could be taken either way and my

37

1 **A.** Yes, that that document from the BAPM again,
2 that same organisation, from 2011 that applied in
3 2015/16, it wasn't updated until 2022 so it did apply at
4 the time of the incidents we are going to be
5 considering, that relates to babies who die within the
6 first week of life either at home or still in the
7 hospital.

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

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

39

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

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

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

15 **Q.** I beg your pardon?

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

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

21 **A.** Yes.

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

38

1 **Q.** Yes.

2 **A.** It is a joint document with our paediatric
3 college and the College of Pathologists, and the one
4 that applied in 2015/16, Dr Garstang -- I mean, that's
5 what our SUDiC policy is based on in managing these
6 babies. Dr Garstang admitted in her evidence on the
7 transcript that that doesn't mention death in hospital
8 at all. She felt that was well out of date at that time
9 because she would have done it differently in
10 Birmingham, but that document that our SUDiC policy is
11 based on doesn't mention death in hospital and
12 Dr Garstang said that a revision of that at the end of
13 2016 which is still in force now is wholly inadequate
14 and needs updating.

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

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

40

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

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

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

42

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

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

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

4 Paragraph 260.

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

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

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

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

23 Q. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

15 Q. I think, although she will speak for herself,
16 what she is saying is that whilst each of them may have
17 separately been identified as a serious incident, it is
18 identifying a serious incident in relation to all three.

19 So the cluster is the incident, not the individual
20 occasion of each death, I think that's what she is
21 saying, but she will tell us because she is coming to
22 give evidence later?

23 A. Yes.

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

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

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

5 **MR DE LA POER:** Thank you. Can we please go to the
6 final email. So let's just scroll to the bottom of the
7 thread. This is an email from you dated 23 June 2015,
8 10.04 to your Consultant colleagues.

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

11 "Rachel Lambie ..."

12 That's Dr Lambie?

13 A. (Nods)

14 Q. "... came to see me this morning, I think
15 because I was the only person in the office when she
16 came, to say the Registrars are very concerned about the
17 recent neonatal deaths and collapses where [Child B is
18 identified] all the infants showed a strange purpuric
19 looking rash that probably wasn't true purpura.

20 However, I pointed out that Child C who also died did
21 not have this rash but it's true that Child A Child B
22 and the recent death, Child D, did show similar strange
23 colour on collapsing. Rachel also said that all the
24 neonatal nurses are very worried. They feel we ought to
25 do something and also what else different the Registrars

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1 can do".

2 So if we just pause there. You had had
3 a conversation with Dr Lambie?

4 **A.** Yes.

5 **Q.** And have you summarised in that email
6 everything that we need to know about the content of
7 that conversation. Does that capture the nature of it?

8 **A.** As far as I can remember from eight years ago,
9 yes, that's the essence of it. And the reason I said
10 that sort of slightly facetious remark probably because
11 I was the only one in the office, I had been involved
12 with Child C but not Child A, Child B and Child D. It
13 is absolutely fine for a Registrar to come and talk to
14 any Consultant about a concern, but my colleagues had
15 been involved and I think one or two of them had been
16 involved in three of those four. So I was passing this
17 message on because they had more experience,
18 particularly I didn't feel Child C had the same rash
19 that I was told the other three babies had, but I had
20 never seen that rash because I wasn't involved with
21 those three babies.

22 **Q.** The final paragraph you said:

23 "Although I have mentioned we are looking into this
24 I am not exactly sure how this is being done."

25 You then go on to speak directly to Dr Brearey and

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1 **A.** But even at the top that we just saw, my
2 colleague Dr Brearey is suggesting how to deal with it
3 and not a presentation -- well, they are going to be
4 presented at the morbidity and mortality meetings,
5 exactly how we fed back to the Registrars at the time
6 I can't remember.

7 **Q.** Well, let's see. I think if we put it in --
8 we can just see that Dr Newby in a reply says:

9 "I agree. I have just been grilled by
10 Dave Harkness. This is causing a lot of concern and
11 upset."

12 Dave Harkness being Dr Harkness who again was one
13 of the Registrars I think on --

14 **A.** Yes, he was, a colleague of Dr Lambie, another
15 Registrar, yes.

16 **Q.** The email threads goes on, we don't need to
17 look at the detail of it, but in short, we can see that
18 Dr Brearey mentions the PMM tomorrow afternoon:

19 "Please encourage all juniors and nurses to attend
20 and discuss in this forum rather than privately?"

21 **A.** Yes, that was one of the morbidity and
22 mortality meetings. And also I might be wrong here, so
23 as I say I am sure you will look into this.

24 I thought the three other babies yes, the -- yes,
25 the three babies Child A, Child C and Child D were

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1 Dr Jayaram and propose a meeting just to allow people to
2 air concerns?

3 **A.** Yes.

4 **Q.** Do you know if that meeting ever took place?

5 **A.** I don't think so. I can't remember now
6 whether it did or not. Unless the Inquiry Team have the
7 document from that meeting I can't remember if it ever
8 took place. I think -- from the email correspondence
9 above, I think my colleagues were going to talk to
10 different Registrars rather than have a meeting of
11 everyone together, I think that's what the emails say
12 about --

13 **Q.** Let's just scroll up, please.

14 **A.** That was in lieu of the meeting, I think. Our
15 worry at this stage was that we had some medical problem
16 on the unit like some -- and you do get superbugs or
17 some nasty infection or, as has happened on some units,
18 contamination of the feeding fluid for babies, there was
19 something that was affecting all these babies. But they
20 seemed to have different problems and Baby C to me
21 seemed different to what I was told about the other
22 children.

23 **Q.** If we can just scroll down a little, please.

24 Are we able to scroll? It is buffering. I think we
25 have jumped to the bottom of the thread again.

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1 looked at as a serious incident together as well. But
2 that wasn't with the Registrars that was with the
3 Director of Nursing, Dr Brearey and one of the team from
4 the risk management department.

5 **Q.** So we are going to move forward from 23 June
6 to 29 June and here we will look at INQ0036166. This is
7 a senior clinicians meeting that you attended on
8 29 June.

9 We don't need to look at all of the detail of it,
10 I know you have had a chance to see this before. We can
11 go to the second page, please, the fourth paragraph. We
12 can see where it.

13 Says: "There was also an issue raised round the
14 fact that with the three recent neonatal deaths the
15 Registrar had been quite worried and feel that nothing
16 is being done. Behind the scenes reviews are going on
17 but it was felt that formal debriefs should probably
18 take place rather than any specific meeting to discuss
19 all three."

20 So again at that time would you agree, Dr Gibbs, it
21 seems that the Registrars are making known their
22 particular concerns to the Consultant body?

23 **A.** Yes. And I was only involved with Child C and
24 there a debrief was held on Child C, I think a few days
25 before 29 June, that involved the Registrar and some of

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1 the nurses who were concerned with Child C's sad death.

2 It was actually Dr Davis that was mentioned before,
3 another one of the Registrars, it wasn't Dr Lambie or
4 Dr Harkness. So at least for one of those babies
5 a debrief had taken place with the Registrar and nurses
6 who had been involved in the resuscitation of Child C.
7 I am not sure what debriefs took place for Children A,B
8 and D.

9 **Q.** Now you have mentioned second -- forgive me,
10 you have mentioned a serious incident meeting. We may
11 be able to bring that up now, INQ0003530. This is
12 2 July and if you want a reference for yourself,
13 Dr Gibbs, I think if you look at paragraph 72 on
14 page 22.

15 I'm sorry to make you move around, you might want
16 to keep a finger in where you are but page 22,
17 paragraph 72.

18 INQ0003530. Now, this may have been what you were
19 referring to earlier. SUI, serious untoward review,
20 2 July of 2015. Now was this a meeting that you had
21 attended or did --

22 **A.** No, I didn't attend that but I knew it had
23 taken place and Ruth Millward was at that meeting
24 because she -- at the top line there "RM" I presume is
25 her. There might have been someone else who has those

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1 because she was involved in the resuscitation for all
2 four babies.

3 **Q.** Just help us to understand the terms in which
4 her name came up. At this time, you had no suspicions
5 of any deliberate harm being caused to babies?

6 **A.** No, and in fact, felt sympathy for Letby at
7 that time because felt she had been unlucky to have been
8 involved in a number of incidents. It can happen to any
9 of us, and it's happened to me during my career, that
10 you have a bad run where when you are on-call or on
11 duty; in a short space of time, a number of unfortunate
12 incidents, cot deaths and other deaths may happen. But
13 then that stops happening if it is just an unfortunate
14 coincidence.

15 **Q.** Now, if we can just complete the 2 July
16 because that meeting, the serious untoward incident
17 meeting wasn't the only meeting that took place. Also
18 taking place, and we will bring it up INQ0000108 --
19 forgive me, I can see you are indicating, Dr Gibbs.

20 **A.** Sorry. But that's a Serious Incident Review
21 meeting and I don't understand -- and it involved those
22 babies. I don't understand why Ms Millward said it
23 wasn't reported as a serious incident and those deaths
24 together weren't reported. What were they having that
25 meeting on all those deaths together for with the

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1 initials. "SB" is my colleague Dr Brearey, "AK"

2 I assume is Alison Kelly, the Director of Nursing.

3 **Q.** We will ask them about the detail of it. We
4 can take it down, that's to mark that moment. But you
5 comment upon that meeting in your paragraph 72, just
6 saying that:

7 "There were informal discussions between
8 Consultants around July 2015, several had been involved
9 with the death on the NNU. It was recognised that Letby
10 had been present on each occasion."

11 **A.** Yes.

12 **Q.** So Letby's name had come up as a common factor
13 in July of 2015?

14 **A.** Yes. Yes, I can't remember how, obviously it
15 had obtained greater significance as time went on and
16 that association persisted, but I can't remember if we
17 looked closely or considered in our informal
18 discussions, and being informal unminuted discussions,
19 there is nothing to go back to check, which is
20 a problem.

21 I am not sure how closely we considered other
22 members of staff as well because some of them might have
23 been involved in several of those and obviously Letby
24 wasn't the only nurse involved in all of those. I don't
25 know if she was the only common factor but she was noted

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1 Director of Nursing and Ruth Millward herself if it
2 wasn't reported? Does it only mean the right form
3 wasn't submitted through Datix? I don't understand.

4 **Q.** Well, you can rest assured she will be asked.

5 We are going to go to page 178, please, and here we
6 can see within Child C's notes that on 2 July there was
7 a Sudden Unexpected Death in Infancy Childhood
8 additional strategy meeting and you are one of those
9 identified as being present?

10 **A.** Yes.

11 **Q.** We don't need to go into the detail of the
12 discussion then. You have told us in clear terms you
13 weren't suspicious at that time of any deliberate harm
14 being caused but just help us with this.

15 You didn't, as I have understood your evidence,
16 think that SUDI applied to deaths in hospital, but this
17 meeting appears to be a SUDI meeting. So just help us
18 to understand that?

19 **A.** Right. Maybe I should qualify what I meant
20 about SUDI not applying in hospital. Of course sudden
21 unexpected deaths can occur in hospital and can occur on
22 a neonatal unit, but if you are talking about the
23 guidelines on the procedures for managing a SUDI, which
24 includes what is known as the Joint Agency Response, the
25 JAR, I didn't think that applied in hospitals to a baby

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

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

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

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

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

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

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

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1 (11.18 am)

2 (A short break)

3 (11.35am)

4 **LADY JUSTICE THIRLWALL:** Yes, Mr De La Poer.

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

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

13 **A.** Sadly that's my understanding, yes.

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

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

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

22 **A.** No.

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

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

6 **Q.** I understand.

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

11 **A.** On 2 July, wasn't it?

12 **Q.** Yes.

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

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

19 **A.** Fine, fine.

20 **MR DE LA POER:** So I think that that concludes
21 2 July 2015 and, my Lady, I note the time. Would now be
22 a convenient moment?

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

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1 persistently high glucose and was given insulin?

2 **A.** Yes, very early in life.

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

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

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

13 **A.** Yes, yes.

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

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

25 During the rest of the day when a colleague was

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

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

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

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

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1 not something that you would see when accessing the
2 notes?

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

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

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

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

19 Thank you, that can be taken down.

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

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

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

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

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1 understand the significance of those results.

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

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

19 **A.** No.

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

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

25 **Q.** INQ0000862. Is this a more familiar view or

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1 two years or so later when I was preparing a statement
2 for the police and then I came across this result.

3 I suppose for those that knew the insulin results on the
4 day or the day after they came back a week after the
5 bloods had been taken, then maybe that's not -- they
6 might not say with hindsight, they will have to explain
7 why they interpreted them in the way they did.

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

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

22 **A.** Kokai.

23 **Q.** Thank you, who is a pathologist?

24 **A.** Yes.

25 **Q.** About the postmortem results?

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1 A. Yes.
 2 Q. For Child C?
 3 A. Yes.
 4 Q. We don't need to go into the science of it or
 5 the medicine of it. But following your conversation
 6 with Dr Kokai, were you satisfied at that time that
 7 Child C's death had been adequately explained or did you
 8 still have concerns?

9 A. I was satisfied that the death had been partly
 10 explained. When requesting a postmortem on a child
 11 who's died, particularly when it was a sudden or
 12 unexpected death and when the cause is unclear to myself
 13 at the ward level, you are hoping that the postmortem
 14 will find a cause so that you can explain to the parents
 15 why their child died. It will not compensate for the
 16 tragedy of losing the child but it is logical to help
 17 a bit to have an explanation for the child's death and
 18 some causes of death will have an influence or possible
 19 consequences for future children or pregnancies and so
 20 on.

21 So in a way it was a relief to find a cause for
 22 death. But without going into the detail again, because
 23 of the unusual nature of the resuscitation and then
 24 (*redacted*), I wasn't sure whether the damage to the
 25 heart that was noticed on this postmortem would have all

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1 situation keeps arising, something very strange is
 2 happening.

3 Q. Just to bookmark 21 August 2015. We
 4 understand that you had a discussion with Child C's
 5 parents, I am not going to ask you about that but it may
 6 be you will be asked some questions about it later, so
 7 we will move forward to September 2015 and Child G which
 8 you deal with at paragraph 159 on page 48 and following.

9 Again, as before hopefully, Dr Gibbs, I can be
 10 efficient about this, just pick out from the following
 11 paragraphs that Child G was transferred to the Countess
 12 of Chester at 11 weeks of age, they experienced a rapid
 13 collapse on 7 September 2015, something that you weren't
 14 involved with, transferred back to Arrowe Park.

15 A. That was a severe collapse requiring
 16 ventilation.

17 Q. Yes. There was -- they then came back to the
 18 Countess and there was a collapse on 21 September 2015
 19 which you tell us about at paragraph 163.

20 A. Yes.

21 Q. And you were involved in the care of Child G
 22 following that deterioration and you describe at
 23 paragraph 172 that you were slightly surprised at the
 24 time of the deterioration but not too surprised?

25 A. Yes. I have a problem with -- and I think

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1 happened at and after the resuscitation or whether it
 2 happened before. It was Dr Kokai's view that the damage
 3 to the heart had happened before the resuscitation and
 4 therefore caused the collapse but it didn't fully
 5 explain it because I then asked "but why did the damage
 6 occur to the heart?" So you keep going back one more
 7 step. But with Baby C being an at-risk baby, very
 8 small, growth retarded, difficulties with perfusion from
 9 the placenta, the afterbirth, before the baby was born
 10 possibly that might have explained why the heart was --
 11 had suffered this insult. But it didn't quite fit
 12 together.

13 Q. In terms of your state of mind in August 2015,
 14 does it follow that whilst you weren't entirely
 15 satisfied with the explanation that you had been given,
 16 you didn't think that there was any more investigation
 17 that was required --

18 A. Yes.

19 Q. -- by you?

20 A. Yes.

21 Q. At that time you were not suspicious of any
 22 deliberate harm being caused by anyone?

23 A. Yes, because sadly it had been my experience
 24 even after postmortem it is not always possible to
 25 explain a death and that is occasional. When that

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1 there is a problem with -- what we mean by a collapse in
 2 a baby and I do mention this in my statement and maybe
 3 we don't want to go into it in too much detail now.

4 We recognise when a death has occurred and we can
 5 monitor those events. I am not sure that we know
 6 exactly what a collapse is in a child. Different people
 7 will mean different things.

8 I wouldn't have said that Child G collapsed in the
 9 morning of 21 September, had a vomit, dropped the oxygen
 10 level but actually didn't need any resuscitation. Later
 11 on that same day, Child G dropped her oxygen levels
 12 again and did need some resuscitation so that second one
 13 was more of a collapse. But in the literature different
 14 definitions are used for "collapse", why does that
 15 matter, if you want to monitor collapse, there is
 16 a warning that collapses may be recurring too often in a
 17 unit and might indicate a problem on that unit. You
 18 need to be able to define what a collapse is and
 19 I wouldn't say Baby G had a collapse in the morning of
 20 21st but she did have a collapse later on.

21 "Collapse" normally means in everyday language
 22 a fall to the ground often with loss of consciousness.

23 That obviously doesn't apply to babies, but whether you
 24 mean the heart or the breathing is compromised what
 25 level of support that requires is all dependent on how

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

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

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

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

25 **A.** Yes.

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

3 **Q.** So not at the time?

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

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

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

24 **A.** Yes.

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

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

3 **A.** Yes.

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

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

8 **Q.** There were further collapses on 26 and
9 27 September 2015?

10 **A.** Yes.

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

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

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

18 **A.** Yes.

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

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

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1 neonatal death"?

2 **A.** Yes.

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

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

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

11 **A.** Yes.

12 **Q.** -- on the neonatal unit?

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

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

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

25 But the babies who lived in West Cheshire would

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1 stay with Dr Mittal. Whether he was aware of the babies
 2 whose forms had gone off to the other areas or not
 3 I don't know.
 4 **Q.** Well, you can rest assured he will be asked.
 5 We are going to move forward to Child I who died on
 6 23 October -- we can take that down, thank you very much
 7 indeed, on 23 October 2005. You deal with Child I at
 8 paragraph 196, page 58. Again, I will just do as I did
 9 before, try to summarise what you say. That Child I was
 10 born at the Liverpool Women's Hospital, transferred to
 11 Chester, transferred back to Liverpool and then
 12 transferred back to Chester. That's your 196. Is that
 13 right?
 14 **A.** Yes.
 15 **Q.** There were significant breathing problems over
 16 three nights, you deal with that at 198?
 17 **A.** Yes.
 18 **Q.** Transferred back to Arrowe Park with suspected
 19 necrotising enterocolitis, (NEC)?
 20 **A.** Yes.
 21 **Q.** Back to Chester two days later?
 22 **A.** Yes.
 23 **Q.** And then five days after return to Chester,
 24 the sudden drop in oxygen saturation which resulted in
 25 you being called in?

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1 decompensated quickly.
 2 **Q.** You tell us at paragraph 4 that you were
 3 unsettled by Child I's death?
 4 **A.** Yes.
 5 **Q.** Now, you have mentioned that the collapses the
 6 period before, one of the matters the Inquiry is
 7 investigating is whether Letby was moved off the care of
 8 Child I on one shift because of concern with her
 9 association with those collapses, so that's a matter
 10 that we are investigating. My question for you is: is
 11 that something that you were aware of?
 12 **A.** No.
 13 **Q.** If that had occurred, is that something that
 14 you would have expected to be told about?
 15 **A.** It -- no, depending on the reason for moving
 16 a nurse off a particular -- was it off particular shifts
 17 or off care of that particular patient?
 18 **Q.** Off care of that particular baby is our
 19 present understanding, we are investigating.
 20 **A.** Oh, right. If it was thought that nurse was
 21 harming the baby then we should have -- well, probably
 22 we should have all known. When I say "we", Consultants
 23 and senior nurses, not everyone in the department.
 24 If it was a concern that -- which I had understood
 25 later on was the reason for moving Nurse Letby off

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1 **A.** Yes.
 2 **Q.** Upon arrival you found that Child I had
 3 improved remarkably, that's your paragraph 201; is that
 4 right?
 5 **A.** Yes.
 6 **Q.** You were then called back in just an hour
 7 later following the same pattern of deterioration as you
 8 say at paragraph 203?
 9 **A.** That's correct.
 10 **Q.** Child I did not recover from that second
 11 deterioration that you attended?
 12 **A.** Yes, tragically not, yes.
 13 **Q.** Was, so far as you were concerned, Child I's
 14 death sudden and unexpected?
 15 **A.** To an extent. And the reason I say that it
 16 was a sudden collapse and Child I did it twice that same
 17 night. But as you already recounted a few weeks earlier
 18 over consecutive nights Child I had had serious
 19 collapses and Consultants had been called in each time
 20 so a little like Child G, I had gained the impression
 21 that Child I was quite a vulnerable, very premature
 22 baby -- had been a very premature baby and was prone to
 23 these collapses. I didn't realise then that the earlier
 24 collapses have now been attributed to harm by Letby. So
 25 I thought this was a baby who was quite precarious who

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1 different shifts, if it was a concern a nurse had been
 2 unfortunate in experiencing a series of stressful
 3 conditions and therefore like we felt early on it was
 4 unfair on her, then to move her out of that situation is
 5 not an unreasonable thing to do. So it depends on the
 6 reason she was moved from that patient.
 7 **Q.** If it was that first reason, ie somebody was
 8 sufficiently concerned that she might be causing harm to
 9 the babies, so not for her emotional welfare --
 10 **A.** Yes.
 11 **Q.** -- is that a situation that you would expect
 12 that if somebody is taking that step, that they would
 13 also take other steps as well, such as notifying senior
 14 management?
 15 **A.** Yes. But she should be removed from all
 16 patient care in that situation, as happened much later
 17 on.
 18 **Q.** Yes.
 19 **A.** Rather belatedly in June or July 2016.
 20 **Q.** I am just going to read you part of the
 21 transcript from Mother I and just ask for your comment
 22 on it, please.
 23 She says:
 24 "Dr Gibbs said that our baby was basically a full
 25 term baby and these collapses shouldn't have kept

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

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

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

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

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

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

4 **Q.** Thank you very much indeed. This is on
5 26 November 2015. It is a meeting that you attended
6 neonatal mortality meeting. You deal with this in your
7 witness statement. It is indicated at the top the
8 period of assessment is August to October 2015, but
9 Child E, as you observe in your statement, is not
10 included in this review. Do you know why?

11 **A.** No.

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

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

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

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

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

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

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

7 **A.** I think a possible explanation for the
8 seizures.

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

11 **A.** No.

12 **Q.** Now --

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

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

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

23 **A.** Yes.

24 **Q.** -- coalesce, if you like?

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

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

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

8 **A.** Thinking of Baby I's death and then thinking
9 back to Baby C's death, the two babies I have been
10 involved with, by the -- and it is not that I don't want
11 to give a date, I can't remember exactly when I became
12 concerned something unusual, not natural, might be
13 happening on the unit, maybe the end of 2015 or early
14 2016 and when we come to it, the thematic review helped
15 to sort of concentrate the concern.

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

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

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

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

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1 still a perpetrator?

2 **A.** Yes.

3 **Q.** Just not the person who was first identified?

4 **A.** Yes.

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

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

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

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

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

3 **A.** No.

4 **Q.** Are we talking Consultant colleagues --

5 **A.** Yes, yes.

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

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

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

25 **Q.** Although in the Stepping Hill case, there was

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

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

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

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

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

24 **A.** Yes. From the Neonatal Network.

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

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1 Dr Subhedar?

2 **A.** Subhedar.

3 **Q.** Thank you very much for the correction.

4 You didn't attend yourself the meeting which took
5 place on 8 February?

6 **A.** That's correct.

7 **Q.** Before the meeting, did you have any
8 discussion with Dr Brearey or Dr V who also attended
9 about Letby or any particular concerns you wanted them
10 to take into that meeting?

11 **A.** I can't remember. I was -- and as far as
12 I knew from informal discussions, I think all my
13 Consultant paediatric colleagues, so the other six, were
14 concerned about the number of deaths and I think around
15 this time, by 2016, definitely the realisation that
16 Letby was being involved with most of them there were
17 some deaths and collapses that I knew she wasn't around
18 at the time but that -- that association was causing
19 concern, yes.

20 That is -- not particularly to look at Letby to
21 look at the deaths and try and find out why we had more
22 than usual was the reason to have that thematic review.

23 **Q.** Now, I don't need to show you it because you
24 have seen it already, but we know that there was a chart
25 or spreadsheet produced by Eirian Powell at which

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1 statement. For some of those babies there were very few
2 nurses's names and I find it difficult to believe that
3 all the nurses who are around on the unit at that time
4 was recorded on that chart for all of the babies and
5 that just means just in case there is someone else
6 that's been missed off.

7 **Q.** We will look at the thematic review document
8 briefly in a moment when we get to the finalised version
9 in March, but there was a CQC visit on 16 to 18 February
10 and some of your Consultant colleagues were spoken to.
11 I was just wondering, were you among the Consultants
12 that were spoken to by the CQC?

13 **A.** I don't remember being one of them. If I was,
14 it obviously didn't stick in my mind, I don't remember
15 though. I knew there was a CQC visit going on.

16 **Q.** Would that meeting have been an appropriate
17 forum, or indeed privately afterwards, to raise with the
18 CQC concerns about the neonatal mortality that existed
19 at that time?

20 **A.** Yes, but I wouldn't have thought it's
21 appropriate to talk about a particular member of staff.
22 There are other ways to deal with that rather than
23 asking the CQC who happen to be visiting the hospital
24 about that.

25 **Q.** So not specifics in terms of members of staff

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1 Letby's name was highlighted in red. Was this

2 a document that you saw at the time?

3 **A.** I don't remember her name being highlighted in
4 red. I did see the document with all the nurses who had
5 been on duty for those deaths entered into it. I don't
6 recall Letby being highlighted in red. I have seen
7 several different versions of that document that were
8 circulated between some time after the 8 February and up
9 to about beginning of March. I am not saying I never
10 did. I can't remember seeing one that highlighted
11 anyone's name.

12 **Q.** We don't need to --

13 **A.** And you would have to look closely at it. You
14 can see Letby's name for each of those, amongst many
15 other nurses. The association wouldn't be immediately
16 obvious if you didn't spend a lot of time trying to work
17 out who is the common person.

18 **Q.** But it would be, do you agree, immediately
19 obvious to you looking at it because by the time that
20 chart was produced, you had Letby's name in your mind?

21 **A.** Yes.

22 **Q.** So from your point of view, an informed
23 reader, you could look at that chart and note the
24 frequency of the occurrence of her name?

25 **A.** Yes. Just a slight concern, as I say in my

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1 but that is an appropriate forum, whether publicly or
2 privately, immediately after the meeting for any
3 Consultant who is speaking to an inspector to say: are
4 you aware of the increasing mortality?

5 **A.** Yes, or to indicate in some -- that we are
6 struggling on the neonatal unit, yes.

7 **Q.** At the same time as the CQC visit, Child K
8 collapsed. Forgive me?

9 **A.** Sorry, just to go back to that CQC visit. It
10 is a bit inappropriate though -- and I don't remember
11 meeting the CQC inspectors, it is a bit inappropriate to
12 just tell the CQC inspectors when they happen to be
13 visiting if you haven't tried to sort that out within
14 your own Trust management structure. It's almost like
15 telling OFSTED you have got a problem with a teacher and
16 you have never told anyone in the school, it would have
17 to be an OFSTED inspection, you have never tried to deal
18 with that problem within the school.

19 **Q.** But wasn't the position in -- on
20 17 February 2016 that the internal investigation at the
21 ward level had been conducted with input from the
22 Network and there still wasn't a clear explanation for
23 the increase in deaths?

24 **A.** Yes, that's correct. The thematic review did
25 identify some sub optimal care issues, none of them

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 **A.** Yes.

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

12 **A.** Yes.

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

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

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

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

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

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

19 **Q.** But you still had a suspicion?

20 **A.** Yes.

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

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

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

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

9 **A.** Yes.

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

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

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

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

7 **Q.** We will move forward --

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

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

18 **A.** Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 **A.** Yes.

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

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

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1 what he had said.

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

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

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

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

3 **Q.** There was a meeting on 11 May of 2016, which
4 you didn't attend. It was Dr Brearey meeting with
5 Mr Harvey and Ms Kelly, also present Nurse Powell.
6 Going into that meeting, presumably firstly you
7 knew that that meeting was happening?

8 **A.** Yes.

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

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

16 **Q.** Absolutely.

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

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

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1 deliberately harming babies?

2 **A.** Yes.

3 **Q.** And did you speak to him after the meeting?

4 **A.** Yes. I can't remember exactly where and when.

5 He fed back to us that no decision had been made but the
6 senior managers were considering the problem and
7 hopefully we would come to a decision. That could have
8 been a trigger, should have been a trigger that we
9 bypass managers and went to the police. And we failed
10 to do that.

11 **Q.** We will just have a look at an email that
12 Dr Brearey sent following that meeting, INQ0005721. You
13 deal with this at paragraphs 270 and following on
14 page 78, but it is the email of 16 May that he sent.
15 The first paragraph is a short summary from Dr Brearey
16 to his Consultant colleagues about the meeting.

17 He describes it as a helpful meeting, sometimes
18 Dr Gibbs there is a difference between what people put
19 in writing and what they say privately. What was your
20 understanding from having spoken to Dr Brearey about
21 whether it was a good meeting or not?

22 **A.** I understood it wasn't a helpful meeting.
23 Who's been copied into this?

24 **Q.** Eirian Powell has been copied in as has
25 Ann Murphy?

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1 there, was that a collapse that you were directly aware
2 of in Child N on 15 June something that you spoke to him
3 and Nurse Powell about?

4 **A.** No, I didn't, because he was involved in the
5 collapse. It depends which collapse. Baby N on that
6 day, Child N on that day had a number of deteriorations
7 and created a lot of difficulties needing a specialist
8 team from Alder Hey to come over and assist and
9 Dr Brearey was involved in that. I was the only
10 involved later on in the evening but I knew Dr Brearey
11 and I am fairly sure, but I can't remember now,
12 Mrs Powell knew about those collapses on that day.

13 **Q.** So although you had received that email, in
14 your mind Dr Brearey already knew about it, didn't need
15 to be told twice?

16 **A.** Yes, he was involved in it.

17 **Q.** We then move forward to Child O on 23 June of
18 2016. You deal with Child O's care at page 84 starting
19 at paragraph 295 of your statement, and what you tell us
20 at 297 is that you were uncomfortable arriving on the
21 neonatal unit to find Child O undergoing
22 a resuscitation; is that right?

23 **A.** Yes, yes. Can I just mention for Child N, to
24 go back for a moment?

25 **Q.** Of course.

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1 **A.** Not the two Executives. I wondered whether
2 the phrasing was representing who had got the email but
3 not -- yes.

4 **Q.** From your understanding from him, that wasn't
5 what he was saying privately about the meeting?

6 **A.** In some sense it had been helpful because
7 I understood that Dr Brearey felt the Senior Executives
8 were becoming were understanding the issues. The
9 unhelpful bit is nothing had been done about it so it
10 was partly helpful but the outcome was disappointing.

11 **Q.** You have told us that that outcome should have
12 been a trigger for further action from the Consultant
13 paediatricians or certainly from you?

14 **A.** Yes.

15 **Q.** The second part speaks about coming across
16 a baby who deteriorates suddenly or unexpectedly or
17 needs resuscitation to notify both Dr Brearey and
18 Ms Powell and you were aware -- thank you, we can take
19 that down -- that Child N suddenly and unexpectedly
20 deteriorated, 3 June and 15 June?

21 **A.** (Nods) I am not sure I knew about 3 June. It
22 might have been mentioned at handover, we have
23 a handover when we are on-call. But I knew the
24 deterioration on 15 June, yes.

25 **Q.** Bearing in mind what Dr Brearey had said
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1 **A.** Again, Child N's parents might not be happy to
2 hear this, but I wasn't that concerned that his
3 collapses were unexplained. They were strange.
4 Eventually -- they haven't been properly explained. He
5 was a complicated little boy that had a blood disorder,
6 it was thought he suffered a bleed into his lung on the
7 day he had these problems, on that 15 June, and there
8 was a great deal of difficulty from four -- two
9 Consultants, two Consultant paediatricians, Consultant
10 anaesthetist and some of the Registrars at viewing his
11 windpipe, trying to put a tube into his lungs to help
12 him breathe, because of a swelling and that could have
13 been related to his bleeding disorder.

14 So just Baby N, I didn't -- it wasn't apparent to
15 me that he had been harmed in any way, it was more his
16 complicated medical problems. As things turned out
17 later on, and once he had gone to Alder Hey and the
18 specialist doctors there for the blood disorder looked
19 on things, they felt it was probably unlikely his blood
20 disorder accounted for his problems but at the time and
21 including when the sad events happened to Baby O and P,
22 I felt Child N's problems could have a medical
23 explanation.

24 **Q.** As you come into the NNU to find Child O
25 undergoing resuscitation, was one of the thoughts that

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

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

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

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

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1 concern outside of the neonatal unit?

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

6 **Q.** 23rd for Child O.

7 **A.** Yes.

8 **Q.** 24th for Child P.

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

16 **Q.** We will --

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

22 **Q.** That's when you became aware?

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

25 **Q.** Child Q deteriorated on 25 June 2016. Were

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

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

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

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

23 **Q.** Child P died the following day, 24 June.

24 Between the two deaths, were you aware of any steps that
25 your Consultant colleagues were taking to raise their

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1 you aware of that at the time?

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

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

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

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

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1 after them. So it was unusual to ask that question.
 2 **Q.** So in terms of marking a moment in time --
 3 **A.** Yes.
 4 **Q.** -- was that the first time that you were
 5 making investigations outside of the Consultant body to
 6 ask others --
 7 **A.** Yes.
 8 **Q.** -- to give you information --
 9 **A.** Yes.
 10 **Q.** -- pertinent to your concerns?
 11 **A.** Yes, and it was perhaps my rather feeble
 12 attempt to try and offer some protection, if some harm
 13 was going on, that it was known on the unit that I was
 14 on-call that day, I was watching who was doing what on
 15 the unit.
 16 **Q.** So were you expecting that it would get back
 17 to all the nursing staff that Dr Gibbs wanted to know
 18 who had care of Child Q?
 19 **A.** Yes. Because I never normally ask that.
 20 When -- when -- and I didn't think Child Q's
 21 deterioration that morning was that significant. He
 22 wasn't that unwell, but I just -- any deterioration was
 23 worrying us after Baby O and P.
 24 **Q.** So we come to the senior paediatrician meeting
 25 on 27 June of 2016. You probably don't need to look it
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1 Dr Brearey telephoned the Medical Director Mr Harvey?
 2 **A.** Yes.
 3 **Q.** Do you know what he said to Mr Harvey in that
 4 conversation?
 5 **A.** No, but I assumed he conveyed those concerns,
 6 including Nurse Letby to Mr Harvey, but he will be able
 7 to confirm. Mr Harvey hopefully will be able to
 8 confirm.
 9 **Q.** There is something of a record of that
 10 meeting, INQ0003116. If we go to page 2 and scroll
 11 down. This is Dr Brearey's email, which you are copied
 12 into as is Mr Harvey. If you just scroll down, please.
 13 It may be easiest just to leave the whole document on
 14 the screen. It begins:
 15 "I thought it might be helpful to put down in
 16 an email what was discussed at the senior paediatricians
 17 meeting yesterday."
 18 So this is the 28th, referring back:
 19 "~... significant concerns about the increased
 20 mortality, the sudden deterioration of apparently well
 21 babies, no cause identified and the presence of one
 22 member of nursing staff at these episodes. There has
 23 been a watchful waiting approach since our last meeting
 24 with Ian and Alison in March."
 25 That may or may not be an incorrect date, we will
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1 up because you will recall it. But what you say in your
 2 statement is that:
 3 "All Consultants expressed serious concerns about
 4 the number of deaths and the persistent association with
 5 Letby."
 6 **A.** Yes.
 7 **Q.** Persistent association is one thing. In that
 8 meeting with your Consultant colleagues, was the fact
 9 that she may be causing deliberate harm to babies spoken
 10 out loud?
 11 **A.** I would be surprised if it wasn't. I can't
 12 recall exactly. I don't think there is any recorded
 13 notes from that meeting, it was an unminuted meeting,
 14 and I would be surprised if we didn't discuss it then.
 15 What might have inhibited us, the senior nurses
 16 were there as well and relationships were proving
 17 difficult, becoming a bit difficult whenever we broached
 18 the subject -- well, I knew from Dr Brearey when he
 19 broached the subject of Nurse Letby it created problems
 20 with the nursing staff, senior nursing staff.
 21 I am not sure of the more junior, the below ward
 22 manager staff, I don't know if they knew anything about
 23 this at all at that time.
 24 **Q.** What you say in your statement is that
 25 following the meeting, your understanding was that
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1 investigate that. It may be a reference to May.
 2 "However ~..."
 3 **A.** I would have thought so, yes.
 4 **Q.** "~... since the episodes and deaths last week
 5 there was a consensus at the senior paediatricians
 6 meeting that we felt on the basis of ensuring patient
 7 safety on the NNU this member of staff should not have
 8 any further patient contact on the NNU."
 9 **A.** Yes.
 10 **Q.** It goes on to refer to the external peer
 11 review, which is clearly a reference to a conversation
 12 he has had with Mr Harvey. But in terms of capturing
 13 what the position of the senior paediatricians was at
 14 lunchtime on 27 June, does that accord with your
 15 recollection?
 16 **A.** Yes, it is.
 17 **Q.** And if we scroll up to the top, so back to
 18 page 1. Again you can leave it on the full screen. We
 19 can see a response from Karen Townsend just to
 20 Dr Brearey. So you weren't on copy for this but we are
 21 going to look at the email at the top because it speaks
 22 about you.
 23 Dr Brearey replies to Karen Townsend's email
 24 saying:
 25 "Just to confirm then Ian and Alison are happy for
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1 LL to work on NNU in the same capacity as last week
2 despite the Paediatric Consultant Body expressing our
3 concerns this may not be safe and that we prefer her not
4 to have any further patient contact."

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

7 **A.** Yes. I mean --

8 **Q.** Thank you. We can take that down. Now, the
9 Inquiry understands, and again this is a matter we will
10 be investigating, that Letby worked day shifts on the
11 28th, so the day that that email was sent the day after
12 the paediatric Consultant meeting, the 29th, so the
13 Wednesday of that week and the 30th.

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

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

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

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

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

6 **A.** Yes.

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

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

13 **A.** Yes.

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

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

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

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1 before she went on annual leave.

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

7 **A.** Probably, yes.

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

11 **A.** I mean, should she have? No.

12 **Q.** Should she have? No?

13 **A.** Yes.

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

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

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

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

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

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

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

12 **A.** Yes.

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

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

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

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

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

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

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

14 A. I didn't know.

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

16 A. Yes.

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

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

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

25 "Steve and I are trying to meet with senior execs

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1 we would carry on discussing them.

2 Q. Page 1. We see that you do exactly that.

3 Starting your email:

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

7 You say:

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

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

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

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

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

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

9 If we then go to page 2, please. In fact,

10 Mr Harvey was on copy to those previous emails and
11 replies:

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

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

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

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

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

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

6 A. Yes.

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

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

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

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

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

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

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

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

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

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

25 And then he makes a reference to a matter which is
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1 to try and offer a few explanations, none of which are
2 adequate, that I was extremely concerned of putting
3 parents -- bereaved parents through the agony of
4 a murder investigation if we got it completely wrong and
5 no one had harmed patients. Also, contrary to what
6 Eirian Powells seems to have put in her statement, I did
7 listen to nurses, I valued their contribution although
8 I might not always agree with it and therefore the
9 strong assertion from the nursing side that we got it
10 completely wrong and Letby had done nothing influenced
11 me but did not convince me.

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

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

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

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

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

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

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

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

13 (1.04 pm)

(The lunch break)

15 (2.05 pm)

16 **LADY JUSTICE THIRLWALL:** Yes, Mr De La Poer.

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

21 **A.** But would you mind, Mr De La Poer, if -- I was
22 finding it a bit difficult to answer some of your
23 questions just before lunch when you were rightly
24 pointing out that I and perhaps my colleagues should
25 have acted more decisively earlier and I would just like
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1 Before I move on to the next phase, it has been
2 drawn my attention that I just need to ask you a few
3 more questions about the moment of that crystallisation,
4 that's my word, not yours, of when things moved to the
5 front of your mind and you were thinking: I have
6 concerns possibly about Letby. I think that your
7 evidence this morning was that that was some time before
8 the end of 2015; have I got that right?

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

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

25 **A.** Yes, after Child I -- after I had been
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1 involved with Child I's death, so not at the time of
2 Child I, and yes, I was beginning to talk about concerns
3 there might be harm but I think that was more early
4 2016.

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

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

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

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

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

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

11 **A.** Yes.

12 **Q.** -- following the postmortem --

13 **A.** Yes.

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

16 **A.** Yes.

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

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

25 I don't know Baby C's parents would know otherwise,

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1 **A.** Yes, yes.

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

6 **A.** Yes.

7 **Q.** -- at that time?

8 **A.** Yes.

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

12 **A.** Yes.

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

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

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

20 **A.** I can't remember.

21 **Q.** In terms of when --

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

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

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

10 **A.** I can't remember. Sorry.

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

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

17 **Q.** That's in February?

18 **A.** Yes, February.

19 **Q.** 2016.

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

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

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1 deal with that as a piece at the time.

2 So let's return, please, to late June of 2016.

3 There were according to records two meetings on 29 and
4 30 June with Senior Executives attended by Dr Brearey,
5 Dr Saladi and Dr Jayaram?

6 **A.** (Nods)

7 **Q.** I will come back to what they were told as you
8 understood it in a moment, but before we get to that, if
9 we could please bring up INQ01002065.

10 If we go to page 2, please, a document exhibited by
11 Dr Saladi, but which I think you have seen. We can see
12 that on 30 June at 8.25 in the morning at the bottom the
13 thread Dr Jayaram circulates an article which you then
14 comment upon and I hope I capture the medicine correctly
15 but fundamentally it is about air embolus?

16 **A.** Sorry, I am just reading it. I don't remember
17 seeing this before, sorry. Maybe --

18 **Q.** If you haven't that's a failing of our process
19 and I apologise. So take your time reading it.

20 **A.** Maybe I have seen this. I can't remember
21 amongst all the documents. But ...

22 **Q.** At all events, having taken a moment just to
23 refresh your memory and it being an e-mail that you were
24 on copy to --

25 **A.** It is fine, it makes sense. Thank you, yes.

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1 air embolus changes from natural gas changes in a body
2 postmortem.

3 **Q.** So that's your state of mind. It has reached
4 that?

5 **A.** Yes.

6 **Q.** I am not suggesting everybody was sure that
7 was what was the case, but it had crystallised to: might
8 Letby have killed and attempted to kill babies?

9 **A.** Yes, this is one way it might have been done
10 and that no one noticed and there was nothing to find in
11 the babies.

12 All of these concerns, including the concerns
13 without knowing about the air embolus, were without
14 knowing about the insulin results. We didn't have to
15 have the insulin results to eventually come to the
16 conclusion harm might have been occurring on the unit.

17 **Q.** And was this an important or unimportant step
18 forward in your thinking at that time? I mean what
19 significance did you ascribe to this article and
20 formulating the possibility in that way?

21 **A.** I don't feel it helped much. It was useful in
22 just realising silent ways, hidden ways of killing that
23 leave nothing at postmortem could have happened. As
24 I have mentioned in this email, I wasn't involved in the
25 babies that had the rash that might have been due to air

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1 **Q.** Yes. Is it right that on Thursday, 30 June
2 and following that there was a discussion, whether in
3 writing or in person, about the possibility of air
4 embolus --

5 **A.** Yes.

6 **Q.** -- as between you and so that we are clear
7 about it, what was being discussed was the possibility
8 of murder or attempted murder being caused by air
9 embolus; in other words, the deliberate application of
10 it?

11 **A.** Yes.

12 **Q.** That was the context of this discussion?

13 **A.** Yes.

14 **Q.** So although not reaching any conclusions, the
15 Consultants at this time are saying between themselves:
16 I wonder if Letby has murdered or attempted to murder
17 children using air embolus?

18 **A.** Yes, and that starts to answer a question,
19 this is just speculation, that why did the postmortem
20 show no evidence of harm? It is a devious and subtle
21 way of trying to harm patients which tends to leave
22 nothing behind afterwards for a postmortem to find,
23 tends to. Some people, as was argued at the Letby
24 trial, there are some subtle indications that you can
25 sometimes see postmortem, difficult to distinguish the

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1 embolus. That rash only occurred in very few babies in
2 the paper that Dr Jayaram is quoting here and those
3 babies had different problems related to the nature of
4 their ventilation from back in the 1970s and 80s so
5 I wasn't sure that that paper really explained what we
6 had seen in our babies but it was interesting that the
7 possibility of air embolus in a more subtle way might
8 have explained some of the collapses.

9 **Q.** Was that something that you ever yourself
10 raised in a meeting as a potential explanation for what
11 might have happened?

12 **A.** Well, I am sure you are not trying to catch me
13 out here, I --

14 **Q.** I am not. Your recollection?

15 **A.** Well, I did not raise air embolus at this
16 stage, it was Dr Jayaram who found this paper.
17 I thought I had raised the possibility of air embolus
18 after seeing this paper but I now think one of the
19 emails on 29 June, I talk about air inside the skull of
20 one of the babies on a skeletal survey X-ray done at
21 postmortem and I wondered was that significant and that
22 would have been air embolus as well. That was --
23 I thought it was after seeing this paper. From the
24 timeline of these emails, I had suggested that before.

25 The reason that didn't seem to take us anywhere is

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

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

9 **A.** Yes.

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

12 **A.** Yes.

13 **Q.** My question was more directed --

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

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

18 **LADY JUSTICE THIRLWALL:** Yes, thank you.

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

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1 the skull.

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

8 **A.** Yes.

9 **Q.** Was present at that meeting?

10 **A.** Yes. Well, I will just qualify that sorry.
11 I thought it was on 1 July. It was some time
12 around end of June/beginning of July and do you know
13 where that meeting took place, have you got that down
14 anywhere?

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

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

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1 that should be investigated?

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

7 **Q.** Yes.

8 **A.** I don't remember that.

9 **Q.** No.

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

13 **Q.** Yes.

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

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

19 **A.** No.

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

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

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1 the police coming to investigate.

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

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

6 **Q.** And --

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

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

15 **Q.** And Mr Cross is saying it is disruptive?

16 **A.** Yes.

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

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

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

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1 how the conversation developed?

2 **A.** Not that I recall. But to me it made no
3 difference whether it be disruptive or not; involving
4 the police to investigate possible murders is going to
5 have a massive impact particularly on the parents
6 concerned.

7 **Q.** Moving to 4 July. You say in your statement
8 there was a meeting with the Chief Executive. Again
9 I can give you the reference but all that I wish to
10 remind you is what you say in the statement is you were
11 told in that meeting there would be a review while Letby
12 was on holiday?

13 **A.** Yes, an internal hospital review and we knew
14 at that time, and I don't remember exactly which date,
15 we knew there was going to be a Royal College review as
16 well.

17 **Q.** Yes, we have seen that may have been one of
18 the first things that Mr Harvey said to Stephen Brearey,
19 but we will hear about that --

20 **A.** But this is the hospital's own internal rapid,
21 rapid inquiry to get done before Letby came back from
22 leave.

23 **Q.** What you say in your statement about this is
24 that:

25 "The Consultants agreed with the senior managers to

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1 **Q.** We can scroll?

2 **A.** Maybe minimising it a bit.

3 **Q.** Minimising it?

4 **A.** But I don't know -- personally I can
5 understand trying to be careful how you put out
6 a message not to cause panic and unnecessary alarm.

7 **Q.** So if we just scroll down so that we --

8 **A.** That's different from misleading people.

9 **Q.** Absolutely. So if we just pause it there.

10 The discussion which precedes this as I am sure you can
11 confirm was about the accuracy of that message and in
12 particular the suggestion that this wasn't outside
13 expected statistical variation. That's the focus?

14 **A.** Yes.

15 **Q.** This is Dr Holt drawing specific attention to
16 Regulation 20, the duty of candour. Was the duty of
17 candour something that you thought was engaged by the
18 situation that was under discussion?

19 **A.** I can't remember seeing this particular email.

20 But it's fine, I mean, I knew of the doubt of candour,
21 so -- sorry, your question was?

22 **Q.** The question was: At this time were you
23 thinking in terms of the duty of candour or ...

24 **A.** I find it difficult to know if -- and it came
25 up much later as well when the police were getting

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1 delay calling the police and undertaking internal
2 investigation as not aware anyone had witnessed harm
3 being caused."

4 Would you like to turn that up or does that just
5 accord with --

6 **A.** No, I accept that, yes. But at this stage, we
7 knew Letby was off the unit and we hadn't decided
8 definitively what else we would do. But having Letby
9 not on the unit was the right thing and that did give us
10 time to then consider other investigations. The problem
11 was she going to come back and that -- that cropped up
12 later.

13 **Q.** Yes. Well, we will just have a look, spend
14 a few moments looking at the review process. Before we
15 do, we just need to bring up an email dated 5 and 6 July
16 INQ0002693. I am going to bring it up on screen and
17 then I am hoping I will be able to deal with it by way
18 of summary, but it will be here if you need to check.

19 This is an e-mail thread, which you can see at the
20 bottom of the first page, is about the comms message and
21 if I can summarise what we will see if we looked at it,
22 there was concern within the Consultant body about the
23 way in which the hospital was characterising what was
24 happening at the Countess of Chester; is that right?

25 **A.** Yes.

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1 involved and we knew we were moving towards the police
2 getting involved, how much the duty of candour might be
3 compromised -- the answer could be never at all, might
4 be compromised if you are going through police and
5 criminal investigations, how much you tell everyone
6 about that?

7 **Q.** That of course is arising at the point at
8 which the police are involved?

9 **A.** Yes, yes.

10 **Q.** So if we --

11 **A.** But without -- just the statistical bit
12 because that's come up quite a lot, not just from what
13 the hospital said about these rises.

14 Statistics are complicated and can easily use the
15 wrong statistics and come to the wrong conclusion. In
16 these emails I was saying I wasn't sure -- we are not
17 saying they weren't, but actually increased -- the
18 fairly substantial increased rate we had would be
19 statistically significant. Why on earth 13 deaths in
20 that year period compared to 1-3 normally, why wouldn't
21 that be significant? It is because you have to compare
22 it to the 3,000 deliveries a year and the 400 babies
23 that go through the neonatal unit and it is not so much
24 the numbers of deaths that was the concern. It was the
25 nature of the deaths that was the worry.

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

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

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

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

15 **A.** Yes.

16 **Q.** And then you say this:

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

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

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1 submitted a main statement and then a second
2 statement --

3 **Q.** Yes.

4 **A.** -- on 6/9. I did submit a third statement on
5 20/9, I don't know if it got through, I can't see it on
6 the list here, and that is a re-analysis of this
7 particular review.

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

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

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

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

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

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

9 **A.** Yes.

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

15 6 and 7, please. So does that look familiar to
16 you, that email?

17 **A.** Yes.

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

23 **A.** Yes.

24 **Q.** Well, as I say --

25 **A.** But could I add? You mentioned I had

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1 **LADY JUSTICE THIRLWALL:** Did you say it was
2 20 September?

3 **A.** 20 September.

4 **LADY JUSTICE THIRLWALL:** Of this year?

5 **A.** Yes, yes.

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

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

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

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

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

15 **A.** Yes.

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

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

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

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1 A. Yes.

2 Q. But one way of identifying some of the
3 unexpected collapses was to identify those who had been
4 transferred out of the Countess?

5 A. Yes.

6 Q. You could then examine those.

7 A. Yes, and find which of those had had
8 unexpected collapses, they weren't all unexpected
9 collapses leading to transfer.

10 Q. No, but it was as I say a proxy --

11 A. Yes.

12 Q. -- as a way -- a shorthand way of trying to
13 look at least some of the unexpected collapses?

14 A. Yes, that is right.

15 Q. As you have made clear, there were limitations
16 to this exercise because unexpected collapses for babies
17 who weren't transferred out wouldn't be captured by the
18 work that you did?

19 A. Yes.

20 Q. You deliberately didn't look at the staffing
21 for those babies; is that right?

22 A. That's correct. I was told a staffing
23 analysis would be done afterwards.

24 Q. And the upshot --

25 A. I was looking at the -- I was looking at the

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1 A. No, because the notes -- Anne gave the notes
2 to another colleague and I mention in my statement who
3 I think it was, but that's who I think it was, so
4 I don't know it was that person and it went off for --
5 to be further analysed.

6 Q. Your expectation was that a staffing analysis
7 would then be done based upon the work that you had
8 done?

9 A. At least a staffing analysis, yes.

10 Q. In paragraph 93 of your statement, you state
11 that you presented the findings to the Medical Director
12 and other Consultants in mid-July?

13 A. Sorry?

14 Q. Presented the findings to the Medical Director
15 and other Consultants in mid-July, would you like to
16 look at the reference?

17 A. No, I never presented the findings. The
18 findings were presented in mid-July.

19 Q. They were presented, forgive me.

20 A. The findings of the hospital's internal review
21 was presented on 13 July. Now, I was part of that
22 review doing this particular review of patients
23 transferred out of the unit. That didn't actually
24 feature in the presentation. I thought it was going to.

25 Q. When you handed over the notes, which

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1 medical notes so I could see which doctors had written
2 the notes. So to be fair I knew the doctors, I didn't
3 know anything about which nurses had been involved.

4 Q. You, with the support of Ms Martyn, who was
5 helping you with the exercise but it was your clinical
6 judgment that counted, identified six unexpected
7 collapses which you regarded as being of concern?

8 A. I would say unusual collapses. Probably
9 I have to go back to all six, probably some of them
10 unexpected, others were unusual in some way.

11 But that was a quick review of the notes. I didn't
12 examine all the notes in any detail and I have to
13 mistake one admission: Baby F was one the babies
14 transferred out and Baby F is the one that had the
15 abnormal insulin results and I said any of us could have
16 seen it at any time, including during this review. But
17 Baby F was transferred out when he was entirely well
18 because the Family lived outside West Cheshire and he
19 was going back home. So as soon as we saw that, we
20 stopped looking at him in the review.

21 Q. So I am sure you will be the first to agree,
22 not a forensic analysis?

23 A. Certainly not.

24 Q. And in fact not an analysis that resulted in
25 any kind of formal report from you in writing?

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1 certainly to a layperson are not the easiest to follow
2 because they are your working notes, did you say in
3 terms: look, there are six children here that we think
4 need a closer look?

5 A. No. We said, as far as I remember handing it
6 over, we have identified some of the babies in whom we
7 think there are unusual reasons for transferring them
8 out.

9 Q. Then left it to others to read your notes?

10 A. Yes.

11 Q. Work out which ones those were?

12 A. Yes.

13 Q. And to go from there?

14 A. Yes.

15 Q. A meeting took place on 13 July of 2016 and
16 you deal with this at paragraph 388 of your statement.
17 You give the date there as 13/6/2016 but it may be
18 that's a typo?

19 A. Sorry, where is that?

20 Q. 388 on page 110.

21 A. Where's the typo, sorry?

22 Q. The date is 13 June 2016, I am suggesting?

23 A. July.

24 Q. It is 13 July?

25 A. That's a typo, sorry, I thought I got the year

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1 wrong. No, the month is wrong, sorry.

2 **Q.** Month. Yes, and you have had a chance to see
3 the handwritten notes of that meeting and, broadly
4 speaking, do they accord with your recollection of what
5 occurred at that meeting?

6 **A.** Yes.

7 **Q.** And you deal in your statement with some of
8 the discussion. One of the things that Mr Chambers is
9 recorded as saying you deal with this at the end of the
10 paragraph:

11 "There is a correlation with nurse but [recorded in
12 block capitals in the notes] we know a change in acuity
13 and activity plus staffing levels were challenged"?

14 **A.** Yes.

15 **Q.** I just wanted to ask you there about
16 a position paper that was written which has a number of
17 graphs and so on in it because you talk about
18 a presentation being made in terms of the activity and
19 acuity. We don't need to look at the whole position
20 paper, we just need to identify it. INQ0003492.
21 Unfortunately it is on its side.

22 **LADY JUSTICE THIRLWALL:** Do you know how to rotate
23 it?

24 **MR DE LA POER:** It may be, because this can form
25 part of the Inquiry record, it doesn't matter. If we

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1 the other units weren't.

2 But that that was 2015/16. Those graphs also show
3 those same problems in 2014 where there had been very
4 few deaths.

5 **Q.** So were you unpersuaded by what was being
6 suggested was the correct interpretation?

7 **A.** Yes, yes.

8 **Q.** You were?

9 **A.** Yes, but I did accept that because -- because
10 of those reasons, that could cause a few more deaths but
11 if you had a few more deaths because you were very busy,
12 didn't have enough staff and so on, by and large those
13 would be the same sorts of deaths you would normally see
14 but a few more of them unfortunately. And if you are
15 busier, you might just get the extra death because you
16 had more patients.

17 **Q.** What you say in your witness statements is
18 that the Consultant paediatricians pointed to the fact
19 it wasn't just the increase but the fact that
20 deteriorations were unexpected and sudden?

21 **A.** Yes, and from the handwritten notes of that
22 meeting on the 13th, you can see some comments that say
23 exactly that.

24 **Q.** Now, in terms of what the Executives' view at
25 that meeting was, can it be summarised in this way that

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1 could just go to page 11, and I apologise, Dr Gibbs,
2 this is hardly the ideal circumstances, but this is
3 a document that has been sent to you before, I believe?

4 **A.** Yes.

5 **Q.** We can see some findings presented there about
6 acuity and activity and on the preceding pages there are
7 a number of graphs?

8 **A.** This position paper is useful and quite
9 helpful and I only saw it when it came through with the
10 Inquiry documents.

11 **Q.** That was really my question, whether or not
12 this position paper itself was presented to you or
13 whether the PowerPoint presentation that you speak about
14 was something different?

15 **A.** Just the PowerPoint presentation.

16 **Q.** Just the PowerPoint?

17 **A.** Yes, I saw this particular paper for the first
18 team when the Inquiry Team sent it through.

19 **Q.** I understand, thank you very much indeed. We
20 can take that down.

21 **A.** The emphasis of that presentation was, as we
22 have just seen there, there was some increased activity,
23 numbers of babies, there was some increase in illness on
24 average with those babies and what we knew already, we
25 were not up to the normal staffing levels like most of

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1 it was wait for the Royal College's visit and report?

2 **A.** Yes, it seemed to be accepted that those
3 graphs, with the changes we have mentioned, could
4 explain the increased death rate and yes, they could
5 explain an increase in the death rate. I don't want to
6 get stuck in the statistics, which are always difficult.
7 I am not sure it would have explained quite such
8 an increase in the death rate. It did not explain the
9 unusual nature of the deaths and that was mentioned at
10 the meeting. But even so, we had agreed, we
11 Consultants -- and I was one of them who agreed -- we
12 would look at the Royal College's review of our service.

13 **Q.** What you say at paragraph 403 is:

14 "Several of us, including myself, considered that
15 since our concerns about Letby were purely
16 circumstantial and the hospital's investigation had
17 indicated an appreciable increase in workload pressure
18 that might explain the higher rate of adverse outcomes,
19 that it would be best to wait for the RCPCH review of
20 our neonatal service to see whether it supported the
21 findings of the hospital's hurried investigation and
22 then to decide on police involvement"?

23 **A.** Yes.

24 **Q.** Now, just help us to understand how on the one
25 hand your view was that the charts that you were being

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1 presented with didn't provide an adequate explanation?

2 **A.** Didn't seem to.

3 **Q.** Didn't seem to?

4 **A.** Couldn't say absolutely not.

5 **Q.** No, but that was your impression at the time,

6 and that they failed to capture the thing that was

7 uppermost in your mind which was the sudden and

8 unexpected unusual cases that you were dealing with.

9 Why in those circumstances were you content to wait

10 until the RCPCH had reported rather than saying: this

11 data is not what you think it is, we need to go to the

12 police now?

13 **A.** Two reasons: we were hopeful the RCPCH review

14 would clarify whether the deaths were unusual and could

15 be explained by what they were going to examine as

16 stresses and pressures in our unit. And secondly, as

17 came up in this meeting, what we hadn't ensured before,

18 which we should have done, that we did not want Letby

19 back on the unit until this had been sorted out.

20 Now, that delayed getting answers for the parents

21 whose babies had been harmed, it prevented any more

22 babies being harmed while these further assessments were

23 ongoing. We had hoped we would have an answer by

24 mid/end of September after the College review at the

25 beginning of September.

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1 came back from holiday.

2 If we just keep moving through.

3 On 19 July, Dr Jayaram sent an email. We can bring

4 it up if you need to, but if I summarise its content for

5 you. He suggested that the paediatricians thought the

6 Neonatal Network should be involved in what was

7 occurring --

8 **A.** Yes.

9 **Q.** -- at the Countess?

10 **A.** Yes.

11 **Q.** Did that accord with your view at the time?

12 **A.** Yes, we had hoped the College review that was

13 due in September might help to clarify matters. But

14 particularly for the hospital's own internal review it

15 would be useful if outside the hospital but still within

16 the region, neonatologists could offer some advice on

17 the graphs that we had seen.

18 **Q.** And when did you learn that the Network would

19 not be involved?

20 **A.** I didn't find out whether they would or

21 wouldn't afterwards, no. But Dr Subhedra, who had been

22 involved back in February 2016, did get involved later.

23 **Q.** Absolutely, when we come to February/March.

24 **A.** He represents part of the Network but I don't

25 think he was involved at this time. But that was either

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1 **Q.** What you say at paragraph 404:

2 "All of us Consultant paediatricians were adamant

3 that if the police were not to be involved at this stage

4 and if Letby was to continue on the NNU, she had to be

5 closely monitored in case she had harmed babies?"

6 **A.** Yes.

7 **Q.** So is this right, that at least your position

8 and the position you understood of others, was that

9 Letby could return to the unit but only under close

10 supervision as opposed to requiring that she be excluded

11 altogether?

12 **A.** Yes, at that time. But close supervision was

13 CCTV cameras and/or she had to be supervised by another

14 nurse all the time. I didn't think that was likely to

15 be possible. They would not get -- CCTV cameras are

16 an issue that the Inquiry is looking at. We would never

17 have got them up by the time she was back from holiday

18 in a few days' time even if they would rush in a set of

19 CCTV cameras. So in a way it was a slightly convoluted

20 way of just trying to make it rather difficult for her

21 to come back.

22 **Q.** We know, in the event, no supervision could be

23 found and she did not in fact return --

24 **A.** Yes.

25 **Q.** -- to the unit as a practising nurse when she

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1 him or the whole Network, I think as Dr Jayaram mentions

2 in his email it was the intention of trying to get those

3 people involved again to offer advice to the Trust.

4 **Q.** If we then move forward to 1 September and the

5 interview with the RCPCH. You deal with this at

6 paragraph 411 having -- and we thank you for this --

7 gone through all the notes of the discussion which took

8 place. What you say is:

9 "The main issue discussed as needing fixing was the

10 concern that we expressed over the number of deaths in

11 2015 and the first half of 2016. Many were unexpected

12 and frequent poor response to the resuscitation was

13 unusual and few babies exhibited strange mottling of the

14 skin."

15 Then you go on:

16 "Babies who deteriorated several times on our NNU

17 seemed to be stable once transferred elsewhere. The

18 cause of death was uncertain in some cases even after

19 a postmortem. The increased number of deaths and

20 non-fatal collapses had caused significant distress

21 among the medical and nursing staff.

22 "Finally we mentioned that we hoped we could again

23 move back to being a Level 2 NNU and that we all like

24 working with neonates."

25 **A.** Yes.

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1 Q. Just pausing, just a footnote to that.
 2 In July the unit had been downgraded --
 3 A. Yes.
 4 Q. -- to a Level 1?
 5 A. Yes.
 6 Q. This is a reference to the fact you wished to
 7 return to Level 2?
 8 A. Yes, by "downgraded", less beds and not the
 9 most intensive babies; so lower risk babies, less of
 10 them.
 11 Q. Now you then go on to say:
 12 "Neither the handwritten notes of this interview
 13 nor the typed transcript record concerns about Letby"?
 14 A. Yes.
 15 Q. "I cannot remember if we mentioned her by name
 16 but I thought we had told the review team that we were
 17 worried about a particular nurse being associated with
 18 most the deaths and also non-fatal collapses. Perhaps
 19 we mentioned this to the review team outside of our
 20 interview session."
 21 A. Yes, there was a comment I mention there. It
 22 is hard to decipher and understand what was meant but
 23 Dr Saladi, one of my colleagues, might be able to add to
 24 that. He made a comment that is recorded in his
 25 handwritten notes that may allude to a problem with

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1 going to look at individual deaths but I think they did
 2 see an overview of the deaths which might have been
 3 something like that thematic review but I am not sure.
 4 We knew they were not going to look at staffing -- well,
 5 they looked at staffing levels. They were not going to
 6 look at individual members of staff and say who did
 7 what, or anything like that. But it is just
 8 disappointing that they didn't pass opinion on whether
 9 they felt the deaths were explained by pressures on my
 10 unit.
 11 Q. You do say, however, you found it reassuring
 12 they recommended an external review?
 13 A. Yes.
 14 Q. That being a reference --
 15 A. Yes.
 16 Q. -- as it turned out to be to Dr Jane Hawdon?
 17 A. That was good. But the disadvantage was that
 18 it prolonged the whole assessment, but that's
 19 a necessary thing to do.
 20 Q. When you learned that there was going to be
 21 further delay having hoped that there would be
 22 a response or a conclusion by September did you return
 23 at any point as far as the Executives were concerned to
 24 the idea that the police needed to be called at that
 25 stage or were you content to let it run its course?

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1 a member of staff. But the Royal College paediatrician
 2 and neonatologist and specialist nurse weren't there to
 3 do a staffing analysis or look at individual staff. So
 4 if we didn't mention her, that wouldn't have bothered
 5 me. We wanted their opinion on the nature of the deaths
 6 and whether it could be accounted for by pressures on
 7 our unit.
 8 Q. Now, at paragraph 411 you were asked to
 9 comment upon what you had said to Facere Melius in terms
 10 of the RCPCH review feeling like a bit of a waste of
 11 time?
 12 A. Yes.
 13 Q. Do you want to just tell us what you did in
 14 fact think the value or otherwise of the RCPCH visit
 15 was?
 16 A. Right. The main value was that it did not --
 17 the reviewers did not find any clear explanation for why
 18 we had an increased death rate and the unusual nature of
 19 the deaths and they felt that the -- that those
 20 questions could not be properly answered until
 21 a detailed external expert had reviewed the deaths. And
 22 the bit about -- I am sort of rude to the Royal College
 23 of which I am a member or a Fellow. We were hoping they
 24 would pass some sort of judgement on that.
 25 But they did say when they came that they weren't

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1 A. Content to let it run its course because Staff
 2 Nurse Letby was not on the unit. As I say a bit
 3 earlier, as you pointed out, we had decided if she did
 4 come back we would have to take dramatic action, which
 5 would probably mean going to the police, but we didn't
 6 have a definite plan of when and how we would do that.
 7 Q. Just help me with that. At what point best
 8 you can say was there an agreement between some or all
 9 of the Consultants that if she did come back on the
 10 ward, you would go directly to the police?
 11 A. I don't think we had a formal agreement about
 12 that, that was just a discussion between us because what
 13 comes up later is when after these reviews were looked
 14 at and presented to us by Senior Executives there was
 15 a plan to bring her back and we had some discussion
 16 about what would happen then.
 17 Q. If we come forward to October 2016 and in
 18 particular to the grievance process that we know that
 19 Letby had commenced, you deal at paragraph 418 and make
 20 comment upon matters that have been drawn to your
 21 attention in relation to what Eirian Powell had said?
 22 A. Sorry, which paragraph was this?
 23 Q. 418 unless?
 24 A. 18 -- 18, right.
 25 Q. Yes.

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1 A. 417 onwards.
 2 Q. 417 onwards, yes, forgive me. That's the
 3 context.
 4 I am less interested in what Eirian Powell was
 5 saying about you in that, more about what you say you
 6 were doing at 418. You say this:
 7 "However, I advised that we should be cautious in
 8 necessarily attributing a causal relationship with Letby
 9 and mentioned the case of a nurse accused of patient
 10 harm at Stepping Hill Hospital in Stockport?"
 11 A. Yes.
 12 Q. And you say that in the context of
 13 Eirian Powell's comments about you in October. Can you
 14 just help us with when you were advising that caution?
 15 A. Oh right, I don't remember and I thought that
 16 was relatively early on.
 17 Q. So this isn't now --
 18 A. No.
 19 Q. -- after the Executives had been contacted?
 20 A. No, no. Well, I have no idea. I don't know
 21 why Eirian Powell made that comment given that
 22 Consultants never listen to nurses and so on. I don't
 23 know why she made that comment about me. But I am only
 24 speculating why she might have made that.
 25 Q. You give us a bit more detail in 419 so
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1 certain incidents, that's what led to the wrong nurse
 2 being arrested initially in Stockport.
 3 Q. So it was the parallel what was being said
 4 about Letby specifically in terms of association --
 5 A. Yes.
 6 Q. -- that brought --
 7 A. Yes.
 8 Q. -- the innocent nurse at Stepping Hill to mind
 9 as opposed to the guilty nurse?
 10 A. Yes, yes, and I think we don't want to go
 11 there too much because of what's been said about the
 12 Letby trials, but there are other nurses who have been
 13 accused of harming children because they seem to be
 14 around at the wrong times that then there's been doubt
 15 cast afterwards.
 16 Q. Well, in terms of what you were saying --
 17 A. But this was the Stepping Hill.
 18 Q. You were talking about Stepping Hill?
 19 A. Yes.
 20 Q. Now, 10 November 2016 is the date on which
 21 Dr Brearey tells us that he reviewed the RCPCH report
 22 and he described circumstances where he was given
 23 an hour and he says that you were present at that. Is
 24 he right about that, that you in November reviewed the
 25 RCPCH report for an hour?
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1 I think you should see that.
 2 Although you say you don't remember, you say that
 3 in terms of your own approach:
 4 "As suspicions about Letby increased in late 2015
 5 and into 2016 I avoided discussing this concern openly
 6 on the NNU with the neonatal nurses because I felt this
 7 was inappropriate and unprofessional."
 8 A. Yes.
 9 Q. You go on to say that you may have discussed
 10 Stepping Hill Hospital with Eirian Powell?
 11 A. Yes, or amongst the Consultants, but obviously
 12 Eirian, if she is saying -- if that's why she said I was
 13 a voice of reason she must have heard that. So it might
 14 have been one of the meetings when she was there that we
 15 had on the Monday lunchtimes.
 16 Q. Again your focus there when talking about
 17 Stepping Hill is about the nurse who hadn't --
 18 A. Yes.
 19 Q. -- killed anyone rather than the nurse who had
 20 poisoned patients?
 21 A. Yes.
 22 Q. Why do you think that was your focus from that
 23 incident?
 24 A. Well, it's simply saying there is
 25 a correlation between a nurse and being present at
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1 A. I don't remember being there. No. And
 2 actually when these reports were presented to us by the
 3 Senior Executives on 26 January 17, there is a comment
 4 in the handwritten notes from Mr Harvey saying that
 5 Dr Jayaram and Dr Brearey had reviewed the notes in his
 6 office, he didn't say me, I don't remember it being me.
 7 If you say am I absolutely certain I didn't see them
 8 there, no, I don't remember it though.
 9 Q. Certainly we are going to come now to that
 10 meeting on 26 January and you deal with this at
 11 paragraph 423 at page 121 onwards. There are notes of
 12 the meeting which I think you have had an opportunity
 13 recently to consider although you didn't see at the time
 14 and there is no part of those notes that you think is
 15 wrong?
 16 A. That's correct, yes.
 17 Q. Whether or not they capture the full tone and
 18 content of the meeting is really what I want to ask you
 19 about. Can you just give us a summary of that meeting
 20 and your experience of it?
 21 A. Yes. I -- many of the -- some of the notes of
 22 meetings I was at including that one, when I look back
 23 at the notes, although I am trying to think back seven
 24 years or something, they don't seem to capture
 25 everything and I think some were just writing notes
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1 down, not by shorthand, we will never get everything
2 down that's said in a meeting unless you have someone as
3 in the Inquiry doing it word by word.

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

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

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

20 **Q.** What stunned you?

21 **A.** The nature of the meeting because I thought we
22 were going to that meeting for the first time, because
23 I don't think I had seen those the College report
24 briefly in Mr Harvey's office, although maybe I did, but
25 we were going to see the two reports, the College report
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1 nurses in a quite emotional tone and then we were told
2 how much we had upset Letby by the Chief Executive and
3 told firmly that the board had accepted the findings
4 that there had been no evidence of any wrongdoing and
5 that Letby was exonerated -- I don't know if he used the
6 word "exonerated" -- but no evidence against her and
7 that a line was being drawn under this and that was said
8 quite firmly. I thought the Chief Executive finished by
9 saying, "Is that clear?" as he looked round the room at
10 each of us. I think some of my colleagues thought he
11 said something slightly differently but they can report
12 on that.

13 **Q.** We are interested of course in your
14 recollection --

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

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

20 **A.** Yes.

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

24 **A.** Yes.

25 **Q.** I mean, in the ordinary course of things --
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1 and Dr Hawdon's external expert review of the deaths and
2 a few of the collapses and we would have a discussion
3 about it.

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

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

11 **A.** Yes.

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

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

24 And then we were -- I say it was emotional,
25 a letter was read out from Letby by one of the senior
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1 and I do recognise in my question that this wasn't the
2 ordinary course of things -- but are management
3 generally open with Consultants in relation to the
4 content of expert reports before they discuss that
5 content with the Consultants?

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

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

14 **A.** (Nods)

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

17 But you and your colleagues wrote a letter to
18 Mr Chambers four days later and we will just bring it
19 up, INQ0003095. Signed by you all. You asked
20 specifically what the board's understanding of the
21 reason for the increased number of unexpected and
22 unexplained deaths on the neonatal unit between
23 June 2015 and July 2016 and "the actions that you and
24 the board now expect us paediatricians to take". And go
25 on to say that you want to read the RCPCH report and the
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1 Casenote Review and give an assurance that it will be
2 kept confidential?

3 **A.** Yes.

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

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

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

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

17 (3.04 pm)

(A short break)

19 (3.20 pm)

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

25 **A.** (Nods)

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1 going to see originally.

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

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

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

10 **A.** Yes.

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

14 **A.** Yes.

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

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

23 **Q.** Those being category 2?

24 **A.** Yes, four patients.

25 **Q.** Which she recommended for broad forensic

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

3 **A.** Yes.

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

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

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

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

17 **Q.** 5 February onwards.

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

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

23 **A.** Okay, right.

24 **Q.** Perhaps it doesn't matter terrible.

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

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1 review --

2 **A.** Yes.

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

5 **A.** Yes.

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

9 **A.** (Nods)

10 **Q.** Why did you do that?

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

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

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

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

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

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1 Q. That was the letter of 10 February 2017?
 2 A. We sent one a few days earlier, the one at the
 3 end of January.
 4 Q. 30 January we looked at?
 5 A. Yes.
 6 Q. That's where you asked specifically for the
 7 board's understanding of the explanation?
 8 A. But even at that stage we had not drawn a line
 9 under it and we defied what we were told and we were
 10 starting to ask questions, and again on the 10th.
 11 Q. If we bring up the 10 February letter,
 12 INQ0003117. So this letter written following --
 13 A. Having read the reports.
 14 Q. Exactly so. You give the dates 3 and
 15 7 February?
 16 A. (Nods)
 17 Q. The substance of the letter goes on to urge
 18 a Coronial investigation?
 19 A. Yes.
 20 Q. Why did you think that the Coroner was the
 21 right person in these circumstances?
 22 A. Because the Coroner is supposed to examine
 23 deaths to try and ascertain why they occurred and we
 24 thought if he had access to Dr Hawdon's report and knew
 25 of our concerns, that that would ring major alarm bells

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

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

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

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1 Q. And you were discussing with your colleagues
2 whether that was a good idea or not?

3 A. I am not sure a good idea whether we could
4 show her the reports because we had been given the
5 reports and told to keep them highly confidential.
6 I thought we could give them to her because she was
7 a fellow paediatrician, albeit a community rather than a
8 hospital. Some of my colleagues felt it better that she
9 go via the Executives which in normal practice I would
10 have given the report to a colleague who is another
11 paediatrician.

12 Q. Was one of the attractions of Dr Isaac having
13 the reports because Dr Isaac had a safeguarding role?

14 A. Yes, and she may raise concerns as well, it is
15 up to her once she has seen the reports.

16 Q. So does it follow from that that at this time
17 you were seeing safeguarding as a possible way of
18 ensuring the concerns were properly investigated?

19 A. No. I think Dr Isaac felt she ought to be
20 involved and we thought she should be involved. We
21 thought we would raise safeguarding issues quite clearly
22 to the senior managers who have a responsibility for
23 safeguarding in the Trust. It didn't necessarily need
24 Dr Isaac as well, but it was fine if she wanted to join
25 in. We weren't expecting her to raise the issues for

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1 a meeting with the Coroner?

2 A. Yes.

3 Q. So trust was breaking down. Is that a polite
4 way of saying you didn't believe that your concerns
5 would be fairly represented?

6 A. I wasn't sure that our concerns would be
7 slanted in the correct way. It was clear from previous
8 meetings going right back to July 13 2016 when we were
9 given the results of the Trust's internal investigation
10 that the Senior Executives' interpretation of data was
11 different to our paediatric interpretation of data. We
12 didn't know quite what view had been given to the
13 Coroner.

14 Q. On 24 February, you had a meeting with
15 Mr Harvey?

16 A. Yes.

17 Q. Am I right in suggesting that that meeting was
18 because Mr Harvey contacted you saying he wanted to talk
19 to you about your July 2016 report?

20 A. Yes, and we had asked to see that report in
21 our earlier letter to the Chief Executive. When we sent
22 letters to the Chief Executive, we assumed, but maybe we
23 shouldn't have done, probably the Medical Director and
24 nursing director would have been shown those by the
25 Chief Executive.

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1 us. We thought we had raised them clearly enough
2 already.

3 Q. When you raised them, and here we are talking
4 about with the Executive Directors, had you so far as
5 you can recall expressly referred to them as
6 a safeguarding concern?

7 A. I can't remember if we did. I thought it's
8 fairly obvious they were.

9 Q. Continuing with our chronology,
10 16 February 2017, a letter from Mr Chambers confirming
11 that the letter had been sent to the Coroner, do you
12 recall that letter, or shall we --

13 A. Yes -- no, I recall it, yes.

14 Q. What was your reaction to the actions that you
15 were being informed the Executives were taking at that
16 time?

17 A. Pleased the letter had been sent to the
18 Coroner, weren't clear if that meant the Coroner would
19 investigate all the deaths but at least some action had
20 been taken. I think it fair to say I can say for myself
21 and I think my colleagues will express their own
22 opinions, trust between ourselves as Consultant body and
23 the Senior Executives was breaking down at this stage.

24 Q. There was mention in that letter about the
25 fact that there had been a meeting and there was to be

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1 Q. Were you told by Mr Harvey anything of what he
2 had done so far as the Coroner was concerned in that
3 meeting on the 24th?

4 A. Yes, he mentioned he had seen the Coroner with
5 Mr Cross, the corporate and legal advisor for the Trust,
6 and that they had shared our concerns with the Coroner,
7 they had copies of our letters to the Chief Executive
8 and the Chief Executive had mentioned the letter going
9 to the Coroner in his letter which at that time
10 reassured me that hopefully a resolution may be coming
11 for our concerns, that the Coroner would consider these
12 concerns in the forthcoming inquests which were on three
13 babies.

14 I know two of them were Child O and Child P. I am
15 not sure who the third one was, possibly a child not in
16 the indictment.

17 Q. So at that moment in time when Mr Harvey told
18 you that, did you consider that you had taken the matter
19 as far as you needed to and it was now in the hands of
20 someone else, or did you think more needed to be done?

21 A. I thought the Coroner must take some action
22 once he has been told all of this.

23 Q. Did you suggest to your colleagues that the
24 ball was now in the Coroner's court?

25 A. Yes, yes because we had said in our letter to

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

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

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

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

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

6 **Q.** The same day -- we will just bring it up --
7 28 February 2017, INQ0003187 -- the seven of you
8 Consultants wrote a letter of apology to Letby?

9 **A.** Yes.

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

15 **A.** Sorry, can you pose that question again?

16 **Q.** Do you want to just read it and then ...
17 (Pause)

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

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1 a Coroner's investigation.

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

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

8 **A.** Yes.

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

14 **A.** (Nods)

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

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

19 **Q.** No.

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

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

4 **Q.** Thank you, we can take that down.

5 1 March another letter to Mr Chambers, INQ0006816.

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

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

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

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

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

18 **A.** Right.

19 **Q.** If my recollection is ... The second bullet
20 point.

21 **A.** Yes. So we are saying there are eight cases
22 altogether.

23 **Q.** Exactly so.

24 **A.** And saying this needs to be investigated.

25 **Q.** Thank you very much indeed.

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

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

7 **A.** Yes.

8 **Q.** One of the matters under discussion was
9 Child K.

10 **A.** (Nods)

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

15 **A.** Yes.

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

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

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

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

9 **Q.** We will move forward to the meeting with
10 Simon Medland QC, as he was then. This was on
11 12 April 2017 and you have had a chance to see now
12 His Honour Judge Medland's note of that meeting.

13 **A.** Yes.

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

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

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

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

23 **Q.** Who had you got that impression from?

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

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

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

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

10 **A.** Yes, yes --

11 **Q.** So at least at 19 March?

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

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

15 **A.** I can't remember that because as I say,
16 I can't remember exactly when I heard about it. But
17 from this email I did know by this time. But this is
18 2017.

19 **Q.** This is 2017?

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

24 **Q.** You don't --

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

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

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

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

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

20 **A.** Yes.

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

24 **A.** (Nods)

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

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

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

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

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

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

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

19 **Q.** And --

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

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1 **Q.** We can just bring that up. INQ0006136,
2 13 April 2017 so the day after the meeting with
3 Mr Medland?

4 **A.** (Nods)

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

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

11 **A.** Yes, and that meeting was arranged.

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

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

16 **Q.** Two more matters from me, Dr Gibbs.

17 Thank you, that can come down.

18 The first is to move outside of our time period
19 that we have been focused on and just draw your
20 attention to the spring of 2018 and in the spring of
21 2018, a table was sent to Mr Chambers providing a list
22 of the Consultants' concerns --

23 **A.** Yes.

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

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

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

7 **A.** Yes.

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

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

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

19 **Q.** 10 May --

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

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1 creation of that table?

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

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

6 **A.** (Nods)

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

9 **A.** Yes.

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

13 **A.** As far as I can remember, generally yes.

14 I did feel by the time we had this to and fro of letters
15 that we probably weren't getting anywhere and we had
16 said enough at that stage. The police were currently
17 investigating and I felt our focus should be on what the
18 police found. This wasn't part of the attempt and the
19 Chair of the Trust was getting -- Sir Duncan Nichol was
20 getting involved at around this time, of trying to
21 repair the relationship between us Consultant
22 paediatricians and senior managers.

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

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

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

11 You were asked specifically about interactions with
12 the Cheshire Coroner?

13 A. Yes.

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

17 A. Yes.

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

21 A. Yes.

22 Q. You set out in your --

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

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

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

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

16 A. Yes.

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

19 A. Yes.

20 Q. If we look at 478, however:

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

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

6 A. Yes.

7 Q. As a result you completed a form?

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

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

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

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

22 A. Yes.

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

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

9 A. Yes.

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

16 A. Yes.

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

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

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

4 **Q.** So --

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

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

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

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

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1 the event, so your witness statement for this Inquiry is
2 written in 2024, describing events that took place in
3 2015. So where I think seek to draw out differences
4 between your recollection and Mother C's recollection,
5 please don't see that as being anything other than
6 a question about recollection rather than probity.

7 **A.** Okay.

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

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

15 **A.** No, it wasn't.

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

19 **A.** Yes.

20 **Q.** Required very little resuscitation, if any?

21 **A.** Yes.

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

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

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

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

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

13 **LADY JUSTICE THIRLWALL:** Mr Baker.

Questioned by DR BAKER

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

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

22 **A.** (Nods)

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

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

3 **Q.** So he was around the second percentile?

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

5 **Q.** Yes.

6 **A.** So that does increase risks a bit.

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

11 **A.** Yes.

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

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

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

23 **A.** No, that's correct.

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

200

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

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

9 A. Yes.

10 Q. His oxygen requirements had gone down
11 substantially?

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

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

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

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

201

1 A. No. It depends. The raised C-reactor protein
2 is an indication of possible, not always infection,
3 possible infection. It would depend on whether the baby
4 showed signs of severe infection with poor circulation
5 and gradual deterioration. He didn't show those signs,
6 so I would not expect him to die from infection just
7 because of the raised CRP.

8 Q. Indeed the CRP was mildly raised?

9 A. Yes.

10 Q. I think it was a little over 20?

11 A. Yes.

12 Q. In severe infection, it can get up to over
13 300, can't it?

14 A. Yes. But not -- unlikely in a little baby but
15 nearer 100, yes.

16 Q. So necrotising enterocolitis.

17 A. Yes.

18 Q. There was no evidence of that prior to the
19 collapse?

20 A. I didn't think so and this was discussed
21 a little bit at his trial. One of his x-rays the day
22 before he died did show slight distention in his
23 abdomen which I think the radiologist reported as
24 possible bowel obstruction.

25 I felt it was quite consistent with a baby that had

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

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

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

8 Q. His respiratory rate and temperature were
9 normal?

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

16 Q. If I put it this way. Given the signs of
17 infection that were present, raised inflammatory marker,
18 would you expect that to result in a sudden collapse and
19 death of a baby in and of itself?

20 A. I just missed the very last bit.

21 Q. Just a raised C-reactive protein?

22 A. Yes.

23 Q. In and of itself, you would not expect that to
24 be the thing that caused a baby to collapse and suddenly
25 die, would you?

202

1 been having respiratory support that blows air and
2 oxygen down the nose and mouth and actually fills up the
3 tummy a bit. But you could say that -- you just worry
4 a little bit, could that slightly unusual bowel pattern
5 be the very beginning of NEC.

6 Q. Yes.

7 A. The postmortem didn't show NEC at all.

8 Q. No, there was no sign of it on the postmortem
9 and also NEC doesn't appear out of nowhere and cause
10 a death, does it, it evolves?

11 A. Usually.

12 Q. Usually?

13 A. Sometimes babies can deteriorate within a few
14 hours with overwhelming NEC and they perforate the
15 bowel. But usually it's a few days of being ill and
16 some babies do die of NEC usually after a few days of
17 being very ill and not improving.

18 Q. And bowel perforation presents in a typical
19 way which wasn't present here?

20 A. Well, a bowel, a bowel perforation which can
21 happen for various reasons, and affected one of the
22 other babies in the indictment, can happen suddenly and
23 cause a sudden quick deterioration. But Baby C did not
24 have a bowel perforation at postmortem.

25 We didn't suspect it in life and he didn't have it.

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1 Because the reason for doing a postmortem -- sorry to
2 rush, but I can see the time -- sometimes you find
3 conditions that you did not diagnose in life and it
4 explains the problem. We didn't have a -- we had no
5 explanation from the bowel at postmortem for Baby C's
6 collapse.

7 **Q.** And looking at the raised lactate at the time
8 of his birth, one of the things that was raised at
9 postmortem was myocardial ischaemia.

10 **A.** Yes.

11 **Q.** Now, lactate can raise in the presence of
12 heart failure?

13 **A.** Yes, any -- any poor perfusions and heart
14 failure is one of those causes, yes.

15 **Q.** Yes, but in Child C's case the lactate was
16 elevated at the start?

17 **A.** Yes.

18 **Q.** And then improved to normal --

19 **A.** Yes.

20 **Q.** -- by the time he collapsed?

21 **A.** Yes and we know from the antenatal scans of
22 the baby -- and that's why the baby was delivered --
23 that perfusion was poor from the placenta to the baby
24 and that could well explain the raised lactate which
25 then improved in the early days of life.

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1 **A.** But that is not the scenario in Baby C.

2 **Q.** I mean, the reality with Child C is that his
3 collapse came completely out of the blue.

4 **A.** Not completely. Well, yes is the short
5 answer. The slightly longer answer: we knew Baby C was
6 at risk of NEC. We know afterwards with the postmortem
7 he didn't have it.

8 Baby C was having a few regurgitations and a few
9 bar stain regurgitations earlier on the day that he died
10 and there was a worry that one of the nurses had just
11 given a small milk feed just before he collapsed and you
12 wondered whether the milk had gone the wrong way. But
13 it was such a small feed it shouldn't have caused
14 a problem even if had gone into the lungs. So that's
15 why I am qualifying it a bit. It wasn't completely out
16 of the blue; it was largely out of the blue.

17 **Q.** Yes, so a potentially vulnerable baby but in
18 terms of his observations they were all stable or
19 improving prior to the collapse?

20 **A.** Yes.

21 **Q.** And a collapse may occur suddenly and
22 unexpectedly, but you would ordinarily in the neonatal
23 context expect to be able to resuscitate that baby or
24 reverse the collapse?

25 **A.** Yes, well, particularly in a baby where it

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1 **Q.** But looking at heart failure as a potential
2 cause of the collapse, would you say that improving
3 a normal lactate is inconsistent with heart failure as
4 a cause of collapse?

5 **A.** Probably. It's not that common to encounter
6 heart failure in little premature babies. It does occur
7 obviously, so I don't have a good understanding of the
8 relationship between lactate and heart failure.

9 **Q.** It's extraordinarily unusual for a baby to --

10 **A.** Yes, yes --

11 **Q.** -- die of myocardial ischaemia?

12 **A.** -- so I am not confident with answering that,
13 you know, improving lactate means you can't have heart
14 failure because we don't see heart failure that much --
15 I don't see heart failure, I haven't recognised heart
16 failure that often in babies.

17 **Q.** I mean, that may in and of itself tell us
18 a great deal.

19 **A.** Yes. Well, heart failure does happen in
20 babies when they have got overwhelming problems like
21 generalised septicaemia, which affects all the organs
22 including the heart, and then you will have a raised
23 lactate but that's because the baby is very ill with
24 very poor perfusion due to the sepsis.

25 **Q.** Yes.

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1 happens suddenly because they haven't been compromised
2 for some time.

3 **Q.** Yes. So children or babies who are stable or
4 improving who suffer collapses in the neonatal setting
5 it's generally reversible with resuscitation?

6 **A.** It's generally reversed?

7 **Q.** Reversible.

8 **A.** Generally, yes.

9 **Q.** So two factors here that were unusual about
10 Child C. First of all, his observations were stable or
11 improving and, secondly, he couldn't be resuscitated?

12 **A.** Yes.

13 **Q.** These were two unusual features.

14 **A.** Yes, but the unusual feature of not being
15 resuscitated might have been explained by his postmortem
16 report because Dr Kokai felt that myocardial ischaemia,
17 the heart damage, had predated his collapse.

18 **Q.** Yes.

19 **A.** In which case that could have caused the
20 collapse.

21 **Q.** I will come on to that in a moment. Were
22 deaths due to sudden unexpected collapses common in the
23 neonatal unit before June 2015?

24 **A.** No.

25 **Q.** And how long had you worked there?

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1 A. 21 years.
 2 Q. When you say they were uncommon, bordering on
 3 never happening at all?
 4 A. Sudden unexpected deaths? No, no.
 5 Occasional, every few years.
 6 Q. Yes.
 7 A. I mean, some babies, like adults, can die
 8 suddenly and nothing is found at postmortem and
 9 increasingly as genetics is improving a gene is
 10 discovered, sometimes found in the family years later,
 11 that causes cardiac dysrhythmia.
 12 So there can be rare causes of collapse which
 13 aren't explained at postmortem which do cause sudden --
 14 cause sudden death.
 15 Q. So I am going to come on then to -- first of
 16 all you had a conversation with Mother C where you said
 17 there would need to be a postmortem --
 18 A. Yes.
 19 Q. -- because the death had been sudden and
 20 unexpected and also you couldn't explain the death --
 21 A. Yes.
 22 Q. -- so a postmortem was necessary?
 23 A. Yes.
 24 Q. And you had a meeting with Mother C on
 25 21 August 2015 by which time a postmortem examination
 209

1 not expected to die, his collapse at the time and in the
 2 way that it happened was not expected, that you found it
 3 unusual that Child C had not responded at all to
 4 vigorous resuscitation but had later shown signs of
 5 life, that the postmortem had not revealed an obvious
 6 cause of death, but that there was an unusual finding of
 7 patchy myocardial ischaemia, which you thought was more
 8 likely to have been the consequence of the collapse but
 9 not the cause of it, and that Mother and Father C were
 10 left with an uncertainty about what had happened.
 11 They felt you had their best interests at heart and
 12 were open about your sense of uncertainty also as to the
 13 cause of death.
 14 A. Yes, and I think, maybe I didn't, I thought
 15 I had indicated the pathologist felt that myocardial
 16 ischaemia explained the collapse and death.
 17 Q. Yes.
 18 A. He thought it was likely to have occurred six
 19 to eight hours before the death, which would have been
 20 an hour or two before the collapse.
 21 Q. Yes. What you say in your witness statement,
 22 and if I can go back to paragraph 71, you refer here to
 23 the postmortem results and you say that it was shown
 24 that:
 25 "~... Child C had died of myocardial ischaemia,
 211

1 had been carried out, but the report hadn't been
 2 published?
 3 A. Yes.
 4 Q. So you had a conversation with Dr Kokai, who
 5 was a pathologist, before you spoke with Mother C?
 6 A. Yes.
 7 Q. Which I think you concede in a letter was
 8 a slightly irregular thing to do, but you wanted to be
 9 able to explain this to her?
 10 A. Yes, yes, and Dr Kokai, like the other
 11 pathologist, was quite helpful in giving preliminary
 12 results of postmortems. But I think strictly they are
 13 not supposed to do that until the Coroner gives
 14 permission -- I hope I'm not getting Dr Kokai into
 15 trouble -- and that can be weeks or months afterwards.
 16 Q. Yes.
 17 A. Many months afterwards.
 18 Q. It was something done so that Mother C might
 19 have answers?
 20 A. Yes, but I think it was (*redacted*). I don't
 21 know what -- I don't think the Coroner would have
 22 objected, but I don't know if the Coroner knew.
 23 Q. Let us not worry too much about that.
 24 But I would say that Mother C's recollection of the
 25 meeting is that you said the following: that Child C was
 210

1 damage to heart muscle from a lack of blood and oxygen.
 2 This provided a reasonable explanation for Child C's
 3 death, although later as I became concerned about
 4 deliberate harm on the NNU in 2016 I wondered if the PM
 5 had revealed the true cause of death."
 6 I appreciate it's semantics, but I want to be clear
 7 about whether you thought that the myocardial ischaemia
 8 provided an explanation for the collapse, a reasonable
 9 one, rather than the death?
 10 A. For the collapse, I wasn't sure that it did.
 11 But I knew it might, if Dr Kokai was right, and knowing
 12 that Child C had had a raised lactate and very poor
 13 perfusion before birth, that might have damaged the
 14 heart.
 15 Q. So I --
 16 A. But I did tell the parents I didn't think that
 17 was the likely explanation, but I wasn't sure and when
 18 we have all the mortality reviews the results of the
 19 postmortem are given there and the death certificate
 20 quotes myocardial ischaemia as the cause of death.
 21 Q. So I accept that you may have felt that
 22 perhaps the pathologist knows better. But what you said
 23 to the parents, and I suggest it's what also you felt at
 24 the time, was that this explanation didn't seem to make
 25 sense as a cause for the collapse to you that the --
 212

1 A. Yes, I wasn't sure that it did explain the
2 collapse.

3 Q. And if we look back --

4 A. I don't think I was explicit -- I don't think
5 I was adamant it does not explain the collapse. I
6 wasn't sure it did explain it.

7 Q. So if we look, please, at INQ0008978, this is
8 to refresh your memory. This is a letter, if we go on
9 to page 3, this is a letter from you to Mother and
10 Father C on 24 September, dictated on 21 October --
11 sorry, 21 August and it follows on, you can see in the
12 first sentence, from a meeting on 21 August 2015.

13 If we look on to page 2 and if you begin reading
14 down, please, from -- thank you -- the second paragraph
15 or the first substantial paragraph on this page, you can
16 see:

17 "Although there were several risk factors in
18 Child C that would increase the probability of death
19 following his delivery, it still was not expected that
20 he would die ..."

21 If you could just read it to yourself in its
22 entirety. (Pause) Then if you could let us know when
23 you have finished.

24 A. I've finished that paragraph, yes.

25 Q. Yes. If you could read then the following
213

1 the time of Child C's collapse and during his
2 resuscitation to have become established histologically
3 since Child C's death did not occur for some hours after
4 his collapse and resuscitation."

5 Then on to the following page again, you are
6 setting out there more of the same. But you go on to
7 say:

8 "I am sorry to have gone over in some detail over
9 the finding of patchy myocardial ischaemia in Child C
10 and it is entirely understandable why the pathologist
11 thought this might have been the cause of Child C's
12 collapse. But on taking his history into careful
13 consideration, particularly the fact that he died some
14 time after the resuscitation, raises the distinct
15 possibility that those ischemic changes followed the
16 sudden collapse rather than preceded it."

17 So again, I mean you are expressing scepticism in
18 this letter as to whether the myocardial ischaemia was
19 the cause of the collapse --

20 A. Yes.

21 Q. -- rather than a product of the collapse?

22 A. Yes.

23 Q. And that's also something you had said to
24 Mother C and Father C in the meeting --

25 A. Yes.

215

1 paragraph and it may help if I read a bit of it out:

2 "The pathologist was impressed by the patchy
3 myocardial ischaemia in Child C's heart and until I have
4 discussed the PM with him by phone, he had felt this
5 could have caused Child C's collapse. He based this
6 assumption on the fact that there was a sudden
7 cardiorespiratory collapse. This would lead to
8 myocardial ischaemia but it takes some hours for the
9 cellular changes (histological changes) to become
10 apparent. Therefore because Child C had clear signs of
11 patchy myocardial ischaemia the pathologist had assumed
12 this problem must have developed during the few hours
13 before he suddenly collapsed because if he died at or
14 shortly after the resuscitation this would not have
15 allowed time for the ischemic changes as a result of
16 that collapse to become obvious when later examining the
17 heart.

18 "However, when I pointed out to the pathologist
19 that because of the slightly unusual, prolonged nature
20 of Child C's resuscitation even though the latter part
21 of the resuscitation was only intended to be a
22 relatively token effort pending the baptism, some signs
23 of life had returned and it was some hours later that
24 Child C died. This would probably have allowed the
25 myocardial ischaemia that would have been expected at
214

1 Q. -- that followed --

2 A. Yes.

3 Q. And also, and I appreciate this may be
4 conflating things we later find out, but if we look at
5 INQ0001993, on to page 14, paragraph 54.

6 We can see here this is a section of your police
7 statement. If we look at that paragraph again, it's
8 saying the same thing. If we look to the bottom,
9 please, that would be particularly helpful. So you can
10 see a sentence that begins:

11 "Nevertheless these residual signs of life for
12 several hours prior to the eventual death would have
13 been associated with extremely poor blood supply to
14 Child C's heart muscle ..."

15 And then finally:

16 "~... taking Child C's unusual circumstances into
17 account related to prolonged but mild resuscitative
18 efforts pending his christening in my opinion it is more
19 likely that the ischemic changes noted at postmortem
20 were a consequence of rather than the cause of his
21 collapse ..."

22 And that's a position you had reached in 2017?

23 A. Did I, in this -- just if we go on a little
24 bit. Did I then explain that Dr Kokai disagreed or was
25 it not in this statement?

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1 Q. It's not in this statement certainly in this
2 section.
3 A. Oh.
4 Q. It's perfectly reasonable. I mean, what I am
5 suggesting to you is that when you were discussing with
6 Mother and Father C you explained to them what Dr Kokai
7 had said but expressed scepticism as to whether --
8 A. Yes.
9 Q. -- that was the cause of death, do you agree?
10 A. Yes.
11 Q. Thank you. That scepticism I would say
12 persisted and we come on to or you came on to have
13 a neonatal perinatal morbidity and mortality meeting on
14 11 February 2016. It is described as a thematic review
15 meeting elsewhere, I think.
16 A. The thematic review when -- when 10 babies
17 altogether were included, is that the one?
18 Q. Yes.
19 A. Yes, I wasn't at that meeting.
20 Q. But you also have a meeting.
21 If we can go mean to INQ0005449. So this is the
22 neonatal perinatal morbidity and mortality meeting
23 record and we can see that your name is fifth in the
24 list of attendees. Can you see that?
25 A. Yes.

217

1 heart and that that had also been the cause of the
2 collapse, we wouldn't see "sudden collapse ? cause"
3 here, would we?
4 A. Well, Dr Kokai felt the ischemic heart
5 problems caused the collapse, I wasn't sure. So there
6 is a difference of opinion there so those two come
7 together.
8 Q. Yes. So the actual cause of death is recorded
9 and it has "PM" for postmortem before it, so indicating
10 where the source is --
11 A. Yes, yes.
12 Q. -- but the narrative section to the right of
13 that puts "sudden collapse ? cause", which suggests
14 a degree of scepticism as to the cause of the collapse?
15 A. Yes.
16 Q. And --
17 A. Can I add also, sorry, there was a letter
18 I sent to the parents in December, I can't remember the
19 date in December, once the final postmortem report had
20 come through and that was after my discussion with
21 Dr Kokai, who was going away to discuss with colleagues,
22 and knowing what I told him about my scepticism, well,
23 the question to him about: did the ischaemia really
24 start before the collapse? And I don't know what
25 discussion he had with which colleagues, but that's what

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1 Q. The first child who is discussed within that
2 list is Child C and we can see the third line down in
3 the middle box discussion and learning from the case.
4 It says, "Sudden collapse ? cause."
5 A. Yes.
6 Q. And, again, would you have been presenting the
7 circumstances of Child C's death to this meeting given
8 that you were his treating neonatologist or
9 paediatrician?
10 A. I might have been. I can't remember. It's
11 not necessarily always the Consultant who presents.
12 Sometimes as a learning exercise one of our training
13 doctors presents but we consultants add in comments.
14 Q. Yes. Is it fair it say given what you have
15 just said about Dr Kokai's cause of death that
16 "sudden collapse ? cause" probably came from you?
17 A. It's likely, yes.
18 Q. And --
19 A. But sometimes in this discussion and learning
20 from the case, we are just summarising what the case was
21 and Baby C died of a unknown cause on the day of his
22 death.
23 Q. Yes, but if you were in a position by
24 11 February 2016 of accepting that the cause of death
25 was, one, a widespread hypoxic ischemic damage to the

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1 he was going to do.
2 His subsequent formal death certificate, well, I'm
3 sorry, his subsequent postmortem report then said -- he
4 presumably discussed it or thought about it --
5 myocardial ischaemia was the cause of death.
6 Q. Yes, I don't think there is any doubt that
7 that's what Dr Kokai felt. But you I think you have
8 agreed were sceptical about that as the cause of
9 collapse?
10 A. Yes.
11 Q. Dr Brearey in his evidence says that at this
12 meeting, and he says it in a police interview, he says
13 that you presented the circumstances of Child C's
14 death to the group.
15 A. All right, okay.
16 Q. And that you put up a slide, or at least
17 otherwise showed the group Child C's observation charts
18 preceding the collapse, which were all stable and
19 normal.
20 A. Yes and that's why it surprises me Dr Hawdon
21 in her report says his observations weren't normal,
22 but...
23 Q. But certainly, can I suggest this; that by
24 11 February 2016, there were audible noises being made
25 within the group of Consultants that somebody may be

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1 deliberately harming patients?

2 **A.** Yes.

3 **Q.** At this meeting, you held up a slide of
4 Child C's observation charts to show the sudden and
5 unexpected nature of the collapse because of a concern
6 that Child C may be one of the children who was
7 deliberately harmed?

8 **A.** It wasn't expressed like that at the meeting
9 as far as I remember. Sorry, I held up a chart saying
10 that he was one the children that we were concerned
11 about deliberate...?

12 Because I didn't think we discussed deliberate harm
13 to patients in a forum with the junior doctors. That
14 had been discussed with the ward manager by Dr Brearey
15 as the neonatal lead and then with more senior managers.

16 **Q.** But here we have a meeting occurring after
17 a point where I think you would accept that you had been
18 concerned about deliberate harm whether or not you could
19 identify the individual?

20 **A.** Yes, at this point I was wondering could
21 Baby C have been harmed, that's correct.

22 **Q.** Yes.

23 **A.** I don't remember expressing that in the
24 meeting. I wouldn't normally do it in a meeting with
25 junior doctors and midwifery team and the obstetric

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1 the parents at that stage. Now, that -- maybe I am at
2 fault for not being candid -- I think has to go through
3 other channels and then later on, if the police get
4 involved, the parents need to know.

5 **Q.** Thank you.

6 **A.** So I am not quite sure what the concern is at
7 this stage; that I had said it or hadn't said it?

8 **Q.** No, the concern is just identifying what your
9 state of understanding was in relation to Child C.

10 **A.** Yes, I was wondering by February 2016 whether
11 Child C might have been harmed, but I didn't feed that
12 back to the parents, no, and that's -- and it can be
13 accepted as a failure of duty of candour. But I had
14 mentioned a bit earlier that I'm not sure whether you
15 can be completely candid with parents when you are
16 thinking you might be heading towards police
17 investigations until those police investigations start
18 and their child is involved.

19 **Q.** Thank you. Mother and Father E F had
20 a conversation with you about Child F and the cause of
21 Child F's collapse and their recollection is that you
22 told them that he had collapsed because of an infection
23 in his lung line and they never found out about
24 hypoglycaemia.

25 Is that a fair observation for them to make?

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1 people that are mentioned in the attendee list.

2 **Q.** Okay, so --

3 **A.** I would discuss that with the other
4 consultants. Dr Brearey was discussing it with the
5 neonatal ward manager and then shortly after this date
6 in February he was escalating it to senior managers in
7 the hospital.

8 **Q.** But certainly by this time, you were concerned
9 that the sudden collapse against a background of stable
10 or improving observations --

11 **A.** Yes, we were concerned about that from when
12 he -- yes, right from his death.

13 **Q.** But to be precise, had been caused by somebody
14 rather than being some unknown natural process. That
15 was what was concerning you as of certainly by
16 February 2016?

17 **A.** Yes. Baby C and Baby I I started to worry
18 about were those natural deaths, that's correct, yes.

19 **Q.** Just a final point in relation to Mother C,
20 sorry, Mother F who I also represent.

21 **A.** I know you didn't ask this question, but just
22 when I mentioned earlier that I might be guilty of not
23 following a duty of candour.

24 When one starts suspecting could criminal activity
25 have taken place, I wouldn't normally share that with

222

1 **A.** When did I have that discussion with them? On
2 the morning, on the morning when he had collapsed?

3 **Q.** Well, he was transferred out, so it was before
4 he was transferred to Arrowe Park.

5 **A.** Right. My recollection, and in my statement
6 my involvement with Child F was on the morning he'd
7 started to become unwell in the early hours of the
8 morning. One of the registrars was involved, phoned me
9 at home, I saw him at 8.30 in the morning.

10 If that, just after that was the time I spoke to
11 his parents. I indeed thought that he was suffering
12 from an infection at that time and I think later on,
13 when his lung line was taken out, it did have -- it had
14 a bacteria on it and it was thought that could have been
15 causing him an infection.

16 I think that was the -- I think it's Baby C, yes.

17 So at that time I did think he was suffering from
18 an infection and hypoglycaemia is a common consequence
19 of infection in premature -- well, in babies.

20 **Q.** But in fact I appreciate the insulin results
21 were never seen by you. You were taken to some versions
22 and I just wanted to make sure you saw the correct
23 version of how it was published. It's at INQ0000844.

24 **A.** But is this blood insulin and blood c-peptide
25 result, is it? Yes.

224

1 Q. It shows, it's a printout within Child F's
2 records of the issue?
3 A. Yes.
4 Q. But it is a printout. It shows an insulin of
5 4657.
6 A. Yes.
7 Q. And c-peptide of less than 169?
8 A. Yes.
9 Q. I think -- I mean, that's a very, very high
10 level of insulin, isn't it?
11 A. Yes, it is.
12 Q. I think you said that you would have needed to
13 work out why somebody might have high insulin levels and
14 low c-peptide levels. But as a paediatrician if you had
15 seen 4657 as the insulin level and a c-peptide of less
16 than 169, you would have known that that was highly
17 abnormal?
18 A. Yes, and if I wasn't sure, which I think
19 I wasn't because I knew when I saw that result two years
20 later doing the police statement, I had to check what
21 would the normal level of c-protein be because premature
22 babies sometimes have different levels and we are not
23 always given the correct level for a premature baby when
24 the result comes back. That would have confirmed this
25 is likely to be exogenous insulin, yes, that's correct.

225

1 A. Yes, yes. And if you see any results in
2 a baby that you don't fully understand, you look up, you
3 check, double check and that would indicate this is
4 likely to be injected insulin, that's true.

5 Q. Yes, thank you, my Lady.

6 A. But I didn't see those results.

7 Q. No.

8 A. But I accept it's a collective failure, as
9 I said in my statement, of all of us on the unit
10 particularly the Consultants who are meant to have the
11 most experience not to have recognised that abnormal
12 result in Baby F.

13 **MR BAKER:** I am grateful, thank you.

14 Thank you, my Lady, I have no more questions.

15 **LADY JUSTICE THIRLWALL:** Thank you very much,
16 Mr Baker. Does that conclude the evidence of Dr Gibbs?

17 **MR DE LA POER:** It does unless you have any
18 questions, my Lady.

19 **LADY JUSTICE THIRLWALL:** No thank you.

20 Dr Gibbs, thank you very much indeed for being so
21 patient and careful in the way you have given your
22 evidence today. It has been a long session and we are
23 very grateful to you.

24 A. Thank you.

25 **LADY JUSTICE THIRLWALL:** You are free to go now, as

227

1 Q. But you would have known that the c-peptide
2 should have risen alongside the insulin --

3 A. Yes, those results suggest injected insulin,
4 yes.

5 Q. Yes. And, again, if you had seen that you
6 would have investigated why the high insulin and low
7 c-peptide in the way that you did subsequently?

8 A. Well, those results came back a week later.
9 I didn't see those results when they came back and
10 Baby F's blood sugars had returned to normal about
11 24 hours later, roughly, maybe slightly longer. So
12 there was no further investigation really to do in the
13 baby at that time. But that was a decision from one of
14 my colleagues that saw the results.

15 Q. All I am saying is if you had seen that
16 result, and I know you didn't, but if you had seen the
17 result, you would have regarded it as highly abnormal
18 and warranting further investigation?

19 A. I think I would have done. The reason I say
20 I think I would have done, I did not see those results
21 and I have admitted I had to check the significance of
22 the low c-peptide when I saw the results two years
23 later.

24 Q. Yes, but you realised that the c-peptide
25 shouldn't be low and the insulin shouldn't be high?

226

1 is everyone else, and we will meet again tomorrow
2 morning at 10 o'clock.

3 **(4.34 pm)**

4 (The hearing was adjourned until 10 o'clock
5 **on Wednesday, 2 October 2024)**

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