Thursday, 3 October 2024

(10.00 am)

LADY JUSTICE THIRLWALL: Mr De La Poer.

MR DE LA POER: My Lady, our first witness today is Dr Newby. May I ask her to come forward, please.

LADY JUSTICE THIRLWALL: Thank you.

DR ELIZABETH NEWBY (affirmed)

Questioned by MR DE LA POER

LADY JUSTICE THIRLWALL: Thank you very much, Dr Newby, it is not easy but now you have got the oath out of the way, do sit down.

A. Thank you.

MR DE LA POER: Dr Newby, can you confirm that you have given a witness statement to the Inquiry dated 4 June 2024?

A. I have.

Q. Is the content of that witness statement true to the best of your knowledge and belief?

A. It is.

Q. We are going to begin by briefly reviewing your medical career. You qualified in 1998; is that right?

A. I qualified from medical school in 95.

Q. You subsequently undertook paediatric training at a number of hospitals, including Alder Hey on

a number of occasions, Manchester Children's Hospital and Liverpool Women's Hospital?

A. Yes, that's correct.

Q. You joined the Countess of Chester Hospital in 2005 in general paediatrics and neonatology; is that correct?

A. Yes. Yes, I -- I did my final training post at the Countess in 2005 and then I became a Consultant there in 2006.

Q. So does it follow from that that you had more than a decade of experience working in the paediatric department and indeed the neonatal unit before June 2015, most of which time you were a Consultant?

A. That's correct, yes.

Q. Whilst you were working at the Countess of Chester, did you sit on the Medicines Management Committee?

A. I did.

Q. Now, a case that we have heard something about involved a nurse being convicted of murdering patients at Stepping Hill?

A. Mmm hmm.

Q. Was that something whilst you were at the Countess that you were aware of?

A. Yes.

Q. We know that that particular nurse was administering drugs as a weapon against patients?

A. Mm-hm.

Q. Did the Medicine Management Committee ever discuss that case that you can recall to talk about how there may be steps to be taken to put further protections in place for medicines?

A. No, no. I suppose the remit of that committee was to look at new guidance that was produced within the hospital that pertained to treatments which would include drugs, et cetera, and to discuss any issues around those drugs from a pharmacy point of view, procurement, supply, et cetera, administration.

Q. So management didn't include, for that committee's purpose --

A. No.

Q. -- risk management --

A. No.

Q. -- in relation to medicines?

A. No.

Q. Thank you very much.

Returning to your career, you left the Countess of Chester in February of 2016; is that right?

A. Yes.

Q. You took up a Consultant post at Stockport NHS

Foundation Trust?

A. Yes.

Q. At least as at the date of your witness statement, you were still there?

A. I am still there, yes.

Q. Is your role the Clinical Director of Paediatrics?

A. It is.

Q. I have already mentioned the Stepping Hill Hospital. That's the hospital within the Foundation Trust that you moved to in the spring of 2016?

A. (Nods)

Q. Although we are jumping in a sense to the end of our timeline here as we are dealing with your career, when you arrived at Stepping Hill it was less than a year after the nurse had been sentenced for using medicines as a weapon?

A. (Nods)

Q. Was that a topic of conversation within Stepping Hill at that time?

A. Yes, to some degree still, yes, it had been relatively recent, yes.

Q. When you arrived there and were among the people who were directly witness, many of them, to those events, did that provoke any thought process on your

part about the experience that you had just had at the Countess of Chester?

A. Yes, yes, of course. I -- the -- the case in -- in Stockport, I believe, there had been some a lot of evidence, there was insulin missing, insulin found, et cetera. There was a lot more procedures in place in Stockport around drug safety, lock -- you know, medicines locked away et cetera as a result of that, that incident.

Q. So I suppose one specific thought process that may have occurred to you, and you tell us whether it did, is I wonder if insulin was being used at the Countess of Chester and whether that might have explained the experience that you had just had. Was that a thought process that you had?

A. I -- at that time I didn't believe -- I didn't think of insulin, no.

Q. So we will come and have a look at the detail of each of the events at the Countess. But before we do, let's just deal with -- here it is paragraph 5 of your witness statement if you want to turn it up, so we are just going to deal with some particular matters relating to the arrangements and situation at the Countess of Chester.

The first matter you deal with is you talk about

the divisional structure and we have heard something about this already but in summary, the Inquiry knows that there came a point in time when the paediatric department was put in the Urgent Care Division and that resulted in it being separated in terms of the divisional structure from the obstetrics --

A. Yes.

Q. -- which was in Planned Care?

A. Yes.

Q. Just tell us from your perspective, whether you thought firstly that that change was a good thing?

A. No. We -- we were all quite concerned about it at the time because of the -- the obvious link between obstetrics and neonates and a lot of the need for shared risk and governance and being in two different divisions seemed to make that difficult, really.

Q. Was that something that you or any of your Consultant colleagues to your knowledge raised at the time?

A. I believe so, yes.

Q. Do you know with whom it was raised? Was it just raised within the division or do you know whether that concern went higher than that?

A. I don't know if it went higher.

LADY JUSTICE THIRLWALL: Where did the idea come from?

A. I don't know, to be perfectly honest.

LADY JUSTICE THIRLWALL: I'm sorry to ask you that out of the blue.

A. No, no it's okay. I think it was to -- I this is an assumption, but to sort of streamline the -- the number and layers of management tiers.

LADY JUSTICE THIRLWALL: Thank you.

MR DE LA POER: Speaking in general terms, do you think that divisional change made any impact, positive or negative, on how the events on the neonatal unit were managed and resolved whilst you were there?

A. I -- I think it -- I think it perhaps gave us less of a voice at the table higher up, if you like. When we were a separate division and we were Women's and Children, we -- you know, we were more equal in a way to the medical or the surgical division and then we got swallowed -- that's not really the right word, but swallowed up into Urgent and Planned Care and I think that probably made things difficult, yes.

Q. Staying with general matters of operation and practice. Just dealing very briefly with the debrief process that took place on the ward: you tell us in your witness statement -- you don't need to turn it up unless

you want to, and I will give you the reference if you do, but it was usual to have a debrief after a death but not after non-fatal collapses?

A. Yes, I suppose -- I suppose that would be the case. I -- I don't know if that would be the case now but I think that was, that was the case at the time, yes.

Q. Staying with the formal response to particular incidents, I would just like to ask you a few questions about the Datix system.

A. Mm-hm.

Q. In your own words, what was your understanding at the time about when it was appropriate to fill in a Datix form?

A. So if you were concerned that care hadn't gone as it should have done and there was something particular that you wanted to highlight, for example a drug error or an administration error or a piece of equipment that was faulty during a resus situation which would have impacted on the teams' ability to manage that patient.

Q. What about being specific here. If there was a sudden and unexpected death on the neonatal unit but there weren't any identified at the time, errors of care, would that serious event in and of itself prompt

a Datix?
A. Yes, it would, yes. Yes. Certain serious events would produce -- would always produce a Datix anyway because whether there was anything apparent at the time, it may be that things become apparent when that case is reviewed.
Q. What about where there is a very serious but non-fatal collapse, perhaps requiring resuscitation. Was that a sufficiently serious event that it could prompt a Datix even if there was no error in care or potential error in care identified?
A. I think that would probably be a little bit more of a grey area. Some people might say yes, some people might say no.
Q. Had you received any formal training and refresher training about the filling in of Datixes or was this just a culture that developed and feeding off your colleagues and seeing what they did?
A. Yes, it was something that we -- we did in our every day practice. The Datix system is clunky, I think is the right word. It -- in filling in a Datix it can be quite difficult to do it because the system only allows for a number of drop down boxes and you have to kind of put your incident into a category and sometimes you think, well, the category doesn't exist for this

incident.
So it's -- it can be quite a difficult system to work with sometimes.
Q. Whose responsibility did you understand it to be to fill in a Datix when an event requiring one occurred?
A. So if it -- so it's everybody's responsibility to submit and fill in Datix at the end of the day if they have flagged up something that's of concern. But I suppose things like deaths which were serious incidents, they -- it would tend to be the shift leader or the nurse in charge after the -- after the death because the -- the medical staff and the nursing staff were -- were busy dealing with the aftermath and so on.
Q. In your experience, was there any co-ordination between people who were involved in an instance where a Datix might be needed to say "This is going to need a Datix, would you mind being the one to fill it in or will you make sure that one is filled in?"
Did that sort of conversation happen or was it just assumed people would go back to their places of work and some or more of them may fill in such a form?
A. No, we would have just expected that would have happened because it was -- it was a mandatory reportable Datix.

Q. But you would have expected the nursing staff or the nursing managers to do it --
A. Yes.
Q. -- rather than it being your responsibility in that situation?
A. Yes.
Q. Dealing with relationships within the department and you deal with this at your paragraphs 16 and following if you want to turn it up. That's on page 4.
A. Mm-hm.
Q. You say this:
"I felt that, as a group of Consultants we had a good relationship with the paediatric and neonatal nursing teams."
A. (Nods)
Q. Now, I would just like to give you an alternative perspective on that for your comment. Eirian Powell, the nursing manager, has suggested that "Consultants thought all staff members worked cohesively because staff did exactly what they were told to do by the Consultants without challenging them".
What would be your reaction or comment on that characterisation of the relationship?
A. I -- I am quite surprised at that, to be

honest. That wasn't the impression I had at all.
Q. She suggests that doctors were quick to criticise nurses when errors were made. Again was that your experience?
A. No.
Q. You were also asked to comment about the relationship with management. Now, you didn't have any managerial role yourself, so what was your impression about the attitude of the paediatric Consultant body about the senior managers in terms of how receptive they were, how engaged they were, how helpful they were, those sort of things? Was there a shared opinion about senior management and how approachable they were?
A. So I suppose I -- as you say, I wasn't in a leadership role at the time so I was a little bit removed from it. Dr Jayaram was the Clinical Director at the time. But there was always the impression that paediatrics didn't have much of a voice at the table.
I think that can be true up to a point in quite a lot of district general hospitals. It's quite a small part of the hospital, if you like, compared to the larger adult medical and surgical specialties.
But I think my experience in Chester is different to my experience in Stockport from that point of view.
Q. That precisely anticipated my next question.

You describe in light of your experience at Stockport that the culture at the Countess was, to use your word, "impersonal"?

A. Yes.

Q. I was just going to ask you just to amplify what you mean by that, please?

A. I suppose it -- that the -- the higher management tiers, it didn't feel welcoming, it didn't feel like you would -- you know, you would just walk up and bang on their door and say "I have got a problem".

You know, they seemed perhaps a bit detached and not visible.

Q. So we are going to turn in a moment to look at the timeline of events, starting in 2015, but just two areas of policy and procedure to ask you about. The first is safeguarding training?

A. Mm-hm.

Q. Now had you received safeguarding training whilst you were at the Countess of Chester?

A. Yes, we -- we all underwent mandatory safeguarding training, yes.

Q. Were you aware, if not of the detail, but of the generality of working together?

A. Yes.

Q. Had you had any specific training in relation

to what to do if you suspected a member of staff of posing a threat to patients?

A. No.

Q. Looking back on it now, do you think that is something that you should have had some training on?

A. Yes.

Q. How did you view the role of the safeguarding department within the hospital, what did you think it was there for?

A. To give advice on safeguarding matters. We would go to our safeguarding team to discuss children that we had seen on the ward, where there was perhaps an allegation of physical abuse, for example.

Q. The way you were thinking about safeguarding at the time, did you view a member of staff posing a risk to a patient, particularly a vulnerable neonate, as being a safeguarding issue?

A. I -- I suppose I didn't think about it that way at the time. But it obviously is, it is. Yes.

Q. Just trying to get under --

A. Yes.

Q. -- why that might be the case. Why do you, what do you think the explanation is for why you didn't view it in safeguarding terms?

A. I suppose a -- a safeguarding investigation

would be led by social care, children's social care, whereas in my head I supposed I perceived that if it was a matter of wrongdoing and harm being caused by a member of staff, then that was a police matter.

Q. Were you aware that in a multi agency response to a safeguarding, you get both --

A. Yes, of course.

Q. -- the local authority and the police?

A. Of course yes, of course. No, I completely understand the police would be involved in a section 47 investigation.

Q. The second area of policy and procedure is Sudden Unexpected Death in Infancy and Childhood and procedure and you deal with this in your witness statement so we can take it reasonably shortly, I believe, but was your position understanding at the time that the SUDiC process didn't apply to babies who died in hospital?

A. I suppose, no, no. No. No.

Q. Have you followed any of the Inquiry evidence that has pointed to Working Together and the Pan Cheshire guidance?

A. (Nods)

Q. Can you see the point that's being made about that?

A. Yes, of course, of course, yes.

Q. So again just trying to understand how you may have come to understand that it didn't apply, what do you think the explanation for that is?

A. So for the Child D whose -- whose death I was involved with, I felt at the time that the correct course of action was to phone the Coroner and discuss the unexpected death with the Coroner as I felt at the time I was working within -- although it was very unexpected, that I was working within a medical model, there was evidence of sepsis and I -- you know, although, although it was unexpected, she had been unwell and therefore I -- I discussed that with the Coroner and I thought I was working within that model rather than it was a completely unexpected and unexplained death.

Q. We are going to come and have a look in a little bit more detail of Child D now, so I think that would be convenient for us to do.

You deal with your involvement in Child D's care from paragraph 27?

A. Mmm mm.

Q. Which is on page 6 of your witness statement.

What you tell us is that you have some -- and I am looking here at paragraph 28 -- independent recall of

the case, although you have of course provided statements to both Coroner and the police about Child D as you say, as the 24 hours was so difficult and therefore memorable, can you just help us to understand what stood out in terms of your memory of that last 24 hours and why it is that period is still with you today?

A. We -- you know, it's very unusual to get a death on a neonatal unit, particularly a child that's not known, for example, to have significant congenital abnormalities.

It was -- it was a very difficult and traumatic event that night for all the staff that were dealing with it.

Q. Your response, as you tell us, to those very difficult circumstances once Child D had died was to contact the Coroner?

A. Mm-hm.

Q. Just help us with what your discussion was, what it was that you wanted to tell the Coroner or the Coroner's office, officer, about the death and what you were expecting to happen as a result of that conversation?

A. So I would have -- I can't remember the -- the details of the conversation, to be honest, but my --

I would have discussed -- I would have given him the case history and discussed that I couldn't, that it was an unexpected event that I couldn't fully explain and I would, and I -- I -- I wanted a postmortem in order to for everybody, really, for myself and for the family to -- to help everybody to understand what had happened.

Q. One of the things you say in terms is that this as a death was unexpected?

A. Yes.

Q. Having had your conversation with the Coroner, did you also discuss it later that morning, the case, with Dr Brearey?

A. I did, yes.

Q. Was Dr Brearey's view based on what you told him that it was the death had most likely been caused by sepsis?

A. (Nods)

Q. Was that a view that at the time, not being a firm conclusion, that you tended to agree with?

A. I did, yes.

Q. Did the discussion include what you describe as lesions on Child D's abdomen?

A. Yes.

Q. What you tell us at paragraph 33 is that you tried to arrange an immediate debrief, you say you don't

recall that but having looked at the email correspondence?

A. Yes, I obviously did.

Q. That is --

A. Yes.

Q. But you don't have a recollection of whether or not that debrief took place?

A. I think, I think I don't recall, I think I don't recall it because it didn't take place in the end. Everybody worked shifts, the nursing staff, the -- the trainees and I think I -- I must have tried to arrange it but in the end it was impossible to get everybody together, for everybody's shifts patterns to align and it didn't and it never came together.

Q. Should there have been a debrief? I mean, how important was --

A. It's definitely -- without a doubt it is good practice to have a debrief it allows people that -- a safe space after an event to -- to offload a little bit because it's -- you know, these events are very traumatic. So it allows for some offloading and some emotional support. But also for people to say and bring any immediate thoughts to the table about what could have done better or what went well.

Q. Of course the context for Child D's death was

that just earlier in the month Child A had died and Child C had died and we also know, and we will come to in a moment, Child B had collapsed. Were you aware of those -- those events even if you weren't directly involved in them yourself?

A. Yes.

Q. So Child D's death compounded, is this fair to say, what everybody was feeling in terms of the distress and worry about those events?

A. Yes.

Q. So is it fair to say that in those circumstances at the very least it is unfortunate that there was no debrief for everybody to come together --

A. Yes.

Q. -- and decompress?

A. Yes, I -- we wouldn't, we didn't manage to come together as a group but I certainly would have had individual conversations with people.

Q. We are going to look at some of those in a moment. In fact, we will come to one now.

You are aware that Dr Lambie says that she spoke to you, just paraphrasing what she said, that it was some time later, and that she says that you were very interested in the sudden colour change that you had observed and that you said that you had witnessed

something similar in another infant patient around the same time.

Do you have a recollection of that conversation and what you might have been talking about?

A. I don't, to be honest. I don't recall seeing the lesions in another patient, no.

Q. Was the rash something that at the time from a medical point of view you were very interested in?

A. Yes.

Q. Or interested to understand?

A. Oh no, yes, yes, we spent a lot of time discussing it on -- on the night of the events myself and the Registrar that was on -- on-call spent some time discussing what could possibly be the aetiology of it and we did as a group afterwards as well.

Q. Do you know who that Registrar was?

A. Dr Brunton.

Q. Doctor?

A. Brunton.

Q. Brunton, thank you. We are going to move forward to 23 June and an email and I wonder if this can be brought on screen at INQ0025743.

If we can go to page 2, please, this is an email which you are sent by Dr Gibbs?

A. Mm-hm.

Q. And he talks about, and we don't need to go over all the detail, I hope that you recollect from the papers the Inquiry provided you with seeing this email. But he is raising the fact that Dr Lambie had come to see him and was very concerned about all four cases A,B,C and D and drawing attention to the strange purpuric looking rash, as he describes it?

A. (Nods)

Q. He goes on to say that the junior doctors were looking for something to be done about it.

A. Mm-hm.

Q. What was your feeling at the time about whether something should be done about these four cases?

A. Yes. No, no, definitely, I knew that the trainees were very concerned about it and we were very concerned about it as well.

Each baby had appeared to be infected, septic, we, we were concerned that we had some bug on the unit, maybe contamination of some equipment, one of the ventilators, for example, so we were extremely concerned about it.

Q. If we scroll up, we might need to stay on the full page view because it is the bottom of the page that we will be interested in, we are going to see an email from you. So if we go to the -- we can see you reply

copying all your colleagues in to it: I agree, you say.

"I have just been grilled by Dave Harkness."

Dr Harkness?

A. Mm-hm.

Q. "This is causing a lot of concern/upset. Can we pull something together fairly soon? I think we need to meet with both, probably separately would be better."

What do you recollect that Dr Harkness was saying to you?

A. That he was also -- that he was also obviously very concerned about the three deaths and he also mentioned the link between the -- the rashes that were seen on each baby.

Q. Thank you. We can take that down but we are going to put another document up and we are going to move forward about a month in time. This is INQ0036166.

If we go, this is a meeting, so you can see between the senior clinicians, you are indicated as being present second from the top of the list, and if we go over the page, there are a number of matters discussed at that meeting on 29 June, I think I said we move forward a month; in fact we have only moved forward three days.

If we look at three paragraphs up from the bottom:

"There was also an issue raised around the fact

that the three recent neonatal deaths, the Registrars had been quite worried and felt nothing had been done. Behind the scenes reviews are going on but it was felt that formal debriefs would probably take place rather than any specific meeting to discuss all three."

So that's the discussion between you all as recorded in the notes?

A. Mm-hm.

Q. Are you able to help us with why it wasn't thought a good idea to discuss all three deaths together?

A. No, I don't -- I don't know. I don't recall that. I do -- I do recall a decision being taken to ask Dr Subhedar, who is one of the Consultant neonatologists at the Liverpool Women's Hospital to come and review them all.

So no, I -- I don't know what I can't recall that.

Q. Thank you, that can come down.

If we move forward in your witness statement to paragraph 37, which is where you deal with a Neonatal Mortality Meeting on that, on 29 July. There was a review of Child D's death.

You talk there about the discussion which took place and in the final sentence of paragraph 38, you say the consensus at that time, and pending Dr Subhedar's

review and any other investigation that was ongoing, was it was likely that Child D had died of sepsis?

A. Mm-hm.

Q. It also appears, and we can bring up the INQ at this point, 0003297, please, that Child D is the one just over the page, we don't need to turn to that.

We can see that Child C's death was discussed?

A. Mm-hm.

Q. We can see at the top the period of assessment is June 2015. Taking that on its face, that would include Child A's death?

A. Mmm.

Q. But Child A doesn't appear to have been discussed at the meeting?

A. Mmm.

Q. We have just looked at a meeting that happened a month earlier where it seems to have been resolved that all three deaths wouldn't be considered at the same meeting. Are you able to shed any light on why Child A wasn't also discussed where the period of assessment appears to include the date of Child A's death?

A. I don't know to be honest. I really don't.

Q. Can you, sitting here now, see any advantage of all three deaths possibly with Child B as well-being discussed given what had been said in the earlier

emails, all being discussed together formally being minuted and everybody sharing their different impressions, thoughts and plans for how it should be managed, can you see that as being a good thing?

A. Of course, yes.

Q. So if we take that down, we will move forward in our chronology. Child E was murdered on 4 August.

A. (Nods)

Q. On 5 August, Child F experienced a deterioration. Now, I don't think you were involved in the care of Child F at that time but I just want to ask you about something that Dr Gibbs has said about it. Are you aware of the insulin and C-peptide result that came in a week later from the Liverpool laboratory?

A. I wasn't aware of it until almost -- after Letby was arrested and we were coming up to the trial.

Q. Dr Gibbs has characterised that as a collective failure of the Consultants. Is that an opinion that you would subscribe to too?

A. At the end of the day it was there, it was a result that was in the department and any of us could have looked at it at any time.

Q. We will move forward, please, to a meeting that you had with the parents of Child D. The Mother of Child D has given evidence and I just want to tell you

what she has said.

She said that you told her that the evidence pointed towards sepsis?

A. Mmm mm.

Q. She said, "what were the test results? Did she have an infection?"

A. Mm-hm.

Q. Her recollection is that you replied "no, she didn't", and then she goes on to say you couldn't explain.

A. Yes.

Q. Now doing the best you can, do you have a recollection of meeting the Mother of --

A. I do definitely remember meeting with the parents, yes, yes.

Q. And just having heard what her recollection of events is, do you have a recollection of saying that, does that sound like something that you might have said based upon the facts or do you remember things differently?

A. I think I would have been explaining about blood culture results and that although we felt that she did have an infection and she was septic as she presented that way, the blood cultures hadn't proven that. But that is something that is often the case in

neonates.

Q. Now, we have mentioned Dr Subhedar already. He, as you tell us at your paragraph 48, came to present the findings of his review?

A. Mm-hm.

Q. You say that was on a Wednesday or Thursday lunchtime teaching session. You say this:

"I remember that it was felt that, although it was unusual to have such a cluster of deaths on a neonatal unit, there was medical explanation for each death and no major deficiencies in care were found."

So that's your recollection of your response to the presentation given by Dr Subhedar?

A. (Nods)

Q. The first thing is, doing the best you can, do you know whether that presentation was before or after the death of Child I in late October 2015?

A. Gosh. I -- I don't. I think it was before to be honest. But I -- I -- yes.

Q. So far as Child A was concerned, and I appreciate that was not a child who you were directly involved in the care of, but you say that there was a medical explanation for each death?

A. Mmm.

Q. Are you able to help us with what the medical

explanation was being said at that time for the death of Child A?
A. I can't remember, to be honest.
Q. There was, we know, on 12 October and you deal with this in your witness statement, a table top meeting to review the case of Child D following the postmortem findings?
A. (Nods)
Q. Do you have any recollection of what you thought upon reading the postmortem findings of Child D's?
A. I suppose I -- it confirmed my belief, there was evidence on the postmortem of congenital pneumonia, ie infection, and therefore a medical model of sepsis seemed reasonable and appropriate.
Q. So if we just take stock at this moment in time about what you were thinking was happening on the neonatal unit, before the death of Child I.
A. Mm-hm.
Q. Were you concerned about the deaths which had occurred?
A. Yes, very.
Q. Were you suspicious at that time that any of the deaths were unnatural?
A. No.

Q. Before the death of Child I, did anybody else suggest to you that they were suspicious that the deaths might not be natural?
A. No.
Q. So we move forward to Child I, please. I am picking up here starting at paragraph 51 of your witness statement, which is on page 11. You tell us you have some limited recollection of events on 13 October. Now, Child I died on the 23rd and Child I's death was preceded by a number of deteriorations or collapses?
A. Yes.
Q. You tell us that your recollection is that you were called in urgently on 13 October; is that right?
A. Yes.
Q. That you found Dr Neame performing resuscitation?
A. (Nods)
Q. That Child I responded to the resuscitation and was transferred to intensive care?
A. Mm-hm.
Q. One of the matters that the Inquiry is investigating is whether or not it was the case that Letby was moved from having responsibility for Child I over the period that Child I collapsed in relation to one specific shift?

A. (Nods)
Q. Is that something that you were aware of if it happened at the time?
A. No.
Q. Now, had it been the case that somebody on a neonatal unit thought that Letby should be moved off the care of Child I for Child I's protection, so not to do with Letby's welfare but for Child I's protection, is that something that you should have been told about?
A. Yes. Yes. Yes.
Q. What do you think your reaction would have been if you were told that such a step had been taken?
A. I have -- I would have wondered what on earth was going on really and if, if -- that we -- did not more than that need to be done?
Q. Now, Child I died on 23 October 2015. That was thought of as a sudden and unexpected death at the time?
A. (Nods)
Q. If that was the thinking, in your view should a Datix have been completed?
A. (Nods) Yes. Sorry.
Q. Now, you tell us at paragraph 54 that you can recall a discussion with Dr Gibbs, plus Dr Brearey and/or Dr Jayaram?

A. Yes.
Q. You say in terms of the date of it:
"... following my involvement with the collapse of Child I in October 2015"?
A. Yes.
Q. So we know your involvement was the 13th?
A. Yes.
Q. We know Child I died on the 23rd?
A. Yes.
Q. Was that discussion before Child I died or after Child I died?
A. I have -- I can't recall. I -- I can't recall. It -- yes, I can't.
Q. Well, if you just think about it, if --
A. It can't have been, it can't have been before, it can't have been.
Q. I was just going to suggest that.
A. Yes, it can't have been, yes.
Q. Because if that had occurred before and then Child I had died, that would have been?
A. It can't have been yes, it couldn't have been.
Q. And as best you can, just tell us what your recollection is about what was said to you and by whom in that discussion?
A. I can't remember precisely who started the

conversation. I was asked if Letby had been there on the night that I was called in to that resuscitation and I replied that I had seen her.

The conversation was then around the fact that she was always on duty when these events had happened and then also some counter arguments that we were in fact a very small unit with a very small pool of nursing staff, so it was not inconceivable that the same poor person might be on duty for a, for a number of events.

Yes, but, I -- I felt the idea that anyone was suggesting that someone was doing this quite difficult. Yes.

Q. Was the possibility that it was deliberate harm that was occurring said out loud?

A. No. It was more that she was always there.

Q. So that was an implication that you took?

A. Yes, an implication that -- that this -- this pattern had been noted. I -- Dr Brearey was reviewing and Eirian Powell were reviewing all the deaths and I knew that they were looking at things like which incubators each of the baby was in, which equipment was used, which staff were on duty et cetera because that had all been discussed when Dr Brearey had reviewed the first three deaths.

Q. What you say in your statement at paragraph 54

in the middle:

"I found it hard to comprehend that a health care professional could be deliberately harming babies and I remember expressing that at the time. However what was happening on the unit was clearly not normal so it had to be considered. They wanted to raise their concerns to the Hospital. I do not know exactly when this happened or the sequence of events that led to the RCPCH review into the neonatal unit or the sequence of events that led up to the Hospital calling in the police to investigate as I left the trust at the end of February 2016"?

A. Yes.

Q. That's what you say in your witness statement?

A. Yes.

Q. They wanted to raise their concern with the hospital. Was that something that was expressly discussed at the meeting?

A. Not, not at that time I think. That was -- I suppose as 2015 went on and into 2016, the thought that something awful could be happening kind of, you know, solidified in people's minds really.

It was completely out of normality that we should have so many deaths on the unit.

Q. So does that -- am I to understand from that

answer that there were more conversations after that first one as the concerns coalesced?

A. Yes.

Q. Who was involved among your Consultant colleagues with those conversations, was it just the same three people you have named or were any of the other Consultants involved?

A. Mainly the three named, yes.

Q. When you say "mainly", that might suggest that --

A. I can't remember who else was involved.

Q. A possibility of others?

A. I wouldn't be able to, you know, name --

Q. Did there come a point at any time in your presence when anybody actually articulated out loud: maybe she's doing this on purpose?

A. No.

Q. Now what Working Together talks about in terms of the need for a response is if somebody may pose a risk.

A. Mmm.

Q. Is that in fact what was being said in these conversations that you were a party to?

A. Yes.

Q. So given that that was what was being said,

should something have been done immediately that that was said?

A. In -- in hindsight yes. It -- it was very difficult. There was an air of disbelief about it. The only -- the only thing that we could say at the time was that she happened to be on the -- she happened to be on all the shifts. No one had ever seen anything, heard anything.

There were lots of counterarguments that she was a very, very competent nurse, everyone had observed good practice, et cetera.

So I suppose we -- we -- it just became a very difficult situation as to -- to -- know where to go.

Q. Just so that we are clear about the time period, we know that you left at some point in February 2016?

A. Yes.

Q. The first conversation, the other end of the bookend, is at the end of October 2015, are you able to be any more specific than that date range as to when things really coalesced in terms of the index of suspicion or concern?

A. I suppose the beginning of 2016.

Q. You aren't sure if any of your other Consultant colleagues other than Dr Brearey, Dr Gibbs

and Dr Jayaram were involved in this?
Why do you think at that stage all seven of you didn't get together to talk about it?
A. I don't know really. I suppose it was just there was a bit of disbelief about it, really.
Q. Now, your statement to the Coroner is date-stamped as being received on 26 October 2015 but you tell us in your witness statement you in fact wrote that statement at the time of Child D's death?
A. Yes.
Q. So when you wrote it, none of this was in your mind?
A. No.
Q. And obviously we know Child I's death was on the 23rd so there are only three days in which you may have had a conversation before the Coroner received that statement. So that's the background.
A. (Nods)
Q. Bearing in mind that Child D's case was with the Coroner, do you think that there was any point when you should have been contacting the Coroner to say: there is this concern which at least my colleagues have about what was going on in the NNU?
A. Yes. At the end of the day, yes.
Q. We have talked about your colleagues' concern.

Can we just be clear. In terms of your personal opinion, obviously you were hearing what they were saying, did there ever come a stage whilst you were at the Countess of Chester where you suspected or was it the position that you were listening to the suspicions of others but holding a different opinion yourself?
A. Yes. I suppose I -- I did -- I did struggle with the idea that somebody was doing this, yes.
Q. So again this is a difficult question perhaps to answer directly. But if somebody had said to you: might Letby be harming children?, having heard all of the arguments, were you in a position of saying: yes, I did think she might be, or were you thinking: no, on balance I don't think she might be? Or were you just: I don't know?
A. I just don't know. It was -- yes.
Q. So it isn't the position then that you were you can say with certainly "I was suspicious"?
A. Yes, yes.
Q. Just a couple more events to review.
We know that in January 2016, Eirian Powell produced a chart of --
A. Mmm.
Q. -- which nurses were on duty and which nurses were allocated to babies and on the chart produced in

January, Letby's name is highlighted in red?
A. Mm-hm.
Q. Is that a chart that you saw whilst you were at the Countess of Chester?
A. No.
Q. Was that a chart that anybody who had seen it talked to you about and said: a chart's been done and her name is there?
A. (Shakes head)
Q. Sorry --
A. No, sorry.
Q. Not at all, you don't need to apologise at all.
Now the thematic review of Neonatal Mortality Meeting attended by Dr Brearey, Dr V and Dr Subhedar occurred on 8 February 2016, when I think you were on the cusp of leaving the hospital?
A. Yes.
Q. You left later that month?
A. Uh-huh.
Q. Were you aware of that meeting taking place at the time?
A. No.
Q. Although you had spoken to Dr Gibbs, Dr Brearey and Dr Jayaram about those concerns or

suspicions that they may have had, the meeting that was to look at the detail of all of the deaths, that wasn't something that they had spoken to you about?
A. I can't remember it, no.
Q. So, for example, your view wasn't sought beforehand about what you wanted said at the meeting about babies that you had had care of?
A. No.
Q. Presumably if you can't remember it you also don't have a recollection of anyone telling you afterwards what happened at it?
A. No.
Q. We are now right on the cusp of your departure, we know that the CQC did an inspection in the middle of February and they spoke to Consultants on 17 February 2016?
A. (Nods)
Q. Were you one of the Consultants who attended that or did you not go to that particular?
A. I didn't attend.
Q. Do you feed anything into that, so did you say to any of your Consultant colleagues who you thought might attend: please can you tell them about this or that?
A. No.

Q. Then some time around late February, possibly even mid-February, is it right that you left the Trust?

A. Yes. I -- I can't remember precisely when but my leaving date was the end of February, but I no doubt took some leave and I don't know when my last working day would have been.

Q. So if we just come to some general matters. I am looking here at page 12 of your witness statement and paragraph 59. You say this:

"I would have expected the Hospital to have been extremely concerned about the number of deaths irrespective of the cause of them and undertaken a review. It may be that the RCPCH review constituted that review but I was not party to those discussions."

A. Mm-hm.

Q. When you say the hospital?

A. Mmm.

Q. In terms of human beings --

A. Yes.

Q. -- who are you meaning?

A. Well, the -- the, the senior leadership team would -- we were -- we were holding regular Mortality Meetings under the governance framework and I rightly or wrongly at the time thought that those would have been fed up the governance chain to the Urgent Care Division

and, therefore, to -- to the Exec Team.

And -- and as with I suppose any incident reporting system, Datix reporting system, individual incidents in themselves are really important but it is trends in a way that are more important because they help you to identify a system issue or a -- whatever may be causing the problem and those trends should be put together and viewed at a higher level.

Q. In light of what you have been told by Dr Brearey, Dr Jayaram and Dr Gibbs, in terms of their index of suspicion, what, if anything, did you think they were doing by way of notifying the senior management of the hospital, following the articulation of that suspicion to you?

A. I -- I suppose at that time in October it was more just a "we have noticed she is always there". You know, could -- you know ...

Then I suppose as time -- as time went on those concerns started to coalesce. I know around the time I left or whether it was just after, it sort of becomes a bit hazy as to what I actually was there for and then what I was told had happened by my colleagues afterwards in a way, that Dr Brearey and I assume Dr Jayaram as well had asked for a meeting with the senior management team to discuss what was happening on the neonatal unit.

Q. That may be something that you think you were told when you were there, but it may be something you have learned subsequently?

A. Yes, I mean I obviously kept in touch with my colleagues after I had left and it was around February time. But I say whether that was just before or just after I left, I am not sure.

Q. Was there any discussion between yourselves about whether the police should be contacted if there were discussions about the need to raise it with the senior management?

A. We -- no, I suppose we felt that we needed to we needed to discuss -- you know, discuss the concerns and then they would help and guide us with what to go with what to do next. It was difficult. As I say, we didn't -- no one had ever seen anything happen. It was just a feeling that she was always there.

Q. What you say at paragraph 61 is that you don't know the exact date that they raised their concerns with the senior management but that should have triggered a request for a police investigation by the hospital as this should have been taken very seriously.

So was it your expectation that one thing would lead to another?

A. (Nods) Yes.

Q. At your paragraph 63 you say:

"I was extremely concerned about the number of deaths and collapses on the neonatal unit as we all were as a group of Consultants."

Then a little bit further down, about halfway down:

"I did find it hard to comprehend that a health care professional might be responsible but what was happening on the neonatal unit was not normal. Everything needed to be considered so I backed them in raising concerns. I did not raise these concerns personally but I was aware that Dr Brearey and Dr Jayaram would raise them they acted as spokesperson for us group of consultants. I do not know at what point they raised them."

Does that really summarise what your position is?

A. Yes, yes, I think that refers to that end period, around February. Yes.

Q. Now, after you left, the Coroner instructed Dr Mecrow to conduct a review of the case. Did you ever see Dr Mecrow's report?

A. Not, not at the time. But, no, no.

Q. So that report is dated 9 June 2016. Now, let's be clear, Dr Mecrow does end up agreeing with the pathologist, although points to areas of inconsistencies see but Dr Mecrow described Child D's death as

disturbing due to her collapse being so sudden and unexpected.

Would you associate yourself with that description in relation to Child D?

A. It was very unexpected. Yes.

Q. The final matter I wanted to ask you about, Dr Newby, were your reflections.

A. Mmm.

Q. You were asked by the Inquiry to consider CCTV?

A. Mmm.

Q. If I just pick out one phrase, it is paragraph 82, you say "very difficult to answer".

A. Mmm.

Q. I just would like you, please, just to speak to that about what your thoughts are about the utility, value or challenges of CCTV on a neonatal unit?

A. Yes. I could -- I could completely understand why the question would be raised. I -- to -- whether you could set up a system that could capture absolutely everything and would mean that, you know, for example someone appearing to give one medicine but giving another, how, how would C -- I don't know.

And, you know, there is an awful lot of very private and intimate care that goes on on a neonatal

unit. Whether CCTV is -- whether families would feel CCTV is appropriate in that setting, but then these events have -- have been really shocking and awful and I am sure families seek to feel reassured.

Q. Are there any other matters that you would like to draw to the Inquiry's attention in terms of you having had an opportunity to think about this very deeply and also have the experience of being a Clinical Director at a different hospital?

A. Yes, yes, I think -- I think there was just this feeling of not knowing what to do and I think in a way it almost made it a little bit more, more difficult to come up with a name because having come up with a name and a person being put forward, kind of led to this counter narrative being put forward as well; that it couldn't possibly be because she was so lovely, she was such a competent nurse, you know, no one had ever seen ...

And therefore it perhaps allowed for this doctors versus -- it became sort of an almost adversarial thing that the doctors were accusing the nurses and everyone was sort of digging in their position whereas maybe what we had to say was: this isn't right and could it be that someone is, I don't know, maybe, maybe that -- I don't know if that would have been easier and not allowed this

real adversarial position that developed, that developed to happen. If we had just perhaps taken a step back and reported the -- and reported the incident rather than trying to work out who had done it, if you like.

Q. So to raise the possibility of unnatural death at the first instance, but not to ascribe it to any one person?

A. Yes, because we didn't there was no, at the time there was -- there was -- there was no -- there didn't appear to be any evidence.

MR DE LA POER: Dr Newby, thank you very much. Those are all the questions I have, my Lady.

Questioned by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Thank you, Dr Newby, for your very thoughtful evidence. Can I just take you back to something that you said quite early on when you were being asked about the change in the divisional structure, the sort of relegation of paediatrics?

A. Mmm.

LADY JUSTICE THIRLWALL: To move from the top table, which I understand. You said that it was a small part of the hospital so you could understand possibly the thinking behind it. But you said: my experience in Chester was different from my experience in Stockport.

I just wondered what was your experience in

Stockport?

A. I suppose that paediatrics does have more of a voice.

LADY JUSTICE THIRLWALL: Was that the case when you went there?

A. Yes.

LADY JUSTICE THIRLWALL: Yes.

A. Yes, and, and we are -- we always remained Women's and Children in Stockport, although at one stage we gained Diagnostics and then lost them again. But it -- I think that divisional structure was more helpful than it is than the two large Urgent and Planned Care divisional structure that we had at the Countess.

LADY JUSTICE THIRLWALL: Yes. Thank you very much indeed.

A. Thank you.

MR DE LA POER: My Lady, we are slightly ahead of where we would normally be for our break, but what that really means is that we are absolutely on target for our plan for today. Can I invite us -- or invite my Lady to direct that we resume at half past?

LADY JUSTICE THIRLWALL: Yes, certainly. So Dr Newby, that completes your evidence, thank you very much indeed and you are free to go. We will resume at 11.30.

(11.10 am)

(A short break)

(11.30 am)

LADY JUSTICE THIRLWALL: Mr De La Poer.

MR DE LA POER: My Lady our next witness is Dr Saladi.

LADY JUSTICE THIRLWALL: Would you like to come to the desk, Dr Saladi.

DR SATYANARAYANA MURTHY SALADI (sworn)

Questioned by MR DE LA POER

LADY JUSTICE THIRLWALL: Do sit down.

MR DE LA POER: Could you please give us your full name?

A. My name is Satyanarayana Murthy Saladi.

Q. Dr Saladi, is it correct that you have provided a witness statement to this Inquiry dated 17 June of 2024?

A. That is correct.

Q. Thank you very much indeed.

Can you confirm for us, please, that the content of that witness statement is true to the best of your knowledge and belief?

A. That is correct.

Q. Reviewing your career, did you start your medical training in India obtaining MBBS in 1991?

A. That is correct.

Q. And an MD in paediatrics in 1996?

A. Yes, that is correct.

Q. Did you subsequently train in the United Kingdom and obtain membership of the Royal College of Paediatrics and Child Health in 1998?

A. That is correct.

Q. A Certificate of Completion of Specialist Training in April 2009?

A. Yes.

Q. Just before you completed that, so in November 2008, did you join the Countess of Chester Hospital as a paediatric Consultant?

A. That is correct.

Q. And to bring us up to date, did you continue in that role until June of 2023?

A. That is correct.

Q. So I am just going to deal with what you can tell us about your perception of relationships between different people working at the Countess of Chester and the focus here, please, Dr Saladi, is on the period 2015 to 2017.

So at the start of that period, please, how were relationships between the Consultants?

A. Very good.

Q. The Consultant body and the junior doctors?

A. Very good.

Q. The Consultant body and the nurses?

A. Good, very good.

Q. You were in the hearing room when I read out to your colleague Dr Newby what Eirian Powell has said of her perception of the relationship?

A. (Nods).

Q. I will just remind you: "that Consultants thought all staff members worked cohesively because staff did exactly what they were told to do by the Consultants without challenging them".

What can you tell us about your experience of that and your comment upon her view?

A. No, I think it -- it was a cooperative unit and we could challenge each other easily and they did challenge us in -- where they thought it was appropriate. It was not antagonistic, we worked as a team. It was a cohesive team. And I am proud to be a team member of there.

Q. So far as how any change that may have taken place in 2016 is concerned, did you perceive any change with any of the relationships that I have just talked about between the Consultants, between Consultants and doctors, or between Consultants and nurses?

A. Not in terms of the relations. Obviously the Consultants, us as a body, were under stress but I suspect that applies to all groups because we were understaffed and we were having busy periods and during that time there were more unwell children. But not in terms of the relations.

Q. In the period 2015 to 2017 what was your view of the senior management of the hospital?

A. I did not have any direct contacts with the senior management. The managers I see are the business manager, which we meet in the Monday meetings. But I didn't think they had much authority to change things. They needed to take it up higher level to get any things changed and the people who are actually making changes I wasn't sure who -- who had that.

Q. So in 2015, if the Chief Executive Tony Chambers had walked on to the paediatric unit, would you have known who he was?

A. Yes, yes.

Q. Had you had any direct communication with him?

A. Not directly with him.

Q. What about the Medical Director, Mr Harvey?

A. Yes, I know, but not direct contact with him. It's not as if there were -- I think there were -- they didn't come to -- we are in a different building in the

hospital so maybe they were -- we don't -- we don't see them often apart from the emails. They used to communicate to us but not sort of person-to-person contact but that's maybe we are a small department in a different building.

Q. Do you think that the fact that you were a small department in a different building made any difference to how connected you were to the whole management structure of the hospital?

A. As I said, because I was not in a management role, I didn't know the difficulties my colleagues were facing, but I could easily interact with other Consultants, we used to meet in the meetings and things like that. So -- but, yes, I didn't have much contact directly with the senior management.

Q. If a problem had arisen in 2015 that you thought you would need to take to the senior management, what was your expectation about how that particular group of people would have dealt with it?

A. I probably wouldn't have taken it directly myself. I would have raised it through my leads which was Dr Jayaram and Dr Brearey and usually -- they used to take them up so I didn't need to directly email or contact the senior managers at any stage, except in probably -- that was in June or July 2016, that's when

I probably directly contacted some of them.

Q. We will come to that.

A. Yes.

Q. Moving away from the topic of relationships. Safeguarding. Had you received training in safeguarding?

A. Yes.

Q. Had you received any training in terms of how you should deal with a situation where you suspected a colleague of posing a risk to patients?

A. I think the important point here is suspicion because safeguarding training is all related to when do we suspect babies are harmed, are coming to harm. So we know what to do when we are already having suspicion, I think.

But we know what sort of situations we need to suspect babies coming to harm, we had training, but that's mainly related to child protection in the community and I suspect we did not have that sort of training when to suspect that sort of -- that sort of thing in the hospital itself.

We were told if you see abusive behaviour, if you see a Consultant or a colleague coming drunk and things like that, which is easy to understand. But I don't think we had what are the situations where you need to

suspect apart from these obvious situations where you are seeing a racist behaviour, or sort of bullying behaviour, or a drunken behaviour, that sort of things, we know that is wrong and it is easy to suspect and it is easy to raise concerns. But I don't think beyond that we had any sort of training.

Q. So far as the process for Sudden Unexpected Death in Infancy and Childhood was concerned, what was your understanding in 2015 as to whether that applied to deaths of neonates on the neonatal unit?

A. Yes. I understood that it applied and when we were having unexpected deaths we were following the route which my understanding is to discuss the concerns with the Coroner.

Q. What we can see from the guidance is that a number of steps are identified at an early stage when following that procedure including contacting, for the Countess of Chester, Dr Mittal?

A. (Nods)

Q. And for the convening of a multi agency meeting, which would involve local authority and police. Did you understand that aspect of the Sudden Unexpected Death in Infancy and Childhood to apply?

A. I suspect my understanding was that was more related to outside the hospital because inside the

hospital we were thinking more in terms of the Coroner, because I suspect -- the suspicion I think that is where, where we are, the suspicion of something unusual or, yes, maybe I am not framing it correctly.

But my thinking was the right person to discuss this is Coroner because they are the ones who sort of we contact immediately within the first -- probably if it is daytime straight away or if it is something happened in the nighttime, then first thing in the morning. We do discuss with the -- Dr Mittal but that's more of there is something called Part B to complete that forms which needs to be done in sort of 24, 48 hour's time whereas Coroners is immediate because they are the ones making a decision whether they are ordering a Coronial postmortem or they are leaving it for us to discuss with the parents to whether they want a hospital postmortem.

So I didn't think I was giving more importance to Coroner, informing the Coroner rather than going in that other route.

Q. Who did you understand within the hospital had responsibility for making sure that you followed the right procedures when it came to those sudden unexpected deaths?

A. I suspect we discussed all deaths and all the morbidity in our Perinatal Morbidity Mortality Meetings

and if there was -- if we thought we were not following I thought that would have been where we would have -- could maybe we should have done differently. I am not sure whether I am following your question or whether my answer is what you are asking.

Q. I understand you to be saying that you relied upon your colleagues to at those meetings to correct any failure to follow the correct procedure, is that what you said?

A. Yes, when we are discussing with the Dr Mittal our safeguarding team which is not usually not in the context of safeguarding, it is because of unexpected death, we do discuss but that is not usually immediate when they are next available which may be in a couple of days' time.

But that's mainly about information, saying that we had an unexpected death and we have discussed with Coroner and this is what is happening. And then I will fill the form when it comes so that you know what our clinical thinking was.

Q. In 2015, were you aware of the crimes of Beverley Allitt?

A. Yes.

Q. Were you aware of the situation at Stepping Hill Hospital where a nurse had been using insulin to

kill patients?

A. I cannot remember now whether I was aware at that time.

Q. Now, we are going to turn please, Dr Saladi, to look at what you say in your statement about events.

A. Mm-hm.

Q. Can I say at the outset that I do understand that a number of occasions you have asserted you don't have a memory, I am going to try and help you with that as far as possible?

A. Okay.

Q. So at paragraph 12 on page 2, you deal with Child A and Child B and in particular at paragraph 13, you make a number of statements about Child A and I am just going to read those out so if you have got them in front of you:

"I was not involved in the care at the time of the deterioration and death of Child A. At the time it was unexpected but we were thinking if it was related to maternal health.

"I do not recall any discussions about unusual patterns of discolouration of Child A.

"I did not have any concerns about Child A apart from if it was related to maternal health condition.

"I do not remember if I attended any debrief."

Doing the best you can, do you remember providing any care to Child A?

A. Yes.

Q. You do?

A. Yes.

Q. Can you help us, please, with your recollection of Child A's condition when you provided that care?

A. Well, I attended -- Child A is one of the twins and I attended the delivery when the twins were born and I think I was resuscitating -- I am not sure without seeing the notes, but I think I am resuscitating Child B who was more sicker at the time of birth and my colleagues were resuscitating Child A but I know Child A is much more stable than Child B at the time of birth.

Q. So at the time of birth, did you have any sense at all that Child A might die?

A. No.

Q. We are going to come in a moment to some contemporaneous records about Child A, not in the medical notes, but before we do, Child B suddenly deteriorated on 9 June of 2015 and you say this at your paragraph 14:

"In relation to Child B.

"At the ward round on 10 June I was looking for

medical causes which caused the deterioration and if it was related to maternal health condition.

"I cannot recall what I was thinking at the time I was probably thinking was it related to sepsis which can give rise to rashes rather than related to maternal health condition which was one of the parental concerns at the time. It was also possible the rash seen by me was much different to the rash seen by the junior doctor earlier as some rashes change with time."

A. Mm-hm.

Q. Now, Dr V's record notes:

"Purple discolouration almost resolved ??? cause."

Were you sighted on the fact -- sorry, I will ask that question different.

Were you aware of Dr V having seen the rash and did you talk to Dr V about the rash?

A. I do not remember if I have seen -- I have discussed about the rash with the Dr V. But I think again not based on the recollection of the event but looking at the notes, I know that the child had rash the previous night which had subsided and by the time I think I have documented the notes that it is quite localised only in some areas and usually for paediatricians there are lots or different types of rashes. The worrying type of rashes are the rashes

because of serious infections and usually those rashes are progressive, that means they are getting worse in front of you or they are becoming much more like a bruise and things like that. Whereas something which sort of disappears or not usually are not usually a concern. At least at that stage because there are lots of causes for the rash and some of the rashes can happen in the newborn period as well.

So probably that's why you didn't stick it -- stick out to me that much.

Q. This rash was associated with a sudden and unexpected deterioration in Child B. Does that make it potentially more significant because?

A. Yes, I would be thinking of infection and I would now check whether we have looked for infection and whether we have covered the baby with antibiotics.

Q. I think you have told us that in an infection the rash will progress or turn into a bruise. In fact, the --

A. Not necessarily all the time.

Q. But the opposite was happening in this case that the rash was resolving and becoming more localised?

A. Yes, but it doesn't mean infection and rash has to always progress. It can decrease as well.

Q. Did you take any steps to try to investigate

the reasons for Child B's collapse?

A. At that stage, there was a lot of concern whether it is related to maternal health condition, though our initial reading from the -- from the literature is probably not.

But we were trying to contact the various specialists whether it is in fact related to it or not, so we were trying to contact the teams in London and I can't say definitely at London but definitely we are trying to contact different teams, whether that can explain this sort of deterioration and we thought we had treated for the other possible causes for the rash like infection.

Q. We are going to have a look at a document which we looked at this morning, INQ0025743. This is an email from Dr Gibbs the day after Child D died. And it is on the second page. Thank you very much.

We can see that that you are one the recipients of this email; do you see that?

A. Yes, I can see that.

Q. Again, just by way of summary, Dr Gibbs is talking about Dr Lambie coming to talk about the concerns of the Registrars?

A. Mm-hm.

Q. Were you aware before this email came into

your inbox of the concerns of the Registrars?

A. No.

Q. Did you speak at any time to any Registrar about them being worried about the deaths and/or the rashes?

A. No.

Q. When you received this email, did you note the fact that according to Dr Gibbs, there seems to have been a rash in Child A, Child B and Child D? So he says that Child C didn't have the rash, so that's what Dr Gibbs is saying in the first paragraph?

A. Sorry, what was the question?

Q. So the question was: did you note when you read it that Dr Gibbs was bringing together those four cases?

A. Yes.

Q. Saying in the case of three of them, there was this rash?

A. I cannot remember whether -- whether what I was thinking when I saw this email because I was reminded of this email only when I received through the Inquiry. So I cannot remember what I thought at that time.

Q. Because you had been involved in the care of both Child A and Child B?

A. Yes.

Q. And you had information you could provide about what you had seen about Child B's rash; is that right?

A. Again, as I said, the rash I have seen I did not think it was anything serious, so probably that's why it didn't trigger anything. So probably that's why this email, I did not remember this email until you sent me through the Inquiry because the rash I have seen is based on what I -- what was documented in the ward rounds, did not sound very serious.

Q. So do you have any memory of speaking to any of your colleagues to try and understand their experience of the rashes for any of these four babies to see if you could further understand what Dr Gibbs was talking about?

A. No.

Q. Again, we looked at it this morning. There was a meeting a few days later, INQ0036166, and I will just help you with the part so that you have it in front of you.

We can see at the top there that it is a meeting that you attended and over the page just to remind you, Dr Saladi --

A. Mm-hm.

Q. -- that third paragraph from the top again mentioning that the Registrars had been quite worried. That's twice in a week that either there is an email discussion or there is a discussion in person about the junior doctors being worried. What did you think about the concerns that you were being told about?

A. See, I don't think at this stage the junior doctors were describing what they were seeing. The -- I suspect because this meeting again I do not have any recollection of it because I suspect if they said some junior doctors have seen a rash, and there is a concern, obviously there were concerns for all of us at that stage because for all the taps in the neonatal unit taps we had filters and there were growing salmonella from the taps even though I do not remember we actually grew that bug from any of the babies.

So maybe I was thinking that is that related to the neonatal unit, the taps and things like that rather than this is a different type of rash which is different to what we see in infections because again until you sent me this, this summary of the meeting, I didn't -- I didn't recollect it. I suspect that's because what was discussed in the meeting was we were thinking maybe it is related to the taps and things like that.

Q. So in terms of how you felt about the

situation at the end of June on the neonatal unit, and by that I mean the fact that there had been three deaths in quick succession plus a collapse of the twin of one of those who had died, were you worried?

A. Yes. In the sense we know in the neonatal units deaths can happen, particularly if there is any outbreak of infection so there can be grouping of the deaths and I suspect we were all thinking, or at least I was thinking that this is all related to are we missing some bug, something else which was happening. But that's why we are having these bad faith with the more --

Q. From your point of view, is that you doing your best to reconstruct your memory or is that something that you have a positive recollection of thinking at the time?

A. Is there a difference between those two?

Q. Well, one is "I can remember thinking that" and another is saying, "Well that's probably what I was thinking, I don't actually remember".

A. Yes, second one. I don't actually remember but I would have thought having a few deaths grouped together is not unusual. It's rare but it is not unusual and usually the sort of things which when we are investigating is some sort of bug or something like

that.

Q. But in fact none of the investigations came back --

A. That is correct.

Q. -- to say that that was the explanation for the cluster, did they?

A. That is correct.

Q. So let's move forward in our timings. Were you aware of the death of Child E at the beginning of August 2015?

A. I know -- I was involved in one death of the baby during this entire period, I was directly involved in the resuscitation and death of one baby which is not in the indictment and I was involved indirectly with the death of Baby A because I was taking care of the -- I was involved with the resuscitation of the baby in the previous 24/48 hours.

Most of the other babies I was not directly involved in. So I would have known them from when I am coming back next day to the work that we had this death or when we were discussing the deaths in the Perinatal Morbidity Mortality Meetings.

Q. Did the fact that there was now a fourth death in a very short period of time increase the level of concern that you had about there being a potential

problem on the neonatal unit?

A. Probably. I cannot remember. But, yes.

Q. The day after Child E died, Child F had a deterioration and we know now, and it was available shortly afterwards, so about a week later, that the insulin and C-peptide levels relative to each other indicated that external insulin had been administered?

A. Mm-hm.

Q. Dr Gibbs has described that as a collective failure that was serious in terms of all of the Consultants. Do you agree with that?

A. I do agree because if the babies have been in the unit for a few weeks, if babies are being in the unit for two months, all of us would have seen those babies in our hot weeks at least twice and in the other times, we would be in -- we would be knowing about those babies only when we are on-call.

So it depends on how long the baby stayed. If the baby has stayed for at least two months we would have opportunity to go to review the notes and we could have seen the results but it may not have picked up an abnormal result when we are looking at the trends because of the system we had. But we could have seen -- I suspect we would have looked for it more if the baby was unwell or if there were continuing concerns about

the baby.
But, yes, we -- we could have seen, we should have spotted. But I accept that as a collective failure.
Q. Returning to your witness statement, paragraph 20 on page 4. You speak about Child H. What you say in relation to Child H at paragraph 22:
"It was not clear why Child H had deteriorated hence why I sought help from the tertiary unit as documented in the notes. Any [unexpected] deterioration in a child is worrying."
A. Yes.
Q. At the time that you were contacting the tertiary unit, and you were worried as you tell us about the unexpected deterioration, did you think back to the events which had happened just in the last few months and in particular the deaths and sudden deterioration of Child B?
A. I don't think our mental focus would be going that far when we are seeing a sick child, what we would be considering is: is it something which is so unusual that we are not seeing? So is it an uncommon presentation of an uncommon condition so that we are not seeing or we don't have experience managing and that's the reason to discuss with the tertiary units where they, they do the neonatology every day so they might

have experience in seeing this condition.
So it is in terms of getting that advice, I don't think in that situation I would have the presence of mind to think about all the deaths which have gone on in that year.
Q. So after this unexpected unexplained deterioration had occurred, you didn't go to see your colleagues to say "why does this keep happening", or anything along those lines?
A. So we are now discussing only about the deaths, but I suspect at that stage we are not seeing the babies who are having collapsed and deaths but we also have other patients as well so I suspect I cannot see how my mind was working.
But maybe we weren't putting all the information together. Maybe we weren't discussing, we were discussing that particular child at that time rather than maybe we were or maybe we were discussing the patients who are coming in that Perinatal Morbidity Mortality Meeting rather than taking a bigger overview. Maybe that's why we, we probably missed looking at it because we -- here we are discussing only about these babies. But we were discussing about all the other patients where we had question marks and where we had morbidity issues, not just in the neonatal unit on the

children's ward as well.
So I don't know whether I am answering you properly.
Q. I am going to just move forward because it may be that we are going to have an example of such a discussion in a moment that I want to ask you about.
A. Okay.
Q. So we will move forward to Child I please, October 2015. As I understand it, you had some involvement in Child I's care when Child I died; is that right?
A. Child I's care during the stay, yes.
Q. Yes. Did Child I's death cause the concern that you have told us there was about the cluster back in June, did that have any effect on the concern you had about the neonatal unit more widely at that time?
A. I suspect we were always looking at medical causes. So I remember this baby because we were seeing this baby with abdominal distension and we are sending them to the regional units and they are coming back because they are not finding anything.
So we were scratching our head. Are we missing something else or are the surgeons missing something else? Why is a baby suddenly deteriorating here and goes and they are doing investigations, they are saying

they are not finding anything and coming back.
So I suspect that should have raised concerns. But I think our focus is still looking at medical conditions and I suspect we were still thinking there is something medical condition which we have not yet understood.
So I don't think we sort of connected with all the other previous deaths.
Q. Now, you will have heard Dr Newby this morning talk about a conversation that she had with Dr Gibbs, Dr Brearey and/or Dr Jayaram as she describes it following death of Child I. Did any of your Consultant colleagues come to you to talk to you about their concerns following the death of Child I?
A. I was definitely discussing with the Dr Brearey about the babies I was involved in, particularly a baby who died with cardio cause, whether the death -- the cardio cause can explain actually the death and he was trying to get the information from the cardiologist so we were having discussion. But I suspect he was discussing with the -- the colleagues or the discussions were not a group discussions but with the concerned colleagues who were involved in the care or the resuscitation at the time.
So I -- I wasn't aware of ...
Q. One of the things that formed part of the

discussion we are told is the fact that Dr Brearey was pointing out that one member of staff appeared to be a common factor at these recent events. Did he have such a conversation with you about that?

A. I do not remember having such conversation until that email, until the seniors meeting on the Monday -- June or July.

Q. So that's 27 June, we will come to that meeting which was the --

A. Yes, before that I wasn't -- I don't think I was aware because I don't think I was aware. I am saying that because I was sleepless for two nights after the seniors meeting and that's what sleepless in thinking and then trying to write that email.

So I don't think I would have heard Lucy Letby's name before that.

Q. Now, if I move forward and I am moving over Child J here because it may be that Mr Baker has some questions for you about Child J, to early 2016. It may be you have already answered this question, Dr Saladi.

We know that in January of 2016 a chart was produced showing which staff or nursing staff were on duty or allocated to babies and Lucy Letby's name was marked in red as it appeared on the chart.

Did anybody talk to you about that work being done?

Were you told that that sort of staffing analysis was under way?

A. In June 2016.

Q. January 2016?

A. January?

Q. So six months before that meeting.

A. I don't think so. I am not sure whether, was there -- was it there in the meeting?

Q. So it is a document that was produced.

A. Okay.

Q. There is no email that suggests that you received it. I am just wondering whether you -- anybody spoke to you about it or anything like that that you can recollect?

A. I cannot recollect.

Q. The thematic review of Neonatal Mortality Meeting took place on 8 February. Were you asked, you didn't attend?

A. I didn't attend.

Q. Were you asked to give any input to that meeting beforehand, did Dr Brearey ask for you to formally say to him what you wanted raised at the meeting?

A. As I said, he did discuss about the deaths where I was involved in and we were having discussions

but I -- I don't think he specifically asked me about other babies or whether -- I don't recollect me being asked to contribute to that thematic review.

Q. We know that the thematic review was circulated to all the Consultants on 2 March?

A. Mm-hm.

Q. We can look at it if we need to but I am sure you will take it from me that one of the first key theme or common theme that's identified is the sudden and unexpected deterioration of all of the babies that the document reviews?

A. Mm-hm.

Q. Did you notice that at the time that you received the report?

A. I think so.

Q. What was your reaction to seeing all of those babies put one after another with that apparently being a common theme?

A. Well, again, unexpected deaths, when we think it is unexpected we discuss with Coroner and they go to the postmortem. By the time the results come, it will take anywhere between three to six months time and so that's when we will know for sure what was the reason.

So I suspect, I am thinking that the Coroner's postmortem will give an answer because at least in the

patient I was involved in, it did give an answer even that there is a cardiac cause.

So I -- that would have been my thinking, that, yes, the postmortem might give an answer.

Q. So to put that answer another way, do you agree with this: didn't seeing that make you more concerned about what might be happening on the neonatal unit?

A. Well, there is concern that we had increased deaths, there is also a concern that as I mentioned about the taps. So we are thinking probably of still medical conditions.

So we were thinking or at least I was thinking that whether we are going through a bad patch.

Q. Were you aware of any plan to speak to the senior hospital management about the increase in deaths on the neonatal unit?

A. At what time?

Q. Well, in early 2016.

A. I do not recollect that. I don't know, I don't think so.

Q. So certainly nobody told you that as far as you can remember: we are going to need to --

A. As far as I can remember.

Q. "We are going to need to raise this with

senior management"?
A. Yes, I cannot remember now.
Q. If we move forward to Child L in April 2016, again Dr Gibbs has characterised the fact that the C-peptide insulin ratio did not lead to immediate action as being a collective failure which was serious.
Do you agree with that also in the case of Child L?
A. If as -- as I explained before if the baby was in the unit for a few weeks all of us would have seen and all of us would have had opportunity to look at the results, though they may not be obvious when we are looking at the trends. Because we would be looking at the results of the last couple of days and then if there is still concern, then we will be looking at the trends.
I don't think it would have shown up in the trends and I don't think we would be looking at the trends unless there is still concern about the baby. So I am not -- I agree that it is a character failure but I do not remember at what stage I became aware of that.
Q. On 11 May of 2016 Dr Brearey met with Mr Harvey, the Medical Director, and Ms Kelly, the Director of Nursing and Safety. Did you know that that meeting was happening at the time that it happened?
A. As Clinical Leads he will be meeting so I wouldn't have suspected that being any -- anything

different.
Q. So do you have a memory of him telling the Consultants, you in particular: I am going to meet with the Medical Director to discuss the neonatal unit and the rise in mortality?
A. I cannot remember now.
Q. It may follow from your last answer but I will ask to be sure. Do you have any recollection of Dr Brearey speaking to you after that meeting and telling you what was discussed at the meeting?
A. Is that in --
Q. In May of 2016?
A. I do not remember.
Q. We do know that Dr Brearley sent an email after that meeting talking about it. INQ0005721. I will just remind you, it is up on screen now. Again this is an email that's sent to you and other Consultant colleagues in which he talks about the meeting.
In bold, Dr Brearey makes a specific request about notifying him and Eirian Powell if there was any baby who deteriorates suddenly or unexpectedly or needs resuscitation.
Now, do you have any recollection, Dr Saladi, of having received this email and thought about what that might mean?

A. I don't think I thought about what that might mean. I thought this is -- I cannot recollect what my thoughts were at that stage, but we know that there was more babies unwell, more deaths at the time so I thought it is getting more information. Information gathering.
Q. Thank you, could we take this down, please.
You were involved in the care of Child N when Child N deteriorated on 15 June?
A. Mm-hm.
Q. My first question about this is: were you aware that Child N had deteriorated on 3 June?
A. I cannot remember now and I do not know whether I was involved with the deterioration of the baby subsequently where I was involved, whether I had, whether I had the presence of mind to --
Q. Dr Saladi, it may be my fault but can I just ask you to speak up a bit?
A. I cannot remember whether I remembered about the previous episode at that time.
Q. Well, Child N's deterioration on the 15th was sudden and unexpected; is that right?
A. Mm-hm.
Q. Dr Brearey had just a few days later sent an email saying that he wanted to know about that. Did you speak to him or Eirian Powell about the sudden and

unexpected collapse of Child N?
A. I don't remember, specifically speaking, but Dr Brearey was actually helping me in that resuscitation. So he knew about that deterioration because we had difficulty in securing the airway in that baby.
Q. Now, the Mother and Father of Child N have given evidence to the Inquiry about speaking to you?
A. (Nods)
Q. They say that you were not able to give a reason for the collapse and it seemed to them that you didn't have any answers.
A. (Nods)
Q. Is that the way that you recollect the conversation you had with them?
A. I remember the consultation I had with them after the baby was discharged and they first came and it was a very stressful consultation for me, that's why I remember, because the parents were rightly upset and rightly angry for the baby deteriorating and needing to go to the Alder Hey Intensive Care Unit.
And I remember because my mouth was completely dry and I couldn't say -- my words weren't coming out properly and -- but I could understand where they are coming from and the feeling. And now I do not remember

the exact words but I think they said: you have provided substandard care and they were asked quite a few questions, they did stuff I remember, but I thought -- I wasn't sure whether they were pointing the -- that I provided the substandard care, or me as part of the Trust provided the substandard care.

And I don't remember now but I probably would have directed them to the PALS that -- the complaints department, and I remember worrying about that meeting because I discussed with my Consultants. They didn't say anything about GMC but I thought they were unhappy with the care I have provided and they -- I was discussing with my colleagues that the parents are going to refer to GMC, what do I do?

The parents said usually -- my colleagues said usually parents don't do that, they don't lightly refer to GMC they probably will make a PALS complaint and now we do what we can because obviously we have to accept that the care was not adequate because the baby did end up in the intensive care and I did not have all the answers. But I don't think I received a PALS complaint as well because I had the notes with me for the next few weeks.

So I thought they were referring -- that was the recollection I had. So does that answer what you are

asking me?

Q. Thank you, I have got no more questions about your conversation with the Mother and Father of Child N.

LADY JUSTICE THIRLWALL: Would you mind if I ask one?

MR DE LA POER: My Lady, of course.

LADY JUSTICE THIRLWALL: You told us what you were worried about and what you thought they might do, but are you able to remember, because this is an episode which you do seem to have a good memory of, can you remember what you told them about what had happened to their baby?

A. In that meeting my mouth was completely dry, I was not able to speak well but I explained as much as I could and I knew that I was not able to answer their questions well because I did not have the answers myself but --

LADY JUSTICE THIRLWALL: So you agree --- sorry to cut across you -- because I think they said it seemed it them that you didn't have any answers. Was that reasonable impression for them to get?

A. I think so.

LADY JUSTICE THIRLWALL: Yes.

A. I think so.

LADY JUSTICE THIRLWALL: You are sure about that,

I don't want to lead you into it if it is not what you mean.

A. Yes, I think so.

LADY JUSTICE THIRLWALL: All right, thank you.

MR DE LA POER: Dr Saladi, I am going to move forward to the meeting that you have mentioned a number of times now which is on 27 June of 2016. This is the Monday meeting which you speak about in your witness statement. It's paragraph 33 if you want to turn that up on page 6.

You have told us already that that meeting caused you sleepless -- two sleepless nights before you then sent an email on the 29th. Can you, as best as you can, just tell us what was being said at that meeting and by whom?

A. I think it was Dr Brearey who was explaining in that meeting and obviously I already knew certain things that we had increased mortality in that -- in that period. But that was the first time that I realised that there was one member of staff who was associated with that meeting -- with all -- all these deaths. And the question was: what do we do next?

And if I remember correctly, it's about: can you refer a nurse or any member of staff, just because they happen to be associated, not causally, but with the

events, okay?

And that was, I was thinking of my own time when I came to UK, because I trained in India and the UK practice was different. So I was when I first came to the UK I was going and attending all the sick children because I wanted to know how is the things different.

So to blame somebody just because they were there I am not saying they were blaming but we were discussing at that stage; what do we do next? That was difficult for me to swallow at that stage, even though I didn't know what to do as well.

But I knew, remembering from -- again from the description, that they were looking at the rota. But I thought looking at the rota just to say somebody is there or not is not a definitive way of answering the question because at that stage we had two ways of entering the neonatal unit. One is the main entrance, which is with swipe access and the people who have the swipe access are the neonatal doctors and nurses.

And then from the back of the neonatal unit, we had stairs to the postnatal ward, which are controlled by the digital lock. And obviously as far as I understand the only people who know that digital lock is again the paediatric -- the doctors and paediatric -- our neonatal nurses, not the paediatric nurses.

So to say if somebody is there definitely in the unit at that time we need to know who could have accessed the postnatal ward as well and I know postnatal ward also is accessed by the swipe card. So that means somebody needs to look at at least minimum the rotas of the paediatric doctors and paediatric nurses and the doctors in the postnatal ward and the midwives in the postnatal ward and I didn't think Steve would have easily accessed that information because we were working in two different departments.

And to definitely say that somebody is there, we need that swipe access, that only the Trust could have had or the police could have had and that's why in the email.

Q. We will come to the email in a moment. I think you have -- so these were the thoughts that were going through your mind on the 27th --

A. Yes, yes.

Q. -- that a more detailed investigation needed to be done?

A. Yes.

Q. Now, there is an email -- and I can take you to it but I hope you will be able to remember it -- from Dr Brearey in which he sends what he describes as the consensus of the Consultants the day after that meeting,

that Letby should be excluded from the unit. Was that the conclusion of you all at that meeting on the 27th?

A. See, after -- see in those couple of days before I sent the email we, I remember we had quite a few meetings so I am not sure at what point that email came. But I can't see the email here.

Q. Let's bring it up. INQ0003116, page 2. It is 28 June there. You are not sent a copy of this but I am asking you about it because --

A. Yes, okay.

Q. -- he speaks about the consensus.

So if you look at the third paragraph:

"There has been a watchful waiting approach since our last meeting with Ian and Alison in March. However, since the episodes and deaths last week there was a consensus at the senior paediatricians' meeting that we felt on the basis of ensuring safety on the NNU this member of staff should not have any further patient contact on the NNU."

A. Death of the last week.

Q. So this is the day after that meeting on the 27th and he begins the email with:

"I thought it might be helpful to put down in an email what was discussed at the senior paediatricians' meeting yesterday lunchtime."

A. This is after the senior paediatrician --

Q. Exactly, the day after. And he is saying the conclusion was of all of the Consultants Letby ought not to have access to patients?

A. I think so.

Q. Was that your view as well?

A. Yes.

Q. We are now going to have a look at your email, the 29 June 2016, sent in the morning INQ0003112. We are going to go to page 3, please. You can see that email begins there -- I know that this is an email that you have looked at closely recently, Dr Saladi, to try to put your thoughts together.

But if I just summarise what the email says, it is that you reached the conclusion and you have set out your reasons in the email that the police were the right people to investigate?

A. Mm-hm.

Q. Is that right?

A. That is correct. Police, I didn't know if there is some -- some other agency which could help. So that question mark was there because if I can explain my thought process at this stage. When we are providing a neonatal care, particularly in a district general hospital, we see four groups of setbacks, okay, one is

unexpected setback, so this is a baby who is receiving a care in the neonatal unit, may be on the ventilator, their oxygen levels comes -- goes down and the alarms go off or it could be a baby who is feeling well until then, suddenly they stop absorbing the feeds or they might start vomiting or the baby who is suddenly well not opens the bowels. Various what we call setbacks. These are the common problems which we see and all the paediatricians and the neonatal nurses who work in the neonatal unit are experienced with this, that these are the setbacks and we explain to the parents as well, that the stay in the neonatal unit is two steps forward and a step backward because of these unexpected setbacks, that is a common experience.

So in these setbacks babies might actually need some extra oxygen and sometimes we might need to even give some extra breaths while we clear their airways and make them settle. So they might even need very brief respiratory support as well.

Then the next group of conditions what I would consider is unexpected setbacks leading on to cardio respiratory collapses. Those are much less common because babies' hearts usually do not stop, as long as they are getting oxygen they keep going, so they don't decrease. So somebody who is needing full cardio

respiratory resuscitation, it can occur in the -- at the time of birth, but after that it is quite -- well, it is less common at least in my experience and usually they do respond and if that is probably the situations where we discuss with regional units, particularly if we cannot explain why they have deteriorated. And if the investigation showed a reason for the explanation, and if that can be managed in the district hospital, they might stay with us.

Or if it is something which cannot be managed or if it is something which needs regional centres, we send them to the regional units which might need like surgical intervention, a cardiac intervention, things like that.

Then the next step up is unexpected setbacks leading on to death. These are extremely rare in the district general hospital. We do have deaths in the neonatal units but they are usually expected deaths. They are expected because there is an antenatally detected abnormality which we know is not survivable and there are some conditions like that. Or they are very extremely preterm and they know that again they are not survivable. And usually in these situation we inform the parents, we prepare them and so those are the deaths which normally happen in a district hospital.

Unexpected deaths are very rare in district hospital because we usually manage to stabilise them and they are usually sent to the regional units and if they are very, very unwell they might deteriorate and they might die in the regional unit after a few days or a decision might be done taken in the regional centre with the discussion with the parents to withdraw the care.

So that's in the district hospital. Unexpected deaths in a district hospital are extremely rare and that's why we usually discuss all of them with Coroner because the usual condition is -- for unexpected deaths is some unrecognised kind of anomalies, cardiac anomaly and that's where we might ask for a Coroner's postmortem or they might say, well, suggest to parents and if they are interested, go for hospital postmortem so that we find out the cause.

Then the next category is unexpected deaths which were unexplained even after investigations. They are extremely rare and I think this is my opinion, unexpected deaths which remain unexplained in a district -- in a district general hospital a paediatrician might see only a couple in their career and I already seen one that year and during that meeting when I am hearing that there are lots more unexpected deaths, which are

unexplained by the other colleagues as well, that is a concern.

I probably did not recognise when we were having these in the perinatal morbidity and mortality meetings because we do not know the information of -- we discuss them usually before the pathology reports are available. So I probably did not recognise that these remained unexplained until all that information is produced or Dr Brearey is discussing at that stage.

So that is a concern, we are having a cluster of unexpected but unexplained deaths at that time and the worry is: could this be due to infection because we had the taps, all the taps covered with filters.

So that means something else is going on and if somebody is saying that one person is also associated with all these deaths, that is even more worrying and the -- sort of that's a suspicion and if we have suspicion and I thought one of the teams who can deal with suspicion is the police because we are not good with dealing with suspicion.

And that was the reason I wrote that email and I said in the last but one paragraph, "it is unreliable information", maybe I should have said "it is incomplete information" because of the reason I mentioned before, that when we are suspecting we need much more

information than just looking at the rotas.

Q. Dr Saladi, you go on to say in your email -- we don't need to look at it, I am sure you remember very well -- that you recognise the police were able to do wider enquiries such as looking into people's lives searching this their homes, that sort of thing?

A. Yes.

Q. So thank you very much --

A. And I think after that we met the senior managers either that evening or the next day.

Q. We are going to have a look at that.

A. Okay.

Q. We are going to have a look at that.

A. Yes.

Q. I just need to ask you one question just to see if you can help us with it.

Over the page, on the screen we are just going to look at the top of it, just to see if you can help us with one very small part of this.

You say:

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

Can you just help us. The Inquiry has received a great deal of evidence about movement from night shifts

to day shifts. Who told you that Letby had been moved from ITU to HDU/SCBU care?

A. I thought most of the information was coming from Dr Brearey. But I don't know whether this was some other team member spoke, but that was my recollection. At least that information was given, but I cannot say who gave that information.

Q. Thank you. If we move up, please, this email thread. We will see on page 2 that Mr Harvey, there we are, we can stop there, has sent an email to all the Consultants saying:

"It has already been discussed and action is being taken. All emails cease forthwith."

What was your reaction to receiving that email?

A. I was hoping that this will generate a discussion because I know the senior the ward manager had a different opinion about probably the deaths and particularly about Lucy Letby and maybe I thought if you could explain these, what I was explaining to you, these unexpected and unexplained deaths why we were giving importance, which all the Consultants had at that time, maybe they would.

But that opportunity did not arise because ...

Yes, I don't know whether I -- did I answer your question?

Q. You have, thank you. So we can take that document down. We are going to move forward to the meeting that you have mentioned on 29 June. It was at ten past 5 and we have some notes of that meeting. INQ0003371.

This is a meeting we can see that you are identified at the top as having attended. Also present "TC", Tony Chambers, "AK", Alison Kelly, "IH", Ian Harvey and the initials on the far right "SPC" we understand to stand for Stephen Cross.

I just want to ask you about one thing you are recorded as saying at page 2, please. About a quarter of the way down you use a phrase that that I think you have used with us:

"Preterm babies two steps forward one step back don't suddenly deteriorate, these babies are relatively stable sudden deteriorate and collapse."

And can you recall saying that to the Senior Executives in that meeting?

A. I might have said if they have documented.

Q. I beg your pardon?

A. I might have said if they have documented.

Q. Yes.

A. I don't remember that.

Q. But that was something that you were thinking

at the time as you have told us?

A. Yes, yes.

Q. Do you remember at this meeting whether Stephen Cross said anything about the police, if not necessarily at this meeting but at the meetings that were taking place at this time that he was attending?

A. In that period, when we were discussing about what is an extra way -- how do we proceed, the thing I remember senior managers were saying is: this is coming across as doctors versus nurses, so that is why we will involve a external body, completely independent, which will have representation from the RCPCH and they will have a nurse representation as well, probably from Royal College of Nursing, and if they say that this is -- if they agree with what you are saying, then we will go with the police.

At least that's what I remember. That was the outcome of our discussions.

Q. My question was particularly about anything that Stephen Cross may have said about the police and whether you had a recollection of him saying anything at all at that time about whether the police should or shouldn't be called or --

A. I think there was talk of red tape and also like the media vans will be all on our grounds and so

there was some concern that we will be in the media spotlight at -- yes.

Q. Now, I will just read it out to you. What you say of this meeting in your witness statement is:

"However, the feeling I seem to remember from the time was that the senior management seem to have made up their mind with the investigation they have conducted without taking our concerns into consideration."

That's what you have put in your witness statement. Can you just tell us about why you said that in your witness statement? We can take this document down, thank you very much.

A. So when we were having this discussion, the question was we were having unexpected, unexplained deaths and we are seeing one member of staff identified with it. How do you proceed with it? Obviously I worked with Lucy and she appeared as a competent nurse, so I did not have any direct worry or suspicion on her.

So I thought they will gather information, they will get all of us together, when I say all of us at least all the Consultants and the ward managers of the neonatal unit and maybe the deputy manager, and get all of us together and share the information as to why they are supporting her so strongly. Would they still do the

same if we can put our thing forward as well?
Unfortunately that has not happened. By the time that we went there they were already talking about, well, there were not enough Datix reports, we have looked at the -- so it -- I was thinking that they were looking for information sharing, at least exploring our concerns. That did not happen and that's why I thought they had already made up their mind.
Q. I think there will just be time to look at the last meeting in June, 30 June of 2016. This is INQ0003362. It should come up on your screen.
We can see you are identified as being present as are some of the others that I have already mentioned. We can also see "DN" as the, or what appears to be "DN" anyway as the second initial along.
Do you have any recollection of attending a meeting that Sir Duncan Nichol, the Chair of the board, attended?
A. I do not recollect. I don't know. I might have met, but I don't remember now.
Q. And if we go over the page just to look at something that Dr Jayaram is recorded as saying. At the very top he is recorded as saying:
"Starting point what is safe reduce service but staff member not addressed. Discuss going to police..."

And a word that I won't attempt to decipher:
"... impact of an investigation."
I will just -- can you recollect a discussion where there was, on the one hand, being suggested that the unit was downgraded but, on the other hand, Dr Jayaram and/or any of the other doctors present pointing out that downgrading the unit didn't address the specific concern?
A. Yes.
Q. What was the reaction as you perceived it from the senior managers as to when that point was made?
A. Well, I think that's what I was saying; that they were looking at it as doctors versus nurses and they would get an independent input from a team, RCPCH, who are independent from us, with representation from the nurses and if they say -- if they agree with us then they -- then they would be going to the police.
At least that is the way I understood it.
Q. Just two more parts. Page 4, please, of these notes. We can see about halfway down, next to the word "Ravi", in terms of what was being said at that meeting:
"Concern potentially member of staff causing harm. Recurring theme."
What I just wanted to ask you about, Dr Saladi, is do you have a recollection of that being said in those

terms? So it's not just that we are worried about a member of staff, but it's that we are worried about a member of staff causing harm, so deliberately causing harm?
A. Which date was it?
Q. This is the 30th.
A. The 30th. I think after I sent my email because we were discussing -- because at that stage, we weren't -- we weren't sure what she could be doing and that is when in one of those meetings people were talking about these rashes, "Do you remember this rash?"
And then I think Ravi had done some research and then he said, "Yes, these sort of rashes were seen in the air embolism."
If it was after that email, yes, it could have --
Q. We had moved over that email. But that email was sent that morning. So it was sent on the morning of the 30th.
A. And this is after that?
Q. Exactly.
A. Yes, it would have. It goes with that then.
Q. The final thing to ask you about about this meeting if we just go over the page and this is just the note. We can see a heading "Actions":
"Review nurse deep dive, exploring new model,

actioning new model, planning team, comms plan, press release TV, downgrade and exclude might as well ring the police now."
LADY JUSTICE THIRLWALL: "If".
MR DE LA POER: "If", forgive me. Thank you very much indeed:
"Is everyone comfortable?"
And then some people are recorded apparently in response to that question. I haven't seen your name there but we can see that Dr Brearey, "Steve B":
"I made my views clear, nagging after last night. We will take on observations; felt obs..."
Again I am not sure of that word. It might be meeting.
LADY JUSTICE THIRLWALL: (inaudible)
MR DE LA POER: Yes, thank you, my Lady.
So at the end of this meeting, were you happy about the decision that there be a review and a nurse deep dive as opposed to the police being called?
A. See, I might be clumping all the meetings together because I can't remember which day which meeting has happened.
But my recollection is the reason -- we did discuss about the police but the reason they did not say is well, it is appearing like doctors versus nurses and we

need independent input and -- because if you are calling police, then all the media spotlight will be on us, nobody will be coming to our labour ward or neonatal unit. So let's get an independent input and if that shows, then we will go to the police.

Q. In terms of the concerns that you had about any risk that Letby might pose, what did you think needed to be done while all this process was going on?

A. I thought by then -- see, when we were having these meetings in those first few days, if I remember correctly, Lucy was away on leave so she was not supposed to be coming for at least a couple of weeks and there were quite a few meetings in those two weeks and at some stage I think the management decided that she is not going to come into clinical work.

Whether they decided or whether we had to insist, I cannot remember. But that decision was made at that stage in those two weeks.

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

LADY JUSTICE THIRLWALL: Yes. Actually just before we do, I'm sorry Ms Killingback, can you put that document back, please. It finished 00018 and can we go to the previous page. Yes, that is the page. Thank you.

A. Sorry, Madam, I have never seen these.

LADY JUSTICE THIRLWALL: You have not seen these notes before?

A. Before you sent this to me. So I have seen this report for the first time when the Inquiry sent this.

LADY JUSTICE THIRLWALL: Yes, so that's a few months ago, isn't it?

A. Yes, but I have not seen at the time of our discussions.

LADY JUSTICE THIRLWALL: No, no, I understand that.

It was just there is a comment that you made or is attributed to you about a third of the way down the page. Do you see, I think that's your name there, isn't it, "Saladi", and you are recorded as saying:

"Why review now and not before?"

It may be it speaks for itself but I wondered if you could recall why you said that at that meeting.

A. "Why review now and not before?"

LADY JUSTICE THIRLWALL: You have told us about the doctors v nurses and then we'll bring the RCPCH in and that they will decide and then we will go to the police.

I just wondered if you recalled why you said, "Why haven't you done this before?" if you did say that, and if you can't remember just --

A. I can't remember.

LADY JUSTICE THIRLWALL: All right.

A. Sorry.

MR DE LA POER: My Lady, I just wonder if I might --

A. I might be talking about the nursing deep dive, I don't know. I am speculating now.

LADY JUSTICE THIRLWALL: No, that's all right. You don't need to do that. Yes, sorry, Mr De La Poer.

MR DE LA POER: I don't know whether there is just one other matter that I could draw attention to on this page.

Dr Saladi, about two-thirds of the way down by your name, it reads:

"You are looking at us, that's what it is using 2 different..."

LADY JUSTICE THIRLWALL: Words?

MR DE LA POER: Words?

A. Cards.

MR DE LA POER: Cards.

LADY JUSTICE THIRLWALL: Cards, yes.

MR DE LA POER: "... security review."

Again, does that help your recollection at all about what you were saying question when you said:

"You are looking at us, that's what it is?"

A. I think they were talking about they were looking at -- they were looking at who accessed the unit with swipe cards, so I might have made some --

LADY JUSTICE THIRLWALL: I see, yes.

A. So I think it might be about the swipe cards, I think.

MR DE LA POER: Thank you very much indeed.

My Lady, is that a convenient moment?

LADY JUSTICE THIRLWALL: It is. Does that conclude the witness or is there more to come this afternoon?

MR DE LA POER: There is some more to come this afternoon --

LADY JUSTICE THIRLWALL: That's fine.

MR DE LA POER: -- including Mr Baker. I will have a few more questions.

LADY JUSTICE THIRLWALL: Of course.

MR DE LA POER: Then Mr Baker will be asking some questions.

LADY JUSTICE THIRLWALL: Thank you. I wasn't trying to hurry you, I was trying to work out where we were.

Thank you very much, Dr Saladi. As you will have observed we are going to take a break now and we will start again at five past 2 and then there will be some more questions for you but someone will look after you

over lunchtime. 5 past 2.
(1.05 pm)
(The luncheon adjournment)
(2.05 pm)
LADY JUSTICE THIRLWALL: Yes, Mr De La Poer.
MR DE LA POER: My Lady, thank you.
Dr Saladi, we are moving forward in our chronology to 13 July 2016 when there was a meeting and I am just going to ask for the notes to come up and we are just going to look at one line within those notes, you have seen them before because they were provided to you by the Inquiry. It is INQ0003365 and if we could move forward to page 4, please.
Now, Dr Saladi, at the bottom of this page, you will see the date Wednesday, 13 July 1 pm. You will see your name appearing just to the right of that dateline.
This is a meeting at which, as the Inquiry understands it, senior managers presented activity and acuity data to a group of Consultants, so that's the contents of this meeting.
We can see it began with an outline from Ian Harvey just below that and then we can see three or four lines down at 1.12, so 12 minutes into the meeting, we see your name, "left room" and then further along the line: "distressed".

My question, Dr Saladi, is whether you can shed any light on whether you recall leaving a meeting with Senior Executives shortly after it began in a distressed state?
A. I do not remember.
Q. Thank you. We can bring that down now, thank you very much. Continuing to move forward through the chronology, we know that you and your fellow Consultants met with the RCPCH on 1 September 2016. You deal with this in your witness statement at page 37 -- sorry, forgive me, paragraph 37, my mistake, the page number is page 8.
I want to ask you a couple of questions about that meeting. Firstly what you say in the witness statement was that you were disappointed to learn that they, the RCPCH, were not looking at the deaths. Can you just tell us what you meant by that and what you understood the RCPCH was looking at?
A. Yes. So when we met the Senior Executives at the end of June, I think, when we presented our concerns and the fact that Lucy was there, at least from the point of view of rotas, their statement, their argument is well -- I am not sure argument is right word but what they said is: it's coming across as doctors versus nurses, so we will get an independent review which

involves doctors as well as nurses.
So as far as I am concerned RCPCH was coming to look at the deaths of the babies and we met them as a group and the first thing they said is: we are not looking at the deaths --
Q. Sorry, no, you speak, please?
A. Yes. And then they asked us about our protocols, whether we are having time for SPA that what is supposed to happen this in a well-functioning department and we sort of answered all of them, obviously we had some issues with our rotas and things like that, we expressed all of them. And -- but it was very difficult to get a report of that and when we called -- I don't know, I think I also called RCPCH, they said it is the property of the Trust and they -- it is their, in their -- I don't know the right word remit or in their gift whether they went to provide the report to us or not.
And it took quite a few months for us to get the report and when we got the report it was on a printed sheet which the Trust said we cannot disseminate and within 24 hours or 48 hours they actually published that report on the Trust website, which is of poor quality, when I said poor quality, it is not the actual pdf document of the RCPCH, I don't think they would have

sent such poor quality document. It's a image of the pages which were reconverted into a pdf document which could not be searched and I didn't know whether RCPCH realised that the Trust was misusing their report in such a way.
I don't think you have it because I don't see that in your bundle, but I do have a copy of that in my Trust things which I don't have access any more. But what it showed is very bad print, difficult to read, the things which are easy to read are in the bold and they never mention in the bold that they were not investigating the deaths and they came out with more than 20 recommendations which were all in bold. So people just go to what is in bold.
Q. Can I just take you back, please, to that meeting on 1 September because I just had one question before we move forward in our timeline?
A. Yes, yes.
Q. Thank you very much indeed, Dr Saladi.
It is this: at the meeting that you had with the RCPCH you and your colleagues said to the assessors who had come that you were worried about a nurse on the unit potentially causing deliberate harm; is that right?
A. Yes, yes.
Q. Yes. We will carry on with looking at the

chronology, we will get to the point of --
A. Yes, sorry.
Q. No, no need to apologise.
There was a meeting on 26 January 2017. You deal with this in your witness statement at paragraph 55, which was an Executive and Paediatric Consultant meeting that you describe it as, at page 10.
You say that although you don't remember the exact contents of the meeting why it was held or who led the meeting, that's your (a) you say:
"I do remember the red face of Tony Chambers, his forceful voice and him banking on the table."
And you say:
"It appeared as if the senior management had completed the investigation without seeking any input from or sharing the report of their commissioning review with the senior clinicians."
Just please, if you can, in short summary form, just give us your impression of that meeting and in particular what you perceived to be the attitude of the senior managers towards the paediatric Consultants?
A. I remember that meeting we were all sitting round the table, Mr Tony Chambers were standing and they sort of said they have finished the investigations and banged the table like this (indicated) and they said we

are drawing a line under it and they said what we need to do, like writing an apology letter and things like that and obviously he was angry, red, that's the recollection of the meeting.
LADY JUSTICE THIRLWALL: Did you say you were angry or he is?
A. He.
LADY JUSTICE THIRLWALL: He was angry?
A. Mm-hm.
MR DE LA POER: Now, I am going to summarise the next section of events for you and perhaps you can just listen to my summary. Is it right, and the Inquiry have seen all of these letters, that after that meeting, there was a back and forth in terms of letters from the seven of you Consultants to Mr Chambers and then him replying, building to a position where the paediatric Consultants said that they wanted the Coroner to be told about their concerns?
A. That is correct.
Q. Is that right?
A. (Nods)
Q. It was early in that period, I think it was around the 7th or so of February, that the paediatric Consultants were given access, all of you, to the RCPCH report?

A. (Nods)
Q. You have told us -- and the word you use in your witness statement is that you had to fight for it?
A. Yes.
Q. Now, I am not going to put them up on screen but you have had an opportunity to refresh your memory from a WhatsApp chat that you and your colleagues had at the time just before the report was released to you and just summarise for us how you were feeling at that time, so 7 February, about how the senior managers were treating you as a Consultant body?
A. Is that after we saw the RCPCH report?
Q. Just before. It was just before and there was a message just after?
A. Our communication, the relations between the senior staff and the senior managers and the Consultants had broken down, okay, and they were not sharing the information and we had to fight for it and in the meantime, two of my Consultant colleagues were involved in -- I don't know whether a grievance process was already going or it started subsequently.
So, and my feeling remained the same, that they are making decisions without taking our views into consideration, particularly our concerns that quite a few deaths remained unexplained, they are not just

unexpected but remained unexplained.
I don't think they were looking at that aspect of the thing well. That's what I thought.
Q. We know that during this period of time there was conversation about Letby returning to the ward. What was your position at that time about whether Letby should be permitted to come back to the ward?
A. I don't think I was aware that she is going to come back to the ward but we all has -- have decided that before Lucy can come back to the unit they need to look at the deaths and they need to have a good explanation as to why these unexpected -- what is the reason for these unexplained deaths.
So we were not happy for her to have patient contact without explanation for these unexplained, unexpected deaths.
Q. Was there any plan agreed between you Consultants as to what you might do if the senior managers insisted upon Letby coming back to the ward?
A. We were discussing at that stage what -- what do we do and everybody, the way whistleblower, the way the report is sent, the way contact some media and give our concerns that this is all being hushed up by the Trust.
But I don't think we had any firm plan as to what

we would be doing because we were continuing to insist that Trust investigate the deaths properly and, yes, it is speculation for me to say what we would have done if she has come back. But I don't think we would have just sat down and let her come back to the unit without our concerns properly answered.

Q. In April, 12 April of 2017, you met with Simon Medland QC, as he was then?

A. Mmm mm.

Q. And you deal with this at paragraph 62. There are just two aspects of that meeting that I would like you to deal with, please.

Firstly, what did you understand the purpose of that meeting to be?

A. I think my understanding is how do we present the case to the police. So he was trying -- before the meeting our understanding is he was going to help us in sort of not formulate, make it explain probably to the police what are our concerns so that it's clear in our all minds.

So I thought it was to clarify the thoughts in such a way. Whereas when we actually met him, it transpired that that was not the case. He was trying to -- again he was trying to prove how it appeared as if they are looking for proof from us. And well, we thought he was

saying that there was not enough proof and the police wouldn't take it, police wouldn't spend their time and energy on this but at least he heard all our concerns.

Q. Well, I was just going to ask you in order to complete the picture, what you say at paragraph 62(c) is:

"He was the first person in any capacity from the trust management to ask for my side of the story and I feel some of my colleagues felt the same"?

A. I agree with that.

Q. So was Mr Medland open to listening to what you all had to say?

A. Exactly.

Q. Dr Saladi, there is one matter further that I just need to ask you about. It involves us just going back slightly in our timeline because one of the areas the Inquiry is investigating is what information was provided to the Coroner and I would just like to deal with that event now.

Now, we know from records that you gave evidence to the Inquest into the death of Child A on 10 October 2016?

A. Mm-hm.

Q. We also know that there were some witness preparation sessions, did you participate in any witness

preparation sessions for giving evidence?

A. From the Trust's solicitors?

Q. Yes.

A. Yes.

Q. Did you have any discussion with Dr Jayaram about what you might say to the Coroner about Child A's death?

A. I do not remember.

Q. Now, can I make this clear. There is no evidence that the Inquiry has yet seen that you were ever asked a direct question about generalised concerns?

A. Yes.

Q. But can we just look at what you knew when you went into that witness box to give evidence to the Coroner?

A. Yes.

Q. So we will just run through very briefly what you have told us: you had attended a meeting on 27 June earlier that year during which colleagues raised the possibility that Letby was killing babies?

A. Yes.

Q. You had written an email two days later in which you said that you thought the police should be called?

A. Yes.

Q. As you have told us you had been part of email correspondence which suggested that air embolism may have been used as a way of killing babies?

A. Yes.

Q. You attended a number of meetings with Executives at which the concerns your colleagues had were being repeated about the fact that they thought deliberate harm may have been caused. You were aware that Letby had been excluded as at that time due to the fact that she might be responsible?

A. (Nods)

Q. You had attended the RCPCH meeting on 1 September, so just a month or so before, at which you and your colleagues were telling the RCPCH that you were worried that the deaths might not be natural?

A. (Nods)

Q. All of that you have told us already and of course you told us with Child A that as far as your interaction with Child A was concerned, was that they were the healthier of the two babies when you had dealings with them and that you had no reason to think that Child A was going to die when you interacted with Child A and provided care.

So my question, Dr Saladi is this: did you tell the Coroner any of that?

A. No.
Q. The question which follows is: why not?
A. Again I think that was probably my first, maybe first or second appearance of Inquest and I was stressed and advice we got from the solicitors was answer the questions, what is asked, don't answer what you think was asked and keep it brief and do not speculate.
So if the Coroner has asked me, I would have probably said. But because it wasn't asked, because what I didn't know is what is speculation at that stage. So that's why I didn't -- I didn't -- I agree I didn't.
Q. Did you think that the information that we have just run through was irrelevant to the Coroner or did you think that it might be relevant?
A. See, we were discussing with that particular child and as far as I am aware, Coroner is aware of the deaths. I didn't need to tell them, okay.
LADY JUSTICE THIRLWALL: Why do you think that?
A. Sorry?
LADY JUSTICE THIRLWALL: Why did you think the Coroner was aware of all the deaths?
A. Well, because when we were having these unexpected deaths, we were referring them to the Coroner.

LADY JUSTICE THIRLWALL: I understand.
A. So there would -- he would I would expect know that there were increased deaths as well. What was your next question?
MR DE LA POER: Well, my question was whether you thought it might be relevant information for the Coroner to know when he makes a determination about the legal questions that he's got to answer about the death of Child A.
A. I was thinking whether rightly or wrongly that I was answering in relation to Baby A my involvement, if I had any suspicion, and my answers were brief and to that point, what he asked.
It is probably in retrospect mistake for me to not share my concerns but that is because of inexperience, I think. I did not have any experience with the Coroner's process and that is why I am much more open now rather than just answering what you are asking, whereas at that stage, I was just answering what is being put to me.
Q. So does it come to this: your position today is that you should have told the Coroner that information?
A. Not just that. The Coroner should have asked me.

MR DE LA POER: Dr Saladi, that concludes the questions that I have for you. My Lady, my learned friend Mr Baker Kings Counsel has Rule 10 permission to ask questions on behalf of the Families that he represents.
LADY JUSTICE THIRLWALL: Very good, Mr Baker.

Questioned by MR BAKER

MR BAKER: Dr Saladi, when you gave evidence at the Inquest, did you feel under pressure not to reveal your concerns regarding Child A?
A. No. I was not -- are you saying I was under pressure not to reveal? No, I was not under pressure much.
Q. So you would have been entirely free to volunteer your concerns?
A. I was under pressure of my own volition, not because somebody has pressurised me, because it was new to me to give evidence like that. So I was under pressure and I was answering only what I was asked. Does that make sense?
Q. You knew what the purpose of the Inquest was though, Dr Saladi, was to find out the cause of Child A's death?
A. Yes.
Q. Did you not think that that might have been

helpful information to the Coroner that you had suspicions that someone may have murdered Child A?
A. Yes, I did think that way yes, it might have been -- it's probably my mistake, I didn't consider from that point of view.
Q. Are you sure you weren't concerned about the consequences for you if you did reveal that?
A. No, in what way?
Q. Well, did you feel concerned that those who employed you might put your job at threat?
A. No, no.
Q. I am going to ask you some questions in general about the early part of the chronology of events, so when people first became concerned about deaths and collapses on the ward. You said in evidence, and indeed it was said by Dr Newby, that there was a concern amongst some that there may be a source of infection on the ward causing collapses and deaths?
A. There was concern, yes.
Q. Yes. That concern was dealt with by investigations as to potential sources of infection, wasn't it?
A. Yes.
Q. Those investigations revealed no source of infection?

A. There was no infection in the babies, that is correct.
Q. Yes, not just in the babies, in the ward either.
A. Well, we were having bugs from the taps.
Q. But filters were put over the taps?
A. I think even with the filters they were still isolating the bugs.
Q. But the issue when it came to the babies is that the babies were investigated for infection?
A. That is correct.
Q. Reliable evidence was obtained that those babies had not been infected by any contamination from the ward?
A. Yes.
Q. Yes. In relation to the rashes that had been seen in Child A, B and D, you saw a rash in Child B and you gave evidence that you were aware that people were contacting various specialist teams for advice regarding the rash?
A. No, for advice regarding the deterioration, not about the rash.
Q. I see. The discussions about the rash in the unit were: this is something that nobody could quite explain what it was?

A. I do not think at that stage I was aware of all the discussions which were going on about the rashes.
Q. But you were aware that if a rash was something that you couldn't explain, but you weren't concerned about it because it had disappeared in Child B?
A. Yes. Well, as I said, rashes are common and we would worry if there are progressive rashes. So we were worried as to why the baby deteriorated needing resuscitation, but I probably did not pick up the significance of the rash which was noticed in the night which has become less prominent by the time I saw in the morning.
Q. But the point is this: This was a rash, one that you saw, that you were not able to explain. It didn't fit with anything that you had seen before?
A. Well, at that stage I was thinking it is probably some sort of infection which is causing the rash.
Q. But infections cause rashes that persist; they are not transient?
A. Not necessarily, yes, they can be transient.
Q. And you were unaware of discussions on the ward regarding other people's concerns about rashes?

A. At that stage, yes.
Q. When it came to looking into the collapses and deaths of the children on the unit, the concerns that you had amongst your colleagues is that these collapses were all unexpected and unexplained?
A. Unexpected, unexplained usually it is not something we have that information prospectively. That takes as I said a detailed postmortem examination which was not available at that stage.
Q. But the concerns that you and your Consultant colleagues were having were as you said in your email of June 2016, that these collapses and deaths were unexpected and unexplained?
A. That is correct, yes.
Q. Yes. And so looking --
A. That is in retrospect.
Q. Yes, retrospect.
A. Yes.
Q. But the point is that looking at these collapses and deaths even retrospectively, you were not able to find a source that explained why the children collapsed, let alone a common source?
A. Yes, that is correct.
Q. So in the case of Child D, who I think you were involved in, there was a suspicion that their death

may have been caused by infection but in fact there was no clear evidence that Child D did have an infection causing symptoms prior to their collapse. Do you recall that?
A. I will have to see the notes, but ...
Q. Well, if you don't recall, it's okay. We can put that to other witnesses. But unexpected and unexplained is important, isn't it?
A. It is.
Q. Because --
A. It is.
Q. -- in the context of a neonatal unit --
A. It is.
Q. -- collapses when they occur are usually expected, but in any event can always be explained?
A. Sorry, say the second part?
Q. So collapses in a neonatal unit are commonly expected --
A. (Nods)
Q. -- and usually can be explained?
A. Yes, it may not always be expected, unexpected can still happen. But usually explainable.
Q. Yes. So it is the combination of unexpected and unexplained that is important?
A. That is correct.

Q. Yes. Finally, I want to ask you very briefly about an interaction that you had with the family of Child J in December 2015. If I just explain to you briefly the background to that interaction.

What happened was Mother and Father J complained that they had found Child J in the COT with their nappy off, their stoma bag off and a towel soaked in faeces wrapped around them and they were concerned because Child J had a Broviac line which was a potential source of infection if it got dirty.

Do you recall having a meeting that you attended with Family J and a nurse regarding that incident?

A. I do not recall the meeting. I might have met but I don't remember.

Q. At that meeting, the nurse said to Family J that they were probably just over-tired and should go home and rest in response to their complaint. Does that refresh your memory?

A. No.

Q. Regarding usual practice or your impression of how perhaps people should have behaved, if a child with a Broviac line was left covered in faeces or wrapped in a faeces-soaked towel, it would be entirely reasonable for their parents to be concerned by that, wouldn't it?

A. Absolutely, yes.

Q. Yes. That should have led to the filling in of a Datix form, shouldn't it?

A. I would agree.

Q. It should have led to an acceptance that their complaint was a reasonable one, not advice to go home and have a rest?

A. I would agree, yes.

MR BAKER: Yes. Thank you, my Lady, I have no further questions.

Questioned by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Thank you very much indeed.

I wonder if I can just ask one question.

Dr Saladi, you were asked the last question you were asked by Mr De La Poer was about what you should have told the Coroner and he asked: is your position that you should have told the Coroner about the other concerns? And you said: not just that, he should have asked me.

The reason he should have asked you is because?

A. He knows that we will be under stress and we may not be coming forth, coming forth with the information. I am not saying that, see he has experience, he knows that we will be under stress and I don't know whether he will be aware of the legal

advice we will be given, so that is be brief, answer only what you are asked and don't speculate.

So that is why I am saying maybe because he is experienced and in that situation, that is a -- I am not experienced in giving Inquests. But he is experienced in running Inquests and I would have expected if he was aware of -- because I was when we were going to the Inquest we are not thinking of all the things, maybe we should, but we are just thinking about what did we do, what is my involvement, did I do anything wrong? Did I miss anything? Our mental process goes like that.

LADY JUSTICE THIRLWALL: Well, you can speak about your mental process. One of the things you mentioned a bit earlier was that the Coroner knew all about these earlier incidents.

A. Speculation, yes, because we would have at least -- I sent two, I spoke to Coroner twice --

LADY JUSTICE THIRLWALL: Yes.

A. -- myself about these babies and I know my colleagues referred some of the babies to the Coroner as well.

So by the time the Inquiry came the Coroner would have the information that there are more deaths in the unit. It is from that point I mention. I wasn't trying to be critical of Coroner. I was just -- I don't want

to come across like that.

LADY JUSTICE THIRLWALL: No, all right. Thank you very much indeed, Dr Saladi. That concludes your evidence. Is there something else you want to say?

A. I want to say two things, madam.

LADY JUSTICE THIRLWALL: Very well.

A. One is about the RCPCH evidence. I think the Trust used the RCPCH evidence in such a way that it showed our department in a bad way initially and they used that to say that all these deaths were due to a poorly run department and if you want I can explain why, how that is done.

The second thing is I want to apologise to all parents for not able to prevent the deaths and prevent the harm done and it is a guilty feeling I carry and I think I will carry for the rest of the life. I am profoundly sorry for that.

LADY JUSTICE THIRLWALL: Thank you, Dr Saladi.

Mr De La Poer, do you want to ask anything arising out of the penultimate observation?

MR DE LA POER: Nothing, thank you very much indeed.

LADY JUSTICE THIRLWALL: Thank you very much. You are free to go, thank you, Dr Saladi.

Now, there is one more witness for this afternoon

and I am told it will be more convenient were we to start her evidence at 3 o'clock, so we will do that and then we will run through to the end of the day. Thank you.

(2.42 pm)

(A short break)

(3.00 pm)

LADY JUSTICE THIRLWALL: Ms Langdale.

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

DR SUSIE HOLT (affirmed)

Questioned MS LANGDALE

LADY JUSTICE THIRLWALL: Thank you very much, Dr Holt, sit down.

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

A. My name Dr Susannah Holt, I am known as Susie, and my qualifications are Bachelor of Medical Sciences and a Bachelor of Medicine and Bachelor of Surgery from the University of Nottingham.

Q. Can you tell us your role at the Countess of Chester Hospital from March 2016?

A. In March 2016 I was employed as a locum Consultant and then in April 2016 I was employed as a substantive Consultant. I was a general paediatrician with an interest in gastroenterology.

Q. You have provided for us, Dr Holt, a statement dated 4 June 2024. Do you have that with you?

A. I do, yes.

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

A. They are, yes.

Q. You tell us at paragraph 4 when you first became aware that there was an issue, you describe it as an increased number deaths on the neonatal unit. When you were interviewing, did you have any idea about that?

A. No.

Q. You tell uses it was at a meeting in April with Dr Jayaram and Dr Brearey. What did they tell you in April 2016?

A. There had been a death on the neonatal unit and it was brought up in the Consultants' meeting the following Monday and it was then I became aware that there was some concerns about an increased death rate on the neonatal unit. The exact details of the conversation I'm afraid I couldn't recall now, but I was aware that there was this death and some preceding that and it was after that I asked for more information.

Q. So there was a death preceding that meeting. In the first conversation you had, were all neonatal deaths grouped as deaths or was there a discussion about

unexpected and unexplained deaths, distinct from other deaths?

A. I couldn't -- I can't recall that kind of detail, I am sorry.

Q. But you describe it as you not aware of an increased number of deaths on the unit, so do I take it it is more likely to have been a broader looking at deaths or you just can't remember?

A. I can't remember.

Q. You tell us at paragraph 8 you can't remember being involved in any specific debriefs or discussions, is that the whole team that you were working at the Countess of Chester in relation to any babies?

A. I wasn't involved in the resuscitation of the deaths of any of the babies and therefore I wouldn't expect to be and wouldn't anticipate being involved in the hot debriefs that may have followed.

With regards to the Postnatal Mortality Review Tool, which was the way this which neonatal deaths are reviewed as standard, I did attend those in accordance with my leave and other things, but again I'm afraid to say with nine years I couldn't tell you exactly which meetings I was involved in and which discussions.

Q. Do you know if you attended anything in relation to Babies O and P, the two of three triplets

who died?

A. I can't remember, I'm sorry.

Q. You of course aren't there in 2015 with the earlier deaths?

A. No.

Q. We asked you whether you had read or understood NHS whistleblowing policies and knew how to raise concerns generally and you said you had a paper copy on your desk. In 2016 was that the case?

A. Yes. So I -- I don't know where it came from but I had a paper copy of the NHS whistleblowing policy and I had read it in relation to some of these worries.

In terms of what date I got it I couldn't tell you though. I just know I had read it during that time.

Q. At some point in that year. You tell us in your statement that between you as consultants you are discussing issues of whistleblowing and the like, but if we look at your statement, you say at paragraph 12:

"'We first wondered about calling the police. In an email sent some months before that if I could change one thing in my life and all of this stuff things I have done, I could change one thing in my life. I would have called the police that day."

I just want to ask you what email you are talking about there? Is it the one we know that Dr Saladi sent

to colleagues about the police and we are all -- we could all be suspects and the police should be called?

A. May I just read that paragraph?

Q. Paragraph 12.

A. Yes. (Pause)

Q. Do you see you refer to an email?

A. Sorry. You will just need to give me a second I have got it. I will just read it.

Q. Okay.

A. Thank you.

Q. While you are doing that perhaps we can have document 003112, page 3, Dr Saladi's email on 29 June.

A. I remember the email and when I received it.

Q. Is it the one that's just coming on the screen because that's in June?

A. Sorry, it's ...

Q. 29 June, do you see that? If we go to page 4, please, Ms Killingback. It's not there. INQ0003112, page 3 and 4.

LADY JUSTICE THIRLWALL: We have looked at it.

MS LANGDALE: It was one from Dr Saladi. Should I read it out to you?

A. It's appeared.

Q. Next page. That's page 1, so we are looking -- if we go to page 4. You see this is the one

from him. You see that:

"I believe we need help from outside agencies"?

A. Yes.

Q. "We are all under suspicion. The only agency who can investigate all of us I believe is the police."

It is that one, is it?

A. Yes.

Q. I just wanted to anchor the time of your paragraph 12, so it is that one in June.

A. Yes, I think that is the one it relates to.

Q. Right, so if we go back to your statement now, that can go down. If we go to paragraph 12, you there -- perhaps we can have that page of your statement on the screen to help others INQ0101112, page 3. Page 3 and 4.

You set out a number of observations there and how you felt about not calling the police. It is page 3 at the bottom, that's right?

A. Yes.

Q. Then if we go to page 4, we see the end the quote. So if we go to the next page, thank you, Ms Killingback.

Can you see there:

"... we all read ferociously. We read the GMC guidance on whistleblowing. We talked to our defence

union. We all read all the case reports about Beverley Allitt."

So you are talking about this time, June 2016, yes? After you have received that?

A. The email was received, it's the first time I think we had put in writing about talking to the police. The context of that interview was kind of my ramblings, I am not sure I would describe them all to being exactly in June 16.

Q. Not the same time?

A. Yes, it was more a description -- the way in which the questions were asked in that interview, it was more of probably a bit of an emotional offload about how hard it was at that time.

Q. Yes, I understand.

A. As opposed to a specific time point.

Q. So if we look at the content of it though, not tying you to June thereafter at some point you tell us that you read GMC guidance on whistleblowing, talked to defence unions, what role could they have for you at this point?

A. So we agreed at one stage to liaise with our various defence unions and we all -- you pay your defence union so you choose a different defence union depending on arrangements about what any different

actions that we could take a different course of action.

Q. So did you talk to them about going to the police or phoning the police or anything like that; you can't remember?

A. I don't think it was specifically about a question. I think it was more that we were in a situation where we had a concern about a raised number of deaths and that we had reported it and a lot of the advice we got back was to continue to pursue within our Trust because I think their feeling was the Trust have heard you and they are taking steps.

Q. So when you say you had reported it, reported it within the Trust to management?

A. (Nods)

Q. Raised concerns with management?

A. Yes.

Q. You say we had read all the case reports about Beverley Allitt. Do you remember doing that?

A. I do, yes.

Q. You say you lived in this sort of slightly dark world of just what did others do and how did they do it. What did you mean by that?

A. How did that come to the attention of the authorities and how did it get investigated? And actually it transpired that it was through a different

means, actually, the death rate was noticed in the intensive care unit of the tertiary hospital.

Q. So you found that out at the time or you learned that subsequently?

A. At and around that time that was information I found out.

Q. You say here:

"I think we were wrong to put faith in the management system to make the right decisions. Because I think, you know, reputation of course, it would cause damage."

Do you want to elaborate on what you meant by that?

A. I was a brand new Consultant and I put faith that the leaders within the organisation, the Medical Director, the Chief Executive, would know and understand how to, I don't know, process our concerns and apply due diligence to scrutinise, you know, and look into our worries. I don't think that is what happened and I felt one of the -- one of the senses I got was that it was protecting their own reputation and being concerned about negative publicity for the hospital.

Q. You say at paragraph 13 that you:

"... recall that we, as a group of consultant paediatricians, spoke to the Local Negotiating Committee representative, at the time, Dr Sean Tighe"?

A. Yes.

Q. Were you involved in any discussion with him or what did you understand had been, if not the discussion with him?

A. No, I wasn't involved in the initial discussion with him. He then attended a paediatric meeting at some point so I do remember meeting him. But again there were so many meetings there is a bit of a blur as to what happened and in what order. But I believe I know Steve Brearey was involved in a discussion with him.

Q. You say there were lots of meetings. Were you all on a corridor I have seen references to a corridor, did you have offices or where were you based in the hospital?

A. Yes. So we were based on the ground floor the Women's and Children's building behind a fobbed door and there were essentially sorry -- five offices off that corridor and then our secretary's office and a further three offices for the paediatricians off their -- off the sort of bigger secretarial room.

Q. So plenty of chance for informal corridor conversations as well as meetings?

A. Yes.

Q. Did you ever have management popping down to

see any of you there or other individuals from other departments?

A. I had very little interaction with senior management in terms of Medical Director, Chief Executive, head of nursing, very limited interactions with them during this timescale in 2016 and through to 2017.

I had a lot of interactions with my clinical lead who was Dr Jayaram and with the sort of our business managers so the people within our division who were responsible for the day-to-day working rota co-ordination, that kind of stuff.

Q. Who were your business managers?

A. They changed a number of times over the -- over the time even I was there. But it was -- certainly I worked with -- I cannot even remember all their names, I am sorry. Emma Jane was one of them at one stage who was our paediatric service manager. But the only interaction I had in the offices was when Sir Duncan came to see me. I don't think he came specifically to see me but he came, but this would have been much later on.

Q. I am going to ask you about that when you met him later?

A. Okay.

Q. But as a routine you wouldn't get any visits from the board on the corridor?

A. No.

Q. In terms of training, you say:

"I did have training from the Trust [at paragraph 14] on the processes used to review deaths retrospectively in adults."

But it didn't cover child deaths or processes.

Can I ask you what your understanding was then about what should be done where there was an unexpected or unexplained death of a child in the hospital?

A. So I think this is a really interesting point and it's something that I have thought a lot about since. The sudden unexplained Unexpected Death in Childhood policy is and should be applied in the hospital as much as it would be in the community. I think perhaps there was a bias in our thinking in that we would very rarely over the course of a career use it in hospital. The way in which it is written I would suggest leans more towards the kind of community deaths which is more typically where we would have met it as a learning opportunity as a trainee doctor and in all honesty, you know, throughout your careers, sudden unexpected death in hospital is actually really, really rare. Really rare.

Q. So I take it from that you didn't know that you should refer to safeguarding boards or Child Death Overview Panel or anything like that at that time when there was a sudden and unexpected death in hospital?

A. So you wouldn't refer to a Child Death Overview Panel, that would be standard process is that all deaths are reviewed in a Child Death Overview Panel that's part of the Child Death Review process.

Q. In 2016 was that your understanding?

A. Yes. Would I refer to safeguarding? So you wouldn't usually refer a child after death to safeguarding. That wouldn't be considered standard process. You would refer a child that you were concerned had come to harm to safeguarding, yes, wherever that had happened.

Q. Might an unexpected and unexplained death raise a question of harm, how could you conclude that if it was unexpected and unexplained, that there wasn't harm caused?

A. Sorry, say that again?

Q. You said you wouldn't unless there was harm, so you wouldn't automatically refer a death, but a sudden and unexpected and unexplained death might be as a consequence of harm, might it, so you can't eliminate that such a death hasn't been caused by harm,

so would you refer it?

A. But you would go through the process so -- sorry, it is the terminology is a bit different. So if you recognised something was a sudden unexpected and unexplained death there is not one referral there is a whole process that you would go through which would involve an immediate and urgent phone call actually to different agencies to put in motion a Joint Agency Response and that would include police, social services, and then you would also proceed with standardised documentation.

So, yes, it is a safeguarding process but it's different to sort of a safeguarding referral, if that makes sense.

Q. Do you know or did you know who were the designated doctors for safeguarding in the hospital at that time?

A. Yes.

Q. Who were they?

A. So my mind's gone blank and I shared an office with her, so that is unforgiveable. Howie, sorry.

Q. Dr Howie Isaac?

A. Yes, was our designated doctor for safeguarding and Dr Rajiv Mittal was our designated doctor for child death.

Q. Overview panel. Did you have any dealings with either of them?

A. As I said, I shared an office with Howie Isaac for some of my first year as a Consultant and Rajiv and Howie regularly attended Consultant meetings and had offices on the same corridor as the general paediatricians at that time.

Q. So do I take it when you had these concerns in 2016 and talking to your fellow Consultants, you would have been talking to do Howie Isaac, or she would have heard of it in any event because you were sharing an office?

A. Yes, I would think so. It is really difficult, isn't it, because I can't pinpoint any dates for you, but like I say, they would attend some of our Monday meetings and they were very much part of our wider department, so I do think they would have been aware of the concerns.

I would caveat that with I was only there for a very short period of time, from the March -- and as I said I really didn't know anything about it until the April -- until the July when it was really very we were it was more open because she had been moved off the unit.

Q. Do you think in conversations with either

Dr Issac or others you were conflating deaths and unexpected and unexplained deaths? In other words, could have been talking about a higher mortality rate or deaths without being specific each time about whether a death was unexplained and unexpected?

A. We wouldn't in regular conversation be emphasising, as you are in this process, "unexplained, unexpected". But actually I would take you back to the context of working in a district general hospital with that level of neonatal unit, we wouldn't expect to have that number of deaths over that period of time, so it would have raised an anomaly that we were having so many in a relatively short period. But like I say, I was only there for the latter part of some of that, so can't attest to the earlier conversations that may have gone on, for example around February time when I know there was a review done, because I saw it.

Q. You saw that February mortality review?

A. (Nods)

Q. When did you first see that?

A. That was in the April when I was told about the concerns and as part of that, Steve and Ravi said I could have a look at and see any of the relevant information.

Q. What did you make of that when you first

looked at that?
A. Hard to say. It's devastating to even think that. It's devastating when any child dies and so it is devastating when you have a run of deaths and every single one of those babies is somebody's loved one and I never lost sight of that and I don't think the other Consultants did either.
So you are inquisitive as to what, where, how has this happened and your first thoughts are always about medical causes I guess because that's my training. You know, can they be explained by infection or ... and I think if I remember rightly within that report, you know, they had thought about things like superbugs which is obviously very important to consider, and they had thought about common medications and rare side-effects.
So.
Q. Had investigated and eliminated them?
A. Difficult to eliminate them but investigated ed them and then thought about ways and means of modifying the sort of guidance going forward, the treatment plans, et cetera.
If I am honest, I don't think I really knew what to think. I was very taken aback by it all and took a bit of time really to process it.
Q. You work in palliative care don't you?

A. Yes.
Q. You, we can see from documents I am going to take you to now, were very sensitive to what parents were being told and how they were being told things; is that fair?
A. (Nods)
Q. If we go, please, Ms Killingback to 0014414, page 1 and 2. Dr Holt, what should come up, my Lady, it is tab 5 for you, is external communication from the Countess of Chester Hospital dated Thursday, 7 July at 2 pm.
This is at a time when the unit is about to be downgraded. We see there what is stated in paragraph 1:
"Temporarily changing the admission arrangements for our neonatal unit to focus predominantly on lower risk babies after 32 weeks."
Paragraph 3:
"We have seen in some of our most poorly babies those with high dependency needs an increase in neonatal mortality rates for 2015 and 2016 compared to previous years. In light of this we have asked for an independent review of our neonatal service from the Royal College of Paediatrics and Child Health and the Royal College of Nursing which is expected to be completed by the end of August."

We know before that the Consultants were sharing various emails about a draft and statistical variations and goodness knows what, and I am not going to take you to that, Dr Gibbs was taken to this yesterday, but you, in the middle of that, raise -- I think we were also taken to this in Dr Gibbs' evidence at INQ0002693, page 7, the question of what will the families be told?
A. Yes.
Q. We see there page 7. You say:
"What will be said to families who have experienced an infant death if they contact one of us, the unit, the Countess? Do we need to inform them by letter separately? Where will we signpost them as this will inevitably impact on their grief? Depending on how you interpret duty of candour I believe the Trust are obligated to inform the families."
You set the guidance out.
First and foremost you say what is the right thing to do and then you talk about the duty. So that can come down, if we may.
But can you explain to us what you were worried about with that press statement in terms of the impact on individuals who had had their babies looked after at the Countess of Chester and worse, died at the Countess of Chester?

A. I couldn't imagine how awful for any family to read in the press or hear on the radio about mortality rates and, you know, there being a change to the designation of the unit where their baby may potentially have been cared for before dying.
I thought it would just leave them, yes, shocked, floundering and jumping to -- well, jumping to conclusions and I thought the most appropriate and the kindest thing to do would be to have actually spoken to the families before we put that on the website. And spoken to them in person if at all possible.
Q. What did you think they deserved to be told before that was put on the website or should be told?
A. I think it -- I think it's really, really difficult but I think the bottom line is that people who have accessed the NHS deserve honesty and we are allowed not to have all the answers at that time but they deserved to know that there were some suspicions around whether the deaths were natural and could be explained by medicine or not. I don't think we can hide information from essentially the general public, our stakeholders.
Q. The Inquiry has heard evidence from parents that they weren't either aware it was happening, when it did happen they didn't get the report before others and

when they did get a report, it was a redacted report.
What do you say about that level of communication with grieving parents?
A. I think it was cruel and I think we should do better.
Q. The external communication refers to an independent review from the RCPCH and also the Royal College of Nursing. As far as you were aware, working there, was anything ever obtained from the Royal College of Nursing or requested of them?
A. Do you mean with regard to the review?
Q. Yes.
A. There was a senior nurse on the review panel from -- who was representing the Royal College of Nursing because I knew of her through palliative care.
Q. Right, so who was that? Which person?
A. You are going to challenge my memory today.
Q. Was it a doctor a nurse?
A. No, it was a nurse.
Q. Neonatal nurse?
A. Yes.
Q. Alex Mancini?
A. Yes Alex Mancini, thank you.
Q. That's the reference to the Royal College of Nursing because she was on that board of review?

A. Yes, so my understanding is that she would have been approached by the Royal College of Nursing as their representative on that panel because I know the other members were from the Royal College of Paediatrics and Child Health.
Q. Soon after that communication from the hospital, you attended a meeting in July 2016 with the management, I think in the boardroom. You refer to it at paragraph 35 in your statement and go on about that later as well and you refer to a position paper that was presented. Do you remember the meeting that I am talking about?
A. Yes.
Q. Can I ask you please to have on the screen just to check, this is one of a number of the documents that were presented then INQ0003492, page 1. While that's just being rotated, I think there were a number of documents that were presented to you, wasn't there, in that meeting?
A. Yes, but I do mainly rely on my -- the information from my interview but, yes, there were a number -- I think there were a number presented but this is the one that I remember with the graphs of acuity on it.
Q. That's right. So if we go on to page 2, 3, if

we could just move through that document, please, there is a number of graphs on it, description of mortality rates.
Can you tell us what you were being told in that meeting? We know -- if I can give you the context, we know from minutes Tony Chambers, Dr ZA, Dr Gibbs, Stephen Cross, Dr Jayaram, yourself, can you remember how many others were there?
A. No, but I remember the message that we were being given which I couldn't corroborate because I hadn't been there in the earlier part of -- well, I hadn't been there in 2010, for example, that we were being told that the rise of acuity and busyness on the unit, that perhaps an increased number of deaths was inevitable.
Q. There are various days between deaths presented we see here, I am not going to take you to them. But you remember following that at the time and seeing that paper prepared I think by Alison Kelly and Ruth Millward, you will be asked about that in due course. That can come down, thank you.
So you saw that paper?
A. (Nods)
Q. You have given evidence in your statement about it. How helpful did you find that review into the

concerns that you had as a Consultant and with your fellow Consultants about the rise of unexpected and unexplained deaths?
A. I thought it was unhelpful.
Q. Why did you think it was unhelpful?
A. I am not sure what role statistics have to play in this situation. The death of each and every baby needed to be scrutinised to understand whether these were sudden, whether they were unexpected, and that had been part of the sort of thematic review to look at where it perhaps wasn't easy. It feels like it should be easy to know if it is unexpected and unexplained and that's not always the case in medicine.
But I think the individual patients were what was important and the matters around what happened to each of them rather than an arbitrary statistic like number of days between deaths. I am not sure how that added any useful evidence.
Q. You say, if you go to paragraph 39 of your statement:
"We were shown charts and graphs of neonatal activity and acuity ..."
Is that a word used frequently, "acuity", in the NHS?
A. Yes.

Q. "... Acuity with the number of deaths superimposed on it. They showed how there were busier periods in 2014 and again in 2015 but it was not a continuously increasing trend. I do not think acuity on the ward was as a significant contributing factor. It did forgot feel like it was an unmanageable workload. We were busy but not so much that impacted on patient safety in my opinion."

That was the evidence of fellow Registrars yesterday, Dr Neame I think said it was no different from other hospitals.

Was that your sense of the position on the ground?

A. Yes, it was. I would agree with Dr Neame. I didn't have a comparison to draw to because I had worked -- the last neonatal unit I had worked was Wirral University Teaching Hospital's which is a different grade of unit. But certainly going to Chester and undertaking ward rounds I felt confident that I had the time to see each of the patients, to consider where they were up to, make a plan for their future care, feed back to the families if they were there and present and then manage any of the sort of troubleshooting of perhaps babies who were newly delivered or on the postnatal ward. I didn't feel like I couldn't do the work that felt necessary to keep that cohort of patients safe on

a day-to-day basis.

Q. Were you doing daily ward rounds at that time?

A. We weren't -- as Consultants we weren't doing daily ward rounds at that time. We were doing -- I think we did two Consultant-led ward rounds in our hot weeks and then it was later on that we separated the rotas and had daily ward rounds, daily Consultant-led ward rounds. The patients on the days that we didn't do a Consultant-led ward round would still be seen by a senior paediatric trainee and we would always touch base with them afterwards to make sure that they were happy with plans for the day, anything untoward, both from a patience safety point of view but also from a trainee experience point of view that you want to make sure that you are delivering good patient care and good training.

Q. So what was your sense in the meeting? If we go your statement again at paragraph 39 you say:

"The conclusions [at that meeting], in my opinion, were reached by extrapolation rather than evidenced."

Whose conclusions, what do you mean by that?

A. If I remember rightly it was Ian Harvey who presented the graphs about how busy the unit was and it was therefore kind of concluded in the report but it was spoken through on the day I think by Ian Harvey that you

know this was a reason to -- a way of explaining the increased death rate and I would go on to say it's really important that we did consider all factors, so it wasn't to be instantly dismissed. It did need thought and consideration because, you know, there are -- if that had been a contributing factor, you would want to take steps to remediate that, that would feel like a much easier intervention.

But yes, it was the conclusion of the report but as explained to us and articulated in that meeting by Ian Harvey.

Q. You say that at the end of the meeting you recall Tony Chambers said: so do you think we are doing enough? Do you remember that now, can you hear him saying that now?

A. Yes, I can hear him saying that.

Q. What was your response to that?

A. I live in Chester, I had two of my children in the Countess of Chester Hospital and I was in my mid-30s. So I had friends, one in particular who was pregnant at the time, and my benchmark of good treatment is how my family and friends would want to be treated and with Lucy Letby still delivering care on the neonatal unit because we hadn't done an investigation that I felt was sufficient, I was really concerned, and

wouldn't have wanted that care for my friends, for my family, and therefore I didn't consider it good enough for the general public.

Q. You said that at the meeting?

A. Yes. I -- I remember giving the example of my friends and not wanting them to have care there because it didn't feel safe with the current uninvestigated concerns.

Q. It appears that the meeting then had a discussion about using covert surveillance on the unit or one-to-one supervision of the nurses, including Letby. Can you talk us through that discussion, what was raised at that point in light of the concerns being expressed by the paediatricians and you about patient safety and babies?

A. So I think much like we had I have done afterwards, you know, people were throwing up ideas to think about, well, you know, what are the potential ways we can improve the safety on the unit and reassure people?

So it was very appropriate to think of the different measures we might consider. I think they were quite flawed and very difficult to do in the kind of timescales that we were talking about. I have toiled over the thought of CCTV and I know it comes up later in

my statement. But, you know, fundamentally to put CCTV cameras over the cots of every single neonatal bed across the country and make sure that they all remained working and checked and all rest of it and then to have some quite covert potentially means of harming babies, I wasn't sure it would be good enough, even if it could be done really quickly, both in the Countess of Chester but also in the wider neonatal world.

Q. It appears that after that meeting, Letby was taken off clinical duties and transferred to work at the risk department, wasn't she?

A. Yes.

Q. The RCPCH report was commissioned?

A. (Nods)

Q. What did you understand the RCPCH report was going to address?

A. I think this is where I was very naive. I thought it would address our concerns and I thought it would do a service review as well. I thought it would be the two things.

Q. Can I just pause there. What concerns, just summarise for me at that point in time what your concerns were as a group of paediatricians as far as you are concerned?

A. So our concerns were that we had a higher than

expected death rate in a neonatal unit, we had no -- we had some medical explanation in part for some of the deaths but as a cohort and it really was that as a group when you looked at it all together, we were very concerned that there was something else happening and we were then aware of this uncomfortable association with one particular team member.

Q. With Letby, who you discussed in the meeting?

A. Yes.

Q. Was that an uncomfortableness, even now I can hear it as you are answering the question and just saying "and we thought Letby might be involved". Was that difficult to say at the time?

A. Yes.

Q. Why?

A. Just on a human nature, that what human wants to hurt, to me any living creature, and then taking it down to, you know, to hurt a baby, to hurt a defenceless baby, to hurt the families, it's abhorrent in society to think of people intentionally inflicting harm.

In the caring profession, it doesn't make any difference, actually it is that fundamental respect for human life, but we are in a position of privilege to look after the patients that we look after. And I am so grateful to the patients that I have looked after in my

ten years as a Consultant and I dread to think how many years as a doctor. I think we are given trust and respect that we will do our best and it just feels even now even when the verdicts came out, it just felt devastating to realise that someone had caused -- someone had murdered these babies.

Q. So when you say "the RCPCH would deal with our concerns", you are in no doubt that there were concerns about an individual and they knew that that they may be involved in harming the babies?

A. Yes.

Q. Were you interviewed with the RCPCH in a group or people or individually, can you remember?

A. I was interviewed in a group.

Q. Was it with Dr ZA, Dr V, was it that group? You probably don't know the ciphers, do you?

A. I think it was, because if I remember rightly Dr Jayaram and Dr Brearey were separate. So I think it was that and there were only seven of us there at the time.

Q. So you were together as Consultants?

A. Yes.

Q. Can you remember if you were asked directly what your concerns were and if you raised how you have expressed them now, the concerns about how this group of

deaths could be explained, an individual, did you say an individual?

A. Yes.

Q. But not by name, or you did, or by rank, did you say who it was, a nurse?

A. I am really sorry I can't give you that detail with any accuracy. We did mention an individual that we were concerned about an individual and -- but I wouldn't know whether we said she was a nurse or whether we actually named her.

Q. When did you eventually see the RCPCH report or a version of it?

A. I think it was in late January/early February 2017.

Q. Can I ask that you have a look please at INQ0009618, page 9. This is a page -- it will come up on the screen?

A. Thank you.

Q. It is a page from the RCPCH report, we know there is two versions, a so-called confidential copy and a disseminated copy. This is from the confidential and you will see findings about an individual nurse. Did you receive a copy with this section in it? Did you read that? Take your time to have a look at it.

A. I don't think I saw this version. No.

Q. And we see on the next page, if you can just go to page 10:

"Advise the Trust to follow corporate processes in responding to allegations of misconduct by opening an investigation. Also recommended a full and detailed independent Casenote Review is required on the deaths prioritising those that were unexpected."

So a recommendation that unexpected deaths needed interrogation and also misconduct investigation. But you say you didn't see that?

A. I --

Q. That version?

A. So I don't remember seeing the page you showed me earlier entitled "The Nurse". I didn't see that page. I was aware of I didn't know the bit about corporate processes but I did know that they had recommended a further Casenote Review because that was the Jane Hawdon review, so I was aware of parts of what you have shown me.

Q. We will come on to Jane Hawdon's review in a moment, if I may. Dealing with the RCPCH, please can we have INQ0101113, page 12. That's a document you helpfully provided, Dr Holt, to the Inquiry and it is the RCPCH in the news and it is an update that you received as a member I believe, of a sort of press

what's going on?

A. Yes.

Q. Have a look at paragraph 2. What it says about the hospital. Can you read us what it says there and why that concerned you when you read it?

A. I thought it was inaccurate.

Q. Sorry, can you tell us what it says?

A. Sorry so:

"The RCPCH has been referenced across the papers this morning as an invited review of the Countess of Chester Hospital's neonatal unit which raised a string of concerns about issues of staffing, led to a police investigation. A neonatal nurse was arrested yesterday on suspicion of murdering eight babies and a suspicion of the attempted murder of six more."

My feelings on this were that it was --

Q. That can go down now, thank you.

A. It was unfair to talk about a string of concerns regarding staffing. I think if they were going to -- we acknowledge and accepted there were some parts of that review process that had good and sound learning for the Countess of Chester, but I felt it presented a negative overview rather than a balanced opinion and I thought the way in which it was written implied that they had been instrumental in a police investigation and

that doesn't sit then and it doesn't sit now with my opinion of what that review process did.

Q. You set out -- if you can go to your statement please at paragraph 47, you say:

"I thought the RCPCH would use their neonatal experience and knowledge to discredit the 'Position Paper' and point out some of the errors in the thinking of the Trust board members."

And you thought:

"... the RCPCH would reinforce our view that the British Association of Perinatal Medicine ... staffing levels were aspirational and not adhered to by many units and therefore unlikely to be a major contributing factor. I thought they would reaffirm that these deaths were suspicious by nature of their gestation, timing and unknown mode of death."

Is that still your view?

A. Yes. I think -- I don't know how much discussion has been had before, so forgive me if I repeat anything but the BAPM standards for nursing were a very sort of set out and actually in a unit like ours would at times mean you have got more staff on than you need for the patients there, which -- yes, more staff, perhaps better patient safety, but also we are in a resource limited system and need to use resource

wisely.

So it's a set of objectives that look at actually what is a safe staffing level rather than a blanket level, I think would have been more helpful and as it says there, you know, a lot of units around us, certainly within the region, would also not have met the BAPM staffing criteria so it felt unfair to sort of highlight us.

Q. Did you think -- you also say at paragraph 53 the statement was factually incorrect. Did you think it could create the wrong impression about the actual concerns and the real issue from your perspective? Real issue that there were unexpected deaths and you were concerned that there was an association of one person with those unexpected deaths?

A. I mean, if I am honest the Royal College shouldn't have been sending out soundbites like that. I don't think they do any more, I think it is unhelpful and I think ...

Q. We know you followed it up with a meeting, shall we take you there?

A. Yes.

Q. INQ00127440001, yourself and Dr Brearey went to meet with a Jo Revill. We see here a note from apology revenue he will to Russell Viner:

"Dear Russell and Mike,

"Emily and I met with two doctors [this is in July 2019] from the Countess of Chester last week to talk to them about the background to our Invited Review service and the ongoing investigation focusing on the College's role during this period. The two doctors, Steve Brearey and Suzy Holt, were very open with us and said they valued having the chance to come to the College to talk about their concerns."

If we go over the page, you set out your various concerns and you say:

"The doctors had asked for the police to be called in following concerns about the unexplained deaths of eight babies during 2015 and 2016. The Hospital's Medical Director decided not to do so and instead called the College to do an Invited Review.

"In terms of reference, this review began as a straightforward description of a service review but then the Trust added a clause which asked us to look into unexplained deaths. This is obviously not what our IR process was designed to do and would have involved different experts, as far as I can understand."

So it continues and you make reference:

"Following our review a Casenote Review was ordered and carried out by Jane Hawdon but she didn't review all

of the cases. The doctors felt that this report [that is the Hawdon report] was less comprehensive and work the doctors had already done and there was a feeling that the reviewers wanted to focus on BAPM standards.

"In their view, the Trust used our report to try to keep the focus on the issue of staffing levels on the ward."

So it continues.

Was that the Jane Hawdon report that you were referring to there, just to check that?

A. Yes.

Q. What was the feedback from that from the Royal College? You said a moment ago you wouldn't think they would do that now, but what response did you get raising those concerns?

A. Not -- I don't recall any further follow-up from the Royal College after we expressed concerns to -- in that meeting. Interestingly, we asked then for a full unredacted copy of the report and actually would have preferred it to have been delivered by the Royal College so that we knew it wouldn't have been redacted and we were told that we couldn't have it.

Q. Whose property were you told it was?

A. Ian Harvey's.

Q. So unless Ian Harvey gave you a full copy, you

weren't entitled. Are you a member of the Royal College?

A. I am a member of the Royal College, yes.

Q. So what happens if you are a member, what do you get for that?

A. It's an annual subscription with access to some events, we are expected to have membership as part of our employment as a Consultant paediatrician. I also sit on one of the committees at the Royal College, one of the training committees at the Royal College, but -- and I think you have to be a member in order to sit on those as well.

Q. But you say you felt let down by their response to this and the information they provided publicly --

A. Yes.

Q. -- about their review?

A. I did.

Q. You also comment in your statement about Jane Hawdon's report and the value of that report and what was needed if she was going to have a look at the babies. What do you say about that what was needed to do a forensic review of the babies?

A. I would counter this with I am not a forensic, forensically trained. I do Child Death Reviews a lot in

my current post and I think it is a really important part of what we do so that we make sure we continue learning.

You need to have access to all the relevant information and that is not always easily kept in one place, there is often multiple sources of patient notes because and it will depend on different hospitals how they record things.

But you would need to make sure you had view of medical notes, nursing notes, feed charts would be really important, medication charts if they are not done electronically, the observation scores so heart rate, respiratory rate, things like that?

Q. X-ray reports?

A. X-ray, yes.

Q. Blood results?

A. X-ray, imaging, you would want all of those things at your disposal. But I also think in such a situation where your colleagues, albeit colleagues you don't know, are raising concerns I wouldn't want to do a review without asking them for statements or being aware of what their concerns were. I think you risk being blinkered and not knowing what you don't know.

Q. Moving forward, 26 January 2017. You weren't able to attend a meeting where your colleagues were

required or requested to send an apology letter but I think you signed up to an apology letter in any event with them, didn't you?

A. (Nods)

Q. Shall we go to the apology letter it is 00031870001. There we are.

Tell us how you felt about doing that?

A. Devastated. I didn't feel it was appropriate. I felt I didn't feel I had a choice and I am quite embarrassed that we ever wrote that letter and sent it. I don't know how it makes the Families feel to -- to see that and have read that. I think it's -- I think it's awful.

Q. Did you have much discussion between yourselves at the time about the wisdom of that or the expectation that you do that?

A. Yes, we had a lot of discussion about it.

Q. It can go down now, thanks.

A. We had a lot of discussion about it. And I think the consensus was that we didn't feel we had a choice and as you can see in the text of the letter, it was an apology for how --

Q. She felt?

A. -- she felt.

Q. Rather than any suggestion that she was

innocent?

A. Yes.

Q. You were also aware that a further requirement of the meeting was that Dr Jayaram and Dr Brearey were to attend mediation with Letby.

A. Yes.

Q. What did you all make of that and how did you think they were coping with that request?

A. It was -- it was a pretty astonishing time. The challenge we had was that all of us feel very passionately about our service and I say that even though I don't work there any more, we all felt passionately about our service and wanting to be able to continue to offer a service and we were providing an amazing service to the paediatric patients as well as the redesignated neonatal unit and eating disorder service and training the next generation of doctors.

I think we all felt that working with our board was going to be better for the population than all of us ending up on gardening leave, which felt like was the insinuation from that January meeting, that if we didn't toe the line then we wouldn't be remaining in our jobs and I think it's important to remember at this point that there was already talk of her returning to the neonatal unit and we still didn't think sufficient

investigation had taken place.

So there was a degree of thinking actually we need to also keep our voice and not be silenced to prevent that happening.

Q. It comes very clearly across from your statement in that earlier interview you did with Facere Melius, you were anxious, weren't you, it wasn't simply about whether you would lose your job, you were very anxious and stressed knowing that the Trust Executives were taking steps for her to return to clinical work?

A. (Nods)

Q. Just can you expand on that, how that felt at that time knowing that that was the projection?

A. It's difficult because now we have got the -- now we have the foresight of what actually happened it changes how perhaps you felt at the time. But there was so much swirling for us all. You know, it's easy now that there is -- it is not easy, that's a poor choice of word. We now know she has been tested in a court of law and found guilty, but at that time we were still dealing with uncertainty. We were still dealing with: can this possibly be true, is that what's been happening? How do we feel about her being returned to the unit and also trying to do your job day-to-day et cetera?

So --

Q. Sorry.

A. It is horrendous.

Q. Sorry to cut across. Who was advocating for Letby at that time? You say she may be coming back. Amongst the nursing or management or doctors, if there were any, you know, who was advocating for her being permitted to be there?

A. I don't know, if I am honest. Certainly none of the medical Consultants that -- the seven of us, none of us were advocating for her return. I wasn't involved in as many of the meetings with the senior nurses on the neonatal unit.

Q. So you wouldn't know what they were saying?

A. I have had second-hand information about some of the meetings but no, I wasn't involved in those meetings directly.

Q. Okay, don't be worried that it is second-hand. What was your impression about which nurses or senior nurses were supportive of her position as far as you were aware at that time?

A. If memory serves me right the previous Nurse Manager, Eirian, had been incredibly supportive of Lucy.

Q. Eirian Powell?

A. Yes, Powell. I believe she actually retired

from work that Christmas, I can't remember.
Q. She was supportive of her. Anyone else? Was Alison Kelly, as far as you were aware or not?
A. My understanding is that Alison Kelly was very supportive. My -- I didn't really speak to any of the nurses on the neonatal unit about it, I didn't feel it was within my remit but I know many of them were good friends with Lucy and were really traumatised and themselves torn about what to think and how to think.
Q. Dr Gibbs gave evidence that he knew Eirian Powell supported her and was positive of her and that caused him to -- I don't know if there was a reference to dithering but there was certainly a reference to a pause in his thinking.
You at paragraph 76 say:
"You cannot have casual conversations about these types of concerns [meaning your concerns that Letby was harming babies] even with close family. I worried they would not believe me. It all seemed so far-fetched; like a storyline out of a movie and not something that happens in 'real life'. I considered resigning."
Was the fact that there were other people expressing very positive views about her at that time, did that impact upon how clearly or how sighted you were on the essential concerns?

A. Yes, I mean, obviously it would because we -- the fact that we knew with certainty around the death rate, the facts that we knew without certainty how that this come about and you had people that you worked with and respected advocating very strongly for her and so much so that Lucy turned up on a Christmas night out that December, that John and I had gone to represent the medical workforce on, and, you know, the two things just seemed so hard to balance; that the nurses were so supportive of her that they would still be inviting her to come on a social evening, I think it was Eirian's joint retirement do.
It was really, really hard to hold in mind and balance all of these kind of conflicting and troubling different opinions.
Q. So you are at a social event with her at this time and is it all medical nursing staff?
A. It was the neonatal nurses and, like I say, just myself and John went, having discussed it -- when we became aware on the day we discussed it with the police because I come back to you are desperately trying to continue to work with these colleagues to provide safe and excellent care and I just -- I couldn't believe it when she turned up, I didn't think she would come and so you are then faced with this.

Q. Just to be clear which December, which year? Was this before your apology letter?
A. I think it was -- I think it was December 2016 but I might need to check that date.
Q. We know there were at least -- there was at least one tea party to reintroduce her to the neonatal unit; do you know anything about that?
A. I didn't.
Q. From what you are saying, it wouldn't surprise you there was still social interaction with her at that point?
A. (Nods)
Q. Can I ask you about a letter, please, at INQ0003095, page 1, tab 11, my Lady. 30 January 2017. A letter from the Consultants to Mr Chambers. You sent your letter of apology at that point. You say:
"Although it was made clear that the Trust board has drawn a line under this issue ..."
Just pausing there, that's a phrase that we hear a lot "draw a line". Who's drawing a line and why?
A. So --
Q. Have you got some water there, Dr Holt?
A. I have some, thank you. Frog in my throat from talking too much.
That is what it was reported the words

Tony Chambers used in the January meeting that I wasn't in attendance at.
Q. " ... would be grateful for written clarification on the board's understanding of the reason for the increased number of unexpected and unexplained deaths on the neonatal unit between June 2015 and July 2016 and the actions that you and the board now expect us paediatricians to take."
And you say there:
"Also each of us would appreciate the opportunity to read the RCPCH Invited Review report and the report of the Casenote Review undertaken by the external neonatologists prior to these reports being released publicly. Obviously these reports are extremely sensitive and so we assure you that they will not be disclosed outside our Consultant paediatric group."
Did you get that report at that time, from what you have said earlier no?
A. So we were told we could go and pick up a report from the -- a copy of the report from the Exec office but it was not a full unredacted report.
Q. If we go to INQ0003117, page 1. Another letter from you all on 10 February 2017. You tell us in your statement you sent this because you had read and considered the review reports from the RCPCH and

Dr Hawdon and had a chance to discuss them as a group.
Were you all in agreement that they didn't provide reassurance around the deaths and collapses? We see what you say here, if we go to the next page as well, please, Ms Killingback.
You concluded this letter:
"It's been eight months since we escalated our concerns to you and we do not consider any further discussion within the Trust is in the best interests of affected families or neonatal staff. Please be assured that we as a paediatric consultant body are making this request because patient safety is our absolute priority. We hope a comprehensive external investigation will be in the best interests of the bereaved families and those affected by these sad events."
Do you know what response you got to that?
A. I think after this there was a verbal agreement that the Trust would have a discussion with the police but then what actually transpired was that they were then invited -- told to go to a meeting with a barrister.
Q. Can I just ask you to look at a couple of emails before we go to that. Just give me a moment. If we can go, please, to INQ0003395, page 2.
So what will be shown in a moment, Dr Holt, is

an email from Dr Brearey to Mr Harvey cc'ing you and fellow Consultants. I would like to remind you of summary of a meeting and agree the summary, I don't know whether it is accurate and have a look at paragraph 2:
"... making it clear there is general dissatisfaction from the Consultant body with the way the Trust has handled this difficult situation since it was escalated. All the paediatricians voiced concerns at the time and all now feel their professional opinions have not been given due regard."
If we go to the next page, page 3. It concludes saying:
"Nim Subhedar stated at our meeting he too was concerned the cause of death and/or deteriorations remained unexplained in several cases. They should undergo further detailed review".
Et cetera.
Then we see the response, if we can go to page 1 of the same series, Ms Killingback, from Mr Harvey:
"Given the circulation list I felt it was important to respond especially since these notes have a particular slant and I am wary if I didn't respond this might become the only version of the truth.
"I am surprise there is no reference to the conversation about the Coroner. I am aware that you

have each had a letter from Tony Chambers that was able to give more detail and confirm. Stephen Cross and I had had a detailed conversation with both the Coroner and the deputy."
What did you understand was the position of the Coroner at this point and the Coroner's involvement?
A. So I know that some of the cases were discussed with the Coroner at the time and I know that the Coroner went on to request postmortems in some of the cases. My understanding was that when Ian Harvey spoke to the Coroner that he felt he had no role to play and wouldn't consider reopening any inquiries.
Q. Is that what you understood from Mr Harvey?
A. That's what -- I don't know where I understood it from, that's what I understood at the time.
Q. Okay. So you don't know who told you that or who communicated that?
A. I think there is an email alluding to it.
Q. If we look at the third paragraph, Mr Harvey in this email is at pains to say:
"It might have been stated, but it was not agreed either, that there were small changes in the acuity, I certainly would dispute this, or that by extrapolation this couldn't play a part. I for one would not limit myself to looking for a single cause."

So he is at pains there to set out what we see.
How frustrating was that, given the position you had all taken on that issue and your experience of other hospitals and staffing, et cetera?
A. I think we were just used to hearing that response from him by this stage. We knew that they -- and by "they" I mean Alison, Ian, Tony and Stephen had a very fixed opinion and it felt like we were struggling to convince them of the need to think differently.
Q. Give me one moment.
The meeting with Simon Medland QC, what did you understand that was arranged for? We know it took place 12 April.
A. It was -- it was a strange request of us. We thought they had agreed to discuss it with the police and then we were told that we were going to meet with this barrister to think about how they framed the information to give to the police or something along those lines, which I think we were very disappointed that there was another meeting with someone other than a representative of Cheshire Constabulary.
Q. Do you think Mr Medland, as he then was, had all of the information about your concerns before then or do you think he came in not really understanding or knowing the level of concerns, what was your sense of

that?
A. My sense of that meeting was that he came in with a similar pattern of thinking to the people that I have already mentioned.
Q. Senior management?
A. Yes. I think he came in well versed in what they thought was going on and I found the meeting really, really difficult.
Q. The decision to involve the Child Death Overview Panel was raised in that meeting, wasn't it?
A. (Nods)
Q. With a view to what, what was the suggestion I think you thought you may have raised it first, somebody raised it in any event?
A. In his meeting in his minutes that we did see afterwards, he says he suggested it. The way I remember that meeting kind of unfolding was we -- there was a sort of amount of discussion at the beginning about what the meeting was for and a kind of understanding that we were perhaps at odds even from the outset. Then we did a lot of the talking and explained why we had concerns.
Q. Which of the Consultants did most the talking about the concerns, out of interest?
A. I'm sorry, I wouldn't be able to tell you.

Q. Okay.
A. And then he asked a few questions and then he spoke a bit about there was a sense of disbelief in him that we could be suggesting that these were potentially criminal acts and I think he was trying to play it down and then when it became -- it felt like he then realised that that wasn't going to be an outcome of the meeting so then there were a few other suggestions made, one of which was CDOP.
Q. Child Death Overview Panel?
A. The Child Death Overview Panel, sorry, yes. And another of which was that, you know, a further internal review by somebody else.
Q. Was the purpose of the -- or the mention of the Child Death Overview Panel at that stage to highlight that there was a representative from the police on that and that was a route to the police or was it separately talking about the Child Death Overview Panel, as far as you were aware?
A. I think it was slightly separate but I think for me the -- it was a bit of: actually, it does put us in front of the police, though, and that felt like -- that felt like a priority.
Q. That was in fact the way through wasn't it with Nigel Wenham and the Child Death Overview Panel,

how eventually, not long thereafter actually, the referral to the police was achieved?
A. Yes, yes.
Q. That meeting with Simon Medland was 12 April.
16 April, it looks as though you all had a meeting with Sir Duncan Nichol, the Chair of the board. Can I ask, please, that we look at INQ00066821, please, and Dr Gibbs chooses to circulate to you all an email summary of the actions Sir Duncan proposed taking at the end of the meeting.
Were you all there at that meeting? Can you remember or not?
A. Sorry.
Q. So it may have been a number of consultants but you don't know if you were there. Did you know Sir Duncan, would you have known him if he walked in the room now?
A. Yes, I do know Sir Duncan. I had cared for one of his family members.
Q. Don't worry about that, so you would recognise him?
A. Yes.
Q. So if we look at what this letter says. Sir Duncan, paragraph 3:
"... repeated several times he had come to listen

and he had understood what we were saying but it was not his role to take sides. He thought it was highly regrettable that there had been a breakdown in the relationship between ourselves and senior managers.
"Sir Duncan urged us to try to repair these relationships for the future, especially given the challenge of the forthcoming reorganisation of Women's and Children's Services in Cheshire and Wirral, although he wasn't sure to what extent this would be possible with Ian Harvey, given that he is leaving in a few months.
"Actions: for communication and trust between senior managers and paediatricians to improve specifically to involve us prior to press releases involving neonates and when there were meetings with other bodies regarding our services."
Was that because he's got the point you were upset by the communications not engaging families or parents and also --
A. I mean.
Q. -- an RCPCH review?
A. Yes, it was communications as a whole. We always wondered what was said to, for example, the Coroner, what was said to Jane Hawdon before the review. We always wondered whether people arrived with a set

bias and felt that if we had been involved in some of these setting of terms then actually we might not have seen so much biased thinking.

Q. Number 3:

"Sir Duncan offered to be our Executive Children's Champion and we should use him in whatever way we felt appropriate and he would work with Rachel, who will remain our Non-Executive Children's Champion."

I am not sure that's the right name, but we will see when we come to the Non-Executive Directors. But what did you understand that role of Executive Children's Champion was about?

A. It's a way of hospital boards trying to have a sense of what's going on in the many departments that make up a hospital. What I would say is that we did meet Rachel, but it was infrequent and certainly not helpful through this process and I don't really remember what Sir Duncan did as our Executive Children's Champion.

Q. What about going to the police at this point? There is no reference here to whether he has expressed a view about going to the police by16 April, that's what you were saying at this point. Was there any -- that's what you wanted championing, was there any movement on that at this meeting?

A. Can you just remind me, what date was the meeting with the CDOP panel?

Q. Sorry, say that again?

A. What date was the meeting with the CDOP panel?

Q. I can't remember now?

A. I think these happened very close.

Q. This is 16 April 2018 with Sir Duncan?

A. I think we had already ...

LADY JUSTICE THIRLWALL: I will look it up.

MS LANGDALE: 12 April. No, that was the meeting with Simon Medland where you discussed the CDOP panel.

A. I think we had the meeting with the CDOP panel in the diary at this point and what I would say is we -- we were slightly exhausted with our Trust and so my focus was certainly on that next meeting with external agencies.

Q. Did you have -- you can't even remember if you were at that meeting with Sir Duncan in 2018?

A. I was because John makes notes that "I think you two" and then mentions one of the other Consultants and me were taking notes. So I was definitely at that meeting. John gets details right.

Q. Was that the only time you met him in the work situation?

A. No so I -- he -- he came down to the offices

and I happened to be on on-call one evening and I had a conversation with him then but I couldn't tell you where in the timeline that happened. We only really had much to do with Sir Duncan in this sort of period of 2018, though.

Q. Going back to your statement, 110, just a couple of things if I may. You went to speak to Mr Green -- is it Mr Green or Dr Green?

A. I believe it is Mr Green.

Q. I thought he was Dr Green, a pharmacist, Director of Pharmacy, who did the grievance procedure or was investigating that. You say you went to speak to him. When was that roughly? Much later or?

A. Yes.

Q. Have a look at your statement.

A. Yes, this was.

Q. Was it after you left the Trust, it looks as though --

A. It was actually, yes, it was, it was at and around the time I was leaving the Trust, if I remember rightly.

Q. That's 2020?

A. Yes.

Q. So what did you say to him about that process then or about the grievance?

A. I sat on one of the pharmacy groups at the Countess and so I knew Chris through that interaction and it became apparent that there was an exchange of emails that was between Chris and Steve that was probably steeped in kind of anger from the -- the grievance process and I was keen to make sure that it didn't impact -- I cannot even remember what the issue was, but it didn't have an impact on our sort of decision-making going forward.

I think we had become so aware that people were given an incorrect account of us and the concerns that we were raising and I got on very well with Chris, I respected him, and I just wanted to ensure that he wasn't acting under false pretences. So I had a conversation with him about the grievance process and about the concerns that we were raising and he did seem to express surprise that he hadn't perhaps been given full disclosure of the situation at the time.

Q. So that was long after it had been completed?

A. (Nods)

Q. Did you say: we had to send a letter of apology and say what you felt about that?

A. I wouldn't know the details, I'm sorry. It was a long time ago.

Q. No, I meant that you sent a letter of apology

to Letby, did he know that?
A. I don't know if he knew that or not.
Q. You didn't discuss her specifically, you just concerned what your concerns were as Consultants?
A. Yes, yes.
Q. What did you make of the facts, what did you hear about of the grievance process at the time and any findings, did you know about that at the time it was going on?
A. It was a really difficult time. It put a huge amount of psychological stress on the whole Consultant body and specifically on Ravi and Steve who really struggled with it, so much so that Steve couldn't be a part of the process. And we were really surprised and saddened when Ravi got, again, a redacted version of the grievance that there seemed to be statements in there that were not evidenced and we didn't recognise as being our behaviour at the time that had been upheld and was sort of almost substantiated by this grievance procedure.
Q. Were you interviewed as part of that or not?
A. No.
Q. So as you sit there, there was a grievance procedure where your conduct was questioned and put together, but there was no investigation into Letby for

the concerns you were all raising about her and her link to unexpected deaths?
A. (Nods)
Q. What do you make of that now?
A. I don't think the grievance process followed the recommended procedures and I think it should not have happened, and I feel angry with those in a position of responsibility who subjected us to that and have never apologised for their behaviours at the time.
Q. Never apologised to you or generally?
A. I think they've got a lot of apologies to make. I am not the most important person they need to apologise to, in my humble opinion. That would be The Families.
Q. I want to ask you about one document, if I may. My Lady, I won't be much longer but there is one document I would like to put to Dr Holt. Please, INQ00067250001. That will come up in a moment.
Do you see this? So this is a table and, as far as the Inquiry is aware, it looks as though it has been -- and I would like your help with this -- put together by paediatric Consultants.
A. (Nods)
Q. Pausing there, there is a lot of writing you all had to do about this, wasn't there? A lot of time

must have been taken by all of you.
A. Yes.
Q. You nod. That's not picked up. But how much time was this taking, setting all these things out in different ways in different versions and letters and emails?
A. Hours and hours and hours of time. We all worked significantly beyond our hours, and it was not uncommon to find someone in the offices until very late at night because at no point did we stop delivering care to other children and young people. So this was all done on top of Consultant roles.
Q. And correct me if I am wrong, but it looks as though on the left there is some comment about a communication, reply by management, and your comment is on the right as a Consultant body. It gets a little bit confusing to the left when I go through the whole document. Is that because different people are inputting into it?
A. Yes, different people inputted into it. So we circulated this, just to try and not duplicate information so that people would add a different opinion. But, yes, try not to --
Q. You all put your own view or opinion in boxes and added it and circulated it. What was it prepared

for?
A. It was in the back and forth of letters with our management structure, essentially, trying to highlight where we felt there were shortcomings in how the matters were dealt with and how we were treated.
Q. It is not dated, as far as I am aware, but obviously we can see the items that you are commenting on. But if I look at the first page, paediatrician's comments, you say here in, and you are referring to a statement that has been made earlier:
"The statement is does not correlate with the statements and actions of the board. Ian Harvey made a public statement in February 2017 saying this means that when we speak with parents, we can now share full and accurate information on an individual basis. This took no account of the four sets of parents for whom there was no accurate information regarding the cause for their babies' deaths. We cannot quantify the impact on their grief of such misinformation."
So you were identifying this, although you hadn't presumably yourselves had contact with parents at this point, either. You could just see there was a chasm there, a massive chasm to say the least?
A. Yes.
Q. If you go to page 9 of the same document,

please. The concern in the left-hand column:

"Please advise us why the medical director chose to select only some negative comments from the reports and to omit to mention that further investigation had been recommended by an external reviewer."

And then the box on the right-hand side, third paragraph:

"It was very clear in the meeting that the Executives who spoke were trying to portray the neonatal unit as a failing and stretched service with Consultants who were being unprofessional, making unfounded allegations against an innocent nurse. Selections of the reports were selected to support this view. This could be interpreted as a form of selection bias."

Do you see that?

A. Yes.

Q. Those reports of course, in part, continue to be stated and quoted and cited, don't they?

A. Yes.

Q. How do you feel about that in terms of how accurate that is?

A. Just angry. Angry that -- angry that we were represented in that way because I don't think it is a fair reflection on the service that we were providing then, and that I hope they continue to provide now, and

I think -- yes, I don't think any -- I don't think anything has sort of -- it's all remained almost as a sort of paperwork from the time, so none of it's been challenged since.

But I would kind of highlight that the most important thing out of all of this time has happened and that was getting investigation into the children's deaths. I don't want that to get lost in this arguing between us and the executive. I don't think those in management should remain in NHS management. I don't think they have shown the morals, the leadership, and the compassion of managers I would want to see in an NHS of the future.

Q. What do you think is important in terms of qualities for senior managers in the NHS?

A. I think it is an incredibly hard job. I think the NHS has many and wide-ranging issues, but I think it's really important that managers remain accountable to the most important people, and they are our patients, and in order to be accountable you need to be able to be visible, you need to have good processes in place, you need to employ the right people and have the right people around you.

But I think when things like this come up, you have to be inquisitive, diligent and thorough and, yes,

I don't think they were.

Q. Finally, in terms of the culture within the hospital, how would you describe the relationships between the doctors and managers during the period I have been taking you through?

A. It's important not to label all of the managers as managers if that -- as in the same terminology, because actually we had our service managers, which is the sort of immediate level that we interact with more frequently, and I think we had a good relationship and a good rapport with them. And that's true of, you know, for example, the women and children's lead I have a really good relationship and I had back then a really good relationship with the lead obstetrician.

Q. Who was that? Dr McCormack?

A. Yes, and then it became Dr Sara Brigham.

The worst of our relationships was actually with the board, with the people that we have mentioned, with Alison Kelly, Stephen Cross, Ian Harvey, Tony Chambers.

Q. So was this more about people than roles for you or a combination? You say there were other managers, senior managers, you got on really well with. So how would you --

A. Yes, it's really difficult because there are

different pockets of people. The way in which the structures work is really complex and so, for example, you have got a risk manager, you have got an HR manager. Individually I got on well with many of the individuals within our institution. The sum of it, the sum of the problem, I still to this day don't quite know what we could have done differently to have had a different outcome because I think the layers of NHS management are part of what makes this so difficult. Whose responsibility was it to do what at what time and whose responsibility is it to challenge when someone in a position of senior leadership is so dismissive of an issue?

And I think it is difficult but I also know then that we had some very direct conversations with these people. So it wasn't that things were getting lost in translation.

Q. From the doctors' or paediatricians' perspective, going to external bodies earlier themselves was obviously a matter that you could have considered or could have done. So we have spoken earlier about phoning the police. What would have stopped you as a group doing that at the time, or earlier, and for those who were there before you in 2015?

A. I can't answer that question. I don't know

why we didn't and it is a huge regret and -- yes, I don't know. But I am -- and I live with knowing that we have to learn from these events and that is personally, as well as organisations and institutions. And, yes, I wish I had done something differently back in 2016.

Q. Dr Issac, of course, Howie Isaac, and Dr Mittal will be giving evidence too but they are safeguarders and you say you were sharing an office with one. Again, referrals via safeguarding to local authorities, just getting out of the Trust, that was a route and an option, not canvassed at the time between you?

A. I am assuming you are thinking about LADO referral in that statement. I have been, I have been part of situations where we have done a referral to LADO.

Q. About a member of staff or is it always parents? We do it for parents, don't we?

A. No, about members of staff on more than one occasion we have done LADO referrals. This situation is subtly different and if we'd had -- you know, if we'd had or if I'd had had significant concern about something that I had seen or witnessed, it was the nature of the sort of circumstantial evidence that made

that feel like a difficult step to take.

In order to make a LADO referral, it is about an allegation about a member of staff; admittedly, that they might have caused harm. There is no high bar of they have to have caused harm. But certainly from a personal point of view, it was the overall situation, it was the body of the number of unexplained incidents that was such a concern and there wasn't ever one individual case where I thought: that needs referral.

Q. The actual structure of Working Together 2015 is about everybody being responsible for child safety, child protection, child safety. So, in a sense, looking for an allegation isn't the test, is it? The test is being concerned for children or babies and you were all obviously very concerned about babies on the unit?

A. And you are absolutely right. It is -- you know, we talk about safeguarding a lot. I regularly am involved in safeguarding meetings. Like I say, it does tend to refer to one child. You do a referral about a situation. But, again, I wouldn't -- I'm not sitting here completely discounting it as a possibility.

I would say, though, that if you had enough evidence to go to a LADO, then, you know, they are not an organisation that will do an investigation. They are part of the threads that pull together and the police

would be involved.

Q. They work with the police, though, don't they?

A. Yes. Again, would they have suggested referral to the police? I can't rewrite history.

MS LANGDALE: Thank you very much, Dr Holt. Is there anything you would like to add or say that I haven't asked you? You have been giving evidence for some time but I would hate for you to leave and you wished you had said something else as well.

A. No, thank you.

MS LANGDALE: Thank you very much.

LADY JUSTICE THIRLWALL: Dr Holt, thank you very much indeed for the care that you have taken, both at the time and in giving your evidence today. You are free to go now. Thank you.

Ms Langdale, tomorrow morning at 10 o'clock.

MS LANGDALE: It's Friday tomorrow. I think.

LADY JUSTICE THIRLWALL: Oh, yes. Sorry, I will be the only one here. So Monday morning, 10 o'clock. Thank you all very much.

(4.42 pm)

(The Inquiry adjourned until 10.00 am, on Monday, 7 October 2024)

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