Tuesday, 12 November 2024

(10.00 am)

LADY JUSTICE THIRLWALL: Ms Langdale.

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

LADY JUSTICE THIRLWALL: Dr Hawdon, please come forward.

DR JANE HAWDON (sworn)

Questions by MS LANGDALE

LADY JUSTICE THIRLWALL: Do sit down.

A. Thank you.

MS LANGDALE: Dr Hawdon, you have prepared a statement for the Inquiry dated 22 May 2024. Can you confirm the statement is true and accurate as far as you are concerned?

A. That's correct.

Q. Before I ask you anything about the statement, I understand you would like to say something?

A. Yes. As I am sure everybody is aware, my sincere condolences are to the Family and others affected by this -- this tragedy.

Q. You set out for us your qualifications in your statement and your various memberships.

Since 2017, you've worked with the Royal Free London NHS Foundation Trust and you are the Medical Director?

A. I am one of the Medical Directors. The structure is a Chief Medical Officer and four Medical Directors reporting to the Chief Medical Officer.

Q. You are a Consultant neonatologist, although ceased acute clinical duties in January 2022?

A. That's correct.

Q. You have had various professional roles including in 2022 appointed Clinical Lead for the Royal College of Paediatrics and Child Health Invited Review service and that continues until July 2024?

A. That's ceased now, yes, that's correct.

Q. The Inquiry is aware -- indeed everyone is apparently -- you in terms of this case were involved in providing a report to the Countess of Chester. If I can take you through the chronology of communications around that and your report and its recommendations.

You tell us, first of all, that you received a telephone call from Sue Eardley from the RCPCH. Can you tell us now what that telephone call was about and what she said to you back in 2016 in September?

A. It is a long time ago and it was a telephone call. As far as I recall she -- the context was that they had had the College review at the Countess of Chester and she had been asked to suggest some clinicians that could take an independent review of some

case notes and she asked if I was happy for my name to be put forward and she stressed that it was not on behalf of the Royal College of Paediatrics and Child Health that I would be doing so; it would be as an independent person.

Q. Did she say "clinicians" in the plural?

A. I don't recall, I'm sorry. I -- I --

Q. That is what you have just said now, isn't it; you said "clinicians"?

A. I don't recall. I know that she was asked to put at -- at least one name forward but I don't know what she had been asked to do.

Q. So what did you understand in that call she was suggesting you might do or be put forward to do?

A. My understanding was to review case notes.

Q. Did you get a sense of how many case notes from that conversation?

A. I did not, no.

Q. Did you get an understanding of why it was necessary?

A. I did not, no.

Q. Did you get an understanding of what they had recommended in totality?

A. No, I did not.

Q. Did you ask or did you not think it was

necessary to ask, or what?

A. My -- my view at the time was that if -- if the suggestion was taken up and I was going to be approached, that it would be the Countess of Chester that would be instructing me as to what would be required.

Q. Did you get any sense of urgency from talking to Sue Eardley about the instruction?

A. Not from that conversation, as I recall.

Q. Did you get any sense of concern from her about the situation at the Countess of Chester from that conversation?

A. Again, as I recall, I did not.

Q. Let's go to the email instructions, please. INQ0014365, page 3. We see there:

"Dear Dr Hawdon,

"I have been given your contact details by Sue Eardley at the RCPCH as someone who might be able to assist us in a detailed Casenote Review of a number of neonatal deaths and near misses. This is one of the earlier recommendations following a College Invited Review which was stimulated by our clinicians highlighting an increase in the number of deaths in our neonatal unit in 2015 and 2016. They also highlighted concerns about the mode of death of some of these babies

in that they seemed to not respond to normal resuscitation measures as they would have anticipated. The Invited Review team have made a recommendation of detailed review and examination to be carried out together with the relevant paediatric pathologist by two independent specialists reporting separately. It is likely that the review would extend to maximum of 13 deaths and between 4 and 6 significant near misses.

"I appreciate you are busy and not surprisingly there is a sufficient degree of urgency to this investigation which might make things difficult, but I would be happy to have a detailed conversation and share more information if you felt that you might be able to help."

You respond at the top:

"I am able to assist but first must ask about terms as I would need to do this in my own time."

You say:

"Do I need to attend the Trust? I do have extensive experience reporting for claims (PHSO and HM Coroner)."

Looking at Mr Harvey's letter, what did you ascertain from that?

A. I ascertained that concerns had been raised to him regarding a number of deaths and regarding the mode

of deaths and near misses.

Q. Did you detect from that there was a real need for a sense of enquiry about the mode of death?

A. I -- I -- there will always be an enquiry about the mode of death and as I -- as I think we will come to, there is only so much that is available from a Casenote Review.

Q. When the request in that letter of instruction came for a detailed Casenote Review, what did you think that required?

A. The there has to be a balance between the sense of urgency and the level of detail that could go into a review.

My understanding was that the sense of urgency was that it was going to be impossible to spend the 10, 12, 15 hours that would normally be required to do a full -- for example for litigation purposes, and so I chose having had a conversation with him, I think you will see about whether they had a structured review tool, I chose to use a nationally accepted structured review tool in order to go through the cases as quickly and as thoroughly as possible within the -- the sense of urgency that he described.

Q. If you go to, please, page 2 of this INQ number, we see a further email from Mr Harvey:

"Many thanks for your quick response. I absolutely recognise the workload required. This is outside normal working time and am happy to consider reasonable fees, either as a one-off or an hourly rate. Not surprisingly having reviewed in-house and had an Invited Review we have copies of most documentation. I think it would be unreasonable and inefficient to expect the review to be carried out at the Trust, with the possible exception of any particular issues or secondary review on the back of the main documentary process."

If we go, please, to INQ0012066, page 1, we will see the letter of instruction. We see there, Dr Hawdon, that 5 October 2016, Mr Harvey sends you this, thanking you for accepting instructions to carry out a review of the case notes and associated records relating to 13 neonatal deaths and four near misses.

Pausing there, did you know which ones and why were selected for your review?

A. I -- I did not know why they were selected other than they were the deaths and near misses that he had referred to in the first email.

Q. The next paragraph refers to the instructions following from an Invited Review by the Royal College of Paediatrics and Child Health. You had obviously spoken to Sue Eardley. Did you think at this point or at any

time subsequently about having a conversation, either with Sue Eardley or anyone else from the RCPCH, to see what they had been doing and dealing with?

A. I think that would have been completely outside my remit, it would not have been appropriate to do so.

Q. So what was appropriate from your perspective, to just take instructions from Mr Harvey on behalf of the Trust?

A. That's -- that's correct, my ...

Q. Did you think to ask him if you could see a copy of that and go directly to him for it or did you not think that was helpful or necessary or what was your thinking when you saw that?

A. I think at that stage I had been asked to carry out Casenote Reviews. Particularly having read that letter and read the other recommendations of the College, I considered at that stage I was part of a process and a defined part of the process was to carry out Casenote Reviews.

Q. He refers in that second paragraph that they recommended a detailed forensic Casenote Review. What's the difference between a Casenote Review as we see you describe it and a forensic -- detailed forensic Casenote Review?

A. So my understanding of detailed forensic is that a much broader inquiry is taken into things that may not be in the case notes. They may be in unit records, staffing records, equipment records. There are -- there is more information available than just from the case notes themselves.

Q. And in the earlier email he'd mentioned -- carrying out together with the relevant paediatric pathologist is what the recommendation was. Who did you think was going to locate or contact a paediatric pathologist if it was considered one was necessary?

A. In -- in my view the only person that could do -- the only organisation that could do so was the Trust.

Q. Would it have been helpful for you to have the instruction at the same time as you working in tandem with consultation with somebody?

A. I -- I believe it would have been. I -- either in tandem or in close sequence with discussion.

Q. When you saw that letter, did you think forensic Casenote Review, did that give you cause to pause in your understanding about what you had been asked to do about Casenote Review or did you just see it as the original task, as it were, just going through the case notes?

A. I -- I as I in my covering letter write I replied regarding the limitations of my Casenote Review and that it could not be a detailed or forensic review.

Forensic can mean a criminal connotation, at that stage I did not read a criminal connotation into it. I read understandably that there had been deaths and near misses that were concerning them and therefore, a detailed review of those needed to be carried out and "forensic" in my view was another word for "detailed" including the broader context of other things around the unit.

Q. So more rigorous?

A. Yes.

Q. But not where there is a suspicion or cause for suspicion around what's happened, a criminal act or deliberate harm?

A. There was clearly concern, there was clearly concern about the number of deaths and number of near misses. The suspicion of criminal intent was certainly not raised to me and I did not read criminal intent into the detailed forensic case note expression.

Q. We see (a) to (d) and there is another one overleaf but just concentrating at the moment from (c).

He repeats -- (a) to (e) are recommendations from

the RCPCH. He repeats examination with the relevant paediatric pathologist of the postmortem findings and any additional information available on their files which might identify cause of death.

We know ultimately you recommended that there should be pathology and pathology investigation. Did you think to say that at the beginning, or let's have that before I do the Casenote Review, or not?

A. I think it would have been a less than necessary delay in the Casenote Review.

Q. If we go over to page 2. It stated:

"We understand as part of this review you may need to consult with a neonatal pathologist."

But you say that would have caused some delay.

Might it have better informed you from the beginning?

A. I am used to in clinical practice the two happening either in parallel or in tandem.

There are different forms of information, both need to happen. But I do think that the two needed to happen and be brought together.

Q. If we go to page 3, we see the children by reference to the indictment ciphers that you were asked to consider and if we go over or go to INQ0003328, page 1, we see when you are sent them.

It looks like they are sent on 14 October, over the page, page 2. We know of course that the recommendation or the suggestion was that you should have electronic copies and they should be paginated et cetera what state were these case notes in when you received them?

A. To my memory, they were loosely filed, they were not well ordered and I don't believe they were complete in terms of they were not full sets of records.

Clearly full sets of records for some of these babies would have been quite large volumes. I -- I received -- I didn't receive large volumes and in the second box there were some loosely filed papers that didn't apply to any of the babies at all; it was -- it took a little bit of sorting out to get the individual babies in some sort of order that I could work from.

Q. In your medico-legal practice were you used to that, getting papers in that state, it is something we know you remarked upon?

A. Very unusual.

Q. Very unusual.

Can we go, please, to INQ0003120 and this, Dr Hawdon, is the letter to Mr Harvey from the RCPCH, Sue Eardley's Head of Invited Reviews.

You didn't see this letter or their report at the time, did you?

A. I did not.
Q. When was the first time you saw that?
A. When it was sent to me with the supporting documents regarding this Inquiry which I believe is in April this year.
Q. We see on this letter, in paragraph 4, reference to a nurse and a requirement that the nurse should move from the unit to other duties and these steps appear to have been taken on the basis of an allegation made by one member of medical staff supported by his medical colleagues.
Over the page please, if we can.
And a recommendation:
"Action required: Trust takes immediate steps to formalise actions taken with the nurse."
We also see under "Action required" the points (a) to (e) that you were instructed upon but you didn't receive this part of the first paragraph ideally using -- if we can highlight that, please, Ms Killingback, the third paragraph halfway through:
"... ideally using at least two senior doctors with expertise in neonatology pathology in order to determine all the factors around the deaths.
"The case notes and electronic records should ideally be paginated to facilitate reference and

triangulation."
Dealing firstly with the points about the nurse being taken on to other duties and an allegation being made about her, do you think you should have known about that expressly?
A. I think it would be for the Trust to explain the rationale for not doing so. It could be that they did not want to bias or influence my review.
Had I been told that there was a suspicion about a member of staff, I would have had a much more detailed conversation with Mr Harvey as to whether it was or was not appropriate for me to proceed and the basis on which I would be proceeding.
But I would also have been asking what other measures were being taken on the basis of those allegations and that action that had been taken.
Q. Well, even with the information that's provided there, with your safeguarding hat on, what would you have said about what are you doing with those allegations? This refers to HR but what would you say?
A. I would have asked what safeguarding processes were being employed.
Q. Would you have expected them to be even on the information as it's given there?
A. In my own practice I would.

Q. And just to be clear. What does that mean, what would you -- what external referral would you make or what would you do with that?
A. So my experience is that Trusts have very good and able safeguarding teams, they are experts and they themselves have close working relationships with social services and the police. So my response to that sort of concern would be to involve the Head of Safeguarding if it was such a serious allegation and agree with the head of safeguarding how that would then proceed.
I -- I would not as a neonatologist or as a Medical Director have proceeded without the involvement and guidance of the Head of Safeguarding.
Q. In what way -- you said earlier perhaps there was a concern that would bias or lead you to some bias approaching the case notes. But surely knowing of this concern is a full picture, isn't it, when you are looking at it?
A. That -- that's correct.
Q. When you were looking at not simply deaths, unexplained and sudden deaths, it is a crucial part of the full picture, isn't it?
A. I would agree, yes.
Q. And in fact we see to the highlighted section that is why the RCPCH are suggesting at least two senior

doctors with expertise in neonatal, neonatology and pathology and they are talking about the need to facilitate reference and triangulation.
I just want to pick up on triangulation in a forensic review. What's the importance of triangulation between disciplines to understand what has happened in some circumstances?
A. Sorry, I didn't mean to interrupt. It's highly important. One person reviewing one aspect can't get a full picture and the pulling together of the information, triangulation is essential.
Q. If we go to the next page, we see they tell Mr Harvey they:
".. have identified four individuals with appropriate expertise and experience who may be able to take this on and I'll advise of these separately and continue to seek alternatives if there is an issue there."
We know that of course ultimately in the police investigation there was a Consultant paediatrician, Consultant paediatric neonatologist, Consultant paediatric pathologist, Consultant paediatric radiologist, Professor Owen Arthurs, a Consultant neuroradiologist and a Consultant paediatric haematologist who was instructed across these cases.

Again, dealing with the point of triangulation, what's the significance of a multi-disciplinary approach into investigations of unexplained and sudden death?

A. Because a number of people have different areas of expertise and there's also other factual information, not just clinical information, to be taken into account with the triangulation.

Q. You mention somewhere in your statement that you didn't know about the insulin administered to two of the babies, in fact you weren't asked to review those babies so wouldn't have seen those case notes and those C-peptide results?

A. (Nods)

Q. So the notes you were looking at were very much the notes provided at the time?

A. That's correct.

Q. You were relying on how full they were presumably about the nature of surprise and shock and concern from doctors and nurses at the time about various events?

A. There were very little, if -- if nothing related to doctors' and nurses' responses. As you know I asked for example perinatal review notes, et cetera, which were not forthcoming.

Q. And you didn't speak to any of the clinicians

or any of the, who you learned subsequently, paediatricians who had concerns, you didn't speak directly with any of those; that wasn't suggested?

A. I did not, my -- my communication was through Mr Harvey.

Q. Mr Harvey didn't suggest that so that you could get a handle on what their concerns were?

A. He did not. As -- as we know subsequently I did offer to take part in a telephone case conference if that was going to be in any way helpful.

Q. In paragraph 32, to go back to your statement, you say:

"I was not aware, at the time of being asked to conduct Casenote Reviews, of the suspicions that a member of nursing staff was connected in some way to the sudden and unexpected deteriorations. If I had been aware, on the basis of my findings on Casenote Review, I would have made urgent personal contact with Mr Harvey urging him to follow appropriate Trust safeguarding and governance processes."

You have referred to the safeguarders and how you would report to the local authority and work closely with the police.

What other processes would have been engaged here?

A. That would have included review of the cases

again internally. It would have included staffing. It would have included questioning whether there had been equipment failures, contamination of nutrition solutions. They are a very, very broad level of inquiry into the circumstances of those babies.

Q. What about the Child Death Overview Panel, where would they fit into this?

A. They -- they are aligned to the safeguarding processes, yes.

Q. What's your understanding about sudden unexpected unexplained events whether they are referred to Child Death Overview Panels or not at that time?

A. I -- I can't say what the Trust was doing at the time. My recollection at the time is that -- is that all child deaths were reviewed by the local panel where I was working and it was also every infant death, every baby death would be very rigorously reviewed by the unit, by the unit's governance processes with external involvement as necessary.

Q. If we can go now to your report and your letter to Mr Harvey on 29th of the 10th 2016 INQ0003358, page 1. I will give you time and others to read this, Dr Hawdon. If we can have the first page and then the second page in a moment, Ms Killingback.

(Pause)

Page 2, you respond along the lines of the (a) to (e) which we traced through the RCPCH letter, Mr Harvey's letter to you and your response.

You explain that you have done a synopsis of key events rather than the level of detail required.

Can you just explain why a synopsis followed rather than a full systematic chronology from each case?

A. Because that would have taken a lot of time, I did a chronology of key events as part of the synopsis and used the MBRRACE methodology.

Q. Roughly how long did you spend on all of the babies in total?

A. I believe I worked pretty solidly during the days of one, perhaps two weekends.

Q. So what's that, two days or four days I can't tell if that is?

A. I can't recall, it may have been three days of about 10 hours each time.

Q. You say you did comment to the extent that it was relevant on the second issue about whether there might have been escalation or opinion from a regional centre. In fact, the comments you made about care or sub optimal care related to matters such as delayed antibiotics, there was no red flag, was there, leading to causation of death in any of the cases that you

flagged up?
A. The -- my review of the cases was that the there were varying concerns including the unexplained and unexpected. But the -- the varying concerns regarding clinical management were around antibiotics, delays in escalation, whether the baby was born in the right unit for the level of care the baby was going to require. It was a varied clinical picture.
Q. In terms of (c), examination with the relevant paediatric pathologist, was the issue, you made the point that the postmortem results had not been available and you weren't in a position to consult with the perinatal pathologist and you suggested that Mr Harvey instruct one.
A. That's correct.
Q. I think we have covered further -- earlier, rather, it wasn't something you thought to suggest before doing the Casenote Review because you saw them as separate tasks at this point?
A. That's -- that's correct.
Q. In terms of the details of all staff with access to the unit from four hours before, you state "I am not in a position to perform this".
You hadn't been sent anything that would enable you to perform that even if it was your expertise or

something you would do; is that right?
A. That is correct.
Q. Have you ever been asked to look at rotas or details and try and forensically examine who was where, when and how often?
A. I -- I don't believe I have, even in my own clinical practice.
Q. Did that surprise you being even asked that? Did that make you wonder: why am I being asked that?
A. I did and it appeared that the College of Paediatrics and Child Health was putting forward many different possibilities that might explain the unexplained deaths or baby deaths.
If I could come back on that, if that's all right.
Looking at who's on duty and who's caring for a baby again doesn't necessarily imply criminal intent. It could be that somebody without the competences could have been caring for a baby or somebody could have been caring for more babies than was safe to do so. So a review of staffing doesn't necessarily mean that there is criminal intent.
Q. Understood. My question was more had you ever been asked to do that? You give reports on medical negligence cases, provide reports, have you ever been asked to look at who was around or is that just

a different --
A. No.
Q. -- part of the task? That is not something for you, is it?
A. No, that's correct. In clinical practice certainly we look at staffing levels and who's available to care for the babies on -- on that particular shift.
Q. If we go now, please, to the conclusions of your report, so it's page INQ0003172, page 44. We see there that you have listed a number of babies where death/collapse is unexplained. You say:
"It is the investigation of cases which would potentially benefit from local forensic reviewers to circumstances, personnel et cetera."
If we go to the next page, please, page 45. So same INQ, page 45. Thank you. Point 6, you say:
"Subject to Coroner's postmortem reports, there should be broader forensic review of the cases described in category 2 above as after independent clinical review these deaths remain unexpected and unexplained."
What did you mean by a broader forensic review?
A. Taking into account various other factors including equipment, personnel, just every detail of the circumstances that could be reviewed.
Q. There is subsequent correspondence between you

and Mr Harvey, when postmortem examinations have been sent to you. If we go, please, to INQ0003102, page 1. While we are finding that, Dr Hawdon, if you had been the recipient of your report with that list of babies requiring who you say require further forensic review, and the death collapse is unexplained, would you have recognised the significance of that grouping?
A. I think even without knowing what we know now if I had been the recipient I would have said something along the lines of: we have a problem here.
Q. If you held additional information of concern, such as about a nurse being present at these unexplained events and paediatricians raising concerns about response to resuscitation, for example, what is the level of concern your report should have triggered, do you think?
A. In my view, as the recipient of that report, and the knowledge of the other information, I have no doubt that it should have triggered safeguarding processes.
Q. What about referral to the police directly?
A. My -- I have only been involved once in a circumstance where I was worried that there might have been deliberate harm to a baby on a neonatal unit and I went through safeguarding in order to involve the

police.
One of the reasons for that is that the police that work with safeguarding teams are very, very sensitive to the circumstances and it doesn't -- it doesn't delay things. But it does mean that police would have a certain skillset to become involved.
Q. So they know the right police officers to go to or the right level, that's the point about --
A. That is correct.
Q. -- ongoing liaison between local authorities and the police?
A. Yes, yes.
Q. In that case you say it doesn't delay, but how quickly, if you make a referral to safeguarding in that case, did the police become involved or notified?
A. Almost immediately.
Q. Because they know who to pick the phone up to and know how to approach these matters?
A. Yes, that is correct, they have processes to follow.
Q. It is different in a hospital, isn't it, in terms of how sensitively it's managed, how it's dealt with coming into a hospital?
A. That -- that's correct. If -- if I -- if I could use the example that I was involved with, the

police came in in plain clothes and passed themselves off as estate staff who needed to take the drug cupboards off the wall in order to do an audit. Luckily there was no mal-intent, but they -- they managed it very professionally without any of the parents on the unit suspecting that there was anything amiss.
Q. Going to this document on the screen, if we may, Dr Hawdon. These are the four babies that you are sent postmortem reports for. You remain of the view that three of them remain unascertained or unexplained and Child D you have by now seen Dr McPartland's report, "cause of death: pneumonia", and you concur and say "delayed antibiotics may have been contributory". We will be hearing from Dr McPartland later. But she tells us that death with pneumonia as opposed to from pneumonia is context dependent.
Do you agree with that?
A. I do, yes.
Q. What is important in assessing context, what do you need to know before you arrive at that distinction?
A. The clinical -- the clinical course leading up to any change in condition and -- and the sad death.
Q. You say in your case you didn't have detail from the nurses, doctors, either about any symptoms or

things that they had observed in respect of Child D other than the ones we have seen you summarise in your notes.
A. I have been back to obviously look at that case and what I identified was that there was a backing off of respiratory support for this baby on the day that that baby sadly deteriorated -- condition deteriorated. And so looking at the clinical details it was plausible that the change in respiratory management had contributed to the baby subsequently deteriorating again.
Q. Plausible, but not when you have the fuller picture of the surrounding evidence that became available subsequently?
A. Correct.
Q. We know that your report -- and I will ask Mr Harvey about this, I don't need to ask you -- Mr Harvey moved things around your report presumably when he got further information. For example, he moves Baby D from the "unexplained" category above to the one that's explained.
That's a matter for him, but as far as you are concerned, you didn't see any further version of your report with notes or additions or things being moved around?

A. That's correct, not until April this year.
Q. But to use that example, given what you said in this email, a change to move Baby D, it would appear to reflect what he may have thought was your view now, having seen the postmortems; is that fair?
A. That's correct.
Q. Paragraph 68 of your statement, you do say review by -- that can go down, thank you Ms Killingback:
"Review by an expert in perinatal pathologist and local/broader forensic review would be separate with differing methodologies but complementary. Expert perinatal pathology review is essential for a broader forensic review of the case where postmortem information is available, and it is important for a reviewing pathologist to receive all relevant information regarding the babies who died."
I just want to give you an opportunity again to say what is "all relevant information" when you are looking at this?
A. So for a pathologist it would be clinical information. I wouldn't be expecting a pathologist to be doing the broader unit based investigation, it would be a clinical pre-session.
Q. You subsequently get further emails from Mr Harvey, if we can go to INQ0099055, page 1. This is

February 2017. Mr Harvey emailing you:

"Apologies for emailing on a Sunday morning but I just wanted to give a heads up. The review features in an unplanned fashion in The Sunday Times. It references your review which was demanded by the College review but there are no names, nor is your name in the public domain. It is not my intention to give your name and certainly not without first confirming with you one item that features in the report and had also been highlighted by our medical team was unexplained mottling although this was only reported in the notes in three babies in your notes review. Our medical team had put great emphasis on this although disproportionately, given the incidence in the notes and my experience of medical memory is that it exaggerates numbers. I would however be interested in your comments about so-called skin mottling as a clinical feature in babies."

And we see above your response:

"Mottling is variable. If transient, probably not of significance, but if longer lasting reflects peripheral shut-down. Reasonable nurses and doctors spot recognise it as significant finding which if nothing else warrants close observation and additional tests if there are other concerns."

There is a contrast there in his description of the

doctors and what he says they are doing and your response:

"Reasonable ... significant finding which, if nothing else, warrants close observations and additional tests".

What did you make of that? Did you spot that mismatch between the way he summarised it and your response: well, if they are concerned, this warrants close observation?

A. That -- that's correct. I was surprised that he asked about mottling because it is such a common finding in babies that are unwell and we were sadly talking about babies who were unwell.

We know now that the allegation was of injecting air and that mottling is said to be a feature of air embolus. That is something that would not have crossed my mind at all at that stage when thinking about mottling. I would be thinking of common causes of mottling of the skin.

Q. If we go, please, to paragraph 75 of your statement. You knew -- you know now Dr McPartland was instructed but were you told at the time that she was going to be instructed?

A. I was not.

Q. Would you have expected to know or have an

input into that?

A. Well, as we've noted, I had said that perinatal pathology review was important after my Casenote Review and I assumed that that would be going ahead and were I to be required to discuss it with the pathologist, I would be called upon to -- to do so, again recognising I was part of a process.

Q. You tell us at paragraph 78 that there were there was further communication in February between yourself and Mr Harvey and indeed one of the things he sent you is a letter I am going to show you now, from the paediatricians to Mr Chambers, so that is INQ0003117, page 1.

Take your time to look at this and if we could highlight please, Ms Killingback, paragraph 2 -- sorry, point 2, not paragraph 2. Go overleaf to page 2, the top:

"The paediatricians said to Mr Chambers 'we do not consider that the episodes of care that she [that is you, Dr Hawdon] considered sub optimal could explain the rise in neonatal mortality and the sudden collapses in this time period'."

Do you agree with that when they say that?

A. That's correct.

Q. So they were right and it was very clear, as

far as you are concerned for another medic that you were not saying wherever you describe sub optimal care that explained a sudden death and collapse in the various cases, particularly those that you had highlighted in that group?

A. That is correct.

Q. Pausing there, Dr Hawdon. We have heard from the paediatricians, and one in particular expressed her frustration that in effect both her, the Royal College review, she is a member of the Royal College, and then your report both were used to deflect suspicions and concerns about Letby and in effect to try and criticise the medical care they were providing on the unit.

Do you understand now you have seen the whole picture how they must have felt frustrated by that?

A. Absolutely.

Q. Here you are wholeheartedly agreeing with them that your report didn't anyway explain these deaths or sub optimal care resulting in deaths, yet we hear this thrown around as if it did. Can I give you chance to respond to that, that it did not do that and why you say it did not do that?

A. The -- we all know that care can be improved and unfortunately sometimes if there are lapses in care, it can lead to babies becoming more poorly and sadly

dying and it's very important that we take that and -- and act on it and I am quite sure they, they did.

I do know from what I was told they were a busy unit and they had -- they had some very poorly babies so that -- the two have to happen in parallel. Their suspicions that there was mal-intent had to be taken seriously and any measures to improve the standard of clinical care for the babies also had to be taken seriously. But the two didn't preclude each other.

Q. So delayed antibiotics did not cause a death, something very different did, but you were looking at those features in the Casenote Review, not simply how a death was caused?

A. That -- that's correct.

Q. You couldn't explain though deaths, that is the point?

A. That -- that's correct.

Q. In terms of the near misses and deteriorations, without fully being aware of what clinicians and nurses had noted at the time, you weren't really able to do very much just looking at the records, were you, if you were missing key information?

A. That's correct.

Q. You referred to mottling; you didn't know about this rash, what it looked like, the concerns the

paediatricians were sharing about that?

A. That's correct.

Q. So it's more of an academic exercise; is that fair?

A. That's correct.

Q. What you really need in a circumstance like this is real people telling you the real events as they remembered them?

A. That -- that's correct.

Q. We see at INQ0014376, page 2, the letter that Mr Harvey sends you forwarding that letter from the paediatricians to him. Page 2 at the bottom:

"Dear Jane,

"I thought it was important to share this letter from ... paediatricians having shared both the College review and your review with them."

He says he's had discussions with the Coroner:

"... initially a briefing at the outset when all the issues were raised and again last week having shared the College review with him."

When he says "all the issues were raised", what did you think that meant, if anything, if you focused on that paragraph?

A. I -- I didn't read anything into it at the time. I -- perhaps the issues that were raised by the

paediatricians.

Q. Next page, please, page 3 of the document. There is a bit of a dig at the College:

"The paediatricians made allegations against one member of staff which we made the Review Team aware of, as did the paediatricians when they met the reviewers. These didn't feature in the final report but were covered in observations by the reviewers that were shared with the neonatal and paediatric leads; namely this was based on coincidence and gut feeling. We intend to now share those comments with all the paediatricians since we are unsure that the leads have."

What did you make of that paragraph, if anything?

A. It's a difficult paragraph to understand but it's the first time in my recall that I knew -- that I learned that a member of staff had been suspicious or implicated.

Q. The next paragraph:

"Our paediatricians repeatedly raised the issue that they still feel hasn't been resolved, ie the unexpected collapse and failure to respond to resuscitation in the way that is expected.

"At one point they even went so far as to suggest that given they had observed unusual mottling, air embolism was responsible. The pathologists at Alder Hey

have assured me that a significant air embolus would be detected at PM, therefore how common is it for a neonate to collapse unexpectedly?"

Was this the first time you knew directly from him there was concern about deliberate injection of air?

A. That's correct.

Q. I don't suppose you have received many letters like that in your medico-legal practice?

A. No, that's correct.

Q. Is this the only one with that allegation or suggestion put there in --

A. Accidental air embolism is not -- is not unheard of and something that is looked, for example, during exchange transfusions that are carried out three an umbilical line. So we are all -- we are all aware that air embolism is a complication.

Did they -- I am trying to see whether they said injection of air?

Q. It says:

"At one point they even went so far as to suggest that given they had observed unusual mottling, air embolism was responsible."

Did that make you, in conjunction with the paragraph above, realise it was about a person, "gut feeling", deliberate infliction of an air embolism?

A. That's right. They are two separate suspicions that appear to go together.

Q. You respond to that email, INQ0014376, back to page 2, if we can. You answer his question about unexpected collapses, paragraph 2 of your response at the top:

"Unexpected collapse in an otherwise stable baby is rare and I agree there had been more cases than would be expected especially those for whom there is no explanation and the PM cause of death is in question. The paediatricians infer more cases that I did not study."

Did you begin to see that there may be more to it?

A. That -- that is correct.

Q. You comment:

"... insufficient details in records and unlikely to have been possible to record in anything but real-time to determine for each whether the collapse and impossible resuscitation were [query] A and C in particular purely out of the blue and unexplained, and C the sinister cause."

So you recognise the need to have accounts individually from people involved in the deaths to see what they say?

A. That is correct and that is what I assumed

would happen.

Q. There are further emails between yourself and Mr Harvey in April 2017. If we can go to INQ0003124, page 1. It starts at the bottom the page, if you can go to page 2 is the body of the email, so it is from you to Mr Harvey.

Broader review. You make reference to a broader review. Actually, sorry, can we go to the email below "Good morning, Jane" first.

"Just wanted to update you on progress and ask you some follow-up questions if I might. One of the sticking points we have met is your use of the phrase 'broader forensic review' with regard to the cases in category 2."

In the third paragraph of the email he says:

"We have instructed a QC to review our process and to give a perspective on the reviews and next steps."

This is Simon Medland QC.

"He has met with the board and the paediatricians and one of the challenges he has given to the latter is to set out what he's described as their best points which are those matters which they say most clearly indicate in their minds reasonable grounds for suspecting that a criminal offence has been committed. I am sure that I would know the answer because I am sure

that you would have called it out in your report but my chairman has asked the question: were there any concerns that there was anything other than natural causes in your review of the cases?"

So he says he is sure he knows the answer but he wants to know whether you would have called it out.

Your reply we see above:

"Most deaths were explained. Some may have been prevented with different management. Completely unexplained on a neonatal unit is rare, so by definition more than one unexplained death does arouse suspicion.

"Unexplained death at home is followed by a very clear process and the same should be followed with unexplained death in hospital. I think on some occasions the team was misled by the PM report and I have commented on these. With due respect, I am not a pathologist."

So first of all, his question of you, you would have called out a criminal act, completely misunderstands your role and ability to do that given what you had, doesn't it?

A. That's correct.

Q. You weren't actually able to look at causation of death in any of the cases without proper accounts from the clinicians, the nurses and the concerns in the

rounder picture and working within a multi-disciplinary team; do you agree?

A. That is correct but unexplained and unexpected deaths are unlikely to be from natural causes.

Q. Yes, because the death of a neonate naturally you can understand what's happening?

A. That's correct.

Q. You might not be able to prevent it but you understand the clinical demise and the gross symptoms?

A. That's correct.

Q. But these ones you were looking at you didn't understand and as far as the deteriorations were concerned you didn't necessarily have the information to see what had happened in those unexpected deteriorations either, you didn't have the body of material, did you?

A. That is correct.

Q. The comfort in the bit that's highlighted "most deaths were explained", you mean there the natural deaths that you had viewed, the non-indictment baby deaths, do you, the ones that you could see a natural cause for?

A. Yes, on my understanding of the records and the postmortem reports, yes.

Q. On your understanding?

A. Yes.

Q. So that didn't link at all to the indictment babies or the group that you had put at the end of your first report and now would concede D should be back in the unexplained category?

A. That -- that's correct. It didn't detract from that.

Q. But at the time it appears you had some reassurance from Dr McPartland's pneumonia -- acute injury pneumonia but you reflect upon that that that's context dependent and you didn't have the context and neither did she from that?

A. That's correct.

Q. You comment in your statement on the communications with the Families about your report and you say this:

"Based on my own experiences as a neonatologist ..."

That can go down, thank you, Ms Killingback.

"Based on my experience as a neonatologist and having held medical leadership roles, it is my personal opinion that there was insufficient covering information and explanation provided to the Families to accompany my reports. It is my opinion that it was appropriate to share the reports but with accompanying information and explanation, preferably in a face-to-face meeting,

especially at a time of grief."

So what did you think about your case notes just being sent in the way that they were?

A. Again, I was not aware of that until April this year and my personal response was of shock.

Q. In terms of parental consent generally, in September 2016, had you asked whether Mr Harvey was seeking parental consent for your review?

A. I believe I did.

Q. Was that in a conversation or in emails or can you remember now?

A. I believe it was in an email. If I could just say, I don't believe I ever had an in-person conversation with Mr Harvey.

Q. Not at all?

A. I don't believe so.

Q. So all of the communication we have between you and him is by email?

A. That, that is correct.

Q. Did you ever think to phone him at any point when you had got some of the emails I have been taking you to now to say, "What is going on here"? Just to sort of get to the nub of it?

A. As you can see, I suggested that I joined a telephone case conference if the Trust was going to

find that helpful.

Q. So you were very much providing a piece of work that they had commissioned, as it were, rather than if this was happening in your own hospital where you might have gone down to have a word with someone and say, "What is going on?" Do you see the distinction?

A. That is correct and as -- as I'm sorry that I keep saying, I felt that I was part of a process and I believed that other parts of the process were happening as they should be.

Q. In terms of information that Families should have, you have seen what Mr Harvey is telling you the concerns the paediatricians had.

Were you surprised, when that letter was forwarded to you, and there were seven names at the bottom, all of the paediatricians, not just one? The suggestion there was one and other support but you saw the letter to Mr Chambers with a number of names at the bottom.

A. Yes. That's -- that's not a surprise. If, if a team has concerns they will discuss those concerns and it's not unusual for them all to put their name to a letter.

Q. I will take you to the email where you do refer to parental consent. It's Q0003123. You are told at the bottom:

"Re: parental consent. We had informed parent ahead of the review that it was occurring. I had not got a particular template ..."

That's to do with your template request for the review?

A. Yes.

Q. So your understanding was the parents had been informed ahead of your review, so you did ask about that. Why would that be important to you, to know whether that had been given?

A. It's -- it's vital that no -- no parent should know that the care of their baby is being reviewed by an external person without them being informed.

Q. It may seem obvious, but why?

A. The baby is their baby and all matters related to their baby are important to them.

Q. You provide reflections in your statement and conclusions from paragraph 114 onwards and you say at paragraph 115:

"I do not consider that I was adequately briefed about the concerns of paediatricians at the time of my first review, or subsequently. I do not know why the Trust chose this approach."

Have you reflected on that?

A. I -- it would be speculation and my

speculation is that those who were instructing me or agreeing that I should be instructed did not believe that that was a likely possibility. But that is speculation only.

Q. You say:

"However, this would not have changed my clinical findings on Casenote Review and my recommendation that broader forensic review should be undertaken."

Just pausing there. With your own clinical findings, you might very well have asked for more direct information, the information that you were missing even on the case notes?

A. I think as we have said, I maybe wouldn't even have gone ahead without some more discussion as to what other processes were going to be more important than my Casenote Review.

Q. Because your Casenote Review could really have followed, couldn't it, more detailed pathology --

A. Yes.

Q. -- x-ray, the need here --

A. That's correct.

Q. -- for x-ray?

A. That's correct.

Q. You say at paragraph 116:

"In my view it would be appropriate for

recommendations to include reinforcing the importance of recognising and exploring concerns of Families and staff, and enacting systems by which there are no barriers to Families and staff speaking up or their concerns being acted upon."

Would you like to expand on that in any way?

A. It's -- it's just fundamental to -- to patient safety and staff well-being that concerns are listened to and acted upon.

Q. We know, because she gave evidence in the criminal trial, Mother E had vitally important evidence to give about her baby and that was gathered during the police investigation and after your report and Dr McPartland's report.

Do you think, at any point, there should have been an invitation to parents to say how they had experienced the death and unexpected collapses of their children and what they might be able to add to the clinical picture in the circumstances?

A. Absolutely.

Q. You refer at paragraph 117 to it being a neutral act to restrict practice or to exclude a professional pending further investigation.

Can you expand on that for us, please?

A. So if -- if we were to take this situation

where there is suspicion about a member of staff, the safest thing for everybody is for that member of staff not to be in clinical practice and it is supposed to be a neutral act. I know for any member of staff it doesn't feel like it, but it is also for that member of staff's protection as -- as well as the protection of in this case the babies.

Q. We describe it very fully, don't we, as a neutral act where parents are suspected of abusing children. They can come to a hospital and be told: You can't be with them on your own, we need to work out what's happened to your child. We're not saying it's you, this is a neutral act, but we're looking after your baby or child.

That's a culture that people understand in a hospital, isn't it? They understand that's a neutral act or should be communicated like that to a parent?

A. That's correct, and that is a very good analogy.

Q. So really moving to the point where that's understood for members of staff, what can be done about the culture to make it the same; in other words, baby safety as the priority?

A. It's my experience that that's -- that's what we do. I can't say what was holding that back in the

Countess of Chester in -- in those -- those years. But it's -- it's just of crucial importance, if -- if there is a concern about safety.

Q. The Inquiry has heard evidence from a number of people about there were concerns about Letby's welfare, her upset, how she felt about all of this, people not being permitted to talk about it because of sensitivity to her situation and it being perceived as gossip, et cetera.

How can that level of concern be taken out of an equation in terms of examining or investigating for a baby and keeping everyone calm in the investigation process?

A. That's -- that's the purpose of the processes; to follow those processes, to have the restriction of practice, to communicate as much as necessary with other professionals, to give other professionals guidance as to what is appropriate and what is not appropriate to talk about.

There is a framework of professional behaviour that we need to remind our colleagues of.

MS LANGDALE: Thank you. Those are my questions, Dr Hawdon. It may be a good time to take the break, my Lady, and we are ahead of time, so perhaps I could suggest 11.30.

LADY JUSTICE THIRLWALL: Very well, I think that will be welcomed. So we will start again, Dr Hawdon, at 11.30.

(11.08 am)

(A short break)

(11.32 am)

LADY JUSTICE THIRLWALL: Mr Baker.

Questions by MR BAKER

MR BAKER: Good morning, Dr Hawdon, I ask questions on behalf of a group of the Families, two groups of the Families.

Can I begin by just asking you a question about candour. It was touched upon by counsel to the Inquiry.

Now, the exercise that you were carrying out or had been instructed to carry out had the capacity to identify issues in relation to the care that was provided to a number of the babies?

A. That's correct.

Q. Were any safeguards put in place as far as you were aware in relation to ensuring that the duty of candour was followed in circumstances where you identified issues?

A. I was not aware. I wasn't told. I made an assumption that normal processes would be followed.

Q. So if we look at paragraph 79 of your witness

statement. You say at paragraph 79:

"On behalf of the Trust, Mr Harvey instructed me to carry out case note reviews and my report was addressed to him."

You go on to say:

"Based upon my own experience as a neonatologist and having had or held medical leadership roles, I would have expected Mr Harvey to share the report with the Trust Executive Team and the senior neonatal team."

You go on to say:

"Based on my experience ... if a report gave additional signals of concern in addition to those concerns which I am now informed were available at the time I would have expected the Executive Team to discuss the totality of the information with the Trust board."

So it sets out really your expectations as to who the reports would be shared with but it doesn't include Family members within that?

A. You are correct. The -- the -- those paragraphs are in response to the questions related to release of the review to the paediatricians and questions as to what my understanding was.

I -- I -- it is a serious omission that I did not say: and results should be shared with Families. But as far as I'm concerned that's a given.

Q. Yes, so it's -- it's really so obvious that a person in Mr Harvey's position should be following the duty of candour and keeping Families informed?

A. To -- to my mind, absolutely.

Q. Yes. We also touched there on the fact this was a Casenote Review. A Casenote Review, I am not here intending to denigrate the quality of the work that you carried out, but a Casenote Review by its nature is a fairly superficial exercise, isn't it?

A. That is correct. It is only based on the information that's provided.

Q. Yes, and if Mr Harvey had said to you that he was looking for a review to exclude homicide you would have said the Casenote Review was absolutely not the level of forensic investigation that's needed?

A. That is correct, it is part of it but absolutely not.

Q. Yes. So a review of the medical records is unlikely to reveal a note that says: "I saw such and such harming the patient" or indeed "I harmed the patient"?

A. That is correct.

Q. But in terms of the exercise that you were carrying out, it was a review of the notes and it was intended to highlight what might be termed service

issues or perhaps more colloquially errors in care?

A. I was simply asked to review them. I -- I identified what may be service issues, but I also identified the unexplained deaths as well.

Q. Yes. But again it would require those issues to be recorded within the notes effectively?

A. That -- that is correct.

Q. Now, you will know from your practice and also your medico-legal work that what's written in the medical records doesn't always tell the full story?

A. That is correct.

Q. Yes, and I think you also said in response to questions from Counsel to the Inquiry that it would have been helpful to be able to speak with the clinicians who were involved in care?

A. If -- if that had been the extent of what I was being asked to do. Certainly somebody needed to be in a position to pull the pieces together, not necessarily me, but somebody needed to.

Q. Again, it goes to the perhaps superficial nature of a Casenote Review is that it doesn't involve talking to any of the doctors or indeed parents?

A. That -- that is correct.

Q. That is true when it comes to identifying homicide or indeed poor medical care, doesn't it?

A. That is correct.

Q. Now, you were asked some questions about the input that the Family may have brought to the exercise and it's particularly relevant in relation to Child E as I think was said. If we go on to INQ0003172 and to page 17, please.

So this is an extract from what's described in your statement as the submitted report rather than -- so it's a final version of a report that you sent and it addresses Child E here.

So we have an outline summary of the notes. Is this a transcription of the notes or is this your analysis of what the notes contain?

A. It's not a transcription. It's my picking out what could be key points of the care.

Q. If we look to the bottom of page 17, we can see at 23:00:

"Gastric bleed desaturation, intubation planned."

Then at 23:45:

"Intubated."

If we go on to page 19, this is a form of setting out issues by reference to codes. We can see the key to those codes below and you have identified:

"Delayed intubation, significant sub optimal care, relevant, possibly relevant."

A. That -- that could be argued. But gastric bleeds are sadly not unheard of in vulnerable and poorly babies.

Q. I think when the case was or the report was updated, did you understand it to be an upper gastric bleed?

A. I think -- I think if we go back to the case I think it was seen to be a gastric -- gastric is the upper gastrointestinal tract, the stomach is gastric. Yes.

Q. Yes, but there is upper and lower?

A. Yes, so the stomach is in the upper gastrointestinal tract and that was the reason they gave retrospective gene because that is a specific treatment for gastric bleeding.

Q. Yes, but if we go to INQ0006765, and to page 23, now this is a later version of the report so now we have had the words "Necrotising Enterocolitis" added in as a box at the top.

Now, that wasn't in your original report, the one we have just seen?

A. No.

Q. Can you surmise as to who has added Necrotising --

A. I have no idea.

And the reason it is possibly relevant is you say the absence of a recorded cause of death.

"Further comment and relevance of care is not possible."

What you are saying in short there is without knowing why Child E died, it's really impossible to say whether any aspects of the care were relevant or irrelevant?

A. That is correct.

Q. So can you assist then, if we go on to page 44, why is it that Child E is in the box of a group where it says: the death collapse is explained but may have been prevented with different care and learning may improve outcome for other babies, because the cause of Child E's collapse and death hadn't been determined?

A. So my understanding of the case based on the information I had was that the gastric bleed was significant and was the -- was the likely cause of the collapse.

Q. Okay, but we don't know what caused the gastric bleed?

A. That -- that is correct.

Q. So in those circumstances where the cause of a gastric bleed is unknown, shouldn't Child E be in the second group?

Q. Now, Necrotising Enterocolitis, we spoke to the doctors involved in the care provided to Child E and the doctor apologised for advising the Family of Child E not to have a postmortem and accepted that the evidence for Necrotising Enterocolitis was -- was poor.

It was certainly evidence in the criminal trial, I think even the expert instructed by Ms Letby felt that Necrotising Enterocolitis didn't fit particularly well with the pattern of problems that led up to the collapse; would you agree with that?

A. I -- I would agree.

Q. So if it wasn't Necrotising Enterocolitis, would you not agree that based upon the notes of Child E's condition leading up until the 3 August 2015, there isn't particularly strong evidence to explain why there's been a gastric bleed?

A. Gastric bleeds are rare in Necrotising Enterocolitis, as you say Necrotising Enterocolitis is a lower gut problem, but isolated gastric bleeds in stressed babies unfortunately are not uncommon.

Q. Yes. But the evidence that she was -- sorry, that he was stressed in the time leading up to that is again not very well made out. It was suggested I think in evidence that everybody felt that he was stable and well leading up to his collapse?

A. Yes, which is evidence that I -- I didn't have at the time. A baby who becomes hypoglycaemic is a baby that is stressed.

Q. But again I think had you had opportunity to speak to the doctors involved, which you didn't of course, that everybody perceived him as being stable and well up until the collapse?

A. If that is what they would have said, yes.

Q. Now, if you had had the opportunity to speak to Child E's mother, she would have described how at about -- and if we go on to page 24, just to help orientate you here, you can see the timings which are taken from the notes.

She would say that at around 9 pm she went down to see Child E on the ward and heard screaming which she described as an agonising scream, not like anything she had heard before. And she found Letby close by Child E and not doing anything and that Child E was bleeding from his mouth and had a significant amount of blood around his mouth and that Letby dismissed her and said there's nothing to worry about and she would call the Registrar to attend.

And Mother E went back to her room on the maternity unit and telephoned her husband, Child E's father, and told him what had happened and he reassured her, "Well

the doctors and nurses know what they are doing".

Now, records were clear, telephone records that that happened at about 9 pm and the notes clearly record at 2210 that the gastric bleed had occurred and the doctor had been called so that would have -- that disconnect between the clear evidence from mother supported by telephone records and what was written in the notes would suggest that somebody has not been honest in what they are writing down in the notes wouldn't it?

A. That -- that is correct.

Q. If there was evidence that somebody had created misleading notes as to the timing of events and when doctors were called, that would have obviously raised alarm bells?

A. That is correct.

Q. That's the information I think Counsel to the Inquiry was alluding to when she was asking you about the opportunity to speak to Family members?

A. Certainly.

Q. Now, gastric bleed, idiopathic gastric bleed, or difficult to explain gastric bleed in a neonate in these circumstances would be very, very rare indeed, wouldn't it? It's plausible but rare.

A. The -- the how rare I think is difficult to

say. But it's certainly not unheard of and is something that I have experienced.

Q. If you had spoken to Child E's mother you were aware that Child E had a Twin because it is referred to in the notes?

A. That's correct.

Q. If you, if you had had the opportunity, would you have been interested in finding out that Child F had also had a collapse, an unexpected sudden collapse?

A. Is Child F the Twin?

Q. He was the Twin.

A. Correct, that would have been concerning.

Q. Yes. And would you, if you were aware of that, had sought out Child F's medical records to find out why?

A. I would have done, yes, or -- or suggested that the Trust did so.

Q. Of course.

A. Yes.

Q. I mean, you wouldn't have been able to access them yourself without the Trust providing them to you?

A. But what I mean is or suggested that the Trust look more carefully into that as well.

Q. Yes. Now if you had discovered that Child F had had an unexpected collapse due to hypoglycaemia and

that was refractive to treatment and transferred to Arrowe Park Hospital, and that Child F had had a blood test result which had shown a very high level of insulin with an unrecordably low C-peptide level, would that have made you concerned about exogenous insulin going given it that baby?

A. Extremely, without a doubt.

Q. Yes. Going back then, please, to INQ0003172, and if we can go, please, to page 5. Now, this is Child O, one of the Triplets, two of whom died.

The order in which the babies appear within a report isn't chronological. What -- what condition were the notes in that were provided to you about these babies?

A. They -- they were -- most of the notes for each baby were together but some were not and they were presented as a sort of stack of -- of sets of notes in -- in no particular order and I chose to work through all them in the order that they were presented.

Q. Yes, so you weren't provided with individual bundles of records; it was a pile of paper?

A. No, some were in bundles.

Q. Yes.

A. Some -- some were loose.

Q. I think one of your emails talks about

somebody else's random records being included within the stack as well?

A. There was something about instructions about photocopying or something very strange.

Q. Yes. Now looking at Child O, I mean, Child O is a healthy 33-week baby, normal weight, reasonable Apgar scores at birth who suffers on everybody's account a completely unexpected collapse on 23 June 2016 which is not capable of resolution with resuscitation which people regard as very strange as well?

A. (Nods)

Q. "Unexpected unexplained collapse, no response to resuscitation."

Now, you list within -- if we go on to page 6:

"[Query] failed resuscitation."

You see under the list of potential errors at 1715:

"Relevance: almost certainly relevant but quality of care?"

Now, is that because it was so surprising that given Child O's condition and unexpected collapse that resuscitation didn't work you were concerned that it may not have been done properly?

A. That's correct. On the evidence from the records available it wasn't possible to tell whether there was a failure of care in -- in resuscitating or

whether it was an understandable failure to resuscitate.

Q. So to deal with that in two parts, first of all, you would ordinarily expect a child in Child O's condition to be resuscitated following this type of collapse?

A. I -- I would expect there to be attempts at resuscitation and I would expect the resuscitation attempts to be conducted properly.

Q. Yes. Well, to put it this way there is no direct evidence in the notes that it wasn't conducted properly because you have put question mark next to "failed resuscitation"?

A. There wasn't enough information in the notes to determine that.

Q. Yes. So taking two things together, one is the resuscitation doesn't achieve the outcome you would have expected it to, so a question mark was it done properly, I can't answer that question because I don't have enough information?

A. That's correct.

Q. Would that not be a key point to go back to the Countess of Chester on and say: well, look, can you get a better account from the doctors involved as to what exactly they did?

A. That is what I would have expected the

Countess of Chester to do.

Q. So this, when you put question mark next to failed resuscitation, that is the prompt to the Countess of Chester to get more information?

A. That is -- that is correct.

Q. Of course if you had spoken to the treating doctors, they would have said: well, forget the resuscitation, the real issue here is that we think this nurse has been harming babies or might have been?

A. (Nods)

Q. I mean, that would have been important information to know, isn't it?

A. That's correct. At that stage this would have been beyond my remit to deal with any further.

Q. Yes, because this is absolutely not the right exercise to identify homicide?

A. That's correct.

Q. If we go to again on to page 44, I won't take you through Child P because your findings are broadly the same.

Page 44 is the final conclusion page. We can see that:

"O and P are included within the death collapses unexplained which is the investigation of these cases which would potentially benefit from a local forensic

review as to the circumstances, personnel et cetera."

So first of all what do you mean by "forensic review" and -- well, I will ask that question in isolation. First of all, what do you mean by forensic review?

A. Sufficient level of detail to take all potential factors into account.

Q. I mean, forensic is -- I would understand the word to mean pertaining to the court process?

A. I -- I take it in my own mind to be detailed and covering as much information as is available.

Q. Okay, so you wouldn't understand "forensic" to mean as in forensic pathology?

A. No, I am not using it as a legal term.

Q. Okay. What about personnel? What's the relevance of looking at not only the circumstances but the personnel involved?

A. It's relevant as to how that baby has been cared for, whether it be negligent acts, purposeful acts, any -- any of those things.

Q. So the reference to personnel could allude to the possibility that there is a person who is deliberately harming?

A. That would be one possibility.

Q. Okay. O and P are in that category presumably

because the collapses are so unexplained?
A. That's correct.
Q. Of course there's been reference to Child E which we can see in the top bracket. If you had had more information about Child E, then Child E would also have gone into that bracket as well?
A. Based on the information you are giving me now, yes.
Q. Now we see Child D under bracket 2. We know that in a later report, Child D was moved, not by you, but by Mr Harvey, into the number 1 bracket, the death or collapses explained but may have been prevented with different care.
If we go back to page 22 of this document. This is a section that deals with Child D. I think your evidence was that you didn't direct Mr Harvey to move Child E into a different bracket?
A. That is correct.
Q. But you were later provided with details as to the postmortem that was carried out?
A. That's correct.
Q. If you had known or been told that the pathologist was not -- if the pathologist were to say that it was difficult to be confident that Child D died "from" congenital pneumonia rather than that she died

"with" congenital pneumonia, would that degree of circumspection about where Child D falls have gone back to how it was before?
A. Absolutely.
Q. Yes. Because it isn't obvious, is it, from the notes -- otherwise you wouldn't have put Child D in that box in the first place -- that she had sepsis before she died?
A. That's correct.
Q. Because the usual prodromal symptoms of sepsis, the usual course of sepsis leading to death, isn't borne out by what's written down?
A. That's correct.
Q. What doesn't really happen in cases of congenital pneumonia leading to sepsis leading to death is that there is an appearance of normal blood gas values, a degree of support with breathing and then a sudden collapse in the presence of normal CRP and other signs?
A. That is correct, that doesn't normally happen.
Q. It evolves in a fairly typical way with a progression, deterioration, organ failure and death?
A. That's correct.
Q. So in terms of where on reflection the children that I have been mentioning should fall, so far

E, D, O and P should all really on reflection be in the box marked "We don't know, it needs more investigation"?
A. Yes, based on the information you have given me, yes.
Q. Now, if we look at Child C finally and this is the same document again at page 24. So premature but not of the extremes of prematurity. A baby who was small due to intra-uterine growth restriction.
Now, one of the things we can see at the bottom of that page is that you do actually have the postmortem report and there's a reference to an ischemic injury to the heart in the postmortem report and immaturity of the lungs.
Now, are you accepting here that immaturity of the lungs is the cause of the collapse?
A. I believe that this is one where I -- I suggested that they reviewed it because we would not expect immaturity of the lungs at 30 weeks gestation to be a cause of death.
Q. No. In fact, can I assist you with what Dr Gibbs said. He was the treating -- treating doctor. He said that in terms of Child C, he did not think -- sorry he said in his evidence that Child C's oxygen requirements had reduced substantially in the days leading up to his death. He thought he was improving

from a respiratory point of view. He did not think that Child C would experience any significant problems at the stage, by 13 June, due to his breathing and he thought the respiratory rate was not abnormal for him.
He said, and I quote:
"Dr Hawdon points out he had a slightly fast respiratory rate but that wouldn't bother me knowing he was a 30-weeker prone to respiratory distress syndrome. We knew he needed support for his breathing and that was gradually reducing so that would explain the slightly raised respiratory rate."
Obviously they are the observations of somebody who was there. Would you accept that analysis?
A. Yes, the -- the clinician that's there at the time is much better placed than somebody looking at case notes.
Q. Yes, I mean I understand that, obviously.
One of the features of the -- obviously the criminal trial is that evidence was obtained from various experts in -- in that case and it was pointed out again that Child C's oxygen requirement on the day of his collapse was 26%, compared to 38 to 40% on the previous day, was said by Dr Evans and Dr Bohin in the trial.
What we can see from the notes that you have

recorded is that there is a fast respiratory rate but normal blood gas values.

A. That's correct.

Q. The observation charts that are recorded I think again show that the respiratory rate on 13 June for most of the day was within the normal range, the higher end of it, but within the normal range so had again improved.

I mean, would you agree that looking at the notes overall we see a pattern of improvement in terms of respiratory function as Dr Gibbs observed in the time immediately leading up to this collapse?

A. Yes, based upon what you are saying, yes.

Q. You would not expect, if respiratory problems, immaturity of the lungs were the cause of the collapse, for that to be happening you would expect them to be getting worse leading up to the collapse?

A. That's correct.

Q. So again -- and I appreciate you had very limited information by the nature of your instructions, but would you agree then based upon what I have said that also Child C really should be in the -- if we go back to page 44 -- death collapses unexplained?

A. I think that is perfectly reasonable.

MR BAKER: Yes, thank you.

Thank you, my Lady, I have no more questions.

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

Questions by MR SKELTON

MR SKELTON: Dr Hawdon, I ask questions on behalf of the other Family group.

I am going to focus just really on the beginning of your involvement again, if I may, and just to ask you a little about the instructions and your reflections on the information you were given.

Ms Langdale took you through the ultimate instructions letter and it's fair to say, isn't it, that nowhere in that letter is it mentioned that the consultants who treated the babies that you were looking at suspected they had been murdered?

A. That is correct.

Q. Or even that there was particular concerns about the quality of the care by a particular member of staff in respect of all of the children?

A. That is correct.

Q. In fact, a month before -- so you were instructed formally finally on 5 October -- a month before Mr Harvey and Ms Kelly had met the Royal College reviewers on Day 1 of their review, 1 September, and during that very first meeting they had explained those

precise facts: there was a particular member of staff that they suspected was harming the children and she was a nurse.

A. (Nods)

Q. Do you feel, in retrospect, that you've been/were misled by Mr Harvey when either during the emails, during your conversations or in fact during your formal instructions?

A. I now feel misled. I can't say who misled me, but I feel misled and, as I have said before, if those details had been made available to me the process I would have followed would have been very different.

Q. Well, you wouldn't necessarily have conducted a Casenote Review at all, would you?

A. That's correct.

Q. And likewise, in respect of the Consultants, if you had known that on their interview with the Royal College they had gone so far as to discuss the mechanism of murder with the reviewers that is clearly something that's completely outwith a standard Casenote Review of the type you were offering to do?

A. Absolutely.

Q. And in your view, and I think this was accepted by Ms Eardley, would you agree that the only appropriate response if a set of Consultants suspects

murder is to call the police?

A. To either call the police or go through safeguarding processes, which would amount to the same thing in the end.

Q. Because safeguarding, by definition, engaged the police?

A. Engaged the police, absolutely.

Q. In the way that you've described.

Looking at your letter of instructions now, do you see in retrospect that there were a few clues dropped in? The word "forensic" Mr Harvey may have been using in fact in the way which we lawyers understand it, which is to investigate crime, so forensic pathology, forensic medical examination; all of that is to exclude criminality. And, likewise, the reference to looking at staffing or particular members of staff who may have been on for the four hours before the collapses was looking to see if there was some conduct that was untoward. Do you see that now in retrospect?

A. Absolutely in retrospect, yes.

Q. But that wasn't apparent to you at the time?

A. It wasn't and I'm sorry that it wasn't.

Q. Can I look again at your brief recommendations in your report and it would be worth having it on the screen, please, at INQ0003172, page 45, and it's really

the last paragraph:

"Subject to Coroner's postmortems there should be broader forensic review of the cases described in category 2 above as after independent clinical review these deaths remain unexpected and unexplained."

Would you have expected those deaths to have been the subject of coronial investigation?

A. I would have done, yes.

Q. Each of them?

A. Yes.

Q. And the reason was that they fell into the standard category for the Coroner being involved and that you hadn't found natural causes?

A. That is correct.

Q. This paragraph doesn't say explicitly how the babies might have died. There's no explanation offered for their deaths at all.

A. No.

Q. Why is that?

A. Because I had no evidence to lead me to think of any cause of death, which is why I said: unexpected and unexplained. It was for the Trust to be looking into why they might have happened.

Q. Are you in fact saying here that something other than medical cause is in play and that could

include a systemic issue, there may have been a gas leak somehow that could have caused the deaths or it could include foul play; murder?

A. That is correct. There were many poss -- there are a number of possibilities which I was not placed to comment on.

Q. You weren't in a place to determine which of those was correct?

A. No.

Q. But those were possibilities?

A. That's -- that's correct and it was for the Trust to look into.

Q. Do you see that it would have been possible for you to have been more explicit in that paragraph, or did you think that in speaking in relatively low-key implicit terms that Ian Harvey would have understood that he needed to rule out foul play?

A. In, in my view as -- as a clinician for a clinician to be told that a number of deaths are unexpected and unexplained is a message in itself.

Q. It means there may be a crime?

A. It means there is something very worrying that needs to be looked into in more detail.

Q. Including the possibility of a crime?

A. Yes.

Q. And in your mind, you couldn't rule that out?

A. That -- that's correct on the basis of the information.

Q. If it was the possibility, if there were a possibility that the babies had been murdered, wasn't this situation more urgent than your report and your correspondence made clear in that months had passed since these babies had died, it may have been a member of staff who was perpetrating the crime and you had no information before you to exclude the possibility that that member of staff could strike again. Did that occur to you?

A. It -- that -- that didn't occur to me because the -- the decision-making lay with the Trust and in my view saying that five deaths were unexpected and unexplained was a sufficient trigger for the Trust to take that seriously if they hadn't already.

Q. But -- sorry to press you on this, but don't you think that if you suspect a crime having undertook a Casenote Review and you can't exclude that possibility medically that you needed to say, "Urgent action is required in this situation because it could happen again"?

A. I -- I didn't suspect a crime. Knowing what I know now, I might have suspected a crime.

I will -- I will maintain that a Medical Director to receive a report that says five deaths are unexpected and unexplained is a sufficient trigger to take the issue seriously.

Q. So as far as you're concerned, are you satisfied that you said enough to ensure that patients were safe on that unit?

A. At the time, I was.

Clearly we all think back to how we might have done things differently. Knowing what I know now, I could have said, "It is a crime", but that's based on what I know now.

Q. There came a point where you were told of suspicions, and that was some months after you had completed your initial review, and if we could have on screen the email exchange in which it was raised with you in INQ0014376. Thank you.

May I just have the bottom bit first, please. So starting with Ian Harvey's email, just so you can see it, if you can read it on the screen. I'm afraid I struggle a bit. (Pause)

So here Ian Harvey I think is starting to -- can we go back up again just to the date there? It may be I think I have given you a wrong reference.

But let me try and explain what Ian Harvey was

telling you. He explains to you in -- when he provided the paediatric Consultants' letter that in fact the paediatric Consultants suspected a member of staff was killing the children. Do you remember that?

A. I do, yes.

Q. And I just want to see your response to it.

For some reason I seem to have a slightly different version than the one that's on screen. It may be that in fact we need to go further down, sorry.

Start on page 3. Page 2 going into page 3. Sorry, just page 2 going into page 3 if that's possible. Thank you, that's perfect. So, sorry.

He was providing you the letter, which you have talked to Ms Langdale about, but he's also explaining that there is one particular member of staff about which they are suspicious and the suspicions are obviously very serious it's clear from his correspondence.

A. (Nods)

Q. Your response, if we go back up, further up page 2, doesn't demonstrate a deal of shock or surprise about that allegation. Did you already know about it or have I misread your response?

A. I didn't and I -- I based on the information that he gave me that he was then following the due process in response to those concerns.

Q. But it was -- the concerns couldn't be more serious, could they; that the Consultants in a unit collectively were concerned that babies had been murdered?

A. Correct.

Q. What doesn't come across from your response is the recognition of how immensely serious that is. Did you recognise the gravity of what you were being told for the first time?

A. I did, and that's why I asked if he wanted to talk on the phone and why I asked, "How will you proceed?"

Q. So at this point you are told about suspicions about a crime. You don't, at this stage, mention urgency of intervention or patient safety or safeguarding or the Coroner or the police.

Do you recognise that given the information you were given, given that you must have known that months and months were drifting by -- this is months after your review, let alone the Royal College and the internal Consultants' concerns -- that nothing was actually happening?

A. My assumption -- and I now know that's a wrong assumption -- was that all those things were happening locally.

Q. What basis --

LADY JUSTICE THIRLWALL: Sorry, we have got some noises off -- I don't know where it's coming from.

MR SKELTON: What basis did you have for thinking that action was being taken in an appropriate and timely way?

A. Because I know what organisational responses should be to such concerns and made an assumption that that organisation was doing the same.

Q. But you must have realised from your own involvement that nothing in fact happened to protect patient safety and you don't even raise it as an issue.

Do you recognise that that should have been something you needed to mention?

A. I -- I didn't know what was being done and what wasn't being done. So I wasn't in a position to comment.

Q. But nor did you show any curiosity about those matters, did you?

A. I did, but the remit for dealing with a worrying situation is with the organisation itself.

Q. So can I put it in the bluntest of terms: told that the Consultants thought that a member of staff had murdered the children who you had reviewed, you needed to say, "Ian, have you taken immediate action to tell

the police or the Coroner or to protect patient safety?"

Those things needed saying in circumstances where you had no reason to think any of them had been done?

A. My reason for thinking that they were being done was because it was the right thing to do.

Knowing what I know now, that's what I would have said.

Q. Did you at any point say that because you remained in correspondence with Mr Harvey for another two months at least and although you did mention CDOP at one point you didn't mention contacting the police directly, you didn't mention contacting the Coroner direct and you didn't express any concern that months were still going by -- bearing in mind this was six months that you were involved in -- in which patients could be at risk?

A. That was why I asked, "How will you proceed?" And when I didn't get a response, I assumed that they were following their own what would be confidential processes.

Q. Leaving aside the point about your assumptions about the right thing to do, do you think that you were reluctant to confront the reality of what was being raised?

A. No, absolutely not. I -- I think it was

entirely my naivety in assuming that other people were doing what I would have expected them to do.

Q. So to be clear, you thought: he understands that children in his hospital may have been murdered, any reasonable Executive in those circumstances would be taking appropriate steps to deal with that urgently and appropriately with the appropriate authorities?

A. That -- that would be my understanding.

MR SKELTON: Thank you.

LADY JUSTICE THIRLWALL: Thank you, Mr Skelton. I have no questions for Dr Hawdon. Do you have any more questions?

MS LANGDALE: My Lady, that concludes Dr Hawdon's evidence.

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

MS LANGDALE: May we resume at 2 pm?

LADY JUSTICE THIRLWALL: Certainly. Will that be with Dr McPartland?

MS LANGDALE: Yes. Thank you.

LADY JUSTICE THIRLWALL: So we will rise now and start again at 2 o'clock.

(12.20 pm)

(The luncheon adjournment)

(2.00 pm)

LADY JUSTICE THIRLWALL: Ms Langdale.

MS LANGDALE: May I call Dr McPartland.

DR JO McPARTLAND (affirmed)

Questions by MS LANGDALE

LADY JUSTICE THIRLWALL: Do sit down, Dr McPartland.

MS LANGDALE: Dr McPartland, you have provided the Inquiry with a statement dated 13 June 2024. Can you confirm if the statement is true and accurate as far as you are concerned?

A. Yes.

Q. As far as your qualifications are concerned, you tell us you are a Consultant paediatric pathologist at Alder Hey Children's Hospital, and your career briefly you were appointed as senior house officer in histopathology at the University Hospitals Leicester in August 2000 and subsequently a specialist Registrar in histopathology from November 2001 to February 2005.

From March 2005 to June 2007, specialist Registrar in paediatric pathologist at Alder Hey. You passed the Part 2 membership examination in paediatric and perinatal pathology in November 2006 and awarded Membership of the Royal College of Pathologists and subsequently Fellowship of the Royal College of Pathologists.

You have been, as I say, appointed as Consultant paediatric pathologist at Alder Hey since July 2007 and you've worked there ever since?

A. Yes, that's correct.

Q. You were head of the department of histopathology for a three-year term from April 2012 to 2015?

A. Yes.

Q. For our purposes, what's the distinction between histopathology and pathology?

A. Pathology encompasses all of the different laboratory medicine disciplines, so as well as histopathology, which is the pathology of tissues, it will also include microbiology and virology, haematology and biochemistry and a number of other laboratory medicine disciplines.

Q. You tell us at paragraph 5:

"[Your] NHS role at Alder Hey includes provision of paediatric surgical pathology service to the hospital and a perinatal pathology service to a number of referring obstetric units."

And:

"In addition to [your] NHS duties [you] perform coronial, paediatric postmortem examinations for a number of Coroners, including paediatric forensic

postmortem examinations undertaken jointly with a forensic pathologist."

My question: why is it necessary to conduct paediatric postmortem examinations in combination with a forensic pathologist?

A. Well, if there is a suspicion that criminal activity may have led to the death or in some types of traumatic death where we might need the assistance of someone with forensic expertise then we perform the postmortem jointly and the role of the forensic pathologist is to consider matters of forensic importance and particularly those relating to injuries, and the role of the paediatric pathologist is to consider natural causes of death and look at growth and development and other medical conditions.

Q. So when you say the forensic pathologist looking for injuries, do you mean potentially deliberate infliction of injuries?

A. Yes.

Q. Because there is a suspicion --

A. Yes.

Q. -- that they may have been caused?

Does that really from the off dictate who and how the pathology investigation should be being undertaken; if there is a suspicion, they go down a different route?

A. Yes. If, when a death is reported to the Coroner, it's clear that there -- it is a suspicious death from the outset, then the police will be involved and a forensic pathologist will be instructed as well as a paediatric pathologist.

Q. You tell us you provided four witness statements in relation to the Letby case. You did a statement relating to the postmortem of Baby D and two addendums and also a witness statement relating to the examination of the placenta of the Mother of E and F; that's right?

A. Yes.

Q. You attach to your statement for the Inquiry guidance surrounding investigations of sudden and unexpected baby deaths in hospital. If we could, I would like to take you to some of the guidance that you have helpfully put together for us in thinking about this topic.

The first reference, please, is INQ0101997, page 1.

Dr McPartland, what will come up here is the Pan-Cheshire SUDiC documentation that you provided so this is Pan-Cheshire Sudden Unexpected Deaths in Infants Guidance April 2023. We will look at 2015 as well shortly.

I would like your help if I could, please, with

page 68 of the document, the INQ reference. This -- clearly this flowchart applies to Sudden Unexpected Death in Childhood or Infancy because it refers to that at the top and it says:

"Child found collapsed at hospital or anywhere other than hospital."

And we see a flowchart on the right-hand side.

So do you understand that where the child is found collapsed in hospital and presumably that could be with or without members of staff there, right, a child found collapsed? Or is that supposed to imply no one is in a room? What did you get from that?

A. Well this -- I mean, as this 2023 guideline indicates this is not usually used for neonates, which I know is what we are concerned with today.

So with a SUDiC process most of the ones that I would be involved with, a child would die in the community or they are found collapsed in the community, resuscitated and brought into hospital. So a lot of them die in the emergency department.

So in terms of what happens before it comes to me in -- at the mortuary I don't have much involvement with that, but this flowchart does indicate, you know, at hospital or anywhere other than hospital.

Q. So you would expect the child to be taken in

and that is why -- or collapsed -- brought in in a calculated state, potentially found collapsed and taken to hospital and then this applies "declared dead and Coroner informed" and the flowchart continues?

A. Yes. A lot of Sudden Unexpected Deaths in Infancy or Childhood, sometimes a child will be found deceased in the community and they are obviously deceased and no attempt at resuscitation is made. Often they are found in a collapsed state and resuscitation is attempted, paramedics will attend. Then they will take the child to hospital and it may be that the child can't be resuscitated, then they are declared deceased often in the emergency department.

Q. Understood.

If we go back to page 63 of this guidance, INQ reference 63, we see at paragraph 1.11.5:

"When a newborn infant suddenly collapses and dies in a neonatal unit, consideration must be given as to whether a Joint Agency Response is required. In most situations this may not be necessary."

Is that because naturally sudden death of neonates, if it is a natural cause that can be recognised without the need for the SUDiC referral or what do you understand by that?

A. Well, the SUDiC protocol is usually used when

we are investigating if there may be something suspicious in the background. When a child -- a newborn infant dies on the neonatal unit, often they have never left the hospital and so in those circumstances, it's more often that there will be a medical cause of death and that there won't be a requirement for police involvement.

So in my experience, the police wouldn't be involved unless there was a particular suspicion that a criminal act had occurred. So, for example, if a mother had been the subject of a criminal assault during pregnancy and then this had resulted in the baby being born in poor condition, that might be an example where the police could be involved. Or if there was birth trauma which might be criminally negligent, that might result in police involvement and the involvement of a forensic pathologist.

But apart from rare instances like that, most newborn babies on a neonatal unit would -- would not be subject to this type of Joint Agency Response.

Q. Dr Garstang gave evidence at the beginning of the Inquiry about safeguarding protocols generally and she said this:

"In practice, if an infant or child dies unexpectedly and with no explanation while an inpatient

in hospital, the SUDiC process would now normally be initiated and there would be discussions between senior paediatricians and the police as to how best to investigate the death. These are, however, rare events."

She went on to say that in Birmingham Solihull, when they are notified by a neonatologist of sudden and unexpected deaths, they may have an immediate discussion with the police to decide whether it's appropriate to have a Joint Agency Response, presumably to discuss what you are raising, whether there is any suspicion or surrounding circumstances that need looking at. Would that happen here or do you think the medics would make a decision about is there anything they are worried about, about family history or generally?

A. Yes, I think it would depend on -- on the hospital and how they conduct their SUDiC process.

But from deaths I have been involved with, with deaths on the neonatal unit, I have never been aware of a senior investigating officer contacting me or being involved with me in most of those cases.

But it might be that those conversations are had in the background but just that then I don't see any police paperwork received in my documentation from the Coroner.

Q. Particularly if it doesn't go forward and it's

a conversation to do a negative check, effectively, it wouldn't necessarily reach you, would it?

A. Yes, it might not.

Q. Next document, please, if that one can be taken down. INQ0013225, page 1. This is Pan-Cheshire guidelines for the management of Sudden Unexpected Death back in 2015. If we can go, please, to page 3. It may seem obvious to you, Dr McPartland, but if we can highlight 1.5, 1.6 and 1.7.

Why is what is stated at 1.5 essential surrounding meticulous records and 1.6, the need for a thorough investigation of the highest standard?

A. Well, because a lot of these might involve safeguarding issues and potentially might result in a criminal process after the postmortem, then meticulous records need to be kept in the event that there might be an ongoing criminal investigation.

Q. The same flowchart appears at page 9 or similar. If we look on the right-hand side, in the first nought to four hours, Sudden Unexpected Death refers in the third box, detailed paediatric history, examination and investigations, complete Pan-Cheshire SUDiC documentation. If suspicious, joint interview of carers with police and/or children's social care.

The suspicion raised in the context of this

flowchart is always about family members, isn't it, and concerns about parents?

A. Yes, that's why they are talking about the parents because when a child has died in the community, the parents are caring for them and so the protocol is very much aimed at detecting child abuse that hasn't been disclosed.

Q. The principle of child abuse is it's often not disclosed, whoever has committed it. So the principles here apply equally if it is a member of staff under suspicion, doesn't it, about the need for rigorous investigation and detailed note-keeping et cetera?

A. Yes, the principles would apply if there was a suspicion a member of staff had harmed a child.

Q. In your experience, is there much discussion within safeguarding training or generally about what to do if it is a member of staff? You are all trained obviously what to do if you are worried about a member of the community and understand a neutral act is to keep a parent or family member away from a child while you are working out what's happened and to try and keep the baby safe.

Are there similar discussions ever around staff or staff members potentially harming babies?

A. No, I think from my recollection of all the

safeguarding training I have attended, it is very much aimed at the parents without a focus on possibility of staff harming children.

Q. There is a need presumably to trust the staff that you work with and do you think that's part of that, that those conversations are not had in safeguarding training, that it might be someone in the room that you have got to think about it?

A. Yes, and I suppose also that it's a rarity, but as this case shows, it's something that should have been addressed more in the past.

Q. That can come down, please, and if we can have INQ0016982, page 1. It's the Royal College of Pathologists guidance which you helpfully provided to us and the report of a working group convened by the Royal College and chaired by Baroness Kennedy.

If we go to page 43, please, INQ reference 43. We can highlight, please, at the top paragraph, 7.1:

"The Postmortem Examination.

"The investigation should be carried out by specially trained pathologists with an emphasis on multiagency working involving close collaboration and the sharing of information between hospital and community-based clinical staff, the pathologist, the police, social services and the Coroner's service."

If we move down on to the next page, 44, at 7.3:

"Prior to commencing the examination, the pathologist should be fully briefed on the history and physical findings at presentation and on the findings of the death scene investigation by the lead health professional or police investigator and the postmortem examination procedure must include a full radiological skeletal survey or other appropriate imaging, reported by a radiologist with paediatric training and experience."

7.3 firstly, how important is it in forensic examinations, forensic postmortem examinations that you have a full brief of the history, physical findings, what the clinicians observed, saw, felt about what was happening?

A. It's very important in a -- in a forensic postmortem that the physical findings are important because they might reveal evidence of injuries before the postmortem or positioning of the body and the history is very important to determine if the child was unwell beforehand. But the social history is often very crucial in these community SUDiC cases in terms of the family environment, the home environment. That's why photographs are important of -- of the infant but also of the scene.

precise circumstances of death.

Over the page at 97 reference to resuscitation procedures.

What's the significance of that?

A. Because there might be marks of medical intervention on the body that you need to distinguish from injuries, so for example if there's been endotracheal intubation as part of manipulating the mouth you might cause some potential injury to the lips or the gums and there might be intravenous lines or lines inserted into the bones of the child.

Q. The procedure below suggests the minimum recommended level of investigation in the majority of cases but says each case should be assessed on an individual basis regarding the extent of additional investigations. We see there the bullet point:

"Postmortem examinations should be performed by a specialist paediatric pathologist with training in this area."

Then the second one:

"If there is any suspicion of abuse contributing to the death, a joint postmortem examination with a forensic pathologist should be carried out."

You highlighted that earlier but it's very clear, isn't it, within the guidance we have gone to that

Q. The skeletal survey, the radiology, what is the significance of that in cases of deliberate injury?

A. The main thing we are looking for with radiology is fractures as part of a pattern of child abuse and those can be difficult to detect at autopsy and sometimes are very subtle and only visible on the X-ray, but they are so subtle that you would need a specially trained paediatric radiologist to detect them.

Q. There are expertly trained paediatric radiologists, aren't there, who look at child X-rays for these purposes?

A. Yes, because many full skeletal surveys would be performed on living children as part of safeguarding examinations, not just on deceased children.

Q. The postmortem examination procedure, if we can go to page 97, please, actually we should start on 96 with the clinical information relevant.

96, please. Thank you. So:

"Prior to starting the postmortem examination the pathologist should have available a comprehensive history and report on the circumstances of the death ideally to include ..."

If we see the bullet points, details of pregnancy, delivery, postnatal history antemortem history and

that's what's required if you know there is suspicion or concern?

A. Yes.

Q. Thank you. That can go down. If we return to your statement, Dr McPartland, the process of neonatal postmortem examination. You indeed set out much -- as is reflected in that guidance -- that you would expect to conduct an effective postmortem examination, firstly details of the obstetric history of the mother in addition to a full medical history of events in a baby's life --

A. Yes.

Q. -- including any particular clinical concerns and the clinician's opinions about the events leading to death?

A. Yes.

Q. "In neonatal events or in neonatal deaths, events occurring in pregnancy and labour often of paramount importance including any placental abnormality, which is assessed by placental pathological examination"?

A. Yes.

Q. It's very important, you say, for the placenta to accompany the baby for examination?

A. Yes.

Q. You also set out the importance of the radiology investigations. Can I just -- so those in the room can follow the questions, no other reason -- have paragraph 25 of your statement on the screen please. It's INQ0102015, page 8, para 25. I don't know if there is a word lost in the last sentence here but I will show it to you, Dr McPartland.

So it's paragraph 25. You explain:

"Postmortem examination involves radiology investigations, typically a whole body X-ray and CT and MRI scan where indicated. Radiology investigations are carried out before I begin the postmortem examination and X-ray images should be available to view on the computer in the mortuary but often the reports are not available. In a forensic case with police involvement I request a report before commencing the postmortem examination which may be an interim verbal report in a case not indicated to be suspicious, such as an in-hospital neonatal death, my practice was to proceed with the postmortem examination after viewing the X-ray images."

Do you mean you don't have to see them after seeing the X-ray images or?

A. No, I mean I would view the X-ray image before doing the postmortem examination.

Q. In every case?

A. Yes. Typically in a Coronial case I go into the mortuary, I ask my mortuary technician if the X-ray has been reported, but often because of difficulty with availability of the radiologist to complete the postmortem reports, often it's not available at that stage.

So then we view them on the computer screen in the mortuary, have a look and then carry on with the postmortem.

If it is a forensic case, because the forensic pathologist is there and the police are there with the photographers, crime scene investigators, ideally we want to know before we start a forensic case if there's any abnormality as it might affect the way that the postmortem is carried out. But sometimes it's still very difficult to get a full written report, so sometimes we are on the phone just at the beginning of the postmortem trying to chase down a radiologist to give us a verbal interim report.

Q. Do you ever chase down clinicians for a verbal interim report or do you rely on notes or summaries that are provided?

A. Well, typically with the postmortem we would receive written information from the Coroner so, as in

this case, I received the medical notes and a detailed letter from the Consultant. So I would always expect to have written information --

Q. Via the Coroner?

A. -- and generally via the Coroner's officer.

Q. Thank you, that can go down.

You tell us at Alder Hey, paragraph 29:

"The majority of the postmortem cases performed at Alder Hey are hospital consented postmortem examinations with a smaller proportion of Coroner's autopsies."

In terms of the hospital consented ones, is it your understanding that a parent must consent for the baby's postmortem?

A. Yes.

Q. So if the parent didn't or in the moment was advised not to and thought "Well, I don't need to know the answer to this", "I think I know the answer to this", or whatever they are thinking in that emotion of the time, does that mean the postmortem won't go ahead in any circumstances or is that decision taken out of their hands if it's seen to be important for the safety of babies?

A. If it's not required by law, so if it is not a Coroner's postmortem, then the decision to have a postmortem is entirely left up to the parents and if

they don't consent, then it won't go ahead.

Q. But if it is a Coroner's postmortem, it will?

A. Yes, even if the family do not want the postmortem, if the Coroner requires it, it goes ahead regardless.

Q. You explain that there's -- you have two Consultant histopathologist colleagues, Dr Kokai and Dr Shukla, and whoever gets which case depends on the rota; you are not allocated cases, it is who's working that week and takes the cases?

A. That's right.

Q. One of the comments you make later on is that you were not aware, until your colleague Dr Shukla referred to the RCPCH review and the downgrading of the Countess of Chester, of an increased rate, if there was one, of mortality there.

But you are all handling different cases presumably as they come in and nobody's handling them -- all of the same ones; is that the position?

A. Yes, usually we would do a week on the postmortem rota in turn covering for each other's leave, so it would be entirely random whether you received a case from a certain hospital or not.

Q. You do refer in your statement to -- and we know perinatal Morbidity and Mortality Meetings occurred

at the Countess of Chester and so did neonatal mortality meeting occur. The distinction I am not entirely clear about at the moment, but it looks like you were invited, were you, pathologists in principle, to the perinatal ones, the perinatal Mortality and Morbidity Meetings?

A. Yes, we would be invited and we were given a list of cases to discuss that included pathology beforehand and we would travel to the Countess of Chester Hospital for the meeting.

Q. In fact, the emails around Baby D, the baby that you did the postmortem for, show that one of your colleagues attended for you, the date of that meeting didn't work, it's Dr Shukla I think who attended that meeting in September 2015. I can put that on the screen, the meeting itself, INQ0005445, page 1.

A. Yes, I did receive the documents sent to me last night and we weren't informed that Baby D was on the list, it was not one of the two cases that was sent to us via email.

Q. For 10 September. It looks as though on 8 September between you and Dr Shukla there is a discussion about who can attend; do you think neither of you may have attended on 10 September?

A. No, Dr Kokai attended.

Q. Dr Kokai, that's right.

A. So there were two cases on the list given to us, one was a stillbirth that Dr Shukla had performed, one was a stillbirth that Dr Kokai had performed. Dr Kokai was going to attend because Dr Shukla and I had another meeting at Alder Hey so Dr Shukla prepared a PowerPoint of his case and Dr Kokai went to present the two cases. But on that email Child D was not listed so we did not know that Child D was going to be discussed otherwise I would have prepared a PowerPoint.

Q. So which cases do you think were discussed at that that ... two others that you think he discussed?

A. Yes, this is a list of neonatal cases. I have never seen minutes like this before. But the meeting always had stillbirth cases first and then there was a coffee break and then neonatal cases were discussed.

So the two cases that we were sent for the list were actually stillbirth cases.

Q. Right.

A. I think what's happened is the neonatologist hasn't given the case details to the obstetrician that we corresponded with so we didn't know that these cases were going to be discussed.

Q. You anticipated my next question. It appears that these meetings refer to in a lot of cases antenatal care, post-delivery care, the obstetric perspective, if

you like, rather than, as was the case for Baby D, a detailed analysis of death and the circumstances of death. Would that be right in terms of your experience of other meetings, you weren't at this one but in terms of others, was the review much more about quality of care provided, antenatal care, postnatal care of the baby?

A. Well, it was both. So this was a joint meeting, both the obstetric team and the neonatal team attended and what would happen if a baby had died in neonatal period then typically the obstetric team would present the antenatal history and then one of the neonatal team would then come on and carry on and present the neonatal history. And then if there had been a postmortem or placenta the pathologist would then present the pathology findings and then there would be a discussion about the whole case.

Q. We know that Baby I was similarly discussed in a meeting on 26 November. Again it's not clear to me if one of you or your colleagues were present for that one, maybe --

A. I checked through all of the emails that we have been sent during this period and the only baby I could find in the list that had been sent to us in terms of the cases we were shown was of Baby A, so

I suspect from this that's been sent to me last night that maybe there were other neonates discussed but that we weren't informed that they were going to be discussed because I went through the list of all the ones sent to me during that period.

Q. Is that a forum where you would expect clinicians and yourself to be able to discuss the case as a whole, so if there were factors you didn't know, for example, out of the blue, didn't expect it, a rash that looked differently that you would share those concerns or consider those issues or not?

A. Yes, you would expect in a clinical presentation of the case there would be full details so often at meetings such as this, things have come up in the clinical history that weren't provided to me at the time of doing a postmortem and that is why it's very useful for the pathologist to be at a meeting where cases are discussed.

But I mean this meeting we are talking about is the -- what was called the perinatal meeting and this was periodically a number of times a year so I don't know if there may have been other neonatal mortality meetings that only involved clinicians which isn't part of this big day event where it's both together.

Q. No, no. You refer in your statement to these

meetings because it's a chance for cross-discussion, discussion across disciplines. So there's no other meetings you would have been invited to in relation to babies at the hospital apart from these, would there?

A. Not at Countess of Chester, no.

Q. That can come down. What would you be invited at for other hospitals? You don't have to say what the hospitals are. Is there a better way of doing this?

A. Well, no, we would go to Stillbirth Review Meetings, now all of them are called Perinatal Mortality Review Team Meetings. We also attend meetings with clinical geneticists to discuss fetal abnormalities.

Q. You tell us from paragraph 36 onwards in your statement that you conducted a postmortem examination of Child D and you received information from the Coroner which we can find at INQ0002045, page 4.

And if we go to page 7 INQ reference 7 and then 8. The information from the doctor -- sorry, it is back one page, please, Mrs Killingback, thank you.

We see here this is Dr Newby's report to the Coroner that's been sent to you. We see the end of the first paragraph:

"Baby well overnight. Baby weaned very well on ventilator. Extubated Sunday morning."

Continues:

"Dr Newby saw the baby Sunday, though Child D was a little bit quiet and a little stiff thought to be clinically septic but seemed well, breathing fine.

"One hour later blood gas after extubation wasn't satisfactory so put back on to CPAP. Quickly corrected and she remained in air with no real increased work in breathing."

Continues then:

"At 1.30 am the night Registrar was called as she had become mottled and had tracking, dark brown discolouration which had resolved after about 10 minutes."

Continues further down:

"Her inflammatory markers were okay and her gas was very good. She then went on to have a further episode of discolouration around 3.15 am. Doing very well at that point, had become more active. Began to be distressed with CPAP so this had been taken off. Then had episode further of discolouration, given bolus of fluid and that quickly settled, doctor called."

Dr Newby concludes -- reported that:

"This had been the third death in 12 days for neonatal. Also a further episode of apnoeic event and CPR for previous Twin deaths. Surviving Twin had successful CPR."

When you read that, what did you glean from that, if anything?

A. Just that final section?

Q. The whole all of it, really, as your role --

A. I don't think Dr Newby wrote this, I believe this was written by a Registrar, because Dr Newby had written a separate three-page document. I think that's why she's referred to in it as "Dr Newby".

Well, it was Dr Newby's -- actually the letter that came along with this was three pages long, so that was a bit longer. Well, I gleaned that the baby had collapsed, you know, very soon after birth and it sounded like there had been -- then there was a delay before she then was admitted to neonatal unit at which point the oxygen levels were quite low, she was poorly, discoloured and so in need of medical attention and then can we go back a page? I don't know, you wanted me to summarise again everything?

Q. Yes. Yes.

A. And she has needed quite a lot of support and has been intubated. Then there is a bit more information in Dr Newby's report but she was extubated and then on a repeat gas after extubation, they weren't very happy about that and put her back onto CPAP.

Then she seemed to do better but then overnight

collapsed suddenly and required increased oxygen and they had thought that it was septic, due to sepsis and they had added in extra antibiotics, repeated some of her investigations and another X-ray and she seemed to be okay but then collapsed again.

Then if you can go on to the next page, and then got a bit more active and then collapsed again.

So it seemed to me that she was at that stage quite unstable before she died and unfortunately they could not resuscitate her.

Q. If that bit highlighted in yellow had said -- reported this has been the third unexpected and unexplained death from their perspective at that time, would that have made you think differently about this death from the way it's reported there, the third death?

A. Yes, because they have just said it is the third death and that included obviously a pair of Twins, where both Twins have collapsed, one has survived and one hasn't died, so thinking about that I would think there is probably something in common for that pregnancy that affected both Twins. And then there has only been one other death.

So just on its own, that wouldn't ring particular alarm bells for me because babies on the neonatal unit are vulnerable, in need of medical support and there

could be a number of reasons why they might die. For example, prematurity or hypoxic brain damage at birth, infection.

So I think for a cluster to be suspicious and not indicative of something like infection you would need it to be pointed out that those were unexpected or unexplained, otherwise I would think there is a pair of, you know, sick vulnerable Twins and one other death and it wouldn't particularly highlight there was anything to be concerned about.

Q. That can come down, thank you.

We know there is a whole process around unexpected unexplained deaths for a reason and it appears in communications around this death and Sudden and Unexpected Deaths are being conflated. There is a practical consequence for that, isn't there, when you read that, you don't think: this is suspicious, this is concerning, what might this be?

A. Yes. I think you would have to say that they were sudden and unexpected because otherwise babies who die in the neonatal unit it might be that they are expected to die if they had a very severe congenital abnormality or very severe hypoxic brain injury. So if you want a pathologist to be alerted to something potentially suspicious you would have to highlight that

they were sudden and unexpected, unexplained and concerning, that there were concerning features?

Q. Well, is sudden and unexpected concerning enough? What we do know by the time of Baby D and the discussion at the Perinatal Morbidity Meeting is that there had certainly been a staff association made, each doctor has given their own evidence about when they were suspicious about that and what it meant in terms of who it meant.

But even the fact of there is one member of staff in common and these are sudden and unexpected without anything more, anything about that member of staff, who they were, what they were like, just that, would that be enough to raise suspicion in terms of the appropriate route to take for postmortem?

A. I think we would very much rely on the information from the hospital because they are in the environment, they are working with the staff and they know what's happening. So all of the information really has to come from the hospital to the Coroner, to the pathologist. So it's very difficult for us to make assessments when we are removed from the environment.

Q. Is it arguably sometimes even more difficult within the hospital because there is not the independence. Somebody says: this person seems great,

that is not possible, they are great, you know. Whereas sometimes from a distance, we know for example in the Beverley Allitt case, it was a neighbouring hospital that picked up on the number of referrals and were worried about that.

So with the distance that might have helped or not?

A. I think I wasn't informed that the same staff member was involved.

Q. I understand that.

A. But I think for it to be picked up at the Coronial stage where they are doing a referral someone would have had to have said that there is an increased number of worrying deaths and we are worried that the same staff member has been involved in all of them.

Q. That would have been enough just to say it like that. Because you say in your statement at paragraph 40:

"I was not under the impression that there were concerns that Child D was one of a group of possible murder cases."

It is quite clear from the doctors thus far no one was saying at this time that the death of Baby D, this was part of a possible group of murder cases. Going to intention is a completely different thing, isn't it, and understanding what's happened before any investigation?

So would you ever expect someone to say: this is possible murder? I suppose they might in some cases.

A. Well, obviously it would be highly unusual in a neonatal unit setting. But for us to pick up that it was suspicious and for me to suggest to the Coroner that he would involve the police you would need to have something very concerning written down on the information provided to you and most likely if it was that concerning, the Coroner would have picked it up before even instructing me and might have made that decision himself to contact the police.

Q. If that box that we have seen, the yellow box, had said "three sudden and unexpected deaths in three weeks", do you think that would have triggered the SUDiC process or should have done?

A. I think if the hospital had raised a concern then probably with their own internal processes it might have triggered a SUDiC process. But I think -- I think the paediatricians who worked there would be better placed to give an opinion on that.

Q. You tell us at paragraph 42 that you conducted the postmortem examination of Baby D, you said:

"The lungs were heavier than expected and I identified areas of pneumonia in the lungs on microscopic examination in addition it hyaline

membranes."
You said:
"... and taking into account the clinical scenario of rupture of membranes before delivery it was likely that the pneumonia was present at birth and was the underlying cause of Child D's initial collapse soon after birth and subsequent death".
You go on to tell us later at paragraph 74 that:
"A conclusion that a baby has died 'with pneumonia' and not 'of pneumonia' is very difficult to make and is inherently subjective and context dependent."
Can you just expand on that for us, please? Why is it inherently subjective and context dependent?
A. Because when we look at the lungs under the microscope, we will see pneumonia but that might vary in extent, it might be a very small amount, or it might be a very large amount. If you have a very large amount of pneumonia in a Sudden Unexpected Death, then it will be very clear that is a very significant pneumonia and virtually all pathologists who looked at that would agree. But sometimes you might have a smaller amount of infection and it's quite difficult then to decide is that enough to be a cause of death or not and that's particularly difficult in Sudden Unexpected Deaths in Infancy in the community where they haven't even had any

symptoms before and the baby is found deceased in bed.
So it depends on the context and in this case we have had clear clinical suspicion of infection and the baby has been treated as such. So as well as the findings, looking at the tissues under the microscope we also have a detailed clinical background of suspected infection in the baby.
Q. You didn't in terms of Mother D have either the obstetric notes or the placenta, did you, and you say at the beginning it's important to have those as well?
A. I had -- Dr Newby had given a summary of the clinical information, so I didn't have the notes but I knew details about her antenatal tests, about the mode of delivery. So the only thing I was missing that became apparent later was that the exact length of time of premature rupture of membranes which had been provided to me by Dr Newby was not correct; it was longer than she had said, so I felt I had sufficient information of the antenatal history. But the main problem is not having the placenta, that was an issue.
Q. You were told in fact it was the Coroner's notification on that report was the reference to 36 hours, but it was 60 hours before --
A. Yes.

Q. -- rupture of membranes, so there was a difference there.
You also note at paragraph 48:
"The appearance of the lungs was unusual because in addition to areas of pneumonia there were hyaline membranes in the alveoli ..."
A. Yes. So those are structures that we would normally see in more premature babies with Respiratory Distress Syndrome and if you see them in older babies or children or in adults, it's a feature known as Respiratory Distress Syndrome or Diffuse Alveolar Damage that indicates a greater degree of lung injury.
Q. You received follow-up communication, didn't you, from the Countess of Chester about this postmortem and if we can go, please, to INQ0101965, page 1, we see here Yvonne Williams from the Coroners' office sends to you:
"Baby's mother has raised a query that I am unable to answer. Waters broke 36 hours prior to the birth, mother states it was 60 hours."
You respond to that INQ0101968, page 1.
You say:
"The Coroner listed the 36 hours. I had copies of neonate notes but not obstetric notes. I think you need an obstetric opinion on the clinical significance of

premature rupture of membranes of 60 hours compared to 36. Copied in Dr Davies."
If we go to the next email INQ0101966, page 1, she's asking you a further question:
"Can I confirm: did you see evidence of infection histopathologically or was it inflammation? Is there a chance this could have been a congenital pneumonia that caused the PROM rather than the PROM causing the pneumonia?"
You respond INQ0101967, page 1. You say:
"I have never seen a case arising without chorioamnionitis, usually inhaled infection, amniotic fluid starts off the pneumonia. I think it's unlikely."
Does this exchange demonstrate what you said before about subjective and context dependent with the queries going backwards and forwards about this?
A. No, what Dr Davies is asking is if the baby had a pneumonia first, could that have caused the rupture of membranes or is it that a rupture of membranes has caused the pneumonia? This is what she is asking me. This isn't so much about the amount, it is about the timing of the infection.
Q. Yes.
A. What often happens is you have infection in the amniotic fluid, and then that the baby then develops

pneumonia after that and then is born with the pneumonia at the time of birth and it is a true congenital pneumonia. With the baby collapsing at 12 minutes of age, I thought that was most likely and if I had had the placenta and that had showed evidence of an amniotic fluid infection I would have been very happy to say it was definitely a congenital pneumonia but because I didn't have the placenta, and the baby had been ventilated during that first 36 hours of life, I felt I couldn't on pathological grounds alone rule out the fact the pneumonia might have developed afterwards during the period of artificial ventilation. I thought it most likely was congenital but I was just being cautious as --

Q. You didn't have the placenta?

A. -- I didn't have the placenta.

Q. Thank you, that can go down.

You say at paragraph 77:

"If I had been notified at that stage of a concern of the same member of staff being involved in a series of deaths, it could have prompted a discussion about possible inflicted causes of death, involvement of the police and a forensic pathologist and combined discussion of clinical features with the paediatrician, alongside X-rays taken in life and death."

We know in fact because of the problems you had with Meditech, we have seen the extensive correspondence that you and your colleagues were very frustrated, you couldn't get access to the X-rays at this time and Baby D was in fact the first case when the Meditech system came into play; is that right?

A. Yes Child D was the first postmortem case booked into our new Meditech V6 system, which had just gone live two days previously.

Q. Who was the effect of that, that you couldn't see the X-ray at the time of doing the postmortem?

A. No, the effect of that was to do with me seeing the X-ray report at the time of editing and signing out the report.

Q. You would rather have seen it before?

A. No. I wanted to see the X-ray report at the time of editing my postmortem report but because of an incorrect set-up in the system when I came to edit my whole postmortem report, the X-ray section was not in the editing file.

Q. So you couldn't see it?

A. So I didn't see it at the time of editing and I commented on it because usually in my final discussion of the case I would add a line in saying: postmortem skeletal survey revealed with a comment.

When I have come back to review the case and that isn't in there I think it is because I haven't seen the X-ray report at the time of editing.

Q. When you conducted the placental examination of Child E's Mother, E and F's Mother, were you told that Child E had died?

A. No.

Q. When did you find that out?

A. Only in the trial, I reported the placenta but I was never told the baby died.

Q. Do you think you should have been?

A. Well, we report a placenta after the baby is born and give our opinion there, then. The fact that the baby dies some days later probably wouldn't affect our interpretation of the placenta, so usually we would only expect to have contact with a clinician later if -- if they felt that what we have seen in the placenta was somehow relevant to the baby's death and it wasn't clear from the report and they wanted a bit more discussion about it. Or if the case then came up at a neonatal mortality meeting and we had to then show the placental findings.

So I wouldn't always expect that they would tell me unless they wanted to later discuss the case.

Q. You tell us at paragraph 96 that your

colleagues Dr Kokai, Dr Shukla and yourself had undertaken postmortem examinations on Child A, C, O and P and you were contacted we know by Mr Harvey in relation to conducting a review of those postmortems in combination.

If we can go to INQ0101999, page 1. This will take us to an email that you say you typed out relatively closely to the telephone call that you had with Mr Harvey; is that right?

A. Yes, because I can see I have said "I have just taken a call from him".

Q. So you set out there what you tell your colleagues. What do you remember about that call now?

A. Well, I remember the call because it's the only call I have ever had from a Medical Director from another Trust and my recollection is as I have detailed there from my handwritten notes.

Q. So he suggests that he would like you to set out -- he is going to send case details and questions of a neonatologist and he would like you to review your reports and any new evidence and comment appropriately.

What did you think "any new evidence" referred to?

A. Well, it was because the neonatologist had reviewed the cases, so we thought I think from the conversation that she had questions. So I think what

I have said there: well, he said in four of the pms it might be worth a follow-up discussion with the pathologist to see if further light can be shed on the further issues. I suggested he should write to us with the case details and the questions of the neonatologists and we would be happy to review our reports and any new evidence and comment appropriately or meet with clinicians to coincide with the perinatal meeting if required.

I think by "new evidence" I meant any -- any new information that they had.

Q. So we then see -- that can go down -- a letter of instruction to you, INQ0102002, page 2:

"Dear Dr McPartland:

"Further to our conversation I am emailing having had the approval of the Coroner to request a review of four cases."

We can all see what that says. Take your time to read that and then the next page.

We see:

"... may be of relevance. Our clinicians have reported one clinical feature that they had noted, in some cases babies did not seem to spend to resuscitation as they would have expected."

Is that all of the further information you got,

this letter?

A. Yes, we only received that email with just, you know, the few lines on each case.

Q. Did you ever speak to Dr Hawdon or see her report; did they send you that?

A. No.

Q. Did they send you the RCPCH report?

A. No.

Q. Did you see -- we will put it on the screen -- INQ0003120, page 1 and 2, the last paragraph on this page 1 and then page 2, if that can go on the screen, please. The "Action required: case review", can scroll up. We just need page 2 now, thanks. And we see there that:

"The RCPCH recommend a detailed forensic Casenote Review of each of the deaths since July 2015 should be undertaken ideally using at least two senior doctors with expertise in neonatology/pathology in order to determine all the factors around the deaths. Case notes and electronic records should ideally be paginated to facilitate reference and triangulation."

Did you see that, the RCPCH --

A. No.

Q. There is also -- you are going to say no, so I am not going to put it on the screen. There is

a section about the nurse and the suspicions or concerns about that, did you see that? Clearly not, if you didn't see the RCPCH report?

A. No.

Q. Do you think if you were being asked to do a broader forensic review of A,I,O and P you should have seen all that information and known what all the concerns were?

A. Yes.

Q. Did Mr Harvey communicate any sense of urgency to you?

A. No, he didn't and I didn't hear from him again for over two weeks.

Q. And we see your response to your colleagues, INQ0102002, page 1. You say to them:

"Please see message below from Countess of Chester. As I mentioned to you previously I will ask the secretaries to retrieve slides and reports refer each pathologist. Maybe we should get together and discuss them at one of our meetings in the New Year."

There is other emails about you emailing to Debbie:

"Due to holidays now, it will be in the New Year."

There is not a sense of urgency that's been imparted to you, is there?

A. No.

Q. Was there any discussion about parental consent or what was involved here or --

A. Well, in the phone call, I indicated that he would need to ask the Coroner's permission to review the cases if they were Coroner's cases. If they were hospital cases, we would normally discuss cases at the Perinatal Mortality Review meeting and that had been mentioned in the phone call; that it might be a follow-up discussion with that.

So I felt that this was all part of the normal process of clinical pathological review that would occur, so I wouldn't have expected when we were asked to give another opinion on a postmortem that we would go back to ask consent for that.

Q. If we go, please, to INQ0003135, page 3. A further email from you to Mr Harvey explaining:

"Apologies for the delay. Although the slides and reports were retrieved from the file in my absence I wasn't able to distribute them to my colleagues until I returned after the New Year. Two of the cases are Dr Kokai's and one is Dr Shukla's and he's been on annual leave."

You then say in another email, I don't need to pull it up:

"We have discussed the cases."

This is 25 January:

"I need to write up my notes, share with my colleagues, I will send it to you by the end of the day. Sorry for the delay, we have been quite busy in the mortuary which has limited when the three of us could get together."

Then you send INQ0003135, page 1, your report.

"A summary of our conclusions."

And you -- the conclusions were -- well, let's deal with this letter first. You say:

"Please note this is not a full and formal medico-legal review. This would involve a second report and take about four hours of work per case with a subsequent lengthy report. If you require an ... analysis of this depth, it is probably best performed independently by someone from another centre."

So pausing there. How much time had the one that you had done taken?

A. Well, I had passed on the reports and the slides to my colleagues for them to review the cases that they had carried out and then we had a meeting, I'm not sure how long it was, probably discussed each case perhaps for 20 minutes or so. That would be our normal practice if we were discussing cases together and then I had written it up.

So what we had done is an informal process of the type that we might normally do discussing a case for a perinatal mortality meeting and it was very much a part of routine practice.

But a Royal College review is quite a formal significant process and that's why I suggested this in the letter that I felt if they had recommended more -- pathology review, that needed to be on a more formal basis than what we had been asked to do.

Q. Effectively, you all looked again at what you had already done, you were not bringing new information to the mix or changing your approach to the case, that wasn't what you had been asked to do, was it?

A. Well, all that had happened is that Dr Kokai and Dr Shukla had then discussed their cases in a group of three with us, which hadn't happened before.

Q. Yes.

A. But no, otherwise it hadn't added much to the original reports.

Q. And you say:

"If you require an indepth analysis, or an analysis of this depth, it is probably best performed independently by someone from another centre."

Why did you say that?

A. Well, that's just normal practice. If you

want to formally review someone's report, then often it would be someone independent because the three of us work very closely together, Dr Shukla and I had both been trained by Dr Kokai, so we wouldn't really be a suitable person to review that work.

Q. We see the report you attached INQ0102007, page 3 and 4. We see there for Child A, Child I, Child A agreement cause of death remains unascertained for Child I.

You say:

"Hypoxic ischemic damage of brain. Chronic lung disease and prematurity. Extreme prematurity."

Over the page Child O: remains unexplained.

You suggest for O and P: discuss potential of genetic causes.

If you had known before you did that review or had that discussion that the paediatricians were interested to know if deliberate harm had been inflicted, what would you have said about that exercise, that it was worth doing or not?

A. Well, I would have said that the police needed to be immediately involved and a forensic pathologist would need to be instructed.

Q. You then receive an email from Mr Harvey, INQ0102010, the report states, this is in relation to

Baby A:

"A very small air embolism might not be detectable at autopsy, does that mean that significant embolism would be evident?"

Your answer is at INQ0102011, page 1:

"Yes, significant air embolism should be accompanied by forth in the vessels or lungs."

This was Dr Shukla's case and you asked him about that, you say?

A. Yes. This was Child A, which Dr Shukla performed so I went into his office and asked what he thought and this is what he said, and I am aware that that is a classical postmortem sign of air embolism, is froth in the vessels or the heart. And I wrote that back to Mr Harvey.

I would stress that we thought the interest in air embolism was all because this child had a long line inserted just prior to the collapse and there had been concern about the line, they were going to pull it out and then the child arrested.

So that's what we thought was the reasoning behind this questioning, not that there had been deliberate external administration of air.

Q. If he asked you the question: is there any evidence of deliberate external administration of air,

how would you have answered that? What would you have said to that?

A. Well, that --

Q. Is that within your expertise or not?

A. That would have alerted us the fact that this was a concern of a criminal case and that this needed a much more in-depth and forensic pathology opinion. So if he had said that to us, we wouldn't have made a brief email response; it would have been apparent that that needed a very different approach.

Q. In this process, the Royal College had conducted a review, Dr Hawdon had done a report and you had been asked to do this with your colleagues and none of you had spoken to each other and seen what each other had said at any stage, but as you have seen, and Dr Hawdon did today, broader forensic review was being recommended from the off, wasn't it, because of the constellation of features that the Trust was dealing with at that point?

A. Well, yes, I have since been provided with all of those documents by the Inquiry and I can see that that had been recommended but hadn't been conveyed to us.

Q. Finally, from your statement reflections, paragraph 136, you set out how your current practice

with respect to the radiological investigation of neonatal deaths is different to that in 2015 and 2016. Can you tell us how it's different?

A. Yes. For the last several years in addition to a whole body skeletal survey, a whole body CT scan is also carried out on all of the coronial SUDI cases.

Since the verdict in this case, where it became apparent that administration of intravascular air had caused death, we have now been requesting our radiology department even to do a CT scan on a hospital in neonatal postmortem cases as well as the Coronial cases, because clearly there is a potential that this could happen even when the case comes as a hospital postmortem and not just as a Coronial postmortem.

But I would stress I don't think that is current practice around the country; most hospital PMs in other centres would not get a CT scan.

Q. One final matter. Mr Harvey is yet to give evidence but he says in his statement he thinks he had a discussion -- he thinks he had a discussion with you verbally that "clinicians had raised concerns over a member of staff and her presence on the ward at relevant times". Can you remember anything like that?

A. No, the only conversation we had was the first one that I made detailed notes in and conveyed to my

colleagues and there was no mention then of anything about a nurse.

Q. He did not get from you that there were concerns that you were raising about the deaths being suspicious in any way. Were you saying anything about the deaths being suspicious or were you not able to, given the information you had?

A. No, in three of the four cases we indicated that we didn't know why the babies had collapsed, but we didn't raise any suspicions from the pathologist review that we had carried out alone.

Q. When you say "we don't know why somebody died, it is unascertained/unexplained", whose responsibility is it as far as you are concerned to follow that up to get answers to that?

A. Well, it might be that in some cases that we find, for example, deaths in the community, that everything has been done that is possible to do if you have done a full range of investigations. I know in one of the cases we recommended that genetic opinion might be helpful because there are a large number of genetic causes that could possibly cause Sudden Unexpected Death that can be investigated by further genetic testing.

But it is sudden and unexpected and it's concerning, then -- then it goes back to a SUDiC

protocol if it's come through that route.

Q. That we discussed earlier?

A. Yes.

MS LANGDALE: Thank you. Those are my questions, Dr McPartland. I think Mr Baker has some for you now.

Questions by MR BAKER

MR BAKER: Dr McPartland, I ask questions on behalf of the Families of 12 children, but in particular on behalf of the Family of Child D. Can I begin by going to paragraph 2 of your witness statement, please, where you set out your training.

You completed your degree in 1999 and obtained your registration with GMC in August 2000, having spent I think a year undergoing a general medical rotation in a hospital?

A. Yes, I undertook a year of house officer jobs; that is half medicine and half surgery.

Q. Yes, and at that point you began the route into histopathology; so your practice diverged from sort of common ordinary medical practice into a specialism of pathology?

A. Yes.

Q. Yes. So in terms of your experience with patients who are alive, if I put it that way, it is limited to this one-year period?

A. As well as the three years clinical training at medical school.

Q. Yes, yes. It's not meant as a criticism because of course your speciality is in relation to different matters, a different type of patient.

But it's correct to say, isn't it, that when it comes to clinical matters, the interpretation of clinical matters, you are often heavily dependent upon information given to you by the clinicians who treat the patient?

A. That's correct.

Q. Or in different contexts from the reports of clinical experts?

A. Yes.

Q. Your speciality is interpreting the findings that you observe on postmortem and then those are applied in context alongside clinical evidence or indeed in some cases reports of other specialties?

A. Yes.

Q. Now, the forensic issue, you do carry out certain types of forensic work, I think I saw from your CV that you have a speciality in interpreting damage to eyes?

A. Yes.

Q. So in that context, you will be brought in, in

cases of homicide or suspected homicide, but for the most part if there is a suspicion of homicide then a Home Office approved forensic pathologist takes the lead as part of a multi-disciplinary approach?

A. That's correct, yes.

Q. We know from the evidence given at the criminal trial that Dr Andreas Marnerides, who leads the Forensic Children's Pathology Service at Guys and St Thomas' Trust in London provided evidence in that context and he is a well-known forensic paediatric pathologist?

A. Dr Marnerides is a paediatric pathologist, he is not a forensic pathologist.

Q. The forensic aspect then is provided by a Home Office pathologist who works alongside a paediatric pathologist?

A. That's correct.

Q. And I think your evidence to Counsel to the Inquiry is that in cases of homicide or suspected foul play essentially is there is a multi-disciplinary approach between a number of experts who interpret different aspects of the case?

A. Yes. So you have a forensic pathologist, a paediatric pathologist and it would depend on the nature of the case if you involved other types of

pathologists.

Q. So a toxicologist may be involved, a radiologist may be involved. It depends on the particular area of interest?

A. Yes, and in a forensic postmortem there would always be radiology and toxicology and then we would do a range of other investigations such as microbiology, biochemistry, et cetera.

Q. And as I understood your evidence if foul play is suspected, then it should be advertised very early so that the appropriate route can be followed in terms of gathering evidence?

A. Yes.

Q. Now if we look to paragraph 36 of your witness statement, we can see here the circumstances in which you were instructed to conduct a postmortem examination on Child D. It was a postmortem ordered by the Coroner.

A. Yes.

Q. And a Coroner's postmortem is a fairly routine exercise in cases of what may be unnatural death but not necessarily suspicious death?

A. Well, the postmortem is -- is ordered to determine the cause of death. If -- I don't see what you -- the distinction you're drawing between unnatural and suspicious?

Q. Well, a Coroner has jurisdiction over unnatural death, so the postmortem is carried out at an early stage in order to determine whether this is a case of natural death or unnatural death, so whether the Coroner's jurisdiction is --

A. Yes.

Q. -- activated?

A. Yes.

Q. So the exercise you would carry out is different in nature, not necessarily in quality, but different in nature to one that is carried out in the forensic context?

A. Yes.

Q. And again you will be guided quite significantly by the information in this context that is provided by the hospital and particularly their staff?

A. Well, and provided by the Coroner, yes.

Q. Sorry, I didn't quite catch that?

A. And provided by the Coroner.

Q. And provided by the Coroner.

So if we go, please, to INQ0002045 and to page 7.

So we can see here this is entitled "Info from Doctor." It's part of a bundle of documents that are sent to you by the Coroner?

A. Yes.

Q. And so the Coroner's officer will obtain an account from one of the treating doctors and that will be set out and provided to you?

A. Yes.

Q. If we look at this account, we have first of all the description of Child D's birth. There is a reference to a full infection screen and IV antibiotics being provided shortly after baby -- Child D was born. That's five lines up from the end of the first paragraph, do you see that?

A. Yes.

Q. First of all, the fact that a full infection screen was performed at or about the same time as the antibiotics being provided, what would you understand a full infection screen to be?

A. Typically they do a blood culture. I'm not sure if they did a cerebrospinal fluid as well and probably blood tests for -- for blood count CRP.

Q. So --

A. But usually they would take the blood for culture before they have given the IV antibiotics.

Q. Yes. I think that's the point I'm making, is that they take the blood culture prior to giving the antibiotics because the antibiotics kill the bacteria in the blood and stop it growing?

A. Yes.

Q. And were you aware of what the outcome of that infection screen was, the microbiology?

A. I think in the notes I had got, they hadn't had any positive results back.

Q. So the blood had been cultured for a period of time, but hadn't grown any bacteria?

A. I would have to go back and check the report, but I think ...

Q. I think you can take my word for it --

A. Yes, yes.

Q. -- that that's what it was?

A. But that's only for bloodstream infection. So that doesn't exclude the possibility of infection in other sites such as within the lungs --

Q. Yes.

A. -- which we not involved with the bacteremia in the blood.

Q. So the note goes on to say:

"Around 9 pm the gas [which we assume was blood gas results, so oxygenation] was improving but still not good so night Registrar intubated and ventilated 9 pm Saturday night. Baby well overnight. Baby weaned very well on ventilator and extubated Sunday morning."

So again it's suggesting the pattern of improvement

leading to extubation following intubation?

A. Yes.

Q. And then a reference here to:

"Dr Newby saw baby Sunday and though Child D was a little bit quiet and a little stiff thought to be clinically septic but seemed well. Breathing well. Intravenous antibiotics increased. Plan to repeat gases and blood soon after extubation. One hour later blood gas after extubation wasn't satisfactory so put on to CPAP."

Now, CPAP is a lower level of intervention than intubation, do you know that?

A. Yes.

Q. Yes:

"... which quickly corrected and she remained in air with no real increased work in breathing."

So that again would suggest, after a short period of positive airway pressure support, her blood gases corrected themselves and she was able to breathe air without -- with no increased work of breathing?

A. Yes.

Q. There is a reference then to the umbilical lines and it says then at 1.30 am:

"The night Registrar was called as [so during the night shift] she had become mottled and had tracking

dark brown discolouration which had resolved after about 10 minutes. During that episode she had required an increase in oxygen but by the time Dr Newby attended she was back in air."

So there is a reference here to a curious episode of tracking mottling associated with a deterioration in breathing followed by a relatively quick recovery.

A. (Nods)

Q. Was it suggested to you that anybody thought that that was unusual?

A. Well, there's a lot more detail in Dr Newby's letter and in the clinical notes and it was noted that they thought this was -- must be something to do with infection.

Q. So again you would defer to the letter from the clinician having greater experience of these things clinically than you would have?

A. Yes, especially as I hadn't seen the rash myself.

Q. Yes. It then goes on to say that her inflammatory markers were okay and her gas was very good.

If I pause there for a second. What are the inflammatory markers?

A. CRP I think they are referring to.

Q. So C-reactive protein?
A. Yes.
Q. Do inflammatory markers commonly alter in the presence of an infection?
A. It can take time for those to rise especially in young babies. So that's why neonates, even if the CRP isn't raised especially at an early stage, they will still treat as infection if clinically they are suspecting it because they are not that reliable.
Q. So there is commonly a lag between the onset of the symptoms and the CRP rising in a detectable way?
A. Yes.
Q. But in serious or overwhelming sepsis, one normally sees a rise in the CRP?
A. Yes. But it could take 24 hours, so you really need serial measurements at an interval from one another.
Q. And there is a reference here to her gas was very good. What do you think that refers to?
A. Her blood gas.
Q. Would it be normal for a -- again it may be a clinical matter and if so please say so -- but, would it be normal for a baby with overwhelming pneumonia to have blood gases?
A. Not over -- no, not if it was overwhelming.

But whether then the child can deteriorate again then with difference gases is a different matter.
Q. So it goes on to say:
"There is a further episode of discolouration at about 3.15 am."
So we are a couple of hours later now:
Doing well, very well at that point:
"Had become more active. Began to be distressed with CPAP so this has been taken off. Then had an episode of further discolouration. Given bolus of fluid and that quickly settled."
"Doctor called. SHO was on the ward just before 4 am. She went profoundly mottled apneic lost heart rate. SHO nurse commenced CPR."
I think we know what happens next.
Did that strike you as being an unusual course for a child or baby to take in response to sepsis?
A. Well, in my experience when babies have died often they do have a fluctuating course beforehand and I have had cases before where a baby has collapsed, been resuscitated and then collapsed again and then eventually resuscitation fails. So a fluctuating course didn't seem to be that unusual to me.
And then obviously she has become mottled and stopped breathing again and her heart has stopped. So

the whole picture did seem to suggest that she was unstable and very unwell.
Q. You see Dr Hawdon gave evidence this morning and she said that this, this pattern leading up to the collapse, was atypical for sepsis. It's not what she would expect to see?
A. Well, I suppose she is a neonatologist with clinical experience that I wouldn't have. As you have alluded to, I would need a specific clinical opinion to go --
Q. Yes.
A. -- into a lot of detail.
Q. And I appreciate in asking you to give evidence on clinical matters, I am pushing you outside of your area of expertise. But I mean, you would agree that if Dr Hawdon said that this was unusual for sepsis, that it is unusual for sepsis? You'd defer to her?
A. Well, I would defer to a paediatric clinical opinion on that matter, but just pointing out that I have had cases where children have had multiple attempts at resuscitation in the hours leading up to a final death.
Q. And I don't disagree. I mean, of course I don't have the details of those cases to understand the differences that there might be. But you would

defer to Dr Hawdon on that issue?
A. Yes.
Q. What the note goes on to say in the final paragraph:
"Reported this had been third death in 12 days for neonatal. Also a further episode of apnoeic event and CPR for previous Twin death. Surviving Twin had successful CPR."
Did anything strike you as unusual about the addition of that paragraph, is that something you would see normally?
A. Well, no, but as I discussed earlier with Ms Langdale, without knowing that any of those deaths were unexpected or unexplained or concerning in any way, a cluster in itself would not raise a suspicion of an inflicted mode of death. And especially as a pair of those are twins, and both have collapsed and one has died, I would assume that there had been something specific about that pregnancy and then there's only one other death.
But as I mentioned earlier, there are a number of causes why neonates on a neonatal intensive care unit might die, so I would need to have a strong clinical steer that this was concerning for it to be flagging that this should be a case with police involvement.

Because I would have thought if that was the case, then whoever wrote that would have flagged that this should be a case with police involvement right at the onset of reporting it to the Coroner.

Q. Thank you. If you could look please at paragraph 62 of your witness statement.

So at paragraph 62 you are talking about interactions with Yvonne Williams and Dr Davies but you say:

"There was no mention within these multiple interactions with Yvonne Williams or Dr Davies of any concern that Child D's death was considered to be suspicious or of any increased rate of neonatal deaths and collapses at the Countess of Chester Hospital."

Now, in fact, you must have known that there was an increased rate of neonatal deaths and collapses at the Countess of Chester Hospital because it's part of the "Info from Doctor" that was provided to you originally?

A. Well, no. They have said there are three deaths in 12 days then. But in terms of overall neonatal death rate, you know, over a period of time or per thousands I hadn't been given any specific information about that.

Q. Ah. So you weren't -- again this is not meant

to be a criticism -- but you weren't to know that the third death in 12 days in the neonatal unit was unusual?

A. Well, I don't know what their normal death rate is because we only see cases that come to postmortem.

So I would require, you know, specific information to say over time they would be worried. Because usually I presume the deaths rates are plotted over, you know, quarterly or something like that, so you would need to look at those numbers to see if there had been a significant increase.

Q. If you had been told that this was very unusual, to have three deaths in 12 days and an unexpected collapse, your approach would have been presumably to ask why or indeed what was suspected to be the cause of it?

A. Well, I would expect it to be flagged from the hospital. So it's important that they report a cluster because then we might consider infections if anything turns up on the infection screen from a postmortem.

But I would very much expect the hospital to report it to the Coroner if they felt they had a local cluster that was concerning because for a pathologist working at a different hospital and not in the unit it would be difficult to -- us to suspect that without being given

the specific information.

Q. Yes. And again because your role is to -- is to effectively interpret signs that you find on postmortem and apply those in a clinical context or apply those in a broader context, and so how you might interpret a piece of information, a sign that you obtained from postmortem, depends pretty much on the wider context in which it's found?

A. Yes.

Q. And so it is crucial for your exercise to be complete for you to be provided with all the relevant information?

A. Yes.

Q. Could we go to please page 34 of the same document. In fact, forgive me, that's an incomplete version. Can we go please to page 832. So this is the -- no, this is -- 832 is the same document, but it has -- this one has missing pages. So 830, thank you.

If we go on then to page 831, so it's pdf number 833, thank you. So we have here clinical history as set out within the postmortem report and it's a much shorter document than the "Info from Doctor" that was provided. Is that because, in effect, you take from the information from documents -- from doctor those things that you see as being most relevant?

A. Yes, because Dr Newby had provided a three-page long letter and I also had over 40 pages of clinical notes. So I'm just putting here together a brief paragraph just to summarise the outline of the case.

Q. Yes. I mean, what it doesn't say here though is that there were periods of improvement or indeed that clinicians felt that at various point Child D was doing quite well.

A. Well, at the bottom of this page, it says she pinked up quickly and started regular aspirations.

So that was when she had improved then after being given IPPB. You would have to go to the next page.

Yes, I mean it's not a full summary, it's just a brief outline and I suppose I would be concentrating more on the deteriorations that led to death.

Q. So if you had been provided with information that the clinicians felt that this didn't fit with sepsis, it didn't look right for sepsis and it was explained why that was, then you would have set that out within, in effect, your factual summary at the start?

A. Yes. I mean, I would have to look at Dr Newby's letter. But as I recall her -- all of the information she gave, and including information that they thought the baby was septic, that they thought that

unusual rash was due to sepsis, the information all seemed to imply that they were thinking that this was a baby with infection.

Q. Again, this goes back to what you said to Counsel to the Inquiry in response to a question about paragraph 74 of your report, that the exercise in determining whether a baby has died with pneumonia rather than from pneumonia is incredibly difficult especially if looked at outside of any context?

A. (Nods)

Q. Because pneumonia is a localised infection and sepsis is a systemic infection and it is sepsis that is far more dangerous in the shorter term than pneumonia?

A. Well, sepsis doesn't necessarily mean that the infection has spread everywhere. Sepsis is the systemic response to the infection --

Q. Yes.

A. So a baby can have sepsis even with the actual histological signs of infection being limited to the lung and with there not been being bacteremia in the bloodstream.

Q. Yes. It is a systemic inflammatory response to a localised source of infection.

A. Mmm.

Q. But on postmortem there is -- and there may

never be -- but there is no evidence of the systemic inflammatory response. There is only evidence of the localised infection in Child E?

A. Yes, the evidence of the systemic response is the -- from the baby's observations and the collapse, the collapse of the baby.

Q. Yes. So things like raised CRP or inflammatory markers that is part of a systemic inflammatory response?

A. Yes, and I believe there was neutrophilia as well with a raised white cell count, wasn't there?

Q. Yes, but the signs of systemic sepsis are, on postmortem, are not there to be seen because those are signs that are observed in life?

A. Yes.

Q. What you have is signs of pneumonia, which again has to be placed in context to be understood?

A. Yes.

Q. And in terms of the severity of the pneumonia, the severity of the pneumonia in this case was not so extreme that even out of context you would be able to say that that was the cause of death?

A. Well, unfortunately I haven't been able to review the slides because they are police exhibits and haven't been returned to me. But I can see from my

report that I specifically mentioned there were larger patches in the right lower lobe of lung and I know from some information I heard reported from the trial that the trial radiologist did agree that there were signs of pneumonia in the right lung.

So I couldn't comment further on it without being able to review my slides.

Q. I don't think anybody in the criminal trial disagreed that there was pneumonia, and I think the issue at the criminal trial -- and it certainly was the position from Dr Marnerides, was that Child D died with pneumonia rather than from pneumonia, and that's because some things came in to add additional context?

A. Yes.

Q. But what I was saying to you is that it's not a case where the evidence that this was a death caused by pneumonia was so overwhelming that it could be determined simply on postmortem without any context to that?

A. Well, as I say, without reviewing the slides it's difficult for me to say. But there was a clear-cut pneumonia.

So, for example if this was a baby who died in the community and that I didn't have all of these observations, on the balance of probabilities you would

probably still say that might be the cause of death. But I think without me reviewing the slides it's difficult for me to give any further comment in addition to the postmortem report.

Q. But again it is inherently difficult to make the decision about whether this pneumonia is the cause of death or it's simply a feature that was present at the time of death because in clinical practice babies have pneumonia and recover?

A. Yes, they -- yes, they do recover. So I think you are right. In this case, I think a lot of the extra information that came out in the criminal trial has significantly, you know, informed people's thinking about the significance of the pneumonia.

Q. Now, one of the things that came out of the criminal trial, if we go on to -- so the following page 832, please. It's 834, pdf number.

Next one down. Thank you.

We can see there a reference to the X-ray examination postmortem skeletal survey and why is there a question mark after X-ray examination, do you ...?

A. I'm not sure. I think that must be that the secretary has put it in and it's a typo.

Q. Okay, thank you. Is this a survey that has been carried out by you?

A. No, the -- this is a report from the Consultant radiologist and the X-rays are done by a radiographer who comes to the mortuary.

Q. Now, the X-rays in this case, both in life and postmortem, were reviewed as part of the criminal trial by Professor Owen Arthurs, a professor of paediatric radiology at Great Ormond Street Hospital and by a number of members of a multi-disciplinary team and it was noted that there were changes consistent with air embolism on various X-rays taken in life and following death and that there was air in the great vessels.

Can you explain where the great vessels are?

A. Well, great vessels you would normally talk about the large vessels in the neck, so for example the large veins leading to the heart or the large vessels leading from the heart. I'm not sure if they are talking about descending aorta as well.

Q. Again, the observation of air in blood vessels on X-rays is something that requires the specialist input of a radiologist?

A. Yes.

Q. It isn't something that you would expect to be able to do on seeing an X-ray yourself?

A. No.

Q. No. And likewise there was evidence at the

criminal trial of air in the great vessels, but that did not result in you identifying froth in the lungs or in the heart on your examination?

A. No.

Q. Was that because, to put it bluntly, being able to find or spot such froth is a lot easier if someone tells you that there's a possibility there might be an air embolism in this case?

A. Well, I've got -- I took a lot of photographs of the postmortem, including 22 internal photographs, and that included photographs of the brain and the lungs and the heart and I have gone back and I can't see any froth there and also there are no air bubbles on the surface of the brain either.

And so I have done a lot of reading about this and it seems to me, although in some cases in the literature there is a large amount of froth in the heart and in the lungs reported there are other cases reported where there has been a significant amount of air visible on postmortem CT, but then the pathologist couldn't identify it at all at postmortem.

So I think from that, and I have had experience of another case since of a postmortem case where a large amount of air was identified on CT and with a forensic pathologist, even with filling the pericardial sac with

water and puncturing the heart we couldn't demonstrate it at postmortem.

So my experience from that reading and that case I have had since then would lead me to believe that you could have a significant amount of air at postmortem and it could be completely undetectable at autopsy.

Q. So your statement to Ian Harvey in the email may have been quite genuine based upon your understanding at the time, but since then you have come to learn that in fact you can have a very significant air embolism without froth in the heart or lungs?

A. Yes, that's correct.

Q. Yes. And if I then can draw some of the strands together. You accept that it's difficult to determine whether pneumonia was the cause of death as opposed to something that was present at the time of Child D's death.

Had you been provided with key pieces of information, ie that the pattern of deterioration prior to or that Child D's condition prior to her collapse was not consistent with sepsis, that there might be a suspicion of foul play involved, then you first of all would have followed an entirely different trajectory in terms of the investigations carried out. It would have been a forensic investigation rather than a hospital

postmortem?

A. Well, yes. If I had been informed there was a suspicion of foul play, that would definitely have been a forensic postmortem with the police involvement.

If a clinician had said only, "We weren't sure it quite fitted with sepsis", that could still be a routine Coroner's postmortem.

Q. Yes.

A. But then, you know, if they really were concerned and if after issuing the postmortem report the paediatricians had come back to me and said, "We really don't think there is pneumonia", then we would have a discussion.

And sometimes in these types of cases before I finalise the report, I'll ask the Coroner if I can speak to the clinician and discuss it, you know, if I'm not sure that the clinical features fit together and then I would rely very much on their opinion.

So I think in this case it wouldn't only be a lack of the clinical features fitting with sepsis or pneumonia. You would have to have the strong clinical steer that it was a suspicious case to warrant insisting on police and forensic pathology involvement.

Q. But to look at it in a different context. If this was a hospital postmortem as it was and you

have equivocal evidence as to whether pneumonia was the cause of death or simply something that was present, if you had received a steer from the clinicians that the deterioration of a child's condition prior to collapse was inconsistent with overwhelming sepsis or collapse due to sepsis, then you would have interpreted that pneumonia in a very different way, wouldn't you?

A. Well, there was a clear pneumonia, but not only was there pneumonia; there were hyaline membranes which indicated acute lung injury, which you don't normally see. So that did lead me to believe that there was more extensive lung injury from the pneumonia than you might expect, so that could explain then why the child didn't behave as the clinicians might have expected.

But from the trial outcome in this case, I am wondering if air embolism and his survival for a couple of hours if that could explain hyaline membrane development and it's not something that's been reported in the medical literature but because it's a bit unusual, I'm wondering if that could explain that evidence of acute lung injury in this case and it would be interesting to look at all of them.

Q. So I mean, in short, of course the evidence that was given in the criminal trial causes you to

entirely reappraise the interpretation of what you saw at postmortem for perfectly legitimate reasons because other experts have become involved and given different opinions from the perspective of their sub specialties. That's correct, isn't it?

A. Well, yes, we have a child who has pneumonia but then there's been an inflicted cause of death on top of that. So obviously that would then change the opinion of whether the pneumonia led to death or not.

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

LADY JUSTICE THIRLWALL: Thank you, Mr Baker.

MS LANGDALE: That concludes the questions for Dr McPartland, my Lady.

LADY JUSTICE THIRLWALL: I have no questions. Dr McPartland, thank you very much indeed for coming to help us this afternoon. You are free to go.

A. Thank you.

LADY JUSTICE THIRLWALL: So we will rise now until 10 o'clock tomorrow morning.

(3.46 pm)

(The Inquiry adjourned until 10.00 am, on Wednesday, 13 November 2024)

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