Monday, 7 October 2024

(10.00 am)

LADY JUSTICE THIRLWALL: Yes, Mr De La Poer.

MR DE LA POER: My Lady, our first witness today is subject to a Crown Court order. We will be referring to her as Dr ZA.

LADY JUSTICE THIRLWALL: Very good.

MR DE LA POER: May I ask her to come forward, please.

LADY JUSTICE THIRLWALL: Yes, please, would you come forward and take the affirmation or the oath, whichever it is.

DR ZA (sworn)

LADY JUSTICE THIRLWALL: Thank you, doctor, please sit down.

Questions by MR DE LA POER

MR DE LA POER: Now, Dr ZA, can you confirm for us, please, that you've provided to the Inquiry a witness statement dated 23 May 2024.

A. Yes.

Q. And are the contents of that witness statement true to the best of your knowledge and belief?

A. Yes.

Q. We are going to deal necessarily very briefly with your background. You are a medical doctor; is that right?

A. Yes.

Q. And you are a member of the Royal College of paediatrics in child health?

A. Yes.

Q. And prior to 2015, you had been a Consultant at the Countess of Chester Hospital for some years?

A. Yes.

Q. In terms of your working pattern during the period we will be focusing on, you were working part-time; is that right?

A. That's correct.

Q. Working Mondays to Wednesdays and a share of out of hours?

A. Yes.

Q. And in terms of the practical consequences of that, does that mean that there were certain meetings throughout the period that we are going to be focused on which you didn't attend because you weren't at work?

A. Yes.

Q. I'm going to consider, please, the relationships between various parties at the Countess of Chester Hospital.

Firstly, as we have heard, Dr Brearey was the neonatal lead and Dr Jayaram was the lead for the paediatrics service. How did you find working with both of those two?

A. I'd worked with both of them for a long time, since my training as a junior doctor, and I had a positive working relationship with both of them. I found them very approachable if I had any issues.

Q. Now, you speak about the relationship in your witness statement between the Consultants and the departmental manager. Could you just help us with who you meant by departmental manager?

A. So at the time I think it was Jackie Blundell and Jo Moore, they were our sort of department manager and assistant managers, so sort of the first tier of hospital management that we dealt with.

Q. And was that a positive relationship?

A. Yes, we had a good working relationship with them.

Q. What was your view about the relationship between the Consultants and the junior doctors?

A. We generally got on well with our junior doctors. We were a supportive department. We consistently got good feedback from the GMC trainee doctors survey, and the reputation of Chester within the deanery was one that junior doctors wanted to rotate to, and certainly that was my experience, having been a junior doctor several times at Chester, was that it was a supportive department and that's why I wanted to go there for my Consultant job because of the positive experience I'd had.

Q. Now, one particular junior doctor, although he wasn't very junior at the time --

A. Yes.

Q. -- that we'll be hearing from later today is Dr U.

A. Yes.

Q. And obviously Dr U is subject to a Crown Court order but you know who I mean by that?

A. Yes, I do.

Q. Dr U was at the final stages of his training and was at the Countess of Chester between September 2015 and 2016; okay? He would be described as a senior middle grade?

A. Yes.

Q. What was your relationship with Dr U?

A. I had worked with him several times throughout both of our careers, always being slightly senior to him. He's someone who I felt a positive working relationship with. I wasn't friends outside of work with him but I think we had quite a friendly working relationship.

Q. We'll come back to Dr U in the course of my questions.

Finally, in terms of the relationships on the ward and in the department, what was the relationship, did you think, between the Consultants and the nursing staff?

A. I had always thought that the relationship between the Consultants and the nursing staff was again positive and friendly. It was only around 2016 when concerns were being raised about Lucy Letby that that relationship became strained.

Q. And we've heard from others that their perception was the strain was because the Consultants took one view of Letby but at least some of the nurses took a different view --

A. Yes.

Q. -- was that your experience?

A. That was my experience.

Q. And in terms of the nurses who were taking a different view, we know that the unit manager was Eirian Powell.

A. Yes.

Q. Was she in that camp?

A. Yes.

Q. Were there any other senior nurses in that

camp, by which I mean those part of the management structure?

A. I'm not sure exactly what position other senior nurses had taken. They weren't very vocal about what they thought in the way that Eirian was, and it became something that we didn't talk about because it caused strained relationships. So I don't know what a lot of nurses' views were because we didn't talk about it.

Q. Now -- and I've asked other Consultants about this -- Eirian Powell has, in her witness statement, said that the Consultants would think everyone worked cohesively because everyone did exactly what they said and didn't challenge them.

Do you have any comment to make about whether that accords with your experience or not?

A. Obviously you only know what people say when you're with them, not what they say when you're not there, but I would disagree that the nurses didn't feel able to challenge us. I think neonatal nurses have al -- have always not been afraid to advocate for their patients, and the nurses were quite about saying when they felt that a management plan wasn't quite what they would have liked. They also were quite happy to ring the Consultants directly if they weren't happy with what

the trainee junior doctors were doing. So I would disagree that they didn't feel able to challenge us.

Q. Turning now to relationships with the senior management, and here I'm talking about those who sit as Executive Directors.

What was your impression, before June of 2015, about the senior managers' attitude towards your department?

A. I didn't really have much of an impression of the senior management. We didn't really hear from them very much in our day-to-day running. We were very much left to our own devices. If we did try and raise issues, we never really heard anything back from them.

So I don't think there was much of a relationship.

Q. Now, one of the words that you use in your witness statement about the period 2015 to 2016 was "disinterested". Just can you help us to understand why you used that word?

A. I think we were a department that generally got on with things. There were problems that were perceived as being bigger within the Trust, so things with adult medicine and the emergency department, and it felt that when we raised any issues that they just weren't important to the -- the overall hospital because we were a small department who were getting on with

things.

Q. Now, what -- we know that paediatrics had recently been moved into a -- the urgent care directorate --

A. Yes.

Q. -- whereas obstetrics was in the Planned Care directorate.

A. Yes.

Q. Do you have a view about whether that made any difference to your department's connection to the senior management of the hospital?

A. I think it did because when we were part of a women and children's directorate, we were far less of a small cog in a big machine, we also worked very closely with the obstetricians, so had a lot of similar issues, and once we joined urgent care, which included the emergency department and adult medicine, it was perceived that they had far bigger problems and issues.

So we were very much sidelined.

Q. I would just like to -- I'm going to jump slightly ahead in --

A. Yes.

Q. -- our chronology but, while we're dealing with this topic of the word "disinterest" that you used draw your attention to three events around the end of

2015 into the beginning of 2016.

A. Yes.

Q. So this is in a sense in the middle of the first part of our timeline.

Firstly, during that period, did you send an email directly to Tony Chambers drawing attention to the staffing and pressure on the paediatric department?

A. Yes.

Q. And have you also -- and you were on copy at the time I believe -- seen an email sent at about the same time by your colleague Dr Saladi?

A. Yes, I've seen that email recently and I also recall receiving it at the time.

Q. And was that also saying something very similar to what --

A. Yes, it was --

Q. -- you were saying?

A. -- and it rung very true with my own experience of working in the department at that time.

Q. And if we just bring up a document now on the same theme at about the same time, INQ0017868, please. Now, this is a corporate directors meeting on 27 January 2016. You weren't in attendance.

A. No.

Q. But if we just look down the list, we can see

about halfway down the Chair of the medical staffing committee a Consultant Anaesthetist, Mr P Jameson, did attend that meeting, and was Mr Jameson a person who you knew or had any contact with?

A. Yes. He is -- was one of the Consultant Anaesthetists who specialised in the care of children and did several children's lists, so we had a relatively close working relationship with him. He was also the Chair of the medical staffing committee, which meant he looked after the interests of the permanent medical staff so we knew him in that regard as well.

Q. So 27 January 2016, about the time that you were sending your email about the time Dr Saladi was sending his email?

A. Yes.

Q. If we move forward to page 5, please, please, three quarters of the way down the page, there is a line ending "PJ", being a reference to Mr Jameson.

A. Yes.

Q. Do you see that?

A. Yes.

Q. "PJ felt the paediatric service was almost at breaking point and needed support before it hits the point of burn out."

Does that resonate with your experience at around

that time?

A. Yes, it does.

Q. Obviously we're not just seeking here specifically about the neonatal unit, this is the whole paediatric --

A. This is the whole paediatric department.

Q. -- the whole paediatric department. Thank you very much, that can come down.

Now, Dr ZA, do you have a view about how the pressures that you and your colleagues were under during this period may be relevant to the crimes that Lucy Letby committed?

A. We were very busy. There weren't enough Consultants for the workloads that we were doing. We also didn't have enough junior doctors, and that meant that we -- it was relatively common that the Consultants would have to act down to cover vacant junior doctors' shifts, which was important to assure the acute safety at that particular time. But that did mean that there was less time for the non-urgent clinical tasks because everything was done to sort of a prioritise that acute safety.

But it did mean partly that Lucy could hide what she was doing within people being generally busy. It also meant there was less time for the non-urgent acute

things like reviewing the deaths afterwards and reviewing other incidents because we were so busy just trying to cover the acute service.

Q. Now, I'm going to move on to a topic where we are going to deal with a number of policy matters --

A. Yes.

Q. -- before we come to our timeline. But the first is safeguarding. Had you received any safeguarding training on how you should act if you suspected a colleague was harming babies?

A. No, I'd received a lot of safeguarding training throughout my career about what to do if parents or careers were harming babies but nothing about what to do if other healthcare professionals were.

Q. Given your experience and looking back, do you regard that as a significant gap in your training?

A. Yes.

Q. In terms of your general awareness of circumstances in which colleagues might deliberately harm patients, were you aware of the case of Beverley Allitt?

A. I was.

Q. And so you knew that insulin could be used as a deliberate way of harming patients?

A. I was.

Q. And were you aware of the nurse at Stepping Hill who had also used insulin in 2011?
A. I think I was aware that there was a nurse at Stepping Hill who had harmed patients but I don't think I was aware that they had used insulin to do that.
Q. So it was within your knowledge that that kind of terrible behaviour may occur?
A. Yes, it was.
Q. We'll come back to those two previous cases shortly, but we'll stay with policy, please.
You tell us in your witness statement that you consulted the Speak Up Safely policy during 2016 --
A. Yes.
Q. -- is that correct?
A. Yes.
Q. Just tell us, why did you consult that policy?
A. We felt that we weren't being listened to when we were raising concerns about Lucy Letby, but we'd already had behaviour that strongly implied that our jobs were at risk if we continued to raise those concerns, so we wanted to make sure that we were exhausting the options for raising concerns within the organisation before taking that to outside agencies such as the police.
Q. Having conducted that research to check your

position, did you establish who it was, if any one person or group of people, that you should be speaking out safely to?
A. That it was the higher management within the Trust, the Medical Director and the Chief Executive that we should be bringing those concerns to.
Q. And across all the various meetings that you attended, did you ever make reference to the Speak Out Safely policy or the fact that you were speaking out in accordance with it?
A. I don't think I ever did. I think that my colleagues did, but I don't have a clear recollection after this time.
Q. And so when you spoke to Executive Directors, in particular those two that you've named, was it your view that you were speaking to them in their capacity under the Speak Out Safely policy?
A. Yes.
Q. The third policy I'd like to ask you about is the SUDiC procedure.
A. Yes.
Q. Have you followed any of the Inquiry evidence about SUDiC and whether or not it applied to the hospital environment?
A. I haven't followed the evidence from the

Inquiry in any detail. I know that the wording of the SUDiC policy was very much that it did apply to deaths in hospital, but that wasn't the practice and the culture at the time. It was only really applied to children that died in hospital having been found collapsed outside the hospital and came in with resuscitation ongoing. It wasn't our practice and culture to use that with children that had died in hospital.
Q. This might be quite a difficult thing for you to put your finger on --
A. Yes.
Q. -- but where was that practice and culture coming from? What was driving that?
A. I think it was something that hadn't -- that it was felt that that was a very invasive process. The SUDiC protocol involved getting the police involved, getting social care involved, and I think the thinking was that anyone who died in hospital must have had a medical explanation rather than an unnatural explanation because they were obviously ill enough to be in hospital. So I think it was felt that that process was very invasive and not necessary, which obviously we now know is not the case.
Q. I would just like it bring up the hospital's

own policy, if we can here --
A. Yes.
Q. -- and just draw your attention to one very small part of it, INQ0003250, and we will go straight to page 33, please.
So this is the Safeguarding and Promoting the Welfare of Children internal Countess policy. Page 33.
We can see there:
"The sudden unexpected death unexpected in 24 hours prior to death of a child under the age of 24 months, irrespective of the place of death, at home or in the community, in the hospital emergency department or ward."
So do you agree, that appears to accord with your understanding the wider documents?
A. Yes.
Q. But that policy specific for the Countess also appears to be in direct tension with what you tell us was the culture and practice in the hospital.
A. Yes.
Q. Does that surprise you that the hospital's own policy appears to apply SUDiC across all unexpected deaths?
A. It doesn't surprise me because I've read these documents as part of preparation for coming today, but

it certainly wasn't my understanding at the time.
Q. Thank you, we can take that down. The final area of policy to ask you about is the Datix system.
A. Yes.
Q. When did you understand, in 2015/16, it was appropriate to fill in a Datix form?
A. So a Datix form should be filled in for any clinical incident, which is whenever something happens that either went wrong or could have gone wrong as sort of a near miss.
There was a sort of pick list of incidents available on the system which kind of flagged up common things that could be reported like a drug administration error. It was common to report all deaths on the Datix system but any clinical errors or clinical near misses should have been reported using that system.
Q. So applying to all events, if there was a concern about a clinical issue, that would prompt a Datix form?
A. Yes.
Q. But specific to deaths, even if there was no concern about a clinical issue, you would still fill in a Datix form?
A. Someone on the team would do.
Q. How about collapses that required

resuscitation so, in other words, a circumstance where a patient but for outstanding medical care would have died?
A. That wasn't our practice at the time.
Q. And, again, looking back on it, do you think it would have been helpful if that had been the practice?
A. Yes, it would have been.
Q. And just in a couple of sentences, why do you think that would have been helpful?
A. I think that we had a change in the neonatal care that we provided over the timeline in question where neonates as a group of patients have always been slightly unpredictable and done slightly unusual things, but gradually over time the rate of these unpredictable and unusual things changed quite dramatically. And I sort of can only liken it to the analogy of putting a frog in boiling water versus a frog being in a pot where you slowly turn the heat up that you don't realise at the time, because it's a gradual increase, how dramatically things are changing, whereas something hard and fast like the Datix system may have flagged that up.
Q. We are going to move to June 2015, although only deal with it briefly. You weren't involved, yourself, in the care of Children A, B, C or D; is that

right?
A. Yes, that's correct.
Q. But did you have some awareness of the fact that there had been three deaths on the neonatal unit in short order?
A. Yes, I was.
Q. And were you aware that there was discussion about a rash?
A. I can't recall whether or not I was involved in that discussion at the time.
Q. Let me just see if I can assist your recollection. INQ0025743.
Now, if we scroll to the next page, but we can leave it on the large page view, my apologies for the quality of the text, but you can see at the top it's 23 June 2015 --
A. Yes.
Q. -- email from Dr Gibbs. You're included --
A. Yes.
Q. -- in the circulation.
A. Yes.
Q. And he's there talking about Children A, B, C and D. He's talking, as you can see in the first paragraph, about a "strange purpuric-looking rash".
A. Yes.

Q. And in particular that Dr Lambie has come to him very concerned.
A. Yes.
Q. That's the email in a nutshell.
A. Yes, I do recall this email now.
Q. So that was -- so is it fair to say that as at, when we come to it, August your colleagues had shared that information with you?
A. Yes.
Q. Did you have any conversations with Dr Lambie about her concerns at the time?
A. I don't think so, no.
Q. And if we scroll to the next page, again leaving it on the overview page, your colleague Dr Newby, at the bottom agreeing, with Dr Gibbs also talks about Dr Harkness, an other another trainee doctor --
A. Yes.
Q. -- coming to speak to her about the concern.
So just looking at the position in June what appears to be clear from these emails is at least two of the Registrars were concerned --
A. Yes.
Q. -- concerned enough to come and speak to different Consultants separately --

A. Yes.
Q. -- on the face of it, and you seven Consultants were discussing the cases between yourselves.
A. Yes, we were.
Q. So we will just take that down.
So that provides us, I hope, with some context for when we get to Child E, which we will turn to now. 4 August of 2015 so just about six weeks --
A. Yes.
Q. -- after that discussion. You tell us in your witness statement that you were present at the time of Child E's cardiac arrest.
A. Yes.
Q. And your colleague Dr Harkness, so the same doctor --
A. Yes.
Q. -- mentioned in that email, told you about discolouration.
A. Yes.
Q. Now, did that prompt any recollection in you on 4 August about this rash and Dr Harkness, both of which we can see was being discussed as a matter of concern just six weeks earlier?
A. No -- Dr Harkness with Child E had talked

about discolouration of the abdomen, which made me think of the discolouration which you see with Necrotising Enterocolitis, or NEC. It didn't remind me of these emails, and Dr Harkness didn't suggest the link between the rash he'd seen on the previous babies.
Q. And just to deal with it. In your witness statement you say you're not aware of the discolouration seen by colleagues. In fact having seen that email, can you see it that you were?
A. I can see that I were. It's difficult to remember the exact order in which things happened with it being a long time ago.
Q. Well, certainly I think it is the case, Dr ZA, that it's only relatively recently that you were given access to that email again --
A. Yes.
Q. -- is that right?
A. Yes.
Q. Now, what you say in your witness statement about Child E's death is that it was unusual because he deteriorated so quickly; is that right?
A. That's correct.
Q. And was that something that struck you at the time?
A. It's something that struck me at the time that

I was surprised at how quickly he deteriorated, but I felt that there was an appropriate medical explanation at that time.
Q. So we will come to that in just a moment.
A. Yes.
Q. But just to try and understand your thought process, we've heard from other Consultants that this cluster of deaths was highly unusual --
A. Yes.
Q. -- for the department.
A. Yes.
Q. So it isn't just that Child E's death stands in isolation, whatever conclusion --
A. Yes.
Q. -- you might reach, it sits very much in the context of just nine weeks previously three other --
A. Yes.
Q. -- deaths.
Do you think that you were sufficiently curious at that stage to look closely at Child E's death, given the earlier ones?
A. I don't think I'd linked Child E's death to the earlier deaths. I think I was aware that there had been more deaths than we would expect on the unit, but I felt there was a medical explanation for E's death at

that time.
Q. And you thought the most likely presentation fitted with NEC --
A. Yes.
Q. -- as you've told us.
Now, you also say this in your witness statement that at the time you didn't realise the significance of abdominal x-ray not showing signs of NEC.
A. Yes.
Q. I just wanted to understand a little bit more about that. Just the first question is this, and I promise you, I'll give you an opportunity to say what you want to say about it, but did you at the time look at an abdominal X-ray?
A. I had looked at the abdominal x-ray, which looked relatively normal, which you do see in NEC. So having an X-ray that shows signs of NEC confirms the diagnosis. Having a normal X-ray doesn't exclude the diagnosis. It was reviewing E's death in hindsight I thought that if the NEC was severe enough to cause him to die, then there should have been signs on the X-ray, but I didn't make that connection at the time.
Q. So really just to go back to my earlier question, do you -- in terms of your level of curiosity at that time in the context of what was happening --

A. Yes.
Q. -- do you think you should have been more curious?
A. Yes, I should have been.
Q. And stripping out hindsight, it's a difficult thing to do I know --
A. Yes.
Q. -- but do you think at the time you should have noticed that the X-ray was normal and that that may be -- contra-indicate NEC or in some way cause you to doubt --
A. It would have made that less likely --
Q. Less likely --
A. -- so I should have been more curious at the time.
Q. And had you been more curious, what investigations were available to you at the time to take that further?
A. I spoke to the Coroner and explained that I thought the cause of death was NEC, which meant that the Coroner and I agreed that we should issue a -- I should issue a medical certificate of cause of death with that as the explanation. Had I not had those thoughts when I discussed it with the Coroner, then Child E would have had a postmortem to look for the

cause of death.
Q. In fairness to you, I just want to give the other side of it.
A. Yes.
Q. What was the other side of your thought process about why you perhaps didn't want a postmortem to take place?
A. I knew that Child E's parents were already devastated and didn't like the idea of a postmortem, and I didn't want to do anything that made what was already an awful situation for them any harder. So it was the wrong decision but it was done with the best of intentions.
Q. Because I'm sure implicit in that is that although the views of the family are extremely important and must be dealt with as being something you should have proper regard to --
A. Yes.
Q. -- in this situation, if a postmortem was required a postmortem should take place?
A. Yes.
Q. Now you filled in a form --
A. (Nods).
Q. -- about Child E's death, I would like just to bring that up, please, INQ0012016, just to see if you

can help us understand how this form is put together.
So I think it's sometimes referred to as the Form AB?
A. Yes.
Q. I'm sure you are very familiar with.
It. If we can please move to page 4, and we can see at the top under the heading "SUDiC", "Death expected", and then there are four options to check, "Expected", "Expected but meets exclusion criteria", "Unexpected NHS commissioning board notification".
The "Unexpected but meets exclusion criteria" box is checked. Can you just help us to understand what that means in practical terms?
A. I think that that's because I've discussed it with the Coroner and we've agreed on a cause of death.
Q. It's difficult, but do you know what the exclusion criteria are?
A. Not off the top of my head, no.
Q. No, but they sit in your mind with the fact that you had agreed with the Coroner that the cause of death could be certified?
A. Yes.
Q. Thank you very much indeed, we can take that down now.
It may be that you will be asked some questions

about interactions with Child E's parents but I'm not going to ask you about those now. I'm just going to move forward, please, to the position on the ward and in particular as between the Consultants and whether or not, now that there had been four deaths, there was a Consultant-wide discussion?
A. There was. I can't recall exactly when but there was a quite a high level of concern that we'd had four deaths at this stage, and very much a worry about what were we overlooking in terms of medical care, environment, why -- why had this happened, what could we do to try and stop this continuing to happen.
Q. In the course of those discussions, did anybody say within your hearing that there was concern that there may have been deliberate harm caused?
A. I can't recall anyone saying it at that stage.
Q. Just so that we time mark that, we are talking about the period immediately following the death of Child E.
A. Yes.
Q. In your witness statement, you make a comment about the level of detail that Letby put in the notes for Child E --
A. Yes.
Q. -- and that that was something that struck you

at the time. Can you just tell us, please, what it was that caused you to notice that note and what your observations about it are?

A. So I noticed that note while preparing my witness statement for the police some years later. There was nothing kind of hard and fast, it just seemed quite a lot of information about the memory boxes and taking pictures of E and F together, and it just seemed more detail than I would have expected but there was nothing sort of hard and tangible, it was just as part of that overall picture that we had of Lucy Letby at that stage.

Q. I'll just unpack that a little bit. Obviously you have huge experience of reading medical and nursing notes --

A. Yes.

Q. -- it follows from what you say that the level of detail about that note didn't strike you at the time.

A. I didn't I don't think I saw it at the time.

Q. But it, later, at a time when you knew there was a police investigation, you did see it --

A. Yes.

Q. -- and it's then that you've made the comments about it being perhaps slightly inconsistent with what you usually see in notes.

A. Yes.

Q. We're just going to stay with Child E here and move forward in our chronology before coming back to Child F. But there was a Neonatal Mortality Meeting on 26 November 2015, which you tell us you didn't attend because it was a non-workday for you.

A. Yes.

Q. Now, although it was becoming increasingly more common for deaths to occur on the neonatal unit they weren't -- it wasn't, as some departments will experience, a department that had deaths occurring very often --

A. Yes.

Q. -- is that fair?

A. Yes.

Q. And those neonatal mortality meetings are important.

A. Yes.

Q. And you shouldn't understand me to be criticising you at all for not going to work that day --

A. Yes.

Q. -- I want to look at a different side of it, which is, do you think, bearing in mind that you were involved in Child E's care and had signed the death certificate, that in fact steps should have been taken

to ensure that you could attend the meeting about Child E's death?

A. Probably with hindsight, yes. But that wasn't how we practised at the time but then we did have a lesser number of deaths at that time. I was also the first person in our department to work less than full time, so that was a relatively new situation for the department.

Q. But it almost always might be the case that a Dr may not be working --

A. Yes.

Q. -- when a meeting is scheduled --

A. Yes.

Q. -- that's just -- that's just how the rota --

A. Yes, they may be on annual level --

Q. Absolutely.

A. -- they may be covering acute things.

Q. Absolutely. So it is not at all a question about the hours that you kept --

A. Yes.

Q. -- it's more about how things were arranged to make sure the most important people attend important meetings.

A. Yes.

Q. And I think you've agreed that really it

should have been arranged so that you could attend.

A. Yes.

Q. So Child F -- we go back to the 5 August -- and we know that a -- that Child F was hypoglycemic on 5 August --

A. Yes.

Q. -- a sample of blood was taken, it went to the Liverpool laboratory and it came back to the Countess on 13 August 2015 --

A. Yes.

Q. -- at a time when Child F's condition was stable.

A. Yes.

Q. Now, we'll just have a look, please, at the results as they appear on the notes. It's INQ0000859, please, and we will go to page 334. I regret to say that that is a less good quality copy than I believe the Inquiry holds. But hopefully --

A. That's fine I've seen --

Q. You've seen this before --

A. I've seen it before, yes.

Q. -- so I'm not asking unfair questions here. And the essential point here is that the insulin level is high whereas the C-peptide level is low.

A. Yes.

Q. And did it form part of your training that that will occur when somebody has administered insulin externally --

A. Yes.

Q. -- exogenous insulin as opposed to insulin that the body has produced --

A. Yes.

Q. -- because you would expect a higher C-peptide level?

A. Yes.

Q. And is this how the results will appear in the notes, presumably more legible, but this is -- this is what will come up when you look at the electronic notes?

A. Yes, yes, this is what came up on our electronic results system.

Q. And is there another significant issue when interpreting these results, namely the glucose level?

A. Yes, you need to know what the glucose level was doing at the time because the body's own amount of insulin and other hormones is a dynamic state and very much depends on what the blood glucose is.

Q. So I think, and you'll tell me if I'm wrong about this, if we go to 337, we can see the glucose result. Can you see that?

A. That's cerebral spinal fluid rather than blood

there.

Q. Right. Well, we can take that down for the time being. At all events, did you check the glucose level?

A. The reason the bloods were done was because the glucose level was extremely low at that point. The bloods were taken as part of what's called a hypoglycemia screen, and that's when a baby has a very low blood sugar, it's to look for reasons why that may have happened, and it's important that those bloods are done at the time of the low blood sugar because of the importance of interpreting them in the light of the sugar result.

Q. This is a hypoglycemic episode.

A. Yes.

Q. Would you expect the insulin levels to be low or high?

A. Low.

Q. Low. And on this result, were the insulin levels low or high?

A. No, they were high.

Q. So that's a first marker that something unexpected is happening?

A. Yes.

Q. And the second marker is the ratio between the

insulin and the C-peptide; is that right?

A. Yes, that is correct.

Q. Now, let's just bring up your notes, which is the same INQ0000859 and page 39, please.

Yes, that's the -- do you recognise that note?

A. Yes, I've seen that before.

Q. It's at half past 10 --

A. Yes.

Q. -- on the morning of 13 August. We can see the SHO, Dr Lidden --

A. Yes.

Q. -- starts the note. We've got the hypo screen results recorded there.

A. Yes.

Q. I don't think we have the glucose recorded but that was something that you noted at the time, was it?

A. Yes, we know that those were done when the glucose was very low --

Q. Yes.

A. -- I can't remember the exact reading, but it was very low at that time.

Q. And you are recorded by Dr Lidden as saying:

"Insulin high, C-peptide low, unusual for hypoglycemia as now well and sugar stable for no further ..."

What's that last --

A. It's an abbreviation for "investigations". I mean, this -- this is quite a short paragraph that sums up what was a sort of much longer discussion. We discussed how the blood results looked as if Child F had been given exogenous insulin, which is an insulin as a medication given.

We checked that it wasn't prescribed. We checked that no one else on the unit at the time was on insulin, thinking about: was it done accidentally?

But the idea that someone could be doing it deliberately just seemed so fantastical and unlikely that that couldn't possibly be what had happened. With neonatal blood samples, because they're so small and often difficult to obtain, we do get unusual results from time to time, and our normal practice if something is outside of what we would expect is to repeat them. We obviously couldn't repeat the bloods at this point because Child F was well with a normal glucose level, so we wouldn't be able to repeat them.

At the time, I just dismissed the idea of someone deliberately administering insulin because it just seemed so impossible, but I deeply regret that that is how I interpreted things both for Child E and F's parents and for all the babies that happened

subsequently. I wish I'd interpreted these in a very different light, but at the time it just didn't seem possible that someone could do that.

Q. Absolutely recognising that you have just accepted very candidly that you misinterpreted those results --

A. Yes.

Q. -- and did not take steps that you should have taken --

A. (Nods).

Q. -- just trying to understand a little bit more about why. You've used that phrase "impossible" more than once --

A. Yes.

Q. -- what about the case of Beverley Allitt, didn't that potentially come to your mind in any way that that is a --

A. It didn't --

Q. -- real life example?

A. I don't know why not. That's -- I've sort of grown up with the knowledge of Beverley Allitt and what she did in sort of common knowledge, and then later Harold Shipman, but it just never -- never occurred to me that that would be something that happened on my ward to the patients I was looking after.

Q. And you've raised the fact that you've had experience of results being surprising and not according with what you think the picture should be --

A. Yes.

Q. -- I hope I've characterised that correctly, presumably that's a relatively rare occurrence?

A. It has -- it's in not that rare in neonates. Because they are physically so small and their veins are so small the taking of blood is more difficult. The giving the lab big enough samples that they can analyse is quite difficult. So the two things that happen are either that the samples can clot because the blood comes out quite slowly or that it can haemolyse, which means the cells break down because of the small veins and the small needles, and the need for sort of pressure to get the blood out. So it would be relatively rare in older children and in adults but it's something we saw not infrequently in neonates that would have slightly unexpected readings, and we would repeat them and they'd be okay.

Q. And had you ever seen that in relation to an insulin C-peptide --

A. Never in relation to an insulin C-peptide.

Q. And so although it existed as a possibility for some results, you hadn't seen for this sort of

result that happening?

A. Yes, but this wasn't a sort of result that we had that often. They went -- they got sent off to the lab in Liverpool, and by far and away the most common result we got back was that the sample was insufficient for them to process, so we were more used to not getting a result because of the technical difficulties.

Q. That was going to be my follow-up question because, again, that isn't this scenario, is it --

A. No.

Q. -- because you did get some results --

A. Yes.

Q. -- with no suggestion from Liverpool that there was any reason to doubt them.

A. No.

Q. Now, just to be clear about two things.

Firstly, and we can look at it if you want to, but looking at your police same you said:

"I did not have anything unnatural in my mind at the time."

You've told us about a process where you discussed it with Dr Lidden, you went so far as to check whether or not any other baby was due to receive insulin on that day, and you've described a thought process where -- which, as you've described it, sounds like you thought

about whether there was something unnatural and dismissed that --

A. Yes.

Q. -- as impossible.

A. Yes.

Q. So just help us to understand, what was your true state of mind, did it cross your mind and you rejected it?

A. It crossed my mind and I rejected it.

Q. And, secondly, just in terms of whether you should have done more, in your witness statement you say "with hindsight". I'm not suggesting that that's wrong, but do you think that you need hindsight to know that you should have done --

A. No --

Q. -- something different?

A. -- I made the wrong decision.

Q. Should it have prompted a Datix form?

A. It should have yes.

Q. Was it potentially serious enough that you should have contacted Dr Brearey or Dr Jayaram?

A. Yes, I probably should have done.

Q. Was it an issue for the nursing ward manager?

A. Again, if I had not dismissed the thought of it being deliberate, then if I thought it was

deliberate, then absolutely it should have done.
Q. Now, you say that you weren't involved in any debrief for Child F. Do you know if one took place?
A. I don't think so.
Q. Given Child F's course, would you have expected there to be a debrief for Child F?
A. No, because he'd recovered from that episode of hypoglycemia and was well enough to transfer back to his home unit *(redacted)*.
Q. If there had been some sort of debrief, do you think that, as they were conducted at the time, those results might have come to the surface and there had been a discussion about them?
A. Yes, I think it would have done.
Q. Just help us to understand the practicalities. Would having a debrief in a case such as Child F completely overwhelm the department if you applied that across the board or was it in fact practical to do that?
A. I think sort of referring back to what I'd said earlier about that sort of gradual increase in acuity and strange things happening, I think at the peak of that timeline it probably would have overwhelmed the department, but in the department as we are now and as we were before this period it wouldn't have done. So it would have been a sensible thing to have done.

Q. And so does that go back in part to what you were saying about how much pressure the paediatric department was under at that time as well as the additional stress caused by the increase in the number of deaths and collapses?
A. Yes.
Q. Now, you were away from the Countess of Chester between December 2015 and March 2016; is that right?
A. Yes, that's correct.
Q. It will follow from that that you were still working in 2015 at the time of the collapses of Child G, H and J. Were you aware of any of those collapses at the time that they occurred?
A. I can't recall.
Q. You were also working at the Countess when Child I repeatedly collapsed over a number of days and then died.
A. Yes.
Q. Were you aware of Child I's death?
A. Yes.
Q. And did Child I's death bring to your mind your involvement in Child E or Child F?
A. I don't think it did. The period where I was off between December and March was a very significant

personal stress.
LADY JUSTICE THIRLWALL: You don't need to tell us about that.
A. And I think that probably affected some of what I was remembering of the previous time.
MR DE LA POER: Absolutely, and it's entirely my fault, Child I died in October 2015 so before you --
A. Okay.
Q. -- went away. So I don't -- and I'm not looking it pry at all --
A. Yes.
Q. -- whether you going off in December affected the period before or not --
A. Yes, I think I have just got confused at the timeline, but yeah --
Q. No, that's my fault.
A. -- I don't recall linking them at the time, other than the feeling that we all had that things had changed and things --
Q. Now --
A. -- were not as they had been previously.
Q. -- Dr Newby, Dr Gibbs have both told us about the period after Child I's death when they were involved in a conversation with Dr Jayaram and Dr Brearey in which serious concerns were raised.

Now, memories perhaps differ about the detail --
A. Yes.
Q. -- and who was at which discussion, so I don't want to misstate the position, but were you involved in any discussions with any of those four people following the death of Child I, so the period November into December?
A. I think I was. I was aware that there was a definite sense of unease about what had happened with several of my colleagues who'd been involved with more of the babies. I can't recall the exact details of that but there was a sort of growing sense of unease and unhappiness at what had happened.
Q. In the course of any of the conversations that you were present at, did anybody suggest to you that they were concerned that deliberate harm may be being caused to babies on the neonatal unit?
A. I can't recall exactly when that was first mentioned, whether it was at that point or in early 2016. I do recall someone mentioning the association of Lucy Letby with the number of deaths and collapses but that being explained by the fact that she did more shifts and she was one of the few nurses with the intensive care qualification who wasn't a shift leader, so was more likely to be looking after the sick babies.

Q. Do you recall who it was who drew your attention to her being in common with these deaths?

A. I think it might have been Steve Brearey but I'm not 100% sure.

Q. And do you recall whether that was before or after you had your period away from the hospital?

A. I'm not 100% sure.

Q. Just to complete the picture in relation to Child F, we'll just bring up an email here please INQ0005890. We're going to jump right to the end of the period that we are looking at.

A. Yes.

Q. This is 6 June 2017, so by now the police have been contacted.

A. Yes.

Q. So we're right at the end, as I say, of the period that we were focusing on.

This is an email from you to Dr Brearey in which you are recalling a baby with high glucose requirements seemed to fluctuate. You say:

"Astha and I did a lot of hypoglycemic bloods and insulin level was high and C-peptides suggested it could be exogenous insulin."

Firstly, can you help us with who Astha is?

A. Astha that was one of our junior doctors, but

I think I must have misremembered who it was because she wasn't involved in this particular case.

At the time of this email, I was on *(redacted)* leave and I just had something in the back of my mind nagging about Child F's results and the fact that at the time I'd dismissed the possibility of deliberate harm, but now, based on what we were thinking, that didn't seem so impossible any more. But I couldn't remember Child F's details and I wasn't in the hospital to be able to look, so I wanted to flag that to Steve.

Q. Thank you, we take that down. So there's no doubt about it, this is Child F that you are --

A. Yes.

Q. -- seeking to recall?

A. Yes.

Q. Thank you.

Finally for 2015, we've heard evidence from Dr Lambie, who left in September 2015, that she came upon a huddle of nurses who were looking at the rota together to see who had been on when events had occurred. Were you aware of such a huddle taking place or any discussion between the nursing about that?

A. I wasn't aware of that, no.

Q. Moving forward into 2016, although it may not be 2016, you'll tell us --

A. Yes.

Q. -- you tell us in your witness statement you attended a workshop when the CQC visited.

A. Yes.

Q. And was that a workshop for Consultants?

A. Yes, it was.

Q. And you tell us that you sought to raise patient safety issues with the person running it and that they suggested you speak to them at the end --

A. Yes.

Q. -- and by the time the end came, they left immediately and you didn't get to say anything more.

A. Yes.

Q. What year did that take place?

A. I think it took place in 2018. I know that some of my colleagues -- Dr Brearey in his witness statement thinks that I raised something with the CQC in February 2016. I don't have any recollection of doing that. I also was on a period of extended leave at that point and I don't think I would have come into the hospital for a CQC meeting.

Q. Just being realistic about it, do you think you would have remembered during that period if you'd come in for such a meeting?

A. Yes, I think anything that I came in for

during that period would have to be very significant, so there's a -- I think I probably would remember it.

Q. And also, would you have been quite an odd choice to be a spokesperson for the Consultant body and the paediatric department, given that you were -- had been out of the loop for a period of time by the time that meeting happened?

A. Yes. I think the meetings are more sort of drop in than sort of nominated representatives. But I don't think I would have gone to represent my colleagues in that period of time. That wasn't where my priorities were.

Q. Thank you. Child L who we can deal with briefly. 9 April 2016, Dr Gibbs has described, as I'm sure you know:

"It is a collective failure by the Consultant body to interpret and act upon Child L's insulin and C-peptide ratio."

Do you agree with that?

A. Yes.

Q. Now, you returned to the Countess of Chester in March of 2016 --

A. Yes.

Q. -- from your period of extended leave.

A. I had a phased return, so I, over the next few

months, gradually increased my clinical duties, so I wasn't sort of fully back at work from March.

Q. But were you made aware of the outcome of the thematic review into neonatal mortality?

A. Yes, I was.

Q. And I think you were allocated a job under that action plan to ensure junior doctors knew about sepsis.

A. Yes.

Q. In that phased return to work period, at the latest, was that when you heard Letby's name mentioned as being a common factor?

A. Yes, that was definitely more of a concern when I came back.

Q. So you've told us it may have been before you went off --

A. Yes.

Q. -- but if we bookmark it as the latest, it's that period there?

A. Yes.

Q. And was it also at the latest during that period that you became aware of concerns by your colleagues that deliberate harm may be caused?

A. Yes.

Q. And was that a view which you agreed with,

disagreed with or thought might be a possibility?

A. It's one that I thought might be a possibility. It was a general feeling of collective unease at the sudden, unexpected and unexplained nature of events and the correlation with Lucy being present, but nobody sort of knew exactly what she was doing to have a sort of positive explanation for it. It was that sort of uncomfortable association at that point and the lack of another plausible explanation.

Q. So you told us in relation to Child F that you considered the possibility of deliberate harm and rejected it out right.

A. Yes.

Q. This is different, if I've understood your answer correctly.

A. Yes.

Q. So is it fair to characterise it as during that period you thought that Letby may be harming babies?

A. Yes, but I didn't have any positive evidence of that. It was more the growing association and the lack of other explanations.

Q. Given that that was your state of mind, that a member of staff may be harming, may be killing babies, should you have done something at that stage to ensure

that there was urgent action?

A. I should have done.

Q. And why is it that you think that you didn't?

A. I think partly because the concerns were coming from my colleagues who were already trying to do things, partly because there was no definite proof, it was just a sort of growing concern and uncomfortableness, and the fact that that would be a devastating accusation to make.

Q. In the context of safeguarding in the community, do you need to wait for definite evidence --

A. No, you don't.

Q. -- in order to act.

And so, in reality, was this any different to that?

A. No, it wasn't.

Q. Did you have any discussion with Dr Brearey about his meeting on 11 May with the Executive Directors Ian Harvey and Alison Kelly?

A. I can't recall.

Q. Do you recall receiving his email on 16 May in which he asked for any sudden unexpected collapses to be drawn to his attention?

A. Yes, I do recall that email.

Q. And what was your understanding at that time about what steps the senior management were taking?

A. I understood at that point that they were aware of our concerns, that they didn't feel there was a threshold to do anything at that point but wanted to be kept appraised of the situation if there were any more episodes.

Q. And were you yourself satisfied at that stage with that reaction from senior management?

A. I think I probably was being a bit more distant to what was happening than some of my colleagues.

Q. So we come to the deaths of Child O and Child P.

A. Yes.

Q. Now, you weren't involved in their care at the time of their deaths; is that right?

A. That's correct.

Q. But is it right that you came -- became aware of their deaths shortly afterwards?

A. Yes, I did.

Q. And was that before or after the senior paediatrician meeting on Monday, 27 June, do you know?

A. I don't know off the top of my head, no.

Q. Was that a meeting that you attended? So the Child O and Child P died the previous week, 23rd, 24th.

A. Can I just check my statement?

Q. I don't think it's dealt with in your statement.

A. Okay. I know that I did have a period of annual leave around the time of those deaths, which is why I wasn't involved in their care. I can't recall exactly which date I returned to work.

Q. Do you recall any meeting at which, as we've heard from other witnesses, a group of paediatricians -- senior paediatricians together with Eirian Powell met and were saying out loud that they were concerned that Letby may be harming babies?

A. Yes.

Q. So you remember --

A. Yes.

Q. -- being present at such a meeting --

A. Yes.

Q. -- whenever it took place?

A. Yes.

Q. You know that Dr Saladi sent an email on 29 June suggesting that the police should be involved.

A. Yes.

Q. Was that a view that you agreed with or disagreed with?

A. Yes, I thought the police should have been involved as well.

Q. Further up that chain, Ian Harvey gave a direction that emails should cease. Do you recall receiving that?

A. Yes.

Q. And what was your reaction to that?

A. That it seemed like this was something very important and it shouldn't be something that we should be told to stop discussing.

Q. Now, on 5 July, you were involved in carrying out a review of Child O and Child P's death.

A. Yes.

Q. And also participating was Dr U.

A. Yes.

Q. What you say in your statement is that:

"I believe that we referenced the increase in mortality and Letby's presence."

And you also say:

"Staffing factors and the possibility of Letby having something to do with the deaths either by incompetence or deliberate harm was discussed."

A. Yes.

Q. I'd just like you to -- in your own words, what was actually said by people at the meeting about Letby and whether deliberate harm may have been caused?

A. I think both myself and Dr Brearey stressed

the fact that we couldn't medically explain these deaths, that there was a -- the continued association of Lucy with sudden unexpected, unexplained deaths and collapses and that that association had gone far beyond coincidence and her working pattern, and, therefore, we thought that she must be involved in some way, either by unconscious incompetence or by a deliberate act.

Q. And so for all of those who were at the meeting, would they have been clear that there was a --

A. Very, very clear. We were far clearer in the discussion than is in -- on the minutes of that meeting.

Q. So not talking in code but speaking your minds.

A. Yes.

Q. The meeting on 13 July, as we know, involved a presentation of information to the Consultant body about the so-called deep dive --

A. Yes.

Q. -- that had been done. I'm just going to put up on screen INQ0006458. This is really just so that you know what we are talking about.

A. (Nods).

Q. I know you've been through it.

So this appears to be a PowerPoint presentation or slideshow that has been provided to the Inquiry. Was

this the presentation that was made to you?

A. No.

Q. And you've been through it and satisfied yourself of that?

A. Yes.

Q. And is there any --

A. Some bits of it may be the same but it wasn't the PowerPoint.

Q. Thank you, we can take that down. Is there any particular information that was put on screen that isn't in that display that stood out for you at the time?

A. Yes. There was a very clear slide projected that had a lot of patient identifiable data of mums and babies, and it sticks very clearly in my mind *(redacted)*.

Q. Did you say anything at the time?

A. Yes, I did.

Q. What did you say?

A. I asked Ian Harvey if he could remove the slide *(redacted)*, which he did. *(redacted)*. Dr Harvey carried on with the presentation and didn't reference it again.

Q. Did he apologise?

A. No.

Q. Now, as the Inquiry understands it, what was being said at the meeting to the Consultant body was that the increase in deaths may be in part explained by an increase in activity and acuity?

A. Yes.

Q. Was that a conclusion, having been a Consultant on the ward, that you agreed with or disagreed with?

A. I disagreed with it.

Q. What was the central point that you Consultants made at the meeting about the data?

A. There was some data about staffing levels and the deaths, but it seemed that many of the deaths had happened on the days with better staffing levels as opposed to fewer staff. And although we had -- we had agreed that we had been busier, the nature of the deaths weren't explained by the increased acuity.

Q. Did the data take into account whether the deaths were expected or unexpected, explained or unexplained?

A. No, and didn't take the gestation of the babies into consideration either when a lot of the babies who'd died were still premature babies but the less extreme prematurities where it's more unusual for children to die.

Q. And was that a point made at the meeting?

A. Yes.

Q. We know that the Trust arranged for the RCPCH to carry out an inspection. What was your view about that as being an appropriate or inappropriate investigative step?

A. I felt that it was an appropriate step. We had definite concerns about Lucy Letby. We didn't have any sort of definite proof or anything concrete, and the idea of experienced, knowledgeable people coming and having a look at the situation with outside viewpoints to know whether our concerns were reasonable or not seemed an appropriate step.

I think it's important to acknowledge that, at this point, Lucy Letby was on annual leave and wasn't working, so in some ways we felt that had taken some of the urgency out of the situation because she wasn't on the unit at that point.

Q. We understand that certain comments were made about the acceptable circumstances for her return CCTV, and direct supervision --

A. Yes.

Q. -- but we know, is this right, that she returned to a non-patient facing role?

A. Yes. We discussed the facts -- the need for

there to be -- if she was supervised practice it would need to be constant supervision by someone who knew the reason why they were supervising her because they wouldn't be able to sort of nip out to go to the toilet or get a drink, it would have to be sort of constant supervision because the nature of what we were concerned about.

Q. You participated in the interview on 1 September with the RCPCH.

A. Yes.

Q. What was said to the reviewers about Letby, if anything?

A. We were very open from the beginning of our meeting that our concern was that Lucy Letby was doing something deliberate to harm babies.

Q. Later that month, there was a meeting with Tony Chambers on 19 September, which you deal with in your witness statement, but it wasn't one that you went to but you do comment upon it. Within the minute meeting -- minutes of the meeting, forgive me, it's indicated that the Consultant body did not feel listened to?

A. Yes.

Q. What was your feel about the approach of the senior managers at that period towards the back end of

2016?

A. It seemed initially like they didn't want to listen to our concerns, and then over time, as we became more persistent, it seemed that they wanted us to be quiet and shut up about it.

Q. And are you able to identify a moment or a period in time when it changed from not listening to "Be quiet"?

A. I think the most definite be quiet moment for me was the meeting -- I think it was the 27 January, which is in my statement. Can I just check that that's the correct --

Q. It's paragraph 85 I think is the one you have in mind, the 26th?

A. Yes, 26 January. I remember this meeting very clearly. We didn't receive the minutes until some time later, and I'm not listed on there but I definitely attended this meeting. There was a very adversarial atmosphere from the moment we first entered the room.

Q. Can I just ask you a few questions about --

A. Yes.

Q. -- about just focusing on a number of aspects?

Firstly, how would you describe the tone of the senior managers, was it the same -- were they speaking with the same tone or was it different?

A. I felt very much -- all of them seemed to be speaking with the same tone and it very much seemed like we'd been called into the headmaster's office like naughty school children.

Q. You had a summary provided to you of what the RCPCH and Dr Hawdon had said.

A. Yes.

Q. As a Consultant paediatrician, are those reports that you would have expected to read before you went into the meeting or would it be usual for it to be presented to you?

A. No, I would have expected to see those reports in advance, have time to read and digest, presumably -- I would expect there to be complex information in there that I would need time to consider, and as being open to learning and improvement you would want to see the detail of those reports to know exactly what was said and how we as a department could improve things.

Q. Is there any particular phrase that you recall being said in the meeting that stands out for you?

A. Yes. Tony Chambers said that he was "drawing a line" and we "weren't to cross it".

Q. And --

A. Which was said in quite a threatening tone.

Q. And what did you think that might mean for

your job?

A. I very much took it to mention that if we continued to carry on raising our concerns, then my job would be at risk. I went home that night and with my husband worked out how long we could pay our mortgage and bills for if I were to lose my job, so it certainly felt real and that that was a genuine possibility.

Q. You mention in your witness statement being taken aside by -- and I'm quoting here "two of the women".

A. Yes.

Q. Do you know who they were?

A. I don't definitely enough to say in this forum.

Q. Are you able to say whether they were Executive Directors?

A. Yes, they were.

Q. And what did those two women say to you when they took you to one side?

A. *(redacted)* they intimated that it was Dr Jayaram and Dr Brearey putting pressure on me to go along with what they were saying, which I said that very much wasn't the case, that I had formed my own opinions, and what I found stressful was the fact that no one was taking my considered medical opinion seriously.

Q. And you said that in those terms to the two Executive Directors?

A. Yes.

Q. We can -- we've heard a lot of evidence about the exchange of letters that then follows --

A. Yes.

Q. -- so we can deal with it relatively briefly. But having seen Dr Hawdon and the RCPCH report, did you think the deaths and collapses had been adequately investigated?

A. No, I did not.

Q. We're just going to have a snapshot of how you were feeling at the time as expressed in an email INQ0006078. It's the email in the middle dated 17 February. You say:

"I am possibly just too jaded and distrustful now but I worry what the Coroner has been told if he has been given our letter from the 10th and this quite clearly points out our concerns and we have to wait for his response."

Why were you describing yourself as "jaded and distrustful"?

A. I think it follows on from the College review where it was apparent when we met with the reviewers that they'd already been told of our concerns before but

had been told that they were irrational and were quite dismissive of what we were saying. I just worried that the Coroner may be presented with our concerns in a similar fashion, but I felt that our letter was quite straightforward and frank, and if the Coroner had that information, then that would hopefully be sufficient.

Q. Thank you, we can take that down.

I'd just like to take you to your concluding remarks at paragraphs 110 and 111 of your witness statement. I should acknowledge on the way, you didn't attend the meeting with Simon Medland QC, did you?

A. No, *(redacted)*.

Q. So I don't need to ask you about that.

So could you just turn up, please, paragraphs 110 and 111 on page 22. Just refresh your memory from that and then just give us, please, Dr ZA, your summary of your experience over this period as captured there.

A. So I've said that when raising concerns we were initially ignored and then later actively bullied and victimised. I genuinely believed that my job would be at risk if I continued to raise concerns. I think there was a false narrative developing that Dr Jayaram and Dr Brearey were ring leaders rather than that we were all professionals who'd come to the same conclusion.

We decided that we needed to continue to raise our concerns collectively as a group of seven and preferably in writing, because then there can be less room for misrepresentation or misinterpretation.

And I also had some soul searching about what I would -- at what point would I be happy to stop raising concerns and stop pushing, and I decided that the only point I would feel that I could sleep at night and live with myself was that if Lucy Letby wasn't working as a nurse or as a similar position, and that someone had a forensic look at what had happened to these babies, and I felt that even if I lost my job I should persist until we reached this outcome.

MR DE LA POER: Dr ZA, thank you. That concludes the questions I have for you. As you know, there will be some further questions but, my Lady, I wonder if that would be a convenient moment?

LADY JUSTICE THIRLWALL: Yes, certainly.

So, doctor, we are going to take a 15-minute break and we will start again just after 20 to.

(11.26 am)

(A short break)

(11.45 am)

LADY JUSTICE THIRLWALL: I'm sorry to have kept you all waiting. Would you like to come back to the witness

box, please.

Questions by MR BAKER

MR BAKER: Thank you, Dr ZA, my name is Richard Baker, I ask questions on behalf of some of the families, including The Families of Child E and F.

A. Yes.

Q. You gave evidence about a decision that was made regarding the postmortem for Child E.

A. Yes.

Q. And I understood your evidence to be that the decision not to have a postmortem was driven by the wishes of the family.

A. I think it was -- I was keen to respect the wishes of the family, but I should have pushed for a postmortem.

Q. Can I tell you what Mother and Father E recall --

A. Yes.

Q. -- of the conversation? They said that when you spoke to them, obviously this is fairly soon after Child E's death --

A. Yes.

Q. -- that you said his death was probably due to NEC --

A. Yes.

Q. -- necrotising enterocolitis, and you said to them that a postmortem could be done and that Mother E then asked you, "Well, what will this tell us? What more information will this give us?" And you said that you were confident that it was NEC and that it wouldn't tell them any more.

Is that a fair summary of what the exchange would have been like?

A. Probably. I don't recall it in as much detail but then it was obviously --

Q. It was obviously more of a significant conversation for them --

A. Yes.

Q. Yes. I mean, the reality would probably mirror that discussion anyway, isn't it, because if you're uncertain as to the cause of death as a doctor there has to be a postmortem?

A. Yes, there has to be.

Q. And so it would follow that unless you said to them that, "I think this is NEC and I'm confident it is NEC", there would have been a postmortem?

A. Yes.

Q. As to the evidence of NEC, you recall in your witness statement at paragraph 34 Dr Harkness telling you about a purplish discolouration.

A. Yes.

Q. In your interview to the police you said you didn't see that yourself.

A. Yes.

Q. Is that still your evidence?

A. Yes, that is.

Q. So it was a transient discolouration, it had gone by the time you got there.

A. Yes.

Q. Now, NEC causing discolouration of the abdomen that's caused by an internal septic process, isn't it?

A. Yes, and that would be permanent and not transient.

Q. Yes. So it isn't transient for NEC. So that's not evidence of NEC?

A. Yes.

Q. Bleeding from the mouth, which had been noted, gastric bleeding, so upper gastrointestinal tract bleeding out of the mouth that wouldn't happen with NEC either, would it, because it's a problem with the intestines, so the baby bleeds from its bottom?

A. Yes.

Q. Would the baby with NEC usually have a soft and non-tender abdomen?

A. No.

Q. Could we look at the Datix, please. It is INQ0000194 at page 4, please. If we could scroll down to page 4, please. I'm taking you here because the medical records are more difficult to navigate around --

A. Yes.

Q. -- but this is a fair -- if we go on to the next page, please, sorry -- this is a fair account of what's written in the medical records.

We can see here an entry for 2 August, so the day before the collapse.

A. Yes.

Q. "Abdomen soft with no distension."

Can you see that?

A. Yes.

Q. And then on 3 August, there's a reference here to the pharmacist and then there's a sentence that begins or a line that begins:

"The baby was tolerating 1ml of expressed breast milk."

A. Yes.

Q. And it says that:

"Feeds could be increased if the abdomen remained soft and no increase in nasogastric aspirates."

And then there's a reference to a baby being examined at 1410 hours:

"... having good tone and movement. Handling appropriately. Had a soft abdomen which was not distended. Bowels not open but bowel sounds present and no suspicion aspirates."

So again audible bowel sounds, no unusual aspirates, that would all speak against NEC, wouldn't it?

A. It would.

Q. And then we come into the time of the collapse, so 2210 hours, which is a few lines below:

"ST4, who is [Dr Harkness] to review the baby as he had had a gastric bleed at approximately 2140. He was alert pink and well profused. The baby's abdomen was soft not distended. Some bowel sounds were heard."

Now, you agreed that a bleed from the mouth would not be evidence of NEC and there is no evidence of distension of the abdomen, there's audible bowel sounds, the abdomen is soft, and, again, that is all speaking strongly against NEC, isn't it?

A. It is.

Q. So in your evidence that really what changed your mind was what you saw on the X-ray, which was also inconsistent with NEC. I mean, there are no real symptoms of NEC, are there, prior to the collapse?

A. No, I think my view was by the fact the

abdomen had looked purple and I hadn't noticed the significance of that not being there when I examined Child E.

Q. Yes. I mean, a decision about a postmortem, I don't want to labour the point --

A. Yes.

Q. -- because I appreciate what you've said --

A. Yes.

Q. -- but a decision about the postmortem is quite important, isn't it?

A. It is.

Q. And making a decision that something is NEC without a reasonable basis for that avoids a postmortem in this case and the postmortem is the opportunity to find out that there isn't NEC, isn't there?

A. Units.

Q. And it's also an opportunity to find evidence of other things that might have been there.

A. Yes.

Q. I think you do accept that a postmortem should have been done.

A. Yes, I completely accept that.

Q. Looking then at Child F. The insulin results received and referred to in Dr Lidden's note of the ward round at 10.30 of the morning of 13 August?

A. Yes.

Q. Now, the family of Child F are still in the neonatal unit at this point --

A. Yes.

Q. -- because we have a document that shows that they were transferred -- or that Baby F was transferred at 12.30. So during the morning ward round Mother E and F -- mother and father EF are still there.

Did you have a conversation with them about the hypoglycemia and the abnormal results?

A. I didn't. I know that Dr Lidden's entry is dated and timed at 10.30 but we had -- I recall having a conversation about the blood results in my office, which I think was later in the day and after they'd left. But I accept that I should have discussed that with his parents.

Q. So that would be very unusual, wouldn't it? I mean a note might be timed retrospectively --

A. Yes.

Q. -- but they're not ever timed prospectively, are they, so it's not -- it's not timed at 10.30 recording a conversation that occurs in the afternoon?

A. Yes. But regardless of whether they were there or not, I should have discussed that result with them.

Q. The insulin results, as the Inquiry will hear, had been telephoned through by Emma Lewis, a Consultant clinical scientist, who made a call to the unit within nine minutes of the laboratory receiving that result --

A. (Nods).

Q. -- is the evidence the Inquiry will hear. How many times have you been called by a Consultant clinical scientist about an abnormal insulin C-peptide result in your career?

A. Never. I don't recall knowing that they'd been called through by Dr Lewis.

Q. Right. So, I mean, you -- did you not know that Dr Lidden or somebody within the team had spoken to Dr Lewis --

A. I can't recall, I'm afraid.

Q. Do you think it's important that whoever received the call should have communicated that to you?

A. Yes, but it was my failure to recognise the significance of those results.

Q. And your -- your conclusion -- well, let's look at it this way, there are two possibilities, aren't there, the test is either right or it's wrong?

A. Yes.

Q. Did you take any steps to explore whether the test might be wrong?

A. No, I didn't.

Q. And so if a test is right, there are two possibilities, either somebody has given Baby F insulin deliberately to harm him --

A. Yes.

Q. -- or it's a major safety failure.

A. Yes.

Q. And so we don't have to go straight to attempted murder to realise there's a major safety issue in a baby receiving exogenous insulin.

A. Yes.

Q. Can you assist then with why, given those three possibilities, you didn't take any steps at all?

A. No, I don't know why. It didn't seem like a realistic possibility at the time, but that was completely the wrong decision.

Q. What didn't seem like a realistic possibility?

A. That it had been done as a deliberate act or an accidental act.

Q. But that would be the answer if the test wasn't faulty, wouldn't it?

A. Yes.

Q. And the possibility, given that it had been produced by a laboratory, you could have contacted the laboratory to find out whether the test was one that was

reliable or not, couldn't you?

A. I could have done.

Q. But it doesn't need for you to think that this is attempted murder, does it, because exogenous insulin in a baby is a serious safety issue however it gets there?

A. Yes, and I should have flagged it.

Q. Finally, and very briefly, you were involved in the care of Child G as well. Do you recall Child G?

A. I would need reminding.

Q. Well, let me ask you a general question --

A. Yes.

Q. -- and just see if you can assist me with this.

Child G was found to have collapsed, she was a very premature baby who had reached 37 plus six weeks of corrected gestational age --

A. Yes.

Q. -- by the time she suffered a collapse with a serious vomit, and that was put down to infection at the time. You assessed Baby G on 7 September, which is a day when she collapsed, and noted that she had a CRP, so c-reactive protein, of less than 1.

A. (Nods).

Q. Is that consistent with sepsis?

A. It wasn't. I do recall now having -- seeing that baby and having that result. Sometimes when the bloods are taken early on in an infection the CRP hasn't risen yet, and that's what I thought at that time because I think I reviewed her not long after that collapse.

Q. Well, let me just assist you. You reviewed her -- or your note is at 22.20 at night and she had collapsed at or about 2 o'clock in the morning.

A. Okay.

Q. The blood test and your note is timed at 1500 --

A. Okay.

Q. -- so about 12 hours after the collapse --

A. Yes.

Q. -- and CRP of less than 1. That's not consistent with sepsis causing a collapse, is it?

A. No, it would depend on the time of when the blood test was taken rather than the time of my note.

Q. Yes. I just say your note has 1500 next to the CRP and your note is timed at 2220?

A. Okay.

Q. So a blood test 12 hours later showing a CRP of less than 1 would not be consistent with infection?

A. Yes.

MR BAKER: Okay, thank you, my Lady, I have no more questions?

LADY JUSTICE THIRLWALL: Thank you very much indeed Mr Baker.

Mr Skelton.

Questions by MR SKELTON

MR SKELTON: Dr ZA, I ask questions on behalf of the other family group.

A. Yes.

Q. I just have two topics, one is just going back to your suspicions about Letby.

A. Yes.

Q. You said earlier that when you came back from leave in 2016 --

A. Yes.

Q. -- that there was concern amongst the Consultant group --

A. Yes.

Q. -- about Letby that she may have been harming children.

A. Yes.

Q. And I think in answer to Counsel to the Inquiry, you said that you didn't have definite proof --

A. Yes.

Q. -- but there was a growing sense of

discomfort --

A. Yes.

Q. -- among the group. And you agreed with him that safeguarding was, in those circumstances, the appropriate response.

A. Yes.

Q. Can you just explain exactly whether that would have entailed had it been triggered?

A. So I don't have any experience of triggering that in a professional situation. Normally if it was raising safeguarding concerns against parents or careers it would involve the police, medical opinions and social care. I don't know whether social care would be relevant in the context of raising concerns against a professional, but it would likely to be a multi-agency response with at least the police and the hospital.

Q. So your internal safeguarding team would have been informed?

A. Yes.

Q. And the police as an external body --

A. Yes.

Q. -- would have been informed from that point?

A. Yes.

Q. I think it's right that none of the Consultants ever called the police.

A. Yes.

Q. You've explored the reasons why that might have happened --

A. Yes.

Q. -- but do you have any reflections on what could happen in the future to enable those like you, who, for members of public, are senior doctors taking responsibility at the highest level for their children's lives, how you could be enabled to make that call if this ever happens again?

A. I don't know because, looking back on it, it seems incredible that we didn't, but it just didn't feel like something we could do at the time and I don't know how to change that for the future.

Q. Well, one answer might be to make it compulsory.

A. Yes.

Q. So if you, doctor, suspect anyone, colleague, friend, family member, anyone else is harming a child, you must contact the police. Would that, do you think, have made it almost easier for you as a Consultant to have broken that barrier?

A. Potentially if that was a sort of obligated process because that would have given us some protection against the internal push-back from the Trust management

if it was an obligated duty rather than a decision.

Q. And looking back, do you recognise that the police were the appropriate --

A. Yes, completely.

Q. And they should have been called from the moment suspicions arose?

A. Yes.

MR BAKER: Thank you. Thank you, my Lady.

LADY JUSTICE THIRLWALL: Thank you very much Mr Skelton. Mr De La Poer.

MR DE LA POER: My Lady I have no further questions for Dr ZA.

LADY JUSTICE THIRLWALL: Dr ZA, that brings us to the end of your evidence, thank you very much indeed for coming today and giving your evidence so frankly. Thank you very much indeed.

You are free to go.

MR DE LA POER: My Lady our second witness is also subject to a protection from the Crown Court in terms of identification. That witness is Dr V.

LADY JUSTICE THIRLWALL: Thank you very much.

Dr V, would you come and take the oath or affirmation.

DR V (affirmed)

Questions by MR DE LA POER

LADY JUSTICE THIRLWALL: Do sit down, Dr V.

A. Thank you.

MR DE LA POER: Dr V, can you confirm, please, for us that you provided the Inquiry with a witness statement dated 5 June 2024.

A. That's correct.

Q. And is the contents of that statement true to the best of your knowledge and belief?

A. Yes.

Q. We will deal very briefly with your background. You are a qualified medical doctor; is that right?

A. That's correct.

Q. I'm so sorry, Dr V --

A. Sorry.

Q. -- it will be me, can I just ask you to keep your voice up a little bit?

A. Okay. That's correct, sorry.

Q. Thank you very much indeed. That you are both a member and a fellow of the Royal College of Paediatrics and Child Health?

A. Yes.

Q. And you had been a Consultant paediatrician

for a number of years prior to 2015; is that right?

A. That's correct, yes.

Q. I'm going to look at the relationships as you experienced them back in 2015. Was the paediatric department a happy place to work?

A. Yes, it was.

Q. Were there any difficulties that you were aware of as between any of the professional relationships?

A. Not that I was aware of, no.

Q. You say in your statement that from June 2016 things became strained.

A. (Nods).

Q. Was that as a result of the moving of Letby to a different role in the investigation that the Trust was doing?

A. That's correct. It was primarily to do with us raising concerns about Letby that the nurse ward manager and consequently probably a group of nurses felt an insult to their profession and consequently were quite difficult.

Q. Now, before that date, so before things became difficult, I would just like you to consider what Eirian Powell has told us. She has suggested that:

"The Consultants would think the relationship was

good because everybody did what they said and nobody challenged them."

I think the word she used was the Consultants would think it was "cohesive". What comment, if any, do you have on that perspective?

A. I don't think I agree with that comment. I don't know what period Eirian was referring to but certainly during my time leading up to that time I remember being challenged about my decisions on many occasions, and I think that was a thing that was almost taken as granted, that the nurses were there, they looked after the babies and were around a lot more than the doctors were, and we always paid a lot of attention to their opinion on what should and shouldn't be done.

So, no, I don't agree with that.

Q. Now, we heard from your colleague, Dr Holt, something about the arrangement of the offices and the corridor that offices were on. Did you use an office down the corridor?

A. No, my office was further -- so initially when -- I think this must have been before Dr Holt started there was just that corridor and there was just the seven of us and we shared offices initially. Then when the number of Consultants expanded and more areas was -- were needed there were three offices created

beyond the -- so there's long consider door then there is a big open area where the paediatric secretaries sit and, at the end of that, there's three rooms and mine was to the right, then there was a middle one and of the left one, and I have been -- I couldn't tell you the exact year but I -- that we moved into that office, I'll have to go back and check *(redacted)*.

Q. We heard from Dr Holt something about where Dr Howie Isaacs had her office. Was that in the general area?

A. Yes, so that was in the general area where the -- so the -- in the -- because the corridor offices are bigger, two Consultants share those offices. The three that I'm referring to, one of which I am, are much smaller, so there's only one Consultant, so there's always an office shared by two Consultants or a Consultant and another, there's a research nurse that shares one with another Consultant. So those offices, because they're bigger -- and that's why Dr Issac shared a room with Dr Holt for a period of time, I think.

Q. Dr Issac was community paediatrician but part of the safeguarding team.

A. That's right.

Q. And does that mean that throughout the period that we're going to consider, you could have found

Dr Issac fairly easily if Dr Issac was in work or did Dr Issac not use the office very often?

A. As far as I remember, when she was sharing an office Dr Isaac was there frequently enough. And whether we could have, yes, we could have.

I think the main issue was how we saw that issue as safeguarding. I do know Dr Isaac was consulted later on when we were having huge difficulties with the management. But I think, in good faith, we started the process by going to the managers because that seemed like the appropriate channel at the time.

Q. Just as you look back on it now, bearing in mind that Dr Issac was around, was a paediatrician, was involved in safeguarding, do you think Dr Issac should have been involved sooner than she was?

A. Yes, I think it would have been definitely worth having a discussion around it with her and then she could have advised us what could be done or another alternative route we could take, or a route that we could take from the start.

Q. Now, we're jumping ahead a little bit here but just focusing on the issue of Dr Issac, were you aware of a period before June of 2016 where there were informal discussions between the Consultant paediatricians about their concern about the neonatal

unit?

A. No.

Q. You weren't part of those discussions?

A. No.

Q. We'll come to exactly when you came to have concerns of your own and when you became aware of others in due course. So far as safeguarding is concerned, had you ever received any training on what to do in the event you were concerned a member of staff posed a risk to babies?

A. No. No. We had -- we -- there's mandatory safeguarding training that we as paediatricians need to complete, but that's to do with children who have been harmed or there's a potential to harm them, how to deal with the families, the children and the processes that involve social care. But not what to do if it's a member of staff or a colleague.

Q. Do you think that's a gap in your training?

A. Yes.

Q. As far as the SUDiC process was concerned, what was your understanding at the time about whether or not it applied to deaths which occurred on the neonatal unit?

A. So I was reading the documents that were sent through, and when you read on I couldn't tell you

exactly what page it is, it does refer to that the SUDiC process doesn't necessarily apply to neonatal deaths, they can be dealt with within the neonatal department, and I think that was what we were doing.

So it wasn't that the neonatal deaths weren't being analysed or discussed. It was not through a SUDiC process because the SUDiC process essentially is for children who have collapsed at home or have been brought very sick to the hospital or to A&E, and then you start the process by -- with the police and the social care visiting the home, which is the crime scene, which again -- I'm not taking this into account, and we can come back to that -- doesn't seem appropriate to a baby dying on the unit because if you have had a baby die on the unit, to call the police in and social care in and make that a crime scene, it sounds for mostly deaths that I'd had before Child O and P had been deaths that we had sadly to some degree anticipated and the discussion with the Coroner or Coroner's officer would inform what I thought of that death, whether that was to some degree expected and explained or not and decide on a postmortem on the basis of that.

So I thought we had a reasonable process to account for expected, but I think we didn't -- the problem is it's unexplained and unexpected in neonates, it's how

you define, isn't it? Unexpected is you didn't expect the child to die in the previous 24 hours by definition, which will probably apply to a lot of neonates as well, but what we expect in neonates is they become poorly and then they gradually decline and get worse over a period of time and then they sadly die.

So to some extent there are certain complications that explain that.

Q. If I --

A. I don't know if I'm --

Q. If I can just stop you there if you don't mind --

A. Yes.

Q. -- I think what I've gathered from your answer is -- and I'll just reflect it back to you -- that your understanding at the time was the SUDiC process did not apply to hospitals --

A. Yes.

Q. -- is that correct?

A. Yes.

Q. I'd like to ask you, please, about your understanding of Datix forms. Please, in summary, can you tell us what circumstances you thought a Datix form was required.

A. So my understanding was Datix was for purposes

of, for example, drug errors, any clinical event, administrative event that you wanted to flag up and whether it would pick up if certain incidents were being reported again and again, whether there was a theme to them that you could then pick up and address and share learning on the basis of that. And then, like Dr ZA said, deaths were reported just as not because they were incidents but just so they would be recognised that they had occurred.

Q. Does it follow from your answer that, like Dr ZA, in the event that there was a sudden unexpected and serious deterioration potentially leading to resuscitation you did not think that that needed to be recorded?

A. That's correct.

Q. I'm going to come to our timeline now, please, and start in June. You tell us in your witness statement that you were involved in the care of Child B on 9 June of 2015; is that correct?

A. That's correct.

Q. And that you considered Child B's deterioration to be unexpected --

A. Yes.

Q. -- is that right?

And that you were called in and arrived after

Child B was receiving emergency treatment.

A. Yes.

Q. Did you see any blotchiness or rash on Child B?

A. I did. I think in my statement I have referred to -- I've said that the Registrar has documented that the rash was much more florid and widespread, and by the time I arrived the Registrar had intubated, they'd given a fluid bolus, done bloods and the rash was blotchy on the right side of abdomen and arm.

Q. I believe -- if you're looking for a reference it's paragraph 34. I don't think you need to turn it up because that is what your statement says.

A. Okay.

Q. What you also say is that Child B was, when you were there, improving and so you were not particularly concerned.

A. Particularly concerned from the point of view of I think in my statement and my handwritten notes I've put "sudden deterioration", this rash, and the treatment and then "much better", and I've put three question marks or two question marks "cause". And then I have considered the differential diagnosis that it could be.

From what I can remember, I wouldn't go into the

details because that might identify this mother had a disorder, and we had been looking into how that might affect the baby, and I think earlier in the day there had been some discussions with the specialist, so there was that in the background on my mind.

Infection obviously with any neonate who deteriorates suddenly we would -- because that's probably the easiest and the quickest thing to do and very common in babies, and then obviously things consequent to infection which can be -- which can lead to problems with coagulation or clotting or platelet disorder, so those were the kind of things going in my mind.

But I think the reassuring thing at the time that I thought, whatever that event had been that baby had improved.

Q. Did you take any steps to investigate why Child B suddenly and unexpectedly deteriorated?

A. No, I did not at the time.

Q. And should you have?

A. I think with hindsight if I had known about Baby A and what had happened and the similarities in the rash between the two babies, I -- I'm not aware if there were concerns by this time that were being discussed about rashes. But I think if I had been aware,

I probably would have taken it back to my colleagues and discussed with them what their thoughts were.

Q. So is it the position that you knew nothing about the death of Child A?

A. No, I didn't.

Q. And does that surprise you now that the following day you are here treating Child B?

A. Yes. See, the thing is, as we mentioned previously how busy we were, so you had one paediatrician of the week who would know about the babies on the neonatal unit and the ward, and then there was an on-call system, so when you're on-call you don't physically know about every baby and every child. You would do a sort of ward round, you would be aware the sick babies and the sick children, and then you're on-call.

Now, previously, previous to this cohort that started in 2015, the deaths would be discussed at the mortality and morbidity meetings, and I think they were so few and far between you would probably find out about them by speaking to colleagues. And whether it was just because it had occurred the day before that I hadn't become aware of it -- and I don't remember, I think the first I learned the similarity of the rash between A&B was when I got these statements.

Q. These statements.
A. Yes.
Q. Well, we'll come to that in a moment, my question was really whether looking back on it, you're surprised. I'll just try and unpack that a little bit for you. We know that deaths on the neonatal unit before 2015 were not common occurrences.
A. Yes.
Q. This is a death that had taken place just the day before.
A. Yes.
Q. And just --
A. Yes, I mean --
Q. Is it in fact surprising that nobody --
A. Yes, I think it is --
Q. -- told you --
A. -- especially with what follows after -- and I don't know whether you're going to ask me that Dr Lambie questions that I didn't know about this and things that I did. Dr Lambie was on that night, and I don't recall her mentioning that she was -- I know she went and found other colleagues and discussed with them and that generated a discussion, following which there was an assumption I was part of that discussion. But at the time, neither the nurses nor the doctor on duty said

this is really unusual, this is what happened two days before, and that might have prompted me to discuss with colleagues.
Q. You've told us that in fact you didn't find out about the similarity between Child A and Child B's presentation until when you did your police witness statement or when you did the Inquiry statements, when was it --
A. I think with the Inquiry statement because -- I'm not quite sure at what point, because when I was doing the police statements I was only doing my statement. I wouldn't have known because I had never been involved with Child A, so I wouldn't have known.
And from -- I mean, I can't remember from eight/nine years ago whether I knew that night when I came in, and I have documented that I have updated the parents whether I knew that they'd lost the twin. I'm really sorry but I don't remember.
Q. Dr V, I understand that your evidence, though, is that if you had known about the connection --
A. Yes.
Q. -- you would have gone to speak to your colleagues about it.
A. Probably, yes.
Q. Well, can I just seek to refresh your memory.

INQ0025743, and we looked at this with Dr ZA this morning. This is an email, 23 June, if we go to the page 2, please.
A. Okay.
Q. We can see at the top that you are one of the people that Dr Gibbs sent that email to.
A. Okay.
Q. And he specifically draws attention not only to Dr Lambie who he's spoken to but to the commonality of the "strange purpuric-looking rash". And, Dr V, my question is this, that if having seen that email, which I'm sure you can agree now --
A. Yes.
Q. -- draws an association between Child A who you didn't treat and Child B who you did --
A. Yes.
Q. -- was that not a prompt for you to go and speak to your colleagues to discuss it further?
A. I honestly don't remember this email. I don't.
Q. Well, do you have --
A. In the bundle that I have I'm not copied into that email.
Q. Well, if you could just accept from me for a moment --

A. Yeah, fine, yeah.
Q. -- that this is the copy --
A. Yeah, yeah.
Q. -- that the Inquiry has --
A. Yeah.
Q. -- and, I mean, on the face of it you are copied in --
A. Yeah.
Q. -- so if it is right that you were sent that email, should you have gone to speak to your colleagues having received that email to try and understand --
A. Yes.
Q. -- more about the rash?
A. Yes.
Q. Now, as you say, there was a neonatal -- thank you very much indeed, we can take that down -- there was a Neonatal Mortality Meeting on 29 July, and you deal with this in your witness statement saying:
"I don't recall discussions with anyone who had attended the Neonatal Mortality Meeting on 29 July."
Obviously Child B who you dealt with wasn't the immediate subject matter of that meeting. But, again, should there have been discussions between the Consultant paediatricians to pool your knowledge, given that the connection or potential connection between

those four babies A, B, C, and D had been identified on 23 June?

A. Yes.

Q. And doing the best you can, what do you think the reason is for that apparent lack of communication at the time?

A. I've -- I've thought long and hard about this. I think people were concerned individually and talking to each other in smaller groups. I don't know whether it was the workload, lack of time, that there wasn't this around the table thrashing out what was actually going on.

I think the perinatal morbidity and mortality meetings tend to be more they were joint obstetric and neonatal meetings. They were more a learning and -- and, from that point of view, chronology of events. To pick up trends, yes, but to bring up issues like if there was potential harm being done, I'm not sure if they were the right forum for that.

Now, whether that needed to be taken out of that mortality and morbidity meeting and something that the Consultants should have come together separately for --

Q. Well, this was -- and I'm here just talking about the period of June 2015 -- this was an extraordinary time for the neonatal ward or unit, wasn't

it?

A. Yes.

Q. And so do you think that that required something that was tailored for this particular situation to have a formal look at that cluster?

A. Yeah, I think that was done. From what I gather, these -- at least three deaths were reported as a serious incident, but -- and -- and looked into but I wasn't aware that that had happened. So I think that was done, so the neonatal lead did pick up that these three deaths had happened in quick succession and there was -- I think it was reported as a serious incident and that was -- then those deaths were analysed.

Q. I mean, if I can just stop you there, you're quite right that there was a serious untoward meeting -- incident meeting, but really the reason I'm asking you these questions is because your involvement was with a baby that --

A. Didn't --

Q. -- didn't fit the criteria for that meeting on the face of it --

A. Yes.

Q. -- and it's -- we can see that on 23 June the association between all four was being discussed --

A. Yes.

Q. -- and you had a valuable contribution to make, didn't you?

A. I did, yes.

Q. Child F, you heard me ask questions of Dr ZA about Child F and the insulin result. Dr Gibbs has described it as a collective failure by the Consultants in relation to the insulin and C-peptide result --

A. (Nods).

Q. -- and the fact that that wasn't acted upon. Do you agree with that?

A. Yes.

Q. Now, there was a Neonatal Mortality Meeting for Child D on 10 September 2015. Do you, sitting there now, have any recollection of what was discussed at that meeting?

A. No, I'm sorry.

Q. Let's just bring up the INQ, INQ0005445.

So we can see that there was another non-indictment baby discussed in the first row. You are one of those in the top right-hand corner identified as attending this meeting. Do you see that?

A. Yes.

Q. And then we can see Child D is mentioned towards the bottom.

A. Yes.

Q. And if we turn over the page, we can see in the left-hand column with text, about halfway down:

"Episode? Purpura in evening that resolved."

A. Yeah.

Q. And obviously we'd seen that email from the end of June where this -- that exact word was used to describe A, B and D, and here you are at a meeting in September discussing D.

I appreciate you say that you don't have any recollection of the meeting, but just think back. You'd seen on Child B purpura, was that something that it would have been relevant for you to raise at that meeting, or is it just focused on Child D and, therefore, it wouldn't be appropriate to say, "Well, that's something that I think I may have seen around the same time"?

A. I don't know. If I can -- I mean, yes, with hindsight, whilst we are putting the chronology of events as we know now, it seems very relevant. But it doesn't look like it jigged my memory that way at the time is all I can say.

Q. Just to examine that for a moment. To try and understand the approach that was being taken by you at the time, obviously when there is a death that is a terrible incident that requires further investigations

and it has its own process, but you have told us that when there is a collapse from which a baby recovers there isn't such formality around it?

A. (Nods).

Q. And that was your situation for Child B, wasn't it?

A. Yes.

Q. Was it the position that at the time the Consultants in relation to anything that didn't result in a death simply just moved on rather than keeping a mental record of it and thinking back to it?

A. I think that is probably up until Child O and P the only collapse that I went to. So it was the first and the last because the later involvement that we will discuss -- and for me, yes, it was an unexpected event. I didn't quite understand what had happened.

But at the back of my mind I wasn't aware that this was happening with other babies and with other people and I think that probably -- that information would have been helpful that if this was known that these unusual events were occurring to all of us -- or with all of us whilst we were on-call that might have rang alarm bells.

Q. And whose responsibility, if anybody's, was it to make sure that when there were things that you could all discuss to derive learning from that that discussion

should be organised?

A. I think the responsibility was from all of us, on all of us, yes. So I'm as much to -- I didn't raise it on any forum either at the time.

Q. Move forward, please, to October 2015 and Child I. Child I, insofar as you were aware, suddenly and unexpectedly deteriorated in the early hours of 13 October; is that right?

A. That's right. I think if I can go back to my statement there was a background to her.

Q. By all means, it's from paragraph 52, page 7.

A. Sorry. Sorry, which bit is my statement in?

Q. It should be the very first tab that you have?

LADY JUSTICE THIRLWALL: It may be tab 2.

A. Yes, sorry, which page did you say?

MR DE LA POER: Page 7. Paragraph 52 is the start of where you deal with Child I, and I've just asked you a question focused on whether you say at paragraph 53.

A. Yes. I've got the wrong -- I don't know where my statement is. Is it --

Q. I don't know whether Mr Suter is able -- my Lady, if you think it appropriate, to see if we can assist the witness.

A. Yeah, I think I've found it. Yeah, so I've put:

"Child I had recurrent episodes of abdominal distension of feed intolerance. She had raised infection markers and had been on antibiotics. The plan was to complete 7 days of antibiotics. On 12 October she was found blue and apnoeic in her COT received resuscitation."

And, yeah -- so that was the collapse, so that was the night of the 12th, and I saw her on the ward round on the 13th.

Q. Yes.

A. Sorry, yes.

Q. Yes.

A. Yes.

Q. So I think it was at the early hours of the 13th --

A. Yes.

Q. -- that the collapse happened --

A. Yes, yes.

Q. -- and you were aware when you came on duty --

A. Yes.

Q. -- of that collapse, and indeed what you tell us is that there was further deterioration later that morning.

A. Yes.

Q. And so, again, just reflecting, Dr V, on what

you've told us, you said that Child B was the only collapse you were involved with. I appreciate that you weren't physically present for Child I's first collapse, but in fact were you aware at the time that Child I also was suddenly and unexpectedly deteriorating?

A. Yes. So I've looked into this and read back on my handwritten notes as well and, rightly or wrongly, at the time I thought there was a reason because she had abdominal distension, and I've written my examination findings that her abdomen was tender. If --

Q. No --

A. Given the -- with abdominal distension the most likely reason was the abdomen, and my assessment that I've referred to my statement was that that was what was causing the problems which led me to discuss her with the surgeons at Alder Hey.

So I think, yes, I recognised that the collapses were happening but I was putting them down to a medical reason, which, again with hindsight, was not the correct judgment. But I didn't think they were unexpected collapses. I think they were consequent to her infection. And then she was -- and I think what I didn't connect was that that happened multiple times, she would improve in the daytime, collapse again at night, she would go away, get better come back, and that

it would happen again until the time that --
Q. So you noted, did you, that a significant number of these collapses were happening at night?
A. Only now with hindsight looking at -- at the time, no.
Q. Now what you tell us having charted Child I's progress over a number of days and there were a number of collapses deteriorations, you say this:
"It never crossed my mind there was even a remote possibility of deliberate harm being inflicted on Child I."
A. Yes.
Q. And just bearing in mind that there had been the deaths in June, and we know that Child E died in August, why do you think it was that that thought didn't even cross your mind?
A. I just couldn't think that that was a possibility. That's all I can say.
Q. Did you have any discussion with your colleagues following the death of Child I about concerns that you or they had about what was happening on the neonatal unit?
A. No.
Q. And you heard me say to Dr ZA earlier that the Inquiry has received evidence that Dr Newby, Dr Gibbs,

Dr Jayaram and Dr Brearey appear to have been talking around that time. You weren't involved in those discussions?
A. No.
Q. And if it be right that they were concerned about what was happening on the neonatal unit, whatever their level of suspicion, should you have been spoken to as one of the Consultant paediatricians?
A. Yes.
Q. Now, there was a Neonatal Mortality Meeting on 26 November which you didn't attend. That was in relation to Child I. Now, bearing in mind that you were substantially involved in Child I's care, and a number of very serious episodes, should arrangements have been made to make sure that you were able to attend?
A. So just to give you a background of how these perinatal morbidity and mortality meetings are arranged, I think I've explained somewhere in my statement, these are preset rolling half days and the idea is that both obstetric and paediatric teams attend, so these are preset for the whole year, like we have for *(redacted)* preset days when they'll be perinatal and paediatric mortality and morbidity meetings. And, as it happens, not everyone can be present at every meeting.
What we tend to do -- because being the governance

lead for paediatrics, what I tend to do is I can move the cases around. If someone says "I want to present X but I'm not there", either they will supervise a trainee with the case presentation and learning or they will move it to a time that they are available.
I don't know what the arrangements with perinatal mortality and morbidity meetings were but I think making an effort that the person who was involved then you come to -- I think Dr Gibbs was at the death -- was he, at the meeting?
Q. Yes, Dr Gibbs was at the meeting.
A. Yes. So, yeah -- and for the collapses that were -- so I didn't witness a collapse as such. They were happening on nights. So if they had -- she had four collapses, then that would have been probably four different Consultants. So I'm assuming that at least some of the Consultants who witnessed collapses were there in addition to Dr Gibbs and whether all of us should have been there, yes, in an ideal world but realistically it's probably, given -- I mean, there have been times when I have been in the hospital but I haven't been able to go to the meeting because I've got something more urgent to do. So --
Q. I think you mentioned it as a perinatal review meeting which takes place with your obstetric

colleagues. In fact this was just a Neonatal Mortality Meeting.
A. Okay. Right. Okay.
Q. So you can take it from me or I can bring it on the screen --
A. No, that's fine, that's fine, I --
Q. So was there greater flexibility around the timing of the Neonatal Mortality Meeting?
A. I don't know because my understanding was unless this -- this was arranged like this, but they're usually called PNMMs and they are pre-decided however times a year. I know that because they get the first pick and I get the second one when we do the -- because they have to liaise with obstetrics, so they take priority because it's two different departments.
Q. Well, we can perhaps investigate that further with another witness.
I just want to deal, please, with one more topic under the heading of Child I. The Inquiry is investigating whether it was the case that Letby was on one shift moved away from being responsible from child -- for Child I.
Is that something that you were aware of?
A. No.
Q. If that happened, as somebody who was involved

in the care of Child I, should you have been told about it?

A. Absolutely, yes. I think it would depend on why she was removed from the care, what the reason had been because that decision would have been made by the nursing staff because there is a shift leader who decides which nurse will look after which baby, and if they have made that decision I think you would probably need to know what the reason for that decision was and, if the reason for the decision was to give Letby some respite from looking after an intensive care baby that's a different matter that probably the doctors didn't need to know about.

If it was to do with the shift leader's concern about harm, then I think that should have been escalated immediately to everyone.

Q. And in fact presumably not just stopping at the Consultant paediatricians but going higher would you say?

A. Yes, yes absolutely. Yes.

Q. So Dr V, we're going to move forward to 2016 and the thematic review of neonatal mortality.

The meeting took place on 8 February 2016 and you were one of the attendees; is that right?

A. That's right.

Q. Just help us to understand why it was that it was -- you and Dr Brearey from the Consultant body, why -- why did you attend that --

A. Yes.

Q. -- given that you hadn't in fact, I don't think, been present at any of the deaths certainly of the indictment babies?

A. Yes. So I remember -- well, there was an email that went round saying that an external reviewer is coming to look at some data that we need to present to them and I need another paediatrician for the meeting to be quorate, and that happened with a lot of other commitments where more than one Consultant was needed or there was a certain number needed to complete a review, and we offered depending on our availability, and it was consequent to that because I was available at that time I said I could go, and it was mainly that more than anything else.

Q. So it was, and I'm not underestimating the complexity of people's diaries, but entirely down to availability --

A. Yes.

Q. -- that you went as opposed to anyone else --

A. Yes.

Q. -- not because you had any special knowledge

or special skills --

A. Yes.

Q. -- or special pre-awareness of the issues?

A. No.

Q. Before you went to the meeting, did your Consultant colleagues know that you were there effectively as -- to represent their interests on that meeting?

A. I think that's an assumption because the email goes out to all of us, and if somebody offers, "Yes, I will go", then it's an assumption that that's a representation from all of us. And Dr Brearey was going to be there as the neonatal lead so ...

Q. And did any of your colleagues approach you before the meeting took place to say, "Look, I have this particular concern about this particular baby, could you see whether that is one of the themes that you identify as part of your thematic review?"

A. No.

Q. Again, looking back on it now, bearing in mind that this is a thematic review and different Consultants had been involved at different stages of the care, does it surprise you that there was no prior discussion with your colleagues who couldn't be there about any particular concerns that they may have had?

A. Yes.

Q. I mean, for that meeting to be truly effective, didn't there need to be that feeding in from the Consultant body so that all of their perspectives were represented at the meeting?

A. Yes.

Q. We will ask Dr Brearey about it, but certainly speaking for yourself, you weren't aware of any such --

A. No.

Q. And going into that meeting, did you have any awareness that any of your colleagues, whether Dr Brearley, other Consultants or anybody else, had any concern at all that these deaths may be unnatural?

A. No.

Q. Did you have any such concern yourself going into that meeting?

A. No.

Q. Now, in the form the Inquiry has received it, the record of that meeting on 8 February has an appendix attached to it with staff names.

A. (Nods).

Q. I would just like to bring up, please INQ0003190.

So this, Dr V, is a version of that appendix but it has one very significant difference to the version that

was appended to the meeting, which is that, as we can scroll through the pages, Letby's name is identified in red whenever it appears.

A. Yes.

Q. Now, this document is dated 19 January, so it's about two weeks or so before -- perhaps three weeks before the thematic review meeting on 8 February, and it was prepared, as we understand it, by Eirian Powell. Did you ever see this version, ie the version with Letby's name in red highlighted?

A. No. No, I've seen it at some point recently. I don't know whether that's part of whether it's been sent in the Inquiry thing. But certainly at the thematic review and afterwards, I wasn't -- I didn't clock on from that thematic review that Letby was looking after or on shift for all of these babies.

Q. Thank you, we can take that document down.

So we'll come to the record, and there are effectively two versions of the thematic review, one which is dated 8 February and one which is 2 March when additional changes are made. But let's look at the version from the meeting that you attended. INQ0003217.

So we can see there that you are identified as one of the attendees, the second on the list, and we don't need to review every line of this, I'm sure you are well

familiar Dr V --

A. Yes.

Q. -- with the content of this document?

A. Yes.

Q. But if we go over the page, we'll get a flavour of what was going on, that under the heading "Summary of Mortality Cases Discussed" we see a table where there is a diagnosis and summary of discussion and any action points arising.

Now, the second entry on that is Child A, and we can see most of the way, it's about five lines up from the bottom, that one of the entries about Child A's presentation is:

"Sudden unexpected arrest." With.

The age that was visible then.

A. Yes.

Q. "Twin also arrested 24 hours later."

Now, that "Twin also arrested 24 hours later" is a reference to Child B --

A. Yes.

Q. -- who you've told us you were involved with.

A. Yes.

Q. At that meeting, did you register the fact, and we are here about eight months later, the fact that you were talking about the twin of a child that you had

provided care to?

A. No.

Q. And -- but bearing in mind you've told us that those sudden unexpected collapses, that was the only one, although Child I perhaps, why do you think that seeing that there was a reference to a twin who arrested 24 hours later that didn't prompt a recollection in you about Child B, the rash and all the discussion that had taken place over email as we have seen it back in June?

A. All I can say to you is I, like I said to you, I do not remember that email and the email version that I have of the rash I am not copied into it in my bundle.

Coming to this, should it have prompted me to think about it? Yes. It should have and no, it didn't. I'm sorry.

Q. And we will just move through the document. We can go to page 3. We can see for Child C, for example, that the discussion included that there was a PM report but no cause for deterioration identified.

A. Mmm.

Q. Do you have any recollection, sitting there now, of the discussion about Child C and the fact that there was no cause for the deterioration that even after a postmortem that was identified?

A. No.

Q. I mean, does that, sitting there now, strike you as unusual that you would have a death on the neonatal unit and a postmortem report, but no cause for the deterioration being known?

A. No. I am just thinking through because pm says "widespread hypoxic ischemic damage to the heart" and because I have followed the transcript, I know there was a prolonged discussion whether that hypoxic ischemic damage was before or after the collapse and I think there were varying opinions on cause and effect, and the baby was IUGR, absent end diastolic flow.

So there were factors there to compromise the baby significantly.

Q. But be those factors as they may, the record of the discussion is --

A. Yes.

Q. -- no cause for deterioration identified.

My question really is, is that an unusual state of affairs?

A. Yes.

Q. Did it stand out to you at the time?

A. No.

Q. If we move forward, please, to page 5, we don't need to look. We can see that there was a discussion about Child I.

A. Mmm.
Q. Obviously you had been involved in Child I's care?
A. Mmm.
Q. Do you have any recollection of bringing your experience of the treatment of Child I to the discussion that took place or was the focus upon Child I's death only?
A. I don't think there was a discussion around opinions. They were presented as chronology of events as they are. I don't recall actively contributing, giving my opinion.
Q. If we go over the page, to page 6. We can -- forgive me, it's my mistake, a reference there -- at page 7. We can see the themes that were identified.
A. Mmm.
Q. And one of the themes is the timing of arrests?
A. Yes.
Q. Now, one of the babies under discussion was Child I and you had seen Child I on a number of consecutive mornings and known about the collapses.
A. (Nods).
Q. Did -- seeing that that was a theme that was identified, did you contribute that you can recall to

the discussion saying: well, I had experience of Child I and now I think about it and look back over the notes, actually that was true for Child I?
A. Yes. I think that had been an observation from the thematic review following which some recommendations were put forward about what more we could look at, whether there had been any deterioration in their observations prior to the time of collapse that we could look -- and so I think Eirian went away to do some more work after that.
So there was some discussion on why this would be, whether there are any factors that we can identify what's happening and at the time what wasn't pointed out was the staff member thing because I think that had been a big thing, which wasn't openly discussed, at least during the time that I was there, and I think she went away and did some work on that and if I am correct I think maybe, apart from one baby, didn't identify any untoward signs of deterioration before collapses.
Q. So we will come back. I do -- you have just given some important evidence if I may say about what was and wasn't discussed in your presence.
I would just like to finish looking at this document and then we will come back to that.
A. Okay. Sorry, yes.

Q. But it is related. If we just go over the page just so that we can understand how the system works.
If we then start at page 9, please, we will see that appendix 1. My question about that was that appears attached to the meeting notes. Was that a chart that you all had in front of you which you talked about in the meeting or did you not see that chart as part of the meeting?
A. I don't remember seeing this Level 2 report and all this. It might have been there, but I -- all I remember is the slides that we have discussed and I think there might have been some staffing analysis slides as well, but just staffing analysis as in doctors and nurses who was on, as far as I can remember. But I --
Q. So that brings me back. Thank you, we can take this document down. That brings me back to the evidence that you have just given.
When you were at the meeting, was there any discussion about the fact that there appeared to be a very strong association between Letby and all of the cases that were under discussion?
A. No.
Q. Was there any suggestion at all that there was

any concern about any particular staff member, even if Letby wasn't named?
A. No. I think the general comments were that no particular association between any medical and nursing staff or something along those lines had been identified.
So there were no themes as such to go by that we could say, "Well, we can change this and make things better", was the understanding that I left the meeting with.
Q. And you left the meeting. Just describe for us as best you can the circumstances of you leaving the meeting. Was it when it was finished and everybody got up and left?
A. Yes. Yes, so basically my understanding was the meeting has come to an end, it probably would have been from this time to time and it may -- I mean, I don't remember going back so many years, but I might have had something. You know, the meeting is from 1 to 2 and at 2 o'clock I have to go and do this.
So even if not everybody has gotten up and left the room I -- my understanding is that the meeting purpose has come to an end, so I can leave now. So I didn't leave as in the middle of the meeting.
My understanding from what I can recall is, yes,

people may have still been sitting there but the meeting presentation bit was over. I probably had another commitment I had to go to, so I left.

Q. Just to conclude this topic, Dr V. You tell us in your witness statement that at some point after the meeting you have had a discussion with Dr Brearey about what was and wasn't mentioned at the meeting.

A. (Nods).

Q. Can you just first help us with when that discussion took place. Was it before the deaths of Child O and P or was it after?

A. No, that was last year.

Q. Last year, as recently as last year?

A. Either this year or last year because I think that had been something on my mind for a long time. It was something that had bothered me a lot to the point that I asked him.

Q. So you sought Dr Brearey out?

A. Yes.

Q. And what is it that you said to him?

A. He was -- basically said, "Oh, we talked about it afterwards."

Q. Can I just stop you there. It will be important to hear what he said, but could you tell us what you said to him first?

MR DE LA POER: My Lady, thank you.

Dr V, we had reached the thematic review in February. The final version of that document is dated 2 March of 2016 and there's an additional section included in it about sudden and unexpected deteriorations. Do you know the section I'm speaking about?

A. Was it part of my bundle? If it was, then I would have looked at it, yeah.

Q. It was let's just bring it up INQ0003251. We are going to go to page 7.

So although the date at the bottom there is still 8 February, in fact we know from the very end that it was updated and there is an additional section, you see number 1 there:

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

Now, that wasn't in the first version.

Firstly, was that discussed at the meeting that you attended on 8 February?

A. No, I don't recall.

Q. Secondly, were you consulted about this change when -- before it was made?

A. Oh, yes, okay. Sorry. So I said to him that, you know, at the thematic review what is coming out is that one of the things that was identified was that Letby was present at all the -- all -- in all -- on all of the shifts when these babies collapsed. But that wasn't what I took away from that meeting.

And he said, "We discussed it after, after the presentation." I said, "Well, I don't remember that", and he said, "Well, it must have been after you left then."

That was that.

MR DE LA POER: Dr V, thank you very much for the time being.

My Lady, I have run slightly past 1 o'clock. Can I apologise for that. Given the witnesses that we have today, can I invite my Lady to rise for just 45 minutes over lunch to ensure that we finish at a sensible time today?

LADY JUSTICE THIRLWALL: Very well. So we will rise now and we will start again at ten to 2 please. If you could be back at ten to.

(1.04 pm)

(The luncheon adjournment)

(1.50 pm)

LADY JUSTICE THIRLWALL: Mr De La Poer.

A. No, not that I can recall.

Q. And, thirdly, did you notice this change when this document was sent to you by email on 2 March?

A. I don't think so.

Q. Child L, April 2016, Dr Gibbs has described this as a collective failure of the Consultants in terms of the insulin C-peptide. Do you agree with that?

A. Yes.

Q. Were you aware, Dr V, that in May Ian Harvey and Alison Kelly met with Dr Brearey?

A. Yes.

Q. You were aware at the time?

A. I only am aware through the email that he sent later.

Q. On the 16th?

A. Yes, that was in May.

Q. Yes.

A. Yes.

Q. What did you understand the purpose of that meeting to be at the time?

A. I didn't -- if I am honest, I didn't about the meeting. It's the content of that email that Dr Brearey had sent that he had a meeting with Ian Harvey and Alison Kelly following which it was discussed that he and I think Eirian Powell should be informed of any

collapses.
Q. Did you discuss with -- if you didn't know about the meeting at the time that it was happening --
A. Yes.
Q. -- when you received that email, did you speak to Dr Brearey about, "Why were you meeting Ian Harvey or Alison Kelly?"
A. No.
Q. Were you curious when you received that email why it was that Dr Brearey had met them and why he was asking to be notified about collapses?
A. Yes, I think with hindsight I probably should have been more curious than I was. At the time, the information that I processed in my mind was following that thematic review, because there hadn't been any pattern noted, maybe going forward this was a plan that had been agreed. And, again -- for something that will follow I can say then or I can say it now -- and maybe asked, "Well, what happens when there is a collapse?" Because when there were we didn't have a plan, "What were we going to do?" But I don't think that really sunk in what it meant at the time until much later.
Q. So we come to the deaths of Child O and Child P. Up until that point in our chronology, so 23 June, did you yourself have any concerns whatsoever

about what might be happening on the neonatal unit and whether any of these deaths or collapses were unnatural?
A. No. So what I did know, and I've mentioned it in my statement, was I'd overheard remarks being made about how when Lucy was around -- around things were happening, and it was more so not being able to quantify, well, is it because she's unlucky that she has shifts which has really sick babies and things happen? And I know from personal experience that you can go through phases where you'll have really bad weeks or really bad on-calls to the point that people say, "Oh, it's you", kind of a thing.
And I put it down more to that than even thinking about harm in that context.
Q. Who was it that you overheard speaking?
A. I think it probably would have been a few comments from Dr Jayaram, probably Dr Newby, once or twice and saying, "Oh she's on today."
Q. If I just stop you there. Dr Newby left in February of 2016, so does it follow that you heard Dr Newby say that before February 2016?
A. Yeah, yeah. So, yeah, yeah, it would have been because I haven't seen her afterwards.
Q. And having heard your colleagues draw attention to Letby before February 2016, does it follow

that you went into the thematic review meeting on 8 February with Letby's name in your mind?
A. No, I didn't, because I didn't think those comments were made to the extent to implicate that -- so somebody being there doesn't mean that they're doing something.
Q. But the point of the thematic review was to look at what might be causing not necessarily to the point of deliberate harm, but what you are telling us is that you heard Dr Newby draw attention to the fact that Letby appeared to be a common factor.
A. No, no, no. So Dr Newby -- sorry, maybe I didn't say it right -- Dr Newby mentioned after having been on-call that, "She has been there a few times when I have gone in with sick babies." So that was the association she had made, and that was the same association -- not implying that she was connected to the deteriorations. So that at least wasn't my understanding.
Q. What about Dr Jayaram, when did you hear Dr Jayaram speaking about Letby being associated --
A. I think again that was in passing, nothing in particular. Just saying that, you know, she's on or she's around.
Q. I mean, this is a very serious matter, isn't

it --
A. Yes.
Q. -- because we're talking about babies who have died?
A. Yeah, yeah. But I don't remember any discussion which implicated that she was actually causing harm.
Q. When Dr Jayaram said -- drew attention to Letby and her association, did you say to him, "Dr Jayaram, what are you saying? Why are you -- why are you drawing attention to that?"
A. I think -- because I think we would normally -- that does happen to member of staffs, for example, you know, if I had had a really bad week or I had had a run of bad weeks people would associate that with that this particular individual is heavy footed or attracts emergencies or sick people, which doesn't necessarily mean that they are the ones causing any problems.
So I just -- whatever the comments were, they weren't that she is doing something. It was that, you know, she's -- she's on, she's there today, or -- but just -- yeah, I didn't ask in more detail is all I can say because I didn't connect that it could mean deliberate harm.

Q. Or even accidental harm?
A. Or even accidental harm, yes, yes.
Q. Do you think you should have asked more questions about why your colleagues were choosing to speak about that in this very, very serious context?
A. With hindsight, yes. Yeah.
Q. Do you need hindsight to see that that is a relevant inquiry that you should be making as a Consultant paediatrician when your colleagues are talking about it?
A. I think with the way those comments was -- were made at the time I couldn't tell you exactly what was said. But I don't remember the way these -- so these were casual conversations, they weren't serious conversations in passing. They certainly weren't discussions that we have talked about the rashes and the connection and discussing with the juniors. None of the juniors ever spoke with me about concerns.
So with the way those comments were made, I think now that I know what I know now I would ask more questions, but at the time it didn't seem concerning.
Q. You were involved in the care of Child O when Child O died; is that right?
A. Yes.
Q. You had received an email on 16 May from

Dr Brearey talking about -- drawing to his and Eirian Powell's attention any sudden unexpected deteriorations.
A. (Nods).
Q. Was Child O's deterioration and death sudden and unexpected, so far as you were concerned?
A. Yes.
Q. And so did you contact Dr Brearey or Eirian Powell to say that you had had such a death that you had --
A. Dr Brearey was there.
Q. Was there? Did you say to Dr Brearey --
A. No, I didn't practically say to him because he witnessed the whole situation.
Q. You tell us in your witness statement that Child O's death wasn't discussed at the evening handover on the night of the 23rd or the morning handover on the 24th, should Child O's death have been discussed at either of those handovers?
A. I think I've tried to explain the purpose of handovers. The night handovers -- so the night handovers the Consultant isn't at for the night team, the half past 8 one. The 4 o'clock one handover that very day I didn't go to it because I was busy on the unit.

The next morning -- so the handovers are generally a tool that are used for sharing information about children and babies who are on the ward and how to manage those problems. It is not normal practice to discuss what has happened.
What we do do is we will speak to the doctors separately or ask them to come and see us and offer support in what way we feel they might need it or signpost them.
Q. So one reason you might have discussed the death of Child O is, of course, there were still Child P and Child R in your care, and you've told us about your experience of Child B and apparently not being told about the death of Child B's twin, wouldn't it have been appropriate if for no other reason so that people knew it when they spoke to the parents of Child P and R to be mentioning the fact that Child O had died?
A. I think I don't recall specifically making that conversation, but I -- given that the statement about Child P, the night Registrar was aware of Child O. The Consultant -- I mean, Friday night I would have -- Thursday night Consultant would have been aware because they were there at the resuscitation.
Friday, I was on-call myself, so I knew. So the Consultant team and the doctors team knew what had

happened with the other twin. So there was that information from that point of view I think was shared, even though I don't remember bringing it up, probably because Dr Gibbs was at -- on Thursday night, and he was on, and Friday I was on-call, and the night juniors, given what Dr Mayberry had done and said, would have probably meant that he knew about Child O.
Q. You say that Child P's deterioration was very unexpected; is that right?
A. Yes.
Q. And you'd seen Child P shortly before that collapse and he was stable and looked reasonably well.
A. Yes.
Q. Now, you describe in paragraph 106 of your witness statement -- and I am drawing your attention to it because you quote something that Letby said and so it's important that we're accurate about this, it's page 13.
A. Yes.
Q. Your paragraph 106.
A. Yes.
Q. Just refresh your memory from that, please, and tell us what it was that you heard Letby say.
A. What I have said in that paragraph, so this baby collapsed unexpectedly and we resuscitated him, and

then I think he collapsed again a little while later when we left the room for a short period of time. After that we resuscitated him again, so nurseries are 1, 2, 3 numbered. Baby P was in nursery 2 and, after we had done a gas I'd spoken to the transport team and they were on their way. I sort of walked across to Nursery 1 and I remember just standing there locking at the clock counting minutes saying -- What have I said? Yeah -- and we'd just done a gas, which was reasonable, and I said something along the lines of, "The transport team are on their way, they should be here soon." So Letby was there and a few other member -- members of the nursing staff were there, and she basically just said, "He's not leaving here alive, is he?" Which I found I think it was more disbelief that she had actually uttered such a sentence, and I said something along the lines of, "Don't say that, he's had a good gas and is stable."

And at the time I don't think it sank in or I actually pondered on -- for what for the next few hours on this information for some time until I had time to reflect on what happened after that.

Q. Dr V, in all your experience of being a doctor, had you ever heard any professional person make a comment such as that --

A. No.

Q. -- at such a difficult time?

A. No.

Q. At your paragraph 110 you speak about Letby's presentation when you went to speak to the parents of Child P --

A. Yes.

Q. -- after Child P had died, and just tell us, please, in your own words, having refreshed your memory, how did Letby appear to you then?

A. Yes. So this is after both of them had passed. There is a corridor that leads from the neonatal unit through double doors into the end of what is called the Lavender Suite, that's like a quiet zone where parents with a loss or any problems it's a contained area which is laid out in a way to make it a bit more peaceful.

So Letby and I went to speak to the parents there. I remember thinking I don't know what I am going to say to them because I just didn't know what to say, and her conversation was very much -- the parents were sitting on the sofas that were there. I think we were both standing. I can't remember if I sat down later on and -- so she was sort of going on about making memory boxes for them and said, "Do you want me to make you --

make a memory box for P the same way I did yesterday?" And it was -- it was just the way she was -- the parents were sitting there and I can't remember which one would have said, "Yes, please", so it was like, you know, they were grateful for her making the memory box, but it was just the whole manner in -- in which she was saying it. I just found it very inappropriate.

Q. You describe in your witness statement her as appearing "very excited and animated", is that a fair way of capturing your experience of how she was behaving?

A. Yes.

Q. Child R was transferred to a Level 3 unit. Whose decision was that?

A. So at the time -- I think again this is mentioned, either somewhere in the statement or notes, that when I'd spoken to Dr Rackham about Child P going across he had mentioned something along the lines of, "We will bring R as well." So the initial plan had been that the two of them will go together.

But obviously when he arrived, Baby P sadly arrested again and then died. After that period, I remember we were in the room and when the final resuscitation was being carried out somebody wheeled baby R next to Baby P, and I think Dad and Mum were

there as well -- I'm sorry, just one second.

After we declared Baby P, Dad was crying and he said to Dr Rackham, "Can you please take him?" And I just remember begging in my head and I just said, "Yes, can you please take him along as well."

So that was -- and Dr Rackham agreed.

Q. Perhaps this is the best way of dealing with this, I'll just remind you of what you said in your witness statement. You said:

"I just fear he [that is Child R] was going to be the next one and there was nothing that was going to be able to stop it."

Was that how you were feeling when you were saying to --

A. Yeah.

Q. -- Dr Rackham --

A. Yeah.

Q. -- "Please take Child R."

A. Yeah.

Q. Now, I'm going to move forward in time to 27 June. Are you okay to carry on?

A. Yeah.

Q. And a conversation that you had with Christine Hurst, the Coroner's officer. We can see in the notes that the conversation was timed at 10.45, and

I hope you've had an opportunity to see what Ms Hurst says about that conversation. Have you had a chance to see that?

A. I have.

Q. I will just remind you of it. She describes you as being naturally very upset. Does that accord with your recollection?

A. Yeah. That wasn't the first time I spoke to Christina Hurst, though, because my note entry -- and I've included it in my statement -- I'll let you finish.

Q. Absolutely, we're aware that you spoke to the Coroner's officer before that, I'm just asking about this very specific conversation on the 27th.

A. Yeah, but I had already spoken to her --

Q. Yes.

A. -- on the 24th. This wasn't my first conversation with her.

Q. No. And she says that she asked you about who was on duty at the time of the collapses. Do you remember her asking you that?

A. No.

Q. And she says that your tone changed immediately, that you became a little short with her, and said words to the effect:

"What do you mean? Don't you think my colleagues

and I are distressed enough without you implying that someone may have done something?"

Does that accord with your recollection of that conversation with Ms Hurst?

A. No?

Q. Was anything like that discussed?

A. No.

Q. To complete it, Ms Hurst says that she replied to you that she was not implying anything and it was her job to ask questions. Again, does that accord with your recollection of the conversation --

A. No?

Q. -- on the 27th.

A. No, no, it doesn't and I've sort of gone back and thought about what Mrs Hurst has put there, and can I add a few comments to that?

One of the things is that in Mrs Hurst's statement she implies that the first and the only time she spoke to me was on the Monday. From my note entry, and I don't have recollection of this, it looks like I spoke to Chris, I've put "the Coroner's officer", and then Christina Hurst, and then I've made a long note entry about the discussion we had about the arrangements, how various things would happen. And the Monday phone call is almost a follow-up phone call from Friday in just

confirming the arrangements about what we had spoken about on the 24th.

I think if I'd had that kind of a conversation with Mrs Hurst, about her asking me if -- who was on duty -- and again something that's in there, the Coroner's notes as well, nothing suspicious -- it would have stuck in my mind, because I think those -- many events from those -- that day are imprinted in my mind and I can't get rid of them. And even if I hadn't documented them, the fact that she'd asked me such big questions I probably would have taken it to that meeting that I went to two hours later and said, "Well, this is" -- because I spoke about everything that had happened and how I was distressed with everything, especially with what followed for months and months after, if I had thought that there was an opportunity to take to someone I'm sure that wasn't information I wanted to keep to myself, I would have -- and you're probably going to ask me why I didn't tell her about -- so I will let you ask and then answer that.

Q. We'll come to that in just a moment. What you tell us in your statement is at the time of this call you had grave concerns about both deaths.

A. Yes.

Q. So if you did have grave concerns about both those deaths you tell us, why didn't you relay those to

Ms Hurst the Coroner's officer on the 27th?

A. Yes. So at that time, my concerns were my suspicions, I hadn't seen her do anything, neither had anybody else. It was just the way these two babies had died with me spending hours and hours going through my mind thinking: what could have gone wrong? What was it that I wasn't getting? And then just these comments and all.

So it -- so if I had mentioned something to her it would just have been, "Well, I can't explain what has happened. I was there for both of them. Dr U was there for both of them. And she was there for both of them." So it wasn't like she was just the common denominator. There were other people there who had been there for two deaths as well. And I felt that the idea of reporting it to the Coroner's officer and then the Coroner is giving them facts, I don't know why they have died, they are unexpected and unexplained.

With hindsight, I probably -- if I was suspicious, even though I had no basis for those suspicions, I should have mentioned it. But my only reason for not doing it at that time was I wasn't sure what to do with the doubts in my mind that I had and I wanted to be in a -- in a more safe space with my colleagues and air my concerns and then see what other people thought.

Q. And so having gone into the -- you then had a meeting two hours later at which it was said out loud that your colleagues were concerned that Letby was deliberately harming babies?

A. (Nods).

Q. So you had an opportunity at that meeting to share your experience, including Letby's presentation and the remark that she made about Child P. Having had an opportunity to hear what your colleagues had to say, would it have been a good idea for you then to pick up the phone to Ms Hurst after that, who you'd just been speaking to in the morning, and said, "I've had a chance to get my thoughts together, I've spoken to my colleagues, we are worried about this"?

A. Yes. But at that meeting a plan was decided about further actions, and the right -- so my colleagues knew that I'd reported to the Coroner, I'd asked for a pm because the deaths were unexplained and unexpected, that bit they knew. I obviously hadn't discussed anything else with the Coroners's officer. From that meeting there was a plan made on how to escalate our concerns, and my understanding, rightly or wrongly at the time, was we're going to go down the way of escalating this. So that is happening now.

Q. Dr V, just to understand that. I mean, did

you view yourself as having a personal duty, your duty to the Coroner to assist the Coroner with the Coroner's investigation?

A. At the time I didn't think the information I had with no evidence and no facts as such would be of any use to the Coroner, if you put it that way. I don't know. That's what I thought then. I would probably do things very differently now.

Q. Looking back on it, do you think that that was the wrong way to think about it?

A. Yes.

Q. I would like to ask you about an incident on what we believe was either 28th, 29th or 30th June which you speak about in your witness statement when you encountered Letby on the ward.

A. Yes.

Q. So it would be right -- you don't give a date in your statement but we know that Letby went on who will on 1 July and in fact didn't return to the NNU after that, so have we got it right that it was in the week that began with you speaking to the Coroner's officer and having the paediatricians meeting?

A. I don't remember that. I just remember that this was another on-call. Now, exactly how long after 27 June, I don't remember. I do remember that it

happened in the following few weeks. If the records show that she didn't come back to clinical work after her annual leave, then it probably was that week.

Q. And was it your understanding at that time that she was allowed to continue to work but that she would be under supervision?

A. Yes.

Q. And who had told you that?

A. I don't remember exactly but that probably was the agreement, but I -- when I saw her at first I think I completely forgot that she was to be clinically supervised, and I just remember being terrified that, "Oh, she's here now, what's going to happen?" And just feeling that terrible things were going to start happening again basically. Until then another nurse intervened and said, "What do you need? I'll get that for you." And then I suddenly remembered, "Oh, she's supervised, she can't do any hands-on clinical work." And then we sort of managed.

Q. Just a couple more events to deal with with you, please, Dr V. The first is the meeting on 26 January 2017. You tell us in your witness statement that you had spoken to Dr David Semple prior to the meeting.

A. (Nods).

Q. What, in summary, had Dr David Semple told you about what to expect from the meeting?

A. So I remember Mr Semple came down and it was the corridor offices, as we've referred to before, and he was in one of those offices and there was a few of us around there. I couldn't tell you who else was there but there was at least three or four of us. And he looked quite worried, and I don't remember the exact conversation but his advice was mainly to keep quiet and saying that, you know, "The execs don't have very good plans about you, so I would suggest that you just keep quiet in the meeting and sit it out."

Q. And in terms of --

A. I may be wrong but I just vaguely remember this statement, "Heads would roll", or something like that. I don't know if I'm -- but, yeah, he, he looked very, very worried.

Q. And again in summary, as we've heard from a number of people, we want to hear your experience, what was the tone of the meeting that you had on the 26th with Tony Chambers and Ian Harvey and others?

A. Very aggressive, very angry to the point of being scary, intimidating.

Q. Two more matters to deal with. The first is your meeting with Simon Medland Queen's Counsel as he

was. What you tell us, and I'll just quote from your statement, is that you remember that:

"He looked quite shocked at the information that we shared with him."

And so just to understand that, we know from the record that he came and introduced himself. Did you and your colleagues then explain at some early point in the meeting that you were concerned?

A. Yes. So I think we each of us individually recounted our experiences. I certainly remember recounting mine.

Q. And your perception was that he looked shocked?

A. Yes. So then we asked him if he had been briefed about our concerns and, from what I can remember, he -- he hadn't been, which wasn't our impression when we went for that meeting.

Q. The final thing I would like to ask you about is your statements to the Coroner. If we just bring up INQ0008605.

This is a statement that you made to the Coroner, and if we move to page 7, this one being about Child O, we can see that it's signed and dated on 3 November 2016 and there is similarly a statement you made on the same day for Child P as well; is that right?

A. Yes.

Q. Thank you we can take that down.

Dr V, at that point in the sequence of events, you had sat at meetings with your Consultant colleagues and talked about the possibility of deliberate harm.

A. (Nods).

Q. You knew that that concern had been raised with the Executives, so it was being spoken about openly with the higher management in the hospital, and no doubt you were aware that the RCPCH were told something similar as well.

A. (Nods).

Q. If we look at those statements to the Coroner, you don't appear to have said anything about any of those concerns. Why were you not telling the Coroner, whether in that statement or in an accompanying letter when you sent it across, that as a Consultant body you were all extremely worried that a member of staff had murdered Child O and Child P? Why didn't you tell the Coroner that?

A. I don't think it was anything I was particularly trying to keep from the Coroner. I think it probably was just my understanding of a Coroner's statement is a statement of facts that -- how things have happened, and I didn't think -- even at that time,

and I know I added later on in my police statements, these two incidents, and I was asked later on in the trial as well why I hadn't included them, all I can say is it wasn't a conscious remission of facts that I was trying to keep from him.

My understanding is -- was that a Coroner's statement is a statement of facts, and whilst, yes, we had our suspicions and we were pursuing our concerns, we didn't have as such evidence to support. However, again, with how things have happened and unravelled over a period of time, I think it was probably not the right thing to do. I should have included those statements. And, again, you know, I think we were pursuing a different line of raising our concerns and felt that since we were already doing that, and my understanding at the time -- or maybe I didn't know at the time -- but later on had also been that Coroner was aware of our concerns.

So I don't know why I didn't put them down but it wasn't something I was trying to hide.

Q. Just to pick up on something you just said there. According to the correspondence, it's not until February 2017 that the Coroner was being told about your concerns in terms, that's what was being reported in the correspondence.

Just think back, when you did that statement on 3 November of 2016, was it really the case that you thought the Coroner knows all about this?

A. No -- yeah, no, it wasn't, it wasn't, you're right, yeah.

Q. And obviously the function of the Coroner is to establish how that baby had come about their death.

A. Yes.

Q. Do you accept that that was highly relevant information that you had to give to the Coroner to help the Coroner determine how Child O and Child P had come about their deaths?

A. Yes.

MR DE LA POER: Dr V, those are all the questions that I have for you. I think that there are two further sets of questions, and I think, my Lady, Mr Skelton is to go first.

LADY JUSTICE THIRLWALL: Thank you.

Mr Skelton.

Questions by MR SKELTON

MR SKELTON: Dr V, I'm going to ask you questions about Child A and Child B, and I'd like you to think very carefully about what you can recollect about the two of those children.

You'll recall just by way of background that one of

them was murdered on 8 June 2015, that's Child A, and two days later his sister, Child B -- twin sister -- collapsed and you were involved in the resuscitation, so you know who I am talking about.

A. Yes.

Q. You, I think after Child A's death, were involved with Child B's care to the extent that you were involved in getting or assisting with investigating whether there may be a haematological cause to the death which may affect Child B. Do you remember that?

A. Yes, I remember that from the documentation which says discussion with the haematologist about mother's condition.

Q. And the reason that that was being investigated was that Child A had died and there was a concern that there may be something that hadn't been identified, a condition that the mum had, which might affect Child B and also cause potential risk to her. Do you remember that?

A. I don't remember -- remember exactly but if that's what it says in the notes, I -- I -- from what I have read the documentation was discussion with the haematologist. I don't recall -- but, yeah.

Q. Well, let's have a look at the medical records briefly then, INQ00000698, page 25, please. I'm hoping

that's going to come on screen. Page 25.

So this is the 9 June, so this is the day after Child A has died, and you see initially a note by Specialist Trainee Beach?

A. Yes.

Q. And this is to do with chasing up some haematology from a different hospital which has a specialist investigatory unit.

And we won't go into the background to the mother's condition but suffice to say there was some concern that the mother's --

A. Yeah.

Q. -- condition may be involved with the Child A's death. Do you remember that?

A. I don't remember it but I can read it. It says that they have discussed with the haematologist and they've asked for some samples from Child A.

Q. Yes.

A. And --

Q. So this is Child B's notes --

A. Yeah.

Q. -- talking about Child A.

A. Yeah, yeah.

Q. And further down we can see another trainee, Davis --

A. Yeah.

Q. -- continuing the same analysis --

A. Yes.

Q. -- this time a message from the obstetrician --

A. Yeah.

Q. -- that had been treating mother A --

A. Yeah.

Q. -- and again discussing haematology and specialist assistance.

A. Yes.

Q. And then if we go down to the bottom, you can see that you are involved, DW, which is "discussed with", Dr V, and you give some advice about progressing things.

A. Yes.

Q. So trying to refresh your memory as best you can, does it look like you must have known about Child A's death and the mother's potential connection with investigation of a haematological condition?

A. From these notes, yes. From memory, I can't recall, I'm sorry.

Q. When you -- do you remember giving evidence at the criminal trial?

A. Yes.

Q. I'm just going to take you again by way of reminder to that because the reason I'm asking you these questions is in answer to Mr De La Poer's questions this morning you said you couldn't remember Child A's death at the time of Child B's collapse.

A. Yes.

Q. And I want to try and get you back into the frame of mind where you may revive that answer. But I don't want to do so without allowing you the opportunity to see what you've said previously.

So may we look at the records from the criminal trial, please, at INQ0010269.

If you could go to electronic page 5 and then focus on the -- it's quite a small print, so I'm going to try and focus on page 14, first of all, which is the bottom left quarter, and if you could expand that quarter, please. Thank you.

So just to put this in context, Dr V, this is quite a long period of examination when you're asked about Child B and you're discussing the records, which I'm going to come on to in a few minutes, about her collapse, and at the end you start to talk about a bit of the background.

So can you see just at the bottom there you were asked --

A. Yes.
Q. -- you were asked about the background:
"So basically the evening before I'd reviewed this baby I had reviewed Child B and we had a background history of maternal (and this is irrelevant) and I had ..."
May we now go to page 15, which is at the top right, it's a different form of transcription, so it's the same page, page 5, just the top right quarter, which is internal page 15.
So just take a moment just to read that through, Dr V.
A. Yes.
Q. It also says you've been made aware that Child A, Child B's brother, had passed away.
A. Yes.
Q. "... and obviously there was an increased alertness and anxiety about what could be done in anticipation for Child B to give us some help etc, etc."
So it looks like -- this is two years ago, I think it is 25 October 2022 -- you could remember Child A.
Does that jog your memory?
A. Yeah, so I think I -- probably when I have prepared this reply I haven't consulted the notes properly, I apologise.

Q. And indeed Mother A was around throughout this period, wasn't she? Do you remember she was extremely distressed, understandably, by the death of her son?
A. Yes.
Q. And she didn't want to leave her daughter alone. And in fact it was only at the moment that she left her daughter that her daughter collapsed. Do you remember Mother A being around on the unit?
A. I don't, I'm sorry.
Q. May we just look at the notes that you have made in respect of the collapse of Child B. And, first of all, I think it is worth starting with Dr Lambie's notes, and if you give me one second, it's in the -- I'll give you the reference. Dr Lambie's notes start -- it's INQ0000698, at page 26, please. Thank you.
So this is a note that's written in retrospect after Child B's collapse by Dr Lambie who you will recall as being a senior Registrar colleague.
A. (Nods).
Q. And she has written -- I'll ask you again just to familiarise yourself with the note but you can see:
"Had acute apnea with no warning."
So the baby just suddenly stopped breathing, without warning, and she notes:
"... widespread purple discolour of skin with white

patches."
So that was a clinical finding that she made at the time.
And without going into the notes, what happens is that they suspect potential sepsis or possible coagulopathy, in other words a blood disorder, and you get called, and presumably you are at home in bed, and are called in and arrive within the hospital within about 14 minutes, I think. Do you remember that?
A. Yes. I don't remember it but it's from reading the notes.
Q. If we go to your notes, which are a couple of pages on, on page 28, please, this is your note, again written retrospectively, so you're arriving at 12.50 am but you're writing this a couple of hours later or so, and one of the first things you note is the purple blotching of the body all over with the slowing of heart rate.
A. (Nods).
Q. And, again, you mention the purple blotching a second time in the first half of your own notes. Do you see that?
A. Yes, I do. I've just said, "Baby tubed by Reg", and obviously the description I have written is what the Reg, had seen then I go down upon my arrival

the blotchiness was on the right mid abdomen and right hand, "pink and active".
Q. That's right. So it's reported to you, first of all, presumably by Dr Lambie --
A. Yes.
Q. -- and then you go and have a look and it's still there and you note where it is.
A. Yeah.
Q. Correct.
And then your note goes on for a couple of pages, but if we go to the next page you can see you spoke to the parents. This is at page 29.
A. Yeah.
Q. It's going to come on the screen page 29. Can you see that there?
A. Yeah.
Q. "Spoke to the parents. Purple discolouration almost resolved ?? Cause."
And then you talk about how the baby stabilised for the time being.
So when you spoke to the parents -- and if you don't remember this, of course say, Dr V -- do you remember mentioning the rash to them and saying, "We don't know what's caused it"?
A. I don't remember that, but how I have written

it there's no reason why I wouldn't have mentioned it because there's a description of what happened, and then there was rash there, and if the parents were present I would have discussed that, yes, the rash was much more florid. And, again, I'm not speaking from memory, I'm just thinking what I would have said to them that I'm not certain what's caused it.

Q. Mother A has given evidence to the Inquiry orally that she remembers speaking to the on-call Consultant who, if she's correct, would have been you because that was you that night, you were literally called into the hospital at midnight, and being asked by that Consultant to take a photograph of the rash. Does that jog a memory?

A. I'm really sorry but I can't remember. I have read Mother's transcript that the on-call Consultant said that they weren't -- they hadn't seen anything like that before and asked if they could take a picture, and then the nurse went off to take a photo -- to get the camera, and by the time she came back the rash had disappeared. So we decided not to take a photograph.

I'm really sorry but I don't remember that.

Q. Just focusing on your clinical thinking, your decision-making and analysis. You have a widespread purple rash on a baby and Dr Lambie has noted as well

that it's sort of disappearing as well. It's come and it's begun, so it's resolved relatively quickly around the same time that the child has recovered.

What is your differential diagnosis for the cause of the rash?

A. So the differential diagnosis at the time would have been a problem with infection, so one of the first things that we think about is: was it some kind of infection? Is it the background related to maternal condition? Is it to do with there's another condition which is called disseminated intravascular coagulation. However, the rash wouldn't be expected to disappear so quickly. We had requested some blood products, but I don't think we needed to give them.

At the time, what I would honestly say is that the idea of the rash having been caused by some type of inflicted or deliberate harm didn't cross my mind.

Q. I understand that, but what we don't see in the notes is an analysis of what it might have actually been diagnostically?

A. Yes.

Q. So you don't appear to have written down --

A. No.

Q. -- what has caused the rash?? X, Y or Z, the things you've just explained.

A. Yes.

Q. Why is that?

A. I think that is basically a lesson for me to write more and put a bit more detail in my documentation when I'm writing down making sure whatever my thought processes are, are documented properly.

Q. And, of course, that is a -- it's a basic tenet of medicine, isn't it, that you note down your thinking in response to the diagnostic science, and in fact it's reported repeatedly there's a rash but there's no analysis at all of what the cause might be.

A. Yes.

Q. You didn't I think also connect Child B to Child A in terms of your notes either at any point; is that correct?

A. That's correct.

Q. And in fact Child A, as it happens, had shown a similar rash as he collapsed and died. Recognising now that the significance of your own notes, it would have been helpful to have connected those two things, and you accept that's a failing on your part?

A. Yes.

Q. And it's also a failing of those who were involved with Child A's care not to communicate the diagnostic signs about his collapse that would have

helped you to understand Child B.

A. Yes.

Q. Do you understand that?

A. Yes.

Q. In other words, you both needed to speak to each other and then would have understood the rash had been common -- a common factor.

A. (Nods).

Q. If you had gone through a formal process of thinking about the rash and had managed to exclude the various diagnoses that you've just explained, so coagulopathy, sepsis and so on, and still couldn't explain it, and also knew that Child B who -- Child A who died had had the same rash, would you have reached the point where you suspected that there was something going on that you needed to investigate further?

A. I think it was definitely probably would have been something I would have discussed with my colleagues or maybe with the tertiary specialist to ask if there was anything I was missing in that. I'm not sure if it would have directed my mind to deliberate harm.

I'm just speaking with the mindset I was in at the time, I think it was fixed on a pathology and that I was missing some information about a disorder that I wasn't aware about, especially given that they were twins, so

there was a possibility that they might have the same disorder.

Q. But you accept I think that the link between the two needed to have been identified at the time --

A. Yes.

Q. -- and indeed the link between those two and further deaths on the unit and similar rashes in respect of those children should have been identified at the time?

A. Yes.

MR SKELTON: Thank you. Thank you, my Lady.

LADY JUSTICE THIRLWALL: Thank you very much, Mr Skelton.

Questions by MR BAKER

LADY JUSTICE THIRLWALL: Mr Baker.

MR BAKER: Thank you, my Lady.

Dr V, I also ask questions on behalf of some of the families. I want to ask you some questions in particular about your interactions with Lucy Letby surrounding Child P.

You've given evidence already about the comment that she made during the resuscitation that he's not getting out of here alive.

You also described a meeting between you and Lucy Letby and the parents of Child P.

A. (Nods).

Q. You've presumably attended other meetings before where it was necessary to talk about unhappy things?

A. Sorry, say the last bit again.

Q. You've presumably attended meetings before where it's been necessary to talk to parents about unhappy news?

A. (Nods).

Q. What was it about Letby's behaviour on this occasion that struck you as unusual, because it clearly was something you've since reflected upon?

A. As I have tried to explain before, it was the inappropriate jolliness, brightness to it, which, as when I was being questioned at the criminal trial, was put to me as could it have been somebody trying to make the best of a worst situation, and that's not how I perceived it, probably because that's not how I would interact with bereaved parents. And my experience of previously doing this with other nurses it can be done in a calm, peaceful, reassuring manner, but not in the manner that she did.

Q. You presumably reflected on this meeting after the event. Did you try to look for legitimate explanations to try and convince yourself that this was

normal behaviour by Letby?

A. I don't know what legitimate explanations apart from what the defence lawyers said there could be, which -- I -- I still thought her behaviour was a bit inappropriate. That was my opinion. That might just have been my personal opinion.

Q. So prior to these two incidents, your evidence is that you had no personal suspicions about Letby?

A. (Nods).

Q. You attended a meeting -- so Child P died on 23 June, and you describe at paragraph 114 of your witness statement attending a meeting where, amongst other people, Eirian Powell was present?

A. Mmm.

Q. Can you see that section there?

A. Yes.

Q. And you say here that you became very upset and emotional at the meeting. In your own words, why did you become upset and emotional when meeting with Eirian Powell on 27 June?

A. On their deaths, that they had died and I didn't know why and how.

Q. Did you say anything to Eirian Powell about what Letby had said to you or in your presence?

A. So I said to Eirian two things, I think I said

to her about the not leaving here alive. I recounted that incident to her. And I said it wasn't just me, there were other nurses there as well, and I also probably recounted the Lavender Suite incidents as well.

Q. So is it correct to say then that the death of occurred on 23 June, prior to that point you had no suspicions personally about Letby?

A. No.

Q. But by 27 June, so the Monday after the Thursday when Child P died, you were emotionally recounting to Eirian Powell your concerns about Lucy Letby?

A. Yes.

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

LADY JUSTICE THIRLWALL: Thank you.

MR DE LA POER: My Lady, just one short matter not by way of question, however, and that is just, Dr V, just to let you know that we've checked with the Countess of Chester and the email that you had dated 23 June 2015 that they hold does have your name on it and I just wanted to alert you to that fact because it may be the Inquiry will ask you to provide a further statement to clarify that fact.

A. Okay.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Thank you very much indeed, Mr De La Poer.

Can I just clarify one thing, from my perspective, and it may be obvious from some of your answers earlier to Mr Skelton, and it may be that I misheard you, but when you were giving your evidence earlier and you were saying that you were unaware -- I'm talking now about Baby B -- you were unaware the death of A, and I think you said you were also unaware that they were twins, or is that -- have I misunderstood?

A. No, I think from the discussion that we've had now, I said earlier that I wasn't aware that Baby A, the other twin, had passed and that probably has been from when I've prepared my statement from the information that I have been given I haven't gone back to the original notes far enough, which we did just now, to see that I actually was aware. So --

LADY JUSTICE THIRLWALL: It seems likely, doesn't it, that if --

A. Yes.

LADY JUSTICE THIRLWALL: -- that you would be aware because you had the other doctors and nurses there?

A. Yeah, yeah.

LADY JUSTICE THIRLWALL: And the parents were

there?

A. Yes.

LADY JUSTICE THIRLWALL: And so I suppose that's why I wondered why you didn't make a link between what had been seen -- what you had seen on B and what was known about A?

A. Yes, I'm not sure I knew about the rash on A.

LADY JUSTICE THIRLWALL: Did you ask anything about the circumstances of A's death?

A. I couldn't remember right now, but I -- I can't recall.

LADY JUSTICE THIRLWALL: All right. Thank you very much indeed.

Now, those are all the questions that we have for you. You are free to go.

A. Okay, thank you.

LADY JUSTICE THIRLWALL: I think we are going to slightly reconfigure the room, so if everyone would leave. I've been asked to stay because it causes less disruption, so I'll just stay here but if everyone would move out and then we'll come back in again. Have I got that wrong Mr De La Poer?

MR DE LA POER: My Lady absolutely hasn't, but it just occurred to me that it might be a convenient moment for us to take our break so that we have a single

session all the way through. I don't know whether that was what my Lady had in mind, and that leaves us with a single block, or whether my Lady wishes it save that break until later in the --

LADY JUSTICE THIRLWALL: That's a very generous interpretation, Mr De La Poer. Let's take the break now and we'll start again at 10 past if we are ready.

(2.53 pm)

(A short break)

(3.10 pm)

MS LANGDALE: My Lady, may I call Dr U and may the witness be sworn, thank you.

DR U (affirmed)

Questions by MS LANGDALE

LADY JUSTICE THIRLWALL: If we just wait a moment because there is a bit of noise at the back.

Ms Langdale.

MS LANGDALE: Thank you. Dr U, you have prepared two statements for the Inquiry, the first dated 3 September and the second dated 9 August 2024.

Can you confirm that the contents are true and accurate as far as you're concerned?

A. Yes.

Q. Dr U, you worked, we know, at the Countess of Chester between September 2015 and September 2016 as

a paediatric Registrar.

A. That's right.

Q. And you worked between September 2016 and July 2018 as a locum Consultant in diabetes and general paediatrics at Alder Hayes hospital?

A. That's right.

Q. You've set out in your statement the culture and atmosphere of the neonatal unit, as far as you're concerned, in 2015 to 2016.

Can I ask you to go to paragraph 10 of your statement, please, You were the most senior Registrar, I think, at that time, weren't you? You were the most senior Registrar?

A. I think so.

Q. Do you see at paragraph 10 --

A. Yes.

Q. -- you set out:

"There were seven Consultants who clinically managed the junior doctors, including myself."

What was your relationship with the Consultants like?

A. I would say it was generally friendly. It was a collaborative relationship, they supported me, and because of my length of training and my -- my previous experience I was maybe able it relieve them of some of

the workload that the more junior Registrars couldn't.
Q. And you say junior doctors would report to the Consultant who was on the hot week, was that a different person each week?
A. Yes.
Q. So how would you describe your relationship with Drs Brearey, Gibbs, Jayaram and the like?
A. Generally friendly, yes.
Q. You say at paragraph 11, as far as you were:
"... aware the nurses and midwives had good working relationships, occasionally antagonism at times mainly due to communication and workload."
Was that your sense of relationships between those two groups insofar as you got on?
A. That's how I recall it. The workload was unpredictable, but sometimes there was a lot of work that needed doing in a short space of time and that did cause some friction.
Q. Junior doctors and the nurses you say good working relationships on the children's ward and between the junior doctors and nurses on the NNU. Was that your understanding or experience?
A. Yes.
Q. I think Eirian Powell has suggested that the Consultants -- what they said had to go or something to

that effect, was that your experience, or do you think it was a very collaborative relationship between doctors and nurses generally?
A. Generally, yes.
Q. Generally yes, collaborative. You say relationships between the labour ward midwives and other clinicians were a bit more strained as they wanted to be autonomous practitioners.
What do you mean by that?
A. Labour ward midwives didn't -- they work autonomously and that sometimes meant that collaboration, communication with the neonatal unit was maybe not as it would like or should have been, such as babies about to deliver and it resulted in a crash call and a run to the labour ward rather than knowing about it upfront.
Q. Rather than -- sorry, I missed that?
A. Rather than knowing that that baby was about to deliver in advance.
Q. Right, right. So the communication put pressure -- the lack of communication --
A. Sometimes.
Q. Sometimes. But overall?
A. Overall it worked.
Q. You say NNU felt the atmosphere was generally

happy and felt positive and no obvious problems in team working.
A. No.
Q. No, as in you agree that's what you think?
A. That's correct.
LADY JUSTICE THIRLWALL: I wonder, doctor, if you just keep your voice up a little bit. We've got very good microphones but I think in the far distant corners it's not so easy to hear you.
A. Certainly.
MS LANGDALE: You say you can't recall precise timings, but in around July 2016 when Letby was restricted to an administrative role you were aware that more questions were being asked in relation to patient management on the NNU and that some of the nurses felt uneasy about being watched.
Can you expand upon that, what do you mean?
A. By July 2016, there had been the deaths that have been tried at the criminal trial and there was a lot more focus on the neonatal unit, and certainly more of the senior neonatal unit nurses were uneasy about the level of attention that was being cast. Whether that was because they felt that they were being watched to see if they made mistakes or whether it was just collectively as a group of nurses they felt

defensive, I wouldn't -- I don't know.
Q. You say there was a general feeling of unhappiness when Letby was suspended. What do you mean suspended, do you mean moved duties in the --
A. Moved to the administrative role.
Q. -- non-clinical -- yeah. So when she moved to that clinical -- non-clinical role, you say -- well, what do you say was the impact on some nurses?
A. They were unhappy that Letby had been singled out and moved. Whether that was due to the lack of communication or whether that was just because they felt that somebody had been identified and moved, I don't know.
Q. Which nurses were unhappy about that?
A. So I don't know their full names. One was Mina and the other, Nurse T, both of whom I --
Q. So a couple when she was moved to non-clinical roles?
A. Yeah. I think there were more but those are the two that I -- that stick out at the moment.
Q. Sorry, I am really struggling to hear you.
A. I think there were more that were unhappy but those are the two that I remember being --
Q. Why do you think there were more? Did Letby suggest that to you or do you know that for yourself?

A. No, I think she may have suggested that to me but I don't recall.
Q. As far as you are aware, for your knowledge, you've got a couple of names that when she moved to non-clinical duties you think -- felt what about that?
A. Sorry, I didn't hear.
Q. What did you think the couple that you've mentioned felt about her being moved to a non-clinical role?
A. I don't know exactly what they were thinking but they certainly seemed sorry for her, unhappy that she'd been moved.
Q. Again, I must ask you, is that something that you got from them or something that Letby told you about them?
A. Both, I think.
Q. I'm going to ask you about your involvement with some of the babies named on the indictment. You gave a number of statements to the police, didn't you, and I think you gave evidence -- yes, you've given a number of statements.
A. That's right.
Q. In terms of Child I, if you go to paragraph 20 of your statement, you attended a resuscitation call, didn't you --

A. Yes.
Q. -- and you had to respond to an acute inventory as Child I had deteriorated; yes?
A. Yes.
Q. You tell us you don't recall if you specifically discussed this deterioration with anyone else, and although there was a debrief much later on, you didn't go to that debrief. Why wouldn't -- why didn't you go to the debrief?
A. I don't know why specifically. It may have been that I was on nights at the time or just not working at the time that the debrief took place.
Q. You do tell us at paragraph 23 that discussions did happen all of the time, in other words even if there's a not a debrief you can have discussions amongst you as clinicians, doctors, nurses about events on the unit presumably. You can have discussions, is that right, you would have informal discussions even if you didn't go to a debrief?
A. Yes, so the people that attend the debrief may then tell others that weren't available to go or were busy at the time, they may pass on those details, yes.
Q. Did anyone pass on to you about that debrief or discussions about Baby I?
A. I'm sorry, I don't remember. I don't know.

Q. Did you have an office or a base -- we know there was a corridor with Consultants and who they shared rooms with, did you share a room with anyone?
A. No.
Q. No. So how did the Registrars work you don't have an office space you just go to work?
A. Yes.
Q. So are there any parts of the hospital you would gather or talk together or have a little bit more of an informal chat?
A. There is an office for the junior doctors on the children's ward. There is a mess for the junior doctors to eat their food.
Q. And who were the fellow Registrars when you were there?
A. There was Doctor S, Dr Upadastra, Dr Mayberry, Dr Ukoh.
Q. My Lady, at least one of those names can't be reported. And I remind people to look at the list who are reporting.
LADY JUSTICE THIRLWALL: Thank you.
MS LANGDALE: So you could sit together and have conversations if you wanted to at different times of the day and -- just to catch up with each other?
A. Yes.

Q. You had started work in September, hadn't you, and so this death of Child I occurred within the first month that you were there?
A. Yes.
Q. Yes. And we know it was a sudden and unexpected death. The Inquiry is very aware of that detail.
Did any of those Registrars or any of the other Consultants or nurses discuss with you, as someone who had been at least in one event with Baby I, that sudden and unexpected death and what it might mean and what needed to be done?
A. I don't think there was an informal discussion but it would have been discussed at the handover meeting between the daytime team and the night team. All of the babies on either the children or -- in fact all patients on either the children's ward or the neonatal unit would be covered as part of this handover process.
Q. Did you understand that Baby I had died? Did you know about her death?
A. I'm not --
Q. I'm not talking about the night you were working, I mean generally, did you know about her death?
A. I'm not sure. I don't know.
Q. Do you know if anyone discussed with you about

her death and what it represented?
A. They may have done, but I don't remember those conversations from -- from 2015.
Q. Would you agree with me that unexpected and unexplained deaths in neonates are rare?
A. They are.
Q. So as a rare event, if it had been discussed with you, do you think you would have remembered?
A. I may have remembered closer to the time, but I -- I don't have a memory of that discussion now.
Q. Child L, paragraph 25. You set out at paragraph 27 that you cared during the night shift on 9 to 10 April for Child L and when you attended to Child L, they had a low blood sugar reading and you worked to stabilise the blood glucose in order to prevent harm from being caused. You set that out.
You also tell us you were unaware of the hypoglycaemia screen test results that had been ordered by Dr Ukoh beforehand?
A. (Nods).
Q. When we look at the notes, Dr U -- and I can take you to them but you may just accept this -- it's a page before where we see an entry to the effect:
"Bloods for hypoglycaemia investigations have been requested."

My question is when you were looking after Baby L, do you look back in the notes to see what somebody has done before you if there's something that you don't know why it's happening or what it means is going on?
A. Yes. Yes, I will have looked back through the notes, maybe only for the previous 24 hours, to see if that explains the current situation.
Q. Well, the note -- the entry I think was at 19.20 on the 9th, so if you had looked back you might have been expecting to see then that those screen tests results had been ordered, at least requested?
A. Yes.
Q. Yes. If you had seen they had been requested, would you wonder why the person before you had requested them?
A. So if the hypoglycaemia screen had been requested it was because the baby had undergone low blood glucose.
Q. So you understood then those tests had been ordered?
A. Yes.
Q. But you didn't obviously have the results, they came in later?
A. So the hypoglycaemia screen results come back at different times because the tests are performed at

different locations. I believe that the insulin level is a send away sample that gets sent to the Royal in Liverpool and takes some time for the result to go back to Chester.
It would be my normal practice to look and see what results were available. I don't recall the results and if I haven't written them down in the notes there was maybe nothing there to comment on.
Q. The results, we know, were provided later and Dr Gibbs has accepted collective failure for the Consultants for not viewing those results, you're aware of that, aren't you, in respect of Baby L?
A. I wasn't aware of that, no.
Q. You weren't aware that the results that were sent back to the hospital test results about the fact that manufactured synthetic insulin could be in his blood? You weren't aware of that?
A. No, I knew that from the criminal trial. I wasn't aware of Dr Gibbs' comments.
Q. Right. So now you are, do you take some responsibility too for not checking those records having treated Baby L and managed his low glucose readings, not looking later to see what those test results were when they had been requested?
A. I wouldn't have expected those results to be

back within that night shift.
Q. No, sure, I meant later, a few days later. I'm not suggesting they were available to you on the day. By 14/15 April you're still working at the hospital, having a look and thinking, "Oh, I looked after this baby let me see what's come back"?
A. No, that -- normally I would only be looking for the results of the child that I was dealing with at the time. I wouldn't go looking back retrospectively. I would have presumed that the doctor looking after that baby on that day would be aware and checking for current results. Otherwise, you would end up looking at the results of every child on the unit every day to see what had returned.
Q. So you would only have done it if you were looking after the child on the day that the results came back?
A. Yes, you would be looking for new results. Generally, if there is a result that is unusual, then it gets telephoned through to the neonatal unit or to the children's ward.
Q. That was an opportunity missed, wasn't it, to detect deliberate administration of insulin to a baby, not seeing those test results at the time for Baby L?
A. So -- yes.

Q. So with your knowledge of how the medical records were put together, how do you think that might be avoided in the future? What could either the doctor in your position or anyone else have done to prevent that?

A. I'm not sure what changes would work best there. It was normal practice in many of the district general hospitals that the results went back to the Consultant named on the top of the request form, and then that way a paper trail led back to the responsible clinician, not the junior doctors that were rotating through shifts or sequences of shifts.

Q. Baby M, you were also involved in Child M's initial deterioration, you see at paragraph 33? You say:

"I have no recollection of whether there was any discussion about the cause of Child M's initial decline that required mechanical ventilation to be commenced and/or any discussion about an unexpected event when I started my shift on the evening of 9 April."

Do you remember that? You stated that, and you don't remember anybody discussing it with you?

A. It will have been covered in the handover from the day shift to the night shift. I don't remember the details of that handover.

Q. You don't recall any discussion about anything unusual about the appearance of Child M, and you didn't attend any debrief. Again, is that because you didn't have significant involvement with Child M?

A. Most likely, yes.

Q. Do you think it would be useful in any event and for learning to have had involvement in any debrief or discussion?

A. Yes, I do.

Q. Child N. Child N you were involved in discussions or messaging, weren't you, with Letby about Child N?

A. Yes.

Q. Can you tell us, first of all, your own involvement or direct involvement with Child N?

A. On this night in particular? Or --

Q. Yes.

A. Okay. So on this night in particular, I was the night shift Registrar and Letby had been looking after him on the day shift. The time differences between the two changeovers meant that nurses and doctors changed over at different times so that there was always cover on the unit.

We had passed several messages. I think later in the night, the earlier hours of the morning and

certainly prior to the start of the next day shift, I think she asked me how he was and I had explained that he'd been unwell over the course of the night and we'd sent some investigations off to see if I could identify the cause of that. And then the following morning, he deteriorated further. And the last intervention that I had to do with him was trying to intubate him and put him on to a mechanical ventilator but I was unable to do that.

Q. And others were able to achieve that later?

A. Yes.

Q. Shall we go to the messages if we can? It's INQ0000569, page 2. It starts at message 17 on that page.

So these are extracts of Facebook messaging between yourself and Letby. Just before I start with that, Dr U, you had, I think, begun in June 2016 Facebook messaging Letby, is that right, around June 2016?

A. Yes, I believe so.

Q. And we have a great deal of messages, if I can just say between, June 2016 and September 2016 about 1,355 messages. There's a large volume of messaging, isn't there?

A. Yes.

Q. Would you like to explain that?

A. Letby was struggling with her mental health and I think I picked up on that and I'd offered some support, and that support, it grew, and I understand that she slept very poorly because of worry and anxiety, and there were often messages that were passed throughout the day and sometimes late at night, earlier in the morning.

Q. If we start around Child N or Baby N., we see in fact at message 17 you say:

"Is he okay?"

She gives you an answer:

"Looks like pulmonary bleed on X-ray."

Then:

"Sorry if I was off during intubation. Bernie ... faffing, et cetera, like things to be tidy and calm. Well, as much as possible."

It continues down the page.

If we go to message 22 -- sorry, 23, message from her telling you how Baby N is. Then saying:

"Sat having a quiet moment. Want to cry. Just mad with so many people."

You say, message 25:

"Oh, Lucy poor little thing and you."

And you continue to discuss Baby N, don't you? If you go down to 27. You say:

"I've never heard of epiglottis in a baby. Odd then his CRP was less than 1. Blood obscuring my view of the chords and inflammatory being going on. Poor you. Are you going to be okay? I'm sure he's had the best care possible and you'll have done everything you can for him."

If you go over the page, it's page 4 of the messages, number 40. You asking her:

"Are you okay?

"Yes, thank you just glad he's okay. Quite impressed they got everyone together so quickly. What do you think has caused his bleed?"

And you say:

"I think there will be haemangioma or collection."

And you continue.

If we go further down the page, message 57. Here you say.

"I called PICU. Stable overnight."

Who have you called? What's happened there?

A. So it's common practice to phone the destination location for babies that are transferred partly to go on the bottom of the handover sheets so the rest of the team are aware of the status of the baby, which helps them prepare for transfer back to the unit if that's going to be required. I will have made that

phone call when it was quieter with reduced workload overnight, just asked for an update, how's he getting on, and then I will have shared that with the shift leader of the night shift or whichever shift it was, and in this instance I've shared it with Letby because she will have asked me if I knew anything more about how he was.

Q. Do you think it was appropriate to be messaging about Baby N with her at this time?

A. In hindsight, no.

Q. Why not?

A. Looking at the content of the messages here, I've shared too much, and from my reflections since this has happened, it's common to give updates on how patients are without naming them, without giving lots of clinical detail to help the recipient understand where that patient is up to. I gave, at the time, details that I thought were helpful but I see now that that probably wasn't the case.

Q. And how do you think Baby N's parents would feel about that?

A. I'm sure that's very upsetting.

Q. Would you have even known if they were being kept up to date at that time about their baby?

A. I didn't know -- I didn't know where they were

getting their information from because I presumed that they were at Alder Hey in the intensive care unit with the baby.

Q. But there was at least a chance that you were giving information that they may not even have known about their own baby at that time. You wouldn't have known that, would you, one way or the other?

A. No, I -- I didn't. I presumed that they'd travelled with the child.

Q. And within those messages, it fleets from information about the child to quite frivolous, casual conversation in the way that friends do, doesn't it?

A. It does.

Q. Entirely inappropriate to have somebody's baby in the centre of that communication after such a serious deterioration and now we know an attack --

A. Yes.

Q. -- an attempt murder.

Can we go, please, to your statement on Child O and Child P starting at paragraph 37. You tell us you have:

"... quite a good recollection of the events as it was a very traumatic experience for all of us on the NNU."

The Inquiry has received written and oral evidence from a number of people about Baby O and Baby P and it

was traumatic, wasn't it?

A. Yes.

Q. Unexpected, unexplained, devastating. Do you agree?

A. Yes.

Q. You also say at paragraph 40.

"I agree with Dr Brearey's statement that Child O as well as Child P were born in excellent condition of good weight and there were no obvious concerns for either of them."

Do you agree?

A. Yes.

Q. These were well stable triplets, weren't they?

A. They were.

Q. You were part of the delivery team.

A. Yes.

Q. One Registrar per baby, all set up to welcome them into the world.

A. Yes.

Q. You say at paragraph 48:

"We were all very traumatised by Child O's unexpected and unexplained death."

You then say:

"We could not attribute it to a non-medical cause and had not observed anything suspicious."

You couldn't give it a medical cause either, could you, it was unexplained, unexpected and you didn't know what had happened?

A. That's correct.

Q. Surely anything unexplained, unexpected and you didn't know what had happened falls in the category of suspicious "We don't know. This shouldn't have happened. Until we know more this is suspicious."

A. Yes, I agree. The problem with trying to attribute a cause at the time of the death is problematic because not all of the investigations have been returned. If this was an overwhelming infection that result isn't going to be available for another 36 to 48 hours.

Q. It may take longer, not 46 to 48 hours for a real forensic scrutiny?

A. Yes.

Q. And that's what's required, isn't it, unexpected, unexplained detailed forensic scrutiny is required to see what's happened. Do you agree?

A. Yes.

Q. Did you know the process to be followed or what should happen after an unexpected and unexplained death?

A. Yes, I'm -- I'm aware of the sudden death

protocols. The -- and I'm unsure as to how much of that was carried out at this time.

Q. Were you aware then what the protocols were, back in -- taking yourself back some time ago now to 2016?

A. I'm not sure. I'm sure that they were part of the induction or had been -- that I had looked at them previously. I don't recall whether I was able to recite them or able to pull them to mind at the time.

Q. Did you and your colleagues, your medical colleagues, have discussions about what should be done? It is clear everyone was devastated, but practically, what should be done?

A. Baby O died late in the afternoon, just into the early evening and I think a large number of the people that had stayed to help with the resuscitation had stayed beyond the end of their shifts, and the process of taking samples, making the extended case notes were done by those that were remaining for the rest of the day.

Q. But I'm thinking more about the process of where the deaths should be referred to. Who should be examining the death? What needs to be considered?

A. Well --

Q. Do you know?

A. Yes, it would have been referred to the Coroner.

Q. You say at paragraph 49:

"There was a lot of discussion amongst the doctors at handover following Child O's death as there were still two siblings who were alive and we wanted to ensure that we considered how best to manage them. This was a medically unexplained event but there were no concerns about mismanagement or suspicions that someone was to blame as far as I was aware."

How can you say there were no concerns about mismanagement or suspicions when no one knew how the death had arisen? Until that has been investigated, you can't assert there were no concerns, can you?

A. I think what I'm meaning in that paragraph is that there was no event attributable to that -- that decline. It wasn't that a tube had been displaced or pushed too far, it wasn't that an incorrect medication had been administered as far as recorded on the prescription chart or recorded in the notes. I'm not sure that any of us would have considered a deliberate act.

Q. Why not?

A. Because I don't think any -- any of the doctors or nurses on that neonatal unit had thought that

there may be somebody causing harm to babies. The -- the professionalism and the good practice demonstrated by all members of the team on that unit didn't raise any suspicions. Certainly, as far as I was concerned, I hadn't seen anything that had worried me. I hadn't seen anything that I had gone back and had a second look and thought "Oh, what was that?" I hadn't observed anything.

Q. Dr Lambie told us last week that by September 2015 she had observed a group of nurses in a huddle conducting an exercise where they were looking for a name or information that might link someone to events on the unit that had been unexpected, caused concern and suspicion, otherwise they wouldn't have been doing that exercise. That was in September 2015.

Did you ever understand that people were putting together information to see who might be present at these unexpected and unexplained events, not just deaths, unexpected and unexplained events be they death or deteriorations, when did you understand that kind of information was being collated?

A. I think that was later in 2016. I don't recall the exact month but it was in the middle to latter half of 2016.

Q. After Baby O's death or before?

A. I'm not sure.
Q. We know that Dr Brearey had sent an email to fellow Consultants saying that he would like to know or be informed about any deteriorations that had happened, and Baby N fell into -- taking into account after that email had been sent. Did you know about that email from Dr Brearey wanting to know about deteriorations or unexpected events?
A. To the other Consultants?
Q. Yes.
A. No, I don't think I was aware of that email.
Q. But you did talk to the other Consultants, you're a collaborative group, were you not aware informally that Dr Brearey was keen to know about unexpected deteriorations or anything suspicious?
A. Not as a result of that email.
Q. What was it as a result of then?
A. I beg your pardon?
Q. What was it -- you say not as a result of an email, what did you hear that from?
A. There was a discussion with the junior doctors in the office on the paediatric ward, the middle to latter half of 2016, where I believe it was Dr Jayaram and Dr Brearey mentioned to us -- I think it was at the end of an afternoon handover -- that the deteriorations,

the -- the neonatal unit was -- I'm sorry, I'm struggling to find the right words -- he had suggested that the neonatal unit was having a bad run, that there were more events occurring on the neonatal unit than had been in previous years and we were I think during that handover asked just to keep our eyes open.
Q. Keep your eyes open, what for?
A. Well, I suspect for things -- for things that may be the cause of the deteriorations.
Q. We know the email Dr Brearey sent was May 2016. Is this conversation around that time -- you sent it to Consultants, but is this a conversation with you around that time?
A. It was around that time, May or June I suspect.
Q. So by the time of Baby O's death, you are aware of that conversation.
A. Yes.
Q. And Baby O's death comes out of the blue.
A. Yes.
Q. Baby P. What was your involvement with Baby P?
A. On the Friday morning that Baby P deteriorated, I was conducting the ward round on the children's ward. I had been told not to go to the

neonatal unit that day because of the events of the previous afternoon.
Q. Pausing there. Why, because you'd endured the death the previous day and shouldn't go back again or what -- why?
A. Yes.
Q. So that was a protective way of managing doctors or nurses, was it, if they'd been exposed to something traumatic before?
A. Yes.
Q. So who gave you that instruction or suggested that you shouldn't go back?
A. That will have been done at the morning handover because both wards were handed over at the same time. It was most likely the Consultant of the week. I think that was Doctor V that week.
Q. Again, my Lady.
LADY JUSTICE THIRLWALL: So that name is not to be reported.
MS LANGDALE: So on that next day, you were told not to go there but did you end up going there?
A. I did.
Q. Right. How did that come about?
A. I was contacted using the bleep system to -- I was bleeped and a message was passed that I should go

to the neonatal unit.
Q. And what was the scene on your arrival?
A. So Baby P was in the far right-hand side of Nursery 2 and there were a lot of people in that room, doctors and nurses, and Baby P was clearly unwell from the monitoring system and just how he looked. I had a very, very quick handover about what had happened but it was clear that he was at the point of needing to be resuscitated.
Q. Did you think at the time, "How is this happening again?" You'd said earlier you were all conscious, two siblings, and here you are walking into that scene?
A. At that time my priority was to resuscitate the baby. I -- and I got on with the tasks needed to get him mechanically ventilated and then starting to put more venous lines in so that more drugs could be administered.
Q. And after the intensity of the scene, did you then think, "How can we be here again?"
A. So the rest of that day, the intensity only dropped slightly. He got a little bit better and then declined again, then got a little bit better and declined. I stayed predominantly at the side the cot dealing with breathing, circulation, volume replacement,

and I -- I didn't have the big picture. I had a summary of what had happened prior to me arriving there.

I didn't know what had happened, I don't think, overnight. And I -- I spent I think the rest of the day in that room. There were some discussions because many of the Consultants came through and joined during the day and I -- I understood that they were discussing with the transport team and what should be done next.

Q. Baby O, P, and R's parents knew that they needed to get Baby R out of the Countess of Chester to keep him safe. They didn't know medically what had happened or how, but they knew Baby R was not safe there. Did you as a doctor think something's happening, he's not safe here after what had happened to O and then P?

A. I was glad that Baby R was transferred. I don't think I had put together the string of events of O and P. I was still looking for a medical cause for their deterioration. But I was glad that Baby R moved.

Q. We know, going back to messages from Letby to you -- if we go back to 0000569, page 5, a message -- 94 and 95, you message her at 94:

"Chaos this morning and triplets this afternoon. What a day."

And she says at 95:

"The triplets delivered. Wow. How did you manage to finish early and actually leave the building?"

So she's asking you, isn't she, about triplets there.

And if we go over the page, page 7 of the message, message number 125:

"What gestation are the trips? Are you on NNU tomorrow?"

And you respond at 126:

"33 plus 5."

Again, somebody asking you about the babies at that point in her messaging. Did you understand why she would be asking that or think that was an unusual thing to be asking you about?

A. That message I presumed was getting ready for returning to work.

Q. Sorry, say that again?

A. I -- I thought that that message was getting ready for returning to work. I believe she'd been on holiday prior to that.

Q. Right. And presumably the fact that triplets were going to be born at the hospital was a big source of excitement. It's very rare, isn't it?

A. It's unusual.

Q. How many sets of triplets have you known --

how many have you been involved in the delivery of?

A. Three, I think.

Q. So if we go to the message over the page at 216, so page 9, 216. It looks as though -- and this is the 23 June, so page 9 of the sheet, message 216, you say here:

"I'm glad you could talk to me and hope I helped."

She says:

"That's okay. Didn't want you collapsing mid resus. Good to talk it through."

"I think the debrief was good [this is you]. We didn't come up with anything missed or delayed. Maybe it is better to do it straight away rather than wait."

What are you discussing, what debrief here?

A. So I -- I think there that there will have been a discussion at the end of the resuscitation so that everybody had the opportunity to say what they'd seen, what maybe hadn't been noticed by others at the time and to then pick up any of the points of information that may be helpful.

Q. So you're discussing at this point a sudden and unexpected death of Baby O between you in the messaging?

A. We did, yes.

Q. If we go over the page, so page 11, message

323, this is the start of the next day, you -- you say there was thought about you not going back to be allocated to the sibling. It appears that Letby was. She was back on, wasn't she, with P?

A. Yes.

Q. She says:

"I've got my student again but might see if she can work with someone else as I don't feel I'm in the frame of mind to support her. Loads of paperwork to finish off."

And she has made reference to Baby P as:

"Stop feeds, is large asps."

Meaning aspirations presumably?

A. Yes.

Q. And you say:

"Large asps. I wonder if they have all been exposed to a bug that B Pen and Gen didn't account for. Are you okay?"

She says:

"I will be watching them both like a hawk."

If we go further down at 324, message 324, she is messaging about Child P:

"Just going to dress him take footprints. Hope you're okay."

Further down, at 330/331 she says:

"I made a fool of myself whilst there. I asked them to be quick for you."

And so it continues.

If we go over the page, at 457, this by then is 25 June, we see at 22.46 Letby saying to you:

"Do I need to be worried about what Dr Gibbs was asking?"

You say:

"No, he was asking to make sure normal procedures were being carried out."

What was going on there? We can see -- we can by all means have a look at that exchange, what's she worrying about?

A. I don't know exactly what she was worrying about. But the -- I think, having looked after the two babies on consecutive days, she was concerned that she would be thought to be responsible for the deaths and, as I didn't know of the number of preceding deaths, I didn't -- it was a reassuring, no, I don't -- I hadn't observed anything that had gone wrong in the resuscitation of O or P.

Q. You were a Registrar, albeit one of the most experienced ones, at the resuscitation. How could you possibly say, no, nothing to worry about? You didn't know what this death represented. You couldn't know.

A. No, it was -- it was a reassuring no because I -- again, I was aware of her mental health problems and the amount of anxiety that she had.

Q. Well, she was worried, wasn't she, if people are asking questions about it?

A. In hindsight, yes, obviously.

Q. And at the time you mistook that for, what?

A. Anxiety.

Q. If you look at page 14, at message 471, you are reassuring her:

"If anyone knows how hard you have worked over the last three days it's me. If anybody says anything to you about not being good enough or performing adequately give my details. I can provide a statement."

She says:

"Sincerely I hope I won't ever be needing a statement, but thank you."

And you then say, message 473:

"You will know that the coch nice mortality rate is a bit higher than the network average. Makes people, consultants look at trends and patterns. That may have been why Dr G came to ask."

It wasn't about mortality rates, was it, it was about unexpected deaths?

And were you aware that Letby had only been moved

to day shifts -- comes back from holiday -- and that's where you knew she had come back from holiday, and that's when Baby O died, the day she came back.

A. I don't -- I don't think I was aware that it was day shifts only.

Q. You didn't know she'd moved to day shifts?

A. I'm not -- no, I don't think so. It may have been mentioned in passing but it wasn't something that -- that I remembered.

Q. She did talk to you about moving to day shifts, didn't she? If we go to page 19, message 681, you see there:

"Eirian has just phoned telling me not to come in tonight and do days instead. Asked if there was a problem. She said no just trying to protect me a bit. We can have a chat about it tomorrow but now I'm worried."

You say:

"Please don't worry."

She says:

"I can't do this job if it's going to be like this. My head is a mess. Why is she ringing at this time? There must be a problem."

And you continue to say:

"You did nothing wrong at all. We all work

tirelessly."

Message 691:

"We did everything possible. I don't see how anyone can question that E has always been very supportive."

And from this point onwards, of course, she was going -- just to finish with messages -- she had to undertake or was undertaking a number of processes, wasn't she, she went on to have a grievance process, and you continued to message her during that time?

A. Yes.

Q. If we go to message on page 27, 1028, 6 July, you say:

"You need to keep this to yourself. The meeting this afternoon looked at everything with Child O and P from birth onwards, reviewed everything, the room, beds medical views and actions. We looked at all documentation, medicine. If you have any doubt about how good you are at your job stop now, documentation was perfect. Everyone commented about the appropriateness of your request for review following the vomits."

What meeting were you referring to there?

A. This was a meeting on the neonatal unit looking at these two deaths. And it was a review -- it was a review of the written medical notes and of the

typed nursing notes and whatever other information was available at the time, and we looked from birth through to death for both babies.

Q. Was this one where Dr Brearey, Powell, Williams, Griffiths you, Dr ZA and Hayley Cooper were present, a mortality review, or was it something different?

A. It may have been something different. I -- I recall it as a meeting in an office on the neonatal unit.

Q. You say at 6 July there when you say -- when you send the message, "This meeting this afternoon", was that the day -- well, actually it's -- what time is that message? Five to 1, so to could it have happened on 5 July?

A. Yes.

Q. Right. If we go -- we can leave the message for a moment -- to that mortality meeting that occurred on 5 July -- mortality review -- it's INQ0005121. So that's page 1, 2. If we go to page 3.

We see the people you said you were likely to be with doctors Brearey, Williams, Powell, Griffiths, Dr ZA. Dr ZA -- and there's one for P as well. There are two babies, everything is being looked at, as you have said. Dr ZA gave evidence this morning to say that

Letby's presence was referred to in this meeting of 5 July and Letby having something to do with the deaths, her continued association, and things had gone beyond a coincidence and she might have been involved in some way either deliberately or through incompetence.

Do you remember that Letby was mentioned in this meeting as Dr ZA told us this morning?

A. I think I was only present for the beginning of that meeting, so for the bits where the cases were discussed, because I was present for both of them. I -- I think I left and then the conversation continued afterwards.

Q. Why do you think it continued after you left?

A. I -- I presume they wanted to discuss what they were considering.

Q. Dr ZA said anyone at the meeting was very clear about this association, but your evidence is that conversation or part of the discussion didn't happen when you were there?

A. I don't think it did. I'm sure that I was just there to give evidence for the -- not evidence, information about the resuscitations.

Q. At this point, it seems everyone has to accept they were discussing or thinking about it, but you say you still weren't at this point thinking that Letby had

an association with the deaths or deteriorations.

A. So I -- I think if I'd left earlier in that meeting I may not have been aware of that bit of the discussion about specific concerns.

Q. If you left that meeting early, it doesn't change the fact that all of your colleagues -- your medical colleagues had those concerns at this point. Do you agree?

A. Yes.

Q. So how is it you're the only one who says you had no concerns at this point? Were you not speaking to any of them?

A. Yes, I mean we -- we spoke all of the time. I'm not sure that we discussed specific members of staff. I'm not sure that we discussed specific babies to that extent.

Q. Why did you say in that messaging I took you to earlier "You need to keep this to yourself" to Letby.

A. I wasn't sure whether the nursing team knew that there was review into the deaths, and I didn't -- I think the unit was still very upset about the deaths of Baby O and Baby P and I didn't want it to be gossipped about.

Q. If they had wanted Letby at the meeting or the mortality review she would have been invited, wouldn't

she?

A. Yes.

Q. So why was it for you to pass on information about that meeting to her?

A. She'd appeared very upset after the deaths of both Baby O and Baby P.

Q. Everyone was upset.

A. They were, they were. And as the nurse looking after the two babies she told me that she was -- she was upset by it, and I was -- I went -- I gave her information to reassure her that her part in the resuscitation process had been very good. I -- I don't think I actually discussed the resuscitation with her or the discussion about it. I just said that her notes were very clearly written.

Q. If we go back to the messages, so again INQ0000569, page 28, at 1071, please, you say:

"I've since had an email from SB [that's Stephen Brearey] which makes me understand what's going on. I'll forward it to you, you might find it interesting."

And you forward an email that you've received to her email address, don't you?

And if we go to it we can see that email at INQ0001445, page 1.

So you're sent this from Dr Brearey:
"I think it's quite likely both will go to an Inquest and you're likely to be asked to give a statement. Can I suggest you prepare it now when everything is fresh in your mind. It can include things we discussed yesterday that might not be in the notes, particularly around Child P's initial arrest and who put IOs in and where and what went through them."
What can you remember was discussed that wasn't in the notes at the meeting of 5 July?
A. My recollection of that meeting on 5 July was about the resuscitations for the two babies. I'm -- clearly there was other -- other items discussed. I'm not -- I don't think I was aware of those.
Q. Well, were the other items the concern of Letby's association with the deaths again?
A. They may well have been, yes.
Q. So does that mean Dr Brearey had raised those concerns with you?
A. I don't recall them being raised as a specific concern about a specific member of staff at that time.
Q. If we were to go back to the notes, we know that Letby says to you -- I can perhaps read them out rather than going back on to the screen -- she says on 6 July:

"Why is it going to Inquest?"
You say:
"Unexplained cause times 2."
She says:
"It's a bit of a worry if it's going that far."
And then she asks:
"Do you think I will be involved?"
And you say:
"Probably not. Your documentation most likely will be used in place of a statement. The questions will be about management and procedures."
She says:
"I don't know what to say. Feels like a bit of a blow considering everyone's hard work."
Why did you send that email to her?
A. Why did I forward that email?
Q. Yes.
A. It was because of the -- the worry about these two babies, they were unexpected deaths, and she had been -- or gave me the impression that she was very upset by them and was doing a lot of -- there was a lot of conversation about these two babies and I was basically trying to give her some insight into what was going on.
Q. That there was going to be an Inquest?

A. Potentially, yes.
Q. Why was it for you to tell her that?
A. It wasn't. Again, in hindsight that was an error on my part.
Q. And you say to her:
"This email has to stay between us, is that okay?"
So you knew you shouldn't be sending it to her otherwise why would you say that?
A. I shouldn't have sent it.
Q. And you knew that at the time, because you say -- you say that.
A. I think at the time I -- I sent it in order to help reassure her that the process was being followed, but I didn't send it as a way of bypassing normal routes. I did it as a reassurance that the process was being followed.
Q. She was also -- she went on to be worried about her RCPCH interview, didn't she?
A. Yes.
Q. And if we go to the messages, 0000569, page 33, message 1234:
"Karen has just come. The panel want to see me ASAP. Waiting for a time slot. The rep isn't available so Karen coming with me."
1234, do we have that? Yes.

Letby asks you:
"Do you think there's a problem?"
You say:
"No, I don't think there's a problem."
You say:
"They will probably want to talk about what you remember. Be calm it is in the a review of you."
She says -- you see what she says there:
"On the verge of a massive meltdown."
You say:
"Remember the debrief with Olivier. I want you to go through in your mind when you meet the reviewers deal with it in the same way. There are no trick questions. You didn't do anything wrong and you are still the best NNU nurse I have ever worked with."
She says she's:
"A bit concerned about going without a rep but Karen says has to be today."
And then if we go overleaf, so it's page 34, so it is page 34. She has the meeting, we see messages going backwards and forwards.
Message 1274, page 34, she says:
"The two members were nice. They didn't ask much about the babies it was more about the unit as a whole. In brief it looks as though there's the potential for

this to go further over a long period of time. H thinks we need it look at taking out a grievance case."

So we know she does take out a grievance, and she messages you about that as well. And you're broadly supportive of her taking a grievance; is that right?

A. Yes. The --

Q. Did you ever think these are your Consultant colleagues, doctors Brearey, Dr Jayaram, who are really worried about her role and what she has been doing and you support her to take out a grievance in whatever way you can, texting or messaging, did you never stand back and think, "My doctor colleagues are really worried about this?"

A. No. What had happened, I'd become part of that support process, largely mental health and anxiety, and a lot of the time the messages were supportive in nature, whilst I was doing other things, and I was providing a conversation on the phone, but I wasn't --

Q. Can we deal with that -- sorry, Dr U, finish if you like.

A. Carry on.

Q. Can we just remove the word "anxiety" and in your reflection would you accept a guilt about being challenged about what she had done having meetings and reviews?

A. In hindsight, yes.

Q. There's reference to her saying she was panicking at some points.

A. Yes.

Q. Yes? So rather than using the word "how it felt at the time", what do you think now when you look at it?

A. Now it does look as those these were moments of panic about the events that had taken place and her role in them.

Q. And getting information about -- from you about babies, how they might have died, how they were?

A. That -- from -- from what felt like being a supportive gesture, that now feels like a massive mistake. It's something that I've considered on a daily basis for the last six to eight years. The amount of reflection that I've done over this is significant.

Q. You supported her, didn't you, at the time in December 2016 to get some observational experience at Alder Hey as well?

A. Yes.

Q. We've got emails in relation to that. But you had a conversation I think, first of all, with the senior retired now surgeon a Mr Lamont about it; is that right?

A. Yes.

Q. And you sent an email, if we go to INQ01078440001. See there at the bottom:

"Dear colleagues Mr Lamont has recommended I email you to enquire about the possibility of arranging some theatre observation time for a neonatal intensive care unit practitioner. Lucy Letby is a band 5 staff nurse with an interest in NICU nursing of post-operative babies. In order to facilitate her personal development, she would like to have the opportunity to observe some theatre sessions. Mr Lamont feels that there is no problem from a surgical perspective."

We see the clinical lead above in the email responding -- clinical lead for training, I should say:

"As long as she has the clearance to work within the trust coming theatre won't be a problem. Will Lucy be visiting on an ad hoc basis or is there a specific date that you would like her to come. I am assuming you are co-ordinating with Mr Lamont."

If you go to, please, INQ0107841. So 0107841, there's further discussion here between whether an honorary contract is required or not. I think it should be -- at the bottom the page is the first one, I think. You've asked prior to that:

"Does she need to complete an honorary pro forma?"

And we see at the bottom the page from recruitment:

"Yes, this is correct. I am sending your email to the recruitment team is there now processing the honorary pro formas. Will the person in question be observing only?"

Comes back to you:

"Yes. A neonatal intensive care unit nurse. She is using the theatre observation to build up part of her PDP. It will just be observation in theatre, most likely two to three days Jan/Feb 2017."

"She would not need an honorary contract. We can issue her with a letter of access. I will contact the Countess of Chester."

I think you say in your statement it was Karen Reece you thought from the Countess of Chester who approved their end --

A. Yes.

Q. -- or gave information about DBS checks; yeah?

A. Yes.

Q. We can ask her about that.

You then send another email, INQ0107842, page 2 -- 0002. I don't think that's the right one. That's it:

"Lucy is having a little trouble being released from Chester to attend Alder Hey for the observation."

This is May 2017:

"Would you mind extending the letter of authority through to December for me?"

That's May 2017.

And then if we go to INQ01078321, we see 9 December 2016 the letter of authority:

"Because it is an observational visit she must be supervised at all times. No direct patient contact is permitted during your visit."

You do not say in your --

LADY JUSTICE THIRLWALL: We just got that one actually.

MS LANGDALE: Sorry. Thank you, my Lady. Have a look at that. Just that page is fine.

So the conditions are set, supervise, "no direct patient contact is permitted" because she's gone through this route.

You don't say, do you, in any of your emails, and presumably not to Mr Lamont either, that she is not occupying any patient-facing role at that time at the Countess of Chester, that she can't be with babies on the unit? You don't set that out in this request at all, do you, the situation at the Countess of Chester?

A. I didn't. And the -- she was still having patient contact at that time. My understanding was that she was conducting the clinical audits in the obstetric

or gynaecology outpatient department and had been to somewhere else within the Countess to cover an audit of -- of a service.

Q. Is that office-based? When you say patient contact, is it contact with patience in an office or --

A. No, so this was in the clinic rooms --

Q. Right.

A. -- and from that, I assumed that the move that she had to the admin role had been for retraining and for then deciding what other interventions were required alongside a masters module that she was reading for.

Q. When the police went to her home, they found -- if we can go to INQ0100851, page 2-3. So 0100851, page 2 to 3.

Next page, 2 to 3, please, not that.

2 to 3 we see there, signed by you -- if we go for 2 first, please. If we can just -- sorry, Ms Killingback, go back to page 2, the first page of this two-page document, we see here a list of what she has done, and I understand it is undated but signed by you, so can you tell us how that was put together presumably for her by you?

A. This was put together because she required documents to add in for her revalidation and the number of times that she had attended Alder Hey I summarised,

and she used that document for revalidation or to assist with the revalidation.

Q. Were you having discussions with Karen Reece or Eirian Powell or anyone from the Countess of Chester at this time about plans for Letby or her aspirations for her career or anything like that?

A. No, I didn't. The -- the request came for the clinical observation and I was told that it had been approved by whoever was managing Letby at the Countess of Chester at the time. I, again in hindsight, was remiss not to complete the loop and check that that was correct. But my assumption here was that in offering a letter of access, with contact with the Countess of Chester, that had all been signed off as appropriate, and if it wasn't appropriate, the HR or the nursing management team from the Countess would have said "No".

Q. A matter you raise on a different point, in your second statement, you refer to a comment reported to you by Letby in which she said a Consultant had referred to her as a baby killer, and you wanted to clarify an elaborate on that. Can you tell us about that now?

A. Yes. So this was recounted to me and this was information second to third hand.

Q. From Letby?

A. She told me --

Q. Right.

A. -- what she had been told which had been overheard by somebody else.

Q. Right.

A. That --

Q. Do you know who the somebody else was who was supposed to have told her that?

A. No, and even if I'd had the name I don't think I would have known who that was.

Q. Was it a nurse -- another nurse?

A. I believe it was a doctor.

Q. No, not -- not a nurse who said it -- sorry, said the comment. Do you think it was a nurse who told Letby somebody had said that about her?

A. Yes.

Q. Yes. So what nurse told Letby a doctor had said something like that?

A. I don't know. I don't think I was ever told that.

Q. Okay. So she told you someone had referred to her as a baby killer, what did she say?

A. So I don't think she was referred to as a baby killer. I think the message that was passed to me was there's a baby killer on the unit.

Q. Right. So Letby said to you that somebody had said there was a baby killer on the unit?

A. Yes.

Q. Did you know who was supposed to have said that?

A. I don't think I did. It -- from further discussions -- and, again, I didn't know the name of the doctor -- I understood it to have been an obstetrician.

Q. And you say:

"At some later point in time, although I can't recall when, the comment was attributed to Letby. I know this as I was told that the consultant obstetrician had to write an apology letter to Letby."

So you knew there was a link with her with that remark?

A. Yes. So I think after that initial comment, at some point it was refined to be directed towards Letby, and I don't know who or where that took place, but I do know that an apology letter was written later on. I don't know the contents of that letter.

Q. And, again, she was the conduit for the information to you, was she?

A. Yes.

Q. So finally from me, Dr U, do you have anything to add or say or reflect upon in the light of the

evidence that you have given?

A. Yes. I -- I have reflected on this daily since -- well, certainly since my first police interviews in January 2018, and I think I've become more aware that I wasn't aware of the full clinical picture, and I provided support by being misled and maybe manipulated, and for that I'm -- I'm really sorry that things have come to end as they have.

I have a lot of regrets about how that period of time took place.

MS LANGDALE: My Lady, Mr Skelton has a few questions. I know there's a statement of evidence we are due to prepared in as well. I don't know if a break is necessary for Dr U, I see the time, or whether we should be pressing on for I imagine 15 minutes in total with the statement read as well, but --

LADY JUSTICE THIRLWALL: Dr U, you are all right for another 15 minutes or so?

A. Of course.

LADY JUSTICE THIRLWALL: Thank you, then we can finish off today.

Mr Skelton.

Questions by MR SKELTON

MR SKELTON: Dr U, can I just recap on your background without trespassing into confidential

information. During the period that the babies were harmed at the Countess of Chester you were the senior Registrar.

A. That's correct.

Q. And from September 2016 you were a locum Consultant with a specialism in part in diabetes and also in general paediatrics?

A. That's correct.

Q. And you are now a *(redacted)* Consultant *(redacted)*?

A. Yes.

Q. Can I ask you first about Child L. It may be helpful to look at the medical notes in this regard just to anchor your answers in the contemporaneous records INQ0001169, please. Do you remember Child L?

A. I don't recall the position of the child within the nursery and I don't recall the events that took place, but I may have more recollection after looking at the notes.

Q. Thank you. Let's look at those, then. May we go to page 13 first. This is just to refresh your memory.

A. Yes.

Q. This is a note by you on 10 April 2016, half past midnight, and if you take a moment there, you can

see that there's -- one of the first notes that you make is about blood glucose and the need for glucose to be administered.

A. That's right, yes.

Q. A fairly common problem with neonates.

A. It -- it can be, yes.

Q. Prior to that, but I won't take you to the notes, there had been a period in which Child L was suffering from hypoglycaemia, for obvious reasons, and you're in fact a continuation of the care that has been given in response to that.

A. Yes.

Q. Father L and M, because there were two babies from the same family, don't recall being told about the hypoglycaemia and its significance. Can you explain why that might have been the case?

A. Yes. So this was half past midnight and on a night shift at the Countess there will have been me and a more junior doctor and it is -- I don't recall who the junior doctor was that night, but it's quite likely that they were a foundation doctor or a GP trainee without a lot of paediatric experience, which meant that I was dealing with the calculations, the practical procedures and all of the management of the glucose on my own.

The junior doctor will have been dealing with requests for reviews either from the postnatal ward, labour ward, children's ward or A&E, and in that way I was protected to get on with looking after Baby L, and the management of Baby L's glucose worked, and I carried on managing it. I didn't go up to the postnatal able ward and leave the neonatal unit and this baby in particular without me supporting them to wake up Baby L's mother and father if he was there to tell them.

Q. Just pausing there?

A. Can I sorry -- can I --

Q. Please go ahead.

A. At the time it was common practice for information about babies to be given to the parents on the morning ward round and they were encouraged to come down for the ward round so that they could be updated. That's what I presumed would happen the next morning.

Q. So at some point they should have been told this?

A. Yes.

Q. And if they weren't told that that may have been a mistake?

A. Yes.

Q. And in fact I think you had to scrub in to do a long line for this child, didn't you?

A. That's right.

Q. Which was -- took you off your otherwise onerous tasks with other children presumably?

A. Well, they weren't onerous tasks. They took me away from being able to leave immediately to respond to something. So for the period of time that it took to site this long line, I will have been supported by the junior doctor who was working with me, and if anything had been -- if I'd been needed for anything clearly I would have abandoned the long line and gone to help. But, yes, it does take me out of circulation for a period of time, half an hour or so.

Q. The previous day -- if we go to page 12 just above that, please, just if you could just highlight the bottom half. Is that a note by Dr Jayaram?

A. Yes.

Q. And is he in that note ordering blood investigations? Is it bloods for -- is it hypoglycaemia or is that another word there?

A. I think it says, "Bloods for hypoglycaemia investigations sent."

Q. So do you think that's the blood result -- the blood testing that's being initiated that comes back five days later?

A. Yes.

Q. Thank you. Can we then turn to what happens in the subsequent period of time.

You I think were on duty subsequently. Is that right, you were on -- I've taken you to the 10 April, but you were also on on 14 April, if we go to page 19, in the morning.

That's you I think there, isn't it, at the bottom, your notes?

A. Yes.

Q. Your handwriting?

A. Yes, it is.

Q. So you are there on the 14th, and if we continue on -- I think you're also there on the 15th; is that right?

A. No, the information at the top there is the remainder of --

Q. Sorry, I'll take you to the page just for clarification. Page 22, further down. That's you there on a cranial ultrasound.

A. That's right.

Q. Just pausing there, can you remember what that was for?

A. No, but I don't recall the baby's gestation or birth weight because they may have played a role in the need for a cranial ultrasound.

Q. So at this remove you can't remember the specific reason that you might have asked for that but it could be to do with just checking on the health of the baby's skull and brain?

A. So the cranial ultrasound is to look for evidence of bleeding within the fluid compartments within the brain and it's to look for those and to look for evidence of other bleeds or other lesions within the brain.

Q. What might have prompted that request? If you look at the page, there doesn't seem to be much of an indication of a reason?

A. I'm just looking at the top of that page.

Q. Yes.

A. And the plan says cranial ultrasound.

Q. In response to what? Is it suspected infection?

A. No, I wouldn't have thought infection would be the planned -- would be the plan for a cranial ultrasound, but I'm assuming that the baby has been jaundiced or there is a concern that blood has been lost somewhere, and the ultrasound is to check that there hasn't been a bleed into the fluid compartments of the brain.

Q. So you were on shift on the 14th in the

morning, and we've seen a note that I've taken you to at 9.20 in the morning, and then the next note in this child's records by you is at 4 pm the next day. Would you have been doing two day shifts in the hospital throughout that period of time?

A. Yes.

Q. If we go back to the page 21, which is above your -- which is earlier in the day on the 15th, you will see that a doctor, name unknown, is making a note about Child L's blood results. Can you see that, it's slightly off the usual run of narrative on the right-hand side in the middle?

A. Yes.

Q. If you were on duty as the senior Registrar on the 15th would you have looked at Child L's notes for that day? I appreciate you said to Ms Langdale you don't have the time and don't necessarily have the need to look back for days and days of every child you look at, but would you look at the day's medical records to see what's going on?

A. No, I suspect because I've just written that short note about a cranial ultrasound I've gone in performed the scan as required, reviewed the images and then written the procedure in the notes. I would have -- as this is a morning ward round, any abnormal

results would usually then be discussed with the Consultant whose week -- who is the neonatal hot week. I think for that cranial ultrasound there were not many of us that could perform the procedure, so I've gone in and done the scan and written the notes down.

Q. So trying to understand how these results would have been recorded and interpreted, they've been picked up, have they, on the ward round in the morning first thing at 9.30?

A. It looks like it as they're entered in the ward round notes, yes.

Q. Can you at this removed assist in who was the Consultant who might have been on that ward round from what you can see from this page?

A. No, I don't recall who was the Consultant for the week of the 15th.

Q. But there always is a Consultant on that ward round?

A. No, there is always a Consultant responsible for the hot week for that week, and then the ward round is done, and at the time, on a Thursday, there would be a Consultant ward round and also one of the weekend days, so a Saturday or a Sunday, and they would alternate with the Registrar.

Q. So it looks likes what's happened is that

whoever this is a junior doctor, not a Consultant, has written down the blood results but there hasn't been any interpretation of them and their significance at all at the time.

A. That's correct, yes.

Q. In terms of the responsibility for that absence, Dr Jayaram organised the -- or asked for the blood results. They come in at a time when presumably he is not here, he certainly doesn't reappear in the notes around this time. Whose responsibility is it to receive and think about the results when they come in?

A. I'm sure every hospital has a slightly different system and, as I explained earlier, it's often the case that the result goes back to the Consultant whose week it was because they were responsible for the care of the babies that week. Unusually, abnormal results are normally phoned through from the lab direct to the neonatal unit so that the team looking after the baby at that time is aware of them. Obviously that may not be the case for an insulin level that's five days old but, again, if it's an unusual result, many laboratories will phone it through.

As for what happened to the results subsequent to the hot week of that Consultant, I don't know. I had presumed that because they're all on an electronic

system I would presume that they go back to the Consultant to have a checklist for, but I don't know how the Consultants organised their results management.

Q. From your perspective, *(redacted)* these are obviously abnormal reluctance and they appear to indicate exogenous insulin having been administered either deliberately or inadvertently?

A. Yes. So these are not results that you would see in the patients that I deal with because this is a result of too much insulin rather than not being able to make enough. But, yes, they are abnormal results and I would have expected that they had flagged some sort of warning or alert.

Q. And in a baby with hypoglycaemia?

A. Yes, on the -- on the night in question if those results had been available, they would have been very helpful. But, as I said earlier, insulin is a sample that gets I believe sent away to Liverpool and then comes back days later.

Q. So there will be evidence later in the week from the scientists. I think there was a phone call from the lab to the scientists in your hospital and then an attempt to call the ward --

A. Sorry, I didn't hear.

Q. And then an attempt to call the ward but no

record of a telephone call. But at some point, whoever has made this note has received them probably by electronics means or by paper copy --

A. Yes.

Q. -- the day after I think they were in fact received at the hospital, so they were received on the 14th and they appear in the notes on the 15th.

No one appears to have looked at them. Had you noticed that, bearing in mind that you were aware of the child's hypoglycaemia, would you have recognised this was something that required immediate follow-up?

A. I'm just trying to look for a blood glucose reading at the time that those results are written down and --

Q. Well, the child has been treated for hypoglycaemia at the time?

A. No, I -- absolutely. But, the -- if the -- the length of action -- once the source of the insulin is removed the baby's blood glucose will return down to normal as I think happened in this case and the calculations for how much extra glucose is required are then dialled back because the baby doesn't need all the supplemental glucose.

I agree that that result is -- that the insulin level is unusually high.

Q. The clinical condition may have resolved, but the problem that may have contributed to that condition, namely insulin that shouldn't have been administered, needs investigation, doesn't it?

A. Yes.

Q. Because there's only really one of two possibilities: deliberate or mistaken?

A. Yes.

Q. Either of which is unacceptable?

A. Yes.

Q. May I just turn briefly to some of the other children, Child M. You were asked about this child a little by Ms Langdale and I don't want to touch on it in any detail of course bearing in mind the time.

In your statement you say that you don't, this is paragraph 34 if you want to refer to it, you didn't observe any clinical signs which made you suspect a non-medical cause for that child's collapse.

Could you just explain what you mean by that?

A. So a non-medical cause would be a deliberate act or an act done in error, that had caused those signs and symptoms and I hadn't witnessed any of those.

Q. But you are alert to the possibility that there may be no evidence of such an act --

A. Yes.

Q. -- clinically?

A. Yes.

Q. And of course insulin administration or air administration is precisely that kind of action?

A. Yes.

Q. If you had been aware the unusual rash recalled but not recorded by Dr Jayaram, might that have affected your interpretation of the cause of this child's collapse bearing in mind Child B's collapse some time previously with the same -- with a similarly unusual rash?

A. There was discussion about babies with rashes and we I don't think had been able to come up with a clear reason for why those rashes were occurring and that continued through to the time that I finished at the Countess.

Q. And it took Dr Jayaram I think to begin to suspect it may have been administration of air and did the research that he will explain no doubt when he comes to give evidence. But none of the rest of you suspected that, is that correct?

A. That's correct.

Q. At any time?

A. It's not anything that I have ever, ever considered would be done. Administration of air is not

something -- you work to prevent that at all costs.

Q. Briefly on Child Q and I only ask this because this isn't something dealt with in any detail in your statement or at all in any depth. You were involved with Child Q's care.

A. Yes.

Q. And there are a number of notes, I won't take you through them, but is there anything that you can assist with when it comes to explaining Child Q's deterioration? What was the cause of it insofar as you were concerned as one of the treating doctors?

A. So the cause of it was unclear. It -- it looked as though he was in discomfort and the signs that were being reported to me, the observations that had been written down suggested something to do with his gastrointestinal tract and with that in mind, I carried out some blood investigations and a blood gas I believe and then an X-ray of his abdomen.

And it was that X-ray that looked unusual and I then contacted the surgical team at Alder Hey who looked at the X-ray because they could see it from -- they could see the same image from where they were and then they organised his or they requested his transfer to Alder Hey.

Q. Did you ever get a satisfactory explanation

for Child Q's repeated desaturations?
A. I don't think there was an explanation at the time, but with an abnormal abdominal X-ray that would potentially cause those desaturations.
Q. Could you be specific about what the X-ray showed which would be the underlying cause for that?
A. Yes, and I -- I can't remember the exact wording of it and it would be much easier with the picture, but I believe that there was some bowel that had moved to a position that it didn't normally occupy and --
Q. Which could be caused by harm or some other cause?
A. Yes.
Q. Ms Langdale asked you about the messages that you had with Lucy Letby and you have expressed a degree of contrition and embarrassment, understandably, about that.
Can I just ask you about messaging generally. These messages that the Inquiry has received are on a platform called Facebook Messenger. Is that on your personal phone or is it on a professional phone?
A. That will have been on a personal phone.
Q. Did you have a work phone?
A. No.

Q. Were you -- were there other platforms, WhatsApp, et cetera, that you were using for ordinary professional interactions about patients?
A. So there was no bespoke platform for communicating, but WhatsApp was used.
Q. Were there particular groups that would be you and the Consultants, you and your fellow Registrars, you and the nursing team or was there just a -- how did it work in practice?
A. There were often groups set up so that if there was a gap on the SHO rota or on the Registrar rota a message could be sent to the appropriate group and say, "Can anybody cover" the gap that's come up at short notice. That, that sort of messaging is -- is common.
Q. And was WhatsApp the way in which you would have been contacted if you were out and about in the hospital and you needed to be recalled urgently to the ward?
A. No. So an urgent recall to the ward would be through the bleep system. There was a baton bleep that was passed from person to person, so that it was always, always held by somebody.
Q. So is it right then that just in terms of WhatsApp there is a dividing line between your professional WhatsApp interactions, which may be about

patients within a professional group, and your personal interactions which will be about your own personal life and et cetera ordinarily?
A. Yes.
Q. But what has happened on Facebook Messenger is those two things have become blurred?
A. Yes.
Q. And you recognise I think that that's inappropriate?
A. Yes, I do.
Q. Because you are discussing patients' names and conditions with a member of staff in a personal capacity?
A. Yes.
Q. Are you aware that for at least some of the parents, and I am thinking in particular of Father N, that's particularly difficult to have seen occur in this case; that their child was the subject of private messaging outside of the ordinary professional communications?
A. Yes, I -- I can understand that and the purpose of the messages at the time was to give clear information that would help in the care of that baby on a subsequent shift. That was the intention, nothing else.

Q. Well, it looks to some extent also like you are just talking about what you are doing at work and there isn't always a clinical imperative to the messages, is that fair?
A. I think sometimes the -- what's going on. Yes, that was the case.
Q. Well, you talk for example about cuddling certain babies and things like that which clearly isn't a medical process?
A. No.
Q. Is there anything you would like to say to the parents whose babies appear on your private messages with Lucy Letby?
A. Yes. Again, I have reflected on that for the last six-plus years.
I fully accept that that's not the way that the information should have been managed, but there was no malice intended in it. It was done to share information that would be helpful on a subsequent day, nothing more.
MR SKELTON: Thank you, doctor. Thank you, my Lady.
LADY JUSTICE THIRLWALL: Thank you, Mr Skelton.
MS LANGDALE: My Lady, I have no further questions for Dr U.
LADY JUSTICE THIRLWALL: Thank you very much.

Dr U, you are free to go. If you'll just stay there for the moment. Do you want to take the next statement now or do it tomorrow?

MS LANGDALE: Yes, I was going to ask Ms Bennett if she would read the next witness evidence from Ms Saunders.

LADY JUSTICE THIRLWALL: Thank you very much, Ms Bennett.

MS BENNETT: My Lady, this is a statement that the Inquiry has received from Erica Saunders, Director of Corporate Affairs at Alder Hey Children's Hospital.

LADY JUSTICE THIRLWALL: Thank you.

MS BENNETT: "I Erica Saunders will say as follows:

"I am employed as Director of Corporate Affairs at Alder Hey Children's Hospital Foundation Trust. This is a board level executive position which covers responsibility for the Trust's corporate governance, regulatory risk and legal matters. Under this remit, I am the Trust executive lead for Public Inquiries as well as a range of other sensitive confidential matters that may arise from the broad aspects of my role.

"Alder Hey Children's NHS Foundation Trust is a specialist paediatric centre providing all aspects of healthcare to over 450,000 children and young people each year. The Trust employs a workforce of 4,500 staff

who work across our community and hospital sites and as a teaching and training hospital we provide education and training to around 900 medical and dental students and over 1,000 nursing and allied health professional students each year.

"It is known that Lucy Letby attended the Trust in order to undertake observational visits during the period January to April 2017. The visits were facilitated and arranged by Dr U who at that time was a locum Consultant in diabetes and general paediatrics at the Trust. This appeared to be the result of a personal connection arising from a professional relationship which developed when he and Letby worked together at the Countess of Chester Hospital. To that extent the request to visit Alder Hey was not made directly to the Trust by Letby herself.

"The initial request made by Dr U with regard to the visits was addressed to colleagues in the theatres management team and education team on 7 December 2016 by email referencing a prior conversation with Mr Graham Lamont, a senior paediatric surgeon and then Clinical Director. The email identifies Letby as 'a Band 5 nurse with an interest in NICU nursing of post-operative babies and states that the purpose of the visits was in order to facilitate her personal

development.'

"On 8 December Dr U was informed that if Letby had clearance to attend the Trust the visits could be accommodated. Dr U responded to enquire as to the checks Letby required in order to attend, ie a DBS check. Dr U later e-mailed members of the HR team to enquire as to whether Letby would require a honorary pro forma. He provided Letby's email address to enable direct communication and stated, 'If you need a in-house signatory to confirm please send the pro forma to me.'"

Following questions from a recruitment officer as to the nature of the activities she would be undertaking, Dr U was informed on 9 December that Letby would require a letter of access rather than a honorary contract. Further, they would contact the Countess of Chester Hospital to:

"Ask them to confirm Lucy's pre-employment checks. Once they have confirmed I will let you know if we need it apply for any outstanding checks ie a DBS."

A pro forma was received from the Countess of Chester confirming the pre-employment checks undertaken by them on Letby's appointment including a DBS. The letter of access was issued to Letby and Dr U separately on 9 December and contained the following condition:

"The observational visit will be for the period

1 January 2017 until 28 February 2017. During this time, you must be supervised at all times. No direct patient contact is permitted during your visit."

Dr U also sought an opportunity for Letby to observe at ENT list. On 9 February Dr U e-mailed the recruitment officer with a request to extend the letter of access until May 2017 as Letby was "unable to get across to Alder Hey but is now able to do so".

The letter was re-issued on the same day to the end of May in accordance with this request. On 3 May 2017 Dr U sent a further email stating:

"Lucy is having a little trouble being released from Chester to attend Alder Hey for the observation. Would you mind extending the letter of authority through to December for me?"

This was actioned on 4 May. The request by Dr U on Letby's behalf was informal in nature. The observational visits proposed did not fall under the scope of the Trust's formal work experience policy thus this was not applied.

The Trust frequently receives requests for colleagues from many other organisations to visit our services as can be seen from the exhibits. The appropriate steps were taken to ensure both Dr U and Letby understood the conditions that applied to the

visits.

So far as the Trust has been able to ascertain, ie via documentary evidence, Letby attended a diabetes multi-disciplinary team meeting on 2 March 2017 at which her presence was minuted. In addition, it is understood that she may have attended an outpatient clinic with Dr U during March and a roadshow related to insulin pumps on 22 April.

The visits were sponsored by Dr U, as can be seen by the email correspondence, and to that extent he was the responsible officer. Media reports following Letby's conviction last August that management at the Countess of Chester "wanted to find Letby a placement at Alder Hey".

The Trust has no record of any approach from anyone at the Countess of Chester. Moreover, as described, the nature of the contact was ad hoc observational visits, not a placement or work experience. Trust senior management was unaware of the arrangements being made to visits by Dr U. Therefore, no enquires were made to the Countess of Chester regarding Letby's role, background or qualifications.

Checks were made at the appropriate level, given the nature of the request as explained.

The Trust took steps to establish the facts in

relation to visits following Letby's arrest in 2018 and again following the verdicts in the criminal case. All written records have been checked where they exist.

And that concludes the statement, my Lady.

LADY JUSTICE THIRLWALL: Thank you very much indeed, Ms Bennett. So we will adjourn now until 10 o'clock tomorrow morning. Thank you all.

(5.08 pm)

(The Inquiry adjourned until 10.00 am, on Tuesday, 8 October 2024)

I N D E X