Wednesday, 2 October 2024

(10.00 am)

LADY JUSTICE THIRLWALL: Good morning.

Ms Langdale.

MS LANGDALE: My Lady, may I call Dr Lambie.

DR RACHEL LAMBIE (affirmed)

Questioned by MS LANGDALE

LADY JUSTICE THIRLWALL: Do sit down, Dr Lambie, thank you for coming.

MS LANGDALE: Can you give us your name and qualifications?

A. My name is Dr Rachel Lambie and I am a community paediatric Consultant.

Q. Dr Lambie, you helpfully provided the Inquiry with a statement dated 28 June 2024, do you have that with you?

A. I do.

Q. Can you confirm for us that the contents are true and accurate as far as you are concerned?

A. Yes, I can.

Q. You are one of a number of Registrars or at least Registrars at the time of the event we are looking at giving evidence today. Can you tell us firstly what being a Registrar involves, the rotations, shifts, how it works and what you are doing now?

A. So a Registrar is coming towards the end of your training as a junior doctor. So I had completed a more old-fashioned style of training so I was a house officer and a senior house officer and then moved on to Registrar.

The training changed and that renamed us ST, so I was what's known as an ST6, which is a middle grade Registrar. So my role in Chester would have been immediately below the Consultant, so if there is no Consultant on shift I would have been the most senior doctor in that department.

My role would have been to look after the children and the babies but also I was responsible for the house officers and the SHOs below me and then I was also responsible to the Consultants on-call for that day.

Q. You worked at the Countess of Chester 27 April 2015 until 1 September 2015?

A. Yes.

Q. So what wards or units did you rotate amongst in that role?

A. During that time? What was called cross cover, so for Chester you covered paediatrics and neonates. So during the daytime you were either one or the other, but on-call you would cover both. So during a nightshift, for example, you cross covered both.

Q. The paediatrics, is that what they call the children's unit?

A. Children's unit, yes.

Q. So children and neonate. So you have experience of both units or wards?

A. Yes, as part of your training as well.

Q. If you go to your statement at paragraph 5, we asked you about the culture and atmosphere of the neonatal unit in 2015 to 2016. What do you say about that?

A. So I felt the culture was very positive. I was asked very specifically the relationships between different people. So personally I thought the relationship between the junior doctors and the Consultants was very open, very supportive. I also found the relationship between the nursing staff and the junior doctors very open and supportive as well.

Q. You say at paragraph 6:

"I recall the Consultants routinely seeking the nursing staff's opinions and views on the children's care and welfare."

Is that on the children's unit or the neonatal unit as well?

A. Both, on the neonatal unit as well, I particularly remember it in Chester, if they were

doing a ward round it was quite normal for the Consultant to actively seek the opinion of the nurses which in my experience you didn't always see. I have worked in a number of different units, Chester did stand out as one where that relationship was particularly prominent.

Q. How regularly were those Consultant ward rounds taking place?

A. Every day.

Q. Every day, once a day?

A. I would have thought so. I can't recall exactly. But at least once a day, I would have expected them to have been once a day.

Q. Did you always attend those when you were on shift?

A. If -- I would be expected to, yes, there might have been an occasion where I was called away, so again you are part of a wider team so if during a ward round there is an incident somewhere else, I might be asked to go and care for that child or baby but then I would always attempt to return to that ward round. But I would be part of the normal ward round team, yes.

Q. You say there was:

"... an overall positive training culture where junior doctors spoke openly with their Consultants"?

A. Yes, very much so.
Q. So could you tell them if you were a bit fearful about doing something new or worried about how it was going on?
A. Yes. As a general -- as a group of Consultants, yes.
Q. You do say the relationship between the midwives and nursing staff and clinicians could be more difficult at times and you would describe as a frequent experience of hostility directed from members of midwifery staff towards medical and nursing staff?
A. Yes.
Q. Can you expand upon that, what are examples of that hostility?
A. I want to make it clear that I didn't find that any different to or particularly different at any other unit that I have worked on in the country.
In my personal experience I found that quite commonly that there was some difficult relationship between the midwifery, particularly if they were asking for medical support. The impression I personally had is it was almost seen as a failure that something had gone wrong for us to be called, which obviously was not always the case.
LADY JUSTICE THIRLWALL: Seen as a failure by whom?

A. By the midwife, but that's my perception. So in my experience it was not uncommon to have an air of difficulty between -- between the two teams.
MS LANGDALE: You do describe it as a frequent experience of hostility, which isn't the same as them feeling perhaps disappointed at asking for medical assistance. What did you mean by "hostility"?
A. Again it's my perception but, yes, hostility is the best way I can describe it. It was -- I perceived it as a feeling of failure that you weren't really wanted, that if the medics were there that was -- that was seen as a bad thing even though it wasn't. We were there to very much support and offer our expertise.
Q. You say that's in common with your experience in other hospitals; that wasn't unique to Chester?
A. Yes, I wouldn't have said Chester was different.
Q. What about the levels of communication? We have heard from parents of babies named on the indictment that they would have to rely on midwives perhaps to take them down to the neonatal unit and phone calls being made between neonatal staff and the midwives to help the post-caesarean section mother get down to the unit. Are you saying those -- what would expect interest that kind of interaction, that that would be --

A. No, I wouldn't have expected hostility there. It was -- the hostility I personally perceived was very much if you were called for an acute situation. So if you were called to the midwifery team or obstetrics to help with a baby it was not uncommon for there to be -- it wasn't every single time but it wasn't unusual for there to have been some hostility, almost the feeling that you weren't welcome that something had gone wrong that you shouldn't be there. It was always seen as a negative.
Q. You do say:
"I did not feel that this impacted on the quality of care delivered to the babies on the NNU"?
A. No.
Q. Can you be confident of that?
A. I can only be confident of my perception. So personally, no, I can't think of an instance where there was a delay in calling us, for example, which would be one time that I think that might have impacted. I can't say I have experienced that. It was very much a -- it made communication a little bit more challenging at times, but not in a way that I felt would have impacted the care of any of the babies in my experience, no.
Q. You say at paragraph 8 you:
"... recall being aware of increasing levels of

anxiety following the death of Child A and collapse of Child B soon afterwards largely due to the unexpected and similar natures of their collapses and the appearance of the unusual rash."
And you say:
"As ... babies become unexpectedly seriously ill, (collapsed) or died, I recall medical and nursing staff reporting to each other they were nervous at the start of their shifts."
I am going to ask you about Babies A and B first and then come back to that, if I may, and what your level of concern was at that time?
A. (Nods)
Q. Dealing with Baby A you set out from paragraph 9, can you tell us when you were called to Baby A?
A. So Baby A was at the start of my nightshift so I was not on the unit. From memory I would have been in handover and there was a crash call put out so I would have been very close to the neonatal unit, most likely on the paediatric ward which is immediately next door, so I would have arrived within a few minutes at most and from recollection, CPR, cardiopulmonary resuscitation, was already under way and I attended very much to assist. CPR was being led by my colleague. I can't

recall whether I took part in the airway or the cardiac side of things.

But I do remember assisting for a very short period of time until my Consultant or Consultants arrived.

Q. You say you recall Dr Harkness and Dr Jayaram being present and another doctor writing down events, a designated scribe, you call this?

A. Yes, so Dr Harkness was my Registrar colleague who was leading the event. He was with the child when they became unwell, and Dr Jayaram was the Consultant who called in, who attended very quickly.

Q. You we know gave the handover the next day to Dr Ogden. Can I ask, please, to Ms Killingback, if we can have on screen, Dr Ogden's statement which is reference 0102019, page 3. So 0102019, page 3.

It is paragraph 12. Scroll down to paragraph 12:

"We were informed in the handover the next day by Dr Lambie (Paediatric Registrar) about Child A's death. I was surprised. I do not recall the details of exactly what we were told in that handover other than he had died. I don't recall specifically who else was in the handover that morning or whether there was any further discussion but the morning handovers were normally attended by the day and night medical teams."

He continues:

"It came completely out the blue. I was surprised by his death. I didn't expect him when I left on 8 June to die that same day."

Do you remember, does that refresh your memory of the handover and the discussions that you had or?

A. I don't recall that particular handover in detail but what she has written would -- would make sense, that is what would normally have happened. So I would have handed over everything that had happened the night before to the day team including any patients that were due to come in, but certainly a significant event of that nature, yes, I would have handed it over to the day team.

Q. We know from his statement your colleague Dr Harkness, I think, had to take some time off, he found that very upsetting, didn't he, that death?

A. Yes.

Q. Various witnesses, Nurse Taylor, Nurse Bennion, Nurse T, Dr Harkness, have given statements to the Inquiry about their surprise at that death and it was certainly unexpected, Dr Harkness says. Do you remember the discussion that morning about that or did that happen subsequently, the discussion about it being unexpected?

A. Sorry, do you mean the discussion I had with

Dr Harkness in particular?

Q. With any of them, either that night or the next day about the unexpected nature of Child A's death?

A. Not the following morning. I do recall speaking with Dr Harkness after Child B had collapsed. I can't remember exactly when that was but it was certainly within a few days because we were both very concerned about the similar nature of the collapse but particularly the unusual rash that neither of us had seen before.

The children were also in very close proximity to each other, so we did discuss those concerns, were they related.

Q. Paragraph 14 of your statement, you detail your involvement in the care of Child B?

A. Yes.

Q. Can you tell us about that?

A. Yes, so again it was -- so this was the following night, I was on nights, the second night of the night shift. It was soon after midnight. I had a crash call, so a very urgent bleep to attend to the unit and I was informed that Child B was having difficulty breathing and was having support -- was being given support for her breathing.

I had been made aware that she had been well

beforehand, she was not highlighted to me as a child that I needed to be particularly worried about, for her in particular. She was covered in a very unusual rash, the only way I can describe it a Registrar that we sometimes see with children a condition called meningococcal septicaemia, it is a very blotchy rash, but that diagnosis didn't fit in this situation so nothing made sense.

Q. Why not?

A. The rash didn't look exactly the same, the rash was moving which isn't what tends to happen with a child with meningococcal sepsis, children with meningococcal sepsis tend to be -- not always, but tend to be -- don't become so acutely ill so quickly.

She also responded remarkably quickly which is not the case for children with meningococcal sepsis.

So there were lots of factors that didn't make sense.

Q. You say at paragraph 15 you didn't fully understand why she had collapsed and you were concerned that she could deteriorate quickly again because you didn't know why it happened?

A. Absolutely, it wasn't an obvious it wasn't a spot diagnosis, there wasn't a single event that I could pin everything on which meant that I didn't know how she

was then going to react to the treatment I was giving her or whether she would then go on to deteriorate. If this was an unusual infection or a contamination, something like that, it could -- she could potentially deteriorate again, so I was very keen to make her as safe as possible which is why I screened her and treated her as if it was an infection as generically as possible. I made sure she was placed on a ventilator so I had full control of her breathing, I gave her morphine, which is what we do for children who we anticipate to be a ventilator for a more prolonged period of time. So I was trying to safeguard her as much as a possible in case she then deteriorated again.

Q. Letby's evidence at the criminal trial was that at the collapse of B she says she was joined by Rachel Lambie and was asked to get the unit camera to take a photo of the colour change.

Do you remember you or indeed anyone else at the resuscitation scene asking Letby to get a camera to take a photo?

A. No, I don't and it's not something that I would routinely do. It would be -- I can't think of an example and it would have to be an exceptional circumstance for me to ask anyone to step away from an active resuscitation to the point where I can't think

of an example where I would do that.

It was also -- the rash was also moving, it was very brief. So no, I don't recall asking Lucy Letby or anybody to either step away from the resuscitation or to get a camera.

Q. Was the rash and its unusualness being discussed between you all at the time?

A. When mean at the time?

Q. When you were with Child B and you could see it?

A. So I recall the nurse that was with Child B saying to me: this is the same thing that happened to Child A yesterday and recalling that the rash was the same.

Q. So one of the nurses on duty with you said that at the time?

A. Yes, one of the nurses that was present with me during the resuscitation I remember them saying: oh no, this is what happened yesterday or last night and the rash was similar, that was mentioned, yes.

Q. At paragraph 18 you explain:

"I was concerned that there may have been a link between the collapse of Child A and Child B primarily due to the recurrence of the unusual rash."

So it was your colleague that had pointed out the

similarity that raised that concern with you?

A. Yes. So I can't recall -- I honestly can't recall whether I knew about the rash when Child B collapsed. I think I must have but I don't -- I don't recall.

Q. Just pausing there, you tell us you don't remember seeing it on Child A yourself or clocking it, if you like?

A. No, no, I don't think I saw it on Child A and I can't recall whether that was discussed in particular. I suspect it was, but I don't -- I certainly didn't go into Child B's collapse thinking "oh, this rash looks similar", that was the first time I had seen that rash was on Child B. But I do recall talking to Dr Harkness in particular but other members of staff, nursing and medical, soon afterwards about the similar nature of the two babies.

Q. You say at paragraph 18:

"I was concerned that they were geographically close to each other and wondered if there could be a link, such as an infection that both children carried, or could be in the environment or some form of product contamination. I recall discussing this with the Consultant the following morning, particularly the similar rash ..."

A. Yes.

Q. Which Consultant was that, Dr Newby or a different one? We know you speak to Dr Newby later?

A. Yes, that was later. I would need to check the medical notes to be certain but I believe it was Dr Saladi that was -- it was the daytime Consultant.

Q. So you were raising your concerns to Dr Saladi, you also did with Dr Newby?

A. So Dr Newby was later, Dr Newby -- would you like me to talk about that?

Q. Yes, please tell us?

A. So I recall Dr Newby coming to find me, it was days or weeks later. She came to find me and I believe it was in the coffee room, it was not a formal sit-down conversation, she came to find me specifically to ask me about the rash.

She had either heard about a similar incident or been involved in a similar incident and was very keen to speak to me firsthand and ask me to describe the rash, I do recall that. But that was some time afterwards.

Q. You tell us at paragraph 20:

"I recall her [that's Dr Newby] that's Dr Newby telling me that this was being discussed amongst Consultant colleagues who were aware of, and shared, concerns raised by junior staff and nursing colleagues

as outlined above".

So you understood the Consultants were sharing those concerns?

A. Yes, and I raised my concerns with the Consultants a number of times and each time I had a very positive response and I was very much under the impression that they were listening, they shared our concerns and they were being dealt with.

Q. Indeed Dr Gibbs was taken to an email -- perhaps Ms Killingback, we can go to it, 0025743, page 2. That's page 1, if we can go to page 2, thank you.

Dr Lambie, you will see Dr Gibbs's email to his fellow Consultants:

"Rachel Lambie came to see me this morning, I think because I was the only person in the office when she came, to say the Registrars were very concerned about the recent neonatal deaths and collapses. Child B where all the infants showed a strange purpuric looking rash rash that probably wasn't true purpura ..."

And then he says:

"Although I have mentioned we are looking into this, I am not sure exactly how this is being done but I didn't say this to Rachel."

So pausing there. What did you say to Dr Gibbs and

was there any action described to you or not or just a "we share your concerns"?

A. So I don't recall this specific conversation, but I do recall speaking to a number of the Consultants about my personal concerns and also expressing the concerns of others because it was a topic of conversation almost every day, particularly as we got later into the events.

Q. Pausing there, you tell us about A and B and we are only interested in the indictment babies, I think you were also concerned about an earlier death --

A. Yes.

Q. -- as well, I don't want the details of that as it is not on the indictment, but an earlier death; was that right?

A. No, an earlier incident.

Q. Incident.

A. So there was a child that predated Child A by about 10 to 14 days and again I would need to check the medical records, I am pretty sure it was Dr Gibbs I spoke to about that incident. It was a very, very unusual incident, something I have never experienced before or since.

That was immediately prior to -- well, 10 to 14 days before Child A. So I was already -- I was

already quite anxious going into Child A and B because I had had that particularly unusual event.

Q. You have provided a statement to the police about that event as well, have you?

A. Yes.

Q. I am not going to ask you about that.

So at this point you are worried about an earlier incident and you are worried about A and B?

A. Yes.

Q. And we see you speak to Dr Gibbs on 23 June. If we go to page 1 of that document, page 2 is currently on screen, if we go back to page 1. We see there Dr Lambie, an email from Dr Brearey to Consultants and you can see he says:

"There is a PMM tomorrow afternoon."

I presume that's Perinatal Mortality Meeting?

A. Yes.

Q. "Please encourage all juniors and nurses to attend and discuss in this forum rather than privately."

Were you ever invited to a Perinatal --

A. Yes, I would have been. I don't believe I attended, I had a look at the minutes, I presume I was on leave or on shift elsewhere. I am not quite sure but I didn't attend that but yes, we would have been routinely been invited to attend, we often presented at

them.

Q. Can you remember attending one where Child A or B were discussed?

A. No, I believe that's the meeting that I wasn't -- I didn't attend. I presume I was on leave or on another shift, I am not sure --

Q. Do you remember being invited for one to discuss those babies?

A. It wasn't -- it wasn't a case you were formally invited, you were expected to attend. They were month -- I am pretty sure they were monthly and it was -- particularly as part of your training you were expected to attend and as I said, we quite often were asked to present. It was part of -- a recognised part of our training.

Q. One record the Inquiry has found about a clinicians' meeting, you are not there -- well, let me take you to it. It's INQ0036166, page 1. This is a meeting you can see Consultants Jayaram, Newby, Saladi, Gibbs, Ann Murphy, I think she was head of children's unit, wasn't she?

A. (Nods).

Q. Eirian Powell.

If we look at the second page, look at the middle two paragraphs:

"Eirian also raised first of all as an aside an issue that neonatal staff felt that parents were not getting updates regularly enough from Consultant staff. Bit of a debate around this, generally the Paed of the week is available and if parents need to be updated the nurses should be able to ask the Consultants to come down. Consultant may not be free at a particular time but clearly if there is a sick child it is anticipated parents would be updated anyway. I have asked Eirian to get the nurses to document specific examples where this is happening. Consultants at the meeting were slightly unclear as to what the issue was."

Were you aware of that kind of issue?

A. No, no, I wasn't, it was -- in my experience it was common practice to speak with the parents on occasions the parents were present during ward round and certainly my memory is that was encouraged, particularly for the very unwell children. It was not unusual for families to phone during the daytime. It was slightly dependent on how busy you were who would answer the phone and it certainly was unusual personally for me to say "I am in the middle of something at the moment but I will contact them back" or maybe give a message to the nurses to speak to them.

So I can imagine at times families would find that

difficult that we were not able to speak to them immediately, but my experience was that as a team we would always try and get back to them or speak to them the following day.

Q. And if you look at the paragraph below that one:

"There was also an issue raised around the fact that with the three recent neonatal deaths the Registrars had been quite worried and feel that nothing is being done. Behind the scene reviews are going on but it is felt formal debriefs should probably take place rather than in a specific meeting to discuss all three."

This is Monday, 29 June, so by then I take that to mean the reference to A, C and D's deaths, the babies we are concerned with. Were you aware what was being done in terms of reviews or anything else that were looking at deaths?

A. No, no.

Q. You of course -- and indeed you say you had a concern about an earlier incident, a deterioration incident, you were concerned about B's deterioration and an earlier deterioration. Do you think those were discussed formally, appropriately, to gather learning from those events?

A. Do you mean with myself?

Q. Yes, with yourself?

A. So I don't recall formal debrief for these children. Again, in my experience, a formal debrief tended to happen more often when there was a death or a -- I was going to say unusual incident but yes, much more with a death. If you had an acute deterioration, I would sometimes expect a debrief if it was very traumatic or there was a particular reason to do so.

But I would not -- I not wasn't surprised that there wasn't a formal debrief for all of the children. I don't know if there was a formal debrief for Child A. I had very little involvement and as such I wouldn't necessarily have been expected to have been invited to the debrief. I would have expected that to focus more on Dr Harkness and the other team that were more involved. But for the other children, no.

Q. It looks like the clinicians' meeting on 29th is only speaking of the deaths and Baby B is lost in that, isn't it, because it is a focus on deaths?

A. That's also a Consultant meeting which as an ST6, so a middle grade Registrar, I wouldn't have expected to have been invited to. I don't know how it worked in Chester, but certainly as you get closer to finishing your training, I was in Leighton as an ST8,

which is the final year, and as an ST8 I was regularly invited to more management-led meetings or Consultant meetings. I don't know if that happened at leighton because I was only an ST6, but I certainly wasn't involved in those meetings.

Q. It looks like long after you had left the Countess of Chester in April 2016, you were asked to furnish a statement to the Coroner about Baby A. If I can ask Ms Killingback for 0008894, page 1. Do we see here that's page 1, if we go to page 2, a brief statement prepared by you in April 2016, confirming the notes and your involvement, such as it was with Baby A?

A. Yes.

Q. Can you remember who asked you to supply that, what they sent you, what their request was?

A. No, not at all. Just looking at the date, I would have been -- I left, I was working in a different hospital at that point. I don't recall being asked to produce this. I mean, I clearly did looking at the information but I don't have direct memory of it, no.

Q. It looks pretty perfunctory, doesn't it, just a few facts, dates, et cetera?

A. Yes.

Q. One of the questions my Lady is examining in

the context of this Inquiry is the adequacy of information provided to the Coroner and indeed how that's put together by the unit in providing it. But it sounds like you didn't really have a brief about what you were required to send or what information you were trying to provide?

A. Specifically related to the Coroner, no.

Q. No. Do you know as a matter of interest what information the Coroner is interested in or should have? It is not a test, by the way, you may not, I just ...

A. From the point of view of the Consultant or the Registrar or just general?

Q. From a Coroner's point of view, what information might be relevant to a Coroner?

A. So, I mean, the situation leading up to the deterioration or deaths of the prior 24 hours, the background to the case, you know, the detailed medical background of that child. But also who was involved, what was undertaken, so things like CPR can have, you know, anatomical consequences. So they would need to take that into account. But also it depends where the death has happened: whether it is in hospital or out of hospital.

Q. Of course one of the key issues might be whether it is an unexpected death, an unexplained and

unexpected death?

A. Yes.

Q. Can you remember when you were asked to put that together -- you may not remember anything about it -- whether that was something you were asked to comment on or not?

A. I honestly can't remember.

Q. Okay. You say at paragraph 22: .

"As the number of unexpected events increased (sudden collapses and deaths) I was concerned and spoke to the Consultants at handover. I recall possible causes being discussed between junior doctors and nurses ..."

Can you tell us what those were? I think you have to an extent, but I just want to see if that developed as more deaths or events occurred?

A. Yes. So as a doctor, you are very much trained to work through differential diagnosis, and you would naturally go to what is common and then as you decide that isn't the case, you would have to raise your concerns to more unusual problems. And at this point, I think everyone felt that the normal -- you couldn't explain it through normal channels, so more unusual events such as an unusual virus, is this an unusual mould or fungus or some sort of infection, particularly

with A and B in particular being so close together? You know, is there something in the immediate environment that we are not aware of?

And then moving on from that, is there anything else linking the two, such as TPN or feeding -- liquid feed products or fluids? Is there a contamination in the bag? Then you escalate through what becomes less and less obvious or less and less common.

Q. You say at paragraph 23 when you left in September 2015, you -- well, tell us what you set out there?

A. So is this referring to ...

Q. The nursing staff in a small huddle?

A. So I remember towards the end when I left in September, as I have already said we were discussing about, you know, is there something going on that we can't explain and I recall before I left walking through the Intensive Care Unit and there was a huddle of nurses in the corner over the computer and I asked what they were doing and one of the nurses replied that they were going through the rota just to make sure that there wasn't somebody that was on for each one. I can't recall precisely what she said, I am paraphrasing. But it was very much: it is an awful thing to think, but we are just looking.

Q. So these were nurses?

A. Nurses specifically, yes.

Q. Specifically.

A. Neonatal nurses.

Q. Neonatal nurses. Do you remember which ones?

A. No, I don't.

Q. So a group of nurses trying to work out, were they looking for the deaths?

A. I don't know.

Q. You don't know?

A. They were huddled over the computer and one of the nurses said to me: we are looking through the rota to see if anyone was on for all of them, and I don't know what "them" they referred to in particular.

Q. And what did you say to that, if anything?

A. I don't recall saying anything. I remember being quite shocked and thinking, you know, oh. I agreed that it's an awful thing to think; I mean, it is the unthinkable. But that's what they were discussing.

Q. But by September 2015 it sounds like people were thinking it. Thinking the unthinkable, there maybe a link here with a person?

A. Yes, they were starting to think the unthinkable.

Q. Were you at any time in your training made aware of the case of Beverley Allitt and the murders in Grantham?

A. Not within training. I was aware of it as a public citizen from the news.

Q. So can you just tell me when you say "thinking the unthinkable", can you just expand on that?

A. So for me personally "thinking the unthinkable" in this case was that there might be a person who's deliberately causing harm.

Q. So by their actions you are saying the nurses were thinking about that by trying to look at a rota and see who's there for these specific events?

A. It was starting to become part of their thought processes yes.

Q. And you didn't ask which events they were putting together for this?

A. No, I recall walking through -- I was in the middle of a shift, I recall walking through the unit, so I was working at the time.

Q. But you described to us as far as A,B and the other incident you have referred to, it was the unexpected and unusual nature of them that was significant, it is not just that there was a death of Child A, it was an unexpected death?

A. Yes, and the unusual nature of what we saw and what I personally experienced.

Q. Did you understand, and you may not have asked, that the task they were undertaking was simply linking a person with deaths or was it following specifically unexplained, unexpected events and seeing if the person was there?

A. I don't know, I just recall them saying -- checking who was on for all of them, is how -- what I remember them saying.

Q. You say in terms of review of deaths and adverse events at paragraph 25, the review held on 2 July by Dr Brearey relating to the deaths of Child A, C and D you weren't aware of that meeting or what was discussed when those three babies were discussed?

Had you been there, you would have been able to assist with the commonality of the rashes, wouldn't you, between A and B?

A. It depends what you mean by "assist". They were fully aware of my concerns and of my colleagues', yes, I would have been very happy to have attended and I would have been very happy to have described the events again, but it would have been repeating what I was very aware the Consultants already knew.

Q. So whether that meeting refers to Baby B or

not as far as you are concerned, the Consultants were aware of the rash on B being similar to the rash on A?

A. My impression was yes. If this -- does this postdate when I spoke with Dr Newby? I am not sure of the timeline.

Q. 2 July yes, it does. You speak to Dr Newby --

A. So they would have been, yes, as far as I am aware, yes.

Q. We asked you at paragraph 27 about how deaths are investigated in the neonatal unit and you say you are not certain how they are investigated. What's your sense now, what do you think -- you are a Consultant now, are you?

A. I am a community paediatric Consultant which is very different to an acute hospital Consultant. So I don't have any experience as an acute hospital Consultant having experienced something like this. So I have never been involved in a child death as a paediatric Consultant, so I am not overly familiar with the processes.

Q. So when you were working there, you wouldn't know what an unexpected death should trigger or events in terms of referrals or generally?

A. Not in detail, no.

Q. When you say "not in detail", what did you

think? You clearly raised your concerns with --

A. I was aware that the Coroner would be informed, I was aware the parents would be informed and I was aware that the Consultants would be discussing it amongst themselves and my impression was raising that through the normal processes through the hospital management.

Q. When you were at the Countess of Chester, what safeguarding training did you get either from the hospital or generally?

A. So you have a mandatory induction when you join any hospital and Chester was no different and part of that is safeguarding training. It is from memory generalised, but within our paediatric training, we have paediatric-specific safeguarding training to our grade. So the safeguarding training you have as a house officer, an SHO, is slightly different to a Registrar which is slightly different to a Consultant. It depends what your level of experience is. And that's mandatory, you have to do that and it's checked and monitored.

Q. Was it useful in the sense that you would know who you had to go to talk to? Sometimes we know what policies say, but we don't know who we have got to go and talk to. So would you have known Dr Mittal, I will tell him any concerns I have got or somebody else,

Paula Lewis, whoever it may have been, I don't know?
A. I mean, I probably would have known at the time, just because I knew who the consultants were, but my memory of working in Chester is such that I would have felt happy to approach almost all the Consultants so even if I didn't know who to go to specifically, I would have been quite happy to have asked almost all of them, you know: I have got these concerns, what do I do, who do I speak to?
Q. Indeed we see that you do go to the Consultants and say what you think?
A. Yes.
Q. You say that towards the end of your placement -- going back in your statement to the very beginning, you say: .
"As further babies became unexpectedly seriously ill, I recall medical and nursing staff reporting to each other that they were nervous at the start of their shifts. I personally recall being nervous at the start of a set of night shifts towards the end of my placement as I was almost expecting something bad to happen."
A. Yes.
Q. I want to get to a sense of how widely this was discussed, so it is not just you as a junior Registrar, who else you are sharing this information

with and discussing with? So you are saying nurses on the neonatal unit shared some of these concerns?
A. Yes.
Q. Who else? You say you spoke to someone out of the unit once as well, another doctor that wasn't on the unit?
A. Yes, so I certainly remember within the hospital -- within our team at handover it was a regular topic of conversation, at handover for a day or a nightshift I remember on more than one occasion almost the heartsink feeling of: oh, gosh, what's going to happen today?
The unit felt -- I don't know if busier is the right way to describe it but it felt different and there was almost an air of anticipation of what's going to happen.
Q. Were you doing night shifts mainly?
A. No, no, I was on a normal rota.
Q. But you say it was at nights?
A. I think I just gave that as an example.
Q. Okay, so you hadn't made a connection between night shifts and what's happening in the day at all, it is just --
A. Not at that point, no.
Q. Okay. So nurses on the ward, doctors in other

units in the hospital?
A. No, not in the hospital. So I spoke with a doctor who didn't work at the hospital, just in an anonymous way, just to express my concerns.
Q. When did you do that, what month roughly?
A. I think that was more towards the end, towards the end of my placement.
Q. So I don't want the name of the person, you did it anonymously anyway, was it a mentor or someone else that you trusted or someone more senior, what was the connection?
A. No, a medic that I trusted.
Q. A medic you trusted. So you took it on yourself to speak with a medic you trusted on the phone or meet with the, or? On the phone?
A. No, no, I met with them.
Q. You met with them. Tell us how that conversation went?
A. So it was -- because it was something that was playing on my mind a lot, that I spoke with him just to not necessarily ask advice, but just to speak about my concerns and as -- he is a medic but he is not a paediatrician and he was able to appreciate that it was an unusual series of events and was asking, you know, what -- what is happening? Are you -- making sure

that I was raising concerns. It was more an ear to speak to because it was -- it was a very significant series of events in my lifetime.
Q. Did the prospect of the police becoming involved --
A. At the very end of my placement, I do recall having a conversation with him saying: it doesn't sound like we are getting to the bottom of this, and they are carrying on. We did discuss the it felt like a hypothetical possibility that, yes, at some point we might be needing to get the police involved. If we can't suddenly find that there is a virus or there's some contaminant or something, you know, we are getting to the point where we might need to be considering speaking to the police. That was more towards the end of my placement.
Q. Was that with this person that you trusted that you had that conversation?
A. Yes.
Q. So you didn't have that with Consultants in the hospital?
A. No.
Q. Just the person you trusted to go to with your worries?
A. Yes, it was very much a hypothetical

conversation of, you know: This is continuing to be really unusual and I am very uncomfortable, as is everyone else I am working with, rather than: this weird thing happened and now it settled. It was persisting.

But again I need to stress that I was very aware that everybody was talking about it and the Consultants were listening and reporting back -- well, not reporting back, but like Dr Newby coming to speak to me, there was to and fro conversation.

Q. Do you remember when, if at all, when you were there if Letby was mentioned by name?

A. Not to me, no.

Q. Who -- did you hear her name via somebody else, someone else in the --

A. The first I was aware -- I don't recall when that was first mentioned to me other than it was after I had left so I believe it was when I was contacted by the police to give a statement. Certainly I am very clear that when I left in September, other than seeing the nurses huddled overlooking at a rota it was never -- it was not suggested to me that it could be a single person and the name Lucy Letby was not mentioned to me.

Q. Did you stay in touch with anyone that was still working there who filled you in later on down the road about anything or not?

A. Yes, there was one other Registrar who had left before I had and I remember speaking to him many, many months later, I cannot even recall if we overlapped but he had worked at Chester. But no, I didn't keep in touch with anyone in particular from Chester.

Q. And in 2015, you didn't hear any names about Letby or anybody making comments about her in a derogatory way?

A. Whilst I was working on the unit?

Q. Mm-hm.

A. No.

Q. But you are clear that there was discussion about the unthinkable and looking for somebody as a common denominator between --

A. Only amongst the nursing staff on this particular period. I don't -- I don't recall a conversation amongst the doctors or a suggestion that it was one particular person by the time I left in September 2015, no.

Q. So where did their concerns start and end by the time you left in 2015, how would you summarise it amongst the doctors? Concerns about unexpected events and not knowing why they happened?

A. Yes, there was established concerns that there were a series of events that were unusual and unexpected

and serious and that they were persisting and that at that time we couldn't explain what was happening but there was full appreciation that we needed to look into what was causing these events, so this was not something that could be dismissed.

Q. In your role, did you have any dealing with the parents of Babies A and B or C, generally, to talk about these events or not; would that have been somebody else who spoke with them?

A. I don't recall specific conversations. From memory, Child B's collapse was so acute and so unusual, my normal practice would be to have called the parents in. I haven't documented the notes that I spoke to them so I can't recall and it could easily have been that I was so busy that I delegated that to somebody else.

I am pretty certain the daytime Consultant spoke to them. The Consultant I called in overnight might well have spoken to them, I can't recall. My normal policy would have been to involve them. I tended to involve parents quite frequently.

Q. You have described the unit as being busy on a couple of occasions. Did that affect communication either with parents or across teams of professionals -- nurses, doctors -- or not as far as you are concerned?

A. I am sure it would have at time to time as it

would in any unit, unfortunately particularly with parents. So again as a doctor I would always have to prioritise the needs of the baby or the child in front of me. Even if I very much wanted to speak to parents, it would be wrong of me to prioritise that over an acutely unwell child, and there are times when you have to do that. But I would always make a concerted effort to either ask somebody else to speak to them at the time, ask them to wait, or get back to them as soon as possible.

The same with speaking to other medics. If you -- on occasion you might miss a handover, if there's an acute resuscitation, you might send one of your colleagues to hand over and get secondhand information that way. But it's something that would always try and be avoided if at all possible. But you simply had to prioritise the needs of the children in front of you.

Q. Did you have any dealing with any of the managers when you were the Registrar?

A. No.

Q. From what you say, that would be typical for your role --

A. In my experience, yes, in my experience for my stage of training that was quite normal.

Q. Did you hear the Consultants or anyone else

talking about management in any way?
A. No.
Q. So nothing negative, nothing positive. It just didn't feature in your daily --
A. No.
Q. -- life on the wards?
A. No.
Q. Reflections. You offer various reflections in your statement of events now. One of the issues you were asked about was CCTV and you say a number of things including:
"... I am not sure I would like to work in that arena. I would be concerned it may negatively affect doctors' and nurses' actions and how they interact with staff, colleagues and families."
Of course, the police now wear body cameras when they go into emergency scenes and they can provide very useful information and material for later scrutiny of events. Do you think that could become normalised in the same way it has had to be for officers if --
A. I think a lot of that will depend on the outcome of this Inquiry. I would be very interested to see what the recommendations are. It certainly is something we could consider.
I think the way it's used in the police force is

very or my impression, because I don't have direct experience of it, might be quite different. If it was a case that we were wearing CCTV that you could then turn on in a certain circumstance and you had control over that, personally, I can only speak for myself, I would be quite happy and comfortable. I'd need to get used to it, but I would be happy to do that.
But the notion of having a camera constantly recording in an environment where you have women who have just given birth, fathers who are new fathers, you are breastfeeding, you are encouraging kangaroo care where you are having direct skin-to-skin contact, I do worry significantly that having a camera there all the time would negatively impact that.
It's also important that people are -- feel confident to speak freely and openly and a neonatal unit can be a very heated circumstance, both between medics and families, and it's important that everyone is happy to be open. That might be a case of just getting used to having CCTV but I think the way it's used in the police force is somewhat different to having a camera fixed in the unit all the time.
Q. If there was somebody in the incubator, so it's effectively the baby that's monitored in the incubator, of course the staff in the surrounding areas

or environs wouldn't be seen, would they, until they came close to the baby or were handling the baby?
A. Yes, I think it's something that I can understand why it's being considered and I can certainly see the positives. I think it's something that would need to be thought of -- just the logistics of it would need to be thought out very carefully again. Particularly for the impact it would have on the parents, I would be most worried about.
Q. This Inquiry has heard evidence from the parents of the babies who were post-caesarean section not able to get to the neonatal unit to see their babies at all --
A. Yes.
Q. -- and to be on another unit, having sight of your baby would be very comforting, wouldn't it?
A. Yes.
Q. So I see for the mother who is able to be next to the baby breastfeeding, there are other issues that presumably --
A. Yes.
Q. -- can be dealt with but for these mothers separated from a baby on a unit it would be a positive advantage, wouldn't it, to be able to see them in the way that --

A. Absolutely.
Q. -- parents --
A. If it's used in that way, then I can definitely see a lot of positives. I just worry about the negatives as well.
Q. You say the most:
"Reflecting on the whole case I feel the most effective way to have prevented Letby from harming as many children as she did would have been for the hospital management team to have acknowledged and acted on the significant and exceptional concerns repeatedly raised by the NNU Consultant body."
Pausing there before we go to that. The first area of course is for the doctors to express those concerns in a unified way, isn't it --
A. Yes.
Q. -- to link the medical facts together in the way that you say they were by the end of September when you left, discussing --
A. That's the impression I had.
Q. That's the impression you had.
A. Yes. Like I say, I wasn't present at those meetings so I don't know firsthand what was said by whom to whom. But my impression very much was that the Consultants were aware, understood our concerns and

shared those concerns.
Q. You say:
"All the staff on the NNU that I discussed these cases with at the time uniformly agreed that something exceptional was happening, with severe consequences."
A. Yes.
Q. And you are clear about that?
A. Yes.
Q. You also refer in the same paragraph to the discussion you had with the non-paediatric doctor anonymously:
"~... and we both theorised that a police investigation may need to be considered if the current events could not be explained by a number of possibilities including environmental toxin or rare infections."
So that was being considered, this pseudomonas, what else might have been going on in the hospital, those things were being looked at?
A. From -- well, from the conversations I had I knew they were being considered because I personally had raised them and I'm aware other colleagues of mine had.
As to whether -- what investigations were actively being undertaken, I don't know. I wasn't party to that

information.
Q. Did you talk much with Eirian Powell about investigations?
A. No.
Q. Did you have much of a -- much to do with Eirian Powell.
A. No.
Q. You say:
"During the court case, I became aware of the significant difficulties the neonatal Consultants had faced in raising and escalating their concerns ... I felt upset and angry as I had relied on trusted the wider management of the hospital to follow an appropriate process once I had raised my concerns with the Consultants."
Would you like to expand upon that, what you heard, what your view is about that?
A. So yes, I wasn't aware of the difficulties that the Consultants were having at raising their concerns and continuing to escalate them until much later and closer to the court case. Certainly at the time, I wasn't aware that they were having difficulties.
From my perspective, as a trainee, I had concerns, I had escalated them appropriately to the Consultants, I was very confident that they were listening to me and

my colleagues, and acknowledged and shared those concerns and were escalating them and I had faith in the hospital process that it would be escalated appropriately and I didn't -- I had no idea that that was not the case.
MS LANGDALE: Yes, thank you. My Lady, I have no further questions.
LADY JUSTICE THIRLWALL: Thank you, Ms Langdale.
Dr Lambie, may I just take you back to one document. I hope I have got the reference right. It is 0008894, which is the report to the Coroner. Thank you.
I have understood your evidence correctly, I think, that this was April 2016 when you were asked to do this.
A. (Nods).
LADY JUSTICE THIRLWALL: And you left the Countess of Chester in September.
A. '15.
LADY JUSTICE THIRLWALL: 2015.
A. Yes.
LADY JUSTICE THIRLWALL: Do you know why you were asked to do this?
A. I don't know for certain other than I was one of the clinicians named. So during the resuscitation one of the -- it's usually one of the more junior doctors or one of the nurses is usually asked to scribe.

LADY JUSTICE THIRLWALL: To write everything down.
A. And I am aware that the house officer at the time wrote my name. I wasn't -- I didn't write in the patient's notes at the time so the only documented evidence that I had attended was my colleague writing my name and then I was asked to provide details of my involvement.
I have written here, "I have been asked to prepare a statement detailing my involvement."
I can only assume it's because I wasn't able to write in the notes at the time but I don't recall exactly why I was asked to, no.
LADY JUSTICE THIRLWALL: And you weren't there throughout the incident, were you?
A. No, I was there at the very end.
LADY JUSTICE THIRLWALL: Yes. So it seems a slightly unusual choice of person to ask because you were the one -- you came in and assisted very near the end.
A. (Nods).
LADY JUSTICE THIRLWALL: You didn't make any notes. I think, was it Dr Harkness who was there?
A. Dr Harkness was the lead, so I didn't make any clinical decisions.
LADY JUSTICE THIRLWALL: No.

A. He led the resus and I helped.

LADY JUSTICE THIRLWALL: Yes. One of the things that we have been looking at in the course of your evidence is the nature of collapses and you have described them as unusual, unexpected and serious. But that doesn't come across in relation to Child A in this report. Is the reason, there could be a number of reasons for that.

Presumably if you come in later you only know it's unexpected if someone tells you that afterwards?

A. Yes and it looks like I was asked to prepare a statement detailing my involvement specifically.

LADY JUSTICE THIRLWALL: Yes.

A. So I would have replied with my involvement was literally I arrived, I helped with the CPR, whatever else I did, Dr Jayaram the Consultant then stopped the resuscitation and then I left to continue my shift and that -- the answer to the question, that was my involvement.

LADY JUSTICE THIRLWALL: Yes.

A. I wouldn't have then reflected on the nature of the collapse because that would have been Dr Harkness's involvement.

LADY JUSTICE THIRLWALL: Yes, thank you. We are just being reminded of Part 2. I think you agree that

it was a perfunctory statement in the sense that --

A. Yes.

LADY JUSTICE THIRLWALL: -- you said everything you knew but that wasn't all that much in the circumstances.

A. No.

LADY JUSTICE THIRLWALL: Thank you very much indeed, Dr Lambie. Is there anything else you want to ask?

MS LANGDALE: No thank you, my Lady.

LADY JUSTICE THIRLWALL: In that case, that completes your evidence. Thank you very much for coming, you are free to go.

As for the rest of us, we will take a break and start again at 11.15.

MS LANGDALE: My Lady, I was going to suggest if we start at 11.30? All of the witnesses today I think will be less than an hour. All have been timetabled in different ways so it may be an opportunity to take a slightly longer break.

LADY JUSTICE THIRLWALL: I don't think anyone is going to complain about that, so we will start again at 11.30.

(10.59 am)

(A short break)

(11.30 am)

LADY JUSTICE THIRLWALL: Ms Browne.

MS BROWNE: Yes, my Lady, if we could call Dr Neame, please.

DR MATTHEW NEAME (Affirmed)

Questioned by MS BROWNE

LADY JUSTICE THIRLWALL: Do sit down, Dr Neame.

MS BROWNE: Could you please give your full name.

A. Matthew Thomas Neame.

Q. And, Dr Neame, you have been provided a witness statement to the Inquiry dated 23 June 2024 and is that statement true to the best of your knowledge and belief?

A. Yes.

Q. Dr Neame, I am going to start just briefly by going through your career. You graduated with a medical degree from the University of Liverpool in 2008?

A. Yes.

Q. You gained full membership of the Royal College of Paediatrics and Child Health in 2014?

A. Yes.

Q. I think your medical foundation training was completed at the Royal Liverpool University Hospital between 2008 and 2010?

A. That's correct.

Q. Having then progressed on from foundation

training to your specialist paediatric training, you spent, as was usual, six month rotations at a number of hospitals and that included Alder Hey, Liverpool Women's Hospital, Arrowe Park and the Countess of Chester?

A. Yes.

Q. If you could just explain, Dr Neame, did that mean that when we are looking at the doctors at the Countess of Chester on the paediatric and neonatal unit below Consultant level, they would, like you, generally have been there on a six-month rotation period?

A. Usually, yes.

Q. Currently you are a Consultant general paediatrician at Alder Hey Children's NHS Foundation Trust?

A. That's correct.

Q. When did you commence that role?

A. Two years ago, August 22.

Q. And I think it is the case that in your current role as a Consultant general paediatrician, that does not encompass neonatology now?

A. That's correct, yes.

Q. If I can turn now to the period that you spent at the Countess of Chester during your paediatric training. You in fact undertook three periods of your paediatric training at the Countess of Chester,

six months from August 2012 to February 2013 right at the start of your training when your clinical supervisor was Dr Saladi; is that correct?

A. Yes.

Q. Then you returned for six months, September 2015 to March 2016, with under the clinical supervision of Dr Gibbs and that's obviously the period we are going to be looking at in some more detail.

Then you returned for a third time, I think this time working not full time but on the 60% contract in 2021 from March to September and on that occasion your clinical supervisor was Dr Brearey?

A. Yes.

Q. Dr Neame, was it an active choice on your part to return to Chester on three occasions for your rotations?

A. Yes, I applied to work there again. It is close to where I live.

Q. Other than geography, was it a rotation you actively chose because you had a positive experience or was there another reason why you chose to return three times to the Countess of Chester?

A. I had had a very positive experience during my first placement there which I think encouraged me to list it as a preference for a subsequent placement and

I think the third occasion was for practical reasons, primarily.

Q. You said you had a very positive on your first occasion. Was that not the case with your second six months?

A. Well, it was more challenging and I don't have happy memories of that placement.

Q. Yes, and obviously we will go through that in detail. Just looking at the level of experience you had when you went in 2015 to 2016, you were an ST5. Can you just explain how many years' experience in paediatric and neonatal practice that meant when you were at the hospital in 2015?

A. So I had had by that point four years of primarily paediatric experience with two six-month placements in the Liverpool Women's Hospital where I was just working in neonatology.

Q. Just to make clear, so four years of specialist training but of course you would have had your few years foundation training. I think you did an many additional year as well prior to that?

A. That's correct, yes.

Q. What were your responsibilities as a Registrar at the hospital?

A. Primarily to undertake clinical work on the

general paediatric children's ward, help them with admissions of new patients and assessments of previously admitted patients and covering the neonatal unit, the postnatal ward and the delivery suite as well.

Q. In that split of your duties insofar as you are able, if you are able, what was the percentage of time or the approximate split between the time you would spend on the paediatric wards and the time you would spend on the neonatal unit?

A. Obviously it depended on the clinical need at the time. Typically, on a typical shift, particularly out of hours, the majority of time would be spent on the children's paediatric side, managing new admissions which would happen quite frequently.

Q. So would it be the case that generally you would be called in to the neonatal unit from the paediatric ward?

A. Yes, more usually out of regular office hours that would usually be the case.

Q. Just to put in context your time at Chester, the previous six months before commencing at Chester in 2015, you had spent six months I think on a neonatology rotation at the Liverpool Women's Hospital under the supervision of Dr Yoxall?

A. That's correct.

Q. The Liverpool Women's Hospital was a Level 3 unit. Could you just explain the significance in terms of the babies cared for and how that differed to the Countess as a Level 2 unit?

A. So the team at the Women's Hospital would admit more unwell babies, they would accept babies who had been born earlier in the gestation, so more premature than the babies admitted to the Countess of Chester.

Q. And at Liverpool, my understanding is your rotation was purely neonatology so you would have come to Chester having had six months purely dealing with very premature babies and babies who needed neonatal care?

A. That's correct.

Q. And you have talked about your split of time spending time on the paediatric ward and then being called into the neonatal unit as required. What was your experience of Consultant rounds on the neonatal unit, how often do you recall they took place?

A. I think they were scheduled for twice weekly during the week and possibly one of the weekend days. I may have misremembered the precise number.

Q. And would that be part of your regular duties if you were there at the time of Consultant round that

you would assist in that?
A. Yes.
Q. Just looking at the comparison with the Liverpool Women's Hospital a little further. You say in your statement at paragraph 11:
"I would describe the culture on the Neonatal Unit at the Countess of Chester as being slightly more informal than at the Liverpool Women's Tertiary Neonatal Unit ..."
You did give some explanation in your statement but could you just expand a little on what you meant by "slightly more informal"?
A. So an example would be that the ward rounds at the Women's would be conducted by the team who had been working overnight or led by that team of Registrars and SHOs. There would be an expectation that each baby on the unit would be presented by the night team to the Consultant working that day with a full explanation of the management of that baby overnight and the full summary of that baby's care prior to that point.
That -- those processes were conducted on a daily basis and it was a very regular, routined way of conducting the department.
Q. Did you consider that the informality that you observed, did you consider that impacted on the standard

of care in any way?
A. I thought it was typical of the way that care had been provided in the district general hospitals that I had worked in, it didn't feel abnormal or inappropriate but it felt on reflection different to the way things were conducted at the Level 3 unit.
Q. But did you have at the time, or indeed on reflection, any concerns about the care the sort of babies the Countess was caring for, did you have any concerns about the standard of care they were receiving?
A. Not the general standard of clinical care. There were times where I felt that we were managing babies who were more unwell than I might have expected to or where we managed babies who had deteriorations and then were not necessarily transferred off the unit in the way I might have expected them to be.
Q. When you say about caring for babies who are particularly unwell, was that something that you observed was a difference from when you had been working on the unit in 2012 to 2013, did you observe there to be a difference or had that always been the case?
A. I don't think the processes or culture had necessarily changed but I think there were more -- a greater number of unwell babies during my second placement so perhaps it was more noticeable but I didn't

get the sense that the culture or standard practice had changed significantly between the two periods.
Q. Setting aside the incidents we are going to be dealing with today, but in terms of the babies who were being admitted, were you aware of any reason for this why you say that you were conscious of babies being particularly unwell?
A. No, I wasn't aware of any reason.
Q. In terms of pressure on nursing staff or on doctors, how did that contrast or did it contrast at the Countess of Chester compared to other hospitals where you had worked? I think you had been at quite a number by now: you had been at Alder Hey, Wrexham Maelor, Arrowe Park, for example, as well as Liverpool?
A. I thought the staffing pressures were very typical of the pressures that I have encountered at other organisations, I don't think it is unusual to -- to feel those pressures.
Q. Turning now to the relationships between staff. How would you describe the relationships between nurses and doctors on the neonatal unit in 2015 to 2016?
A. I didn't notice anything unremarkable about those relationships or interactions during my time there.
Q. So nothing particularly good but nothing

particularly bad, do I take from that?
A. Yes, that's correct.
Q. Were you aware of any sense of resentment from nurses on the neonatal unit that the doctors were perhaps less present on the neonatal ward and spent perhaps more time on their paediatric duties?
A. I wasn't aware of that.
Q. In terms specifically of relationships, I have been talking about relationships between nurses and doctors, I was thinking of doctors in your -- of your level of seniority. But the relationship between nurses and Consultants, did you see that as a positive relationship or again was it -- I think you used the expression "unremarkable"?
A. Yes, I didn't notice anything unusual or remarkable about that.
Q. Again, just reflecting back to your earlier period in 2012/2013. Any difference in the relationships between nurses and doctors between those two periods?
A. No.
Q. Just very briefly, you returned of course in 2021, this time Letby had been charged with murder. Were there differences then in the relationships between nurses and doctors that you were conscious of?

A. No, I don't think so. The atmosphere was, particularly for me, I found it slightly unusual working there but not in terms of unusual relationships between colleagues.

Q. Turning then to the relationship between midwives and doctors and nurses. You say in paragraph 6 of your statement that you -- part of your duties included attending high risk obstetric deliveries. Can you just give an indication of the sort of extent of involvement you would have had with midwives and those working on the obstetric unit in terms of a proportion of your time? How frequently would you be involved working on the obstetric unit or with midwives?

A. So I would suggest that on most shifts we would be called to at least one or two deliveries where it was anticipated there may have been some challenges or committee cases and probably similarly called to the postnatal ward once or twice per shift to review a baby.

Q. When we are looking at being called out then you are talking about how often you were called to the obstetric -- how often can you relate that to the neonatal unit, how often as a general rule would you be called there?

A. Much more usual to be called to a neonatal unit, but that would be typical in any setting I have

worked in.

Q. So several times in a shift, would you be expecting -- in every shift, would you spend some time on the neonatal unit, for example?

A. Yes, usually.

Q. And what was your perception of the relationships between nurses and midwives or indeed between midwives and doctors on the neonatal unit, did you have any observations about those particular relationships?

A. No. I wasn't aware of any difficulties or challenges.

Q. We have just heard evidence that Dr Lambie experienced some she described as hostility from midwifery staff towards medical staff. Was that something that you were aware of?

A. It is not something I experienced.

Q. Looking now at the relationships between your fellow doctors, so those at a similar level of you who are completing their paediatric training. What were the relationships that you had or you felt were usual between the other doctors also undergoing their training?

A. I think I would describe them as aimiable, productive, healthy working relationships.

Q. And how many doctors were there approximately in your six-month intake? Paediatric trainees, that is?

A. I think perhaps seven.

Q. And sort of aimiable professional relationships, would you discuss your cases, seek advice from those at similar levels of seniority?

A. Yes, we would have regular discussions and handovers about care.

Q. Dr Lambie ended her six-month rotation at the start of September just when you were starting. Was there a system of handover, did you have a handover from Dr Lambie or have any contact with her or would that have been normal?

A. No, I wasn't fully aware of who had preceded us on the rotation.

Q. So there wasn't a settle-in day where you spoke to the Registrars who had been there for the six-month period before?

A. There is an induction but it is provided by the Consultant and nursing teams, not by training doctors.

Q. You say in paragraph 8 of your statement.

"Colleagues seemed supportive during more challenging periods, for example following episodes where babies had become unwell or collapsed or had sadly

died."

In practical terms, how were your colleagues supportive?

A. In sort of typical human ways, I suppose, checking in and acknowledging that those situations are difficult and being friendly and open to further discussion.

Q. So would it be normal to have a discussion with one of your fellow Registrars if you had had to experience a baby dying or collapsing having to undertake a resuscitation?

A. Perhaps not extensive discussions but certainly to acknowledge it as a difficult situation.

Q. And did you personally seek that support, do you recall those sorts of conversations with colleagues after the collapses of H or the collapse or indeed the death of Child I, both of which you were involved with?

A. I don't think I sought those conversations or support, but I am sure I discussed those, you know, challenging episodes with colleagues informally at times.

Q. But do you have any specific recollections of discussions you would have had about those incidents with anyone in particular?

A. I recall during the week that Child I had had

a number of episodes having a discussion, I think it was a morning handover just reflecting on the fact that it had been a difficult challenging week and in many ways had been more -- far more challenging than a typical week on a neonatal unit.

Q. We are going to go through that in a little bit more detail now.

As part of those discussions, those sort of supportive discussions, I have asked you about specifics, Child H and Child I. Were there any discussions that you had with any of your colleagues, whether at your own level or more senior, about concerns you had about the number of collapses or deaths that were occurring?

A. Only in very general terms similar to the way I have described it just now, just reflecting on the fact that it was more that that week in October when Child I had a number of collapses in particular was busier and more challenging than I had expected.

Q. You have said when you alluded to the period overall, the six months you spent 2015 to 2016 to being a difficult period. Was it your impression not only for you but for others working on the unit at that time that they too would have said this was a period where there were an unusual number of collapses or deaths and that

was something that was known and was affecting those working in the unit?

A. Yes, I think that was acknowledged informally by the doctors I was working with.

Q. Can you give a little bit more detail in terms of that would have been discussed at breaks or whether you recall any meetings where that was specifically raised?

A. I -- I don't recall specific detail around those conversations and I certainly don't recall any sort of formal acknowledgement or processes for reflecting upon that general observation.

Q. But your experience of this being a difficult six months when there was an unusual level of collapse or deaths was something that you would have felt was commonly held by those who were at your level --

A. I think it was understood that it had been a surprisingly busy period.

Q. By "busy" you mean a surprising number of babies collapsing or dying?

A. Correct, yes.

Q. Just looking at the relationship with Consultants. How would you describe the relationship between trainee doctors such as yourself and the Consultants?

A. I felt that I had good relationships with them. I felt that they were approachable and supportive.

Q. So had you had any concerns or difficulties, concerns about procedures or concerns about a particular case you were dealing with, was that something you felt freely able to raise with a Consultant?

A. Yes.

Q. Did you ever go to your supervisor, Dr Gibbs, with specific concerns or queries, either in relation to Child H or Child I or indeed just the number of collapses that were occurring at this period?

A. No, I didn't raise any specific concerns.

Q. Why was that? Was there any inhibitor in you going to speak to Dr Gibbs or was it something that you felt they were aware of, he was already aware of? We have heard Dr Lambie did raise those concerns, was that something you considered?

A. I didn't feel that there was anything preventing me from doing that. I think I was focused on, you know, the possible clinical reasons for deteriorations that I had noted and focused on my clinical performance and I don't think I was sort of thinking far beyond that in terms of the broader or systemic factors on the unit.

Q. Just so that we can understand how the relationship with the clinical supervisor worked, would you be -- would you have a scheduled regular meeting where you would raise any concerns or would it be an ad hoc situation where if you had a concerns you could go to them?

A. So both -- we would have regular scheduled supervision meetings and I would use my clinical supervisor as a first point of contact if I had other specific issues that I wanted to discuss between those episodes.

Q. Do you recall discussing Child I or Child H in any of those supervision meetings with Dr Gibbs or indeed any of the other Consultants that you may have spoken to?

A. No. I possibly would have completed some reflections or some supervision discussions with Consultants around the management, but I think that would have been from a sort of clinical learning perspective, not from a concerns about practice on unit perspective.

Q. Obviously one of the hierarchies that exist in hospitals is that when a Registrar feels the situation warrants it they will call out a Consultant. Was that something you felt very freely able to do?

A. Yes, I did do that freely.
Q. And you didn't feel there was any inhibition on calling a Consultant when that was --
A. No.
Q. Their level of expertise was needed?
A. No, no inhibition.
Q. In terms of relationship with managers, did you have any interaction at all with managers at the hospital whilst you were there in 2015/16?
A. Not that I recall.
Q. And just so that we can get a feel of that, would you for example have known, recognised, Ian Harvey the Medical Director or the Chief Executive, would you have known who they were?
A. No, I don't think so.
Q. The Board of Directors, as far as you are aware, did they ever come on the unit, did you have any contact with any of those individuals, even if not to speak to them, but aware of their presence?
A. Not that I was aware of at that time.
Q. So it would be fair to say, would it, that as far as you were concerned, they weren't visible to you working on the unit?
A. Yes, I wasn't aware of them. They weren't visible to me.

Q. Just before we turn on to another topic, finishing off the issue of relationships between staff.
We have said and looked at the way training worked going through rotations of a number of hospitals. Is there anything you want to add, I think your evidence is that it was relatively unremarkable but how the Countess compared in terms of relationships between doctors nurses and midwives to other places you had worked?
A. Just very typical of a district general hospital.
Q. Thank you.
Turning to the issues of what you had had in terms of reports before you started at the Countess.
You say in your statement to the Inquiry, this is paragraph 12:
"Prior to starting my role on the Countess of Chester's neonatal unit in September 2015 I had heard reports of the neonatal team having 'a bad time'. My understanding was that this was a reference to episodes where babies had either died or required unexpected escalations of care or transfer to tertiary Neonatal Units."
Can you recall approximately when you were hearing these reports?
A. No, I -- I can't, I'm afraid, it's about as

detailed as that in terms of memories I have of --
Q. I am just going to put a suggestion to you and you can either say that seems right or that you simply have no recollection, we know now that four babies died in under two months between early June and early August 2015 and we have heard from Dr Lambie that those issues were being discussed at the Countess of Chester, so that would have been the August, the month -- your last month at Liverpool before you moved to Countess of Chester.
Does that seem about right in terms of when you were hearing these reports of the bad time?
A. Possibly, or I think one of my colleagues in the Registrar group had been working in Chester prior to me starting there, so possibly from him. I'm afraid I just have a sense of being aware that episodes may have happened, but it's not more specific.
Q. You say you were you had heard reports.
How widespread was your impression that those reports were amongst the community, for example at the Liverpool Women's Hospital, was it something that was being generally discussed?
A. I don't recall it being discussed there. I am not sure if it was amongst trainees or possibly when I started at Chester that I became aware of it. I just

recall having a sense of being aware of that but no details, I'm afraid.
Q. So you are not able to assist as to who you heard these reports from, was it colleagues at your own level or was it from nursing or Consultant level?
A. I -- my sense is it would have been from discussions with colleagues at my level.
Q. You have said that when you were at Liverpool, you were under Dr Yoxall. Was it, as far as you know, something that he was aware of or that you ever discussed with him as a concern as your current supervisor about to go on to Chester, did you discuss with him that you had heard these reports and that was causing you any concern?
A. No, not as I recall.
Q. You say in terms of the reports they were having what you had heard was they were having a bad time. Just to go into that a little further.
As a doctor, presumably there would be some speculation as to the cause of babies dying or collapsing. What is your recollection that people were speculating or discussing as being the cause of the bad time that was being experienced at Chester?
A. I don't recall any speculation about the cause. I think the assumption, or certainly my

assumption, would have been that that was bad luck and a bad -- a bad run I have no recollection of discussion of a cause for those.

Q. So just in case this prompts your memory, no discussion of infections, concerns about the standard of care?

A. No, I don't, not aware of anyone expressing those concerns.

Q. Just to look at a wider historical situation. We know that in May 2015 there had been a nurse at Stepping Hill who had been sentenced for murdering patients by the admission of insulin. Was there ever a sense when you heard "a bad time" that there were discussions even only speculation or rumour that there might be someone involved in criminal action?

A. No.

Q. Once you arrived at the Countess of Chester, and I think you are unsure -- you say prior to starting the role you had heard the "bad time", whether that was at Liverpool or in fact whether just as you were arriving at the Countess of Chester, do you have any clearer recollection of what was being talked about in terms of increased mortality or concerns once you arrived at Chester in September 2015?

A. No. We weren't briefed or I don't think it

was addressed specifically at any point.

Q. So you might have not been briefed about it, but was it something that -- amongst your seven or so trainees who were all starting together, was it something that was a topic of discussion between you?

A. I don't think in any more detail than the general sense that I tried to convey in my statement. Certainly I don't recall any discussions about specific clinical cases or circumstances around those, those deaths or episodes.

Q. Because the impression that Dr Lambie gave, obviously she was there at an early period and had been involved in some child deaths which I appreciate was not the case of you in September, but that impression was of it very much being discussed on the unit and something that was being discussed at Consultant and indeed at Registrar level.

Was that an impression you had when you started in September or not?

A. No, that's not my impression and not my recollection.

Q. In relation to Child H, I think you have had an opportunity to review the medical notes and you refer to two collapses of Child H that occurred during the night of 26 and 27 September 2015, so this was within

the first month of you starting --

A. (Nods)

Q. -- at the Countess of Chester.

The first occasion you were bleeped at 2051 and attended Nursery 1 and on that occasion -- we don't need to go in the details but on that occasion, a breathing tube was replaced and Child H stabilised quite quickly?

A. Yes.

Q. Then turning to the second occasion. You were called out then a second time at 1.30 in the morning and if we go to paragraph 16 of your statement where you deal with this, you say:

"I reported that in relation to the second episode there was 'a sense of being more concerned on this occasion [as compared to an early deterioration] because it wasn't completely clear while she [Child H] had deteriorated. There wasn't as clear an explanation'."

What did that make you feel, the lack of explanation, what was your response to that?

A. That she needed some further assessment and further investigations in order to try to identify the cause.

Q. You called I think Dr Saladi, the Consultant, at home?

A. (Nods)

Q. You had to do chest compressions and I think adrenaline was administered?

A. That is correct.

Q. Can you give an indication of how unusual that was to have to call out a Consultant from home, chest compressions, administration of adrenaline? You had obviously been there only under a month at this time but was that something you had experienced before, was that a very infrequent occurrence having to call the Consultant in in those circumstances, just so that we can have a feel of how unusual that was as an incident, let alone the fact that this one you say you were unsure as to the cause, but as an event how unusual was that?

A. So I wouldn't describe it as being unusual to have to call the Consultant for advice or further support. I would say that it's relatively unusual to need to use adrenaline as part of resuscitation of a neonate.

Q. Insofar as you can recall, and I appreciate you won't have gone over every medical note of every child you saw, was that the first time as far as you recall that had happened since you started at the beginning of September?

A. Yes.

Q. Looking back, for example over the period you

spent in Chester in 2012/13, can you recall that sort of incident having occurred then?

A. I -- I can't recall, I'm afraid, and I think I would have been working at a much more junior level where I wouldn't have been as involved in episodes like that one.

Q. But it is fair to say this was sufficiently unusual that it very much stuck in your mind, the administration of adrenaline with Child H?

A. I don't think I can recall every episode where I have used adrenaline in my career, it is not unheard of.

Q. Yes.

A. In the -- difficult to quantify.

Q. You say in your statement at paragraph 19:

"My reaction to Child H's collapse episodes was that they were challenging and unexpected episodes of deterioration."

What would you have done in that situation at the handover, what discussion would have taken place regarding the collapse of H, given as you say the challenging nature the unexpected episode, and it not being clear to you why Child H had deteriorated? What discussions would flow over that at handover or indeed beyond handover?

A. So it would be a discussion of her previous medical care, her background and then a summary of the events and then a recommendation in terms of ongoing assessments or investigations and ongoing management.

Q. You have told us that you had heard discussions of the bad time before you started. You are now in a situation where you have been involved in what you describe as an unexpected episode of deterioration for which there wasn't a clear explanation.

Did you make an association with what you had heard and what was in fact now happening to you and feel that was something that you needed to raise with those senior to you raise with the Consultant body?

A. No, I didn't see those events as being associated.

Q. That translates I think to being that that wasn't something you would have discussed with other doctors and nurses, you didn't raise it with Consultants but was that a concern that you raised with your fellow Registrars?

A. No, I don't think so. I had called Dr Saladi early in the second episode so I was confident that one of the Consultant team was -- was aware and it would have been handed over to colleagues in the morning in terms of the plan and I think the plan was for

a transfer so I think I felt satisfied that the episode was understood.

Q. If I could just turn you to paragraph 20 of your statement.

You say there:

"In a witness statement provided in relation to the investigation of Child H's collapse episode I reported being 'surprised by how many poorly babies there were (at the Countess of Chester Hospital) but I did not think it was suspicious'. I do recall having a subjective sense there had been a higher than expected frequency of episodes where babies required stabilisation or resuscitation during my time at the Countess of Chester Hospital."

So you seem there to be linking in some way Child H's collapses and your subjective sense that there was a higher than expected frequency?

A. Yes, I don't think that statement refers to that period in time, I think that's possibly further on in my placement.

Q. So at the stage of H's collapse, your concerns there hadn't developed to the point and we will go on to deal with Child I in a moment?

A. I would agree with that.

Q. In relation to H, you were -- there were also

going on at this period unexpected collapses of Child G that had happened in advance of Child H. Were you aware of that, was that something that was being discussed?

A. I am sure I would have had or I suspect I would have had awareness through handover processes and those discussions. But I -- I couldn't recall details of those episodes.

Q. Did you ever consider at this stage -- just on H, we will come later to Child I -- that there was any safeguarding issue and that concerns for the child themselves meant that you should be reporting the matter to anyone other than discussing it at the handover, which I think is your evidence, that it was discussed at the handover?

A. No, I didn't.

Q. You say in your statement at paragraph 21:

"I do not recall attending a formal debrief or discussion between doctors and other medical staff in respect of the collapses that Child H experienced on 26th to 27th ..."

You have said that it was an unexpected episode and in paragraph 18, you have described some of the steps that were taken to investigate potential causes, x-rays, blood test, ultrasound.

Do you think on reflection that there should have

been a debrief if only from a learning perspective for you and others involved as to what had occurred and what was the cause of the collapse of Child H?

A. Well, I certainly think there could have been I suspect -- her, as I understand it, prompt recovery may have a factor in that not happening.

Q. But would you say that was usual at the time that there was not a debrief. Were you surprised there was no debrief in the case of Child H?

A. No, that didn't surprise me and I think that's probably because, as I understand things, she made a good recovery soon after that episode.

Q. And we have heard that debriefs tended to be more common in a situation where a child died. Would that be your experience too?

A. Yes.

Q. Paragraph 22 you say:

"... I did not have any concerns that Child H's collapse had a suspicious cause. I was not aware of any colleagues who may have had suspicions about the cause of Child H's collapse."

Is it right that you weren't conscious then of the sort of anxiety about working on night shifts that we were hearing from Dr Lambie?

A. So I think night shifts as a trainee are

always more challenging. You are less well staffed and less well immediately supported, I felt supported in terms of being able to access Consultant colleagues, but they weren't in the building so I think most trainees experience anxiety about working night shifts.

Q. But the situation with H, as far as you were concerned, didn't lead to particular heightened anxiety either your own or others who were discussing that situation?

A. No, not that I am aware of.

Q. Turning then to Child I. I think you knew Child I because you had been working at Liverpool Women's Hospital when Child I was born?

A. Yes.

Q. On 13 October, you were bleeped to attend Child I, chest compressions were needed and Dr Newby was called in as a Consultant?

A. (Nods)

Q. And you say at paragraph 24 of your statement talking about the collapse on 13th that it was unusual for a baby to deteriorate so quickly.

A. Yes.

Q. Were you aware at that stage that Child I had previously collapsed unexpectedly on 30 September?

A. I suspect I would have had some awareness of

that, but I don't recall how.

Q. What would be your normal practice where there is a collapse in terms of looking at notes, would you -- would you examine the notes to look back and see their past history?

A. Yes.

Q. After this unusual collapse on the 13th, was that something that was discussed at the handover as I understand it, is that correct?

A. It certainly would have been raised at handover. I don't recall that discussion.

Q. But did you consider it should be raised in any other forum or did you -- having had the experience of Child H which was now unexplained and now a further unusual collapse, did you feel this was something that you should now be raising at Consultant level?

A. Well, I think I was confident -- well, I was confident that Consultants knew about the episodes as I had called Dr Newby in and she was there. I think similarly I was quite focused on the potential clinical explanations and ...

Q. Did Dr Newby or indeed any other Consultants discuss with you concerns they had, wider concerns beyond that specific collapse of Child I?

A. No.

Q. On the following night, 14 October, Child I collapsed again and on this occasion Dr Jayaram was called out and again chest compressions commenced and adrenaline was given?

A. (Nods)

Q. Again, Dr Neame, can you indicate or give some indication of how unusual it was in your experience to have that experience of consecutive collapses on consecutive nights requiring chest compressions of a severity that Consultants needed to be called in?

A. Well, I think it that's slightly more challenging from a clinical perspective because I think there are cases where babies are unstable due to an underlying clinical condition and that might precipitate further events, that was certainly my interpretation of what was happening by that stage.

So using adrenaline in a resuscitation situation in a district general hospital was unusual but managing very unwell children and seeing complications of further -- of periods of instability represented by further periods of instability felt plausible clinically.

Q. If I could take you to paragraph 26 of your statement, you say there:

"... I recall formal discussions ([for example]

during ward rounds and during discussions with colleagues from tertiary neonatal centres and the Alder Hey surgical team) and informal discussions amongst the clinical team relating to the unusual course of Child I's presentation."

Then you go on to say:

"My recollection is that although Child I's death was surprising and unexplained there would be an ongoing attempt to try to identify the cause through a postmortem assessment."

So was it your understanding that indeed matters were being looked into in relation to Child I?

A. Yes, that was my perception through that period, was that we, the team, were searching for a clinical explanation for her instability and episode.

Q. Thank you, Dr Neame. If we just could put up INQ0000536. This is tab 8, my Lady, in your bundle. That is the witness statement of Dr Rachel Chang who was a Registrar and if we can just go down towards the bottom of the page.

It says there in the last paragraph talking about this period on the handover of the 15 October:

"Matt Neame was having a really difficult stretch of nights with Child I as she had been very ill. Night after night he was really shattered. He was glad to be

finishing nights, I think, but I can't remember any comment or concerns from him about the three nights he had looked after her. He was just very glad to be finished as it had been so understandably stressful".

Then if we could turn over to page 7. Scroll down to page 7 and we see there in the penultimate paragraph:

"Matt Neame had been resuscitating poor Child I every night shift, then every morning at handover I would be like 'Oh my God, poor Child I and poor you', then we would have a day shift of where we would say, 'Oh she's not been too bad' as she had seemingly recovered quite quickly."

So what Dr Chang seems to be saying is that there was an apparent pattern where Child I would deteriorate at night, bounce back to some extent into the day and you were involved in those episodes?

A. (Nods)

Q. If we can go now to 0099075 at page 12 and this is tab 10, my Lady, in your bundle. So that's 0099075 and page 12. At paragraph 36, this is the statement of Nurse ZC that's been given to the Inquiry.

She says:

"The second instance was with Dr Matthew Neame who similarly had a run of bad shifts. My understanding was he had in fact previously completed a rotation at

Liverpools Women's Hospital's NNU which cares for some the sickest neonates in the Northwest. He returned to the NNU at the Countess of Chester earlier and has made comment that he had used more adrenaline during these night shifts than he did in six months at the Liverpool Women's. He again made a comment along the lines of 'it's always Lucy that ends up with these babies too'. Again, there was no further discussions or him suggesting anything was with intent."

So that's one additional aspect to the pattern. We have looked at the fact that these were deteriorations that happened at night, that Child I then seemed to recover during the day, and then we are adding to that that you had observed that Letby was on duty at the same time. Did you draw any conclusions from that or did you have any concerns arising out of that?

A. No.

Q. We have heard from Dr Lambie back in September that there was a suggestion of nurses huddling and looking at who was on duty on a rota. Was that something that you were aware of, other nurses or anybody suggesting to you that should be considered of who was on duty when these collapses occurred?

A. No, I wasn't aware of any of those discussions.

Q. The Inquiry are considering an issue of whether there was an instruction that was given on the afternoon of 14 October, so after the second of the consecutive collapses, experienced by Child I that Letby be taken off caring for Baby I.

Did you have any knowledge that Letby was or there was a suggestion that Letby should be taken off caring for Baby I?

A. No.

Q. Just staying again with Baby I. It appears that it was the death of Child I and indeed the -- which happened on 23 October, I think you weren't involved on that occasion; is that correct?

A. That's correct.

Q. But the death of Child I and indeed the previous collapses that raised Dr Brearey's concern, and indeed to some extent Dr Gibbs's concerns we heard yesterday, at about this time, too.

Do you have any recollection of either Dr Brearey or indeed of any Consultant coming to you and asking you for your views as the doctor involved in these collapses as to your views on the reason or any concerns you had?

A. No, I don't recall that.

Q. I think it follows, but I must ask you, did anyone come to you and ask you about who were the nurses

who had been on duty during those collapses?
A. No.
Q. In the case of Child H and Child I, they were significant collapses, where the child required resuscitation. Did you consider making a Datix entry for any of those collapses?
A. No, I didn't.
Q. Why was that?
A. I think at that time my perception of the Datix would have been that it would be used if there had been a mistake or a clinical error or a problem with the equipment and I didn't perceive that to be the case during those episodes.
Q. Maybe you can help. Had you felt there was a reason for a Datix would that be something that you would have been filling in or would that be something that would be generally done by the nursing staff?
A. Often there would be a discussion about who had identified it and who had the most useful information about the incidents but certainly it is something I would have felt comfortable and confident to do.
Q. But it was nothing that either occurred to you or was suggested by anyone that a Datix should be entered for any of those episodes, the Child H or the

Child I collapses we have been discussing?
A. No, it wasn't suggested as far as I recall.
Q. If we could now look at 000526, page 10, which is tab 7. Sorry, no, I'm afraid that's an incorrect reference.
It's 0003288001. This is a neonatal mortality meeting that you attended in relation to Child I. We see your name there "Attendees" at the top.
Do you have any recollection of this meeting?
A. I don't think I recall that meeting. I think I recall an informal debrief discussing Child I, but I don't think I recall a formal mortality meeting.
Q. Because we see there, certainly in the middle of the page, we see a summary of the case and we see there that the collapses on the 13th and the 14th are recorded there and obviously that was something that you would have had direct evidence about?
A. (Nods).
Q. And I think it's correct, is it, Dr Neame, that you had concerns and didn't have an explanation as to why those arrests had occurred at this stage?
A. I think certainly the immediacy of the first episode was very surprising. As I tried to express earlier, I think the subsequent episodes were less unexpected in that Child I was less stable by that point

and had frequent clinical signs that could have subsequently caused a deterioration.
I think they were still surprising in terms of how severe they were. But, I hope that's a fair way of expressing it.
Q. We see in the paragraph in the middle box "Discussions and learning from the case".
There is no discussion about the collapses. Were those meetings meetings where there was a free discussion about any concerns? I'm trying to understand why there was nothing in that discussion and learning in relation to the collapses.
A. So I don't have a clear recollection of this Morbidity and Mortality Meeting. Other mortality meetings that I have a sort of vague recollection of at Chester I think were quite Consultant-led perhaps and quite focused on presenting key events without input from junior colleagues. That -- that's a vague recollection of some meetings that I had attended at my time there.
Q. So just to interpret that if I can. That -- was that a meeting, would it have been led by Dr Brearey, first of all, would that be your recollection?
A. Well, the only meeting that I am certain I can

remember to do with Child I was a quite informal debrief and discussion amongst the team around her course on the unit. But I -- I don't recall that as being a formal Morbidity and Mortality Meeting with an in-depth discussion of the clinical course.
Q. So you, as far as you are aware, can't recall this neonatal mortality meeting that would be discussing, as is apparent from it, the period from August to October and the deaths that had occurred in that period. That's not a meeting that you recall?
A. I don't recall it, no.
Q. Thank you. If we could just turn, while we are looking at the recording of incidents, to 000526 and page 10 of that and this is tab 7, my Lady, in the bundle.
Dr Neame, this is an extract from a statement that you gave to the police and if you could go to page 10 and you deal here with some of the note-taking in relation to Child I. We see there, are we on page 10, yes, that you were called to attend Child I and that's at the top of that paragraph and that's relating to -- it's not immediately apparent from this page -- but that's relating to 15 October and then going down the page, we see:
"My next note was then 19 October at 09:50 hours."

And if we could go to the next page, please, we see that's dealing with the note, the continuation of the note that you were filling on 19 October and it says:

"I discussed her [that's Child I] with the surgical team at Alder Hey and the Registrar there who had discussed her with the on-call Consultant. There was a query about arranging another investigation for her to have a barium x-ray of her tummy to see if there was any explanation for her tummy problems. A barium x-ray can give a clearer picture of any blockages in the bowel."

Then at the bottom of that page, your next notes were on 22 October at 11:30 and then if we can go on one more page, so this is still the note of 22 October, you say there at the end of the first paragraph:

"The plan was to chase up the previous investigations, the contrast enema and keep her nil by mouth until then."

Were you aware, Dr Neame -- obviously sadly Child I died the following day, but were you aware why these tests that you were chasing up had not taken place prior to that?

A. My recollection is that during that period it was very -- it had been very difficult to get her transferred over to Alder Hey to have a further assessment and to have those investigations completed.

Q. You say then at the bottom of the page:

"I don't recall ever there being a good explanation or understanding of Child I as to why she had episodes where she became unwell so quickly and sadly died."

Does that accurately set out your view?

A. That's a good summary of the overall feeling I have about her care. I think there were episodes where I felt there was certainly a plausible clinical explanation. But I think reflecting on the overall, you know, on her care and her course overall I think that's a fair summary.

Q. And if we could go just to paragraph 40 of your statement. I think if we could put that up on screen, that's INQ0102351 at page 10, and again this is somewhat of a summary really of your evidence -- of your witness statement:

"I recall developing a subjective sense of concern about the number of deaths and unexpected deteriorations on the Neonatal Unit during my placement there in 2015-2016. I recall discussing these concerns informally with colleagues, for example highlighting that shifts had been unexpectedly busy at Consultant handover meetings but I did not raise these concerns formally. In part, I believe this is because I was confident that these observations had already been noted

by the more senior cohort of medical and nursing colleagues, and in part this was because I held the assumption that the episodes were related to unexplained or unexpected medical factors rather than being caused by factors related to deliberate harm or incompetence."

Just looking at that, you say you were confident that observations had been noted by a more senior cohort. What was the basis of that confidence?

A. The fact that I had, you know, been escalating the concerns directly to Consultant colleagues as they arose. They were often present as I was managing the challenging clinical situations and I felt confident that they would have found them, you know, challenging as I did and my perception was that they were a, you know, relatively close coherent group who would be familiar with how much pressure the unit was experiencing.

Q. And then you, just looking at the expression you use there, "unexplained or unexpected medical factors". In effect, that means that simply there was no explanation for these. That's what that's saying, isn't it, there was unexplained or unexpected, is that correct?

A. Well, it's saying that my perception was that they weren't immediately explainable, but that with

further assessment or investigation that we would identify medical causes.

Q. Do you now considering, looking at this with hindsight, was that a situation where there should have been consideration of whether there was a non-medical factor, either deliberate harm or negligence, for why those were happening? Is that something that should have been within the range of possibilities that was considered?

A. Well, I think absolutely it -- it should have been and I think it's hard to know when, when that threshold should have been met.

But, yes, I think it's difficult to disagree with that given everything we know now of course.

Q. But at that stage for you, Dr Neame, you hadn't reached a point where you were considering non-medical explanations, is that correct?

A. No, that's correct.

Q. Then just dealing briefly with safeguarding.

What was the training that you had received in relation to safeguarding training either at the Countess of Chester or indeed prior to that?

A. So I can't remember precise details of the training I had undertaken. But I remember clearly that by that stage of my training, I was required to have

a good understanding, well, have a clear understanding of the typical presentations that might indicate that a child had been subject to deliberate harm or a non-accidental injury.

That would have included reflecting on clinical cases, discussing them with senior colleagues and also attending training courses designed to promote the recognition and response to -- to child protection issues.

Q. Did you at any stage in this, particularly by the stage towards the end of your period in February when you had dealt with the issues of the collapses of Child I, did you at any point consider that there was a safeguarding issue that was developing here?

A. No.

Q. Turning finally then to your reflections and, Dr Neame, you set out in your witness statement your reflections which will of course be considered.

But I just wanted to look at one of those that you deal with at paragraph 6 and you say that you would like the Inquiry to recommend that: neonatal units should aim to enable the parents of babies to stay with their babies around the clock and that you think more contact between babies and families would make it harder for staff to perpetrate criminal actions and that closer

contact between family members improves clinical outcomes.

Is that something you just want to expand upon very briefly as to why you feel that is so important with your additional experience obviously now as a Consultant paediatrician?

A. I just think that's not just my experience. I think there's evidence that babies have -- experience better outcomes when they spend more time with their caregivers.

With respect to the particular issues in this, this case, I think it would have made it much harder for a medical professional to behave abnormally or with -- cause harm if there was a parent with the child.

I think the neonatal settings that I have worked in previously have not been well set up in terms of the sort of architecture or layout in terms of making it easy for families to spend large amounts of time with their children. I think efforts are made with comfortable chairs and so on, but that's very different to, you know, being able to stay with your child which would be the norm in a paediatric ward or a children's hospital.

Q. And the lack of that was something that you were conscious of when you were at the Countess of

Chester?

A. I think that's something I have reflected on since being involved in this case.

MS BROWNE: Thank you very much. You may have some further questions from my Lady.

LADY JUSTICE THIRLWALL: No, I have no questions for you. Thank you very much indeed, Dr Neame, and in particular for your reflections which are extremely helpful. I know that you have made a number of statements including the ones we have been looking at today. Thank you for all of that and you are now free to go.

A. Thank you.

LADY JUSTICE THIRLWALL: I think, Ms Browne, the next witness is attending by videolink.

MS BROWNE: Yes.

LADY JUSTICE THIRLWALL: So that is fixed for 2 o'clock. So if everyone could be back in the room just before 2 o'clock so we can get started on time.

(12.43 pm)

(The luncheon adjournment)

(2.00 pm)

MS LANGDALE: My Lady, may I call the next witness Dr Mayberry who is giving evidence over the link and needs to be sworn.

LADY JUSTICE THIRLWALL: Welcome, Dr Mayberry the next voice you will hear will be from my clerk who is going to administer the affirmation.

THE WITNESS: Sure.

DR HUW MAYBERRY (affirmed)

(Evidence via videolink)

Questioned by MS LANGDALE

MS LANGDALE: Can you give us your name and qualifications, please?

A. Sure so my name is Dr Huw Francis Mayberry, I hold a Certificate of Completion of Training in Paediatrics (Paediatric Intensive Care) from the General Medical Council. I have also completed a Special Interest Module, or a SPIN, in Paediatric Cardiology. I am a member of the Royal College of Paediatrics and Child Health. I have held memberships with the Paediatric Critical Care Society and the European Society for Paediatric and Neonatal Intensive Care.

My degree is an MUDr awarded by Charles University in Prague in 2011.

LADY JUSTICE THIRLWALL: Just pause there, Dr Mayberry. Can everyone hear sufficiently well? No. I wonder if you could move forward, I gather there is a problem with the sound so if you can move forward,

that might be the best thing to do.

MS LANGDALE: Shall we try that? (Pause) That sounds better.

If you can't hear me, Dr Mayberry, at any point just raise your hand and I will do the same for you so we don't keep speaking into a vacuum of people not hearing us.

A. That sounds good.

Q. Thank you.

You have provided helpfully the Inquiry with a statement dated 9 April 2024. Can you confirm for us that the contents are true and accurate as far as you are concerned?

A. As far as I am aware yes, the contents are true and accurate.

Q. You have it with you, I believe, Dr Mayberry, so I can take you through it today?

A. Yes, I do yes.

Q. Can I ask you a couple of questions before I do. We know from your CV that you were working at the Countess of Chester between March 2016 and September 2016 in specialist paediatrics; yes?

A. Yes.

Q. Did you know Dr Ogden or Dr Lambie, those who had come before you, in Dr Ogden's case March

to September 2015 and the same I think for Dr Lambie?

A. I haven't met Dr Lambie to the best of my recollection. Dr Ogden is somebody who I have met in other contexts. I can't remember if I knew Dr Ogden before the Countess, before I worked at the Countess, but I am -- I do know who she is and I have met her on other occasions.

Q. I notice it is obviously not uncommon as Registrars or trainees you move around. Arrowe Park, in your case, Alder Hey, Countess of Chester and also Liverpool Women's. So presumably there is sometimes overlap or connection or communication between Registrars rotating in their roles?

A. Yes, there can be. To the best of my recollection, I don't think I worked with Dr Ogden before I worked at the Countess of Chester.

Q. Dr Ogden, I will ask for it to be put on the screen so you can see it Dr Mayberry, she in here statement -- the reference number is INQ0102019, page 8. It is paragraph 32 of her statement. It doesn't refer to you, Dr Mayberry, but I want to draw to your attention what she says at paragraph 32 on page 8.

A. I don't have that on screen currently.

Q. You will shortly, don't worry, I think it should be coming. Can you see it now?

A. Yes.

Q. We can't see you while you are looking at it but I will take it down as soon as I can, Dr Mayberry.

If you look at paragraph 32, Dr Ogden says when she was at the Countess:

"I do recall finding the numbers of collapses or deaths on the unit at that time as unusual and concerning. I am unsure specifically when this appeared to me as unusual but it is likely to be around the time of several of those collapses/deaths that occurred within a few weeks of each other in June 2015. Whilst I do not recall that I specifically approached any Consultant in particular to raise specific concerns I believe the whole department was discussing this informally as being unusual and that the senior Consultant team were raising this and investigating what could have caused this."

That can come down from the screen, Dr Mayberry.

A. Sure.

Q. I can tell you that we heard from Dr Lambie this morning that in the same period in around June, she says she does:

"... recall being aware of increasing levels of anxiety following the death of Child A and collapse of Child B soon afterwards largely due to the unexpected

and similar natures of their collapses and the appearance of the unusual rash.

"As further babies become unexpectedly seriously ill, (collapsed) or died, I recall medical and nursing staff reporting to each other they were nervous at the start of their shifts. I personally recall being nervous at the start of a set of night shifts towards the end of my placement as I was almost expecting something bad to happen".

When you arrive, were you aware of that concern or discussions, sense of unease that both have described in their statements?

A. I think on arrival it wasn't something I was particularly aware of. As I have written later on during my statement Dr Brearey did tell me that historically the Countess had had a low mortality rate, that that had increased over the period before I had arrived and that they had started asking for other people to be involved with that.

I don't recall exactly when that conversation took place. It was an informal conversation. But I wasn't aware of a growing sense of unease at the time.

Q. I think it is paragraph 12 of your statement, Dr Mayberry, you set that out, you say:

"As time went on I do recall growing anxiety about

the mortality rate. From what I understood Chester traditionally had a low mortality rate compared to the rest of the region and it wasn't understood why that had changed."

A. Yes.

Q. So you can anchor yourself and everyone in the room can, Dr Mayberry, when you were there we know that L,M, N and Q suffered deteriorations and O and P died.

So when you were there, O and P, the triplets which we will come to later, died, but you say nevertheless you were aware from Dr Brearey some growing anxiety about the mortality rates. I just want to unpack that.

When you say "mortality rates", does that mean simply death rate or did you have any sense or unease about unexpected death rate or discussion about that?

A. Sure. To the best of my recollection, all that was referred to was the mortality rate as opposed to anything unusual about the deaths.

Q. So it was the crude indicator, a mortality rate full stop and the number?

A. Yes.

Q. You understood from Dr Brearey that that was being investigated because it was higher?

A. Yes.

Q. Or it had changed?

A. Yes, it increased, yes.

Q. Was he a supervisor of yours or a -- I don't know what you would call it?

A. He was my -- he was a Consultant so he is somebody I guess would supervise me in the sense he was the most senior person on-call or on a number of occasions. My designated supervisor was Dr Gibbs though.

Q. Did Dr Gibbs ever say anything to you about mortality rates?

A. If I am honest, I don't fully recall. A conversation I recall most clearly was the one with Dr Brearey.

Q. Was that soon after you arrived, later on? I mean, you arrived in March 2016?

A. Yes.

Q. When did that conversation roughly take place with Dr Brearey?

A. I think it probably would have been within the first couple of months but I find it hard to be more specific than that.

Q. Fair enough, but you knew soon after your arrival there was concern about that number and what it represented?

A. Yes.

Q. But nobody ever spoke to you about what it might represent or anything like that?

A. No, I think Dr Brearley said they didn't understand why it had gone up and that's why they had sought external opinions and advice.

Q. What external opinion did you think that they were getting?

A. So I thought that they were getting a Network review, so a review from the Neonatal Network, and then later on a review from the Royal College of Paediatrics and Childcare.

LADY JUSTICE THIRLWALL: I'm sorry to ask, would you mind just keeping your voice up a little bit more and a bit closer to the microphone, thank you.

A. Sure, sorry, so my understanding was that it was a Network review, so a review from the Neonatal Network in the area and a review from the -- later on from the Royal College of Paediatrics and Child Health.

Q. And in what context did Dr Brearey give you this information, was it in a passing conversation, in an informal discussion, what kind of set-up was it where you learned this?

A. I believe it was an informal discussion but I can't remember too much more context to it, sorry.

Q. Informal discussions, presumably they take

place between doctors, doctors and nurses and people all the time walking around a hospital? When you catch a moment, you catch someone, you have a conversation, is that how it is?

A. Yes, you do have informal conversations.

Q. Did you have any discussion with fellow Registrars about the mortality rate?

A. No, not really. The -- I am getting a lot of feedback, does everyone -- are you having trouble hearing me?

Q. We are not having trouble hearing you. I'm sorry that you are getting feedback. Can you hear me?

A. Yes, I can hear you.

So I didn't have a conversation with other Registrars, to the best of my recollection about it was quite low on the number of Registrars on the rota and by its very nature I think at times we were down to 3.5 working equivalent Registrars on an eight Registrar rota. You wouldn't necessarily see the other Registrars on a very regular basis.

Q. Did you ever ask "what are the numbers" when you were told there was an investigation or consideration, I should say, into the mortality rate, did you say, "Well, how many is it usually, what's it now?" or ask any questions out of curiosity. I am not

saying you should have done, but were you curious what that was about?

A. No. At this point this was my first year of being a Registrar and it was my first job working in a designated neonatal unit as a Registrar and I think I was probably focused largely on making sure my own practice was as good as it could be and up to date and I understood that there were processes taking place in the background to look into what had happened and why it had happened.

Q. Understood. At that stage in your career, Dr Mayberry, did you know whether and if so there was a difference between what should happen when a child dies in hospital and when a child unexpectedly or without explanation dies in a hospital, would you have known that or been aware of that important distinction then?

A. I think I would have had some awareness of it but probably I would have had some awareness but not as extensive perhaps as I do now.

Q. Sure. What's given you a greater awareness now: training, knowledge, experience?

A. I think probably a combination of all of those things.

Q. Did you, at the time you were at the Countess

and generally, know very much, if at all, about the case of Beverley Allitt the nurse in Grantham Hospital who had been convicted of murdering patients? Did you know anything about that case when you started medical training?

A. I knew historically just from general sort of news about some of Beverley Allitt's case but it's something that didn't come through training or anything like that. It was more a from sort of general news.

Q. And in general, would that heighten any awareness in you or colleagues generally or do you think it was sort of consigned to the past and just a case or what do you think?

A. I think it's something that you did sort of think of in -- as something to be aware of in the background. I am not sure it's something that came into day-to-day thinking, though.

Q. So background knowledge but not day-to-day thinking because that seems unthinkable, or how would you define thinking about a nurse murdering patients?

A. I think because it's -- potentially it was more historic, it was something that was relatively -- well, it was rare in its nature, and I guess they are probably the main -- the main things that it was historic and it was rare and so it's not something you

would think about on a day-to-day basis and there were a number of other things which were more likely to affect and -- affect children and put their lives at risk.

Q. We asked you, Dr Mayberry, about the culture and atmosphere of the neonatal unit in 2016. You tell us Dr Gibbs was your assigned supervisor and was responsible for helping you with any difficulties you might face. Did you find Consultants, particularly Dr Gibbs, helpful to you in their capacity as Consultants? Were the relationships good and harmonious as far as you are concerned?

A. Yes, I didn't have any problem or any issue with any Consultants there. When I was on-call and I needed help, the Consultants would often come in even middle of the night they would happily come into help. I didn't have any problems.

Q. That was a super clear answer, Dr Mayberry, so wherever you are sitting now is a good place to be. It was very audible, thank you.

You also say in your statement at paragraph 8:

"... Consultants didn't really discuss the interactions with management with junior members of staff."

You are a junior doctor, you are setting out on

your career at this time. What role did management play, if any, in your understanding of your career and your future ahead, what did you make of the role of management and how the Consultants got on with them?

A. So I didn't hear a great deal about how the Consultants got on with management. I think what I did hear was probably limited to their attempts to increase the number of Registrars on the rota and that seemed to be the extent of my interaction, my knowledge of management interaction with Consultants.

Q. That they did increase the number?

A. No, that the Consultants were trying to get more Registrars on that rota and that they were approaching HR and management to try and do that.

Q. Did you think that would be a good thing, to have more Registrars?

A. Absolutely, yes.

Q. What was your shift pattern like?

A. My shift pattern in itself was fairly standard, I recall. Having said that, what you needed to do on a shift was much more difficult and hectic than you would have had to do in another district general hospital and I think that was down to the fact that they were so short on numbers of people on that grade rota with there only being 3.5 working time equivalents on an

eight -- what would normally be eight doctors fulfilling this role and the Countess was a busy hospital.

It had a large range of services to cover as a paediatric trainee and it meant that you had to do what would be expected normally of eight Registrars with 3.5, so it was busy.

Q. You were going into the children's unit, neonatal unit and A&E as well?

A. A&E and other clinics, yes.

Q. You say the interactions you experienced between medical, nursing and midwifery groups were always friendly and professional. Did you ever sense tension anywhere between midwives and doctors, nurses and doctors, or not?

A. Not -- not really, no.

Q. You say:

"From a medical perspective ... Dr Brearey was the lead and would promote the latest and most up-to-date neonatal medicine, encouraging trainees to read and follow the ... (British Association of Perinatal Medicine) guidance."

So did he encourage best practice in individual sessions with you or just generally signpost what was going on or how did what work?

A. He did it in a variety of ways. He would

often discuss changes in guidance. In terms of things like individual practice he would also help with that as well. I think at the time for example one of the things was around UVC incision, the umbilical venous catheters. BAPM had changed what they suggested in terms of how you insert them and how you secure them and he was saying, you know, we should -- if you do it like this, then that's a bit of an older practice. We should try and do it in this new way with the BAPM guidance, so he would provide individual feedback as well as promoting good practice in general.

Q. You say that the nurses, you had a good relationship with the nurses, they were friendly and professional, your interaction was good with them?

A. Yes, I believe it was, yes.

Q. You also say that the culture in the Countess compared very well to other hospitals you have worked in that's Arrowe Park, Leighton Hospital, and you also say it had a good reputation. What was it about the Countess of Chester that had a good reputation as far as trainees who wanted to apply to work in those units were concerned?

A. I think it had a -- what was known to be a very supportive Consultant body, people who would help you with help and guidance and it had a fairly friendly

atmosphere that people were encouraging in terms of development of junior staff and would try and promote up-to-date guidance and help push things forward.

Q. You say the Consultant body were known to be clinically sound, supportive towards juniors and pleasant to work with.

So there was no sense, was there, from your perspective of arrogance or they know best and not listening to concerns or voices around them?

A. No, not at the time I worked there. No.

Q. Did you ever witness them being dismissive or not concerned about matters raised by nurses or patients or anyone else?

A. It's not something I recall witnessing, no.

Q. You say you had little direct interaction with senior management but you did attend a corporate induction. Can you tell us about the corporate induction and what you say at paragraph 15 you were taught about?

A. Yes. So my memory of corporate inductions has become a little bit more hazy but one of the things that stuck out to me was -- one of the things that stood out was the importance of not losing your handover sheets.

Now, every doctor knows that your handover sheet has a lot of important information for patients on it

and that you would never want to lose that because you don't want to breach confidentiality of a patient.

But one of the things that came up was the fines that the Countess would go through if you -- if you lost a handover sheet, however much money that was and that this was unacceptable.

I thought that was very unusual. Everyone at induction goes through, like, make sure you don't lose confidential information and Caldicott guidelines and things like that, but no one in any other corporate induction I had attended had mentioned the cost of fines and I thought that to be very unusual.

Q. Was this in 2016, so was this early on in March, the beginning or a bit later on in your ...

A. At the beginning.

Q. So your induction very much told you about the importance of handovers. Can I just understand at that time, were the handovers written and on paper, you know, was there something you could physically take?

A. Yes. So normally, handover consisted of two things. You would have a piece of paper which would have a short summary of the most important points about why a patient was there and what jobs they needed -- what investigations they had had done and what jobs they needed doing and that's fairly standard at the time

across all the NHS Trusts.

That would allow you to also write additional notes next to it to help structure your day and help make sure that you did everything that the patient needed to have done.

There was also accompanied with that a verbal handover from the junior doctors with the Consultants present to say what was going on with each patient and potentially patients who were due to come in as well.

Q. At the criminal trial it was made clear, Dr Mayberry, that Letby had handover sheets for a number of children in plastic bags under her bed at home; in fact kept 231 handover sheets.

At the induction was it being highlighted that if you took them, there was a fine and would you have expected as a doctor working there that someone would notice when you have taken a handover sheet or not, are you not looking retrospectively or how does it work?

A. So the handover sheet, normally the way it worked is the handover sheet gets printed, you write your stuff down on it and then at the end of the day there is a confidential waste bin where your handover goes in to, then that is taken securely it is in the sort of waste bin of it and shredded and destroyed so that patient confidentiality is kept, you know, safe.

It's not that every handover sheet is necessarily tracked in some sort of a way. If it were that you ended up, you know, taking them home I am not sure somebody would -- it would be a good way of tracking that based on the --

Q. Don't worry, I am not asking about tracking it. It was more that the hospital are telling you there are fines for it because of patient confidentiality and you were not expecting that. Have you had that kind of induction anywhere else since?

A. Yes. In terms of -- not in terms of fines specifically but everybody knows that you should be getting rid of your handover sheets and disposing of them in the secure, you know, bins where you throw them away.

LADY JUSTICE THIRLWALL: Dr Mayberry, can I just ask you, I didn't quite hear and I am not sure that the transcriber did either: when you were talking about the induction, and that everyone is aware of the guidelines, did you say "Caldicott Guidelines" or some other sort of guideline?

A. So yes, Caldicott and information about how to how to make sure that you -- only the right people have the right information and you dispose of any

confidential waste properly.

LADY JUSTICE THIRLWALL: Thank you very much. Sorry, Ms Langdale.

MS LANGDALE: Thank you.

In that induction, either that one or any other, did you have any safeguarding advice about who to speak to if you were concerned about a child, concerned potentially because of a member of staff's treatment or family members; anything, concerns for a child, child protection, was there a generalised induction around that?

A. Yes. There was an induction around child protection, I think it was one of the community paediatricians who did it.

Q. Would you have known the name of the community paediatrician or the person to go to if you had a safeguarding concern?

A. So safeguarding concerns out of hours at the Countess of Chester I believe were discussed with the duty Consultant paediatrician.

Q. Did you have any discussion at any time around Datixes and what the importance of a Datix was after any event and what type of event?

A. I think there were some discussions around Datix and that if you saw things which you thought were

a risk to patients, or -- not or -- or caused patient harm then you should fill out Datix forms to make sure that those concerns could be addressed and followed up with.

Q. You tell us, going back to the topic of management, you briefly interacted with management about the cap on locums for junior doctors at a significantly reduced rate.

Can you tell us about that?

A. So in terms of the Registrar rota and some of the Level 1 rotas, so the rota below the Registrars, there were a lot of gaps obviously because there is designed for eight people and only 3.5 people were at times running on that rota.

The -- at the time I think or it might have been a bit before this there was a cap put on locum fees with the aim of trying to -- I don't know, trying get expenditure and things down.

It became clear that the cap across the region wasn't working and people weren't going to work for a reduced rate and most hospitals in the region lifted that cap and went back to the rates that they had traditionally paid people.

At the Countess, that approach wasn't taken during certainly the early part while I was there and they

remained steadfastly holding on to that cap. It meant that people in other parts of the region when locums came up were being offered significantly more money to go and work in another hospital, like Alder Hey or Arrowe Park, and so people -- if you had a choice of where to work, people weren't taking up the locum offers at the Countess of Chester.

Q. Did you raise that with other doctors or managers individually?

A. Yes. So that was raised with a number of different Consultants who knew about it. As I said, I didn't really have a relationship with the managers so I didn't have somebody I could really speak to about that on a management level and the Consultants assured me that they were pushing hard to fill the gaps on the rota and had also asked for the cap to be raised.

Q. We are aware there was a medical staff committee, was that something you were aware of or would have had any relevance here or not?

A. No, it's not something I was aware of.

Q. Okay. Moving now, if I may, to Child N in paragraph 19 of your statement. Looking at your Inquiry statement and your police statement, I don't need you to go to your police statement, it is clear that you are speaking about events on 15 June 2016, at paragraph 19.

We now know of course that Letby has been convicted of the attempted murder of Baby N with inflicted trauma to the throat. Taking yourself back to the evening obviously you didn't know that then, but can you set out for us your involvement with Baby N as you set it out here?

A. Sorry?

Q. As you set it out here, I don't need the pages of your police statement, just what you set out here.

A. So I think most of my involvement was with Child N. I believe it was in the afternoon, actually, and I was holding the emergency bleep for the neonatal unit. To the best of my recollection I wasn't assigned to the neonatal unit, but I think --

Q. Sorry, we lost you there, Dr Mayberry. To the best of your recollection, you weren't assigned to Baby N?

A. Sorry, I wasn't assigned to the neonatal unit.

Q. To the neonatal unit.

A. I covered the bleep for a brief period of time from one of the doctors who was assigned to the neonatal unit that day and I believe I was assigned to the paediatric ward.

Whilst holding the bleep, the emergency crash bleep went off and there was a call to the unit because

Child N's oxygen levels had dropped to 44% and 3ml of blood had been aspirated from the nasogastric tube beforehand. I can't remember which member of staff initiated the call. I used an airway manoeuvre and a NeoPuff device ventilated Child N until their oxygen saturations were 100% and I requested the crash bleep to Dr Saladi, given that the previous Registrar had had a lot of difficulty in attempting intubation. Whilst awaiting the arrival of Dr Saladi, I instrumented the airway and saw a large swelling at the end of the epiglottis only just see the bottom of the vocal chords which is the area where you would normally put a breathing tube in.

At this point Dr Saladi arrived and given the difficulty with the airway, I handed over Child N's care to him. I don't remember much more about who was present and what was happening as my sole focus was to improve the oxygen levels in the critically unwell child.

Q. Did you discuss what you saw at the back of the throat at the time then with anyone?

A. Yes, I did. I can't remember if I discussed it with Dr Saladi at that point when he came. I did later on discuss it when I came back to the neonatal unit later on, and there was a Consultant anaesthetist

present who was Dr Campbell, who I wanted -- who I discussed it with because I hadn't seen anything like this before and I was wondering as somebody who is more experienced with airways what her thoughts on it were and if there was anything else that I could do in the future to improve my practice if I came across the situation such as that.

She told me that the view on the airway was a Grade 4 which is the most difficult grade of intubation and that she had been unable to intubate the child. I believe an ENT team and a paediatric intensive care team were mobilised from Alder Hey and they did not find any difficulty in intubating the child.

At some point I asked Dr Gibbs about what they found and he told me it was a Grade 1 airway and that they hadn't had any difficulty in intubating the child.

Q. You say:

"I do not recall attending a debrief for Child N."

Was there any informal discussion between doctors and nurses who had been present that day or at that time about Child N?

A. There was obviously that informal conversation that I have referred to.

Q. You and the anaesthetist?

A. Yes, and with Dr Gibbs subsequently. But

I don't recall a debrief. There may have been one but I don't recall it.

Q. The Inquiry is aware that Dr Brearey had sent an email to Eirian Powell and his fellow Consultants on 11 May 2016 saying:

"If you come across a baby who deteriorates suddenly or unexpectedly or needs resuscitation on NNU please could you let me and Eirian know. We will keep a record of these cases and review them as soon as practicable".

As far as you were aware, were you invited or asked to say what your involvement was or what you had seen or what you may have been concerned about at any review?

A. No.

Q. Child O. At paragraph 23, you tell us you were working nights. Tell us of your involvement with Child O and when you learned of Child O's death and how you felt about that?

A. So for Child O I was on the night of 22 June 2016 and I was working as a middle grade doctor, so on the Registrar rota.

"At some point in the night, I don't remember the exact time, Sophie Ellis, who was the nurse looking after Child O, requested a review of Child O's abdomen because it was mildly distended. Although she was not

worried about him, she felt he looked slightly uncomfortable. When examining Child O I could feel that his abdomen was soft although it was slightly distended, he wasn't uncomfortable. This would be a common finding in a child on high flow nasal cannula oxygen and I wasn't particularly concerned about him. As I finished examining Child O and left his nursery, the emergency bleep went off and I had to immediately attend to that. I realised that I didn't have time to document my findings and so I quickly told Sophie what I had found and asked her to document the information in her notes, ie what I had found, and then I left to attend to the emergency."

I subsequently found out about Child O coming back for the following shift the next evening, I did originally believe that that was with a -- with --

Q. You weren't sure who told you about it originally, were you?

A. No.

Q. So, leaving aside who told you about it, what were you told when you came back on shift to -- how did you learn about it, what did they say?

A. So what I was told was that Child O had deteriorated during the day and suddenly there was a concern about NEC and that the child --

Q. Sorry, we are losing you there a bit. You say you returned, you learned there was a concern?

A. About NEC, and that the child had deteriorated very quickly.

Q. And you say at paragraph 26:

"... 'I had a brief conversation with Sophie where I expressed my shock at what had happened. Sophie also agreed that he had been fine for the rest of the previous shift and she stated she was also shocked at what had happened'."

A. Yes.

Q. You can't recollect further details other than what you have said previously to the police and what you have repeated in part now. So can you remember how you were shocked or why you were shocked?

A. I was shocked because nothing seemed unusual on that nightshift and with the initial concern about NEC that wouldn't normally fit in that kind of timeline.

Q. You then go on in your statement to speak about Child P and your involvement with him on that next night. Tell us about that.

A. So in terms of my involvement with Child P, received a call from one of the nurses in the neonatal unit but I don't recall who it was. There was a concern about a large amount of milk being aspirated from the

nasogastric tube. This was a relatively common occurrence normally. There was no other concern about Child P at the time.

But given what had happened to Child O and that these were triplets, I thought that the best thing to do was stop all the feed and start some intravenous fluids to replace that.

Upon arrival in the neonatal unit, my crash bleep went off indicating an emergency was taking place and as I was standing in the corridor I checked with the nurse who was there at the time to see how the triplets were doing and they told me that apart from the aspirate, they were otherwise fine in themselves and I knew that I didn't have time to review them so I asked them to put in place the IV fluids.

Q. So did you have any cause to be clinically concerned about Child P that night?

A. With the exception of what had happened with Child P's sibling, no. The -- and the child was otherwise well and checking back during the night, I think I called from Resus to the neonatal unit, things seemed to be going okay since and everything had been settled and blood gases had been fine up to that point. So no, I didn't have a reason beyond that to be concerned. I think Dr Gibbs to the best of my

recollection had started antibiotics which would be the other -- the other thing to think about, but that was already covered.

Q. When did you learn Child P had died?

A. Again coming back on the next nightshift I learned that Child P had passed away, had died.

Q. Are you all right, Dr Mayberry?

A. Yes.

Q. So paragraph 34, you say:

"I felt devastated, shocked and bewildered. I felt and still feel deep sadness for the two babies involved and their parents. I had only been doing two and a half years of paediatrics but I hadn't come across anything like this. Triplets are rare and I thought they must have had some sort of common genetic or gut problem.

"I remember those present being in a state of shock, deep sadness and bewilderment."

Who did you speak with on the day of learning of P's death when you say you remember shock and bewilderment? The Inquiry has heard evidence from a number of people in written form and orally, but who were you talking to about that?

A. I spoke to Jess Birkett I remember about it and she was probably the main person I spoke to at the time about it. I don't recall who else I spoke to but

I remember the atmosphere in the handover room was distinctly different to how it normally was. People were normally fairly chatty and bubbly but there was a lot of quiet and a lot of upset.

Q. Can we have document, please, Ms Killingback of INQ0004891, page 1. This is an email from Dr Brearey to you, Dr Mayberry:

"You reviewed the triplets' care and I think at least Child O and probably Child P will go to an inquest. You may be asked to produce a statement for the inquest. It is probably best to get it ready now rather than wait six months when they ask you and it is not fresh in your memory. I can help with format et cetera if you need help. Dr V and Dr U are doing the same and have the notes. I can let you know when they are finished with them."

Did you ever get the notes -- that can come down now, Ms Killingback, thank you -- and did you ever do a statement?

A. I didn't receive the notes. So I was aware that Dr U and Dr V -- sorry, from what I recall, had the notes at the time and they were the people who were preparing a statement.

I was also keen to prepare a statement but the notes never appeared. I did ask for the notes again but

at the point where I asked them further and people went to look for them, they said that they had gone to the Coroners already and I believe I discussed it again at a later point with Dr Brearey in person, not via email and to say I have tried to get hold of the notes but they don't -- we don't have them and I think his -- at the time he said I think it's very unlikely that you were likely to be called about this given that you weren't there at the point where they deteriorated, so not to worry too much about it.

Q. Were you aware at that time whether there were suspicions or not about a particular member of staff being involved in causing deliberate harm to babies?

A. No.

Q. How well did you get on with all of the nurses on the unit?

A. I got on well with all of the nurses, I didn't have, as far as I am aware, any problems with any of the nurses.

Q. On 30 June 2016, we know from a text message sent from Dr U to Letby -- sorry, from Letby to Dr U. Letby says:

"Had a nice chat with Huw, said I should go for a Band 6 and take the unit forward, I am one the nicest nurses he has worked with."

Can you remember saying that to Letby at any point, encouraging her in her career and saying she is one the nicest nurses you have worked with?

A. I don't -- I don't recall specifics at this point in time. She wasn't somebody who outwardly -- outwardly she appeared to be a competent nurse who when you asked for things, you know, she did them and she wasn't somebody who appeared, you know, incompetent and she generally had a fairly friendly demeanour towards other members of staff.

Q. Did you ever have any suspicions or concerns yourself about her?

A. No.

Q. Were you aware whether others did?

A. I don't -- I think I have written in my statement about the only other occasions. One was -- sorry, I just need to make sure I refer to them by the right acronym -- Nurse ZC who worked in the paediatric ward who had told me that Lucy Letby had been her student and that she hadn't seemed particularly engaged, I think was the -- was the term that she used and she asked me how she was getting on. I guess the only other conversation was the deputy ward manager in the paediatric ward had mentioned, and I think this was after -- I can't remember the exact time but I believe

it was after the issue with the triplets, that Dr Brearey had thought that Lucy Letby was a bit odd and that the fact that both the triplets had died was a bit odd.

That's the extent of everything that I recall being said.

Q. So what's the name of the deputy ward manager, can you remember who you are talking about there?

A. I -- I don't know if they have an acronym which I should refer to as in a -- the name, am I allowed to say their name in full, as in I don't know if they have -- if they have an anonymity.

Q. If you -- you can let us have the name afterwards, okay, so we can take the name from you via email.

So the deputy ward manager, someone spoke to you, but this looks as though that was after O and P had died because it's a reference to what Dr Brearey said, yes?

A. Yes.

Q. What about Nurse ZC, was that at an earlier stage that she said as a student Letby hadn't seemed engaged and what did you think of her in effect.

When was that conversation with Nurse ZC?

A. The truth is I can't remember the exact time it was. I believe it was probably earlier than that,

but I couldn't tell you an exact time, sorry.

Q. You tell us in your statement at paragraph 46:

"In terms of investigations, neonatal deaths were not investigated by doctors at my level."

You weren't invited to provide a statement or comment, just for internal review about the deaths of O and P. So was the first time you provided anything in writing to the police?

A. Sorry, could you repeat the last part?

Q. Was the first time you provided anything in writing about your care of the babies to the police when you did a police statement? Had you written anything before then?

A. No.

Q. Nothing. Because we have seen Dr Brearey say while it's fresh in your mind, write stuff down. But that for one reason or another didn't happen.

A. Yes.

Q. Paragraph 59 of your statement, "Speaking up and notification of police and other external bodies".

You have had some training on the Sudden Death in Infancy process but you say:

"I do not think it was sufficient to deal with the situation which arose at the Countess. I did not receive any training on Child Death Reviews."

Are you talking historically when you say you hadn't had any training on child death reviews or now? Just expand on that paragraph, if you can.

A. Predominantly historically at that point in time.

Q. When you say you have now had training on the Sudden Death in Infancy process but you don't think it is sufficient to deal with the situation, in what way was it lacking?

A. I think much of the Sudden Death in Infancy process is focused externally. Much of it is focused on children who die in the community and come into hospital either moribund and about to arrest or arrested and dead.

There doesn't appear to be a sufficient -- a significant proportion of much of the SUDiC process which is associated with what if a child dies unexpectedly as an inpatient in hospital.

Q. In terms of that not just with your experience at the Countess of Chester, how comfortable would it feel to express concerns about a colleague that they are causing deliberate harm in some way?

A. I think in my experience that's probably changing a lot over -- over the course of my career and training.

I think that -- I think it's becoming more common to speak up and to voice concerns as -- as things go on. I think that is -- is changing as a process.

Q. In what way?

A. I think it's -- it's encouraged more now to than ever to speak up for when you see things which aren't right or if you are worried about a process. And I think people of my level, as in my experience and below, feel more empowered and encouraged than before to speak up when you are not happy with a situation.

Q. I mean it sounds from what you said about Nurse ZC she was trying to do exactly that; just check in with you if you had any concerns. She just says, "I didn't find her engaged. What do you think?"

Did that conversation, as it took place, feel an appropriate conversation, someone just sharing concerns or did it feel something out of the comfort zone what you were being asked there. How did you receive that?

A. I think it was somebody who was wondering about how somebody who was their trainee had progressed and whether they were somebody who had become more engaged with time and as they got more interest in the job and took on more. I think that was probably the context in which I took it.

Q. So you didn't think it was a deeper request,

"Are you worried about anything else?" Just if they are engaged properly?

A. Yes.

Q. We asked everybody including you, Dr Mayberry, thank you for providing them, for reflections and comments.

On CCTV, you say effectively you don't think it would have been effective or halt what she did, paragraph 64 and 65, and you don't think CCTV would necessarily be effective.

A. I think -- so there is a number of aspects to the CCTV question. One is I am not sure it would have dealt with a lot of the ways in which she killed people and it may have given false reassurance that things were right and I think in my statement I particularly reference the point of her injecting air into -- into children's bloodstreams. I think --

Q. What you say there, just to make that clear for those who haven't seen that paragraph, you say -- well, expand on that because it's hard to tell. You wouldn't be able to tell looking.

A. I think -- so -- so in terms of if you look at syringes that are used to give children medications, one of the common syringes is a 1ml syringe, which is often made out of glass, and at the point where that is filled

with fluid sometimes it can be really hard to tell looking directly at it is there fluid in this or, you know, is it misfilled with air?

So part of my job in what I do now as a paediatric intensivist is that sometimes I have to provide anaesthetics for children having procedures done on the unit and I'm responsible for administering those medications.

So I would always check that you could see that there was -- that you could push fluid to the end of the syringe and coming out of the top of it before you -- before you gave that medication to a child to make sure that it was all okay and that there wasn't any air in it.

But I am not sure if you would be able to tell from a digital image further away in the same way that you, you know -- if you are doing that check because if you are looking at it really closely you still might not be able to tell whether there is air or fluid there.

I think the other thing that has crossed my mind since I wrote that statement is that at the time when all of this happened the Countess was very short-staffed on the medical rota and in order to provide, undoubtedly what needs to happen is further oversight and overview in some way. But you also need to have staff present

who can do those investigations who have the time and I think having safe staffing has got to be an integral --

Q. Sorry, I missed that. Have a safe ~...?

A. Having safe staffing, sorry.

Q. Safe staffing.

A. It's got to be an integral part of making sure hospitals and units are safe and you will be able to do further investigating and more safety checks when you have sufficient staffing.

Q. What sort of staffing for babies in intensive care? Do you think one-to-one nursing is enough or it should be two-to-one, two nurses to every patient?

A. I am probably -- I am probably -- I think one-to-one is the ratio that has normally been used in both neonates and paediatric intensive care units.

Part of it is about -- so you should always ensure I think that there is a minimum of one-to-one as best you can.

But it's also not just about the numbers alone. I think it's about having experienced people who are present and experienced people who can look and say: wait, what's going on there? And: what are you doing there? And wondering, and -- and can raise suspicions from that point of view.

When you are continually stretched as a service, as this service was I think back then, it's increasingly hard to pick up on smaller things which are happening which may be untoward.

Q. Are you aware whether some of the neighbouring hospitals had advanced neonatal nurse practitioners operating on the intensive care units and is that something that you are referring to when you say greater experience of people?

A. I think -- I think neonatal nurse practitioners are very helpful in that they have a lot of experience in neonates and they are somebody who is there as a constant on a unit. Doctors will often rotate round to build up their experience in different hospitals and different areas.

But having a member of staff who's there constantly, who knows the practices of the hospital inside out and has that experience over time in the unit, would be helpful.

Q. So stability and consistency within a unit?

A. Yes.

Q. You set out at 67 a number of recommendations you think would be beneficial.

Your first is a broad cultural change within the Ministry of Health and executive boards mandating that

concerns of senior clinicians are listened to and that patient safety is prioritised over all else.

Would you like to expand on that?

A. Yes, sure. I think with regard to that comment what -- maybe what I haven't said explicitly there is that the level, firstly, the level of staffing wasn't sufficient; certainly at a Registrar level and that while it seemed from my level like the Consultants were trying to improve that situation how much engagement there was further up, I am not entirely sure and that's probably a question I guess for them.

Certainly the thing about locum caps and things like that it wasn't a particularly safe initiative to -- to drive down the supply of doctors looking -- looking for locums.

And I think the last thing I am referring to in it is probably whether it's been broadly publicised now of Consultants raising their concerns at an earlier point in time. From what I can tell in what's been written in the media felt that that wasn't addressed in sufficient time.

Q. You also say:

"In cases where clinicians feel they are not being listened to by the board, they should be encouraged to 'break the glass' and contact police directly"?

A. Yes.

Q. You say things are changing. Do you think the culture now as a doctor, would you feel able or unable to do that if you were sufficiently concerned or suspicious of the conduct of another member of staff?

A. I think the GMC in its guidance does say that people should be protected in terms of raising concerns. I think it probably now has shifted more and more towards people being -- feeling like they are more protected if they do raise concerns.

Q. You say there should be education for staff on how to spot concerns where another member of staff is harming patients. What kind of education are you referring to there? Something different from medicine training, which obviously you all have. What is it?

A. I think that there is some guidance into I don't know whether -- I think that there is some guidance into how people can pick up on things which are untoward with other staff members in terms of them doing other things. If there is some learning that can come out of this Inquiry and other things of things that you can -- might be identifiable in those patients then that should be widely disseminated.

Q. So heighten awareness of other attributes?

A. Yes.

Q. Characteristics that people might need to be more vigilant about?

A. Yes.

Q. You also say:

"Consideration should be given to mandating the presence of security systems relating to drug access in neonatal units."

What are you particularly referring to there?

A. I think a lot of units now have electronic security systems relating to dispensation of drugs, so that you know who is accessing those drugs and they have to provide their, you know, thumbprint or whatever to get access to the drugs.

I think in terms of things like, you know, insulin and -- which Lucy Letby was convicted of putting into TPN bags that that would have provided more evidence if -- if that was something that had had to be released from -- from an electronic system.

Q. Dr Mayberry, those are all my questions.

Is there anything else you would like to add or supplement to your evidence thus far?

A. So there is nothing I think from an evidence point of view. Just I would like to express my deep sorrow to the families who were involved and I can't imagine what they have had to go through.

Questioned by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Thank you very much indeed, Dr Mayberry. We can see how much you have thought about this over a long time and thank you.

There was just one point I just wanted to clarify with you if I may, when you were talking about the possibility of having some training so that people could pick up signs in relation -- and you spoke a lot about -- in a few sentences about things that may be untoward with other staff members.

Then you went on to say if there is some learning that comes out of this Inquiry or other things that you might be able to identify in patients then that should be widely disseminated, and I just wanted to make sure that I had understood that correctly.

So, on the one hand, flagging behaviours by staff, for example, but then did you mean to say something about patients?

A. Staff. Sorry, I -- I think staff was probably what I was referring to.

LADY JUSTICE THIRLWALL: No, I completely understand. We all use the wrong word, some of us quite frequently.

But anyway, thank you very much indeed, also for your other reflections and for being with us this

afternoon.
Thank you. You are free to switch us off.
THE WITNESS: Thank you.
LADY JUSTICE THIRLWALL: Thank you.
MS LANGDALE: My Lady, can we resume at 3.35? We will still complete the evidence in good time this afternoon.
LADY JUSTICE THIRLWALL: All right. So we will rise now until 3.35.
(3.08 pm)
(A short break)
(3.36 pm)
LADY JUSTICE THIRLWALL: Ms Langdale.
MS LANGDALE: May I call the next witness.
DR CASSANDRA BARRETT (affirmed)
Questioned by MS LANGDALE
MS LANGDALE: Can you give us your name and qualifications, please.
A. My name is Cassandra Barrett. I am a paediatric general paediatric Consultant. I gained my CCT last year in the summertime. I have a special interest in respiratory medicine.
Q. Dr Barrett, you provided us with a statement dated 28 June 2024. Have you got that with you?
A. I do, yes.

Q. Can you confirm if the contents are true and accurate as far as you are concerned?
A. Yes.
Q. We see from this that you worked at the Countess of Chester between March 2016 and September 2016 as an ST1?
A. I did, yes.
Q. You followed that -- you then went on to Liverpool Women's Hospital and your supervisor there was Dr Yoxall?
A. That's correct.
Q. You are the last of four Registrars to give evidence today. I think you have heard the evidence of the last two?
A. (Nods)
Q. Can you just briefly tell us, what stage were you at at the ST1 stage?
A. So this was the first year of my paediatric training, so although it's termed an ST1, this is often called a SHO, so a senior house officer. So I had done a placement in paediatric A&E at Alder Hey Children's Hospital and then rotated to Chester Hospital.
Q. So just got going?
A. Just got going.
Q. You probably -- I don't know, did you know

Dr Lambie or Dr Ogden?
A. I did not know Dr Lambie, I had met Dr Ogden at a previous placement I had done.
Q. So did you know Dr Ogden at the time when you were working at the Countess or did you know her subsequently?
A. I think I had met her before but she wasn't somebody I was in regular contact with.
Q. I won't take you to the same bit, you have heard me read out how Dr Ogden says in June 2015, that she had found:
"... the numbers of collapses or deaths on the unit at that time as unusual and concerning. I am unsure specifically when this appeared to me as unusual but it is likely to be around the time of several of those collapses/deaths that occurred within a few weeks of each other in June 2015. Whilst I do not recall that I specifically approached any Consultant in particular to raise specific concerns I believe the whole department was discussing this informally as being unusual and that the senior Consultant team were raising this and investigating what could have caused this."
Did you ever have a chat with Dr Ogden or did she ever say anything to you about that?
A. No, I hadn't spoken to Dr Ogden about it. All

the feedback I had had from other trainees was very positive about the department.
Q. So when you went there so in March 2016, had you had feedback then from other trainees?
A. Just when you told people what placement you were going to next they would say: oh, that's a lovely place to work, you will have a really good experience.
Q. Is that the medical grapevine, people who have just qualified and know each other?
A. Yes.
Q. Or the people still working there or were they round and about in the vicinity?
A. This was the people that I was working with at that time, so different levels of doctors who had worked there before.
Q. When you went on to go to Liverpool Women's Hospital, what were the differences you noticed between the two hospitals, if any, and particularly their neonatal units?
A. So the neonatal unit at Liverpool Women's Hospital is significantly bigger. They have got many more cot spaces. As it is an intensive care department they have more staff, you just solely cover the neonatal unit and not cross covering between paediatrics and neonates.

Q. When you say "more staff" how does that work for the baby? So in the neonatal intensive care set-up how many nurses would be looking after a baby at Liverpool and how many in Chester?

A. I believe it was one to one and then there would be a shift leader as well that would have an oversight of the unit too.

Q. So in Liverpool one to one shift leader. What about in Chester when you got there?

A. I can't remember fully because I have only worked there for six months, whereas I had done a whole year at Liverpool Women's and that was more recently. I believe in the higher intensity room it would have been one to one but I don't know for definite.

Q. And a shift leader as well or you don't know? Best to ask the nurses?

A. I don't remember that, sorry.

Q. You heard Dr Mayberry giving evidence earlier about the position for registrars and locums and Chester's approach to that. Did you hear that evidence?

A. I did, yes.

Q. Does that accord with your experience when you were there in 2016, that it would have been helpful to have more Registrars?

A. I think I remember that there was a shortage

of Registrars but we had a good group of Registrars that were very supportive. I don't remember there being a shortage on the rota that I was on, the SHO rota.

Q. You don't know whether there was an issue of getting good locums, it is not something you were sighted on anyway --

A. No.

Q. Culture and atmosphere. You say at paragraph 8 of your statement the lead Consultant during your period working there was Dr Brearey. How did you get on with him?

A. I would say we had a good working relationship. He appeared to have a very detailed knowledge of neonates and it was clear he was the lead and his presence was often felt or requested at times.

Q. Dr Mayberry said he encouraged learning via the materials that were available to you all. Did you do that?

A. Yes, he did. I think Dr Mayberry probably had a closer relationship with him as the paediatric Registrar that would have been doing lots of the procedures, at times I was more there observing.

Q. Dr Brearley also had a conversation with Dr Mayberry, you heard, about the mortality rates. Did he have that conversation with you at any point?

A. Not that I recall.

Q. Were you aware of that? It is clear from Dr Ogden and Dr Lambie and Dr Mayberry people were being made aware of a raised mortality rate or concerns about that. Were you ever made aware of it?

A. That wasn't something that was discussed amongst the SHO body that I was part of.

Q. Okay. Did you have discussions with nurses or anyone about that?

A. No, not that I can recall.

Q. You heard Dr Lambie say again she was more senior than you, wasn't she, but she had seen nurses in a group and had a discussion with them about that issue. Did you ever have such a discussion with nurses or Consultants or anyone else?

A. Not that I can recall.

Q. You said the medical professionals appeared to have a good working relationship with all members of the MDT. Does that mean multi-disciplinary team?

A. Yes.

Q. So who is in the multi-disciplinary team?

A. So that would be the doctors, nurses pharmacists, any of the ward clerks and cleaners. Everybody that is on the wards at the time.

Q. Okay. You say you had no contact with the

managers. Did you know who they were? Would you know who the board was or the managers?

A. No, no.

Q. Did you get much patient contact?

A. On the neonatal unit?

Q. Yes. So our shifts were slightly different to the Registrars so we covered either a long day or short day on the children's ward in A&E and then there was the neonatal unit, but we would go to the deliveries and call for a Registrar if needed and spent a lot of time on the postnatal ward doing newborn baby checks. So we would aim to be on the neonatal ward round alongside the Consultants and the Registrars.

Q. And how frequently were the Consultants doing the ward rounds, as far as you remember?

A. I can't recall this. I do remember that on a weekend they didn't go every day because they were covering paediatrics and neonates and I didn't think that they were there every day on the neonatal unit either.

Q. But in the week you think so?

A. I don't recall them doing a ward round every day on the neonatal unit.

Q. So who did you go to if you were particularly concerned about a patient then?

A. The paediatric Registrar.
Q. Then the paediatric Registrar can contact a Consultant if they wanted to?
A. Yes, yes.
Q. Were you ever aware of that system failing and not getting hold of a Consultant?
A. No, that was never something that I had seen witnessed on my shifts.
Q. You set out at paragraph 15 your involvement in the care of Child M on Saturday, 9 April and as you know Letby was convicted of the attempted murder of Child M and his twin brother, L, on 9 April.
Can you tell us, as you do there, you set out your involvement with Child M?
A. So I had been upstairs on the postnatal ward and remember coming down and using the computer and as I was on the computer I heard a shout from Nursery 1 for help and as I entered the room the child was in full cardiac arrest receiving full resuscitation.
My role was then to assist with the resuscitation whilst Dr Ukoh, the paediatric Registrar, was leading the situation and Dr Ravi Jayaram arrived after he had been called from home.
Q. You say in your statement:
"I didn't have any concerns about M's deterioration

as I had not been involved in Child M's care that day prior to the deterioration."
So you didn't have any understanding of what was happening?
A. No.
Q. You were a responder in that situation?
A. That's correct.
Q. And with others more senior than you taking the lead?
A. Yes. So Dr Ukoh had done the paediatric ward round that day so he had already seen the baby and knew the case, so he was leading.
Q. Are you aware whether there was any consideration of completing a Datix in relation to this event or not?
A. I didn't hear it mentioned.
Q. Did you know at that time what a Datix was?
A. Yes, I did know what a Datix was.
I think my understanding of a Datix and when to complete is has probably increased throughout my training, but it is something that even at our very junior levels we do know about.
Q. What did you, at that time, think a Datix form was about?
A. I thought it was there to document, well, to

record any errors that had happened, whether that be a prescription error or the wrong drug being given to the wrong patient, and any potential near misses as well as that -- any breaches of confidentiality too for the case to be reviewed.
Q. Would you have thought any unexplained event should go on a Datix just because you didn't know what had happened or not? Would that fall into the category?
A. I don't think that would have fallen into the category for me at that time, whereas now it definitely would.
Q. Now it would?
A. Now it would.
Q. What's your understanding now as you sit here about the importance of Datix or what's supposed to be recorded there?
A. So now as a paediatric Consultant we have -- all of the Datixes in our Trusts are sent to us so therefore we attend the meetings where these cases are discussed. It's useful to pick up any learning points and to see if there is anything that can be changed or made different and to get input from all the different members of the multi-disciplinary team that attend that meeting. But it picks up on themes.
Q. Did you ever, when you were at the Countess of

Chester, see a nurse or a doctor or anyone fill in a Datix or hear them talking about that?
A. Not that I can recall.
Q. No. Did you have -- we heard again Dr Mayberry talking about induction. Did you have induction at the beginning of your training on any issues?
A. So we would have been at the same paediatric induction.
Q. Okay. So you had the same warning of a fine for the handover note?
A. I actually don't recall that, but obviously Dr Mayberry does.
Q. What do you recall being trained about?
A. I have been to so many inductions that I can't specifically say what was in that induction.
Q. Do you think child protection or safeguarding was one of the topics, can you remember now?
A. I can't remember now, but it often is. On every rotation that we do it's part of it.
Q. Do you share Dr Mayberry's observation that it would be useful to know as a doctor what might assist you to spot when those around you might be deliberately harming children?
A. Yes. So I think at the paediatric ST1 level

I was, I didn't have any knowledge about Beverley Allitt. So I think if -- if that was openly discussed and themes came out that were -- and how they picked it up and what she was doing that might then help to trigger us to think about it in complex situations.

Q. So by the time you were working there, you didn't know about that case or the misuse of insulin and all of --

A. No.

Q. -- the other things the Beverley Allitt case tells us about?

A. No.

Q. When did you first learn about that case?

A. I think it was after Lucy Letby's case came to the press.

Q. One of the recommendations that followed the Beverley Allitt case, there was an Inquiry into that, and one of the recommendations was that there should be a heightened awareness of that case and what the nurse had done in that case. From what you are saying, that doesn't seem to have translated through to the NHS, does it, at --

A. No.

Q. -- your time of working?

A. No.

Q. You were at the hospital when Babies O and P were -- died and Letby subsequently found guilty of their murder.

Can you remember when you were first told about the death of O and P?

A. I was on shift the day that Baby P died but I wasn't covering the neonatal unit. So that's how I had heard about it happening.

Q. How many people expressed surprise or upset? Tell us what the atmosphere was.

A. I think generally after the death of any child, expected or unexpected, there is often a feeling of sadness amongst the team and it would be evident that something had happened to upset the team.

Q. Nurse Lightfoot, as you know, says that she recalled when there was a set of triplets and two of the siblings died on consecutive days:

"I cannot be date specific but I walked past Dr Barrett in the corridor and she spoke directly to me and said words to the effect of 'Nurse Death's on again.'"

You tell us you did say that.

A. I did say that at the --

Q. Do you know when you said that, which day or what --

A. I can't remember exactly, but I think it might have been the days after the second triplet had died when I had been allocated the neonatal unit to cover.

At the time of saying that, I didn't have any awareness about the suspicions amongst the Consultant body with regards to Lucy Letby actively causing harm. Never did I think the unthinkable, as we have mentioned earlier in the day, that somebody would be going to work to actively harm babies that we were going to work to help.

Q. What association had you made about her though to say "Nurse Death is on again"?

A. I had noticed that she was there at a couple of the unexplained collapse and child deaths.

Q. So O and P.

A. P.

Q. Or others?

A. Not sure about O, and the baby that we discussed earlier. So I had noticed she was there, but I thought that was more of bad luck rather than her being the causative agent.

Q. Was that the first time you said that to someone in the hospital?

A. Yes.

Q. Had you been thinking that before because --

A. Not --

Q. That she was associated with events that were concerning?

A. Not that I can recall. I think having to go to the neonatal that day I was -- the neonatal unit, I was anxious and it was a comment that I made but it wasn't something that I was regularly saying.

Q. I think another nurse and Nurse Lightfoot says that Nurse ZC may have been involved in that discussion with you, but you don't remember that?

A. No.

Q. Do you remember saying it to Nurse Lightfoot?

A. Yes.

Q. Were you saying it to her or did she hear you saying it?

A. Yes.

Q. Was it a direct conversation with her?

A. A direct conversation.

Q. You are confident about that?

A. Yes.

Q. And what was her response to you when you said that?

A. She didn't respond.

Q. Did anyone after that come and speak to you -- anyone, Dr Brearey, a manager, anyone -- and say, "You

shouldn't be saying that about a colleague."
A. No.
Q. "And we know that you've said it", or not?
A. Not that I can recall.
Q. And it's not something you said to other doctors or you generally spread about the unit, if I can put it that way?
A. No.
Q. Did you know the number of deaths on the neonatal unit between 2015 and 2016?
A. No.
Q. Did you know how many unexpected or unexplained deaths had happened on the unit?
A. No.
Q. How many deteriorations or collapses of babies were you aware of? You were obviously aware of O and P, you have told us that, but they are babies murdered.
What about babies that had collapsed or deteriorated, did you know about any of those other than M?
A. So I can remember being on night shifts particularly with Dr Mayberry where there would be an unexpected collapse. But I had never done neonates before to know whether that was normal or not normal to happen.

Q. Was that the one he was talking about today?
A. I don't know because I've not seen the notes, sorry.
Q. Right. So you had been present for another night shift unexpected collapse?
A. (Nods).
Q. And you had learnt of the deaths of O and P?
A. Yes.
Q. Did you know, as Dr Mayberry knew, that there were described as investigations but the RCPCH completing a report in relation to the unit, did you know about that?
A. I think I learnt about it after I had left the neonatal unit.
Q. Who told you about it after you left?
A. I am not sure whether it was Bill Yoxall, who was then my clinical supervisor at Liverpool Women's Hospital.
Q. Yes. So he was your supervisor as we highlighted earlier in September 2016 to March 2017.
Did Dr Yoxall when you were working at Chester, did he go between the hospitals at all? Did you see him in both hospitals or just when you were --
A. No, I never saw him at Chester Hospital.
Q. So what did he say to you when you were there

at Liverpool about what had happened?
A. So as part -- every placement that we start with our new clinical supervisor, we would have a meeting and they discuss where you had been on your last placement and obviously he had an understanding at that point of the increased number of deaths and unexplained collapse. So he just acknowledged that I had been in Chester and that it had been a difficult time.
Q. So he's taking -- you are coming to the hospital, he is your supervisor, and he says, "I know you have had a difficult time, there has been collapses and deaths at Chester"?
A. Yes.
Q. He says that at the beginning in September 2016, does he, when you first go there?
A. Yes.
Q. So you understand him to be aware of what is going on in Chester at that point?
A. Yes.
Q. Did you speak of the earlier collapse that you say you knew about in the night of those sorts of events to anyone in the children's unit or elsewhere?
A. Not that I can recall.
Q. There must have been conversations though,

mustn't there, between the wards about what was going on? These are upsetting events, aren't they? We can see that.
A. Yes.
Q. So normal conversation might lead one to relay what's happened the night before or the day before?
A. Yes, and I think there were those conversations and, like we have heard earlier, you know, within handovers you would find out what had happened the day before. Because overnight and on an evening, the doctors would cross-cover paediatrics and neonates. The nurses might have said on the neonatal side, "Oh, the doctors were busy last night on paediatrics" or vice versa.
Q. You heard Dr Lambie this morning -- it may seem a long time ago now -- was saying that by September 2015, the thought of someone causing deliberate harm had crossed her mind. Indeed she was speaking with somebody who she trusted outside of the hospital.
When did that thought cross your mind? Don't worry about comments and what they might have meant or not. Just honestly reflect. When did you think about that?
A. When Lucy Letby was taken off clinical shifts and we noticed a difference.

Q. So when she was moved from the ward to working in the risk units.

Are you okay?

A. (Nods).

Q. You noticed a difference. Do you want to expand on that?

A. It became evident that there was less deteriorations and less cardiac arrests.

Q. Did you discuss that with colleagues at that point?

A. (Shakes head).

Q. You just held that view?

A. Yes.

Q. Had you been told not to discuss her with colleagues? Was there any sense that you couldn't do that because there was other stuff going on, you know, she was being moved around the hospital?

A. I don't think we were specifically told not to discuss it. I think the Consultants recognised that it was a difficult time for everybody that had been involved, but I don't recall them asking us not to discuss it.

Q. Did you know what the managers' involvement was, if any, at this time or that was nothing to do with you?

A. No, nothing.

Q. That was the consultants?

A. Yes.

Q. You tell us in your statement at paragraph 42 when you were at Countess of Chester you did notice there were frequent deaths on the neonatal unit:

"~... but this was my first exposure to neonates and therefore I didn't realise that the deaths were beyond what would be expected."

Were you aware at the time it wasn't that there were deaths; that they were unexpected deaths and people were surprised by them? What sense of that did you get when you were there; that these weren't babies that people thought were going to die?

A. I think it was clear that they were unexpected because people would often afterwards be sat down trying to think about any potential causes, looking solely for medical causes.

I specifically remember with the triplets everybody was thinking of different metabolic conditions, how they are inherited, could there be any genetic predisposition for those babies as well.

But you could tell people were surprised.

Q. And people, no doubt we've seen evidence of this, started worrying if they had done something wrong.

You know, maybe they'd put the long line in the wrong place, maybe they had done something different. Was that the atmosphere, that people got very worried about everything?

A. I think naturally as doctors we always worry if we have done everything possible that we can. So yes, it was, you know, it was --

Q. A tense time?

A. Yes, yes.

Q. You tell us:

"As a senior house officer, I was the most junior team member and I was not aware of the investigation process for deaths in the neonatal unit and what happened following the deaths or when postmortems were being requested."

I don't think you're alone there, Dr Barrett, at any age. But, what did you think at the time? Was there a discussion about that?

A. I do remember the Coroners being discussed and -- but I wouldn't know which patients were being referred to the Coroner.

Now I have a much better understanding of the SUDiC, Sudden Unexplained Death pathway and it's something that I have to use within my role. I don't remember that ever being discussed or used for these

babies.

Q. And at the time, did you understand that an unexpected death in hospital is an unexpected death the same as anywhere else and it triggers various referrals or was that just not something that seemed to be appreciated?

A. I don't think I appreciated that at the time.

Q. You say you don't recall attending any debriefs or discussions following clinical events for the babies named on the indictment.

Do you think there should have been debriefs or discussions between all those involved in the care to share observations and see what people thought?

A. Yes. I think debriefs have a really important role, not only for the kind of psychological well-being of all the staff that have been involved in these traumatic events but to try and pick up on any common themes or pattern recognition and look at how we can improve care for the future.

Q. You tell us you didn't turn to any professional body for advice with regards to events at the Countess. Did you feel supported by the Consultants there and generally did you feel like you needed help or advice from anyone else?

A. Yes, so the Consultants were very supportive.

I didn't turn to anybody particularly at the time because I didn't feel I needed any extra support than what they were already giving us.

Q. We have asked people about reflections or potential recommendations. You have heard me discuss a number of them today. One of them is CCTV perhaps in the incubators for newborn babies in neonatal units.

What do you think about that as an option?

A. So I think initially when I had read about the CCTV I thought it would be a CCTV camera within the room and I share the same feelings as Dr Lambie as, you know, with the families and breastfeeding, expressing milk, it felt like an invasion of their privacy but I think if it was in the incubator that seems like a good idea to me.

But like Dr Mayberry commented as well, it's difficult even on those cameras as to whether you would be able to see there was air in syringes or that it was insulin being given, not the saline flush.

Q. Do you have any other reflections about how the healthcare environment could be improved to avoid what's happened at the Countess of Chester happening again?

A. I think as I said before I had no understanding about the Beverley Allitt cases. So I think education around that and picking out any common

themes that have come up from -- from previous Inquiries and education even in medical school. During paediatric training we have a lot of safeguarding training but a lot of it is about parents causing harm to their child and we are very much skilled at recognising that but I don't feel like we are trained in how to recognise that another healthcare professional that you trust has been causing harm.

MS LANGDALE: Yes, thank you, Dr Barrett, those are my questions.

LADY JUSTICE THIRLWALL: Thank you very much indeed, Dr Barrett. It's a good job we didn't take a break because now you are finished.

Thank you for coming and in particular for your reflections as to what might help and also the way you have thought through, first of all, what a CCTV camera might do and also what it might be very useful for. Thank you very much indeed and you are free to go now.

A. Thank you.

MS LANGDALE: My Lady, that concludes the evidence for today and we have three Consultants giving evidence tomorrow.

LADY JUSTICE THIRLWALL: Very well. So we will rise now and we will start tomorrow at 10 o'clock.

(4.07 pm)

(The Inquiry adjourned until 10.00 am, on Thursday, 3 October 2024)

I N D E X