Tuesday, 8 October 2024

(9.59 am)

LADY JUSTICE THIRLWALL: Ms Langdale.

MS LANGDALE: Good morning, my Lady, may I call Dr McCormack and can he be sworn.

LADY JUSTICE THIRLWALL: Yes, certainly. Who is going to -- ah, there you are. Thank you, Mrs McQueen.

DR JIM McCORMACK (affirmed)

LADY JUSTICE THIRLWALL: Thank you, Dr McCormack, Ms Langdale will be asking the questions.

Questions by MS LANGDALE

MS LANGDALE: Dr McCormack, can you give us your qualifications, please.

A. I qualified in medicine from Queen's University, Belfast in 1982. I did a further postgraduate degree in MD at Queen's University in 1997 and I became a member of the Royal College of Obstetricians and Gynecologists in 1987 and was conferred fellow of the Royal College of Obstetricians in 1999.

Q. Dr McCormack, you provided a statement to the Inquiry dated 7 June 2024. Can you confirm whether the statement is true and accurate as far as you are concerned?

A. Indeed it is true and accurate. Do you think

I could speak to the mothers before we carry on?

LADY JUSTICE THIRLWALL: Yes, of course.

MS LANGDALE: Yes, you may.

A. I just wanted to say I read all of their mothers' and family transcripts and found it very moving and compelling to hear them all tell their experiences. I wanted to start my evidence today by expressing my sincere sympathy to them all for their terrible loss and suffering, and commend the enormous strength and resilience they've shown in coping with the unimaginable events following. Thank you very much.

Q. Dr McCormack, we sent you indeed some of the transcripts of evidence and I will return to those in a while, if I may. When I am asking you questions the link seems pretty good now and the signal --

A. Yes.

Q. -- but if it drops and you can't hear me raise your hand and I will do the same for you; okay?

A. I will.

Q. I will also do the same if I think -- and I don't want to overspeak when we're not in the same room -- if I think I need to move on to something else. So it's questions as well as gestures to look out for if you would.

In your statement at paragraph 12, you refer as

well to having been an associate Medical Director at some point. You tell us further up, I should say, by 2015 you'd had 23 years Consultant clinical experience in obstetrics and gynaecology, but you also say at important professional responsibilities at one point you were an associate Medical Director. Can you tell us when that was?

A. I've forgotten the exact year but with introduction of the new Consultant contract and I was employed as an Assistant Medical Director for approximately six months to interact with all the Consultant staff, make them familiar with the actual contract and ensure they understood what was involved before they considered moving to the new contract. Once the contract had been introduced, then my tenure in that post stopped.

Q. Was that something you were interested in as a role? What were the expectations of that even as a short-term role?

A. I -- I think I may have showed some knowledge of the different attributes of the new contract at that time and they have may felt it was -- I was a good person to select and do that job.

Q. You were the ...?

A. A good person --

Q. Good person.

A. -- to select with that knowledge to do that job or undertake that job.

Q. You tell us the responsibilities at paragraph 16, chair of the women and children's governance board, firstly.

A. Yes.

Q. And also lead obstetrician for perinatal mortality morbidity meetings?

A. Indeed.

Q. Can we look at one of those meetings, just to see what they look like. The perinatal morbidity and mortality meetings, and the INQ reference number is 0003294/1. So 0003294, page 1.

This is what we see, and indeed on page 2 we see a reference to Child A.

Can you tell us what the purpose of the meetings were and who was invited? And if we go back to page 1, if we look at the date, in fact the date of the meeting is 24 June 2015, so I assume the period of assessment is March to June 2015?

A. Will I give you some context to the perinatal meetings and their organisation?

Q. Yes, what was the -- what was the aim and who attended?

A. Okay. Well, the meetings were organised in advance because we chose days where there was no clinical activity to allow members of staff to attend. So each year there were 12 days in the calendar year that clinics were stopped and I would have chosen four of those days for the use for perinatal mortality meetings. So they were chosen in advance and then confirmed with Dr Brearey that they suited for him and then allocated those days.

At each of the meetings, secondly, my Registrar was allocated to secure the most recent of the still births to be presented and he would have prepared a complete PowerPoint presentation for those with all the events, and the same with the paediatric Registrar.

At that time -- at that time I was also inviting the pathology Consultants from Alder Hey hospital and they would have been invited about three weeks prior to the meeting, if there happened to be a pathology presentation for those particular deaths.

Following the meeting -- these were prepared by Dr Brearey and myself. You haven't got any of the ones that I prepared for the stillbirths, but all the reports you have, with the exception I think of three, are from the perinatal meetings and these are his summary of the events that took place.

These summaries are very brief, they were meant to be brief, they are meant to be an aide memoire for staff to look at and be able to recall exactly what was happening, because don't forget the perinatal mortality meetings were to review for learning, and the environment was one of expected entirely natural deaths. And, in addition to that document that you put up, Dr Brearey would also have sent a letter or a note to all the members of staff with the three or four or five learning points from the meeting. And the purpose of the meeting was entirely a learning environment.

And the last point I would make about it is that within the hospital we had an intranet and we had an S-drive for the Women's and Children's directorate so all this material for learning, the summary items, the concerns about learning, the presentations from each of the two doctors at a particular meeting would all have been put on the intranet because not all staff that were involved may not have been able to attend because obviously they may be covering the neonatal unit or the labour ward.

Q. The meeting record -- just pausing there, Dr McCormack, the meeting record doesn't record who did attend it, but you're telling us, you and Dr Brearey could invite people and routinely did invite people?

A. All the available -- it was a compulsory attendance for anybody who wasn't actually working or on annual leave, so any of the junior staff Consultants would attend. On average we would have had an attendance of, I don't know, 15/20 people.

Q. And that's anybody who had been involved in the care of the baby, was that the expectation?

A. No, it was meant to be all the junior staff that were available and all the Consultant staff available because it was a -- very much a learning exercise environment --

Q. If we look at Baby A --

A. -- and a very open and transparent discussion of events.

Q. Let's just look at what it says about Baby A then if we go back to page 2. If it's a learning environment, we see here it says "awaiting pm".

There's not a lot you could learn at that point, could you, without knowing forensically --

A. No --

Q. -- about that death?

A. -- and that's absolutely correct in that particular scenario. But the letter that would have gone out would have enumerated the 3, 4, or 5, 6 learning points from that particular meeting, and

Dr Brearey would have sent that out to all the other Consultants and to all the junior staff.

LADY JUSTICE THIRLWALL: Would he have done that before or after the meeting?

A. It was done after the meeting, my Lady.

MS LANGDALE: That can come down now, thank you, Ms Killingback.

Were you aware the way that event is described at the meeting with the line in situ that that was a sudden and unexpected death of a stable baby?

A. Like it's nine years ago now, and I -- I can't particularly recollect the exact discussions, but that would -- I am certain would have been something that Dr Brearey would have highlighted and the junior doctor who was presenting the case would have highlighted at the meeting.

Q. Because we know that after Baby A's death, members of the medical and clinical staff were shocked, upset. One of the younger doctors took some time off. It was an unexpected death of a neonate. That's a rare event, isn't it? An unexpected and unexplained death.

A. Yes, certainly on talking to the other paediatricians that -- I think that would be the case. I'm not sure whether that's just bridging into the neonatology expertise as opposed to me being an

obstetrician.

Q. Can we go to paragraph 33, please, of your statement if you have it with you.

A. I have.

Q. You say that, in your experience at the hospital, the relationship between the obstetric team and the NNU has always been very good and that was unchanged in 2015 and 2016, and there would have been daily clinical care discussions which would usually have occurred as necessary between the obstetric Consultant who was managing the labour ward and the equivalent Consultant on-call for the NNU.

You've highlighted communication between you and Dr Brearey, which I take was very good from what you're saying?

A. Yes, and that refers to the actual on-call Consultant obstetrician on the labour ward, and if he had concern about any of the patients on the labour ward he would have been able to have direct conversation whoever was the neonatal Consultant on-call. But the working relationship that obstetrics had with the neonatal unit I would have described as excellent, and this was something -- I have been a Consultant for 23 years now, we all knew each other well and we would have worked well in certain situations, for instance you

had a witness, the teamworking, if you were on the labour ward and there happened to be a collapsed baby and the team came in to -- to resuscitate, or for that matter an elective section, and -- and I had no concerns about the working relationship between ourselves and them.

Q. Can you tell me a bit about the layout of the Consultant offices and the administration, the opportunity for what I would call corridor conversations or informal conversations when you're passing each other?

A. We were very fortunate because our building really was all very close to each other. So the neonatal unit was next to the labour ward, and our offices were very close to that building. The ground floor had all the neonatal offices and the top floor had all the obstetric offices. And it wasn't unusual for me to walk downstairs and speak to John Gibbs or one of the others about a particular issue I was concerned. Our relationship for discussing things was very good.

Q. So things that were worrying them they could share with you and vice versa, and did?

A. I would agree with that.

Q. That's how concerns were raised informally. More formally, at paragraph 51, you comment on the

previous structure with a separate Women's and Children's division might have allowed more focused discussions of the issues at that management board level.

So can you expand on that, why do you think it would have been better retrospectively to have a different structure? Set that out.

A. Well, I'm not convinced that it would have been because the structure that we had in 2015 had been changed in 2010, it was a structure that we were very familiar with and --

Q. Was that driven by cost or anything else, why was it changed, do you know?

A. I think it was changed for financial reasons. We used to have a separate director -- directorate for Women's and Children's, which includes neonates, paeds and gynaecology, and with our own directorate manager, Clinical Director, et cetera, and they changed that and integrated the departments to then two directorates then to Planned Care and Urgent Care.

And -- but we'd been working in that environment then for four years by the time it was 2015, and I think that I thought that even within the environment we got we still had good contact with the paediatricians, and we had good links still with senior management in the --

in Planned Care. Our divisional Medical Director in Planned Care in fact was a gynaecologist, and our Head of Midwifery sat on the QSPEC board as well. So I don't have concerns about -- about -- about -- about those changes.

Obviously if you said to me now and we were going to redo it by choice I think we would choose to have neonates within -- within our own directorate but --

Q. As it was before the financial motivated changes?

A. Sorry, Ms Langdale?

Q. You'd have it as it was the prior structure if --

A. Yes, yes, I think we would. And I -- I don't know whether it has changed to that now. I imagine it has. But the point I was making was when you asked would it have made any difference with very like-minded individuals surrounding you, and I think the only example I can give you in relation to that would be, for instance, the governance board.

Now, the governance board at the time in 2015 had very like-minded individuals around the table. We had the lead in obstetrics, we had the lead gyaeny, we had the Head of Midwifery we had the lead paediatrician we had the lead nurse in paediatrics, and so that was an

environment that I thought would have allowed appropriate discussion. But, you know, I -- I was conscious that wasn't the case, because --

Q. Did you have discussion on that lead governance board about sudden and unexpected deaths on the neonatal unit and whether someone might be causing them?

A. No, definitely not. And that's exactly what I was just going to say was that if -- if -- in my preparation for my evidence and looking at all the other evidence like it is clear that Dr Brearey and Dr Jayaram, you know, were relentlessly pursuing directly to Senior Executives their concern about harm to babies and possible causes of the deaths.

Well, I never saw that at the governance board, so --

Q. Let me ask you about the women and children's care governance board for now, if I may.

A. Yes.

Q. And you tell us at 52 -- paragraph 52:

"It did include staff from obstetrics, paediatrics neonatology and gynaecology within the board."

A few questions I may of some of the meetings. If we could go to INQ0004235, first of all, at page 2, box 7. While we're finding that, Dr McCormack, I'm

certainly not going to ask you about the details of a particular case this far away and one that doesn't impact on the Inquiry. What I want to ask you about is the rationale behind it.

So at paragraph 7, reference to a stillbirth:

"Waiting to find out how it will be taken forward in relation to an investigation. OSR completed and it highlighted issues with care provider decision-making. An ethos of transparency external reviewer to analyse this case as no one in the Trust outside of the division with expertise to review the case."

So what was the basis in principle for taking cases to external investigation, and was that simply something that fell within the obstetric team to investigate?

A. I -- I can't recollect what that --

Q. That can come down, now thanks.

A. -- particular stillbirth was and what the issue was in relation to expertise, and it would be very unusual for us to do that. There was a climate -- an increasing climate for stillbirth reviews and stillbirth learning meetings to include an external reviewer, and that was one of the reasons why we considered the two different reviews with an external attending to it.

But, for our own purposes, the only external person

that we ever regularly had at our perinatal meetings would have been the pathologist, which was -- which was a very valuable input to our meetings --

Q. Indeed. Let --

A. -- and, and we only properly started that not more than two or three years before 2015.

Q. Can I ask you then to contrast in the same document -- sorry, Ms Killingback, if we can have it back at page 3, so 0004235 for Baby A.

We see here reference to documentation excellent, multi-disciplinary working was excellent, clear reviews, precise managements, excellent escalation from midwifery to medical staff when there were concerns, no issues with any element of care, will be subject to neonatal review and will be discussed at perinatal mortality review meeting.

No mention there of external or pathology or the invitation for someone elsewhere to investigate at that point.

A. No.

Q. Can you explain the difference in approach for the committee, understand that in principle?

A. Because this, this was part of the risk management review of the deaths, so when a neonatal death occurred, and I may not be completely clear with

the neonatal structure, and you can confirm that with one of the neonatologists, but a Datix would have been issued, and the Datix was just a paper record of -- a computer record of a concern about risk, and one of the risk team then would have sent that to Dr Brearey who was the lead in clinical risk, and he would have prepared for the purposes of the risk team an SBAR. And in cases where there was concern about the obstetric management he would ask us to do an OSR. And this is the OSR report which I think I did on Child A.

And could I point out, in my statement, I'm not sure what page it is, it's on item 69 where I said I hadn't done an SR, I apologise, and in fact when I started to lock through evidence I realised the only one I did was Child A.

So this is a summary of me sitting with the notes to look through the obstetric notes for the benefit -- for the benefit of the paediatricians to know were there any serious risks that could have had an effect on the neonatal care afterwards. But this --

Q. So when you -- sorry, Dr McCormack, can I just focus on what it says:

"No issues with any element of care provided."

Were you commenting on antenatal care? Because it was not within your remit, was it, to comment on

anything post delivery if you were not present for that care or didn't know what happened in that care?

A. Well, I -- I wouldn't -- I wouldn't comment on any. So once the baby is born, then all the care is the care of the paediatricians and neonatologists. So any report you would have of an obstetrician would stop at the delivery. So that review that you see and read there under "Obstetrics Secondary Review Actions" is just referring to the care that Mother A had during her pregnancy and looking to see was there any issues with that care that could have been relevant for the outcome post-natally?

Q. Was a neonatologist present at the meeting? It can go down now, thank you.

A. No, not the all.

Q. Why not? Sorry, pausing there, why not? You've got a situation where you know that the antenatal care has been excellent, you say, and this baby has died and it's an unexpected and unexplained death.

A. Well, this -- this -- this isn't actually -- this was no -- I tell a lie. The -- the -- the SBAR would have had the risk manager added and would also have had the Head of Midwifery. So the three of us sat down and then discussed the case, and then I would have prepared the -- the report that you've just read.

But the report was directed to midwifery care and obstetric care up to the point the baby had safely delivered. And after that time -- so I wouldn't have commented on it being unexpected, I wouldn't have commented on it being a neonatal death at all, and --

Q. Would you have asked about it as a matter of professional curiosity? You've looked after this patient, she has had her babies, would you just ask and say, "What do you think happened there then?" You've got an informal arrangement --

A. I might have been part of a discussion at one of the perinatal meetings, there's no doubt about that, and I chaired it and would engage different people to make comments. But in respect of the -- of my request to review the case, the case would only be reviewed entirely relating to clinical matters in obstetrics, and the Head of Midwifery at that particular -- was looking at issues relating entirely to midwifery care, as she will tell you in due course, I'm sure.

Q. I'm sure that was the process. I am asking now about the excellent communication that existed between the groups and informal conversations, and you said concerns in the perinatal mortality morbidity meeting may have been raised. What concerns were said? You said earlier to me that Dr Brearey would have said

unexpected and unexplained. What was being said -- leaving aside the structure and the governance and the process, what was he saying to you?

A. Well, for me to reflect now what was actually discussed, and I haven't got a record of it, it's extremely difficult, quite honestly.

Q. Sometimes we have a sense, though, don't we? We have a moment where we remember something really significant was told to us or we were worried or professionally curious enough to go back again and say, "What was that about?"

A. Well, I -- I am certain -- I would think that the key features in each of the cases would have been discussed at the perinatal meeting, and the nature that it was unexpected, sudden, failure to respond to resuscitation, all the things that we have read in various reports from the paediatricians would have been -- would have been discussed at the perinatal meeting. And, like, it's very difficult to think back but I don't think at any case -- in any of those cases there was a feeling or a concern that these deaths had been caused by intentional harm.

Q. I will go to that later, if I may. I just want to deal with concerns so unexpected unexplained, do you know when a rash was discussed with you? Was

that -- who raised that? When was that raised with you? That's a feature -- as you say we've all read about that and --

A. That -- that wouldn't have been discussed with me at any stage.

Q. Right. So at no stage that.

What about -- you mentioned --

A. Being quite frank, Ms Langdale, I wouldn't have had a serious conversation with the paediatricians in relation to those features.

Q. No, I'm just asking whether their concerns were shared with you. I'm not suggesting you sat down with a paediatrician --

A. I'm certain -- I'm certain that with the peculiarity of the rash and the rareness of it and them unable to explain it and even at a senior level unable to explain it I'm sure it was mentioned at the meeting.

Q. Right. And equally we know Dr Gibbs, as far as Baby C was concerned, was curious and had never seen in a natural disease process after the resuscitation for the heart to effectively start again. Did he share that concern with you?

A. No, he didn't. But I -- I obviously have seen that on the evidence that's been given.

Q. Yes.

A. And I -- I didn't actually consider the cause of death in relation to Baby C because of the -- how ill Baby C was during her pregnancy.

Q. I will go to Baby C later, if I may. Let me stay with neonatal minutes Women and Children's Care Governance Board.

A. Okay.

Q. Can we go, please, to 0004249. This is the minutes of the Women and Children's Care Group for 22 October, page 2, and we see under "Neonatal" 47 -- 47 incidents reported. Do you see at the top of the page?

A. Could you make it -- yes, thank you.

Q. Not, it's number 47. "Neonatal", here we go.

A. 47 incidents reported. Yeah.

Q. That's not the section I want, sorry. Yes, it is. 47 incidents reported. Two moderate harm incidents relate to neonates that sadly died --

A. Yes.

Q. -- and the five top categories are said to relate to seven babies with feeding problems. Is moderate harm an appropriate category for a baby death, do you think?

A. No, definitely not --

Q. Just continue for a moment, Dr McCormack. The categorisation of baby death appears through the

documents to have been interpreted differently. So we know for Baby D it records the risk grading as actual harm none, no harm caused. So there doesn't seem to be consistency. Was there consistency and do you think the categories were always described appropriately?

A. No, I don't at all and -- and that was allocated by the risk team. Not by any of the medical staff.

I think there was several boxes on the Datix form that had to be completed and those -- those -- that terminology has resulted from ticking whichever box they have ticked --

Q. So it's not a medical person necessarily?

A. -- and on reflection it's entirely inappropriate.

Q. So it sounds like that's a matter for the risk team, is it, if they're ticking the boxes, you don't think medical team?

A. No, none of the medical team have produced that. This report is from the risk team, their quarterly trend analysis, and they will have ticked the box on that Datix report "Moderate harm". And if you look at, for instance, the Datix report that you showed -- that you've got in the pile from C or A you will see those boxes where they can tick those to

describe which -- what description they want to use for it.

Q. So it sounds like you'd agree there should be a clearer process to accurately categorise deaths within this system and it may well have been helpful, wouldn't it, to have an unexpected and unexplained death category, for example? That can be taken down?

A. I think there actually is one.

Q. You think that's --

A. I'd have to -- I'd have to look at the Datix, but I think there is an opportunity to tick that box as well. You -- like, you can confirm that with the risk team when you're talking.

Q. If we can go to a meeting, January 2016, INQ0004293, page 2. We see at box 7, "Child D Case Review":

"Need clarification on approved abbreviations. DP will check what are classed as the approved abbreviations."

There appears there to have been a concern that abbreviations were adopted without standard uniform application. Do you know what that was about and do you think there should have been a standard application?

A. Well, that -- that was a review undertaken by Dr Brigham. And in fact when I was looking at that case

recently that was a locum on that night, and the locum used abbreviations that were not accepted practice. And that was the comment Dr Brigham made in her OSR report.

So they -- they were -- staff were highlighted that. But that particular night it was a locum doctor on.

Q. We'll come to the Brigham report in a moment -- that can go down, thank you -- but there was a lot of review of notes and record-keeping and learning in that sense within the Brigham review, wasn't there, but not anything addressing causation of deaths or what they might represent, nothing of that type?

A. I think that's correct, and that still falls back to the fact that in -- in Dr Brigham's review it was an antenatal and midwifery review. Again, it wasn't reviewing the -- the clinical care or clinical outcome of the babies after they were delivered because that would have been the remit of the neonatologists. So that particular report entirely was to address were we missing something antenatally or was there something antenatally that could have contributed to the deaths, and that was the purpose of the review.

Q. And we know -- I was going to come to that later but you're dealing with it now, Dr McCormack, thank you -- the learning from that was very much

directed to antenatal care or, in the case of Baby D, record-keeping. It was not examining forensically, or in any sense attempting to, the causation of deaths in the babies on the indictment that were included in that review.

A. I would have --

Q. It was really an obstetric review -- it was an obstetric review, wasn't it?

A. It was a what?

Q. It was an obstetric review really, not a neonatal --

A. It was an obstetric review. But you -- you -- you talk there about the learning. Like, there was very significant learning from that particular report. There were two essential: one intrapartum death and one neonatal death from hypoxia during their -- all from misinterpretation of a CTG. And you can see in Dr Brigham's learning thing two or three pages are to try and address that particular element of care. And I'm just highlighting that the review was to address obstetric issues. And there were bigger obstetric issues relating to that particular report.

But you're perfectly right, the report doesn't address any issues relating to the cause of death with the neonates.

Q. And we see the fact that it was called an obstetric and neonatology review appears to have created a sense of false reassurance that some of those neonatal deaths were considered or scrutinised in the sense of understanding the cause of death, and they were not, that was not the purpose of that review.

A. I'm not sure I would agree with that. Right from the onset, the purpose of our review would be to look to make sure that our care didn't impact on any of the neonatal deaths. And -- and the review that we would have done would have been entirely confined to obstetric care and midwifery care for that reason.

Q. So it looked at whether obstetric care could cause the death but nothing in neonatal care or pursuant to the delivery of the babies?

A. Absolutely, because we hadn't got the expertise to comment or review relating to neonatal care.

Q. Going back to your statement, Dr McCormack, paragraph 54. You raise the Datix management form that was raised in respect of Baby C. And if we can go to that document, it is INQ0003229. It begins on page 1.

And if we go to page 2, we see your name.

And we see at page 3 the SI panel meeting.

Can you just tell me, the ticks, does that

represent who goes to these serious incident reviews?

A. Well, the serious incident panel is a specific panel and it includes usually the Nursing Director and Medical Director, and I assume those other people. So at that particular one I interpreted when I read and looked at that document that only three people were at that particular -- and I know in fact from other evidence that Mr Harvey actually wasn't present at that meeting.

Q. And the meeting looks as though it's 2 July. It's just a point to clarify. You say in your statement the SI meeting on 2 August, you mean this one presumably, 2 July? Or was there another meeting, as far as you were concerned? I haven't seen anything to suggest there was, Dr McCormack. I just want to clarify at paragraph 55 you say --

A. Yes, I think that's an error because I'm talking about the panel relating to when Child C was discussed, and there only was one serious incident panel, and I think Baby C was discussed at that meeting. So my apologies for that, that is -- I think that is --

Q. And did you have any input into that?

A. No. That's decided by the risk team, so under review of the SBARs going back from Dr Brearey and from Jo Davies -- Dr Davies did that report for the OSR. So

those two reports would have gone back to the risk team, they make a decision that, look, this needs further review, and it will be assigned then to -- to have a serious incident panel.

I think in this case, because of the time frame for the three deaths, I -- I think that the -- they -- they've reviewed all three at the same time.

Q. Dr McCormack, I don't need to take you to it -- the document can come down -- but we know at that serious incident panel the name of the investigating officer Debbie Peacock:

"Report on STEIS. No."

And there's comments:

"Awaiting pm but likely acute bowel distension sepsis."

So no report on STEIS. Did you understand what should be reported through the STEIS system? What was the --

A. I couldn't tell you right now but there was a list of events that should be reported through STEIS.

Q. You looked after Mother C in her pregnancy and she described the antenatal care that you provided very positively, and we know that you had a meeting with Mother C after the death of Baby C, and you have attached -- and we see your notes of that meeting and

what was said.
You were able in the meeting with Mother C, weren't you, to explain and discuss how it was that the baby was preterm delivery and had severe intrauterine growth restriction. You were able to discuss that with her, the antenatal issues and the birth at 30 weeks. But you were not able to discuss death, were you, or to understand the death at that point; is that right?
A. Yes, that -- that's absolutely correct. The reason that I saw Mother C back for her review was specifically to review the pregnancy. It had been a very difficult pregnancy and it would be not frequently that we see a baby with growth restriction from 18 weeks, and it was important for me to see her back because it was highly likely she was going to have the same problem next time.
And, secondly, I knew the cause of the growth restriction because of the placental biopsy and examination of the placenta, and that condition really causes a very abnormal change in the placenta which results in the placenta not working well. And --
Q. You --
A. -- and I wanted to discuss that with her. And in mums that do have that there are other blood tests that --

Q. Don't worry, I'm not going to ask you about those -- I'm not going to ask you about those, thanks, Dr McCormack, it's what you were discussing.
You tell us in your statement you weren't aware of the circumstances in which Child C died until evidence was presented at the criminal trial.
A. My apologies for that. I -- I -- I didn't realise what the circumstances you were asking. I thought you were asking the circumstances relating to how the perpetrator had caused the death. I obviously was aware of the collapse, the failure to resuscitate, and I had been present at the perinatal meeting when it was discussed. So when -- when I read that circumstances I was thinking in my mind that, you know, in relation to whatever mode of -- method had been used to actually kill Baby C, and that's when I answered that that's what I was saying. I obviously was aware of the sequence of events after delivery because as we've discussed in relation to perinatal meetings.
Q. So who told you what about Baby C, which Consultants or doctors discussed his death with you? I mean, you're meeting Mother C, you're discussing future pregnancies, presumably as a matter of -- professionally, even if it's not your expertise, neonatology, you want to understand as much you can

about that death before you speak with her?
A. Well, I wouldn't per se have addressed the issue of the actual death. I -- I -- and I can't be certain, but I may have discussed that death with John Gibbs before I spoke with Mother C., but from what I was going to say it wasn't actually strictly necessary.
Q. So Dr Gibbs tells us that that was an unexpected and unexplained death. So he has told you that as well, presumably, if you're talking to him before you speak to Mother C.
A. Yes, he -- well, I think that would have been pretty clear when we -- when we discussed it at the perinatal meeting. I don't remember -- I don't recollect a specific discussion with John Gibbs, and I wouldn't have had -- I wouldn't have needed to discuss any element of the neonatal care with what -- with what I was going to discuss with Mother C.
My brief was a very clear brief on what elements I needed to go back over with Mother C and -- and make sure she understood why Baby C was -- was -- was restricted, that it was likely to happen again and our plans for her future pregnancy.
Q. If -- if --
A. I -- I honestly wouldn't have addressed with

her issues relating to the neonatal death. I just wouldn't have discussed that, and still don't discuss that with --
Q. Even if you knew about it -- my question, Dr McCormack, for you and other doctors is if there are concerns that it's an unexpected and unexplained death and you don't know, you just don't know --
A. Yes.
Q. -- wouldn't you share with the parent that you don't know, who may then say, "Well, how are you investigating? How are we going to find out? I want to know"? Is that a conversation or do you just not say much about the bits you don't know?
A. Well, it's not the bits you don't know, it's the bits that you don't really have an expertise in.
So the neonatal team would be responsible for that degree of discussion. And I certainly would have empathised with Mother C in relation to Baby C, but I wouldn't have addressed cause of death, possible cause of death with her at that meeting, I wouldn't have -- it wouldn't be considered to be an area that an obstetrician would discuss. And -- and being absolutely open and honest with you, I never ever considered that this death could have been from deliberate and --
Q. At this point -- at this point when it's

unexpected and unexplained -- I understand you're not as ans obstetrician able to say this is what happened, but don't we defer to other experts -- I might say to someone "Well, I'm not the commercial lawyer you need to go and find one" -- that when someone's asking you about something or you realise it overlaps with the area you're talking about you defer to another expertise or discuss who they might get the answers from.

A. And I think that would be very valuable, and I'm absolutely certain that the paediatricians would have done that and would have discussed that with the network and shared the concerns about the different things. But I -- I have to -- I have to say that that discussion and that professional discussion I wouldn't have undertaken it with Mother C because it was --

Q. Would you have undertaken it with Dr Gibbs and say, "Well, who are you going to find out then? What pathology -- are you going to make sure you speak to a pathologist", clinical pathological interaction?

A. Well, the difficulty with mother -- sorry -- sorry --

Q. With Dr Gibbs. If you wouldn't have said it to Mother C, would you have said it to Dr Gibbs, "Who are you going to get to investigate the death?" Just look at the -- to see what's being done around finding

out, or did you think that was not a matter for you?

A. Well, it -- it -- it was a matter for our learning and, and I -- I can't actually remember but I think it was George Kokai that did the pathology report who would have been most likely at the perinatal meeting. And I think there would have been less of that discussion because, certainly from my perspective when I saw the post-mortem result and the immaturity of baby's lungs, like, I presumed that this was a death entirely consistent with prematurity. And I knew that this baby was very sick. I knew that it had abnormal doppler. I knew there was no (inaudible).

I knew that the growth of the baby was very abnormal, it was small, and that is a baby for me that when I saw that post-mortem I would have said to myself, "Right, well, that's typical with my experience with that sort of mother -- with that sort of outcome."

Q. It's a requirement, isn't it, not to apply general principle looking at patients whether they're babies, whether they're the elderly? You could say old people die but they don't always die unexpectedly or in an inexplicable fashion, do they? The fact as a group they're vulnerable to death doesn't mean we say they're old, they've died. You need to examine the cause of deaths particularly if they are unexpected and

unexplained, don't you, whatever the age of the prematurity or the age?

A. I --

Q. You're not the only one to express that view, Dr McCormack, but I'm challenging the view if you're a premature baby you are more likely to die, therefore I'm not going to scrutinise when there's a death of a stable baby that wasn't actually very sick -- premature but not very sick.

A. And I accept what you say. I'm only saying that in -- in Baby C's case there was a post-mortem report that actually had a cause of death. So -- and I know there's some debate about the interpretation of it, but to look at it, it's not as if the pathologist is saying this is unexplained --

Q. I was challenging your -- sorry, pausing there, Dr McCormack, we'll deal with that later -- I was challenging your assertion because the baby was premature. But you agree with me that's a generalisation and there is a need to be more specific?

A. Yes.

Q. In terms of Mother C, finally, she was having regular appointments with you at the time the announcement was made that the RCPCH were going to be

coming involved, and there was an investigation into deaths at the hospital.

We've seen the communications, you may have been aware of it at the time how the hospital announced they were going to downgrade and that there was going to be an investigation. And Mother C remembers discussing that with you in her subsequent pregnancy and saying how let down she felt to read about that RCPCH investigation in the paper, and you said to her that the Consultants had been told all the patients had been informed about the RCPCH investigation, those parents who would have been affected, whose babies had died in the period that the press announcement was referring to.

Can you remember her raising that with you in the subsequent pregnancy and you saying you thought that she and indeed others who were impacted upon would have known about this?

A. Well, my only recollection of any discussion about the RCPCH report would have been when I was at the board meeting on 30 June. And I -- I do remember as part of that meeting them discussing communications and press releases, and it was only to that extent, and I certainly would have expected there to be an adequate communication with mum, and certainly it's very -- very unreasonable to find that she discovered it in the

press. But I don't actually recollect that conversation with --

Q. It sounds like you thought it, so you may well have said it.

A. Indeed.

Q. So she's right about that, that's something you were concerned about you were at that meeting, the communication strategy meeting --

A. Yes.

Q. -- and it was obvious they should know, isn't it, all those parents that were affected and should have known before, arguably, if there were concerns still about the deaths?

A. Absolutely. Absolutely. There should have been full warning of what was expected so that they could prepare for that information.

Q. You were also providing antenatal care, weren't you, for the mother of O, P and R triplets? And Mother O, P and R says that at every scan you would express disbelief she was still pregnant and successfully carrying the boys as close to term as possible. Does that resonate with you, this is a naturally conceived triplets not as rare for you as the rest of us but still pretty rare I'm assuming?

A. Indeed, and I would have seen Mother O, P and

R very frequently in the pregnancy. There's no way to assess that the babies are growing normally without regular scans, so I would have had very frequent scans with her where I would have had the opportunity to discuss issues with her or address any concerns she had.

And there always will have been a risk of her going into premature labour, but we would have considered 34 weeks as term with a triplet pregnancy, so once it got to that stage, then she would have been delivered by the fact she was 34 weeks, which is the time we would have considered appropriate for ending the pregnancy with a triplet pregnancy.

Q. Mother O, P and R says you were a huge part of her pregnancy, she put all her trust in you and she felt like you looked after her very well in that antenatal period.

A. Well, it's that bond that occurs I think. When you're seeing mothers we -- we are -- we are in a very special place and build up upon over the weeks you are looking after a mother, so I would -- I would entirely agree with that.

Q. You were involved in November 2015 in that Brigham review we've referred to stillbirth and neonatal deaths, and that's November 2015. A question from Mother O, P and R's perspective and our perspective is

this: did at any point you think it was sensible to suggest care at another hospital, Liverpool Women's Hospital and to have delivery there, or did you ever question whether the Countess was the right place for her or them to have their children?

A. Well, I think probably the opposite. I think I -- I -- I would have said to the mother frequently I thought it was unlikely that she was going to deliver in Chester, because for her to deliver in Chester we needed three baby cots, and at that time, in 2015 -- pardon me -- we were having great difficulties managing our high risk pregnancies and often had to move them to another hospital.

So I wouldn't have been concerned with her delivering in Chester. My only concern was I would only know a day before or the morning before whether or not there was three available cots there.

Q. So the questions --

A. I say --

Q. So why not encourage her to be elsewhere? That's the point, if you were concerned about the services, why not say "Don't" -- from the outset, "Don't have them here, go to Liverpool Women's Hospital"?

A. Well, I think it may well be the same case in another unit. So Liverpool Women's could be completely

full, and I -- I would have said to her that I couldn't have said to her which unit she would go to. Like to get three cots available for a triplet pregnancy it might be difficult.

Q. The review that was conducted in 2015. We can go to INQ0003222, page 1, review of neonatal deaths and stillbirths.

Page 1 and 2 is the summary, Dr Sarah Brigham's summary.

Go to page 2. Results, 18 cases identified.

We know that within this review babies A, C, D and E were included, Baby I wasn't, even though the date of death preceded it.

I think we've agreed it largely focused on antenatal care obstetrics and not certainly investigations that needed to be conducted for the deaths I've referred to. But did the fact --

A. -- focused on midwifery and antenatal care.

Q. Yes. But the fact that it was even being done at all, did that worry you that this needed to be done at all? It can be taken down now, thank you.

A. Well, the reason that we under -- we undertook the review was because we were aware of the increasing deaths. I think -- in the previous years I think we had nine or eight stillbirths and, at that stage, we had 12

stillbirths. The expected stillbirth rate at 2015 was about four per thousand, so we should have had 12. And the same for paediatrics, we should have had six. So we decided that we would review -- and you will remember I mentioned the need for an external assessor at reviews and so we thought it would be entirely appropriate to undertake it.

But just to give you some idea with the clinical variation of the stillbirths, that --

Q. Don't worry, sorry, Dr McCormack, I need to move you on there, if I may, I don't need to know about that variation, but can I take you to paragraph 69 of your statement. You say:

"I did attend discussions with doctors on the NNU in respect of the deaths of the babies named on the indictment after their deaths. I would have been present when some of these deaths were discussed jointly with the Neonatal Team at the PNM. If requested, some of the deaths were also reviewed at Obstetrics Secondary Review by the Clinical Lead but I was not involved with those discussions."

A. That is the correction I made earlier to you --

Q. Yes.

A. -- that I've said there I was not involved in

these discussions, but clearly when I went to look at the evidence to prepare my review I did the OSR on -- on Mother A, so I was involved in relation to that.

Q. And, really, Dr McCormack, it comes to this, although the paediatricians in detail are being asked questions here about what they did or didn't know, there is a sense that other people around them are removing themselves from conversations that they have had or documentation that they have seen. But you agree with me, you did attend discussions about their concerns, you knew that they were worried about the deaths and that they were unexpected, unexplained and some of the clinical features?

A. That's correct. But I would have to say that at any of the meetings -- the perinatal meetings that I attended or engaged in any discussion the understanding was that this was a natural death and -- and it -- it -- it wouldn't have been -- it wouldn't have really been considered by -- by me that the risk was -- that the deaths were being caused by -- by harm.

Q. Dr Lambie told us that in September 2015 she observed a group of nurses in the neonatal unit trying to work something out, she wasn't sure what they were working out, but she said it was clear it was potentially linking someone to causing deliberate harm

to babies because there had been a number of unexpected and unexplained events and they had started to think the unthinkable, a group of nurses.

A. Yes.

Q. September 2015. You're doing your review -- or the Head of Midwifery is, November 2015. Are you hearing conversations or discussions about the "unthinkable" as people have described it?

A. I don't think -- well, I think there may well be a time period where people start to think is there another reason for this and is this from intentional harm. And the -- the earliest time, I think, for us probably would have been the triplet pregnancy where we delivered a babe at 34 weeks, three babies in excellent condition, and you will know from the papers the survival rates at this gestation should approach above 95%.

So that -- that was -- was certainly a consideration at that stage.

Q. So you -- never mind everyone else, you were saying that you certainly thought about that after the triplet deaths.

A. Well, we certainly considered at -- at that time that -- that, look, this is a very strange happening now. I think the discussion in the neonatal

unit may well have been confined entirely to the neonatal unit. I'm not devoiding myself from thinking of the situation. But I -- I know that in discussions I had with paediatricians there -- there wasn't a discussion and -- and -- and a discussion to say to us, "Look, we are concerned here this must be intentional." That was not something I heard at -- in any interaction with the paeds. What I did think after the triplets that this was certainly something very strange.

Q. You are recorded as saying there that you think the discussion may well have been confined entirely to the neonatal unit. These are colleagues that you have conversations with. Are you saying Dr Brearey, Consultants aren't talking to you about concerns that someone else is involved, deliberately causing harm, their suspicions about this?

A. Well, I -- I can't talk for Dr Brearey.

Q. No, I'm talking -- asking you -- I'm not asking you to talk for him -- that he hasn't said that to you?

A. Well, you know, I -- I sat with him right through whatever number of governance board meetings, and the paediatric team had an opportunity to highlight their concerns at that stage and -- and that wasn't the

case. Anybody who was at that governance board meeting still understood that it was likely that these deaths were -- were from natural causes.

Q. Let me ask you about paragraph 74 please in your statement:

"Requests for postmortem examination were usually made in all deaths but only undertaken with maternal consent ..."

But you were only involved with stillbirths as an obstetrician.

A. That -- that's correct. With the Alder Hey Inquiry and the difficulties with the organ issues at that time it completely changed our ability to undertake post-mortems that had been sent for examinations, and they weren't undertaking without explicit consent from mum. And we were fortunate in relation to a stillbirth that nearly all of our placentas went for examination but the mum had to decide and consent to having the pathological examination of their baby for either a neonatal death or a stillbirth.

Q. Did you understand that was necessary from a neonatal death that you needed mother's consent or not at that time?

A. Yes, you definitely needed consent. They had to complete a consent form for organ examination and for

keeping specimens for teaching. And it was -- it was a very extensive document that mum had to read it and sign.

Q. So if a mum said she didn't want one, there would be no circumstances where you would say that should happen or not?

A. Well, I think you would have to -- from my perspective in -- in -- with relation to stillbirths, it may well be that a scan has shown very serious abnormalities and it's clear that these are present with the baby and that a post-mortem may not be necessary. But if there was strong concern of an issue you would try and encourage the mother to consider it, but it was -- it was a difficult conversation quite honestly. They'd just lost the baby and suddenly you were -- you were in a position where you were discussing very serious things with them.

So it -- in general it was a fairly immediate thing for mum. They knew straight away, "Yes, I want that, I want more information", or "Oh, I didn't want that to happen." So there wasn't a big persuasion thing, the mums themselves knew, in my experience, fairly immediately, and -- and -- and that's usually what happened.

Q. Paragraph 83 you refer to Dr Brearey

undertaking a multi-disciplinary review, the thematic review of neonatal mortality, dated February 2016. There's a subsequent one in March. When did you see that, do you know?

A. The thematic review?

Q. Yes.

A. The thematic review I didn't see it until June 16.

Q. Right. So we asked you whether it had been -- at paragraph 82 you answer this I think -- whether it was the intention that the neonatal unit would complete their own review or they would be combined. There was some suggestion that they might be combined, the Head of Midwifery review and Dr Brearey's review, but that didn't happen, did it? His --

A. I don't -- I don't think there was ever an intention because I don't think there was a discussion prior to either that, "Look, you do this and we do that."

We looked at the stillbirths and the neonatal deaths, and they reviewed the years of the neonatal deaths. So the two reports are entirely separate and I think properly supplementary.

Q. In terms -- you referred earlier to the obstetric review and the learning from it, can we go to

INQ0015135, and we see a Lorraine Millward emails many people. Page 1, 2 and then 3 we see the content of the email.

LADY JUSTICE THIRLWALL: We haven't got it yet.

A. I think that she was one of our risk staff and --

MS LANGDALE: She was. And it's 0015 -- here we are go to page 3, if we may, Ms Killingback.

A. And although the report was received in Women's and Children in December, I think some of the learning hadn't been completed until the end of March because I~think we changed the -- just let me find it.

Q. If you look at the email here -- it's there:

"We must ensure a Datix is completed for all neonatal deaths or stillbirths."

That went to a lot of people, didn't it, that email?

A. Yes, because I think one of the stillbirths hadn't been Datixed and it was sent to remind them of the importance of a Datix in relation to a death.

Q. And what was your understanding of the importance of the Datix? What information -- that can go down now, thank you -- what should it incorporate?

A. When you complete it?

Q. Yes. The nurses complete it, do they, or

doctors or both, who should complete a Datix?
A. Both -- well, both would complete it and -- and you really produce a small synopsis of the event and -- and the risk staff then -- depending on where it came from then obtain more detailed SBAR assessment of exactly what that involved.
Q. Dr Brearey's thematic review, February 2016, appeared at the Women and Children's Care Governance Board. If we can find, please, INQ0003212, page 5. Page 5, please. Thank you.
You're chair of this board, I think, then and we see there the thematic review is referred to higher than expected mortality rate. Cases have been reviewed at NNIRG. Perinatal mortality review and action plans have been made:
"An obstetric thematic review did not identify any common themes or identifiers that might be responsible for the rise in mortality in 2015."
Your review wasn't even attempting to look at whether any person or individual could be involved in deliberately causing deaths, was it?
A. No, not at all. Both of these reviews were on the basis of a natural death, and the investigations were based on that. I don't think there was any, these -- these -- these aren't -- aren't, for want of

a better word, a "forensic" review of everything surrounding the death.
Q. So your evidence is that there was an assumption even behind the thematic review that these were natural deaths just looking for any learning -- clinical learning or generally, it wasn't even a question whether forensic scrutiny or suspicion of someone was being factored into the analysis?
A. Well, I'm not sure about that because Dr Brearey modified his report after three weeks and he did add in some features that would have suggested that it was odd, in other words he did mention that there were sudden deteriorations, and he also mentioned that six out of the nine deaths had occurred at an odd time between 12 midnight and 4 am, and it would be slightly unusual to have your deaths confined -- confined to that time period.
But -- so he has included those but hasn't gone as far as saying in the report, to my knowledge on reading it, that it was caused by intentional harm. And this -- this report was undertaken on 8 February, so ...
Q. The time, deaths occurring in the night, you've just picked that up, so was that something -- that can go down, thank you -- was that something, looking at that review, that did jump out at you as

being unusual or unexpected?
A. Well, I think it did. And he had got it as one of his -- top of his -- top of the little list, sudden deaths and -- and the time period, and I think that was -- they would have been two factors I think he was highlighting, and certainly on reading it, I was reading as, well, that is a bit odd.
Q. You went to two meetings I think -- I think the Inquiry understands they both happened on 30 June -- one with the paediatricians in the morning and one with management later, and you deal with these at paragraph 110 of your statement. It was a meeting you were invited to attend at 7.30 on 30 June.
A. Yes, these two meetings -- there was two meetings. One was at the request of the paediatricians in early morning and the other one was to join them at a board meeting on 30 June.
I think the paediatric meeting was -- occurred in response to the deaths of the two triplets.
Q. Pausing there. The unit and everyone was in shock about that, reeling and devastated, weren't they, nobody expected that, and you say yourself at that point you were thinking someone could be responsible?
A. Correct. Though, the paediatricians we met them one morning early, so the Baby P died on the 24th

and the meeting with the execs was on the 30th, so I assume this meeting was early on the Monday, the 27th, or early on Tuesday morning, but it was at half 7 in the morning.
Q. Leave aside the date that may be contentious, but we've all have got the point, you're at this meeting, all of you together, and what happens at the meeting -- what do you say that causes some response?
A. Well, we -- we had no idea -- well, it was very unusual for the paeds to ask to meet at 7 in the morning. It was very well attended by obstetricians. There was three paediatricians there, Dr Gibbs, Dr Jayaram and Dr Brearey, and some senior neonatal staff of which one was Eirian Powell. And Dr Brearey I think quite early on, the meeting was not long, it couldn't have been anymore than 15/20 minutes but he said there was great concern -- or the there is concern that a nurse was causing intentional harm to babies on the unit.
And, like, my remark, it seems I could have expressed myself better and maybe said, "Is this intentional harm causing deaths?" But I did say that, "Are you saying that a nurse on the unit is a murderer?" And he replied, "Yes." And like we were absolutely shocked at this stage, and everybody was taken aback

from in an obstetric point of view -- obviously the paediatricians were aware of this for some time -- and the meeting really finished very quickly.

They also mentioned two other things at the meeting, one, that they were considering downgrading the unit and, two, that they were thinking about external review. And they asked us -- they had a planned meeting with the executive team on the 30th June and would some of the obstetricians like to attend. And the meeting finished. And we were at the back of the room and the paediatricians and nursing staff were at the front and, as we left, they filed out first and we filed out afterwards.

I had no idea of the impact on what I'd said to Eirian Powell. I didn't witness any interaction with her and Dr Brearey. And I -- on the way through and out to my clinic I had no contact with anyone. And the first time I knew that there had been any concern with what I had said was when Ian Harvey rang to ask me to apologise seven months later.

Q. Pausing there --

A. So --

Q. -- let's go back a bit, first of all. So you say you said -- are you saying a member of staff is a murderer or something like that? What were your exact

words?

A. Well, from what --

Q. -- as far as you can remember?

A. -- I remember saying I think I said, "Are you saying a member of staff is a murderer on the unit?"

Q. So you say -- you're saying, "There's a murderer on the unit", and you say, "We were all surprised with when Dr Brearey said it." You've already told us you were thinking after these deaths of O and P and all that had gone before something had happened, someone is causing harm. That was in your own mind, wasn't it, it can't have been a complete surprise when Dr Brearey said it to you?

A. Well, don't forget that was only -- that was only two/three days before.

Q. Yeah, but it was in your mind, these perfectly health triplets, two of them had died unexpectedly and everyone was devastated you didn't know why.

A. Yes, but I hadn't discussed it with anybody else and I hadn't actually heard the paediatricians standing up or coming across and saying to me, "We also think that. There is great concern on the unit." So it still was a surprise to me to be confronted with the paediatric team, the three senior paediatricians saying, "Look, we have" -- they didn't say "grave concerns",

they said "there was concern". So --

Q. Eirian Powell will give her evidence about this meeting but, as far as you're concerned you didn't see Eirian Powell you said in the meeting, you didn't see her talking to Dr Brearey, you didn't appear -- you didn't have any feedback about that comment when you were in the meeting from anyone; is that the position?

A. Correct. Absolutely correct.

Q. Right. So no one says anything at the time and then months later you get a telephone call from Mr Harvey, so do pick up and tell us again in your own words.

A. Well, I got a call from Mr Harvey, could I come over to his office, and I wasn't expecting anything. He would have rang me and odd time to facilitate a Level 2 report from a department, and I was expecting something like that.

I walked into his office, sat down with him and he said to me, "You are going to have to make an apology to Lucy Letby." Now, I didn't even know who Lucy Letby was at that meeting of the paediatricians. One, Steve Brearey didn't say the name of the person nor whether it was male or female, but I didn't know who she was, and he passed me the report for -- no, he didn't. I asked to see the report because he said it had been

documented in the report that I'd called Lucy Letby a murderer. And I said, "That's not the case. It's definitely not the case." I qualified what Dr Brearey had said and asked him, "Are you saying that a nurse on the -- on the unit is a murderer?"

Q. So you did say a nurse rather than a member of staff or you can't remember which? Before -- I'm not sure these --

A. I said a nurse. But he said a nurse.

Q. Right, he said a nurse.

A. Steve Brearey said, "We are concerned that a nurse is intentionally harming babies on the unit." So I said in response to that, "Are you saying a nurse is a murderer on the unit?" And it had been disclosed in the HR report from Annette Weatherley that I had called -- it had moved then to say I had called her a murderer.

I didn't call her a murderer. I didn't know who she was. And I said this to Ian Harvey. I said, "Look Ian, I'm very -- this -- this -- this isn't right. You know, that's down in an official document now. I've got a HR document with that in it and I'm a bit unhappy about that."

Q. Were you sent that at the time -- the Inquiry's got the grievance procedure documents and the

findings -- were you sent what Annette Weatherley said to you at the time or have you had that subsequently through this Inquiry process?

A. I have only had that through the Inquiry process, but I did get --

Q. Right. So at the time you just listened to Mr Harvey telling you what --

A. No, I didn't. I asked him, "Could I see the report?" And he produced the report and I read the section that he was talking about and gave it back to him. So I read a small paragraph where the bit said, "Jim McCormack had called her a murderer."

So -- and I said, "Well, look, I'm a bit unhappy with that. I shouldn't really have to apologise." And --

Q. So you weren't allowed to take the report out, you were just shown the paragraph that referred to you by Mr Harvey in his office?

A. Correct. Correct. I didn't see the report until you provided it recently.

Q. And that was the same page that you saw about where you were supposed to have said something in what way you said it; yes?

A. Correct.

Q. So if we go to INQ0012076, page 1, we see your

apology letter dated 8 March.

A. Yes.

Q. You say "I appreciate" -- to Lucy:

"I appreciate you have had a very difficult and stressful time during the course of the investigations into issues relating to the neonatal unit. I have been reported to have made an inappropriate comment during meetings with the Consultants and senior nursing staff when discussing events related to the neonatal unit issue. I wanted to apologise if this caused you any distress."

And you explain there:

"I am only aware recently that first name is Lucy and I have specifically avoided knowing your identity or name to try and afford you some anonymity when you returned to work in the neonatal unit. I have made no specific derogatory references personally about yourself."

A. Correct.

Q. At the time, did you think you should have to be sending that letter?

A. No, I didn't. Not at all. I didn't send the -- and I was surprised that she accepted it when I -- when I was writing the letter because I was really saying nothing. I didn't actually apologise for calling

her a murderer. So I was surprised that she didn't come back and say, "I want Mr McCormack to actually say." So my letter that I wrote I was very careful in what I said that it didn't actually say that because I didn't actually do it, and so I was -- I was -- I was surprised that in fact she had accepted the apology and -- and took it exactly as it was.

Q. Did Mr Harvey -- that can come down -- think it was a reasonable thing that you had to do? Did he say that to you or what was your sense of what he felt about it?

A. Well, I think he was in the position because he -- I can't remember what -- I -- I think ... Do you know in my statement where it's discussed?

Q. It's only if you remembered anything in addition --

A. But, I -- he -- he certainly was because he said to me that -- and I can't remember the words in the statement but he said to me that the chairman wants -- needs an apology from all those involved to address the issue and that I hadn't choice because the paediatricians had already replied. And he said to me, "Look, do you want to go and add your name to the paediatricians?"

So I'm sitting down, when I'd finished with

Ian Harvey, I toddled over and Ravi Jayaram was in his office and so I went in and he smiled at me expecting me to come in because he knew I probably would come in and always thought I would be pulled up on that remark. And he showed me what their letter was and I said, "Well, look, thanks for that I -- I don't think" -- and I wasn't really working on the unit and I didn't want to be included in that group, and so I said, "I'll make a separate letter."

And so I prepared the separate letter, met Ian Harvey and said -- and he was actually quite helpful about some comments and saying, "Don't say that." And that was the final letter that I sent -- that I gave to Ian Harvey.

Q. So in that process you found Ian helpful -- Ian -- Mr Ian Harvey helpful to you and you thought he was doing it at the direction the Chair of the board or you thought it was necessary in any -- in any event?

A. Definitely he said to me that it was Tony Chambers had insisted that an apology letter was written. He -- he I don't think -- he was helpful to me in the text of the letter. That's what he was helpful to me with.

Q. So he was helpful with the text but he said Tony Chambers required that of you?

A. Tony Chambers required that an apology be -- be provided.

Q. Did you have a conversation with Mr Chambers about that?

A. No. No, the only thing I asked -- because I was then in a position when he said that four paediatricians had apologised I thought, "Well, I'm not really going to be in a position I can get out of this it's already been documented in the HR report." And I thought it wasn't going to be something that I was going to be unable to avoid.

Q. Standing back, and you're retired now Dr McCormack, what do you make of that HR process that you ended up writing that letter, and the paediatricians had as well, to someone who's now convicted of murders --

A. Well, I think it's extremely disappointing, extremely disappointing, and I said to Ian Harvey at the time -- and I actually specifically asked Ian that, you know, of all the departments in the hospital to be producing the report and -- and not to have confirmed from a person, "Is that what you said?" Or, "Are there any truths to it?" I -- I couldn't understand it. And I asked Ian could he go back and address that with the HR team because there seemed to be something amiss with

me that an investigation had a remark to that extent resulting in what was happening I hadn't got an opportunity to -- to discuss the situation and the sequence with which the remark was made.

Q. Dr McCormack, I have only got two or three more questions, are you all right to continue? Is that all right with, my Lady? The time -- I notice the time.

A. Yes, I'm all right.

LADY JUSTICE THIRLWALL: Yes, thank you very much, Dr McCormack. Yes, please do continue.

MS LANGDALE: Another meeting, please, at INQ0003362, page 1, it starts at page 1.

This is a meeting on 30 June that you tell us you attended, Dr McCormack, with there Dr Jayaram, Mr Chambers, Mr Harvey, Dr Brearey and Ms Fogarty, and it's understood that the handwritten notes are made by Mr Cross.

A. Correct.

Q. And this is a meeting where a downgrade of the unit is discussed and also RCPCH review. You make the point in your statement, Mr McCormack that you didn't have the chance to review the minutes or approve them. You saw these notes I think -- was it the first time when we sent them or had you seen them before?

A. No, the first time I saw them was when you

sent them, and -- look, I think -- I think they're fairly representative. They're only notes, obviously. Nobody's reviewed them and said -- I was only making the point that they're Stephen Cross's notes without someone looking at them and changing them. And my impression was that they -- they -- on my recollection that they fairly represent what was discussed at the meeting. That's what I thought when I read them.

And, you know, I had somewhat prepared after the -- after the meeting with the paeds that were going to this executive team -- because it was a very senior team, there were six of the Executives there, and I thought it would be an opportunity to discuss the issues and --

Q. It's interesting you say that, Dr McCormack, because six of the Executives and, of course, seven paediatricians -- as an Inquiry we see many letters signed by seven paediatricians. In your experience, how rare is it to have that number of people committed to the same intention or documents and writing around an issue, does that happen very often, in your experience?

A. Well, you know, I -- I -- at that time I'd stopped most of my senior roles so I wasn't at big board meetings and big meetings, so in the past I might have sat round the board with those.

But for everybody in the room there, there was eight Consultants and seven senior members of the exec -- six senior members the executive team, plus the chairman of the board. So it was a -- it was a fairly serious meeting.

Q. If we go to page 4, you are discussing the RCPCH instruction or potential instruction and you -- look next to your name Jim McCormack:

"Do they know about nurse concern?"

A. Which page is that?

Q. Can you see that?

LADY JUSTICE THIRLWALL: It's on page 4.

MS LANGDALE: Page 4. It's on the screen at the bottom, in the last few --

A. Can you make it a bit bigger?

Q. You see the handwriting? Here we are.

"Do they know about ..."

A. Yes, I do, yeah --

Q. So you're raising --

A. -- and I remember asking this because I wasn't really that supportive of them doing the external review because of what Ravi and Steve had said about their concern about harm, and I thought that we -- even though I -- it was only very recently I'd thought of it, I thought that this wasn't going to address the

intentional harm.

The expertise of the Royal College of Physicians I understood, having had previous obstetric reviews, it was all about manpower and about your guidelines and about how you address risk. It -- it wasn't going, I didn't think, to give us information that was going to help us address the issue of intentional harm, and that's why I asked them:

"Do they know about the nurse concern?"

And he said quite clearly, "Yes, the issues have been highlighted and including the nurse issue."

Q. And then you say -- carry on with what you say then. See the --

A. I then said at that stage I don't think it's fair to ask the college to do a forensic -- I didn't use the word "forensic", I think he -- Stephen Cross has put that in. But I would have said I don't think it's fair to ask the college to do this review and I meant that in relation to the nurse issue, because I couldn't see how they could address that in another review. And I knew from the two reviews we'd done, albeit they can be criticised for various things, that there was certainly no concern in relation to natural deaths with the two reviews, and I couldn't see the college being able to address that. And I specifically had in mind that this

was something that was in the realms of the police would be able to do a better investigation, and that's what I was -- that's what I was saying at that stage.

LADY JUSTICE THIRLWALL: Sorry, Dr McCormack, just to be clear, so what appears beneath the yellow, that's all what you were saying?

A. That's all what I was saying, yes.

LADY JUSTICE THIRLWALL: Thank you.

MS LANGDALE: And if we go to page 5 at the top of it, that's presumably SPC, Stephen Cross:

"Outline and police action."

A. Yes.

Q. Can you remember what Mr Cross said about that, about police?

A. That was the -- that was the surprising thing because -- and everybody spoke forcefully at the meeting, like Steve and Ravi spoke forcefully about their issues, and Stephen Cross made it absolutely clear that it would be the end of the unit, there would be black and white tape up everywhere and gave a very unwelcome tone to the suggestion that the police should be involved?

Q. When you say black and white tape everywhere, what did you mean by --

A. Sorry, blue and white.

Q. Blue and white?

A. Yes. You know they way you get the blue and white tape. His -- his quotation, not mine, blue and white tape round the wards. And in fact to stand up for the police, their investigation when they suddenly arrived they were very accommodating, you wouldn't have known they were there, and entirely unobtrusive.

Q. But he was saying blue and white tape everywhere, what, that it would be disruptive to the unit, close the unit, be a problem, what was the inference did you take from whatever he was saying?

A. I took that it would become a crime scene and that there would be blue and white tape all around and that it would be the end of the unit. Like, those were the -- his remarks, and it wasn't so much the content of the remarks but for us to be talking about the need for a police investigation and contact the police to address a specific issue it didn't seem a very supportive remark to address that particular issue of intentional harm, because that had been brought up by both Ravi -- sorry, by both Dr Jayaram and Dr Brearey and, at that time, no one, except myself, had said, "Look, this is something that the Royal College of physicians will not address and it's something that is a police expertise."

Q. And then you say:

"Women around the country are not stupid, choice ..."

And then what did you say after that?

A. Well, that was in relation to the unintended consequences. I'm not -- my recollection of exactly what it was -- but I was saying that, look, police, no police you know if -- if you're talking now, women are very educated as regarding their pregnancies and they will choose their unit depending as they -- as they see, and if there's increasing deaths with no intervention they will move to another unit. If the police are brought in and they've concerns of that they'll also move to another unit.

It had no bearing on the need that we required, in my opinion, at that stage if the two Consultant paediatricians had grave concern and I think this is the first time at the meeting that they actually openly declared it that I was aware of, and I just thought that it looked very like, in my interpretation, that the only resolution at that time was police to address that issue.

Q. That can go down now, please.

Then can we go to 0014605, page 31. While we are finding that, Mr McCormack, whilst that was the only time you say you heard them openly say that in those

terms, and you say earlier that day you used the term "murderer", that's not to say they weren't raising concerns for some time that someone would be deliberately -- could be deliberately harming.

A. I would agree with that.

Q. Because it's very easy, isn't it, to say the concerns weren't expressed loudly or clearly enough in the terms that you raised in the meeting on the 30th, but the concerns were still there, weren't they, and still evidenced by the sudden and unexpected deaths repeatedly that were occurring, and deteriorations?

A. Yes, and -- and we've discussed that a couple of times.

Q. Yes. If we go to this page, this is your interview with the RCPCH I think because it says at the top "Three midwives, Jim and Sarah." And it looks, and it's just for clarification for the record:

"Detailed second report. All cases have been OSR. Went through all the cases together looking at them."

It looks like you're talking about the Head of Midwifery or someone is that Brigham review that you'd gone through, stillbirths and neonatal deaths, yes, that told them that that review had been conducted?

A. Yes, I think so.

Q. You don't have much recollection of it. Do

you know if somebody interrogated that a little bit further, as I have today, about what it represented and did and did not do?

A. My recollection of the meeting was it wasn't really -- there wasn't any persistent questioning or confirmation in relation to anything that was said, but if you hadn't sent me that copy of the written text, I would have no recollection whatsoever of what was discussed.

Q. So not memorable at all, from your perspective, in terms of trying to find out what was happening with --

A. No, and that would reflect what I said previously about the nature of a college review. They weren't there to investigate deaths. They were there to undertake a review.

Q. Looking at the governance structure that was in place at the hospital at the time, Dr McCormack, how do you say concerns about a staff member should have been reported and addressed through the governance structure that you had there? The document can come down, thank you.

A. Well, I did discuss that slightly earlier with you in relation to the members of staff at the governance board. The governance board had senior

obstetric, gyaeny, paediatric staff, and when there was an issue on the board, the particular staff that that related to and their expertise related to would have clearly discussed that, and that's what I was saying to you in relation to the governance board and the paediatric. At no stage did -- was any concerns shared directly at the board.

Now, I don't know why that was, but, you know, it may well have been that he considered this the incident so sensitive in relation to the staff involved that that wasn't a discussion. You'll have to enquire why that was. But certainly I got the -- I got the impression -- and don't forget, everybody at the board had no knowledge still of the talk of intentional harm and concern in that regard.

So the only people coming to the meeting who would have access to that information were the head of -- the nursing head of paediatrics, the lead, Dr Jayaram, or I think once Dr Brearey came. And, as you said previously, they were beavering industriously elsewhere to ensure that the Senior Executives understood there was an issue with intentional harm. But that wasn't the nature of their conversations at the governance board.

Q. Were you aware of the case of Beverley Allitt at that time?

A. Oh, absolutely. I was 23 years a Consultant. And, you know, that -- that would have been something that all of us at that time would have been -- would have been shocked about.

Q. So as those cases were repeating themselves, Baby A, Baby C, Baby D, E, I and then the deaths of the triplets, O, P, never mind the deteriorations in between, and there were a number, were you thinking for yourself, whatever they said "We could have somebody here intentionally harming or killing these babies?" Irrespective of what they -- how they articulated their concerns to you, just the numbers and the patients that you'd seen who were --

A. And, again, we've discussed that previously in relation to at what stage you arrive and consider, look, this does look to be something very abnormal, and should we be considering intentional harm? And I assume there must be a threshold by which -- by which that -- that actually happens.

And I have to be honest with you and say I didn't reach that threshold until June 16 with -- with, as I have discussed, the triplets and then the subsequent visit of the paeds and then the subsequent visit with the board, and, you know --

Q. Do you think you should have reached that

earlier -- do you think you should have reached that earlier looking back and listening to what people were saying?

A. But I -- I think -- you know, I used to do perinatal meetings and there was a chain of events in labour ward and you would have discussed it, and it was very easy when you look back and you say, "Well, why didn't we make that decision?" And -- and I think the same is very valid of this. Like, if you think of there has only been four deaths as a result of Beverley Allitt, and we've 7,500 deliveries a year since that time, and I think that the -- the realisation of intentional harm is something I think very, very difficult to grasp. And, you know, I still -- when I heard -- read John Gibbs's statement and he was ashamed of his -- that they hadn't -- I think any of the clinicians involved have a feeling of shame that in some way that they couldn't actually have prevented that.

Q. You tell us in reflections that medical examiners and their introduction would assist with this and provide independent scrutiny of deaths not referred to the Coroner, is that your view, that the --

A. I -- I have no experience of medical examiners. They've only actually been brought in now in the last -- I think they were only appointed '23/'24 but

my suggestion was that this is an office within your own hospital that has expertise about deaths and would easily facilitate this type of discussion. In other words, you could go confidentially and talk to someone and it would give you the ability then to -- to source the place or Coroners or whatever it was, and I just thought that it's a role I would have thought should be emphasised greatly.

And -- and even as far as education, if you talk about Beverley Allitt and then Chua, and then Norris, and all these guys, you know I have never seen in my 23 years an educational meeting where someone comes in and just reminds us of these things. And, like, Chua was, what, he sentenced the same year and still we're not aware of that. And from the medical examiners they have that great ability now I think maybe as part of an education to raise it, even though I've mentioned extremely rare, and that would be a role I think could easily be highlighted.

Q. You also say:

"I think it is necessary to have established links with the police and Trust Executives to permit discussion at any time to assess the need for police involvement or investigation."

Do you think being at that meeting there just

wasn't enough awareness of how to contact the police?

A. I don't think there was enough awareness to contact the police. I'm not sure whether it was self-belief that this isn't happening or -- or what exactly it was, and you'll get the opportunity to ask them. But my point was -- and I have to apologise, I hadn't realised there was a memorandum of understanding already in some existence of contact the police (inaudible) and I hadn't actually realised, because I've nothing to do with the child death overview reviews, I hadn't exactly realised there was contactable police there as well.

But I did think that for this sort of scenario, where one of the senior execs to be able to speak to a senior police officer in confidence and say, "Look, we have a genuine concern here in the hospital. Our two paediatricians have grave concern of intentional harm. There is no evidence whatsoever to support that. Look, can I have a chat with you?" And I thought that could have been -- like, even after a meeting I had in a board on 30 June, I thought that was a discussion that should have been available at that time without leaving it to much, much later.

MS LANGDALE: Thank you, those are all my questions. Thank you, Dr McCormack.

A. Thank you.

MS LANGDALE: Does my Lady have any questions?

LADY JUSTICE THIRLWALL: I have no questions, thank you very much. No questions from anyone else.

Dr McCormack, thank you very much indeed and for sitting a bit later, that concludes your evidence and you are free to switch off.

A. Thank you very much, my Lady.

MS LANGDALE: My Lady, can we resume at 12.05.

LADY JUSTICE THIRLWALL: Yes, so we will adjourn until five past 12.

(11.47 am)

(A short break)

(12.06 pm)

LADY JUSTICE THIRLWALL: Mr De La Poer.

MR DE LA POER: My Lady, thank you, our next witness is Dr McGuigan and I wonder if you might step forward, please.

LADY JUSTICE THIRLWALL: Dr McGuigan, would you like to come up to the desk, please.

DR MICHAEL MCGUIGAN (affirmed)

Thank you, Dr McGuigan, please sit down.

Questions by MR DE LA POER

MR DE LA POER: Please could you give us your full

name.
A. It's Michael Patrick McGuigan.
Q. And, Dr McGuigan, can you confirm, please, that you provided the Inquiry with a statement dated 30 May 2024?
A. That's correct.
Q. And are the contents of that statement true to the best of your knowledge and belief?
A. They are.
Q. Did you qualify as a doctor in 2002?
A. Yes.
Q. And you became a member of the RCPCH in 2005; is that correct?
A. That's correct.
Q. Since 2004, have you worked exclusively in paediatrics and neonatology?
A. That's correct.
Q. Did you become a Consultant in paediatrics in 2012?
A. Correct.
Q. And did you initially work as a Consultant in Crewe in paediatrics and neonates?
A. That's correct.
Q. In June of 2016, did you apply from a job at the Countess of Chester?

A. Yes.
Q. And did that job begin on 9 January 2017?
A. It did.
Q. Finally, just to complete the overview of your career, in December 2018, did you become the clinical lead for the paediatric department at the Countess of Chester?
A. I did.
Q. And was that in effect taking over from Dr Jayaram?
A. Yes.
Q. And did you continue in that position until December 2023?
A. Yes. Yes.
Q. So we're going to begin the substance of my questions, Dr McGuigan, by just dealing with your understanding of ordinary medical practice in paediatrics before you arrived at the Countess of Chester.
Firstly, what was your understanding of the purpose of debriefs?
A. Debriefs were often conducted after there had been either a difficult resuscitation or an unexpected -- or resuscitations that had ended in a death there would usually be a hot debrief, as in

immediately -- as soon as possible in the half hour/hour or so after the event, a meeting of the doctors, nursing staff who were involved in the resuscitation, and sometimes a cold debrief a few days later to discuss sort of after the events.
The purposes of those debriefs, in my mind at that time, were two-fold. The first was to support the staff who had been involved. For example, a staff member may leave a resuscitation thinking because I didn't do this at this time this is why the patient died, an opportunity for people to raise concerns and potentially correct things that needed correcting for people. So immediate staff support. And then also giving staff an opportunity to share any immediate feedback or learning from the process of the resuscitation, perhaps a piece of equipment wasn't as handy as it could have been or something else would have been helpful, you know, whether there's any immediate learning from the resuscitation that's taken place.
Q. At the start of your explanation for debriefs, you said -- and here we're talking about before you got to the Countess -- that these debriefs would occur when there was a death but also when there was a collapse leading to resuscitation which didn't ultimately and happily end in death. Was that uniformly the case at

Crewe or did it depend upon the person who was leading the resuscitation effort, or were there some other factors that governed whether a debrief would take place?
A. Yes, I don't there was any policy on it, so it was always a decision by the person leading the team based on the severity of the resuscitation. Certainly if there was a cardiac arrest as part of the resuscitation I think it would be usual for some kind of debrief to take place afterwards.
Q. And when you got to the Countess of Chester, did you find that in those early months their approach to debriefs was the same as you had experienced at Crewe or was there a difference?
A. Yes, I don't think I ever particularly remembered when I was rotating round as a junior doctor different hospitals having a different approach to debriefs or having any formal policy about debriefs. I think practice was probably fairly similar from place to place.
I don't remember if there are any debriefs in those first few months, but I don't remember the practice being different to where I'd worked previously.
Q. When you were in Crewe, did the hospital you were working at use the Datix system?

A. They did.

Q. And before you got to the Countess, what was your understanding about the circumstances in which a Datix form should be created?

A. I think my understanding was that a Datix form was usually being completed when an incident happened where there could be learning so, for example, if a mistake had been made, if a drug error had been made. I don't remember it being routine to Datix, for example, that there had been a collapse or even necessarily that every death would be Datixed at the time.

It's really hard thinking back, you know, because it is quite a long time ago, but that would be my recollection was that -- and that's changed a lot in the years since but my recollection at the time was it wouldn't be routine necessarily to Datix a death or a sudden collapse in the way that it would be now.

Q. When you got to the Countess of Chester in those early months, did you find that the approach of the paediatric department was the same as that which you had previously experienced in relation to Datix or were there differences?

A. I think there were inevitable differences because of the situation that they were in, that they were investigating a number of unexplained deaths and

collapses and, therefore, the expectation in how we would respond particularly if there was an unexpected event on the neonatal unit was different by that point.

Q. So you think the policy that you were met by had been influenced by the events of the previous months?

A. Yes.

Q. You mentioned that the procedure has changed since the circumstances you experienced at Crewe. Is it now your understanding that Datixes would always be created in relation to a sudden unexpected collapse that does not end in death but for which there is no immediate or obvious explanation?

A. Our practice now would be any significant deterioration in a patient's condition that led to them needing intensive level care of support would be Datixed, and that would be on our children's unit as well, so any child, even if there were no concerns about the care, who needed to go to intensive care at Alder Hey we would Datix that and we would review all those incidents.

Q. And do you regard that as an improvement to the system or is it overly burdensome and impractical?

A. I think it's an improvement to the system. The problem sometimes can be that if you -- people might

not necessarily perceive there was a problem with the care but once there's opportunity to review the care in more detail in the cold light of day that there might be useful learning that comes out of that, so I think it's a good change of practice, and I think it reflected a big change in general in how we've approached these things over the last few years. We didn't have HSSIB investigating neonatal deaths and brain injuries at that time.

I don't think we had the perinatal mortality tool at that time, or it had been recently introduced, so there's been a lot of changes in how we approach child death particularly in neonates over the last few years.

Q. The sudden unexpected death in infancy and childhood protocol, and here I'm speaking about something the Inquiry has heard quite a lot about, namely the convening of a Joint Agency Response or a multi-agency reaction where local authority and police will be involved very quickly, so that SUDiC process, when you were at Crewe, did you follow that SUDiC process in relation to sudden unexpected deaths on the neonatal unit?

A. I've thought a lot about this in preparing for my evidence. I can't think of an example anywhere that I've worked where there's been a sudden unexpected death

of an inpatient that's led to a Joint Agency Response.

Q. And so that we understand the geography of where you've worked, has that largely been confined to the north-west or is this -- has your career spanned more areas than that?

A. That was in London and Bristol as a junior doctor, SHO level, and in the north-west since middle grade Registrar level.

Q. And we know that Working Together was published or republished in 2015, and that's the version that we have been looking at closely. Your career since 2015, has that been confined to the north-west or --

A. Yes.

Q. It has been?

A. Yes. Yes. And when I thought about it preparing for this evidence, I remember attending training as a Registrar -- a full day of training in managing sudden unexpected death in childhood and it being made clear in that training that if you had an unexpected unexplained death in hospital that the same rules would apply in terms of activating a Joint Agency Response.

But I think it probably reflects that sudden unexpected -- well, certainly sudden unexplained death in hospital patients is not a common event, so it's

probably not something that would be activated very often. But I can't recall a time when that has been activated in that situation.

Q. And, finally in terms of your experience, before you got to the Countess of Chester, had you ever previously encountered a situation in which there was concern raised about a particular staff member, whether doing harm deliberately or inadvertently, so where there was a concern about an individual, I'm not asking you to name them, but had you encountered that before you got to the Countess of Chester?

A. No, I can't recall any -- any.

Q. So this question is very much a hypothetical in those circumstances. If there was concern about a particular individual, what is your view about whether or not, whether anonymously or by name, that -- a standard governance meeting should be discussing that issue?

I can put that in a different way, if you like, that is the standard governance structure equipped for discussing a concern like that about a particular person or should there be a separate route by which that person is discussed and the risk is managed?

A. I think my answer to that would be that within a governance meeting there's lots of people with

different roles. There might be an audit lead there, there might be -- you know, there might be a variety of people there and that a sensitive investigation like that might not be appropriate to be discussed within a governance meeting setting and might be discussed separately. If that happened and I was leading that governance meeting, I certainly would be thinking about whether in some way it needs to be acknowledged that this process was going on.

But I would be mindful of -- of having a fair process for the individual concerned and the confidentiality issues with that against the need for that to be -- have the oversight of the governance committee.

Q. So are you perhaps, and you tell me, envisaging a hybrid situation where the detail of it isn't discussed at the governance meeting but the fact that such an investigation is taking place might be mentioned and minuted so that at the governance level, whichever tier that is of the hospital, a track can be kept of the fact that that is occurring?

A. Yes, and I guess it depends on what the level of concern is. You know, I'm trying to think back whether it's hypothetical or not, there must be circumstances where there's concerns about how a staff

member is performing in some way. But, yes, I -- I can't see that it would be usual practice for that to come through a governance board meeting.

Q. So does it follow from that that if you don't think that that is the appropriate route, that it is extremely important that there is a clearly designated route by which those concerns can be investigated, monitored and progressed?

A. Yes.

Q. And looking back to your time at Crewe, were you aware of any such route existing at Crewe?

A. No, I think -- I suspect there may have been a route but -- and I suspect -- you know, I was a relatively junior Consultant at the time -- that if I'd spoken to people in more senior positions that there would be a route for progressing that but I wasn't familiar with it.

Q. So we're just going to move chronology logically through your experience of the Countess of Chester and in fact events begin for you before you arrive in January of 2017. You applied in June of 2016; is that right?

A. Correct.

Q. And the Inquiry has received evidence that there was a press release by the Countess of Chester in

early July of 2016 about the downgrading of the unit and, given that that was a place that you wished to work, did you become aware of that press release?

A. Yes, my memory is that it was made between the job being advertised and my application being completed.

Q. And was it drawn to your attention by those that you had applied to, ie the Countess said, "You should be aware of this", or did you just see it in the press or --

A. Not by the Countess but because there was a change in designation of the unit that was communicated around all the local hospitals so that we were aware of that. So I knew it through -- through the Neonatal Network rather than directly from Chester.

After I'd applied for the job, Dr Jayaram then contacted me to say, "There's been developments here and I think you need to come and speak to us before you come to your interview to understand a bits more what's happening."

Q. So we'll come to that now. You describe this as a pre-visit --

A. Yes.

Q. -- where you met with Dr Jayaram, and was that at the Countess?

A. It would have been, yes.

Q. And was that meeting such that you just went straight into a room and talked to Dr Jayaram or did you gather any feel for the unit as you walked through?

A. Yes, so --

Q. How much information did you gain from that first meeting outside of what Dr Jayaram told you?

A. Yes, so the usual process of applying for a Consultant -- substantive Consultant job would be that you would meet a number of members of the organisation. One of the nursing leads took me on a tour of the estate and the paediatric and neonatal units, so I spoke to a number of different people as part of my pre-interview visits. But in particular Dr Jayaram had asked me to make an appointment to speak to him because he wanted to give more information on what was happening with the neonatal unit.

Q. What was your impression outside of what Dr Jayaram told you in August or July of 2016 of what sort of place it was to work and how it was functioning and how people's morale appeared?

A. Yes, the people I met were nice. They seemed to have good relationships with each other. I knew some of the people who worked there who liked the teams that they worked with. Lots of our junior doctors will have come from Crewe who've rotated from Chester in

a previous and said good things about it and that it was a God place to work. So I -- yeah, I had a good impression of the department, which was partly the reason I decided to continue with my application there.

Q. Did anyone other than Dr Jayaram tell you about events of the recent months or anything about why the unit had been downgraded?

A. Gosh, I don't remember. I don't remember.

Q. Tell us, please, what Dr Jayaram told you in that pre-visit meeting with him.

A. I can't remember what I said in my statement. I don't remember --

Q. Paragraph 8 if you wish to remind yourself.

A. Yeah, what I've said there -- what I remember is that is those facts that there had been a spike in mortality, that there had been a Royal College review commissioned, that they'd downgraded their status of the unit while investigations were taking place, and presumably with an intention of dealing with those issues and getting back up to Level 2 status again.

Q. And, as you've told us, you continued with your application following that pre-visit.

A. (Nods).

Q. Is that because you were comfortable with what you were told?

A. Yes, that's right. Yes.

Q. Now, we're going to come in a moment to what you were told when you were appointed and turned up for your first few weeks of work. But what I would like to just deal with first had, please, is your impression at the very earliest stage of your arrival in January of 2017, because I think it wasn't immediately that you were told about more detail of the concerns; is that right?

A. I think it was in the first week that I started that Dr Jayaram came to speak to me to give me more detail about what the concerns were and where they were up to at that point.

Q. Well, doing the best you can to disentangle things in terms of when you did and didn't know things --

A. Yes.

Q. -- before you were told about those very serious matters, what was your impression of the department that you walked into fresh?

A. It felt very similar to where I'd come from in Crewe. Like I said, the junior doctors rotate around and my understanding of Chester was it was a unit that had a good reputation, that it was good for training, the trainees liked going there, it was a popular place

to work, that the trainees who went there felt supported by the team they worked with, and it was a good unit to work in, and that's, you know, what I found when I started and started working on the wards and going to handovers.

Q. And so does it follow if that that you didn't detect from your interactions with various people before you were told more about the concerns that there was any dysfunctioning within any of the relationships?

A. No, I -- I would have met Mr Chambers and Mr Harvey as part of my pre-interview visits. As far as I remember, Mr Harvey was on the appointments panel for my interview. You know, a conversation, 20 minutes, they seemed like nice people and, you know, I -- I had a good impression of the place I was coming to work in.

Q. Did either of them tell you anything about what was -- what you now know was going on in the background at the time that you met them?

A. I don't remember what we discussed.

Q. If you just think -- think back, do you think it would have stood out in your recollection, as it has for Dr Jayaram, that you were given some information about the challenges the hospital was facing at that time?

A. I don't remember. Mr Harvey we met in the

coffee area of the education centre with all the candidates that were interviewing that day, so certainly I don't think we would have discussed anything like that.

Mr Chambers I met on his own. My memory of talking to him was talking about where things were likely to go with paediatrics and health in that part of the world over the next few years, thoughts about how Chester and Arrowe might work more closely together, and I don't remember discussing the neonatal issue with him.

Q. Knowing what you do now, do you think that was something he should have talked to you about even in the oblique terms that Dr Jayaram had?

A. I don't know. I obviously walked into a very difficult position -- situation that I didn't appreciate I was walking into. It was also an evolving situation. There was lots of confidential issues in there. I think I can understand why I was only given limited information at that point.

I think I would have liked to have understood the difficulty of the relationship between the paediatric Consultants and the execs at that point, but I think that had deteriorated a lot more between July/August and then when I started in January.

Q. What you tell us in your statement was that

you observed good relationships between the clinicians and managers at the ward level --

A. Yes.

Q. -- in the department, and that you found the Consultants to be supportive of each other.

A. Yes.

Q. You also say that what you discovered upon arrival was that outside of the department those relationships were strained.

A. Yes. So there's various levels of management, but -- that their relationships with the higher level management, ie the executive level management, was very strained at that point.

Q. And was that something simply that you were told or, as perhaps we shall see, was that something you observed for yourself as events unfolded?

A. I don't remember. I think -- I think it probably became clear to me at that meeting at the end of January I attended in the third week of working at the Countess of Chester.

Q. And you said that it was very different to your experience at Crewe in terms of that interaction between those outside the department at managerial level and the department.

A. I guess I hadn't really had time to settle in

and -- and see what the normal relationships would be like. My experience at Crewe was very good in that both the Chief Executive and the Medical Director had invited me to meet them in my first two or three months in the post and welcomed me and got to know me a little bit.

I obviously arrived here and by the third week we had this very difficult meeting. So I walked into a very difficult situation.

Q. Again, we're going to look at the detail of this, but just dealing with your summary of the position. At your paragraph 61 -- you don't need it turn it up unless you want to -- you observe that the Consultants could have given up. Was it your perception over the course of those early months that the Consultants' concerns could have resulted in them simply stopping raising problems?

A. They certainly could have done, but I never saw any intention that they were going to stop until they were satisfied that the issues they were concerned about had been addressed.

Q. In terms of the quality of the care on the neonatal unit that you observed -- again, you deal with this in your witness statement -- but just describe for us in your own words what you thought of that?

A. Yes. So what I was able to witness working

there was working on the neonatal unit seeing the policies and practices they had in place, seeing the expertise of the nurses who were looking after the patients talking to me about what was happening with the patients, hearing the other Consultants talking about patients at handovers and how they were managing the patients. And, as far as I could see, the care was excellent quality. I agreed with the clinical decisions that my Consultant colleagues were making on the patients, and I didn't -- I felt like I was working in a place where the doctors and nurses knew what they were doing and providing a good level of care.

Q. Just dealing with the governance arrangements and matters of management and the divisions. Again, this is something you deal with in your witness statement, we can turn it up if needed, but what was your view, having walked in to the situation that you did, about the divisional structure that the hospital was operating, in other words the fact that paediatrics was in Urgent Care whereas obstetrics was in Planned Care?

A. Yes. I don't think you see that as much when you are not in a clinical lead role within a department. But certainly I was quite surprised at the way it was divided. And clearly we've heard from Dr McCormack this

morning, the paediatricians' and the obstetricians' offices are very close, the neonatal labour ward was close. So there was lots of interaction between the two. But it did concern me that the governance structure and the divisional structures were -- were so separate --

Q. And --

A. -- and I hadn't seen that anywhere else I had worked.

Q. Was it under your clinical lead position that the divisional structure changed to what it is now or did what change before you took over that role?

A. Yes. So over the year after I started probably in 2018, there was a decision to bring women and children's back together as a single directorate within one division. So we were in the Planned Care division, which included all the surgical services, women and children's became a separate directorate with its own directorate management within that division, and then in the last year we have separated out and become our own women and children's division separate from any of the other divisions in the Trust.

LADY JUSTICE THIRLWALL: I'm sorry, Mr De La Poer, does that mean you have a seat at the board table, as it were?

A. Yes, so that means that the women and children's division is run by a triumvirate of nursing manager, which is the Director of Midwifery, the Medical Manager, which is the Clinical Director for the division, and a divisional manager and that those three people then speak directly to the execs as their immediate managers above them.

LADY JUSTICE THIRLWALL: Thank you.

MR DE LA POER: And is that a change for the better?

A. Yes, very -- it very much feels that way. And I think it's easy in any organisation for which predominantly deals with adults, you know, often is starting its morning with 30 patients in A&E corridors, lots of busy wards and trying to keep operating lists going, it's potentially very easy for the needs of the smaller patients to be lost within that, and certainly I think that being in a separate women and children's division again just gives the -- it just gives a bigger voice and easier to make sure that that voice is heard.

Q. You say in your witness statement that the governance support in place at the time, meaning when you arrived:

"... struck me as minimal and insufficient."

Please could you just tell us what you mean by

that?

A. Yes, that was perhaps from listening to the people that I was working with, you know, who perhaps had those risk lead roles at that time and if a significant incident occurs and you want to have an investigation it takes a lot of time to do that investigation. Somebody needs to prepare the timeline, to get the statements, to bring all the information together. Often these things can be 30, 40, 50 pages long, and it takes a lot of time, and without the personnel to be able to do that, you can't have that rigorous analysis of the events, and from what I understood, the amount of support they had from people to do that at governance level wasn't there.

And I think we've heard from other people that, and this is what I was aware, that sort of the Consultants were basically finding time to do that outside of their normal working hours to try and process -- and so many significant events had happened in such a short space of time -- trying to process that.

Q. So where was there a lack? Was it in the paediatric department or was it in the risk department supporting --

A. Yes, so my understanding was particularly the risk -- midwife risk nurses who would support with that

process were lacking.

I think as well within job plans, you know, Dr Brearley was the neonatal lead but also took the responsibility for the neonatal risk. The plan had been, and what ultimately came when the Consultant after me was appointed, was that a second Consultant took on, you know, a PA a week to be the neonatal risk lead and took that role separate from the neonatal lead.

So that led us to a place where we had -- and ultimately we've got more midwife nursing risk support from the risk team, but also more time within the Consultant job plans to have the time to look at neonatal risk and assess it properly.

LADY JUSTICE THIRLWALL: So when you talk about a job plan, that's a sort of -- is it how many hours you spend on what?

A. Yes. So a job plan, yes, would be how many hours have you got in a week to work.

LADY JUSTICE THIRLWALL: Yes.

A. And what do you spend that time doing. If your time is full of clinics and clinical work, but you also need time to do other things like being a clinical lead role or working in neonatal risk, for example.

LADY JUSTICE THIRLWALL: Thank you.

MR DE LA POER: So now, is this right, there are

two people effectively doing the job that Dr Brearey was doing during this period?

A. Yes. Yes. They don't spend their full time doing that, you know, but sort of two people doing -- or the work has been split between two people with one taking a lead perhaps on service development and neonatal standards and that sort of thing and one taking a lead on term admissions, incidents, Datixes, reviewing all of those things to make sure that that's being managed correctly.

Q. Finally, before we come to what you were told when you arrived and what then transpired, you say that:

"Management within the division at the time also struck me as lean."

Again, can you just tell us what you mean by that?

A. Yes. What I mean is that there weren't many managers within the directorate, and managers have an important role in getting things done correctly. And then when we faced challenges, that's when you particularly see that. The challenge they were facing in 2015/2016 was a spike in neonatal deaths and trying to understand what was causing that. In 2020 it was Covid. In 2021 it was our transition to a new electronic patient record. And each time when the situation is stressed when you lack that management

support you particularly feel it.

There's been a general sort of expectation in terms of managers, so all units now are expected to have a director of midwifery, which we didn't have before, so that's a senior, you know, midwife who is the nursing lead for our division. We had a Matron for paediatric nursing but we now also have above her a lead nurse for paediatric and neonatal nursing.

And, again, I see a huge difference in -- you know, the Matron trying to do that whole job by herself was just overwhelmed, they didn't have the time to do all the things that needed doing with in terms of whether that might be service development or responding to incidents and risks, and both the Director of Midwifery and the Head of Paediatric Nursing would have significant roles in the risk and governance management within the department.

Q. And just so that we understand which of the people that we are very familiar with you're talking about, when you refer to the Matron, are you talking about the role that Ann Murphy was doing at the time?

A. Yes. So we still have a Matron, which is the role Ann Murphy was doing at the time, but above her we now have a Head of Paediatric and Neonatal Nursing who has a more senior role.

Q. So we come now to the point in your first week when you are told more about what the problems had been.

A. Yes.

Q. Just in your own words, what information were you given and by whom?

A. Yes. So my memory is that in that first week Dr Jayaram wanted to speak to me and explain the situation in that not only had there been a spike in neonatal deaths, but a number of the deaths were unexplained and unexpected, that there were a number of features of those deaths which had raised concern, for example this pattern of recurrent mottling and rashes on the skin which they'd not seen before and that there -- that he'd come across some evidence that that potentially might be linked with air embolisms.

My memory of how he explained it to me was that they had come to recognise that the unexplained collapses and deaths were all occurring when one member of staff was on shift and that that member of staff had been moved from working days and night shifts to only working on day shifts, at which point the collapses at night had stopped, and they'd only been happening during the daytime and, therefore, they'd reached a concern that between the unexpected nature and the recurrence of this individual associated with them that there might be

somebody deliberately causing patient harm.

It was then explained to me that the way the Trust had decided to approach it is they wanted to make sure that there wasn't any systemic problems in how the neonatal department was practising before, you know -- I think his words might have even been, "Make sure there's no problems in our own backyard" before sort of looking at that and, therefore, they'd commissioned the Royal College review, and that had led on to an external Casenote Review and that the reports from those two were due back imminently to then sort of work out how we would proceed next with this concern that somebody might have been deliberately harming patients and that that person had been moved out of clinical practice while those investigations were taking place.

Q. Now, you were interviewed by Facere Melius, the organisation, and what you told them was that you had been a Consultant in Crewe and you couldn't remember a single baby who had suddenly and unexpectedly deteriorated and died, do you recall saying that to them?

A. Yes. And in 2017 I think I put that in my email as well. I -- I thought that what they were -- what Ravi was describing to me in that meeting that first week was very unusual and I could think of babies

becoming sick maybe sort of having a sudden collapse, having some resuscitation which they responded to, continuing to deteriorate, perhaps transferring out to a Level 3 unit, continuing to deteriorate and dying.

But I couldn't think of a time where a baby had suddenly collapsed and died out of the blue. And they were describing this happening on a repeated frequent basis over that year period of time. So it struck me as very unusual what was being described to me.

Q. The phrase you use in your witness statement "extremely concerning". Does that represent your state of mind at that time?

A. Very much so, yes.

Q. Having had this described to you, one professional to another, did you think this doesn't sound like a problem, or did you think that the Consultants might be thinking along the right lines?

A. Yes. Certainly, you know, with full awareness of what had happened in Stockport, full awareness of Beverley Allitt, that combination of repeated sudden unexpected unexplained collapses and deaths associated with one member of staff being on duty certainly I was immediately concerned that that needed to be appropriately investigated to ensure that somebody wasn't deliberately harming patients, and perhaps was on

the understanding that those investigations were in progress through the Casenote Review and the Royal College review.

Q. What was your view, in that first conversation when all this information was given to you, about whether the RCPCH were an appropriate body to be investigating in these circumstances?

A. Yes, I think it was a lot to take in to be honest. I don't think I got as far as thinking through the Terms of Reference and how they had gone about that.

Q. Was there any discussion between you and Dr Jayaram in that first conversation about whether the police should be involved?

A. I don't remember.

Q. In that first conversation, did you consider that what you were being told was a safeguarding issue or did you think about it in different terms?

A. I think in the way that I'm usually thinking about safeguarding issues it -- it felt different and clearly it was a safeguarding issue. I probably was thinking patient safety rather than safeguarding.

Q. Had you had any safeguarding training about how you might raise concern about a colleague if you thought they might be causing deliberate harm?

A. I've certainly had a lot of safeguarding

training as a paediatric trainee and as a paediatric Consultant. A lot of that would have been relevant to that specifically, you know, as a paediatric Consultant that's about being prepared to think the unthinkable, being prepared to investigate something according to protocols. You know, for example, a baby presenting with a bruise, even if everything else seems in order, that we would still go through the process of investigating that according to protocols because you have to be prepared to think the unthinkable and you can't judge people just by the way they come across to you. You need -- it's based on making sure things are investigated appropriately.

I can't remember if I had any specific safeguarding training on if I was concerned a member of staff might be harming patients. I don't remember. If -- if I had, it was perhaps in relation to thinking about perhaps sexual abuse. I think there had been a paediatrician at that point in the media who had been convicted of sexual abuse on patients at work.

So I must -- I'm sure -- it's hard to recall what training I had had but certainly I think a lot of the generic training we'd had about safeguarding was very applicable to the situation. But I don't know if I would have been fully clear on the best way to raise

concerns in that situation.

Q. I mean, looking back on it now, with the benefit of hindsight, you acknowledge that the principles are equally applicable but your thought was patient safety, not safeguarding, do you think it would have been better to think about it as a safeguarding issue and do you think that's how people should think about this sort of issue should it ever arise in the future in those terms, that this is a safeguarding issue?

A. Yes. I think when people were making their decisions about how to manage and investigate the situation that they are thinking through all of those, there's lots of things they take into account. And in some ways patient safety and safeguarding are the same thing, you're trying to protect children from -- from harm. I guess patient safety we're often thinking about non-deliberate harm rather than deliberate harm.

Yes, I -- yes, I don't know if safeguarding was the word that came to mind.

Q. I suppose one advantage about thinking of it in that way is that there are trained safeguarders within the hospital who you can immediately go and tell who are outside all of the management structures and whose single remit when you raise that with them is to

pursue it relentlessly.
A. Yes, and I think, you know, if there had been an allegation that somebody had, you know, slapped a child or, you know, touched a child inappropriately or anything like that that would be the obvious path to go down. But I can see why perhaps it wasn't the obvious path to go down when people were considering how to investigate this case.
Q. So you have had your initial briefing in situ from Dr Jayaram?
A. Yes.
Q. Was there any more discussion that you had with any of your other colleagues before that meeting on 26 January to better understand the situation that you had walked into?
A. I don't remember. The gap between that conversation, you know, settling into a new place, you know, and all those things and the meeting that happened later that month was so short, I don't remember if I had many more conversations in the meantime.
Q. There came a point when you and your Consultant colleagues were invited to a meeting which we now know took place on 26 January of 2017.
A. Yes.
Q. Why did you go to that meeting?

A. That's a good question. I believe an email came round saying can we try and find a time when as many of the paediatricians are available, Consultants are available as possible and, therefore, I was included in that email when people were asking about availability, and then I was invited to the meeting.
My understanding from having to spoken to Dr Jayaram is that we were waiting for these reports to come back and, therefore, this meeting would be a chance to discuss those reports. So as a Consultant within the department it seemed appropriate to be invited and go along to hear the outcome of the reports on the department.
Q. Now, as best as you can recollect, what was the terms of the invite that you received to that meeting?
A. Yes. As best as I can recall, and my earliest written recollections of -- from two years later when I was giving a statement to the police, but the best that I can recall is that the invitation was unusual in that it wasn't saying, you know, "We want to share these reports with you." It was that you were invited to this meeting.
My memory was that there were words along the lines of it's not a disciplinary matter at this point and you

don't need to bring Union representation or something like that. That just gave me a flavour that this was not quite the meeting I was expecting.
Q. Now, for transparency, Dr McGuigan, I showed you an email this morning and I will just tell everybody what the reference is. I do not want it brought up on screen. That's simply because it hasn't been appropriately redacted, not because there is anything sinister about it. INQ0057567. That's for everybody else so that they know what you have seen.
That's an email that you were a recipient of which started with Ian Harvey asking for dates for the meeting; is that right?
A. Yes, that's right.
Q. Having had a chance to refresh your memory this morning about that, is that the email that you are referring to mentioning, "Not disciplinary, don't bring Union reps"?
A. I don't think that's the email. I think that's an email that's gone via the paediatric secretaries to liaise with the Consultants about a convenient time for the meeting. My memory is a separate email inviting us to the meeting with a confirmed venue and time.
Q. Have you been able to find the email that you

received?
A. No. I -- my email address is an NHS email address and there was quite limited storage, and I presume at some point it's ended up lost and sort of rather than archived. I looked hard for it in 2019, but I wasn't able to find it at that point.
Q. Just so that everybody understands, the Inquiry hasn't yet identified that but you've given us your recollection of what was in it.
You've told us that you were expecting that at the meeting there would be some discussion about the reports that were pending. In your experience, if you were to go to a meeting to discuss a report, would you expect to see the report ahead of the meeting so that you could read it or would you expect that you would simply receive a copy or be told about it for the first time in the meeting?
A. Yes, I think the NHS isn't famous for efficient meetings, but, yes, I would expect that the report would be sent out before the meeting, people can read the report and then come to the meeting to discuss it together.
Q. And did that happen in this case?
A. No.
Q. Were you party to any pre-meeting discussion

between the Consultants about the approach that was going to be taken in the meeting or with any other person who was giving information about what the meeting might contain?

A. I don't remember a pre-meeting. I remember that because we needed to walk over that most of us walked over together and that in the corridor on the way over that there was a discussion that there was a feeling that the execs were after somebody's scalp and that the plan would be that the Consultants wouldn't be speaking up within that meeting for fear that if they spoke up they might be scapegoated in some way and, therefore, we were going to listen to hear what was being said and that we would then come back and speak together before rather than anybody raising questions within the meeting.

Q. The Inquiry has received evidence that a person by the name of Dr David Semple may have given some information ahead of the meeting. Were you aware of that at the time?

A. No.

MR DE LA POER: So -- my Lady, I'm conscious of the time and I'm also conscious that this is an important part of Dr McGuigan's evidence which perhaps best be heard as apiece. I wonder if now would be a convenient

moment just to rise and we will come back after lunch to deal with this.

LADY JUSTICE THIRLWALL: Very well. Dr McGuigan, we are going to rise for a break and would you be back please ready to start at 2 o'clock.

A. Thank you.

LADY JUSTICE THIRLWALL: Thank you.

(12.58 pm)

(The luncheon adjournment)

(2.00 pm)

LADY JUSTICE THIRLWALL: Mr De La Poer.

MR DE LA POER: My Lady, thank you. Dr McGuigan, we had got to the point in your narrative that you were entering a meeting that had been convened on 26 January 2017. And what sort of room did that meeting take place in?

A. I think it was the boardroom, so a room with a long narrow table and everybody sat round the table.

Q. And was everybody dispersed throughout the room or was it doctors on one side, managers on the other, how was it arranged?

A. I was at one end of the long table, Tony Chambers was at the opposite end of that table. A lot of the managers were clustered seated near him, a lot of the paediatricians were clustered seated near

to me, but I think at least one the nursing managers was sat on my side the table.

Q. And what was the atmosphere as you walked in and everybody took their seats?

A. I don't know if I remember that now.

Q. You begin your narrative of this meeting by saying that Ian Harvey provided a summary. Can you just give us a flavour, please, of what Ian Harvey was talking about?

A. So he was giving a summary of the Royal College of Paediatrics Invited Review, which he explained contained 22 recommendations about improvements that could be made to neonatal services and the results of the -- the Hawdon review, the external Casenote Review, which he told us hadn't identified any evidence suggested foul play and that, you know, concluded that the deaths were natural causes.

Can I take the last bit back? I can't remember -- I don't think he said he concluded the deaths were natural causes, but the feedback from the Hawdon report was that there was -- there was nothing concerning that had been revealed from that external Casenote Review.

Q. The way you put it in your statement and you do caveat it by saying, "I don't remember his exact words", was:

"The interpretation was there was no evidence that babies had been deliberately harmed."

A. Yes.

Q. Does that capture it?

A. Yes.

Q. And again doing the best you can, was that delivered in a measured tone from a seated position --

A. Yes, yes.

Q. -- or -- nothing that stood out about the style of that presentation to you?

A. No.

Q. You tell us that the next event was that a statement by Letby was read out. Was that given any introduction by anybody?

A. I think it might have been written by Letby's parents, if my recollection is correct. There was some degree of introduction that there had been a grievance procedure and that this letter would summarise, from Lucy Letby's experiences, the suffering that she'd experienced over the preceding months while she'd been under investigation.

Q. You say in your witness statement of that document the statement was relatively long and very emotive.

A. (Nods).

Q. I would like to bring up a document on screen to see if you recognise the statement that was read out, just to help the Inquiry understand exactly what happened at this meeting INQ0012080. Just ignore the highlights on it, that's the form in which we've received it, and take a moment just to familiarise yourself with the content of it.

(Pause).

It goes on over the page. I mean, you'll have noted that it appears to be addressed -- forgive me, if we could go back -- it appears to be addressed to the doctors, at least inferentially, the highlighted section at the bottom that:

"Analysis tables relating to the mortality rates had columns amended by your team."

A. (Nods). Yes.

Q. If you don't know, you don't know, Dr McGuigan, but does this document ring any bells for you in terms of prompt your memory in terms of what was read out at the meeting?

A. I've not seen this document before. But, yes, that -- that's similar to what I recall was it was an explanation of what Lucy Letby had experienced, what she'd found upsetting and how she felt that -- well, presumably the result of her grievance, why she felt

that she had been treated badly.

Q. And so if not that document itself, then a document of a similar tone?

A. Yes.

Q. Thank you, we can take that down.

After the statement or letter was read out, did Tony Chambers speak?

A. He did.

Q. And you deal with this at paragraphs 18-20 of your witness statement if you want to turn it up, but it may be that you have a recollection sitting there of what he said.

So do you want to just walk us through as best you can remember what he said and how he said it.

A. Yes, when I prepared my statement I looked back at the written statements I'd made in the past, the earliest of which was 2019, which was obviously a lot closer to events than it is now. I recognise that different people have reported different recollections of what was said in that meeting.

I think from my perspective, you know, there's meetings since then that I've been asked about from a year later that I don't remember much about the meetings, but this one was very striking. I'd just arrived in the hospital, you know, I'm three weeks into

the job and I've gone to this -- this rather remarkable meeting, so the events still stand out to me.

My recollection of what Tony Chambers said was that the conclusion of the process was that the reports had been received, they'd identified that there were areas of neonatal care that needed to be addressed, that they'd not -- that the external Casenote Review hadn't found anything of concern, and that while the Consultants weren't wrong to raise concerns that the way it had been carried out was inappropriate and that he had met with Lucy Letby and her parents, had apologised to them, that Lucy Letby would be returning to work on the neonatal unit and the Consultants would be expected to apologise to her before that happened, that they would be accepting the recommendations of the Royal College review and that that would be published on the Trust website in the next few weeks.

Q. And in what tone and from what position in the room did Tony Chambers say that?

A. So my recollection is that he was seated at the other end of the boardroom table from where me and the -- what I remember the other paediatricians were sat at that end of the table as well.

Q. And the tone?

A. The tone was -- my memory of the tone was that

it was a measured tone, that it was serious, stern but not angry or shouting is my recollection.

Q. And have you had an opportunity to consider the typed record of that meeting?

A. Yes. I -- in 2018, we, in communications with the exec, said we'd never seen minutes of that meeting. I first saw minutes of that meeting I think in May 2019, so about two years afterwards when I was interviewed by the police.

Q. So we're just going to bring those records up, INQ0003523, and we'll turn to page 2, please.

Firstly, having considered those nearer the time, do you regard this typed record as broadly reflecting what was said at the meeting?

A. They're fairly brief, aren't they? In some parts, yes, in terms of who spoke and the board -- I didn't recognise some of the things that Dr Jayaram is reported to have said and I disagreed with the recollection of some of the things Mr Chambers said.

Q. Well, let's just look at the latter first. In the middle of this page on page 2, at the end of the largest paragraph in the centre:

"It is recorded he [that is Tony Chambers] said 'Let's be clear that we need to draw a line on the past and it is about how we go forward in the future."

A. (Nods).
Q. Is that a fair and accurate summary of what Tony Chambers said, as far as your recollection is concerned?
A. No, that -- that differs from my recollection.
Q. You used the word "distortion" in your witness statement; is that a fair way of describing it?
A. Yes, the word "line" is in there, but the phrasing has changed a lot from what I recall him saying, and that sounds quite reasonable to say you need to draw a line in the past and think about how we go in the future, but that's not at all what I remember him saying.
Q. Well, tell us best you can what you remember him saying.
A. So my memory is that he -- that he said, "I'm drawing a line under this", and then looked up at us and said, "Do not cross that line."
Q. And in what tone did he say that latter part?
A. In quite a severe, stern tone.
Q. Others have recalled that the table was thumped or struck at some point during Tony Chambers's address to the Consultants, is that a recollection that you have?
A. I don't remember that.

Q. Now, over the particulars of claim I think is the part that you don't recognise in terms of Dr Jayaram. That first sentence:
"Dr Jayaram stated that consideration would have to be given to any poor Consultant performance."
Do you recall him saying that?
A. I -- I don't remember him saying anything along those lines. The only thing I really remember him saying was, "Can we see the report", because it had been made clear at that point the Trust were making the decisions on these reports and that the paediatricians wouldn't be allowed to see them and that the first sight we would have of the Royal College report would be when it was published on the Trust website.
Q. And as somebody who had no investment in what had happened before, what did you make of the suggestion that the Royal College report would be published on the website apparently containing criticisms of the paediatric department before any of the Consultants had seen it?
A. Well, I really wanted to know and what I wished I'd asked in that meeting was, is that report in front of you to say there are serious failings on the neonatal unit and these explain why you have had so many deaths on the neonatal unit, or does that report say

there's -- overall the care looks okay but there's probably some things you could improve and here's some recommendations?
But, you know, I wasn't given the chance to read the -- well, ultimately we did get to see the report before it was released, but ...
Q. But would you expect a report that contains comments upon the running of a department to be published for the world to see before the people it's commenting upon have had a chance to read it?
A. I think this is why the meeting is so shocking, that a report has been received on the neonatal unit and that I'm going to read it when it's published on the Trust website despite being a Consultant in that department. I would expect -- I would expect not just to read it but that the people with expertise in the neonates in the hospital would be expected to help the Trust to understand the content of that report before they made decisions about based on it.
Q. Thank you, we can take that document down.
And so coming out of this meeting, once it had finished, what was your impression of how the situation was being managed by the Executive Directors?
A. Yeah, I came out of the meeting very shocked,

expecting that I was going into a meeting where it was going to really get the answers to what the paediatricians had been wanting to be investigated over the last year, and came away with a feeling that there had been a Royal College review that had made recommendations but, from what I heard, hadn't really identified significant failings on the neonatal unit that explained the spike in mortality in a unit that prior to that had a good reputation, had a low mortality rate and in many ways was quite advanced in some of the aspects of patient safety and care that they had in place, and that -- and just felt that an external Casenote Review wasn't the level of investigation that was needed to be able to exclude somebody harming children. So I left thinking that there's no answers there and this hasn't been investigated in the way that it needs to be investigated.
Q. What did you make of the expectation that the Consultants would apologise and how that had been handled?
A. Well, it was hard because the Consultants' concerns were that somebody may have been harming patients, that they had good reasons to be suspicious that somebody may have been harming patients, and that the person who had fallen under suspicion hadn't

really -- there hadn't been an investigation sufficient to clear that allegation and, therefore, the idea that they would be expected to apologise to her was ridiculous really to apologise whilst still actively concerned that it hadn't been investigated.

Q. Now, there was a meeting on 27 March which you didn't attend. But did you send an email in advance of that meeting setting out what your views were?

A. That's right. There was -- on 27 March, Dr Brearey and Dr Jayaram were meeting with Tony Chambers and Ian Harvey as part of ongoing discussions that the paediatric Consultants were concerned about the level of investigation that had happened. Before they were meeting with the execs, the Consultants were meeting together to have one final discussion about what views they wanted Dr Jayaram and Dr Brearey to say on their behalf at that meeting.

I would normally have been at that meeting but there was a gap on the junior doctor rota the night before, so I stepped in to cover the night shift. So reflecting over that day I decided that I wanted to send an email with my thoughts so that they could be heard within that Consultant meeting the following day and, therefore, potentially reflected on to Tony Chambers and Ian Harvey.

Q. Just by way of a short digression before we get to that email, you were effectively acting down to cover the junior doctor rota. We've heard a bit about that. Was that something that happened not infrequently?

A. Yes, there was sort -- there were times when it was better and there was times when it was worse, it depended on exactly what staffing we had on our current Registrar rota. Registrars come from the deanery and they rotate every six months, so you might have gaps sometimes, not gaps other times. If somebody goes off on long-term sick it is not very easy to get cover in. And there weren't and continue not to be very easy access to paediatric locums at that level to be able to cover the gaps. So it wasn't infrequent that a Consultant had to act down to cover a Registrar gap to ensure that care remained safe in the Trust.

Q. Let's have a look at the email you sent INQ0101093. And if you want to turn up your witness statement, because you devote a substantial portion of your witness statement just to talking about your reasoning. It starts at paragraph 27, and I'm not inviting you to read it out loud, but let's just have a look at the email and you can talk us through what was in your mind and why you framed it as you did. Over the

page, please.

So we can see your email at the top, and so just talk us through it and why you included what you did.

A. Yes. So, firstly, what had been happening on the neonatal unit for that period was very unusual. There was a high number of deaths and collapses. They were a number that were unexplained, unexpected and, you know, it needed an answer of what was going on, whether that was poor care or whether that was an infection that was spreading in the unit or whatever it was it needed an answer.

I'd read by that point the Royal College review, and while there were recommendations on there I didn't see anything that really explained the high number of deaths that we had seen over that period. And points that had been drawn out and highlighted, you know, including in the media at that point, about shortages of staff, shortages of nurses weren't substantially different from other units -- the staffing wasn't different to other units I had worked in substantially.

Some of the -- some of the staffing levels that were being discussed were potentially aspirational targets that a lot of units were looking to sort of whether they could get there over time but weren't at the moment. So I didn't see any significant differences

in the staffing levels that explained the -- the mortality.

And I was -- I'd arrived from another hospital. I'd moved -- I'd started work as a Consultant and I felt I was working with people who were good at their jobs, who had good processes in place, you know, competent nurses, competent doctors. I didn't feel I'd seen an explanation for these unusual unexplained unexpected events, and there was this nagging worry that there was one individual who always was there when these were happening. And, therefore, I felt it hadn't been -- I felt it hadn't been investigated properly.

Q. And that is the very thing that you begin with:

"My opinion is that this can never be investigated properly without a police-led investigation."

You go on to indicate that you don't think the Coroner is an appropriate alternative to that or an adequate alternative to that.

A. Yes.

Q. Is that fundamentally because of the time that that process would take?

A. Yes, that was the other approach that was being considered was that a number of these deaths still need to go there through the Coroner's process and that

would be an opportunity to raise concerns and potentially a way to lead to other investigations. But that if you waited for that, by the time you got there you've left even more time without investigations and more time for memories to lapse and for sort of the investigation to become harder.

Q. You've already told us about your opinion about the RCPCH service review.

A. Yes.

Q. Your penultimate paragraph, something you've told us already, but this is you saying it at the time:

"In five years at an equally busy Level 2 unit in Crewe I can't remember a single unexplained collapse and I think the events you have described to me are extremely unusual."

A. (Nods).

Q. And then, finally, this:

"Ultimately you suspect a crime has been committed and I think there is an obligation to report this to the police whether or not your managers agree."

Now, "obligation", a very powerful word. Presumably you gave considerable thought to how you were going to frame this for the Consultants because there was going to be no back and forth about what your opinion was. Why did you choose the word "obligation"?

A. Well, the other discussion that had been happening over those preceding weeks was about whistle-blowing and whether what the Consultants were considering doing, which was speaking to the police, even though the Trust was saying that this shouldn't go to the police, whether that would be considered whistle-blowing. And what I'm saying there is, you know, I don't think this is whistle-blowing -- I haven't said that word -- I don't think this is whistle-blowing, I think this is you suspect a crime has been committed and you need to inform the police.

Q. And might have -- get lost in that natural construction but it's need, that was your view at the time?

A. Yes.

Q. You've mentioned about the potential disadvantages of just leaving it to the coronial process in terms of delay. Did you, at that time, in March, have concern about the delay that had already been caused and what was it that you thought that delay would affect?

A. So I -- I've mentioned already that sort of as time passes it gets more difficult to remember events, so the more time that passed the more difficult it was for people to recall what exactly had happened.

We've heard that in one Thursday, Friday, Saturday in June 2016 two babies unexpectedly collapsed and died and a third unexpectedly collapsed in a three-day period, and over the following week lots of discussions happened about whether this should go to the police or not. If a police investigation had been launched at that point, you know, those post-mortems potentially hadn't been carried out yet, there might have been more detailed toxicology, infusion bags might still be around that could be -- you know, there was all sorts of potential opportunities, even at that point, to investigate more thoroughly that were missed by a delay in police investigation.

Q. Two days -- thank you, we can take that down -- in fact I think it was three days, my mistake, after that email, two days after the meeting that you couldn't attend, you tell us in your witness statement that you received contact from a person called Tracy Bullock. Firstly, who was Tracy Bullock to you?

A. Tracy Bullock was the Chief Executive at Leighton Hospital in Crewe where I'd worked for the previous five years as a Consultant.

Q. And was she one of the people that you told us about that you had met and had got to know you a little bit when you were working as a Consultant?

A. Yes. Yes, somebody I knew well from working there and had a friendly relationship with.

Q. And the contact in the first instance, according to your witness statement, was that you received a request to contact her by telephone.

A. Yes, that's correct.

Q. And what initially did you think that conversation might be about?

A. I had no idea. I really wasn't expecting it was going to be about events at Chester. I really didn't know. My secretary contacted me, we arranged a time, and she called me I think the following day or two days later.

Q. And when you spoke to Ms Bullock what did she say to you?

A. What she said to me was that as a Chief Executive working close to Chester Chief Executives spoke to each other about situations they were facing and she'd become aware of the situation in Chester and that she hadn't clicked that I had moved on from Crewe and was now working in Chester but that an email from me had been read out in a meeting in the last few days, and she wanted to contact me really to give me a bit of friendly advice and warning about the situation I was potentially finding myself in.

Essentially what she was saying is that her understanding of the situation was that there were problems on the neonatal unit, that the Consultant paediatricians were refusing to accept that there were problems in the standard of care on the neonatal unit and instead they were pursuing this other line of inquiry, that there were two particular -- I think she used the word "ringleaders" or certainly two particular leaders of that and things were likely to end very badly for those two, and she was concerned that my reputation potentially could be dragged down along with them if I wasn't very careful in how I was conducting myself.

Q. Let's see if we can just unpack a little bit of that. The email of yours that had been read out, did you infer that's your email of 26 March?

A. Yes.

Q. And the meeting, therefore, must have been the meeting on the 27th --

A. Yes.

Q. -- that you couldn't attend. Had you been aware until that point that your email was read out at that meeting? Had anybody told you that they read out?

A. Yes, I think Dr Brearey had told me that sort of at that meeting he'd said, "Look, here's an email from a Consultant who's just joined our department

working in a similar hospital down the road and these are his thoughts about the situation here."

Q. And so who --

A. Sorry, I was going to say also my understanding that the outcome of that meeting had been that Tony Chambers had agreed that there would be an approach to the police.

Q. So that's something that was fed back to you by one of your Consultant colleagues?

A. Presumably by one of my Consultant colleagues, yes.

Q. After the meeting. Who had you understood was present at that meeting on the 27th? Obviously the Consultants were all invited.

A. No, it was only -- I think it was only Dr Brearey and Dr Jayaram representing the Consultants for that meeting.

Q. So why -- why might you have attended, you were giving your apologies effectively?

A. So there was a meeting at 11 am where the paediatric Consultants were joining together to talk about the situation and what they wanted Ravi and Steve it say on our behalf --

Q. And then --

A. -- and then a meeting at 5.00 pm was Ravi and

Steve meeting with the execs.

Q. I understand. And so that meeting at 5.00 pm, Dr Jayaram and Dr Brearey, and who did you understand that they met?

A. Tony Chambers and Ian Harvey. I'm not sure who else.

Q. And did Ms Bullock tell you who she'd got her information from and who was it who thought there might be ringleaders and that it might end badly for them and that you're --

A. My understanding was that her information was from Tony Chambers as a friend and local fellow Chief Executive.

Q. Chief exec to chief exec?

A. Yes.

Q. And what was your reaction to being provided with this information by Ms Bullock?

A. I -- I think at this point I was already treading very carefully and thinking very carefully through my actions. So I was grateful for the warning in a way but I was already, you know, very aware that I was in a difficult situation.

I kept the conversation to myself and just reflected on it, really. But it was really -- it was only later months really that I realised it helped to

understand the thinking at that time, that certainly Tony Chambers appeared to be seeing it that the paediatricians were looking for a better excuse than saying your department is not doing very well and were refusing to accept that there was a problem in their department.

Q. And did Ms Bullock indicate to you who the two ringleaders were supposed to be?

A. No. But I think it was obvious that it would be Dr Brearey and Dr Jayaram.

Q. And were they acting as ringleaders, as far as you were concerned?

A. No, not at all. No. And I think you've heard that from other people here that the concerns that were being expressed were the concerns of the whole paediatric Consultant body.

Q. Just a few more matters to deal with by way of your overall reflections. You say in your statement that you are struck looking back at how difficult it was for the entire Consultant body of seven paediatricians to have their voice heard in an organisation.

A. (Nods).

Q. Would you like just to tell us why you wrote that and what it was about the situation that you now see looking back?

A. I think in the NHS we're aware there's a lot of people who work -- some of them are in more powerful positions -- or power and some less positions of power. There's lots of people who are in NHS organisations might have concerns and be trying to speak up and the Freedom to Speak Up process is trying to make sure that when people have concerns that they are able to have their voice heard.

You'd have thought that it would be relatively easy for a Consultant to speak up within an organisation because they're people who have a relative amount of power within an organisation. You'd have thought that when all of the Consultants within a particular specialty are trying to say something that that would be relatively easy to have that voice heard, but that's not how it appeared to me looking back at the experience that happened over that period.

Q. And from your perspective, are you able to identify why you think that was?

A. No. And I think coming in, having not been a part of it, it was very difficult to understand the timelines and what had happened at different points, and there's a lot that I would like to understand from this Inquiry myself.

Q. Turning to your concluding remarks and just

some observations that you make there generally. You identify the role of the children's champion as been an important one. Just tell us about the children's champion when that came about and why that might be generally an appropriate role?

A. Yes, the children's champion was a recommendation from the Royal College report. I don't think I'd heard of a children's champion before I read that report, I think it was a relatively new recommendation by the Royal College. The idea of a children's champion was somebody sitting on the board who took a particular role in championing children's issues when they were being discussed at board level.

I'm not sure what we got in place the first year or so was quite right, but sort of once we got to a position where we got it right, we had a non-executive director who took a lead in thinking about children's -- within the hospital. And when I was clinical lead, she would contact me on a regular basis. I was free to speak to her at any time if there was anything I felt that I was stuck on that I needed to sort of get some escalation on. If I'd not spoken to her for a while she would contact me and say, "Can I catch up with you? And let's just touch base on what's happening with paediatric services." Or she if came across something

at a board meeting that thought it would be helpful to get my opinion on, she would contact me.

I think those roles have moved on now so that now it's a mandatory expectation that all units will have a neonatal safety champion and a maternity safety champion, and that the lady who took on that children's champion role ultimately took on all those roles, and we now have both a non-executive and an executive who has those champion roles within sort of patient safety and children's and neonates and maternity.

And I think in an organisation where it's a big organisation, there's lots of things happening, there's lots of people involved, you know, that -- that link between the execs, non-execs and the paediatricians and neonatologists I think is very helpful.

Q. Data. You comment upon the relative usefulness of data and in particular how data when it is of a historical character is perhaps less useful to day-to-day care than real-time data.

Do you see a role for real-time data in terms of day-to-day paediatric care and improving your service?

A. Like I said in my statement, I think because the numbers are small often changes are just the natural variation and statistical distribution. So I don't know if I do, and the time it takes often to get the data

back it's probably missed the opportunities to intervene would be my opinion.

Q. But when things start to go wrong, so not necessarily business as usual but where things start to go wrong, might data in real time have a role to play there?

A. Yes, I think in general data is really helpful and there would be lots of data we would want to look at in a neonatal unit to help understand that the care we're providing is good, not just mortality rates but all sorts of outcomes which we get now benchmarked against some of the units.

Q. And, finally, just an insight that you had into the CCTV question, should it be on neonatal wards?

A. Yes.

Q. You present both sides of the argument for it. But I don't know that we've heard this necessarily from any other person, certainly not very many other people. The way in which CCTV might be presented as a good thing, do you want to just help us with that?

A. Yes, I think you probably heard already the sort of concerns the staff have of having CCTV cameras on them all the time, the privacy concerns in a unit where women would be breast feeding and these types of things, and expressing, and how you balance that. But

often on the -- most of the time on the children's ward, certainly in the district general hospital, most of the time any small children in hospital their parent or one of their family members will be with them at all times.

And the neonatal is quite different to that because the babies are in for such a long time it's quite common that most babies there will be quite frequent times where they're just on the unit being looked on the staff without their parents there, and I think that's quite difficult for parents. We try and make our unit as welcoming as possible. We now have beds next to the cot spaces so the parents can stay. They're open 24/7 access. We have a siblings' room so that if there's a toddler sibling it doesn't obstruct the parent in spending time on the neonatal unit.

But the idea of video links has been quite popular, regardless of the safety thing, that being able to check in and look at your baby at any point while they're on the neonatal unit seems a good thing, and I would have thought a thing that most parents would welcome.

MR DE LA POER: Dr McGuigan, thank you for answering my questions.

My Lady, those are all the questions that I have for Dr McGuigan and there aren't any Rule 10 questions?

LADY JUSTICE THIRLWALL: Thank you very much.

Indeed, Dr McGuigan. Thank you very much indeed for coming to give us your evidence, it has been very helpful and you are free to go.

A. Thank you.

MR DE LA POER: My Lady, with your leave I will now hand over to Ms Browne.

LADY JUSTICE THIRLWALL: Very well.

Can the witness be sworn.

DR PAUL JAMESON (sworn)

LADY JUSTICE THIRLWALL: Do sit down, Dr Jameson.

Questions by MS BROWN

MS BROWN: Could you please state your full name.

A. Dr Paul Morpeth Jameson.

Q. And you've provided a statement to the Inquiry dated 31 May 2024. Is that true to the best of your knowledge and belief?

A. Yes, it is.

Q. Dr Jameson, you graduated from the University of Liverpool Medical School in 1986 and are a fellow of the Royal College of Anaesthetists. You have a clinical fellowship in paediatric critical care from the University of Toronto and you were appointed as a Consultant anaesthetist at the Countess of Chester in 1996; is that correct?

A. That's correct.

Q. And what is your current role, Dr Jameson?

A. I'm a Consultant anaesthetist at the Countess of Chester Hospital.

Q. Thank you.

Turning to your role on the Medical Staff Committee at the Countess of Chester, you were chair of the Medical Staff Committee from approximately 2011 to 2019, and I think it's correct that that's an elected and unpaid post?

A. That's correct.

Q. And who is it that elects -- who elects the chair of the Medical Staff Committee?

A. So you put yourself forward or you're nominated and seconded, and then there's an election for that post by the -- all members -- all permanent members of the medical staff within the Countess of Chester Hospital.

Q. And I think it's the case that, certainly since your appointment as a Consultant in 1996, there has been a Medical Staff Committee at the hospital.

A. That's correct.

Q. Turning to the purpose and role of the committee, you address this in your statement and it is at paragraph 15, and you say it's threefold. It represents the interests of medical staff, it provides

a forum where mutual concerns can be discussed between colleagues and the MSC enables communication between medical staff and the Trust management.

A. Yes.

Q. If I can just turn to what's tab 6, my Lady, in your bundle and it is INQ0098143. These are the terms of reference for the Medical Staff Committee. They're not dated, Dr Jameson, but we know from other documents that they were in fact drafted by Mr Butcher the ophthalmic surgeon who was the secretary to the Medical Staff Committee from approximately 2010 to 2020, and they were drafted in 2017.

Do you recall approving these Terms of Reference?

A. Yes.

Q. And is it fair to say that although they were formalised in 2017, and I think based on a BMA document, they reflected what had already been the case, they weren't a -- they weren't a departure from what the Medical Staff Committee had --

A. No, that's correct.

Q. And just going to this document, then. We see there under the heading "Membership" that the membership consists of all Consultant medical staff, all permanent staff and associate specialist doctors and appropriate representation of junior doctors is determined by the

committee. What did that mean in practice, representation of the junior doctors?

A. We asked for junior doctors to -- for a representative of the junior doctors. In fairness, I don't think we ever had any junior doctors attend.

Q. Thank you. And then going down, we see standing invitations are normally issued to the Chief Executive. So for most of the period we'll be talking about that was Tony Chambers, the Chairman of the Trust board, so Sir Duncan Nichol and any Clinical Director, and then we see beneath that the words:

"The Chief Executive, Chairman of the Trust board and Medical Director [of course, Ian Harvey] may be asked to retire from the meeting of the discussion of items where it is felt their presence would not be appropriate."

So it seems there, Dr Jameson, it was engaged that there might be occasion on which those individuals might attend but equally there might be an occasion where they would be asked to leave the meeting?

A. That's correct.

Q. And prior to the events we're looking at, 2016 onwards, were there any instances that you can recall where as a matter of course the Chairman, the chief exec or the Medical Director would attend these meetings?

A. The Medical Director would fairly regularly attend.

Q. So that's Mr Harvey?

A. Yes, often because he would want to address the Medical Staff Committee about particular issues. I don't remember Mr Chambers attending any of our meetings.

Q. Thank you. And looking at meetings, just going down towards the bottom of that document, we see the committee should meet on an average of once every six weeks but as a minimum four times a year.

And then if we can go over the page, to page 2, we see there the chairman -- at the top of the page:

"The chairman must arrange an extraordinary meeting if more than four members request it in writing."

And then below that in the centre of the page:

"The chairman of the committee is to be the spokesperson for medical staff in the Trust."

And would you agree with that characterisation of your role as chairman and as spokesperson?

A. Correct.

Q. Turning back to your statement, Dr Jameson, you expand a little on the role in paragraph 20 of your statement and you say that, in addition to the role of spokesperson, you saw your role as one of interfacing

with the senior management regarding the wishes of the Medical Staff Committee. And later on you define "senior management" as being the Chair -- being the Medical Director, the chief exec and the Chair of the hospital board.

A. Correct.

Q. And if we could just go to, my Lady, tab 7 in your bundle that's INQ0017868. This is the corporate directors group and it's a meeting on 27 January, and we will see there that it was attended by, amongst others, Mr Chambers, Mr Harvey, Mrs Kelly, Mrs Hodkinson and your name appears in the centre of the page, chair of the medical staffing committee Mr Jameson.

And if we go over to page 5 of that document, we see there that an example of you acting in your role as spokesperson. What was being discussed was the paediatrics business case.

And if we go to the bottom of the page we can see that what was being discussed was a business case to appoint two Consultants. And we see about 10 lines up from the bottom your initials:

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

So we see you there, would you accept, acting as

a spokesperson for your paediatric colleagues and quite forcefully supporting their business case?

A. Yes, that's right. Do you want me to expand on that?

Q. No, it's just to make the point --

A. Thank you.

Q. -- that was the role you took within those sort of meetings.

A. Yes.

Q. Yes. Sorry, Mr Jameson, if there is something you think is pertinent to say regarding that that goes to the event that we are looking at.

A. The only point I would make is that because I worked fairly regularly and closely with the paediatricians in my role as being one of the paediatric anaesthetists at the Countess of Chester Hospital, so I was regularly on the ward, I think I had quite a clear understanding of their workload dealing with the sick and injured child and their dedication to that service, and so really felt they needed help and support in the expansion of their department.

Q. Thank you very much.

And going back then to paragraph 21 of your statement, you say there that:

"Historically the Chair of the Medical Staff

Committee had a place on the Hospital Board and that was ... the case with the previous management structure ..."

When did that change? When did the Medical Staff Committee no longer have a place on the board?

A. From memory, I can't remember exactly when but it must have been after that meeting that you've shown the minutes there?

Q. I think that wasn't a board meeting that was -- that was a meeting which you were invited to.

A. Right. Historically, I'd always been invited to the -- to the hospital board meeting. Then I think probably around 2015/16, I noticed I wasn't being invited, so I asked the -- the Chief Executive's secretary if she could send me the date of the next meeting and I turned up to the next meeting and then was asked to leave that meeting because it was felt that the Chair of the Medical Staff Committee didn't have a role on that meeting. And from then on I didn't attend hospital board meetings as I was uninvited.

Q. And did you raise an objection to that, that you were no longer able to attend those meetings?

A. So, I brought it up with Mr Harvey, the Medical Director, and his explanation was that it was felt that the medical staff were like any other staff

group and, therefore, shouldn't have a place on the hospital board ahead of any other staff group, and that was the thinking and reasoning behind it.

Q. And it was -- did you understand that to be Mr Harvey's position or as his own personal view or something that had been decided on collectively?

A. I think he was transmitting a collective view, as far as I was aware.

Q. And did you feel that that decision represented a change where staff views were not given so much importance?

A. It made it very difficult to be chair of the Medical Staff Committee because it took away that interface I had with the senior management teams, I didn't know them as well, I didn't speak to them regularly in that environment, I didn't know what was going on within those management and, therefore, the role almost became impossible because my only interface with senior medical staff was through the meetings with the Medical Director. So I was aware I would get his -- his view that was to be transmitted to me and so I felt it was an issue.

Q. And just looking at the timing of this, was there any event that you understood provoked the decision to not allow you to attend board meetings?

A. No. I think it was just a restructuring of their management structure within the hospital. I think maybe they felt they were needed to be a leaner management board to make decision-making and communication easier. But I never got a clear explanation about why it occurred. I didn't know if it was a national directive, a regional directive or just a local directive.

Q. And I think you said date, the best you could do, was that approximately 2015?

A. Around that time, just because you sent me the minutes of that previous meeting that you brought up, and I think that was one of the last meetings I'd have been at.

Q. Well, that was a meeting, the one we've just looked at, the corporate directors group, that was 27 January 2016.

A. Well, it must have been around 2016 then.

Q. If I could just turn to the topic of safeguarding now, Dr Jameson and you address this in paragraph 63 of your statement, and you say there that you've undergone regular safeguarding training throughout. Does that relate to regular safeguarding training throughout your time at the hospital?

A. Yes, because of my role as a paediatric

anaesthetist I have to undergo Level 3 safeguarding training and keep that up to date. So I have done throughout my career.

Q. And -- so presumably you would be familiar with the Working Together to safeguard children guidance?

A. So I'm familiar with it but it's a while since I've undergone that training because it's three-yearly.

Q. I'm not going to go through it in detail but just in terms of the key principle that safeguarding children is everyone's responsibility and that each professional and organisation should play their full part, you would be familiar with that as a principle?

A. Absolutely.

Q. And at paragraph 64 you say there in relation to that:

"... if any person, either a member of staff or anybody involved in harming a child or baby in hospital ... I would know to inform the safeguarding officer and that this [would] be clearly documented as per safeguarding training."

And, Dr Jameson, just to check, that would be your understanding now but was that your understanding in the period from 2015 onwards as well?

A. Yes, it would.

Q. And were you aware of who the designated doctor for safeguarding was in 2015 to 2017?

A. I would have been at the time because it would have been -- we sort of had a safeguarding intranet page, so if I had a safeguarding issue my first port of call would be the -- if it was a paediatric patient would be the paediatric team on-call and then they would highlight it through their safeguarding process.

Q. And what level of concern would trigger reporting to a safeguarding officer?

A. So from my point of view as an anaesthetist, it might be that we might see some physical harm to a child that we would then highlight, or within a history we might highlight it, and within the -- the admission notes of every patient there is -- the Trust does have a safeguarding box, so the admitting team should have considered safeguarding.

Q. And in fact the designated doctor for safeguarding at the time was Dr Mittal. Does that ring a bell?

A. It does, yes.

Q. And if we can go back now to paragraph 22 of your statement. You say in there -- that paragraph that you were first approached or you believe you were first approached by the paediatricians around the end of

January/early February 2017.

If we could just go to look at that date, first of all to tab 2, and the document number is INQ0012995, page 1.

LADY JUSTICE THIRLWALL: Ms Brown just while that's being looked up, may I just check that the transcript is still working for everyone. Plenty of nods around the room. I think it's just mine. I can manage, I just wanted to make sure we weren't all in the same position.

MS BROWN: And this is an interview or the copy of a record of an interview that you gave in July 2020 to Facere Melius, and you say in the middle of the page:

"I was approached I think -- it was sort of February/March of '17 by a number of the paediatricians who were basically in crisis. They -- and that was the first I heard really anything about the neonatal concerns. There had been the odd sort of rumour within the hospital."

Just stopping there. What was the rumour that you had heard prior to them approaching you?

A. So I think all I'd heard -- at that point, I may have heard that a member of staff was -- had been excluded from the neonatal unit but no more than that.

Q. Did the rumour extend to why that member of staff had been removed from the unit?

A. No.

Q. But presumably that would be something, if it was a rumour, that would be the subject of a conversation if someone was being removed. Was there speculation?

A. To my memory, no. I mean, the neonatal unit was very much a very small part of the hospital and unless you were directly involved in the neonatal unit, you probably wouldn't know what was going on. So in all honesty, I cannot remember hearing the specifics about -- or remembering that rumour this far away from it, but obviously remembering that Dr Jayaram contacted me February -- January, February, March 2017.

Q. And prior to that, prior to the contact from the paediatricians, were you aware already of the increased mortality rates?

A. No.

Q. Dr Tighe can't remember precisely but he thinks he might recollect speaking to you in early 2016, some informal discussions about mortality rates. Is that a conversation that you can recall?

A. I can't remember. I know that we did discuss it in 2017 because the paediatricians had approached me because of their concerns regarding grievance procedures that were being brought against them.

Q. Just going back to the document there. You say you were approached by a number of paediatricians. Who were the paediatricians that first approached you?

A. I was first approached by Dr Jayaram and then Dr Jayaram asked if I could meet within -- in his office, and I spoke, from memory, with Dr Jayaram and Dr Brearey.

Q. And if we see as well in that paragraph, the passage we're looking at, you say that they were feeling bullied and harassed and what they were trying to do was raise patient safety.

A. Correct.

Q. And if we could go over to page 2, just trying to date this. Your evidence is that, doing the best you can, it was approximately February. I just want to see if it may have been slightly earlier.

We see there towards the bottom paragraph:

"They came to me when the Royal College of Paediatrics Child Health report came in and they were -- you know, they were only allowed access it to a brief period of time and then when they were given a redacted report."

Now, we know that they were -- Dr Brearey and Dr Jayaram were allowed access to it for a brief period in November. Does that help you at all? It's

a slightly confusing --

A. Yes, no, I think they came to me actually very specifically after -- in -- after their meeting that was discussed slightly earlier about being asked to write a letter of apology, and that's when they first came to me in my role as the chair of the medical staff. But at that point, they did -- then gave me a narrative saying that earlier they had been -- these were the issues that they were -- they were, in their words, probably battling with and they brought up the fact that they'd only been asked -- allowed to see briefly a redacted Royal College report earlier.

Q. So the redacted report was in February, and in terms of asking to write a letter of apology, that would bring it closer to December. We're going to look at a document that talks about the letter of apology. But -- so at the very -- the end of 2015, beginning of 2016, would that be?

A. No, that was much later than that that I first heard of. It was certainly 2017.

Q. Sorry, 2017, sorry, my error. But it was between January -- between December and February?

A. Probably, yes, to the best of my recollection.

Q. And, Dr Jameson, was an explanation offered to you as to why they had waited until January,

February 2017 to come to you? We know, of course, their concerns arose much earlier.

A. I feel at that point their concerns were that Lucy Letby had been removed from the unit and then there was a suggestion at that point that they were to apologise to her and that she was to be allowed back on the unit. And from their point of view, I think when they were pressing for a full investigation that they felt that Ms Letby was excluded from the unit patients weren't at risk, but I think they were very fearful at that point that she might be reintroduced to the ward and what on earth could they do and, therefore, they looked for the support of the Medical Staff Committee.

Q. And if we can look at paragraph 24 of your statement, you list then what their concerns were, which I think you've highlighted, but they were concerned about the increased morbidity and mortality of the neonatal unit, so the number of deaths and collapses on the neonatal unit, they were frustrated about how this was being handled by the senior management and, going down, serious concerns regarding patient safety and that these were concerns of the whole department.

A. Exactly.

Q. So at that stage, at the latest February 2017, there were specific concerns about the rates of babies

dying that had been communicated to you that that was from all of the department, and you were aware, at this stage, that the issue related to a particular nurse; is that correct?

A. Correct.

Q. And they were communicating as well that they were frustrated by the response of senior management?

A. I think they were not only frustrated, I think they were quite fearful about their jobs and so their frustration was -- and fear was huge.

Q. And, Dr Jameson, in your role as spokesman who has then been approached by the paediatricians, why did you not go to Ian Harvey or Tony Chambers at that point on their behalf and say, "This matter must be reported to the police"?

A. I did go to Ian Harvey and the first thing I expressed to him was that this was a whole department that I knew, respected. I knew they were not only thought of as good paediatricians and it was a strong department but because of some of the work I'd done with the -- regionally with paediatrics I knew it was a very well-respected department regionally, and that their concerns should be really treated with the utmost importance.

Q. And you say in your statement that you

championed their cause by saying that they should be listened to. But did you say specifically to Mr Harvey or any other senior executive that the police should be approached at this point and that you as a spokesman were making that point to him?

A. I think I used the words that this was a safeguarding issue and that, you know, if the paediatricians are asking to go to the police, then the senior managers should go to police?

Q. And just looking at safeguarding, we know that at this stage whilst Letby was off the ward there weren't any restrictions on her registration at this stage.

We've looked at the fact that the paediatricians were coming to you with serious issues of patient safety. When you heard of their concerns, did you enquire as to whether they had informed the safeguarding officer?

A. I have no memory of doing that. But they were very clear to me that they were pursuing all avenues.

Q. Sorry, who was saying they were pursuing all avenues?

A. This was -- this would be Dr Jayaram and Dr Brearey, and they were very clearly stating to me that they wanted to go to the police but had been told

that they should not at present.
Q. And what did you do actively to support them by going to the police, did you consider going to the police yourself?
A. I felt that I should very clearly go to the senior execs and say is all due process being followed? Because the details of actually what had gone on, I knew very little of the actual details other than knowing that I knew and trusted the opinion of my paediatric colleagues.
Q. And did you consider that you needed to make a safeguarding report?
A. I didn't. I probably regret not doing that but I felt that because this was 2017, and I'd been told that due process and investigation was being followed, I regret that.
Q. And if we can go to paragraph 34 of your statement where you set out the actions you took. You say that you recall meeting with the Medical Director Mr Ian Harvey and you felt your role was to stress that the paediatric department were highly regarded, and you say:
"I had at least one or maybe two meetings with Mr Ian Harvey within his office. These were non-minuted meetings ..."

minuted?
A. In retrospect I should have done that.
Q. And you say at paragraph 37 that:
"... Mr Harvey did not want any external involvement by other members of the Medical Staff Committee ... he very clearly stated the matter was in hand."
What reassurance did he give you that the matter was in hand?
A. He just very clearly stated that there was a full investigation going on. He didn't mention to me the Royal College reports but he made it clear that he was in charge of governance and that this was not something for the Medical Staff Committee to get involved with.
Q. And did you think he was right about that or did you think it was a matter for the Medical Staff Committee?
A. I think we should have been more vocal in stating that the police should have been called earlier.
Q. And you then say that you also met -- so these are meetings with Mr Harvey, but you also met with Sir Duncan Nichol. And what took place in those meetings and when did they occur?
A. So they occurred in the months after when I'd

Why did you not take minutes of these meetings, given the severity of the matters that were being discussed?
A. I suppose that our meetings had always been relatively informal meetings within his office and what I was trying to do was make it clear to him that I had faith and belief in my paediatric colleagues and the points they were making, and I was hopeful that that would -- would stimulate him to reconsider the process that he and his team were going through.
Q. You say there that Mr Harvey:
"... made it clear to me that these issues were not a matter for the Medical Staff Committee to get involved [in] ..."
What was your response to that?
A. I -- at the time I felt that the way we could help support the paediatricians was just to reassure them and make it clear that in effect we -- we had their back, that if they were threatened with losing their jobs that we would -- as a Medical Staff Committee we would support them.
Q. Did you not consider this was a meeting that you should minute a clear statement by you on their behalf that the police should be contacted and if the executive didn't do that that was something you wanted

first become aware, and at that point I think the police had been called, so it was round the time that the police were involved.
Q. So February, when the paediatricians first approach you, the police weren't contacted for a few months after that. Given the police in these months were not being contacted, did you consider going to Sir Duncan Nichol when Mr Harvey was clearly not taking action at that point to contact the police?
A. I think I spoke with Sir Duncan Nichol and explained that I had concerns and that my concerns were one and the same as the paediatricians and that he was fully informed of that.
Q. So that's quite significant, Dr Jameson. Your recollection, is it, that you went to Sir Duncan Nichol before the police had been contacted to say that in your role you felt the police should be contacted?
A. I'm not certain of the exact timings when Sir Duncan Nicol and I started a dialogue. It was around about the time that the police were called, so I couldn't honestly say when -- when I had that first meeting.
Q. But do you recollect or not saying to Duncan Nichol the police need to be called in this matter?

A. No, I don't recollect saying that to him.
Q. And going down to paragraph 41, you say there:
"Primarily my meetings were just to try and support them to act as a sounding board ... [and] to try and facilitate meetings with ... Duncan Nichol ..."
Do you feel on reflection, Dr Jameson, that in fact the Medical Staff Committee should have done something more than being acting as a sounding board?
A. So what I'm referring to there is a period of time after the police had been called and when we were trying to support the paediatricians while they were navigating gauge this very difficult time when the relationships between the senior managers and themselves had totally broken down.
Q. And you address then the very specific issue that you've mentioned before, the fact that the paediatricians were only permitted to review a redacted report, and you say your response to that was one of disbelief. Can you just expand on that briefly?
A. Yes. My feeling is that the experts in the running of the neonatal unit were the paediatricians and that if a report had been asked for it should have been shared with them immediately in an open, transparent, inclusive way, where team working is at the heart of running a safe unit. And I -- I genuinely could not

believe what I learnt of this in early 2017 that they wouldn't have been sharing that report from its -- from its very first time it was available so that they could learn from it.
Q. And you say there:
"I think he stated to me [that's referring to Mr Harvey] that ... it was handled appropriately though this meeting was not minuted ... [it] is only my memory of the meeting."
When Mr Harvey gave these responses that it was handled appropriately, what -- what response did you make to that, given your disbelief at what had been going on?
A. I think at that point my relationships with Mr Harvey were the communication was quite short and brusque. I don't think he was really interested in my view as chair of the Medical Staff Committee, so it was -- it was as simple as that.
Q. And if I could turn now to the general management style of the Trust, which is something you address at paragraph 45 in your statements, and you say that:
"My observations regarding the management style of Mr Tony Chambers and Mr Ian Harvey, is that there was certainly a marked change in the management style

compared to the previous Chief Executive ... Medical Director ..."
How would you characterise the management style of Tony Chambers and how did it differ?
A. The previous Chief Executive and Medical Director were very opening and welcoming of -- of medical opinion and being questioned. Certainly I felt that I almost didn't have a relationship with Mr Chambers after I had been asked to leave a sort of management board meeting. And my meetings with Ian Harvey, though we had them regularly, were always quite superficial.
Q. And if I could turn you to -- my Lady, it's tab 3 in your bundle and document INQ0103247. This is the statement of Jeremy Butcher. He's the ophthalmic surgeon who is the secretary to the Medical Staff Committee, and if we could turn to page 2 and paragraph 11. He says there:
"Paul Jameson, the chair of the MSC, told me that he no longer sat on the board of the trust. He also told me that Tony Chambers had said that he considered the Consultants as no more important than any other staff group such as porters."
Is that something you recall saying?
A. I can't recall wording it in such a specific

way, but certainly Mr Harvey had said it to me that one of the reasons that we weren't -- we weren't -- the chair of the Medical Staff Committee wasn't required on the board because we were just like any other staff group and no more important.
Q. And just following that theme, if we could turn now to INQ0012995 and page 5 of that document. This again is the interview you had in 2020 about events, and you say, looking towards three quarters of the way done that page:
"Certainly the impression I got about Tony Chambers is very clearly that senior medical staff were not that high up on his priority in running the Trust."
Can I just stop there. Is that -- where you say senior medical staff, are you referring specifically to the paediatricians or are you referring to Consultants more generally?
A. I think Consultants more generally.
Q. "... and he sort of ..."
And you go on:
"... and he sort of openly made that clear and he wanted -- you know, his view, maybe rightly or wrongly, you know, senior medical staff are just like any other medical staff."
Again, is there anything you can say to expand upon

that view in terms of how Tony Chambers viewed senior medical staff?

A. Not specifically, other than saying that when I felt he didn't value the chair of the medical staff within involvement with the board but also, as we've heard earlier, the conversation with the paediatricians when they were very clearly told what to do.

Q. And what are you basing your opinion upon there, Dr Jameson?

A. My own personal view.

Q. And your own personal experiences?

A. Yes.

Q. And any experience in particular?

A. No, other than the -- that -- that issue where I did turn up at a board meeting where I expected to have a place and then be politely but firmly ushered out of the room.

Q. And going back to your statement -- that document can come down now, thank you -- at paragraph 48. You say:

"When I discussed the paediatricians concern with Mr Ian Harvey, he certainly gave me the impression that he felt they were a difficult department to interact with."

How did he give that impression and what was it

that he was saying to you?

A. I don't think he said anything directly but it was just his overall body language and he made it clear he didn't want to discuss their issues with me.

Q. Thank you. If we could just look now at a few of the minutes of the Medical Staff Committee, so if we could go first to tab 8, which is, my Lady, tab 8 in your bundle, and that is INQ0004451.

This is the Medical Staff Committee meeting on 1 November 2017, so about nine months after you first -- the paediatricians came to you.

And we see that you were sitting as the chair, Mr Butcher the secretary, and there were six others present. That seems like a small number. Was that characteristic of the meetings, the numbers that would turn up at a meeting?

A. Unfortunately it was, it wouldn't be quorate at that number, and there was a disengagement with the Medical Staff Committee over this period of time.

Q. Was that related in any way to the fact that the Medical Staff Committee didn't have a seat on the board, in your view?

A. I couldn't answer that.

Q. Going over to page 2 of that document, you say there the -- at the top of the page:

"The committee understands that the police investigation to premature baby deaths is ongoing."

And you told the committee that:

"... would continue to offer our support to our paediatrician colleagues."

And that was the stance of the committee at that stage?

A. Correct.

Q. And going over, tab 9 in the bundle, my Lady, and document INQ0004485.

This is a meeting, so seven months later, in June 2018. Larger numbers here. You sitting at the chair, Mr Butcher the secretary, and approximately 31 others.

And if we go over to page 3, we see there under "Any Other Business" that you told the committee that the paediatricians were feeling marginalised, stressed and isolated, and that there may -- that they may "have an extraordinary MSC meeting to demonstrate support for our colleagues". And you urged good attendance.

If we can go then to -- it's one tab on in the bundle, INQ0083556, this is a chain of emails where you were discussing that meeting.

And if we can go to page 3 of that email chain, which is the first in time, you wrote to

Detective Inspector Hughes, you introduced your, and you say in that email that the paediatricians have approached you as the chair to ask if you can call an extraordinary meeting, and you go on to say:

"The meeting will not discuss the issues related to the investigation. It will be limited to the breakdown in Trust, communication and relationship between paediatric medical staff and senior management and their concerns."

Just pausing there. Was that how you saw the issue there, a breakdown in communication and relationships?

A. At that point it was because the investigation was now ongoing but it had moved on to that breakdown in trust between one group of Consultant staff and the senior managers.

Q. And you wanted essentially the police to say whether they felt it was appropriate to have that meeting. And I think we can see if we go to page 2 of that document, which is the email in response, that Mr Detective Inspector Hughes responds and said that he is aware of the breakdown in relationship between doctors -- some of the doctors within your organisation of the Trust and that he is happy for the meeting to continue. And he says with some foresight:

"I'm quite sure that at the conclusion of this

investigation a public Inquiry could well be commissioned and I am certain most of these concerns will be raised in that format."

And then if we can go on to page 1, we see, just to follow the trail, that you forwarded that email to Sir Duncan Nichol and made clear that the police were happy for the MSC to call an extraordinary, meeting and you add your view that you also feel that a public Inquiry is inevitable.

And if we can go -- and this is -- we are almost at the end of the documents now, Dr Jameson -- to the minutes of that extraordinary meeting, which is INQ0098147 and tab 11 of the bundle. There are actually two meetings that are referred to there, there's a pre-meeting on 11 September 2018 and that was attended by Sir Duncan Nichol, Dr Gilby, so that's the new Medical Director, Mr Harvey having retired by now, yourself and Mr Butcher.

Why was there felt to be a need for a pre-meeting?

A. At the time, because there was such -- this huge breakdown in trust between a group of Consultants and the senior managers, that one of our -- one of the concerns of the Medical Staff Committee -- because I didn't really hear about the issues on the neonatal unit until 2017, one of my concerns was could there be

other departments where there was a similar breakdown in trust between -- and, therefore, we needed to explore this. Also we felt that there would be highly likely that from the secondary meeting that the Medical Staff Committee might ask for a vote of no confidence in Mr Chambers.

Q. And we'll come -- that didn't happen in fact, we'll come to that, but that was -- so was the risk of vote of no confidence that you felt -- you, therefore, felt the need to have the pre-meeting, were you alerting Sir Duncan Nicol and Dr Gilby to that vote at that point?

A. Yes.

Q. And we see then -- sorry, you also say there that the minutes will not be circulated by email to ensure confidentiality. What was the particular confidentiality issue that you were concerned about?

A. I think we were very much concerned at this point about The Families of the bereaved that -- you know, it was -- we were still all the medical staff -- and I did want to say earlier that contact with the present medical staff -- that all the medical staff in the Countess of Chester were very much aware of the -- the absolute pain and loss that all these families had gone through, and so we felt it was important that, you

know, the court case hadn't gone ahead but we were discussing -- you know, hugely delicate and upsetting for the family and we didn't want that The Families to be hurt any more than they'd already been hurt.

Q. Thank you. And we see there then it goes on to the minutes of the meeting of 19 September, and we see huge numbers attending. I think if one counts it up it is over 100.

And turning over the page to page 2 of that document, you gave a statement on the purpose of that meeting emphasising the confidentiality and read out a statement from Detective Inspector Hughes stating that there should be no discussion about anything that would prejudice the investigation.

And you made the point about the minutes that you would review them for accuracy but they wouldn't be circulated, or I think they would be accessible for those who attended. And you told the committee then that you'd invited Sir Duncan Nichol, Dr Susan Gilby to the meeting.

Mr Butcher's views were he felt their presence might inhibit discussion. Was that something you agreed with?

A. No, I didn't. I felt at this point that Dr Susan Gilby was new to the Trust and new as a Medical

Director, and I knew her view on the way this had been handled previously was very different from the previous Medical Director's and --

Q. What -- just expand on what you mean by that, very different?

A. Well, within a week of her being appointed, she was very clear that she couldn't believe that the paediatricians hadn't been treated in a more trusted and collaborative and open, transparent way.

Q. And we see there in the middle of the page Sir Duncan Nichol told the committee he was there to listen, and he told the committee that Tony Chambers had decided to stand aside as CEO, and that Susan Gilby would be acting CEO. Was that the first time you and -- not only you but all those 101 doctors attending, was that the first time they were informed that Tony Chambers had decided to stand down?

A. Yes.

Q. Were you aware of it prior to this meeting?

A. I think I might have been made aware of it, I don't know, half an hour before the meeting.

Q. And what happened then was there was a presentation by Dr Gibbs, and in that presentation some slides were shown, and these minutes in fact reproduce what was on those slides, and he sets out

the -- Dr Gibbs set out the history.
Did he talk -- can you recall, did he talk through the events or how did that take place in practice?
A. I cannot specifically remember his presentation but it was very much a narrative timeline of the events.
Q. And we see that reflected in fact in the notes here, which in turn reflect the PowerPoint slides. He talks -- I'm just going to pick out one or two -- June 2015 the serious incident meeting held after the three deaths.
Going down then, July 2016, the Consultant paediatrician demanding action from the police. That's following the death of Child O and Child P.
Then September 2016, the RCPCH review. And then coming right down after various other events to meeting with a QC and then contacting the Child Death Overview Panel.
And in May 2017 the Deputy Chief Constable informing the Chief Executive, who at that point would have been Tony Chambers, that the police investigation would take place, and that history was set out to you?
A. Yes.
Q. And were you already well aware of this history at this point?

A. No. That was really the first time in detail that I understood the timeline.
Q. And then we see the concerns set out. And then just very briefly, the lack of action of patient regarding serious patient safety concerns, only two paediatricians had -- briefly saw the redacted RCPCH report. Did you understand that to be Brearey and Jayaram? Dr Brearey and Dr Jayaram.
A. Correct.
Q. And then the fact that the executive decided deaths and collapses were explicable but the paediatricians disagreed, was that expanded upon in the meeting?
A. I think later in the meeting, when other paediatricians presented, there was more information. But I was the same as almost everybody else in that meeting, it was utter disbelief that this had occurred.
MS BROWN: My Lady, I'm conscious of the time, I have probably about another five minutes. I don't know if you permit to carry on to the end.
LADY JUSTICE THIRLWALL: Yes. Dr Jameson, are you all right to continue for another five minutes?
A. Yes, thank you.
LADY JUSTICE THIRLWALL: Thank you. Let's do that.
MS BROWN: So just dealing then -- the other

concerns. At the end of that they also -- there's reference to repeated misleading statements concerns regarding what has been said to parents. That was another concern that was discussed, was it?
A. That was the first time that I'd heard of that, though in my -- one of my meetings with Mr Harvey he was very clear that the Medical Staff Committee shouldn't get involved was because he was in discussions with families and, therefore, there was a patient confidentiality and sensitivity that would be around the discussions I had between February and May of 2017.
Q. And as far as you can recall, Dr Jameson, these concerns, which we're obviously just viewing as a list here, was there a lot of discussion of these amongst the 101 doctors that were present or did Dr Gibbs in effect run through a list, insofar as you can recall?
A. At the time there was quiet shock displayed by the whole meeting, but we were very clearly going to allow all the paediatricians to say what they felt was important?
Q. And I think if we go over the page, to page 4, we'll see that some notes have been made, a summary of what the paediatricians said. So we have -- and I'm just going to pick out a very brief line from each of

those -- Dr Saladi referred to the fact that the Consultants were concerned about deaths being unexpected and unexplained, and that these were not then investigated appropriately by the Executives.
Dr ZA talked about the relationship with the executive board had broken down to the extent that current patient safety was jeopardised. And Dr ZA also had concerns that there was victimisation of two Consultants.
Can you assist -- one assumes that is Dr Brearey and Dr Jayaram, are you able to assist if that's who was being referred to?
A. Yes.
Q. And, again, a reference there to concerns that the grieving families had been misled over the cause of their child's death.
Dr Jayaram spoke as well. He was attempting to obtain some minutes of board meetings. He refers to board documents that could not be specified in this forum.
Do you know what he was referring to then?
A. No, I don't.
Q. And he -- also going over the page, this is page 6 -- suggested things said in the Speak Out Safely forum had been used against the paediatricians. Were

you involved Dr Jameson in the Speak Out Safely?
A. No, I wasn't.
Q. Dr Brearey then spoke. He was concerned about press statements being inaccurate or misleading, and he picks out in particular a comment by Mr Harvey -- this is halfway down -- comments by Mr Harvey that there were only two infants for whom the cause of death was uncertain, and Dr Brearey said that was inaccurate.
And Dr Brearey also referred to a May 2018 interview with the Chester Chronicle where Tony Chambers is reported to have said:
"There were just a few niggles that our clinicians said, 'Look, we have got 90% the answers but there are still bits that we need to in a sense be clear we have not missed anything'."
And Dr Brearey felt that didn't reflect accurately the paediatricians' concerns.
And then, finally, Dr Holt, and this maybe gives us some idea of what had been intended by the meeting and what in fact occurred. She highlighted the purpose of the meeting had changed in the light of the events. Was the purpose of the meeting, Dr Jameson, to have a vote of no confidence on Tony Chambers?
A. The purpose of the meeting was to clearly allow the paediatricians to voice their concerns and the

way they had been treated, and then following on from that if the Medical Staff Committee had felt that this complete breakdown in trust between one whole department and Consultant group would suggest we have a vote of no confidence in the Chief Executive, then we would have taken that forward, if that had been the view of the Medical Staff Committee.
Q. And that would explain in part the numbers of those attending at this meeting.
A. Absolutely.
Q. Then going on, there was a discussion, as one might expect, following the paediatricians. And just so that I'm correct in this, the minutes would imply each paediatrician took the floor for a moment and set out their particular concerns; is that correct?
A. Yes.
Q. And we see on page 8, "RJ", so that's a reference, one assumes to, Dr Jayaram:
"... said that he had been told at the beginning of the process that the idea of intentional harm would be a convenient possibility."
What did you understand he was referring to there?
A. I think you would have to ask Dr Jayaram, so I don't know what he's referring to there.
Q. And then the conclusion there, we see at the

bottom, you say that:
"The main aim of the meeting was to facilitate the paediatricians ... expressions of their experience."
And that you -- consideration for a further extraordinary meeting.
Was there a further extraordinary meeting?
A. No, we didn't have a further extraordinary meeting after that. But the other conclusion that I said on the page before when we specifically asked whether any other departments felt bullied, marginalised, threatened or treated in the same way as paediatrics it was important that we raise that question in this forum.
Q. And as a result of that, you didn't feel the need to go forward to another extraordinary meeting to look at another department?
A. Yeah, yes.
Q. And just on page 9, then, the final page of these minutes, you thank -- well, first of all Sir Duncan Nichol thanks Susan Gilby and you, and said the non-executive directors would look at the culture of speaking out. Then you thanked colleagues for attending in such numbers and you said the previous senior management had not wanted the meeting to happen.
What's that a reference to and who's that

a reference to by senior management?
A. That was in reference to the meetings I had with Mr Harvey where he very clearly stated that he felt the -- this issue was not one at that time that was to be discussed by the Medical Staff Committee as in when I was having the discussions with him in early 2017.
Q. And just with that, so 2017, when the matters came to you as chair of the Medical Staff Committee, this meeting 2018, was it the opposition of Mr Harvey to this meeting that meant that the forum that the MSC created for discussion of this meeting wasn't used it appears until September 2018?
A. I think we didn't use it before that point because there was the period of time where we were waiting for the police involvement. And after the police involvement, there was a hope that there could be a reconciliation in that we hoped that the senior managers would understand that the paediatricians were the ones who were speaking out and needed to be supportive, and certainly that's what Sir Duncan was trying to -- trying to take forward, but that failed really at every turn.
Q. And there is just one final matter on the documents. You've been shown I think a letter dated 1 December that was sent by Ms Weatherley to Letby, and

I think your evidence is that that wasn't a document you saw at the time.

A. Correct.

Q. And this relates to the grievance, and in that letter -- so although you clearly didn't see the letter but what Ms Weatherley concluded was that the -- Letby's removal from the unit was orchestrated by the Consultants with no hard evidence to support this action, their behaviours and comments fell short of what was expected by the Trust.

Was that a conclusion that you were aware of at any time?

A. No.

Q. And also in that letter, Ms Weatherley talks about the fact that apologies would be required from named Consultants who had made unsubstantiated comments and refers specifically to Mr McCormack, Dr Brearley Dr Jayaram and Dr V. The question there is, were you aware of the comments these doctors had made which prompted the recommendation for an apology?

A. No.

Q. And, finally, Dr Jameson, if I could just return to your statement for your reflections that you set out at paragraph 71, you say:

"It is my view, on reflection, that as soon as the

paediatricians raised any concerns regarding the increased mortality within the neonatal unit by any member of the department, that these should have been immediately passed on to the Local Authority Designated Officer and the police".

Dr Jameson, whose responsibility do you consider it was to contact the local authority and specifically to contact the police?

A. I think the paediatricians informed senior management of their concerns and, therefore, senior management, probably jointly with the paediatricians. In a -- in a healthy Trust one would hope that that trust and respect for both would mean that they would both draw that conclusion. It's easy with retrospect to say that, but fundamentally at one and the same time they should have been going to the local authority and police.

Q. And when you were aware of the patient safety concerns that had reached you, and the concerns that the management weren't reacting to respond to that, did you feel on reflection that that was also part of your responsibility to go to the police?

A. I felt at the time because Lucy Letby was excluded from the unit and, therefore, the unit wasn't at risk. But, in retrospect, I think like all those

involved, I wished I'd been more forceful in saying to the senior management that, "You must go to the police."

MS BROWN: Thank you very much, Dr Jameson. There are no Rule 10 questions, my Lady.

LADY JUSTICE THIRLWALL: Thank you, Ms Brown.

Dr Jameson, thank you very much indeed. Often a barrister says five minutes they mean 15. I suspect you probably guessed that.

A. Yes.

LADY JUSTICE THIRLWALL: So thank you for being patient with that, and you're free to go. So we will take a break until five past 4.

(3.48 pm)

(A short break)

(4.05 pm)

LADY JUSTICE THIRLWALL: Ms Langdale.

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

LADY JUSTICE THIRLWALL: If you would like to come and take the affirmation.

DR SEAN TIGHE (affirmed)

Questions by MS LANGDALE

MS LANGDALE: Dr Tighe, you have provided the Inquiry with two statements, the first dated 18 June 2024 and a short statement of clarification 4 September 2024.

Can you confirm the contents of true and accurate, as far as you are concerned?

A. Yes.

Q. You were a Consultant anaesthetist at the Countess of Chester Hospital from August 1993 to April 2021; is that right?

A. Correct.

Q. You're retired now.

A. Yes.

Q. And you were, while you were at the Countess of Chester, chair of the BMA local negotiating committee; is that right?

A. Yes.

Q. Can you tell us what that roll entailed and what more about the BMA?

A. Yes. Well, the BMA is the main Union of -- representative Union of all doctors and I was an elected chair of that and, as such, was the Union representative for the doctors employed by the Trust, and my role was mainly in negotiating terms and conditions with the executive dealing with complaints and concerns of colleagues with regard to application of those terms and conditions and in disputes with management.

In that role, I enjoyed an excellent relationship with the executive through quarterly meetings that we

had, called the Local Negotiating Committee Meetings, and we generally came to very satisfactory mutually advantageous decisions.

Q. When you say -- through the period 2015 to 2016 and 2017, were you having those LNC meetings then with the Executives?

A. Yes, we would have had around that time.

Q. And so when you say you enjoyed excellent relationships, can you tell us which executive officers you enjoyed such relationships with?

A. Sorry, I'm having difficulty hearing you.

Q. Which executive officers did you enjoy such good relationships with in 2015 to 2016?

A. Okay, so the Medical Director.

Q. Was that Mr Harvey?

A. Ian Harvey, the Chief Executive -- several Chief Executives in fact over my 10-year tenure, and the representatives of the Human Resources department. Also on the committee was Dr Jameson, the chair of the Medical Staff Committee, who you just heard from, and there was always a BMA representative from -- employed by the British Medical Association in attendance as well.

Q. You tell us in your first statement, Dr Tighe, about an informal meeting with Mr Harvey, the Medical

Director, in his office in early January 2017 where he asked or requested that you attend a meeting on 26 January between the CEO, himself, other board directors, senior nurses and the paediatricians as a witness. Can you tell us about that conversation and what Mr Harvey was asking you?

A. The informal conversation --

Q. Yes.

A. -- before the meeting?

Q. Yes.

A. Yes, he asked me to come and see him and -- to discuss me attending as a witness to a meeting that was to take place between the paediatricians and the Medical Director and himself. And this was really the first time that I'd heard any detail at all about the problems on the neonatal unit.

The Medical Director appraised me of his view of the current situation, assured me that he had undertaken an independent analysis that had not -- that had not registered any firm evidence that harm was being done and that it was much more likely to be a statistical aberration or related to poor clinical performance.

He told me that, as a result of the concerns expressed by the Consultant paediatricians, two independent reports had been commissioned by the Trust

and he handed me one of them to read. I can't remember whether he actually let me take that away or not but I assume he must have --

Q. Was it redacted?

A. -- because I refer to it later. Very significantly redacted. I mean, about 50% of it was blacked out. And I did not see the Jane Hawdon report but he told me that that had not raised any concerns. And, therefore, the purpose of the meeting was in order to consider the reinstatement of Ms Letby back on to the unit as she -- he also told me that she had been removed from -- from a clinical role for some months by that time and had raised a grievance procedure which had been upheld, and the result of that was that she was -- they were hoping that she would be reinstated, and that all I had to do was literally sit there and be a witness.

I think he was actually doing that in order to be seen to be protecting in some way the interests of the paediatricians. An independent party, if you like, to observe the proceedings.

Q. So to be helpful for the paediatricians. Was the request from Mr Harvey that you should be there to be helpful and supportive of them or when you say protecting?

A. I can't remember exactly what it was but I got

the impression that I was there as an independent observer.

Q. You say in that paragraph 5 he gave you:

"... a detailed explanation about the concerns expressed by the paediatricians, including a description of his personal analysis of a series of unexpected deaths on the NNU ..."

Did you understand that Mr Harvey had done a personal analysis of the unexpected deaths?

A. That was my impression, yes.

Q. What did he say to you about that, his own analysis? I see what you say about the RCPCH and Jane Hawdon's but about his own analysis?

A. Well, I couldn't really -- I didn't really say anything about it. I had no -- nothing to go on. He wasn't actually showing me the data.

Q. But you understood that he'd done something himself to reassure him --

A. I understood that he'd done something himself, he was the Medical Director, and with the very limited or zero knowledge I had at the time I had to take his word for this.

Q. You say here:

"The MD also raised concerns about the professional behaviour of some of the paediatricians ..."

What were those concerns about their professional behaviour that he raised in that first meeting with you?

A. There was also an issue over alleged -- alleged negative remarks that Ms Letby had accused some of the Consultant paediatricians of making and that if those allegations were to be upheld those would be considered professional misconduct.

It has to be said, however, that the paediatricians vigorously denied every making --

Q. I'll go it that in a moment. Sorry, to interrupt, Dr Tighe, but just dealing --

A. But that's what it was about. And also it was also that one of the -- some of the relatives had threatened to refer some or one of the paediatricians to the General Medical Council.

Q. So that was my next question, was it Mr Harvey, because that's his evidence to the Inquiry, that it was Letby and her father who'd raised the possibility of reporting the Consultants to the GMC; is that what he was saying to you or that he was --

A. No, I got the impression that it was one of the parents -- the parents of the -- of the children that had threatened GMC action. I wasn't aware that Ms Letby or her father had threatened to do so, although I might be not remembering that correctly. It might

well have been the other way round, as you say. I don't know.

But all I remember was there was the -- the potential for GMC referral was mentioned and that frightened me on behalf of my paediatric colleagues, because the potential -- the actual GMC referral is an absolutely disastrous thing to happen to any clinician because you are guilty until proved innocent in effect, and they would be automatically suspended from clinical practice until the GMC had made their decision. So it's a very, very major thing to happen and, as my evidence shows, a lot of my actions subsequently were to prevent that happening.

Q. At what cost would you say you would prevent that happening?

A. By encouraging my paediatric colleagues to do the right thing but to also be seen as co-operative and understanding of the executive point of view.

Q. If we go to the meeting itself, the reference is INQ0003523 and it starts at page 1. This is the meeting that you bore witness to. Did you say anything in the meeting?

A. I have seen this, yes.

Q. Did you say anything in the meeting --

A. No, nothing.

Q. -- when you were there?

A. Only afterwards when I spoke to the paediatricians informally.

Q. We see at the beginning:

"Mr Harvey reported that running in parallel to the above reviews was the HR process relating to the grievance."

What did you understand or did he say about the grievance process, can you remember?

A. Well, it was the first time I'd heard that -- no -- that there was a grievance. Mr Harvey might have mentioned it in the informal meeting in his office beforehand that a grievance -- no, he had mentioned it, there was a grievance procedure had been enacted and as a result that grievance procedure had concluded that she was to come back to work.

Q. And if you see at page 2, paragraph 3, it's recorded Mrs Rees read out Lucy's statement to the meeting. Do you remember that, a statement being read out?

A. Yes, I do.

Q. What did you make of that in this meeting?

A. Well, I thought it was completely inappropriate. We had been told that the meeting was to explore the reports -- the contents of the reports and

to explore the possibility of Ms Letby returning to work, not to hear a 20-minute melodramatic dissertation from Ms Letby herself.

Q. We know -- I think it's -- that can -- it's been on the screen earlier -- we know that there was reference in that letter to suggestions of various names that she had been called. Do you remember that?

A. Yes.

Q. And what did the Consultants say in response to that?

A. Well, they completely denied that they had said anything derogatory.

Q. Can you remember which one said anything specifically or not really, they just all said they hadn't?

A. I think it was Dr Jayaram, and they followed that up and also to say, "Can we please have details of exactly what these derogatory remarks were?" And that was no comment was made.

Q. In the statement -- and, again, I don't need to call it up -- but the statement that was read out said:

"Members of your team have been heard to publicly make comments such as angel of death, murderer on the unit, cold and calculated."

So that's what was said to the Consultants.
A. That I think is what Ms Letby was referring to.
Q. Yes.
A. But the way it was presented to us was that it was directly the Consultants that had said that not members of their team. The Consultants recognised that members of their team may possibly have said that.
Q. What do you think the tone of that meeting was? How would you describe it?
A. Well, it was -- it was pretty shocking really.
The -- first of all, it was extremely one-sided. The paediatricians hardly had any opportunity to say anything, and in fact hardly did say anything. The tone started off with the Medical Director being fairly placatory but just describing factually his -- his own and the board's interpretation of the two reports, concluding that there were no concerns, other than perhaps organisational issues and staffing issues, and it was followed up by the Chief Executive, whose tone was dictatorial, somewhat regimental, demanding that the board had made their decision, that this was final, and that the paediatricians were to draw a line under the whole thing, and were to accept Miss Letby back to work and were to apologise to her for the derogatory remarks

that they had -- that had been alleged they had made.
Q. Given that was the tone, did you think to speak up about this at the time in the meeting or say anything --
A. No --
Q. -- and if not, why not?
A. -- I didn't think this was my role. I was being specifically asked to sit there and be a witness and say nothing.
Q. In the earlier meeting that you'd had with Mr Harvey or --
A. Yes, yes.
Q. Did the paediatricians expect you to be there?
A. I expected some paediatricians to be there I didn't expect all of them -- I think all of them all of the Consultant paediatricians were there. I'm not sure. But I knew they were going to be some paediatricians there. That was the whole point of the meeting.
LADY JUSTICE THIRLWALL: But did they know you were going to be there?
A. I'm not sure. Ma'am, I'm not sure.
MS LANGDALE: At the top of the page on the screen, we see Mr Chambers stated that:
"The Speak Out Safely process had been

professionally managed, he noted emotions were running high at the time. Things have been said and done that were below the values and standards of the Trust. He added that an action would be developed from the outcome of the grievance".
What did you understand to be the Speak Out Safely process and did you know if that had been used or not?
A. Sorry, could you repeat that question again I'm having terrible trouble hearing you because of the echo in here.
Q. There is an echo. Me too.
A. And I've got bad hearing.
Q. Mr Chambers stated that the Speak Out Safely process had been professionally managed. Do you know what he meant by that and do you know if that process had been used?
A. No, I don't know what he meant by that. I think he was referring to freedom to speak out, the policy that the government were pushing at the time and following previous Inquiries. But it was -- I got -- it was almost a passing remark.
Q. You tell us in paragraph 12 of your statement, if you would like it go to it, you -- the document can come down now, thank you, Ms Killingback -- you met with Dr Jayaram on the morning of 29 January 2017 in his

office. What did you discuss with him then? The meeting, of course, had been on the 26th, what was your conversation with him about?
A. Right. I think actually this was probably a typo or error here. I think it's probably the 27th, the morning after, which was a Friday --
Q. Right.
A. -- the 29th was a Sunday. I doubt I -- he or I would be there unless we were on-call together.
Q. So it was the Friday looking at your subsequent letter.
A. So the content of the meeting, yes. Well, I was -- after the -- after the actual meeting on the 26th I met, after, in the corridor with Dr Jayaram and Dr Brearey to express my surprise and shock as to what we had both just witnessed and my deep concern for them and the position they were in and this particular conflict with the Trust, and this request to apologise for something that they firmly confirm that they had nothing -- that they had firmly denied, and so I had said to them, "Look, there's nothing to be lost by making a reserved apology for perceived hurt and it is not going to do any harm and you -- and it still leaves you complete freedom to proceed in any direction you want to go." But I said, "As your Union representative,

I'm extremely disturbed by the -- by the pressure you are being put under", and by the -- what I saw as a direct threats to them that if they didn't do as they were told by the Chief Executive there were going to be consequences. I think he even said, "There will be consequences." I thought this was completely inappropriate and realised that my position as a witness was no longer as such. I was now their Union representative because there was potential that their jobs were at stake. And that's very much where my role was in defending their terms and conditions and defending them should there be any threat to their employment as a result of what I thought they were doing, which was very much the right thing.

So I had had that meeting with them. But I said, you know, "If it's a matter of -- the other issue here is that the Trust want to let Ms Letby back to work. What do you think about that?" And they said "Under no circumstances. That is completely impossible. That is our bottom line and we cannot have that."

So I said, "Well, I'll help. I will do whatever I can to make sure that happens." So I said, "To take the heat off, let's think about writing this apology so we can proceed with the more important issues."

So I then --

Q. Sorry, just to --

A. -- met with Ravi the following morning. Sorry.

Q. I was just going to say you met him that following morning, but can I just ask you about what you said about the threats.

Dr ZA -- there is a cipher list if you want to see who that is, I can't give you the name of that doctor -- in her written evidence says she remembers someone saying:

"Senior management in the Trust were keen for someone to stick their head above the parapet and get blamed and they could get their head knocked off."

And she referred to the fact it may have been you saying that. You don't remember saying that --

A. Yes.

Q. -- but this threat of the GMC, did you discuss that with the doctors?

A. No, I didn't. Not -- well, I did discuss it the following morning with Dr Jayaram. I did raise that issue that I was aware that there were threats of GMC referral and that I was very concerned about that.

Q. So you did on the 27th discuss that threat of referral and you said a moment ago that was the worst thing that you -- when you were describing being

reported to the GMC you said that's just the worse thing, you wanted to avoid that if you could.

A. Yes, yes. It would be -- when, in my view, my Consultant colleagues had done absolutely nothing wrong and in fact quite the opposite, were proceeding in an extraordinarily professional and courageous manner I thought that would be disastrous because the GMC only has one way of doing things and that is suspicion and that's it.

You know, there's nothing -- that's what happens. Overnight you are suspended and then of course the paediatricians would have no ability to proceed with their case.

Q. You then went home that weekend and I understand from your evidence read the RCPCH report, did you? Or you tell us. What did you look at?

A. Yes, well, I then -- I was very disturbed by a) the meeting itself, b) the subsequent meeting with Dr Jayaram in his office where he went into further detail and don't forget I knew very little about this until Dr Jayaram sat me down and told me what had been going on.

So I then went home and did some research and, yes, my research was extremely disturbing and I wrote the letter that you have that you no doubt are about to

refer to.

Q. I am. Let me put that on the screen so you can tell us. INQ0003489, page 1 and 2. That's your letter of 29 January 2017. Please tell us what you are setting out there at paragraph 2.

A. So I start off by saying, you know, you've got to recognise that the Trust are doing something, they have come to a conclusion, the board has come to a conclusion. But that if you think they are wrong having now read the reports -- which of course they hadn't seen, they hadn't seen the case report at all and they hadn't seen the unredacted report -- and having seen that and considered them as impartially as you can, you cannot draw a line under this because there is by definition a significant risk that serious crimes have been committed and therefore could be committed again if not in this Trust then in another.

There was talk of Ms Letby being moved to Alder Hey so I was actually concerned that if that were to occur we still had a major responsibility to prevent that happening.

So -- but I gave them the alternative on paragraph 3, which is: however, if after reading the reports you agree the Trust has done everything they possibly can then of course you can take the accused

person back and draw a line under as you have been asked.

Q. You say in paragraph 1:

"I have done some background reading and there are disturbing similarities with the Beverley Allitt case and others."

So you were aware of that case.

A. I was aware of that case, yes. I read it up and there were others in the United States of professional staff murdering patients, murdering their own patients.

Q. If we go to page 2 of this letter, you set out there assurance for all the deaths or as many as possible, at 2, have been subjected to detailed forensic pathology and toxicology, including all remaining infusions, blood samples, et cetera, and you set out what's needed to allay concerns.

At paragraph 262 you believe a full forensic examination must take place:

"This has not been adequately carried out and this can probably only be done properly by the Coroner and the police."

Yes?

A. Yes. I was concerned that although I wasn't aware of the full details, I was highly suspicious that

the Royal College report had not been properly briefed about the concerns of the paediatricians, had been briefed by the Trust executive and therefore there was a biased briefing, if you like, and that was my only explanation as to why they had not addressed the issue that we were all -- we were all so concerned about.

All that was in the college, redacted college report that I saw was criticism of -- of the neonatal unit, organisational aspects. But it turns out that they did look into those issues and it was in part of the redacted part, but at that time we hadn't seen it.

So my concern -- and similarly with the Casenote Review for the pathologist, I was concerned that she had not been properly briefed either.

Q. Is this Dr Hawdon?

A. The Hawdon Report.

Q. She's not a pathologist but that review?

A. So I was -- I was thinking to myself how, both in the interests of Ms Letby and anybody and the -- and the Trust the only way out of this was to have a detailed forensic investigation and a detailed forensic investigation includes detailed toxicology.

I note that the Shipman Inquiry recommended, one of the recommendations -- I think it was 263 or something -- recommended that full toxicology is carried

out on every autopsy. But it was obvious that they had not tested for unusual drugs, otherwise they would have an answer.

Q. That can go down now, please. Then if we can have instead INQ0003159. This is a two-page letter from Mr Chambers, the Chief Executive, to Dr Jayaram and setting out there at paragraph 3:

"I confirm that a copy of the report was shared with the Coroner on 20 January following which a meeting with Mr Rheinberg, the Trust Medical Director and Director of Corporate and Legal Services was held at the Countess on 8 February to ensure the Coroner was fully briefed on all matters."

The Inquiry is investigating, Dr Tighe, what information the Coroner was provided with and I know you are not appraised with the details of that and indeed you didn't provide information yourself to the Coroner. But we see here on 16 February that it's confirmed by Mr Chambers that the paediatricians' letter of --:

"Dr Jayaram's letter of 10 February has been shared with the RCPCH College Review team and Dr Hawdon for comment in view of the fact you are not satisfied with the findings of those reports."

If we go to page 2 of this document stating:

"In summary there has been a thorough

internal/external review into the unexpected increase in mortality levels for newborn babies on our neonatal unit for 2015 and 2016 compared to previous years."

And setting that out. You are told, that can go down now, thank you, you are told by Dr Jayaram that the Coroner has been informed or given that information and we see your response at INQ0006079, page 3.

This is from you, is it? Dr Tighe, you see the email?

A. Yes.

Q. Yes:

"I am slightly surprised and pleased that the Trust has so rapidly escalated your concerns verbatim to the Coroner and to the authors the two recent reports."

And you set that out. What did you think was happening at this point when the Coroner had been given information from Mr Chambers?

A. Well, I thought that the Coroner had been given the letter that the Consultant paediatricians had sent to the Chief Executive saying that they still had major concerns that had not been answered and that they wanted him to open a full forensic inquiry as I had advised them to do.

I -- I was pleased that that had happened because I had confidence in the Coroner and the Coroner's

service. I felt that the Coroner -- it was so obvious to me that what was happening was of major -- at least demanded forensic, further forensic detailed investigation that the Coroner would also see that and would take action and if necessary would then refer to the police. It seemed to me that that was the process that we should go through.

I was however, well, not aware that the Coroner, I'm not sure if it's at this time or later, the Coroner had actually been extremely dismissive and had said that it was not in his jurisdiction.

Q. Well, we haven't heard evidence about that. We will I'm sure in due course, Dr Tighe.

That can come down.

You say the Coroner could then have considered referral to the police. Did you at any point with the paediatricians discuss they might go directly to the police if they had these concerns or indeed you might go directly to the police, one of you, someone?

A. Well, yes, that was part of the conversation I had with Dr Jayaram on the morning, after the meeting on the morning of Friday the 27th.

We did discuss that and my feeling was that we should go to the Coroner first. I had confidence in the Coroner that was, it turns out, misplaced. But I felt

it was the Coroner first and the police after if the Trust could not be convinced to do that themselves.

I felt the natural approach here was to encourage the Trust to go through the proper channels and do it themselves as soon as possible, bearing in mind please that our bottom line was already met. Ms Letby was no longer working on the unit.

It was by this time apparent that she was never going to go back to the unit under any circumstances. So we had time. As far as I was concerned at this point, the point of the letter you just showed me after the Coroner had been informed by the executive, that actually we had -- we had plenty of time. There was no urgency to contact the police. Our bottom line is our patients were safe and Ms Letby was no longer on the unit and wasn't going back there.

So in a sense, I had some sympathy with the Trust in wanting to see due process and in particular not wanting the media circus to get involved and upset The Families who, by this stage, knew nothing --

Q. And I think --

A. -- and they had been extremely -- and there was no process in place. They had discussed it, but they hadn't formulated a policy as to how they were going -- and what they were going to inform the parents

about when a police investigation -- so I thought it was appropriate that due consideration should be taken about how that was to be done.

Q. Indeed you tell us you reflected back in 2020 and you probably can now, about the position Mr Chambers and Mr Harvey found themselves in. How do you view that?

A. Yes. Could you be more specific about what you are asking me? Sorry.

Q. Yes. You made a further comment in 2020 I think about feeling -- who was more responsible or who was finding was under pressure to suggest -- let me find the exact --

A. Is this the comment where I had expressed some sympathy with the Chief Executive?

Q. That's right, yes.

A. Yes. Okay. Yes. That's a bit semantic really. But do you want me to go into detail about it?

Q. I just want to know what you think. Whether it was then or now, what do you think?

A. Right. So I put myself in the Chief Executive's position if I was sitting in the boardroom with -- surrounded by other non-medically qualified executives and whom the only medically qualified person in the room was the Medical Director

and the Medical Director was telling you, the Chief Executive, that there was nothing to be worried about and that the paediatricians were making a huge fuss over nothing, what would I do as a non-medically qualified Chief Executive who had himself appointed the Medical Director to that job?

Would it not be seen as a lack of confidence in the Medical Director not to accept his -- his professional medical opinion and so I had some sympathy for the Chief Executive in the position that he found himself in during this whole process which was in effect, I hate to say it, but in effect being driven by the Medical Director.

Q. Why do you say being driven by the Medical Director?

A. If the Medical Director had taken due consideration of his Consultant paediatrician colleagues, the experts in neonatology that he had available to him, and involved them from the start in a thorough external, independent investigation which they lead because they are the experts and which they subsequently interpret, then I think this whole thing would have gone in a very different way.

Q. You tell us at paragraph 19 about the culture and atmosphere at the hospital and if you go to your

statement, you say:

"In general, relationships between clinicians and managers, nurses, midwives and managers and between medical professionals between June 2015 and June 2016 were quite good at COCH in my opinion. However, there was an element of distrust between consultant paediatricians, senior nurses and senior managers as a result of the allegations made by the former."

And you refer then to:

"... professional rivalry as most Board members were from the nursing profession."

Can you expand upon that, please?

A. Yes. This is supposition. It's just struck me again that if I was in -- if I was sitting on the board as an Executive Director or whatever that the board were -- all the professional people on the board other than the Medical Director were from the nursing profession.

The -- some -- most of them were no longer in practice but, nevertheless, their backgrounds was from -- were from the nursing profession. The only medically qualified person on the board was the medical. There were other non-executive directors who were -- who were not to do with -- who were not medically or nursing colleagues, as far as I was aware, I may be wrong on

that, but as far as I'm aware.

So the nursing profession and their views of the nursing profession were overwhelming on the executive board.

The accused was from the nursing profession. Would it not, therefore, be natural for the nurses to defend their own and perhaps perfectly understandably on the basis that this situation -- this accusation was so utterly unbelievable and so extraordinarily rare that surely it cannot possibly happen here and that we must be wrong -- the paediatricians must be wrong, and that they must be victimising this poor nurse.

And if I'm sitting there as an executive, non-medically qualified, at the board and I'm being told all this I think I might actually accept it.

Q. You say:

"I think that this obviously did, these relationships, very negatively affect the quality of care on the NNU as Ms Letby was allowed to continue to murder babies after major concerns were raised in February 2016."

What do you say were the major concerns being raised in 2016?

A. Well --

Q. Later on you say -- just to be clear, you then

say:

"In my view, she should have been removed as soon as the paediatricians made their concerns known in late 2015, early 2016."

What concerns are you relating -- referring to there?

A. Well, by February 2016 there had been several more unexplained deaths and there had been -- and Dr Brearey had raised this formally with the executive. I think you should have records of those meetings.

Q. Sure. So you don't -- my question then, you don't know specifically when they were raised. They weren't raised with you in February 2016 or earlier --

A. No.

Q. -- this is your understanding of the chronology?

A. That is my understanding indeed. And so I felt that, with hindsight and the knowledge I have as a result of this Inquiry, that there was a very strong case to suspend Ms Letby in February and certainly March 2016 after that meeting.

Q. In terms of reflections in your statements on page 9, 22(d), you say:

"It was clearly inappropriate for the MD to mount his own internal investigation and to analyse this

himself, with no input from his own paediatric experts, or from any of the expert researchers employed by the Trust."

Are you referring there at 22(d) to that piece of work that the MD was telling you he'd done in that preliminary meeting before you attended --

A. I'm sorry, reflections -- could you give me the reference again.

Q. It is paragraph 22 of your statement and then it is d on the next page?

A. Yes.

Q. On the next page?

A. C?

Q. D. See are where you say:

"... clearly inappropriate for the MD to mount his own internal investigation and to analyse this himself ..."

Can you find that, Dr Tighe?

A. It's all about the Coroner I'm looking at. I'm looking -- which --

Q. That's paragraph c go to the one below paragraph --

A. Para d. Right. It's my hearing again, sorry.

Yes. So the Medical Director's first response was to analyse the staffing data himself and cross-reference

that with the deaths and serious clinical incidents. I'm not sure if he did do serious clinical incidents but it was certainly the deaths and --

Q. Do you think it was the deaths?

A. -- if I remember, Ms Letby was alleged to be present at every single one of them and that this was one of the main reasons that my Consultant colleagues, paediatric colleagues, had raised concerns. And he did this himself and he mounted his own investigation. He didn't have any input from his own paediatric experts on site, or indeed -- we actually had a very well-established research department at the Countess of Chester Hospital with some internationally renowned research experts who would have known an awful lot about research methodology and particularly statistical analysis, and he didn't do that, he did it himself.

Q. Do you know that? I mean, Mr Harvey can give evidence himself about that, but he may well have employed assistance from others in the Trust. Do you know he didn't or --

A. No, I don't know if he didn't --

Q. No, okay, so we can ask him about that.

A. -- but the -- it subsequently came to my attention that the -- that the quality of that report was not particularly good and did not justify the

conclusions that he came to, ie that there were perfectly reasonable explanations for these deaths and, and unexplained incidents.

MS LANGDALE: Thank you, Dr Tighe, I have no further questions. Does my Lady?

LADY JUSTICE THIRLWALL: No, thank you very much indeed, Dr Tighe. I'm sorry about the echo --

A. It's all right.

LADY JUSTICE THIRLWALL: -- it is maddening.

A. It is all right, I need to get a hearing aide.

LADY JUSTICE THIRLWALL: But thank you very much for your help. You are free to go.

So, Ms Langdale, tomorrow morning.

MS LANGDALE: Tomorrow at 10 o'clock.

LADY JUSTICE THIRLWALL: I will adjourn until 10 o'clock tomorrow.

(4.49 pm)

(The Inquiry adjourned until 10.00 am, on Wednesday 9 October 2024)

I N D E X