Wednesday, 13 November 2024

(10.00 am)

LADY JUSTICE THIRLWALL: Ms Langdale.

MS LANGDALE: Good morning, may I call Dr Jayaram.

DR RAVI JAYARAM (affirmed)

Questions by MS LANGDALE

LADY JUSTICE THIRLWALL: Thank you very much, doctor, do sit down.

A. Thank you.

MS LANGDALE: Dr Jayaram, you have provided a statement to the Inquiry dated 30 August 2024?

A. That's correct, yes, I did.

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

A. I can confirm that, yes.

Q. You have a copy of it in front of you, should I refer you to any of that?

A. I have.

Q. Before we begin, I understand there is something you would like to say?

A. Yes. I would like to say to the parents and Families of the babies affected by this awful tragedy that I would like to apologise for any personal failings and omissions that I may have made in the period leading up to June 2016 and afterwards that might potentially

have made a difference to avoiding problems.

I want to acknowledge that I will take personal responsibility for things that I could have done better and in retrospect seem fairly obvious that could have been done better.

And I would like also to apologise as well for the systemic failings that could have contributed to this not being picked up as soon as it could.

Q. Understood, Dr Jayaram.

A. Thank you.

Q. You in your statement tell us that you graduated in 1990 and you were appointed to the role of Clinical Director for Children's Services in March 2009?

A. That's correct.

Q. I think you were working at the Countess of Chester since December 2004; is that right?

A. That's correct, yes.

Q. You set out various responsibilities at paragraph 6 in your role as Clinical Director for Children's Services.

What were the additional roles and obligations with that job?

A. The role of Clinical Director was very much a sort of a managerial administrative role and in simple terms as I have outlined in my statement it was being

the representative of the department to management and -- and being a representative, a representative of management back to the department.

In terms of hierarchies, I was the line manager for my colleagues. It didn't mean that I was more senior. Clinically we were all equals, but I was responsible for appraisals of my colleagues. I was responsible for liaising with management around issues around service development.

I oversaw other aspects of the department in terms of education and training and risk and governance although other individual colleagues had specific roles in those areas.

I also had a role in liaising with external agencies such as primary care commissioners in terms of issues around service development as well and dealing with any issues with regards to concerns around staff, concerns around the service.

Q. Before we go to the specifics, what culturally was the Countess like in your experience over that period of time in terms of relationships between Executives, senior managers, doctors, doctors and nurses and the like?

A. Are you talking from the time I started as Clinical Director?

Q. Yes, broadly, and whether it altered in 2015/2016?

A. Yes, so when I started as Clinical Director, we were part of the division of Women's and Children's Services, so obstetrics gynaecology, paediatrics and neonatology were under one wing, we had our own departmental professional managers, people to run risk and governance.

Within the division I had very, very good relationships with managerial staff and there were good links with more senior Executive management as well.

We didn't always agree but people would generally listen and there were opportunities to actually discuss things openly and find -- find solutions.

There were -- there were always potential conflicts in that the wider issues of the Trust in terms of finance, there is a limited budget, we may not always have felt we got the priority we wanted to.

In early 2010, there was a reorganisation of the divisional structure and it was proposed that the division of Women's and Children's became obsolete and that there should be a rationalisation of divisions in the Urgent Care and Planned Care division. And the discussions at the time I recall it was felt that essentially, acute medicine was mainly Urgent Care and

surgical specialties were Planned Care.

But I remember at the time thinking that was quite a simplistic view because there is elements of Urgent and Planned Care in all medical specialties.

Where it became difficult was with regards to paediatrics, neonatology, obstetrics and gynaecology because the majority of acute paediatrics, if you like, was Urgent Care. I think gynaecology there was a lot of planned surgery. But maternity and neonates being integral to each other didn't really fit into either Urgent or Planned Care. And there were a lot of discussions really as to how -- how they should be divided and in the end after a lot of discussion it was -- it was decided that paediatrics and neonatology would sit in Urgent Care and obstetrics and gynaecology would sit in Planned Care.

Q. Do you think that was the right decision retrospectively?

A. I think the difficulty with that is that it caused difficulties in terms of separating neonatology from obstetrics and maternity. We were allowed to keep a governance board but it was never clear to me where lines of escalation would go because obviously neonates sat in Urgent Care and maternity sat in Planned Care.

It also meant that as a specialty, paediatrics and

neonatology had a much smaller voice. I can't speak for obstetrics and gynaecology and Urgent Care, whereas we had our own division and representation directly to the board we were then, if you like, treated as another "ology". So, for example, in adult medicine there would be sub specialties such as rheumatology and I think it was acknowledged that paediatrics needed more time and effort and in terms of my role as Clinical Director at that point I was changed to a lead clinician but it was acknowledged that I needed to have an acknowledgement of the increased time, although on paper I had four hours a week to undertake that work that was paid for. In practice, with my clinical workload, a lot of the management was done in admin time or my own time. I think --

Q. How much time, pausing there, is admin time?

A. So in our --

Q. Were you given formally, I mean, within work hours?

A. Formally --

Q. Yes.

A. -- it was four hours a week, so one programmed activity.

Q. Did that change through events that we are looking at?

A. No.

Q. Or was that always the position, four hours?

A. No, it stayed that way.

Q. When we see the countless emails and communications, you are all as paediatricians doing those in evenings?

A. Yes, in our contracts we have around, depending on your contract, between two and two and a half sessions -- a session is four hours -- for non-clinical work, that includes continuing professional development, audit, educational supervision and administration time doing paperwork as well. That's -- that's there anyway.

Q. Moving now to my first topic, Dr Jayaram, you have clearly covered a lot in your statement and been referred to a lot of documents. I am going to take the questions today, if I may, thematically and the first one that I would like to ask you some questions about is guidance around Working Together to Safeguard Children and processes that should be used.

You refer in your statement to a number of these pieces of guidance and I know that you have seen them.

So the first one, please, if we go to Working Together to Safeguard Children, this is the general 2015 guidance and this is government guidance. If we go to

INQ0014575, page 91, you make the point, Dr Jayaram, and we see it with this chart, that in fact this guidance referring to:

"Processes for rapid response to unexpected death of a child very much relates to deaths in the community and/or deaths where family members might be suspected of causing harm to the child, support for carers, other family members, discussion between paediatrician and attending police officers and the like."

So at the time, would you have found 'Working Together' particularly useful in telling you what to do where you suspected a colleague may be causing harm to a child?

A. I think in answer to that question, for me may I refer to it as the SUDiC guidance, meaning Sudden Unexpected Death in Childhood --

Q. Yes, yes.

A. Just for brevity's sake.

I was fully aware of the SUDiC processes.

Q. Shall we go to that one that the hospital had, your Dr Mittal's guidance processes, let's go to that since you refer to it.

A. Yes.

Q. INQ0014165, page 1. So this is, if we go to page 2, this is Countess of Chester guidance about

safeguarding and promoting welfare of children -- sorry, page 33.

This is the guidance, the SUDiC guidance that the hospital had. Do you mean this, are you aware of this?

A. Yes. So my understanding of, of the SUDiC process and it's a process we followed frequently in, for example, babies brought in after Sudden Infant Death at home or arrests at home, and there was a clear process that in terms of documentation and pathways to follow.

In terms of the neonatal unit, and this is something I have reflected on at length, at the time even at the point where individually and as a group there was consideration that these events didn't seem to fit, I did not consider using the SUDiC process because it never occurred to me that it would apply to babies on a neonatal unit.

Now, it says "hospital emergency department or ward".

Q. It does.

A. Again, in those situations usually in this situation, it would be a situation where the child is on the ward because of an injury, if you like, or an illness that had happened outside of hospital and I will admit in retrospect that looking at this guidance, there

was potential to initiate SUDiC processes in these situations.

I think one of the issues earlier on, particularly with some of the babies who -- who died during 2015 particularly in the first part of this time period, is that we weren't at those points thinking outside of natural deaths, if you like.

Q. We will come to that.

A. Sure.

Q. Just if I can focus on the process for moment?

A. Yes.

Q. We are in agreement that this does flag up at least if it's unexpected and sudden so that is not the same as a sudden natural death but sudden and unexpected?

A. Yes.

Q. Unexplained, unexpected, then this process should kick in and there's also reference here, isn't there, to the Child Death Overview Panel and the purpose of that panel to understand why children die and put in place interventions to protect other children and try to prevent future deaths.

So standing back, that is what this is all about, isn't it?

A. Yes, it is.

Q. You don't know what's happened, it needs investigation?

A. It does.

Q. Investigation is to be seen as a neutral term --

A. Yes.

Q. -- whoever it involves, whether it is a family member or a staff member, you investigate and find out what's going on to protect future babies. That is what safeguarding is about?

A. Yes.

Q. So when you look at this now, are we in agreement that this process, the SUDiC process should have been invoked even when you simply don't know, it's Sudden and Unexplained Death, you don't know why, you don't know if it implicates anyone or not, you just -- it is a Sudden and Unexplained Death that merits attention?

A. I can't -- I can't disagree that in this situation looking at this SUDiC is a process that should have been initiated. With regards to CDOP as part of the notification of deaths, there is a form that's filled in and so the CDOP paediatrician is informed of deaths. I think I have said in my statement I have no knowledge of what the process is after the CDOP

paediatrician has been informed.

Can I also say that it's not that none of these deaths were investigated -- not, not investigated but they were investigated outside --

Q. Outside the process, we will come to that?

A. Yes.

Q. We are simply looking at this as a concept at the outset --

A. Yes.

Q. -- and trying to understand where the Countess of Chester was with this?

A. Yes.

Q. Because you are not alone in failing to realise that this process should have been triggered, clearly?

A. Yes.

Q. But Dr Mittal, he is the designated doctor for safeguarding. Did you have any conversations with him or did he approach you to discuss this SUDiC process and whether and if so it should apply to any of the babies --

A. No, there were no conversations either way.

Q. Throughout the whole period we are investigating?

A. Not that I can recall with me specifically.

Q. And not with any of the nurses as well who may have had responsibilities in some cases for safeguarding, you know there is designated officers for safeguarding et cetera?

A. Yes. No, because I think -- and again this is something that I have had a long time to reflect on, thinking about the concept of safeguarding, you know, as paediatricians we are fully aware of safeguarding in terms of parents potentially causing harm, other people causing harm and even in terms of staff members, if we saw somebody verbally abuse a child, physically abuse a child, or considered it.

I think one of the issues here is that initially, again we weren't thinking beyond natural causes and -- and I will come back to this I am sure in due course. It was once you start thinking the unthinkable, how do you -- how do you bring it forwards? And I fully accept that had the SUDiC process been initiated, the difference between what happened in terms of investigations that were done for each of the events compared to what would happen with SUDiC is that there would have been other professional agencies, particularly the police, involved as well.

Q. And professionals who listen with a safeguarding perspective?

A. Yes.

Q. I think later on you refer to when you finally spoke, so Hayley Frame or CDOP and somebody else, with the same concerns that they were sudden and unexpected, same member of staff involved?

A. Yes.

Q. The response you got was completely different, you say?

A. Completely different yes.

Q. And again they had understanding of safeguarding?

A. Yes.

Q. So if you were to summarise their response to their facts, the facts that you had been stating for a long time, what were they?

A. They essentially said: so what you are telling us is that you have got a group of seven paediatricians who have all been involved with babies where they have had sudden unexplained collapses and haven't responded as you would expect to appropriate treatment and you have noticed the association with an individual member of staff with each time and you can't explain? You are not, you can't think of any natural causes that would explain these things? Essentially we need to look further.

Q. So an immediate response to those set of facts when you are looking at it from child protection perspective or what might be happening to babies now elsewhere?

A. Yes.

Q. Was that refreshing to get that observation or clarity of thought?

A. It was a relief at that time in -- I think it was late April/early May 2017 because I think by that stage, we had said exactly these same things to many people so many times and were repeatedly, repeatedly being reassured, falsely, that yes, it could be that but we need to make sure we have excluded lots of other things first.

Again, you know retrospect again, I only wish that at earlier stages both myself and colleagues had actually been more assertive and said, you know: we -- we don't think you can look any further without people who can look more forensically at it.

Q. Just finishing with the guidance, you referred us to something called a Just Culture Guide, NHS Just Culture Guide which describes the process to follow and if we go, please, to INQ0107964, page 5.

A. So I was -- I was asked as one of the questions in my Rule 9 request whether I was aware of --

now of any specific guidance as to what to do if a situation like this is suspected and my initial thoughts were no actually I wasn't and, and actually at the time I wasn't.

Now, I know many colleagues have been asked about their awareness of the Beverley Allitt situation and I was aware of that. That was actually happening when I very first started my training in paediatrics as a very junior doctor. I was not aware at all of any recommendations that had come out of that in terms of specific processes and avenues that could be followed.

Q. One of the recommendations of the Clothier Report, which followed it, was that there should be heightened awareness in the NHS of this case, of the Allitt case, to let people know that this could happen in their space, in their watch, and it could be a nursing professional who was responsible.

From what you are saying, that heightened awareness either through Policy documents or more culturally wasn't in place at the Countess of Chester at the time of these events?

A. I cannot recall safeguarding training that I have had, not just at the Countess but in my training as -- as a paediatrician in training, which ever specifically talked about the situation where it might

be suspected that a professional colleague could be causing deliberate harm.

Now, I found this Just Culture Guide because in answer to that question, I wanted to know if there was anything. And I stumbled across this.

Q. Perhaps we can enlarge the first box 1A and also the Just Culture Guide?

A. And I believe this was published around 2018 or 2019 but I wasn't quite clear.

Q. Did you have to dig hard to find it or was this something you were aware of before you were asked the question?

A. I heard about it because a colleague of mine who's a relatively new Consultant had been involved in -- there is a new structure, PSIRF, the Patient Safety Incident Reporting Framework and she had been on some training for PSIRF and when I was asking people if they had known -- knew about anything, she mentioned that she had seen this document and forwarded it on to me.

Q. I am curious, Dr Jayaram, what you are supposed to take from 1A was there any intention to cause harm. Intention is very difficult to judge, isn't it, at the outset and the focus ought to be on the harm caused to the child, shouldn't it?

A. Yes.

Q. What is the harm and then what might be involved?

A. Yes.

Q. Intention is a different step, isn't it, it may be obvious in some cases but --

A. Well, it is very subjective because if one is investigating an incident and there is a possibility that an individual could potentially have caused harm, how do you establish whether or not there's any intention to cause harm without actually asking that individual? And I think it would be very unlikely particularly if we apply this document to the situation that we were in at the Countess, it would be unlikely that they would respond yes to that question.

And I would imagine because in 99.9% of the time there isn't going to be an intention to cause harm because we don't go to work to look after children and babies with the intention of causing harm, but what I was also interested when I saw this is the first recommendation is to follow organisational guidance for appropriate management action and then there is a number of issues.

Now, I am not aware of any -- outside of SUDiC processes of any specific organisational guidance even

now but I don't know about in other institutions.

Q. That can come down now, thank you.

Certainly for the cases we are looking at, the SUDiC guidance was enough, wasn't it?

A. Yes.

Q. It covers first of all what should be done in terms of referral but secondly, as your experience illuminates, referral to professionals who should understand this --

A. Yes.

Q. -- should immediately get and grasp what you need to do which isn't exercise judgment but undertake neutral steps and measures to ensure children are safe while you are finding out what's going on?

A. I agree.

Q. So the SUDiC process made loud and clear that it applies just as much in hospital as out and when members of staff are involved would cover, do you think, the lack of knowledge around this area that we appear to be seeing in the Countess of Chester at the time of events?

A. Yes, I think so, particularly if we are thinking outside of natural causes, without a doubt.

Q. Well, a death that's sudden and no natural causes and we have heard evidence that with neonates if

they die naturally -- they may die suddenly, but naturally you can see what it is?

A. Absolutely.

Q. So it doesn't fulfil that important component of unexplained, does it; it is a sudden natural death?

A. (Nods)

Q. Can we move now then to the babies in question and your clinical involvement with each of them and what you saw at the time and I am going to separately thereafter look at how doctors were sharing concerns and then concerns with the Execs. I am sure the areas and themes will overlap a bit but so that we can make it manageable for you and with the documents as well, we are dealing first of course for you with Child A.

And you have, if it helps you, your notes of Child A INQ0000017, page 18 and 19 of your notes.

Go to page 19, the last paragraph. We see you informed the Coroner and in your written notes you are discussing the possibility of abnormal heart rhythm caused by a long line or a complication from the umbilical catheter and you are looking at unrelated events as well, such as a bleed of the brain.

But you report it to the Coroner don't you, and you are concerned about this death at the time?

A. Yes. I was concerned because clinically it

didn't seem to fit with anything obvious. I think, as I have written there, I have kind of written my thought processes through things we know could cause sudden, sudden deterioration.

Q. You also later on refer to, if we go to INQ0001982, page 11, you tell the police about the discolouration of the baby, so let's look at that.

The penultimate paragraph, you talk about:

"He had unusual discolouration, you would expect babies to look fairly ghastly and pale and grey, but he had an odd sort of discolouration where there were flitting patches of pink areas on a background of bluey-grey skin. These patches seemed to appear and disappear. It wasn't like [a] rash [or sepsis] ... it would flit and reappear and disappear. It didn't fit with anything I had ever seen before."

You explain you didn't put those in at the time in your notes?

A. No, I didn't and this is again something that in retrospect I wish I had for many reasons.

At the time of Baby A's collapse and resuscitation, I had been called over, I noted it, I didn't really at the time appreciate the significance. When I came to write my notes I didn't document it. You know, I have subsequently been, you know, it's been suggested to me

that it's a false memory but I know that other people saw it as well, so ...

Q. I am just asking you about the rash. I am not repeating territory you have been through about that.

A. But the -- no, but the description there is what was happening.

Q. That can go down, thank you.

You, we know, had no direct involvement with Child C, D or indeed the collapse of B. You weren't -- you were in outpatients clinic then you were travelling to a conference when Child B collapsed, you were on professional leave when Child C died and Child D you had no direct involvement with, either.

At paragraph 221 of your statement, if we can go to that, you say about Child C:

"I don't recall at what point I was made aware of their case although I knew that Dr Brearey was going to be meeting Eirian Lloyd-Powell on [22 June] to discuss the deaths of Children A, C and D so I would have been made aware of the death of C by Dr Brearey at some point between [17 June] ... and when the meeting took place on [22 June]."

We are going to come later on to their meetings and information that they were sharing around the three babies, but were you very much reliant on their

discussions for information about B, C or D? At this time?

A. At this time, yes, and I'm not sure it had a huge amount of detail at this point.

Q. We will come to it later what you were -- you got from them.

Children E and F, you tell us in your statement you don't have any independent recollection of involvement with Twins E and F. The case notes record you were present at their deliveries and also that you provided advice on the management of the hypoglycaemia of Baby F on 5 August 2015.

You now know of course that the blood tests that you requested revealed results that the hospital didn't see until much later and I think you say -- well, tell us when you first became aware of the abnormal results suggested of the insulin?

A. I first became aware of the results with Baby F once the police investigation had been undertaken. It was already ongoing. I wasn't aware until that point.

Q. So having requested tests would you later on as a clinician go back and look for it or if you are not around the next few days and you are into another week do you leave other people to pick that up?

A. So it depends on the context and when they were requested. So the way we worked is that they would be -- there would be a named Consultant for the baby but we worked on a week at a time covering the neonatal unit.

So at the time of the hypoglycaemic episode for Baby F I was the on-call Consultant, it was discussed at handover that the sugars were low. We as a matter of routine have a serious of investigations that we request when a baby is hypoglycaemic and again usually there are physiological explainable reasons for it in premature babies, but one of the tests is as well as looking at glucose and other indicators in the blood is to do an insulin and C-peptide level.

Usually once those results are requested the results will come back -- there is often a big of a lag time. It wouldn't ordinarily be that the on-call Consultant would be the one responsible for chasing those results.

What should happen, however, because of on-call systems and handovers that the handover system should be robust enough to note that these bloods have been taken and that the results are outstanding.

And one of the problems with some tests, insulin C-peptide particularly, there can be a lag time of

sometimes several days for those results to come back.
At the time, there were systems for abnormal results for anything to be flagged up by a phone call from the labs, otherwise paper results come back.
I can't explain why this result was not actively chased, although having done these investigations for many years in hypoglycaemic babies invariably the results come back normal or slightly high insulin levels because of Congenital Hyperinsulinism or small for gestational age.
And so there's almost an element of well, these results are always normal and I don't know why this one wasn't looked at, whether -- there are a number of things that I think need to be considered; process of handover, is it recorded? We have handover sheets that are updated twice a day, it should have been on the handover sheet as an outstanding result to chase, it should have been in the notes as an outstanding result to chase.
I don't know myself whether this result was phoned back and I'm not sure at what point the paper result came back or to whom it came back to.
I -- I would say and I don't think any clinician would disagree, that although I was the one that suggested the bloods should be done it was an out of

hours on-call thing, it wouldn't have necessarily been me that should have actively looked them up, but there should have been a better process for ensuring that these results were actively looked for and that should apply to any test, why do a test unless you are going to look at the result?

Q. Dr Gibbs in his evidence to the Inquiry said that this was a collective failure of the paediatricians. Would you agree with that?

A. I -- I would -- I would agree. Because as I say, if you do a test, you are trying to find something out. The result should be looked at. You can't assume it is going to be normal.

I think another issue here as I understand is when it was looked at, the significance of the results was not -- was not understood. I -- I can't comment on that.

Q. We know from the Beverley Allitt case of course insulin tests were very important in recognising foul play --

A. Yes.

Q. -- had taken place?

This was a missed opportunity here, wasn't it?

A. I agree.

Q. The point of Baby F?

How are results taken now, what's the system for --

A. So the system is different now. We have an electronic case note system and then electronic results system. So we don't have paper results.

So any, any result for any test comes back on to the electronic system, it will appear on in the kind of results inbox for the ward of the patient and also the named Consultant as well and results have to be endorsed.

So we get regular updates of results that have not been endorsed. So when I say "endorsed", somebody has to physically look at the result and sign that it's been looked at. Abnormal results, be they high or low or outside the quoted normal range are usually flagged up in red.

Q. Are they flagged up with an "H" and an "L", something to make it quick and easy to see what's high and what's lower than normal?

A. Yes, and again there is still a system where if there is concern the lab will phone up. But it's not always clear who they speak to and how the results when they had been phoned through get communicated through to the right people.

So the system is I think now more robust than it was but there is still potential for things to be

missed.

For example, if a baby or a child is admitted under a Consultant's name who isn't the named Consultant or there's another Consultant in another specialty in the hospital with a similar surname and the same initial and that happens occasionally, but usually what will happen is person the result comes back to will say "this isn't my result" and will forward it on. So there are -- there are safety nets there.

Q. Has there been internal learning from this case or this set of results actively, or has this just been the case?

A. Yes, I would say there absolutely has particularly with regards to sort of looking at hypoglycaemia investigations. Number one, understanding of what the actual numbers mean; and number two, the importance of making sure that all results get looked at.

Q. Baby G., you had limited involvement in the care of Child G but you had taken over as paediatrician of the week on 7th of the 9th and at the morning handover you would have been updated she had a sudden deterioration overnight but at the time of the handover she was relatively stable.

We know of course there was a conviction in

relation to Baby G for overfeeding with milk?
A. (Nods)
Q. And her father gave powerful evidence to the Inquiry about how she vomited and how she presented.
You did not have any other clinical involvement but were you involved in any debriefs or discussion around the collapses of Baby G on 7th of the 9th or 21st of the 9th?
A. I don't recall being involved in any of those discussions.
Q. It's difficult to see indeed if there were discussions around the babies who collapsed or survived from an Inquiry perspective. Can you help us with what the protocol or practice was if a baby survived or recovered from a deterioration, was there due attention given to discussing what may have happened to the baby?
A. So I think that's a really important question and I will -- I will try and answer it as best I can having thought about things.
It would all depend on the circumstances of the event and the collapse. And bear in mind particularly earlier on we were thinking within the realms of, of natural events.
So if the baby survived we would often say: well, they were premature, maybe sepsis, but they are fine

now.
Now, sometimes these would get Datix reported, particularly if it was clear there had been some kind of error or omission that might have contributed to it, for example a cannula that had tissued or observations to suggest abnormalities, to suggest deterioration that had been missed and if they were Datixed they would have got further review.
But there was no standardisation of which ones would be Datixed and again if they weren't Datixed and the babies got better it was kind of, well, thank goodness for that, let's carry on.
Now, in retrospect, I do think that if we Datixed every -- and this is where it gets difficult, do you Datix every deterioration, what is the threshold at which point you report? You know, so some babies may deteriorate but not arrest and turn around.
Had they been Datixed and -- and one of the things with the perinatal Morbidity and Mortality Meetings is that we would have ordinarily have discussed, been more likely to discuss babies who had had non-fatal collapses. What was happening around this time is that there were so many catastrophic fatal events to discuss that there was almost a lack of time to discuss them.
Q. Just dealing with the Datix point. A Datix of

course is when you see something that might be a problem or an error so you Datix that error. The staff error. Of course if we are dealing with a member of staff who is deliberately harming they are not going to self report that and you are not necessarily going to see?
A. No.
Q. -- that it is not an error, it is a deliberate act, isn't it?
So in terms of how the Datix system might work, simply reporting in the way you are required to report a Sudden and Unexpected Death because it's sudden and unexpected and you don't know what happened, if it's a deterioration that is sudden and unexpected as opposed to a sudden deterioration in a naturally deteriorating baby, do you think that would go some way to triggering the level of discussion? So there isn't a need to own a particular error or mistake in the circumstance; it is just we don't know and actually --
A. Yes.
Q. -- this is a problem that we don't know?
A. Yes, and I agree and I think now my -- my threshold for thinking beyond natural events is -- is -- the bar is very low and I do think there is an argument for saying perhaps in these situations if there is no clear explanation, as well as Datixing perhaps even

thinking going down the SUDiC line as well. Because it can apply to near misses too.
I think in terms of a Datix had some of these non-fatal collapses been Datixed they would have been reviewed but I suspect the outcome of those reviews would have been we can't see any specific clinical issue and it may not have brought us any further forwards because again we are thinking within the confines of natural events.
Q. Baby H, and if you go to paragraph 279 of your statement, we know you were called in at 0132 hours as Baby H had increasing ventilator requirements for a few hours. She seemed to have stabilised by midnight but had a sudden deterioration at 0114 hours.
You say you didn't have specific concerns around the care of Child H or the conduct of Letby at that time.
Looking at paragraph 279 and 280, though, you do recall observing to Dr Brearey privately the next morning something. Can you tell us what you said to Dr Brearey?
A. Yes, I --
Q. Also your thoughts or observations about the valve on the chest drain --
A. So having been called in that night and again

it -- as I walked in it struck me it's -- it's Letby again. And my thinking at the time is, you know, she's very unlucky that she seems to be associated with all of these.

Again -- and I in terms of the chest drain valve, it was something at the time there was a lot of hands in the incubator there was a lot of -- of -- of moving, there is a lot of procedures. I saw it seemed to be in a closed position and opened it and I mentioned to Dr Brearey the next morning that it was -- it was -- it was Lucy Letby again, simply because I was thinking, well, she's -- she's very unlucky.

Now, obviously knowing what I know now and subsequently when I -- when the investigation was launched talking about these and sort of before then talking to Sue Hodkinson, I raised this because again retrospectively and again I -- I can't say whether that was deliberately closed or not, it wasn't something that I had even considered at the time, because at that time I was not thinking somebody could be causing deliberate harm. I had noticed that association with Letby being present but not with any, any thought of anything untoward.

Q. And the chest drain in a closed position rather than open, is that easy to -- well, what did you

make of that?

A. Well, at the time my thought process -- and again trying to make things fit, there was a lot of handling going on, there was a lot of hands in the incubator, there was a lot of -- a lot of examination.

I was wondering whether it could just have been accidentally knocked. Now, again, thinking about it, it could happen but in retrospect it's less likely. The honest answer is I don't know.

Q. You mentioned that you spoke with Sue Hodkinson about that in March 2017 and we will go to that later, if I may.

A. Yes.

Q. But at that point around Baby H, you had those thoughts and you had that conversation with Dr Brearey.

Baby I. You were away from the hospital I think on professional leave on Friday, 23 October and you were debriefed around 2 November, you say, about the death of Baby I and if we go to paragraph 294, can you tell us what you say at paragraph 294 and 295?

A. So it says:

"When I returned to work in early November 2015 and became aware of the death of Child I, and the repeated associated presence of Letby, I became concerned for the first time that Letby could somehow be causing

inadvertent or even deliberate harm.

"My initial reaction to this was to tell myself this is ridiculous but once the thought was there it became harder to ignore given the unusual nature of the events and her presence every time. I recall there were several informal 'corridor conversations' between Consultants at this time. I cannot recall who amongst us was the first to articulate possibility of Letby causing inadvertent or deliberate harm but when expressed openly it became clear that I was not the only Consultant with these concerns."

Q. We are going to come to the mortality table later but the informal corridor conversations, can you remember who they were between at this time? Clearly you, Dr Brearey, anybody else?

A. I think Dr Newby may have been involved and Dr Gibbs as well. And I think -- I can't remember specific conversations, but my impression was that all of us had begun to consider whether her presence was of significance rather than just coincidental and bad luck.

I -- I don't know whether all of us had genuinely begun to consider could she potentially be causing deliberate harm. And again that's something, you know, we are still not -- finding it difficult to think the unthinkable.

But as I have said in my statement once that thought is on your radar, it's very hard to shut it away. But you also become very aware of the fact that you run the risk of confirmation bias as well and seeing things that aren't there.

Q. Paragraph 304 you tell us with Child J you were out of the hospital and you don't recall being made aware of the collapse on 27 November on your return on Monday, 30 November. You say:

"As [Lead for Children's Services], I had not been made aware of collapses routinely. If [it] was reported via Datix it would have been escalated and reviewed by the neonatal [lead]."

That might be true ordinarily but in these circumstances did anyone find you or come and tell you about Baby J?

A. Not that I can recall specifically. That's not to say they didn't but I don't recall and I would imagine -- again I am speculating here -- that had I been told I would probably have asked actively who, who the nurse was. But the genuine answer is I can't remember.

Q. Baby K. You have given evidence in two trials about Baby K. If I can ask you to summarise, what did you see at the time and what did you say to anyone at

the time about what you saw and your suspicions or concerns?

A. I would like to talk in some detail about this, if I may.

So Baby K was a very premature baby who -- in whom -- the mother had not been able to have been transferred to a tertiary centre, so at 25 weeks gestation was born at the Countess in the early hours of the morning.

Baby was stabilised on the neonatal unit, unwell but stable and -- I mean, I will go into the details. They have been widely reported.

But another nurse -- I'm not sure if she is ciphered or not so I won't say names, but another nurse was the named nurse looking after the baby and told me that she was going to the delivery suite to update the parents and that Letby was -- we used the term "baby sitting" so another nurse sort of covers while another nurse has to be away.

Now, it's been reported, there is a narrative that, you know, I walked in and caught Letby doing something and that is incorrect. I was sitting outside the room writing in the notes, but by this stage I had significant discomfort -- this was February 2016 -- and I just felt uncomfortable knowing that Letby was in the room.

And actually I was convincing myself that I was being completely irrational and ridiculous and so I got up and went in just to make sure everything was fine.

There's been a lot of speculation about whether the alarms were there or not and all the rest of it but I didn't walk in and see anything happening. What I walked in was to find a baby clearly deteriorating and then when I went to assess Baby K, the endotracheal tube was dislodged but importantly, the nurse looking after the baby, who I believe ordinarily by this stage would have flagged up this deterioration, because in a baby of this gestation whose oxygen saturations are dropping, the first thing you do is look at the baby, look at the ventilator, the chest isn't moving, it's likely it's a tube problem, not responding at all.

And at the time, my priority was to resuscitate Baby K, which we did successfully. I will take this with me to my grave, I at that point thought: well, how has that happened?

Now, in isolation in that if nothing else had happened before or after, I would have probably thought nothing more of it. But was it just coincidence that this baby who had been stable to this point in the period where the nurse looking after the baby and Letby was supervising the baby, this event happened?

Now, it's been said to me in many different fora: why didn't you just pick up the phone to the police? Or why didn't you raise it with somebody else? Or why didn't you do anything at all? And I know that, you know, it's been flagged up by one of the previous Executives that if they had known about that they would have done something and something of a mea culpa: why didn't I? And I lie awake thinking about this.

There is a fear because it's such a seemingly outlandish and unlikely thing that someone is causing deliberate harm, it's the fear of not being believed, it's, you know, said to me: why didn't you just stand up and tell everyone what you thought had happened? It is the fear of not being believed, it is the fear of ridicule, it is the fear of accusations of bullying and I appreciate -- and I will say this to the parents of Baby K and all the other parents -- that seems entirely selfish, just thinking about me and not the baby.

But these are the realities. I am trying to explain why that -- and I didn't want it to be that. I -- I internalised it and I -- I -- I wonder and I will never know if I had articulated that concern at that point, would it have made a difference?

Now, bear in mind by this point, the Thematic Review Dr Brearey had undertaken had already been done

we had seen a draft report. The staffing mortality analysis that had been done had already flagged up Letby and in the context of those, I should have been braver, I should have had more courage because it wasn't just an isolated thing, there was already a lot of other information.

Now, whether -- I can only -- I can't speculate on how people might have responded. But I am just trying to -- I am trying to -- sort of trying to explain my thought processes at that time.

And -- and I don't know whether it's appropriate to say this here, it's been suggested to me that I just made that up which is, you know, I will refute it is nonsense. There is no reason I would.

But what I will say is that, you know, I think that is somewhere where I should have had -- I should have had more courage.

Q. Is Baby K, we will come to it later, one of the babies you spoke to Sue Hodkinson about in March 2017?

A. I can't remember.

Q. Okay.

A. When we come to it.

Q. Okay, do you remember if you spoke to Dr Brearey about your description of that event at all

about Baby K at the time or not?
A. I -- I can't remember in detail. I think I sort of mentioned it in the sense another event had happened and Letby was there but I don't think I specifically articulated the thought processes I was having at 3 o'clock in the morning.
Q. So did you articulate those thought processes that you were having at 3 o'clock in the morning, you say, with anyone in the hospital?
A. I think between ourselves not at that point, there was a -- and as time went from February 16 onwards, there was an increasing feeling between all of us that, however unlikely, unwanted, abominable the thought of Letby causing deliberate harm could be, that elephant in the room was becoming bigger and bigger and we -- we felt completely impotent to know how to deal with it. We knew that the Thematic Review had been done and hadn't identified any obvious clinical causes.
And I assume colleagues were also aware that that Thematic Review had been escalated through to the Medical Director and the Director of Nursing with a request for a meeting. I naively -- I am going to use the word "naively" quite a lot I think today -- assumed that the Nursing Director and the Medical Director would look at that and see the pattern and act.

And maybe I was reassured that, you know, there is, there is enough there for people to act anyway. But, yes, I -- I can't really articulate more about Baby K.
Q. Well, again I suppose picking up on what you said about speaking to CDOP it depends who you are giving that information to someone with a safeguarding perspective --
A. Yes.
Q. -- had that information by this point there had been a number of collapses a number of deteriorations and you were saying they are sudden and unexpected leaving aside a member of staff?
A. (Nods) And I think it's also and again this is my misunderstanding at the time, I understand entirely now that having enough grounds for suspicion is enough to escalate and I think for example had I walked in with Baby K and witnessed something then that would have been very easy, you know, that's -- that's a no-brainer but I think this was all -- you know, it was all very circumstantial and I think we felt or we believed because it was such an outlandish and unlikely possibility that we -- you know, did we need more to raise it?
And of course it took us in the end until the third week of June in 2016 to feel we had enough to raise it.

Q. Did you at that time not understand mere suspicion is enough? I know -- we will come to the Execs, they were looking for proof and what was your evidence and all that stuff, that comes out repeatedly. Mere suspicion is enough, that is not what you appreciated?
A. Yes, no, I just didn't understand, I don't think any of us understood that at the time, particularly in this situation involving a member of staff.
And of course when you think about safeguarding in other situations, for example a child who has come in with unexplained bruising.
Q. You know mere suspicions --
A. Of course suspicion is more than enough to trigger the process.
Q. Child M. You say the presence of Letby at the unexpected collapse of Baby M added to your concerns and that is at paragraph 361 of your statement.
If we can go, please, to your police statement at INQ0001982, page 11, Child M, at the bottom if you go over to page 12.
You attended after he had collapsed. Resuscitation was under way; displayed the same type of unusual blotching as Child A:

"Didn't fit with anything I had ever seen before."
You tell us in your statement that you went on to discuss this with Dr Brearey.
So you had seen these patches, blotches again that were odd. What were you thinking at that point, what did you start to think about?
A. Again, I hadn't at that point, although myself and colleagues were -- had begun to wonder about the possibility of Letby deliberately doing something, we hadn't really started actively thinking about what might be being done.
And again in these situations Letby was there, it was an unusual, very unusual collapse and this unusual discolouration. Again we are thinking along the lines could this be sepsis? But it doesn't quite seem to quite fit, could this be some kind of cardiac event didn't seem to quite fit.
And when I discussed with Dr Brearey essentially I mentioned, you know, it was another one with the blotching but in this situation we actually had a successful resuscitation.
Q. So again -- that can come down, thank you -- the pressure fell off that the child resuscitated well?
A. Yes.
Q. And it wasn't something there was debriefed,

discussions?
A. It sounds awful to say, had the outcome been different it might well have triggered a more in-depth response.
Q. You say at paragraph 374 of your statement:
"An event such as that around Child M might usually have been discussed at the [Perinatal Mortality Meetings]. However, given the number of deaths there had been there was not the capacity in the scheduled three monthly meetings to discuss the non-fatal collapses."
We see in fact Baby E isn't even reached in one of the meetings that Baby E is supposed to be being discussed.
Just dealing with those meetings generally, having reviewed a number of notes of the meetings, they don't -- usually because the postmortem comes in later -- usually review postmortem and clinical findings at the same time in great detail from the ones we have seen for the babies of the indictment?
A. Yes.
Q. Is that your experience more generally of them?
A. So ideally by the time a baby is discussed at the Perinatal Mortality Meeting we would like to have

the postmortem back and, you know, the pathologist will come down and discuss.
This was -- there were -- this wasn't happening as frequently, so babies were often being discussed without the postmortem findings. Ideally, when the postmortem findings were back, they would -- they should have been rediscussed. I don't think that was happening consistently just due to time constraints.
Q. We have seen the records of those.
A. So to an extent the value of the Perinatal Mortality Morbidity Meetings was not as effective as it might have been without those.
I think the important thing about those meetings as well -- and I have thought long and hard about this -- as to whether they would have been a forum to flag up the specific concern about deliberate harm. Again, it's very much like a lot of the meetings looking at systems, looking at processes, looking at what was done, how it was done, was it done at the right time, was it the right thing, was it too late?
It -- I don't think it is a forum where it would have taken -- if I may use the analogy of the Emperor's new clothes, you would have needed somebody with the courage of the little boy to actually put their head over the parapet and say, "There is no clothes" and

I don't think in that meeting it's something that would have necessarily been on anyone else's radar.
Q. Before we even get to deliberate harm, what was necessary was that the doctors and the nurses and the parents in some cases -- let's be clear, the parents had key information to provide?
A. (Nods)
Q. -- particularly the Mother E in relation to --
A. Yes.
Q. -- her baby. They all needed to be in the same spot discussing this, didn't they, to share their own observations about who had seen what, because the meetings are dependent on the notes that arrive there --
A. Yes.
Q. -- and the people who attend?
A. Yes.
Q. We haven't seen notes of meetings with all the various people who make observations, for example, on Baby A or Baby C or Baby D all in the same room discussing it with a postmortem report where the contradictions and inconsistencies can be fleshed out?
A. Yes.
Q. It is not possible, is it, in the context of meetings with only one of the doctors who wasn't there?
A. I think that's a really important observation.

So even in terms of Perinatal Mortality Meetings, the doctors, nurses, midwives involved wouldn't necessarily be available or free to attend the Perinatal Mortality Meetings at that time.
The rapid reviews that were undertaken by the neonatal lead, the neonatal ward manager and the risk facilitator did not routinely have people in attendance who were there at the time. If it was escalated to a higher level they might be there if there was a Level 2 investigation and you made a really important point which I had never considered before, yet it is so obvious: parents' observations need to be included in these as well, every time, you know, not necessarily present, but, you know, information from the parents needs to be there.
Q. You either have everybody who's present writing things down, which of course they eventually did in a police station investigation, giving statements to the police for that perinatal or neonatal mortality meeting to discuss, or you have to have them there but would you agree with me, certainly in the babies we have been looking at, they were relatively superficial analyses and refer a lot to obstetric care, antenatal care --
A. Yes.

Q. -- things like delayed cord clamping, important but not what this was about?

A. Yes, no, I agree.

Q. They can in some sense give a false reassurance. You see a load of documents and think: well, that was considered then. Well, not really for the information that we are analysing.

A. Yes, yes, and I think -- I suppose if you don't ask the right questions you are not going to find the important answers.

Q. And if you have a set process, you are not going to?

A. No.

Q. If you just follow a set process you are not going to get the important answers?

A. No, I agree.

Q. You refer to a Level 2 investigation, I don't know what that means, but if something's really odd, actually having a debrief, hot debrief -- I don't know what you call it in the NHS -- but everyone around a table to discuss it --

A. Yes.

Q. -- is what was required.

Is there room for that thinking outside the box or the processes?

A. So in terms of debriefs, a hot debrief is sitting down immediately afterwards and, you know, does anyone -- is everyone okay? Any thoughts about what's happened? What can we do differently?

A cold debrief is more when the dust has settled, there is time to think -- there may or may not be postmortem findings, to have a think through what we did well, what we could have done better, what for the future can we do.

Now, I think those are important, essential.

I think interestingly had those debriefs happened and -- and they tend to be the hot, the cold debriefs are usually planned to try and find a time where the majority of staff involved can be present. Now, of course in these situations Letby would have been present as well.

So I can only speculate on again whether those discussions might have been more revealing, but I do think that even with her present there's an opportunity for the -- for everybody to express -- I suppose to say this doesn't make sense and it triggers an opportunity to look further.

Q. Well, Letby's presence might have been helpful to the extent that, for example, discussing the medical notes around Baby E, there was a direct conflict between

Letby's notes and Mother E's evidence?

A. Yes.

Q. So again having everybody there can still be useful?

A. Yes, yes, and it depends on the level of detail in the discussion as well. But, yes, absolutely, I couldn't disagree.

Q. Child L was another child that you had actually recommended changes to fluid management for and requested blood tests, same as my questions earlier about Child F. Obviously that insulin test result wasn't appreciated at the time. Missed opportunity, would you say? As you have said before, that should have been picked up.

A. Yes. So I am aware with -- sorry, it was Child L, wasn't it?

Q. Yes.

A. I am aware with Child L that when the insulin C-peptide result came back, it was documented in the notes by one of the junior paediatricians in training.

I wasn't clear when I saw the notes whether those results had been discussed with anyone more senior, but an impression was given that the result was back and I think the error carried forward that there was nothing abnormal.

Now, interestingly, at the time of the episode of hypoglycaemia, it was the same day as the baby's Twin had the non-fatal collapse and had problems with resuscitation.

One of the things with this baby's hypoglycaemia is that I was not at the time -- even with Letby being present, I was not at the time concerned about anything unnatural going on and to the extent that we know that premature babies who are on the smaller side can become hypoglycaemic, again if they are hypoglycaemic, we need to do the investigations to exclude other things, but the amount of glucose that was needed to maintain normal blood sugars, although higher than a normal healthy baby, was not at a point beyond what I had seen in babies in similar situations with natural reasons for hypoglycaemia.

So I saw this little one a few days later on a ward round on a weekend, and I think I wrote in the notes "resolved hypoglycaemia". I wasn't prompted to look to see whether the investigations had come back.

So I didn't look back in the notes. One of the reasons I guess I didn't look back is the hypoglycaemia had resolved. Secondly, I hadn't had a suspicion that there was anything unnatural going on. Thirdly, and to be honest, I will be honest, I don't recall whether

I had been told whether the results were back or not, I can't remember what was on the handover sheet for that time to say it was an outstanding result or it may have been at handover, it had been handed over that the results were back and everything was normal.

And again, I have thought long and hard about this. Was there a prompt for me to look back in the notes and see or double-check? I think because I hadn't had a suspicion in this particular situation of the glucose, the low glucose being something that was unnatural, it wasn't really a prompted resolve, as often is the case.

Q. Child N, we know you were on annual leave when events occurred in relation to Child N.

Child O and P, you were away from the hospital on 23 June and you became aware of O's death on 24 June and you deal with this at paragraph 392 of your statement and the Inquiry has heard evidence from both Karen Townsend and Karen Rees about this.

Can you tell us now the conversation and the meeting you had with Karen Rees on 24 June -- you sent us the calendar invite, we know that meeting had been set up but tell us now.

A. Karen Townsend or ...?

Q. Townsend, sorry, first.

A. So Karen Townsend was the Divisional Director

for Urgent Care, so she wasn't clinically based but she was -- had ultimate management responsibility of the division. I got on well with Karen I didn't meet with her very often and I had requested a meeting with her to discuss a number of issues around the department and the service including this as well.

Karen suggested meeting on that Friday morning in the Comfort Zone. The Comfort Zone is a charity-run cafe with a big sort of seating area around it as well.

Now, it was on my list of things to discuss with her about our concerns about Letby. The meeting was set up before the Child O -- before Child O had their event. So at the meeting, I think I discussed about there are a couple of issues around the service in terms of I think the -- I can't remember specifically around -- I think Karen Townsend kept a note of it but I raised to Karen Townsend the specific concern that we had; that as a group of Consultants -- and I think this is very important, because it seems to have been carried forward from here, and this is a narrative that seems to have become embedded, that it was just myself and Dr Brearey.

But I stated that as a group of Consultants we were concerned, extremely concerned, about these events and we were all at a point as a group where we felt that natural causes had been excluded as far as they could be

and we were really concerned about her being on the unit.

We had -- the Thematic Review had been discussed with the Medical Director and the Nursing Director who just said: wait and see, but we felt we couldn't wait and see and my intention really in asking Karen as a Divisional Director was to get some help and support as to what to do. Because we were not comfortable with Letby at this point continuing to work unsupervised on the unit.

Now, I had not had the specific conversation with Karen Townsend previously and I know that she said it is the first time she was aware of any of these concerns. If I may, because I have seen a copy of Karen's transcript, she commented that if she had had more information she would have put it on the Risk Register.

Now, I didn't want to talk to her that morning because I wanted her to put it on the Risk Register; I wanted to talk to her that morning because she was in a position where something actively could be done to ensure that Letby wasn't working unsupervised on the unit. I mean, I'm not sure being on the Risk Register that day or any time would have necessarily made a difference.

So that's my recollection of the conversation.

It wasn't a confrontational conversation at all, and I just said to Karen, you know, please help, you know, can you escalate this? Can you do something?

Q. Then did Karen Rees come and find you and have a further conversation?

A. Yes. So I was in my office, I can't remember whether it was late morning or early afternoon, and Karen Rees came to my office and said that, you know, she had heard from -- Karen Townsend had told her that myself and Dr Brearey thought that Letby was deliberately harming babies and wanted her moved from the unit and she said to me: I can't do that without evidence, give me some evidence.

I can't remember what I was doing at the time. But I said to her: look, if you want the specific evidence, Dr Brearey can give you lots of details. She suggested that I -- I phoned Dr Brearey, I can't remember whether I did, I knew that he was in clinic at that time.

So I knew that she was then going to go on and talk to Dr Brearey. I left mid-afternoon, I think that afternoon because I wasn't there for subsequent discussions. So my -- my request really of Karen Townsend and Karen Rees was to sort of say: look, we are really worried about this, we are not as a group reassured that keeping her working unsupervised is safe.

Please do something.
I could have been more forthright. I could have said specifically, "You must remove her from the unit" and I didn't say that.
MS LANGDALE: Thank you, Dr Jayaram.
I think that's a good moment to take a break. May I suggest a 11.35 return?
LADY JUSTICE THIRLWALL: Yes, thank you, Ms Langdale. So, doctor, we are going to take a break and we will start again at 25 to 12.
(11.17 am)
(A short break)
(11.40 am)
LADY JUSTICE THIRLWALL: I'm sorry to have kept you all waiting. Ms Langdale.
MS LANGDALE: Dr Jayaram, may I move now to the Inquest for Baby A in October 2016, so we are moving on in time.
You prepared your statement to the Inquest back in July 2015. In common with your medical notes at the time, that doesn't make reference to the rash and you tell us because at the time of events when you did the Coroner's statements in your notes, you didn't appreciate the significance of that?
A. No, and I can't remember writing the statement

but it -- it really wasn't in my mind at that time.
Q. When you write a statement we have heard from some of the junior doctors you sort of get a pack about what's required or what's to be done. Did you get anything about guidance on putting statements together?
A. I don't recall getting anything specifically on this occasion. I had written statements previously for safeguarding proceedings and things.
Q. Dr Lambie told us she understood it had to be factual about your involvement in the baby --
A. Very much so and we are always told that you should not speculate but just stick to facts.
Q. The Inquiry has a notebook from a paralegal called Josh Swash about meetings around that time between Execs and legal department. If I can ask for INQ0108406; page 9. This is a telephone conference on the morning. It looks like there was a meeting earlier with some of the doctors and but you weren't at that, Dr Jayaram.
Were you invited to an earlier meeting, do you remember?
A. Yes, I recall that there were two dates, I think the first one I had other clinical commitments and couldn't go.
Q. So you attend for this telephone call between

the people listed, so Stephen Cross, legal, Louis Browne, Queen's Counsel, yourself, Dr Saladi, Dr Harkness and a Dr MacCarrick.
If we go to page 10 we see noted Louis is explaining the Inquest, the objective of the Inquest, pointing out -- someone is pointing out PM unascertained, the postmortem says unascertained death. Cross pulmonary arteries, no suggestion it played a part in the death.
Dr Harkness makes contributions.
Then if we go to page 11, Dr Jayaram: still to this day Ravi doesn't know why this happened. 27 years in paediatrics, never seen this kind of situation.
Did you say that in the meeting or is that --
A. I probably said words to that effect, that, you know, I couldn't -- I still at this stage couldn't explain what had happened and it ...
Q. If we go to page 12, Dr Saladi, Coroner -- he says if the Coroner asks -- it looks as though it says if the Coroner asks how did it inform future practice -- and I don't know who says this, do you know who says:
"Review Royal College of Paediatrics, pattern of deaths appear unusual, further inquiry required, forensic review"?
Then there is a reference:

"If review is outside of the remit of your knowledge, then say so."
Just to anchor us in time, it says the review is ongoing. At this point, the Royal College review has been received but you haven't seen the Royal College review but someone has spoken to you about it; is that right?
A. Yes, so at this stage my understanding of where things were up to is as follows: the Royal College review had taken place, I had had if you like a hot debrief from Ian Harvey a few days after they had been to feed back to me what they had fed back to the Executive board.
Q. What was that?
A. So essentially that we were told that they hadn't identified any significant issues with clinical practices, that there were a number of recommendations around team working and leadership although he didn't specifically say what areas, and that they had recommended a forensic -- full forensic Casenote Review and I think at the time he came to see me I actually sent an email to colleagues summarising his conversation pretty much contemporaneously of what he had said was due to happen and it was a full forensic review involving neonatologists, pathologists, all the notes,

all the staffing patterns.

My understanding therefore at that time was that the College hadn't identified any concerns around clinical practices, but they had recommended in terms of investigating our specific concerns, further there needed to be a more detailed review.

Just to take a step back in July 2016, Ian Harvey had undertaken a review of case notes which we as a group of Consultants felt hadn't really looked in a way to address our concerns.

So we thought, well this is probably a good thing because it's going to be a full forensic review.

I was also -- after this meeting, Stephen Cross sent me or emailed me a copy of an email he had sent to the Coroner.

Q. Let's get that one up then. Just before I go down from this meeting -- take this meeting down. What did you think of the purpose of this meeting was, what was it about the pre-inquest discussion?

A. My understanding of the pre-inquest discussions is just to make sure everybody was aware of the process and the kind of things that would be discussed. I didn't feel at the time that there was any specific agenda to sort of direct me as to what to say or not to say.

Stephen Cross, as the legal adviser -- and also we knew that he was an ex detective -- had told us in July that it would be absolutely inappropriate and the wrong thing to involve the police at that stage. So again once again naively I assumed that might be the right -- the right advice.

So my understanding was that the forensic review would take place. Now, again, having talked to the College reviewers and I know exactly what Dr Brearey and I told them, we kind of worked on an assumption that the findings would either find something that we hadn't seen, in terms of clinical care, clinical issues, or they wouldn't and then actually that would then be the prompt for the next step, would be to go on to involve the police.

There was, I don't think complacency is the right word but there was an element that it wasn't as much -- there wasn't as much of a sense of urgency because at this stage Letby had been removed from the unit and wasn't working clinically and I at this point had not -- was not aware that actually she and some of her representatives were under the impression that the College reviews would be used as evidence as to say whether she could come back or not.

Q. Sorry, can I take you back to this note?

A. Yes.

Q. It says here:

"If review is outside of the remit of your knowledge, say so. Don't say anything unless you know."

Do you know who was saying that?

A. I'm thinking it would either have been Stephen Cross or, or I forget the name of the QC. Louis Browne?

Q. Louis Browne?

A. I think there is another comment -- maybe it's on the page before this where it specifically said "if you don't know, don't speculate".

Q. Yes, that is the page before?

A. Yes, it is just underneath where it says "I&S" and that was Louis Browne:

"If you don't know the answer, say, no speculation."

Q. Let's go to the emails you wanted to refer to before. That can come down.

If we have INQ0107964, page 24. You see the email at the bottom:

"Dear Mr Rheinberg."

So this is an email from Stephen Cross to the Coroner:

"You will recall that in your absence I advised

your deputy that the Countess was undertaking a review of neonatal deaths by the Royal College which was undertaken at the beginning of September and the Trust is awaiting their report.

"The Review Team have indicated they were entirely satisfied with the care within the neonatal unit and raised no concerns. However, they recommended that a detailed forensic Casenote Review of each of the deaths from July 2015 should be undertaken, so consequently this is still a work in progress."

Then the next page:

"I have instructed Louis Browne ... counsel in the matter and is fully aware of the review and Dr Jayaram as the Lead Consultant is fully aware of this matter."

Pausing there you hadn't seen the letter of instruction, the response or the report, had you, until the review?

A. Not until -- not until this point but this -- when this email was forwarded on to me, Stephen Cross attached the letter -- a copy of the letter of instruction.

Q. To Dr Hawdon or the Royal College?

A. The one to Dr Hawdon.

Q. So if we go to the next email, then, go back to page 24:

"Dear Louis,

"Thanks for the case conference, most helpful.

"Further to our conversation regarding disclosure to the Coroner regarding the current review being undertaken, please see email below. I attach for information our letter of instruction regarding the continuation of the review."

You saw Dr Hawdon's letter of instruction attached to that?

A. Yes, you can see it was attached at the top, "DrJHawdon.docx".

And when I read that it was very detailed and it outlined what actually had been my understanding of what Ian Harvey had fed back to me after his initial feedback from the Royal College, of a very detailed review involving two independent neonatologists with pathological input, looking at all the notes, all the rest of it.

So my impression from this, although I note that Stephen Cross actually says he hasn't sent the letter of instruction to the Coroner, was that the Coroner, number one, was aware of our specific concern and that's a big assumption, because reading this, it doesn't specifically say that but --

Q. Aware of reviews going on --

A. Sorry?

Q. Aware of reviews going on at the very least?

A. Aware of our specific concern about an individual.

The Coroner was also aware that very detailed forensic level reviews were going on and so my -- my understanding at the time of the Inquest is that the Coroner was already aware of the concerns that we had. And that these -- this had been a recommendation from the College and this was being undertaken.

Q. That can be taken down. We had various copies of minutes or notes of the Inquest including the Countess of Chester notes and also the Family representative at the Inquest which is the fullest.

So if we could go to that, we see at INQ0107909, page 5, we see at page 5 beginning the second last paragraph:

"Mr Rheinberg moved on to questioning Dr Jayaram."

We see those two paragraphs and over the page the top three, you are being asked very much factually about that long line position, arrythmia and the details of your medical involvement.

Then we also see if we go to page 8, you are recalled by the Coroner to assist with knowledge of the circumstances concluding with any cause of death and you

say here, Mr Rheinberg asks you whether or not you have seen anything similar and you say:

"Dr J confirmed that normally death in neonates is the end point in a course of events and normally they can be resuscitated. He confirmed there have been similar cases of neonates dying in similar circumstances on the unit which they have not been able to explain. He confirmed that they had downgraded the unit so that they do not care currently for preterm babies and they have also requested an independent review and they are still awaiting the formal report. However, the initial feedback from that is nothing can be found that is wrong with any of the training, any of the practices or any of the equipment."

Were you thinking the RCPCH reports when you are referring to that?

A. Yes.

Q. "However there is a potential issue with staffing. As far as Dr J is aware, this report is to go back to the Executive board and they decide whether or not to release it to the public. Mr Rheinberg asked whether or not it would be possible for the family to receive a copy. Dr Jayaram said he is of the personal view that it should be made available for the public and he would have no issue with a copy being provided to the

family. However, as he pointed out, it is the Executive board's decision. He has to confirm, however, that the events that happened to Child A do not make any clinical sense to him at all."

And you set out in relation to the cardiac conductivity your concerns.

Is that note accurate, as far as you are concerned, does that encapsulate it?

A. I think that is more accurate than the original Countess report that I was originally supplied and I think that accurately reports what I said.

Q. So you were making clear you couldn't explain the cases, they were unexplained deaths, you had had several cases similar and reports so far had said no issue with care from the RCPCH, but an issue of staffing is being looked at?

A. Yes, and I -- I was aware that the deaths had been -- I think bar one of them had been reported to the Coroner. And I was also cognisant of the fact we had been told: do not speculate. And, again, hindsight: I didn't specifically say I or we as a group are concerned that an individual member of staff is causing harm.

I was trying to make it clear to the Coroner that I did not understand what was going on here and

I couldn't think of a clinical explanation and there had been other things like this as well. But I didn't explicitly say that.

Q. Stephen Cross's email which was forwarded to you made it clear he was in direct communication with Mr Rheinberg?

A. Well, it gave me the impression that, that the concern that we had, the specific concern regarding Letby, was on the Coroner's radar. Now I in retrospect don't know whether that is the case or not because I have not been party to -- to those discussions.

But certainly my understanding is that the Coroner was aware that a very detailed Casenote Review was going on because nothing else clinically could be found.

Q. Yes, thank you, that can be taken down.

I am now going to move to a different topic, Dr Jayaram, of the discussions of concerns amongst doctors themselves. So we will go back in time again to 2015 and if we can go to INQ0003110, page 1.

This is a document that we see Dr Brearey copies you in and it's where there's going to be analysis of the three deaths, A, C and D.

If we go over the page, there's an agreed action plan about how that's going to be done. We know now of course that the deterioration of Baby B was not part of

that review; that was in terms of the value of that review was serious omission, wasn't it?

A. I would agree.

Q. In terms of pulling together the rash, the unexpectedness, the outcomes?

A. Yes, I think it -- had Baby B been discussed here, it might have added more context and information and directed thinking in a different direction. But that again is -- is speculation.

Q. We then see a series of emails moving on in time in June, INQ0025743, page 1.

If we go over to page 2 first, it's the first email from Dr Gibbs.

"Rachel Lambie came to see me this morning to say the Registrars are very concerned about the recent neonatal deaths and collapses ... Child B where all the infants showed a strange purpuric looking rash that probably wasn't true purpura. I pointed out that Child C who also died did not have this rash but it's true that Child B and the recent death, Child D, did show a similar strange colour change on collapsing.

"Rachel said that all the neonatal nurses are very worried, they feel they ought to be doing something and also asked what else different the Registrars can do."

Did you ever speak to Dr Lambie yourself? She's

given evidence to the Inquiry about how she felt about coming into work at this time and some of the nurses likewise thinking something's going to happen?

A. I don't recall speaking to her or her speaking to me directly around this time.

Q. Dr Gibbs says:

"They feel we ought to be doing something and also asked what else different the Registrars can do."

And he says candidly to you and his fellow Consultants:

"Although I have mentioned we are looking into this, I am not sure exactly how this is being done."

If we go to page 1 for the other series of emails the one at the bottom of the page, from Dr Newby. She says:

"I agree, I have just been grilled by Dave Harkness. This is causing a lot of concern/upset. Can we pull something together fairly soon?"

If we go up the email, the next one above from Dr Brearey.

"There is a new PMM meeting. Seems well-timed. Happy to put together quick presentation so we can discuss all of this together. I presume we were due to discuss the other two anyway."

The email further below:

"John and Liz. Please encourage junior nurses to attend and discuss in this forum rather than privately."

So Dr Brearey preferring that's discussed in a forum rather than privately.

So that shows us a number of things, doesn't it? First of all that it's clear the juniors were really upset about this, they were thinking about this, weren't they?

A. Yes.

Q. And correctly, as we now see the whole picture, that they were concerned and upset about this?

A. I think we -- we were concerned because it was it didn't seem to make sense. It was the -- this run in a short period of time of unusual events.

Q. It doesn't seem -- and again in a hospital where you are all managing your own rotas and where you are supposed to be working, it doesn't seem as though a meeting between the senior Consultants and the juniors to share this level of concern was had at that time, does it, or if there was, you weren't there?

A. I don't recall. So I was actually out of the hospital on "This Morning" and I don't think I was back in-- I think this was a Tuesday, I wasn't back in until the Thursday.

When I was sent this email it was my first

recollection of -- of seeing this email. So, again, I may well not have seen it at the time. I know that in the senior clinicians' meeting the Monday afterwards this email was referred to and there was a suggestion that there needed to be a series of formal debriefs arranged. I don't know if they ever happened.

Q. We can pick that up with Dr Brearey but if you look at the top, the last email at the very top, I don't think -- Dr Brearey says:

"I don't think they warrant a presentation for all three yet. I would rather discuss Child A in detail. Not sure who's presenting that."

Of course viewing them together as a cluster would have been very helpful, wouldn't it?

A. I agree and again I can't speak for Steve Brearey's thinking at this point, but again you referred earlier to following processes and I suspect this might be -- we need to do this when we have got more information, postmortems, et cetera. But that's speculation. But I can't disagree that I think discussing these three and Baby B as well could have been more revealing.

Q. If we take that down, please, and have instead document 0036166, page 1, this is a senior clinicians' meeting on 29 June.

Dr Brearey is not there but you are present for this one and there is discussion about the business case for paediatric Consultants and if we go overleaf to page 2, on the fourth paragraph:

"There was also an issue raised around the fact that with the three recent neonatal deaths Registrars had been quite worried and feel that nothing is being done.

"Behind the scenes reviews are going on but it was felt that formal debriefs should probably take place rather than any specific meeting to discuss all three."

Can you even remember that being discussed now?

A. I can't, I can't remember the meeting. I -- I probably put this record together. I don't remember the discussion. I can't remember whether Steve Brearey was at this meeting or not. Sorry, can you go back?

Q. No, he wasn't. If you go back to page 1 he's not?

A. But I think that the discussion that had taken place on email might have contributed to that, but first of all I can't remember the discussion, I can't remember what the pros and cons discussed of discussing them together or separate debriefs was and how that conclusion was made and I don't know whether those debriefs then took place.

Q. If we go to 0005580, page 1, it's an email from Dr Brearey attaching his summary and data on 1 July --

A. Yes.

Q. -- for a meeting. And you are cc'd with this so in fact stuff was being done?

A. Yes.

Q. But obviously the juniors didn't feel part of that and getting their input as to what they had seen?

A. Yes.

Q. Felt we have seen their evidence, of course, about how shocked they were?

A. Yes.

Q. Out of blue.

Very helpful information to have to assist the thinking of senior Consultants, wasn't it?

A. Yes, I agree.

Q. So we see he attaches a summary. One of the pieces of information that appears to be put together quite early on, if we go to 0003191, page 3, is the business of pattern, the pattern of those three deaths.

So Dr Brearey has pulled together the neonatal mortality deaths. I am assuming it is him, we will check with him, but in his review of those years previously and there's three in three weeks.

Now, patterns are only part of the picture. But when you see it like that, three in three weeks, it is a pattern, isn't it, it is an unusual pattern?

A. It is an unusual pattern.

Q. That can go down, please. We then have an illustration but I think you accepted this earlier, a discussion at the neonatal mortality meeting 0003228, page 1. Dr Brearey's has emailed a number of people to request at short notice another neonatal mortality meeting on Thursday, that is not the right one. 0003288, page 1.

We see there Child I, this is the discussion for Child I and considering the circumstances awaiting the PM, there is not much that can be presented or in the learning there. And we see the attendees at the top, do you agree?

A. Yes.

Q. I think Dr Neame, to be fair, was involved in Child I but in terms of setting out clinical findings against pathology, need for review. It's not very detailed, is it, for --

A. Not on these minutes, no.

Q. The Thematic Review that Dr Brearey is preparing, he gets input from Dr Subhedar, which we see -- that can come down, please -- at INQ0103111,

page 1. We see Dr Subhedar has said one additional comment:

"You might consider adding somewhere that relates to the theme of some of the cases involving babies that suddenly and unexpectedly deteriorated and whom there was no clear cause for the deterioration/death identified at PM".

So Dr Subhedar is making the point that acknowledging where it's sudden and unexpected as opposed to a death might bring greater clarity for the reader and generally?

A. Yes.

Q. We then see at INQ0005643, page 1, Dr Brearey's invitation to Dr Subhedar to be an external panel member. Was that discussed with you about who might be an external panel member or assist with this?

A. It was discussed that we needed to get a senior tertiary level neonatologist.

Q. Again, looking back, do you think this Thematic Review by the time rotas and staff rotas were being put together by Eirian Powell and the like, that there was a need even for what the doctors were trying to do for someone to do this externally, even if the connection wasn't being made the police that somebody else might be doing it?

A. I think in retrospect to have somebody external and independent doing even this exercise, the Thematic Review would have been helpful more in the sense that any accusations of bias, prejudice, ignoring things, would have been easier to counter.

I think at the time we didn't know what was going to happen in terms of, in terms of response to the concerns that we -- we subsequently raised. But I think at this stage, I think knowing what I know now if this had been done by somebody external, it would have been more powerful.

Now, who that should have been, should it have been somebody from the neonatal network? Was there enough at this stage to say it should be the police? I don't know the answer to that. But I don't think at this time it was an inappropriate decision for Steve Brearey to decide to do it himself.

Q. We see the final version 1 March of the review is -- if that can come down please -- INQ0003251, if we can go to page 7.

When you say impactful, numbers 1 and 2 I suggest are impactful, aren't they?

A. Yes.

Q. "Sudden and unexpected" and "timing of arrests", we know that in the case of Shipman,

Dr Reynolds, a GP, was concerned about the pattern of deaths for some of her patients dying in the afternoon at home alone and they were Dr Shipman's patients. Patterns can raise suspicion of themselves.

Dr Brearey has put that there, the arrests between midnight and 4 am. Did you understand what that represented in terms of suspicion, those times or not?

A. By this stage, yes.

Q. What did you think the significance of that was?

A. I was aware because there had been in the mortality table and the review that it was unusual that these things were happening at this time. I was also aware that Letby's presence was a consistent finding as well. And in conjunction I think if you look at points 1 and 2 together, that's sort of two massive red flags for indicating things need to be looked at in far more detail.

Q. That can be taken down and another document --

A. Can I just comment as well?

Q. Yes.

A. The action after 2 I think is important because one of the things from a clinical point of view that we wanted to investigate ourselves in terms of practice was: was there anything that we clinically had

been missing that might have -- might have flagged up that there could have been interventions that could have been made if these babies had been deteriorating. So I think that action is a very important, a very important exercise.

Q. Thank you. INQ0103144, page 1, please.

This email is sent -- and you are cc'd -- by Dr Brearey. It is after Baby M, before Baby N saying:

"We would like to keep an eye on things. If you do come across a baby who deteriorates sudden or unexpectedly or needs resuscitation, please could you locate me and Eirian know. We will keep a record of these cases and review them as soon as practicable."

When you read that email, if you read that email, what did you think was happening at this point?

A. I was already aware from Dr Brearey that his report of this meeting was that he had explicitly expressed the concern about the association with Letby being present, explicitly expressed the concern that we, as Consultants, were concerned about the possibility of this association being significant in terms of either inadvertent or deliberate harm and we really were uncomfortable that this -- uncomfortable at her working and that we felt this needed to be investigated in a way that was appropriate.

Steve Brearey told me that at this meeting, Anne Murphy, our Matron, and Eirian Lloyd-Powell, our neonatal unit manager, were quite forceful in suggesting that what Steve was suggesting was completely wrong, unlikely, and Steve Brearey told me that there was such a degree of push-back that he didn't feel that he could do anything else other than accept this final decision.

So I know that when he sent this email obviously Eirian Powell and Anne Murphy are copied in but this was where really as a group, we were just frustrated and lost because we had our concerns. The Medical Director and Director of Nursing had seen the Thematic Review, had seen the staffing analysis, had heard directly from Steve Brearey on our behalf our concerns, but still felt at this stage a watch and wait approach was the appropriate thing to do and it was -- it was very frustrating.

Q. Just pausing there. On all of the emails between the doctors right until the end when there is that question of you suggesting or inviting Eirian Powell to sign something to say there is no rift between the doctors and nurses, the paediatricians, a lot of the emails are shared with Eirian Powell, aren't they?

A. (Nods)

Q. She is the person that's in that group as the neonatal ward manager. She is a profoundly supportive of Letby at that time, isn't she?

A. Yes.

Q. And Dr Gibbs said her support for Letby -- I think he used the word "dithering" -- caused him to pause for thought because obviously he valued her views.

What would you say about that, I mean, first of all what was your experience either talking to Eirian Powell or generally of knowing what she said about it, about how much she supported Letby at that time, and did it impact on your assessment of the situation?

A. I think for everybody the -- the first moment that it comes into your head that a colleague could potentially be -- could potentially be causing deliberate harm is a -- is a real -- a real blow and it's difficult to know how to handle it and as I discussed earlier I think for myself you lock it away and then more and more comes out and you just can't lock it away and then there is the danger of confirmation bias but you know that it has to be taken seriously, however improbable it might seem.

And I think for -- again, you know, speculating on Eirian's thought processes, I think that she hadn't reached that point, if you like, on the journey. But

I think -- and this is important and I think we all do it and I have done this as well -- I think it shows that we need to have open minds and we need to listen to each other and I think -- I didn't appreciate this at the time but knowing what I know now, and documents, other documents that I have seen, I think that there was the initial response of denial because it's so improbable but I think that denial became the truth for some of these people.

And so every action taken after that was, rather than from a position of considering all possibilities was taken from a position of it could be anything but that. And I think it's important, you know, as a ward manager you support your staff, you know, you have to support your staff, you are -- you are responsible, you have to look at the pastoral care, their welfare as well. But your ultimate duty is the safety of your patients as well and it, it's a difficult one to balance.

I suppose an analogy is if by this stage it was clear that strange things were happening every time a certain infusion pump was used, you would probably note that and in a neutral way, take that infusion pump out of service and look at it. Now it's much harder with people and in terms of what's being suggested here,

it's even harder. Of course, Letby had been moved off nights in the March.

Q. Let me come to that later, shall I, Dr Jayaram?

A. Okay.

Q. I need to move you on, if I may?

A. Sorry.

Q. Not at all. That can come down. I am interested to ask you now about discussion of concerns in the meetings, the broader governance meetings and to state at the outset the absence of discussions of the details of these issues we are investigating.

18 June 2015, if we go to INQ0004235, page 3, we see at the top the Datix of Child A being referred to. Documentation excellent, multi-disciplinary working was excellent, clear reviews etc, etc.

There's no mention of Baby B. There's no mention at this stage of any concerns about it being sudden and unexpected. You are one of the people I think attendant at this meeting.

How are these items discussed, because the minutes are always very short, I don't know how long the meetings take, and they are not really informative if you are doing what we are doing after the event, the luxury of going back and seeing how things are fleshed

up or fleshed out?
A. So the Women and Children's Governance Board was a monthly meeting. It's -- there are Terms of Reference for it, but it very much was a forum that took an overview of things so rather than actually investigating things itself reports should have been brought to it. Having said that, I am fully aware that later on Datix reports of other babies who died were not brought to the meeting.
Usually what would happen if something had been identified that required a change in practice, a change in systems, any kind of -- or any kind of quality improvement, it would be brought and then that quality improvement plan, action plan, would then be monitored here and signed off when it was done.
Again, is this a forum where -- two things, really.
Had each of the reported deaths been discussed at this meeting or even flagged up at this meeting, it might have caused other people to ask the question and raise concerns. The second question is: was it a forum where the specific concern about a member of staff could be explicitly raised? I would think probably not.
Q. Pausing there, I am not suggesting that should have happened?
A. Sorry.

Q. Just that the death was sudden and unexpected?
A. Yes.
Q. If you take us back to our beginning conversation, if everybody understood "sudden unexpected" triggers investigation?
A. Yes.
Q. Concern, what can I add, is there something of importance here? Just the description, a Datix doesn't really cover it, does it, we know why the Datix was completed?
A. Yes.
Q. It doesn't really cover what the central issue is. And just if I may continue, Dr Jayaram, we know nothing of notice in relation to these babies 30 July meeting or 19 November. And I think the 16 June 2016 is the next time we see reference and that's at INQ0004308, page 5.
As that document's being called up, Dr Jayaram, I think there are 18 attendees listed, most give apologies and seven attend.
So what's the reality on the ground for these larger meetings, seven out of 18 doesn't sound great to me, but is that typical?
A. Yes. I think that the trouble with these meetings is that the agendas were very, very large,

there was a lot of stuff to be covered, a lot of it was almost more process: we have to talk about this, we have to talk about this.
Q. So it is process-driven?
A. It is very process --
Q. What you are required to talk about rather than --
A. Yes, in my -- in my view it was very process-driven and I think it was therefore difficult to make it more reactive. I think as well in terms of this being a forum for -- I think it could have been flagged up, that these were sudden and unexpected, in terms of it being a forum for discussing therefore potential cause, I'm not sure I would usually be -- myself or Dr Brearey would only -- would usually be the only paediatric medical person there and there may be one or two people from the paediatric nursing background.
However, I do think if they had been flagged up, then it may have been spotted.
Now, the thing I was never sure of is how these minutes were then escalated and this is one of the difficulties when we had the division of Women and Children's, there were much clearer lines.
They would have been I think since the Urgent Care governance board and the Planned Care governance board

but I don't know how they would have been slated beyond that.
Q. It says on page 1 how they are escalated, it says:
"Alison Kelly receives minutes for escalating to Trust board"?
A. Okay.
Q. So if she chooses to, they can be escalated to the Trust board?
A. Okay.
Q. Just going back to your answer, it was process-driven. Do you mean this committee, do you mean governance generally in the hospital?
A. I think this meeting was, was very, very process driven. I can't speak for other governance meetings across the Trust but I do -- and I don't think this just applies to the Countess, I think this is an NHS-wide thing, I think there are a lot of processes that are put in place that are there to help to achieve an outcome, but sometimes or not infrequently the process, if you like, becomes more important than the outcome, because it --
Q. And they become superficial?
A. It becomes easier to monitor the process and to actually try and change the process is -- is

difficult.

I will entirely subjectively say I always found these meetings very difficult because the lion's share of issues discussed were -- were obstetric related. Now whether that's, you know, my and/or Dr Brearey's fault for not speaking more, I don't know.

But it was -- it was a difficult, it was a -- it was a forum that I think, given the importance of risk and governance, could have -- could have been more effective, could have been made more effective.

Q. In terms of its composition, if we go to page 1 and see the composition of members, a number, as you say obstetricians, Head of Midwifery.

We see in a number of the reviews and documents discussions about antenatal care, obviously important, post delivery care, really important. Perhaps different from solely focusing on the infant, which is what you are dealing with by the time you have got a neonate.

A. I mean, I think ordinarily if you look at maternity and neonatal care it probably is appropriate to devote more time to the obstetric midwifery side because ordinarily that is usually the higher risk area where there are more problems.

Q. Yes.

A. And of course as a consequence, we were in

this unprecedented bizarre situation where we probably over-focused -- no, we -- not probably, we definitely over-focused on that side of things and under focused on what happened after birth in this meeting.

Q. The last meeting that deals with any of babies on the indictment O and P is INQ0003213, page 1.

And that is 21 July. If we go to page 3, we see -- actually, pause at page 1, we see again around 19 people invited, eight of you I think attend?

A. Yes.

Q. We see on page 3 "neonatal incident".

A. Where it says "NPSA Level 2" that means there is going to be a more detailed -- so they have the initial neonatal review with Dr Brearey, the governance facilitator, ward manager and NPSA Level 2 is a more detailed tabletop discussion with more people. But there is no other detail on there. Sorry, what date was this meeting? This is --

Q. 21 July 2016.

A. Yes, so by this stage we are our concerns had been formally escalated and various actions had been undertaken.

Q. So there is not really much information being provided there at all at this point, is there?

A. No, no.

Q. So it does look like a bit of a tick box, we have raised them but not a lot goes on?

A. Yes, and I think, reflecting on this, I think -- I can't speak for others but certainly for me my perception of these meetings being very process-driven was perhaps one of the reasons why, given the gravity of what we were looking at certainly by the time we had our specific concerns about Letby, we were escalating these issues outside of the formal processes, if you like.

Now, I am not saying that was right or wrong and it might be that because they weren't being escalated through the formal processes, it's possible they weren't on the radar of people whose radar that they should have been on.

But having said that, I think that, you know, the -- the processes -- the process we did follow escalated this to a senior level of the Trust.

Q. Thank you, that can go down.

CQC visit briefly.

We know there was an inspection in February 2016 and if we go to 00173390206, there's the notes of a meeting where you and Dr Brearey are present.

You tell us you don't recall discussing the numbers of neonatal deaths with the CQC inspectors and you

didn't discuss the draft Thematic Review with them either?

A. Yes, I -- I think I said in my statement I have absolutely no recollection of what was discussed at this meeting at all.

Q. Yes.

A. So I can only go on what's been on these written notes. Dr Brearey may have more of a recollection, so --

Q. Well, it looks as though on the first page 206 there is discussion about Mortality and Morbidity Meetings. And if we go to 0207, at the bottom, does that refresh your memory at all?

A. No.

Q. Number of meetings, times five, times four?

A. No, no, I mean I presumed it was a discussion around how frequently perinatal meetings were taking place but, I can't, I have seen this document. I -- it doesn't trigger any memories of it.

Q. You tell us at paragraph 331 of your statement you:

"... subsequently learnt that the inspectors were told that as a group of Consultants we felt that we were struggling to be heard in raising patient safety concerns and not being listened to, although I was not

aware they had been told this at the time. We were also at that time still waiting for the two new consultant posts that had been approved to be advertised and continuing to regularly act down to cover middle-grade gaps as well as dealing with a significantly more intense workload on the NNU."

Indeed it looks at page 209 as though that's a conversation in this meeting about middle grade Consultants 6 to 8, can you see at the top?

A. Yes.

Q. When a CQC visit is arranged, are there any meetings that you would have attended in preparation for the CQC visit or not or does that just --

A. I -- I may well have been invited to some because usually when there is a CQC visit there is quite a lot of anxiety about making sure the various documents, bits of paper, that they are going to be looking at are up to date.

Q. Yes.

A. And again entirely subjective, cynical view -- and again it comes back to process versus outcome -- I do feel that much of the time the focus is more on making sure that everything looks right on paper for the CQC rather than -- and again I don't think this is unique to my organisation, I think this is NHS-wide,

I -- I think that quite often it's a lost opportunity because if there are things that need improvement, to my mind surely a CQC visit is an opportunity to get some leverage to improve things.

But I think the problem is is the consequences of getting a negative CQC report are such that sometimes papering over the cracks is the right thing to do.

Now I am not -- that is just an observation, entirely subjective from me and others may well disagree.

Q. In terms of feedback or of assistance to those visits, if you had been asked a question, an open question what are you worrying about the most or what's troubling you at the moment --

A. I think in that forum if you go back to the attendance list there, I think that would have been a difficult one because actually if there had been an open question there is an opportunity. So by this stage we had had the Thematic Review several, not all of us, had the specific concern.

Given the make-up of the number of people in the room, it would have been a difficult -- a difficult one to breach but --

Q. What, because you all had different views of the same --

A. And you are also fully aware of professional colleagues having different views, the risk again of being accused of victimisation, bullying. But again in retrospect, there would have been no safer environment because there were independent people there.

Q. What do you mean "the risk of being accused of bullying" --

A. Well --

Q. -- "and victimisation", because we have seen this theme referred to among within the expert evidence so what's the worry about raising --

A. The worry again because the thing we were concerned about seemed so improbable and even though we had a significant concern there is still that element of doubt and again we didn't have "evidence", and we had the misguided, as I know now, belief that we couldn't do anything unless we had evidence, that people would just not believe it, and actually then turn it round and make it an issue around, as some people believe, cover-ups, bullying, victimisation and, you know, I -- I can't -- I don't have a crystal ball so I didn't know what was going to happen in the future.

But my -- my view on what happened when we did put our heads above the parapet is exactly that now that is not a justification for not raising it earlier but

and -- I think there was an opportunity here -- because they were -- there were independent people there.

I was also aware that because Ian Harvey had asked for it, Ian Harvey had specifically asked for a copy of the Thematic Review.

Q. Let's go to that, that can come down that document, please. So we see at INQ0003140, page 1, we see at the end:

"Dear Steve ..."

If we can get that on the next page.

"Am I correct in thinking you commissioned an external review? If so, is there any early feedback ahead of the visit?"

Then we see, if we go back to the previous page, Dr Brearey:

"it wasn't an external review, we did have a review of all the cases to identify themes or common learning. I have attached the draft minutes and actions. I have only circulated to the attendees so far. Once I have feedback I will circulate it more widely and make sure actions are completed."

A. So I obviously didn't see the email from Ian Harvey to Steve Brearey but I was copied into this. So I was aware that Ian Harvey had requested a copy of this Thematic Review in advance of the CQC coming. Now,

I don't know.
Q. Let's go to INQ0003114, page 1. Mr Harvey suggests whether it can be joined up with the obstetric review when it's signed off at governance board. We know the Brigham review had been conducted?
A. Yes.
Q. Which was very much an obstetric review, not a neonatal review.
A. Yes.
Q. We see at the top there an email to you and Eirian.
"I think we still need to talk about Lucy, maybe when you are back and free the three of us can meet to talk about it."
So at the same time, Dr Brearey is suggesting you, Eirian and he speak about Letby. Did a meeting as far as you recollect happen around then to discuss Letby herself?
A. There was never a meeting between myself Steve Brearey and Eirian Lloyd-Powell that took place. I think that various people were on leave at different times but I was never part of a specific meeting and I think shortly after this was when Letby was moved from nights to days. I can't remember, I think it wasn't long after this, but I wasn't part of that --

Q. That is April, yes?
A. -- decision-making process.
Q. If we can go please next, Dr Jayaram, to INQ0003089, page 2. We see there at the bottom you are cc'd into this, an email between Eirian Powell and Alison Kelly asking to arrange a meeting to discussing how to move towards with regards to findings of the review.
At the top another email reply from Alison Kelly:
"Thanks for the update. Could you please send Ian and I the report? Once we have reviewed this I think it would be good for me, you, Ian, Steve and Ravi to meet and discuss."
Did you ever have such a meeting around them?
A. No. No and I was never -- I was never invited to a meeting and certainly a meeting with myself, Dr Brearey, Eirian Lloyd-Powell, I think the meeting that eventually took place was the one that was referred to earlier in May 2016, which was some time after the initial request.
Q. There's another request for a discussion if we go to INQ0003142, page 2. Later on in time, sometimes --
A. Another observation, sorry, is that this was sent on 17 March. But I am assuming that what was sent

to Alison Kelly by Eirian Lloyd-Powell was the review that had been sent to Ian Harvey in the February, correct me if I am wrong --
Q. We will follow that up with them.
A. I don't know.
Q. I am just asking your understanding, if I can?
A. Okay.
Q. So if we look at this, we see an email from Dr Brearey to Alison Kelly:
"I am hoping Karen has spoken to you about our mortalities last week. We are going to discuss the matter at our senior paediatricians' meeting on Monday. I was wondering if it might save time if you and Ian could join us to discuss the ongoing issues."
If we go back to page 1, Karen did discuss -- the reply comes:
"Karen did discuss this with me last week. I am looking to touch base with her again. I will discuss with Ian this AM re trying to attend your meeting. from our previous meeting held several weeks ago we agreed we would meet in July anyway so the timing is appropriate."
So in the May meeting, agreed to meet in July.
Was there any ability just to create informal meetings or immediate meetings depending on the circumstances or the level of concern?

A. I suppose there's always an ability to create an immediate meeting if people are free and there is a high level of concern. We knew that we were going to have all the other relevant people in the room on -- so I think that email that Steve Brearey initially sent to Alison Kelly was actually sent on a Sunday so we knew that we would have everybody in the room on the Monday lunchtime, or the majority of the people in the room on the Monday lunchtime for the senior clinicians' meeting which is why I think Steve Brearey has invited them to come to that meeting.
Q. We then see an email from Dr Brearey INQ0005749, page 3. If we go to the next page, please. We need to go to page 3, sorry, thank you:
"There has been a watchful waiting approach since our last meeting with Ian and Alison in March. Since the episodes and deaths last week there was a consensus at the senior paediatricians' meeting. We felt on the basis of ensuring patient safety this member of staff should not have any further patient contact."
And conclusion to this email:
"I understand Ian and Alison met with Eirian and Ann yesterday and the outcomes from that meeting don't entirely fit with what was suggested at our senior paediatricians' meeting hence it would be helpful to

meet sooner rather than later with nursing and medical colleagues together."

That didn't happen, did it, nursing, medical colleagues, even Execs together. There seemed to be a separation of meetings by this point?

A. No, from this point, and there were a lot of meetings from this date through to mid-July but even after that, I do not recall any meetings where any of the senior Executives, the medical staff and the neonatal nursing staff were in a room together to discuss things.

Q. There was a meeting, wasn't there, on 29 June, if we go to the handwritten note at INQ0003371, page 1. A meeting arranged to discuss concerns face to face with senior leadership team taking place in Tony Chambers's office is how you describe it in your statement?

A. Yes.

Q. What time did that meeting take place? It says 5.10 pm, is that when it took place?

A. It is probably about right at the probably at the end -- at the end of the day. I think it was fairly hastily arranged.

Q. Earlier in the day there had been email communications, hadn't there, if we can pull these up. Sorry to change the documents, Mrs Killingback, but we

need to go to INQ0003112, page 3.

The email at the bottom, 29 June, is Dr Saladi's email around we need:

"... potentially I believe we need help from outside agencies who can deal with suspicion. The only people who can investigate it is the police."

We see your response above:

"Thanks, Murthy. Steve and I are trying to meet with senior Execs to discuss this issue. They don't seem to see the same degree of urgency as we do.

"Until we have met with them I am reluctant to go to an external non-medical agency, ie police, off my own back. I am going to speak to the MDU today to find out where I stand as lead with regards to these concerns."

Ian Harvey of course is cc'd into that and we see his response, page 2:

"Ravi, absolutely being treated with the same degree of urgency. It's already been discussed and actions being taken. All emails cease forthwith."

Dr Gibbs we know responds to you two about that and the request to cease forthwith.

Then we see at page 1 at the top your response. Can you tell us from Dr Saladi's email and yours what had happened in the day that arrived at you sending that email or whether you already knew that was the case, how

was it that you --

A. So I think when -- can you scroll back down to Ian Harvey's "emails cease forthwith"?

Q. Yes, that is page 2 at the bottom.

A. After that was sent, I recall Ian Harvey because the Executive offices were the corridor opposite to where our offices are in the particular building. He came down to my office and said to me that we have already had a discussion, we just need to get a bit more information but we will ultimately go to the police.

Now, I am aware, because I have seen a copy of Ian Harvey's statement, that he says that he can't remember saying that. But I wouldn't have actually put that in an email unless I had been told it.

What I didn't know was what, who had discussed things and what had been discussed and what action was being taken at that point. So in terms of the sequence of emails, obviously "all emails cease forthwith", we just took him out of the copy list, because obviously we wanted to express our concerns to each other.

But yes, my understanding -- so that Ian Harvey email was at 0858, I think I sent my email -- sorry, can we go back up to the top?

Q. You sent that at 10.24?

A. At 10.24. So I think between 0858 and 1024,

that is the time period that Ian Harvey had come down to my office.

Q. If we go back now to the handwritten notes of the meeting which was 003371, page 1. This is the meeting in Mr Chambers's office. You are halfway down "Ravi, entirely subjective".

What do you tell us using the notes as you wish to refresh your memory, what do you say at the meeting?

A. I think I was saying exactly what I continued to say and what I eventually said when we met with the CDOP panel; that these were babies who were obviously on the neonatal unit because they had medical problems or prematurity that meant they needed to be on the neonatal unit. But the majority, if not all, of these babies were stable and didn't show any signs that they were deteriorating and then suddenly deteriorated and then also pointed out that they didn't seem to respond to appropriate interventions as they ought to have done.

So essentially I suppose sort of articulating on the first two points that you highlighted on the Thematic Review, I didn't talk about the timings but the fact that these were sudden and unexpected and there was always an association with -- with Letby.

Q. Page 2. Comments attributed to TC, Tony Chambers. Why did we call the police? Presumably

why didn't -- do you remember what you said?
A. I can't remember that comment.
Q. You didn't call the police so we will have to ask him about that.
You say -- it says next to "Ravi police" "what if no conclusion". Do you know what that means?
A. I think it was if the police come in and the police say "there is nothing to see here, not for us", what do we do next, because we still haven't got any explanations.
Q. We see Mr Chambers goes on:
"Issues can explain: is this suspicious, criminal or are we missing something?"
Is that "causal link between nurse"?
A. It says "causal link between nurse" and he makes a comment "Dr Harkness is no longer working here".
Now, I am aware that Eirian Lloyd-Powell --
Q. Not interested in that.
A. Sorry.
Q. Let's move on, sorry, I am just conscious of the time, Dr Jayaram.
If we go, please, to 30 June there is another meeting at 0003362, page 1. Again handwritten notes appear to be taken by Mr Cross and you hadn't seen them before we sent them?

A. No.
Q. Mr Chambers said he had informed the CQC of its plan to downgrade the unit with a model of care yet to be agreed and commission an Invited Review from the RCPCH due to the increase in deaths with no obvious explanation. That's what you tell us in the statement. Was that what was discussed at the meeting?
A. I think we -- we discussed at the meeting our discomfort about Letby practising unsupervised. The downgrading of the unit was discussed and we felt that that would be appropriate because we had no specific answers and we wanted to sort of make sure we could be safe and that -- the College review was -- was discussed as well.
So I think that bit's accurate.
Q. Page 2 at the top, you say:
"Starting point, what is safe? Reduce service but staff member not addressed. Discussed going to police."
As far as you were concerned, was the service reduction going to address the concerns you had about Letby?
A. No, because given -- given the possibilities, it could be that we were looking after babies that we weren't equipped to look after, so it made sense until we had had further investigation to downgrade the unit,

but what I was saying there is that we had already articulated that we had a specific concern about Letby and downgrading the unit didn't address that.
Q. If we go to page 3, near the top you say:
"Do we need to engage our partners now?"
A. That's talking about other neonatal units, neonatal network because if we were going to downgrade and stop taking babies below 32 weeks' gestation it would have an impact on other services around the region within the neonatal network.
Q. Over the page, page 4, you comment that:
"Concern potentially a member of staff causing harm, reoccurring theme."
A. Yes.
Q. "These babies should never have died" Sarah says.
The actions on page 5.
Dr Brearey saying:
"... made my views clear the other night."
Is that with his email around the topic?
A. Sorry.
Q. You see at page 5 --
A. Yes.
Q. -- Steve Brearey:
"I made my views clear last night" --

A. Yes, I think Steve -- Steve was saying actually surely it should be the police at this stage.
Q. There is a reference page 6 from you:
"Not Execs v clinicians. Appreciate support from Execs. Plan for a pragmatic way forward."
Were you actually thinking you were getting support from the Execs or was that speak to try and get what you wanted next?
A. At the time, it was a really strange feeling because in terms of the words that were being spoken, to an extent it was: we hear you, we are going to -- we are going to help you, we are going to sort this out.
But it just didn't feel that the issue around our specific concern about Letby was being taken seriously. I can't remember, I have put it in my statement, but in one of these early meetings, Mr Chambers made a remark when we specifically suggested the possibility of Letby potentially causing deliberate harm, that was along the lines of, and I think the wording is really important here, and I don't know if I got colleagues who can back me up on this, when he said: I can see how that would be a convenient explanation for you but surely there must be something else.
And I remember that just made me think "convenient?" Because it really wasn't convenient. But

what I realise now is that right from the -- that point there was a reluctance to consider what we were suggesting could be going on and the possibilities that could be going on.

So I kind of -- I have -- this is a very crass analogy and I apologise but I have likened it to -- and I will probably get slated for saying this, likened it to being in some kind of abusive relationship. I was working on the naive assumption that the people who run the hospital would all be pulling in the same direction in terms of patient care and patient safety. And of course what I am hearing is that it just didn't seem quite right, but I have no reason not to trust these people because they should be pulling in the same direction and, you know, they are wise, they are paid higher -- large amounts of money to run hospitals and if they are suggesting this is the right thing, and it couldn't be that, it couldn't be that, I just I guess I accepted it.

I -- I -- I was, I -- I was too trusting with a -- -- well, I was appropriately trusting, why shouldn't I trust the people who run the organisation in which I work? But it just didn't smell right.

Q. Paragraph 465, you do say:

"I recall Mr Chambers explicitly saying in one of

the meetings around this time he '... could see how it would be a very convenient explanation for you but there has to be something else'."

We also know, if can be put on the screen please INQ0103147, page 1, that on 7 July this external communication was put up about the downgrade. So a week after that meeting.

We can see what's said there, if I give people a moment to see it. This caused in its draft form and generally some amount of communication between you as doctors. Again, at this point there is a lot of communication, isn't it, taking you away from --

A. Yes.

Q. -- the day job.

But if we look at this, your email, INQ0002694, page 9, this was thoughts on a draft, we would have to look carefully if they are still there or not but the reality is you were expressing 2694, page 9:

"I am uncomfortable with the complete absence of any reasons for downgrading. How does this sit with being open and honest and the duty of candour? The second sentence should reflect in my view 'this is temporary, not permanent', needs some kind of openness about why has to be given."

You say:

"I appreciate we don't want to cause alarm but people aren't daft, they will immediately ask why. The absence of any reasons makes it look like we are trying to hide something."

So obviously the area of communications is a whole different thing, we all know usually people at the top an organisation sign off on communications, it's important?

A. Yes.

Q. But to the extent that you were being asked about these communications, you seem to be flagging up that you know the need to be open and honest is important. Did you think that?

A. Sorry?

Q. Did you think it was important that in communications around the downgrading generally the Trust ought to be being honest at this point?

A. I -- I think there was a balance because obviously to articulate explicitly the specific concern we had raised may not have been appropriate.

But there was no, there didn't appear to be any sort of reasoning given behind it and I just, I just felt and again it was my, my view that it would probably although the statement I believe properly in good faith was put out to sort of smooth calmed waters, there was

the risk that it would actually cause more consternation.

Q. That can come down, please. And another meeting note of Stephen Cross, 0003365, page 4. And it's a meeting on 13 July.

You tell us it is a meeting that was called to give you the findings of the deep dive review that had been undertaken and to be informed about the Trust decisions on any further actions.

A. So I think this was the meeting at which so what had happened between the end of June and now is that Ian Harvey had tasked a number of staff with doing some Casenote Reviews.

I wasn't part of that process and if I know that my colleague John Gibbs was and a number of senior nurses were and a number of people around the Trust and this is one of the things that came out of the meetings at the end of June, to do a more in-depth review the case notes to look for any trends or anything else that might be causing the increase in the death rate.

Q. Was this the meeting where he produced various graphs and a presentation himself?

A. I -- I can't -- I can't remember whether it was this. I think it was this one because there was another meeting the next day, but looking at the --

I think -- does it mention it in the minutes?
Q. You tell us the meeting the next day we know was an extraordinary Board of Directors.
A. So I think this meeting was where he presented those graphs and interpreted the data as I guess what -- what we were being told is the data suggests that it's chicken and egg; you have had a higher acuity of babies and therefore you have been more busy and therefore the staff have been busier, it's inevitable that a full-time nurse who's done the intensive care course is more likely to be involved with any of these babies because she is there more for them and therefore really that -- and there were graphs presented, I think, that were interpreted as suggesting acuity had gone up, intensity had gone up --
Q. I'll come to those in a moment. If you just look at page 5 at the bottom. Somebody has asked the question about what would we do if this was a doctor? How would we deal with it? It's Mr Chambers. And you say at the bottom:
"Doctor would have been suspended."
A. Yes. It was, it was -- it was a strange, it was a strange comment --
Q. Yes.
A. -- because it doesn't matter whether, you

know, if you're a doctor or a nurse or a physio or a ward clerk, or any other person working in a hospital, if there are suspicions about you causing deliberate harm you would be suspended.
And I have realised, again subsequently having seen other documents, that there was a suggestion that because the individual we were worrying about was a member of nursing staff we were reacting very differently. And the suggestion I -- I think here was if this was a doctor, we wouldn't be suggesting all of these things, you know, and I think the suggestion was if it was a doctor, you would -- you would perhaps be more nurturing and not as -- not as accusatory.
And, I think the other point I made here is Ian Harvey's data's all very well, but it doesn't actually address the specific issue of these babies suddenly deteriorating.
Q. Let's quickly have his presentation on the screen please, INQ0002837, starting at page 2. Page 1 actually tells you how it's summarised.
That's what it purports to do. Did you know if there had been consultation with any of the neonatal network or others?
A. Not that I was aware of.
Q. Or if it had been taken from MBRRACE or

anything else? Did you have any idea how this was put together?
A. No. I think this was BadgerNet and NNAP data, I think. It says it uses BadgerNet data. Badger is the neonatal database. All neonatal units enter data into Badger
Q. So if we just pause for a second only, please, Mrs Killingback, on each page 2, 3, 4, 5, 6, 7.
A. So this -- this is the striking one where it basically very clearly demonstrates what we'd been saying: there had been a quite marked and obvious uptick in deaths on the neonatal unit since 2015.
Q. Yes.
A. Now, this was an interesting graph because there are -- again, my interpretation of it -- there are dots that are coloured in red.
But it doesn't to my eyes -- and maybe that's because I don't want to see a trend, I don't know -- it doesn't show a trend. If I look back at 2014, I could colour in some of those dots red as well.
And of course we were -- we did have more activity because we had sicker babies, but we had sicker babies for reasons that we know about.
I think that that's also -- care days, of course if you've got sicker babies you are going to have more care

days. Now, if you then look at that -- and again, sorry, can you go back to that one?
If you go back to 2014, I could have put some red dots in there as well. But of course care days were going up because we had sicker babies and those sicker babies, you know, chicken and egg were effect, in retrospect, rather than cause.
Then of course the next one looking at acuity. Yes, of course acuity was going up because we were having -- we were having sicker babies.
And I think there -- was there one more about staffing as well?
Q. What do you mean when you say "sicker babies"?
A. Well, we were having babies who were more unwell because what we know now is they were being made more unwell.
Q. So you weren't saying constitutionally you were getting iller babies?
A. No, no.
Q. You were saying that the ones were presenting --
A. There wasn't a trend of smaller babies, more premature babies. The babies that we had were babies that we had previously always looked after as you can see from the data from previous years.

But again the reason that acuity was going up was because of what was happening to these babies and of course because of that, of course there were going to be more intensive care and high dependency, high dependency days. And again if you look back at November 13 and January 14, May 14 there's been troughs and peaks throughout.

And again if you look at numbers, the numbers are small. You know eight; it goes up to 10 babies with a birthweight below 2 kilograms. It's not to my mind something that you can then look at and say, "Well, here's your answer."

Q. The specific point, Dr Jayaram, is that it doesn't address the individual circumstances --

A. Well --

Q. -- or required scrutiny for each of the babies --

A. No.

Q. -- who died or collapsed?

A. It -- it -- these slides as presented did not address the specific question of the specific concern we had about the association with Letby.

Q. Let's just -- two more documents before we break, if I may. The first is the extraordinary Board of Directors meeting, minutes of meetings held on

14 July, INQ0004216. Sir Duncan Nichol is present, Mr Higgins, Mr Chambers, Mr Harvey, Mrs Kelly, we see on page 1.

We see at page 3, again I don't need you to repeat it, we are familiar with this description, except you add here: not what you have been saying all along about sudden and unexpected and these babies weren't the ones we were expecting to die. You refer to the fact:

"The unit has been busier as not unusual across the region, neonatal cots are reducing, hard to recruit staff, lower staffing and higher intensity will lead to more risk. That said, when looked at these babies no direct effect on each patient."

So that the staffing issues were broader across the region as far as are you were concerned?

A. Yes, and I think there's -- there's data from NNAP that actually suggests that although we were not 100% compliant with British Association for Perinatal Medicine standards for staffing in terms of the skill mix, we were not an outlier by any means compared to any other organisations. We were bang in the middle for average. And those also were not new circumstances. There hadn't been a sudden change in terms of where we were with our staffing compliance.

Q. Sorry, over the page, page 4, you say

something that you say -- you state what you are going to say was confidential and not to be minuted?

A. I think I explicitly stated the concern about Letby.

Q. Why did you feel the need in a board meeting like that to say it shouldn't be minuted?

A. Again I had increasing discomfort here. Again this, this dissonance between, you know, these people should be on our side but there seemed to be a pattern emerging that they didn't want to listen and I was already becoming concerned that this, if minuted, could potentially come back and -- and bite me on the backside and be used against me.

Q. At page 5, the third paragraph, please, and you, I think:

"The actions are proportionate as a holding measure ..."

Is this the instruction for the RCPCH?

A. Yes, the RCPCH and the regrade.

Q. "... as far as possible. The worry is at the end there is no conclusion or idea what's going on and this could be a delay."

A. Was it discussed in this meeting about specific measures around Letby being supervised when I'm just talking about proportionate measures? I can't

remember whether it was this meeting or another meeting.

Q. So it may have been about staff. But did you see the RCPCH review, which is what you seem to be commenting on at the end, the review could ultimately be a delay, were you flagging that up?

A. Well, at this time we hadn't seen the Terms of Reference of the RCPCH review, so we didn't know specifically what they were going to be looking at.

I think we had downgraded. I think, I think by this stage we'd -- I think by this stage we'd -- we'd basically said, "Look, we are uncomfortable with Letby continuing to work on the unit. You have to decide how you are going to address that, be it CCTV, be it one-to-one supervision, be it something else."

But I can't remember whether that was this meeting or whether that was the meetings at the end of June.

MS LANGDALE: Yes. Thank you, that's a good place to stop, Dr Jayaram.

LADY JUSTICE THIRLWALL: Thank you very much. We will take a break now.

Ms Langdale, how long a break do you think is wise?

MS LANGDALE: 5 past 2.

LADY JUSTICE THIRLWALL: 5 past 2. Very good. We will rise now. Back at 5 past 2.

(1.15 pm)

(The luncheon adjournment)

(2.05 pm)

MS LANGDALE: Dr Jayaram, you tell us at paragraph 518 of your statement that you requested a meeting with Ian Harvey to update you with verbal feedback from the RCPCH review panel:

"... and also to explain to me why the adverts for the two new Consultant posts that had been approved earlier in the year, had been delayed."

The meeting took place at 4 o'clock on 8 September.

The Inquiry has heard evidence, Dr Jayaram, from the RCPCH interviewers and I don't need to ask you about the fact that you made it clear as was described at some times with emotion in your voice about what was worrying you and your concerns including about a nurse and about Letby.

So you clearly set that out yourself with Dr Brearey in those interviews.

In your meeting with Ian Harvey we see you subsequently emailed your colleagues on 9 September 2016, at INQ0103167, page 3. So that would begin -- if we had gone to the previous page which we don't need to -- to say, "I met with Ian Harvey yesterday afternoon, this is a distilled summary of things discussed."

Then we see you say:

"They did acknowledge the concerns we raised over foul play and recommended a forensic detailed independent review of all the cases.

"This would be far more detailed than the Thematic Review and be conducted by two teams independently. Sue Eardley gave four names to Ian."

You weren't, at this time, shown the report, were you?

A. No, we, we weren't shown the report. I mean actually, at this stage, I didn't even assume that any kind of written draft report would have been available because I think this was only a week or so after the two days of the RCPCH visit.

So this was a summary of -- of my interpretation or my recollection about what Ian Harvey had told me at the meeting that I had with him on the day before.

Q. Thank you. That can go down.

Moving to October and the grievance, can we see please INQ0107964, page 43. Sorry -- before we go to that, Dr Jayaram, I should ask you to confirm, paragraph 520, you say at that discussion with Ian Harvey that we have just looked at:

"The first issue discussed was the RCPCH Review Team feedback, he did not give much detail but suggested

that the immediate feedback from the team had been that there were no issues around the service itself that needed urgent attention. He told me that they had noted our plan to appoint two new Consultants ...

And:

"He used the words 'no smoking gun' [being] identified to explain the increase in death rates but didn't detail what data had been looked at to make this conclusion."

Is that right?

A. That's correct, yes.

Q. And when you asked if they had addressed specific concerns around Letby's potential link, and he told you they had not investigated this specifically but had recommended a detailed independent forensic review be undertaken; yes?

A. That's correct, yes.

Q. So going then to this letter on the screen. When you received that, what did you think was going on and in particular what did you think paragraph 2 represented, if anything?

A. I was surprised to receive this, to put it mildly. I think it came via email. Now, by this point, I was aware that Letby was not working on the unit and I had been made aware at some point prior to this,

I can't remember when, that she was working in the risk and governance department.

When I received this, my first reaction was surprise and -- and anxiety, really. Because I -- I appreciate it's probably a formal template kind of letter, but it was the line about, "anything I say not only will form part of this investigation and may be presented in disciplinary hearings should this be necessary".

Now, up to this point -- not even up to this point, even now I am not -- I wasn't sure whether I had done anything or said anything out of place or that was potentially going to get me in trouble. As we discussed before lunch, I had been quite cautious to an extent asking for things not to be minuted for fear of some kind of come-back.

And I think as well, it -- I think it recommended bringing a Union representative. Now, I have been a member of the BMA from the time I qualified as a doctor, never really had to use them for very much. But the very fact it said that just filled me with quite a lot of uncertainty and concern and so, as a consequence, I contacted my BAPM representative.

But I actually I think my reply to Dr Green when he sent this email saying "can you set up a date?" was

"yes, I think that's fine but can you tell me what it is I am supposed to have done?"

Q. We have seen those can I take you firstly to INQ0004356, page 3. You are asking your Union representative about it. If we go to page 3, and the advice in short, they suggest to you:

"You request a copy of the grievance policy and an agenda. Inform the Trust you have sought BMA advice and will return contact when you can establish the availability of your representative. Forward all correspondence to myself along with a copy of your contract policy and agenda as soon as you receive these pieces of information."

And we know you in fact, not with this person who advised you, attended with another BMA representative on the day of the interview and you are expressing here, aren't you, at the top:

"We as a group are still uncomfortable that our concerns have not been fully addressed but understand why the Exec body is being cautious about escalating things. My worry about this HR meeting is what I will be asked and how I reply. Clearly if I am asked 'did I have any concerns?' I can only give a subjective view and if I raise the possibility of deliberate harm, am I putting myself at all sorts of risk? Although I stand

by the fact that we ..."

A. It should say "escalated".

Q. -- yes, "escalated and therefore fulfilled a duty of care".

You also, if we can go to a second document, INQ00063110001, asked Mr Cross, the internal -- well, did you see him as the internal person to go to for legal adviser support?

A. Yes, I mean the irony of this now is not lost on me that he was the Trust's legal advisor and I wanted some kind of advice as to how much I -- how much detail I could give about our specific concern, given this was an investigation of a grievance.

And I in the back of my mind had a concern that this could be used against me and you know I am, I -- I sort of facepalm and laugh at myself that the person I asked was Stephen Cross, in retrospect.

Q. You are saying very clearly the Trust and, as you say, he is legal adviser for the Trust:

"... but we are sure that one of the questions will concern why we had concerns about X. As you know we had noticed the association between unexplained collapses in the presence of X, felt it was a matter of patient safety until this had been looked into further. We were not involved in the decision to move her to non-clinical

services."

As you say, that was an Executive decision, wasn't it? You made representations about your concerns but you weren't writing letters removing her?

A. No, so -- so at the meetings in June and July, we asked them to do something about our concerns around Letby working unsupervised and we discussed CCTV, there was one-to-one supervision discussed. No conclusions were made in any of the meetings that I was in attendance at with the Executive board at all and I subsequently heard through a grapevine, really, at some point in the next few weeks that she had been moved to Risk and Patient Safety. And I think that's important because, again, it seems to be a recurring theme that there was some kind of ultimatum put by myself and my colleagues that, "if she's not moved we will call the police".

And I am not really quite sure where that's come from. But we were --

Q. I just need to ask you one thing about that; did you ever say "threaten to call the police"?

A. No, no, I don't.

Q. So I need to ask you --

A. Others may recollect differently I do not believe at all, at any point an ultimatum was given that

"if you don't move Letby we will call the police".

Q. Perhaps you wish there had been now --

A. Had we given that ultimatum -- actually, I wish we had done, but we didn't because we were trying to remain as respectful as possible.

So all we wanted was to be reassured that Letby was either practising in a supervised way or other actions would be taken.

Q. Looking at the second paragraph of your email to Mr Cross:

"If we are asked what concerns we had how should we play this? I think we should make it clear that the whole Consultant body had concerns about patient safety and these concerns were escalated appropriately and leave it at that. Inferences may or may not be drawn but if put on the spot and asked directly, specifically what duplicate asked directly, specifically what the concern was, it would be wrong not to be explicit. This however could unleash a whole other cascade of events. Advice gratefully received"

Your meeting had been brought forward that Thursday.

We have seen from emails, Dr Jayaram, that Claire Raggett emailed you and asked you to phone him. You say you did phone him, but don't recall the

conversation now?
A. No, I have absolutely no recollection.
Q. Do you think you did definitely call him?
A. I -- if I did I can't remember.
Q. Okay.
A. It would seem there was an arrangement made to have a call, I cannot remember whether I spoke or not.
Q. You certainly can't remember advice that shed light on the problems that you are identifying --
A. No.
Q. -- both to your Union rep and to him.
A. No.
Q. So when you go into the grievance interview have you had any satisfactory answer to what you should be saying or not, about the suspicions or concerns?
A. So my BMA rep said "see what the question is like" but essentially said "don't say anything speculative" and they were with me and said that they would intervene if they felt the line of questioning was inappropriate for the purpose of the meeting.
Q. Let's go to the meeting then that you are in, INQ0002879, page 47.
A. I think, before the meeting as well, I had some communication with the HR representative to ask whether I was there as a witness or as somebody who was

potentially being investigated and I recall the reply that came back was that I was there as a witness --
Q. Witness, that's right?
A. -- at that time.
Q. So you had got that back from her -- that was Lucy Sementa I think -- that you were a witness.
Then we see the first question from Dr Green. First of all, did you know Dr Green at all?
A. Yes, in fact I was actually on one of the informal interview panels on the day he was appointed to Director of Pharmacy. I didn't have a particularly close working relationship with him, he was fairly quiet and I didn't really have much occasion to have much to do with him but I had met him on several occasions.
Q. So no bad blood, no good blood, as it were --
A. No. There were no issues, there were no axes to grind from my side.
Q. If we look here, your paragraph 1, you set out:
"Premature babies are at high risk, our rate comparable to neighbouring units. There was a rise in mortality and they were not the babies you would have predicted. None of these babies responded to timely resuscitation manoeuvres. As a group of Consultants, we were very concerned that the babies were deteriorating

and needed to look at why. It was raised to the Executive board about increase in death rates, also reviewed individual cases internally. Stephen Brearey organised a Thematic Review with external reviewers. There didn't appear to be anything in terms of clinical practice equipment or the environment that was relevant. There did appear to be an association with Lucy Letby, either looking after or being present at the time of the deaths. Discussed with the obstetricians, we were all concerned we were potentially putting babies at risk when there was something that might have been a factor concerns were raised with the Executives."
Two answers down you also refer to an incident with the Triplets "babies who were getting better, were stable, who suddenly collapsed".
Those, you make clear, they were stable, suddenly collapsed and the same at the top, you make clear, they are not babies you'd have predicted to collapse. You don't say "sudden and unexpected with no explanation", you know we were dealing with that term earlier?
A. Yes.
Q. You do, when you read it as I have, see that you said they were stable and then they suddenly collapsed?
But other than that in that paragraph, do you think

that's a fair summary of the concern for the babies: that they had collapsed and weren't being --
A. I think so, yes.
Q. Do you think retrospectively, again flagging up sudden and unexpected, well, deteriorated when we didn't expect them to, might have made that it wasn't simply the association of the nurse around a death, it was the association around unexpected inexplicable deaths with no medical cause identified by the paediatricians?
A. I don't know whether in this forum, in the grievance investigation with Dr Green, specifically saying that would have made a difference. Those words had already been used explicitly with the Executive Team who commissioned, presumably, Dr Green to do this and I don't think Dr Green's investigation here was specifically to consider what was happening with the babies. It was very much around Letby's grievance.
So I think in my opinion, using those words, in what's documented in the first paragraph of this transcript, probably wouldn't have made a difference. And, okay, I'll put myself out here, one of the reasons I also think it wouldn't have made a difference is that my subjective view, with a little bit of evidence behind it, is that the findings of this grievance process -- or

the -- the desired outcomes of this grievance process -- had possibly been predetermined to an extent.

I -- I don't know but ...

Q. We have seen all the evidence that was in the grievance pack, Dr Jayaram. I am going to take you just to some of it but rest assured the Inquiry has seen all of the material that was available and was interrogated to the extent that it was in that hearing.

If we look at page 48, Dr Green says:

"So to clarify, was there any suggestion from any of the Consultant team that Lucy had been deliberately harming babies?"

You say, "We discussed a lot of possibilities in private."

He says that:

"That's not a yes or no."

You say:

"We discussed a lot of possibilities in private and took our concerns to the Executive board"

When you said "discussed a lot of possibilities in private", what did you expect or hope that he would hear from that?

A. What I wanted, by using those words, is I felt that what we had discussed was not -- because I didn't really understand, I still hadn't had -- in fact I still

don't really understand, well, until I had seen the written grievance, understand what the issue being investigated was.

And actually these are very sensitive issues and I didn't feel, on the one hand, that Chris Green needed to know and number two, again, because of my concern that explicitly stating my concern in this forum could be used against me.

Do I think that had I said it it would have made a difference to things happening sooner? No, because I think in this situation I don't think that as previously what I and my colleagues had been suggesting would have been taken seriously.

Q. The next Dr Green question:

"If Lucy was to return to the unit would you have any concerns?"

You say:

"That decision should be made by those who removed her after completion and outcome of the report."

If the report shows no foul play, Dr Green asks, would you have a problem with her returning?

You say:

"If the Executive board felt it was appropriate for her to return then she would be back working on the unit. If subsequently there were further associations

we would raise concerns but that would be speculation."

And he says:

"The nursing staff have said that Lucy is a good nurse, very experienced and well trained in looking after the sicker babies. It's likely that Lucy as a nurse will be looking after a baby that dies, therefore she will be associated."

And you make the point:

"In a small unit with high intensity babies every nurse will be associated with babies that deteriorate."

Then it's the HR representative who asks about percentages or a threshold of the number of deaths for a unit this size. What did you think you were being asked here? On the face of it, if she is back at work and there is another death, it is just an association. Was this future planning or future proofing, or what was this?

A. I am not really sure where this was going. I remember feeling very uncomfortable with this line of questioning which is why, you know, I was asked would I be happy and I have given a very, if you like, third person answer that if the board felt it was appropriate, then -- then she would come back, but we would continue to monitor things.

And I suppose looking at the transcript now,

Dr Green was trying to suggest: well, it's inevitable she will be involved because, you know, she's very good and experienced and looks after the sicker babies. And I didn't -- I didn't at this time take away from this I didn't really understand what the subtext may or may not have been, it just struck me as a very unusual line of questions given that the invitation to this meeting was to sort of investigate, investigate a grievance, I didn't -- a grievance of which I didn't actually have knowledge of the substance.

Q. You subsequently much later made a Freedom of Information Request, didn't you, in 2017 I think or 2018 even?

A. Yes, I did.

Q. I don't need you to turn it up, I am just going to take you two sections or comments that were reported to Dr Green and ask for your comment upon them, if I may.

My question earlier was you didn't ever see what people had said about you until you made that Freedom of Information Request; is that right?

A. No, no. So I -- I was subsequently -- I mean, I am sure we will come to it but following the meeting we had with the Executive board as a group of Consultants with their feedback from the two reviews,

one of the things that we were told was that some of us would have to go through mediation with Letby and it was -- I guess under duress and we can come to that engaged with this process.

Q. I am going to come to that. Can we take it in my chronology, if that is okay, Dr Jayaram?

A. Yes, of course.

Q. Because we will get to that. It is just to ask for your comments on the information that was given to Dr Green?

A. Okay.

Q. The first is INQ0002879, page 10. Ian Harvey was interviewed by Dr Green. 2879, page 10. We see there in the fourth box from the bottom:

"There has been a number of behaviours on the ward that do not reflect too well. I had to go and speak to RJ that some of the trainees had been making reference to 'angel of death' but no specific person was named. There was behaviour in the clinic it being heard talking about killing babies on the unit. I had to speak to Ravi about comments about killing babies. This was not denied and Ravi Jayaram did accept that it was inappropriate."

A. I mean --

Q. Also before you comment on that can I show you

both, because there's another one at 0038:

"Ravi Jayaram was heard by a nurse [this is Eirian Powell providing this information to Dr Green], Nurse T in outpatients and asked if anything had come from the review to say somebody is causing these deaths on this unit. Nurse T is now anxious to return to the unit after the Ravi Jayaram statement and Eirian Powell escalated to Karen Rees."

So two people there provide that information to Dr Green. Nurse T, if I can tell you her evidence to this Inquiry is that in outpatients, she heard something to the effect of you saying after the review: just because they haven't found anything doesn't mean there isn't something to find.

Something like that. Just something commenting on the review, not calling names, not saying "baby killer", "serial killer", saying just because they haven't found anything doesn't mean there's not something to find in reflection on the babies that had died unexpectedly.

So first of all, dealing with that. Do you remember making that kind of observation about the review; that that didn't mean that it was a clean bill of health and there wasn't something to find?

A. So the first thing I will say is, although I can sometimes have a big mouth, I wouldn't have been

in a public area saying what Eirian Lloyd-Powell was told I had said, explicitly someone is killing babies.

Q. Yes.

A. I may well have had a conversation with a colleague around the lines of -- well, if, if the -- "if the review doesn't find anything, it doesn't mean there isn't anything to find". Because I can't remember whether, whether by this stage we had seen the draft report. Having seen the draft report there wasn't anything in there that suggested to me that they had -- they had found any association.

So I won't deny I probably made a comment around the fact that even if the report doesn't find anything it doesn't mean there isn't anything.

Q. Quite. Well, that is obvious, isn't it? Correct?

A. And I don't think that is an inappropriate comment.

With regards to the "angel of death" thing, I remember Ian Harvey came to talk to me because he had reports a member of the junior medical staff had been overheard referring to Letby with -- with that epithet.

Q. When you say "that epithet"?

A. The angel of death.

Q. We have heard Nurse Death, was angel of death

something that you --

A. I mean, I never heard anyone saying it.

Q. Either of them: Nurse Death, or angel of death?

A. Not explicitly. I think people -- I am aware that the junior medical staff, the trainee paediatricians by this stage had noted the association with Letby's presence at these unexplained events. I think in medicine we sometimes have very black humour and, you know, over the years some people may have a run of very busy on-calls with very ill children and you might say something like that, but there's never any implication that you are accusing them of doing something. I can't comment for any member of the trainee paediatricians making that comment.

I suspect it was more about the association because they were -- they had noted the fact that there were always sick babies when she was on but I can't speak for them and I don't even really know which member of the junior medical staff it was.

Q. Going back to page 10, which is Mr Harvey's discussion he says he's had with you, so let's look at that box again about what he says to Dr Green. Do you now remember him speaking to you about comments he says about killing babies?

A. No. I don't remember, I remember him talking about the comments of the "angel of death". I don't remember him talking about me apparently explicitly using those words in clinic. And I certainly wouldn't have in a -- you know, in a, in a -- even if I was in a clinic room, there's people walking past, there is a lot of traffic I wouldn't have used those words.

Q. You were not asked yourself by Dr Green about any of that, were you, as you have just described?

A. I don't -- I don't recall -- I have not seen anything in the transcripts.

Q. We then see there is a meeting on 26 January, if we go to INQ0003523, page 1. We see there who's in attendance. Mr Harvey, Mr Chambers, Mrs Kelly, Mrs Hodkinson and the list continues.

And we see over the page Mr Harvey is giving details of the Royal College of Paediatrics and Child Health Review and the reasons why it's been commissioned. Highlights recommendations from the report, that is page 1, then page 2:

"Mr Chambers stated the Speak Out Safely process had been professionally managed. He noted emotions were running high at the time."

He sets out:

"We need to remind ourselves how we got into the

position. The Trust encourages staff to speak out and the only reason we went where we did was because of the Consultants' comments. An apology has been given to Lucy and her family."

Was it discussed with you before this meeting that what you were apologising for with anyone?

A. Nothing had been discussed with us prior to this meeting. If I may take a step back.

Myself, Dr Brearey and I think Anne Murphy had had brief sight of a draft report from the College in November. I couldn't stay for the whole session. I wasn't made aware directly at the point that the final reports came back to the Trust and in fact I found out because Jim McCormack, who was an obstetrician, some time in mid-December came to my office and said: have you seen the reports? And I said: they are not back. He said: oh, they are. I said: how did you know? He said Julie Fogarty, who is the Director of Midwifery, told him.

So I went down and found Ian Harvey and expressed my annoyance, to put it mildly, that these reports were back and they hadn't told us but other people seemed to be aware. He told me that the Trust board needed some time to digest the contents and come up with a plan and they would feed back to us in the New Year.

So the New Year came. I -- I repeatedly asked Ian Harvey could we see them and so this meeting on 26 January was arranged. So we were told that we would get feedback from the reports and an account of what the Trust's plan moving forwards would be.

Now, we were quite concerned that they wouldn't let us see the reports first and we as a group made a decision that whatever we were going to be told, we would just take it on board and not come up with any immediate responses and try to digest what we were, so I didn't -- I thought that we would get the important findings of the service review and the outcome of the findings of the Casenote Review.

The meeting itself was -- I don't think "bizarre" is a strong enough word to describe it, really.

There were seven of us including my colleague Dr McGuigan who joined us two or three months before who hadn't been with us whilst these events were taking place and I -- I don't think these minutes really reflect the tone of the meeting.

Ian Harvey didn't actually show us any extracts of the report. He gave us some bullet points in which my understanding, and certainly I think my colleagues' understanding, was that there was evidence of deficiencies in care.

Q. Go back to page 1 for those, just to see how the minutes summarise it. Sorry. Carry on.

A. There were issues around -- so it doesn't really say what he said there. There were issues around leadership and escalation and there were issues around relationships with nursing staff. He also said that the Casenote Review hadn't identified anything and I think he used the term "no smoking gun" quite frequently.

So essentially what we were told first was that the Casenote Review hasn't suggested anything any foul play the service reviewers highlighted a number of issues that need addressing but there's no single unifying factor and then Mr Chambers then -- and this is where it became very odd -- started relating to us how there was evidence from the grievance procedure that we had treated Lucy Letby very badly, how she had -- how she would have good grounds to report us to the GMC for some of our behaviours, how he had had to have extensive discussions with her and her family to apologise for her behaviour.

It was -- it was strange because he was almost suggesting that he was somehow our protecter because if it hadn't been for him, we would have been reported to the GMC.

Q. So it moved from this report of the RCPCH

conclusions or highlights from Mr Harvey straight into what --

A. Yes.

Q. -- they had to say to Letby and her family and what you should be saying?

A. It was more about the grievance I think than the RCPCH report and I think it says in the first page about I think Mr Harvey is talking about the findings of the reports and the grievance report being triangulated which is interesting -- we might cover it later on -- about sort of interpreting all those things together.

What -- so we weren't expecting this at all. We -- we did not know that this was going to be part of this meeting.

And then we were, we were, we were told that, you know, she's coming back, you will have to work with her. Some of you -- he didn't say who -- will have to undergo mediation and again, I recollect this clearly, I think other colleagues will, he said: I am drawing the line under it, you will draw a line under it and if you cross that line, there will be consequences.

Now, the difficult thing here, we kind of -- I think I asked for one clarification when Ian Harvey did his first bit and I said to him: are you suggesting that these events are related to poor Consultant care?

And he didn't really answer directly, he didn't say yes, he didn't say no. Because we had agreed that we wouldn't say anything when Mr Chambers made that remark we -- we didn't say anything and it was very difficult because we were all just absolutely blindsided by this.

Then he said "I think we need to hear from her". And I thought at this point Lucy Letby was going to come into the room but Karen Rees then read out a statement from Lucy Letby to us which was a very -- assertive, you know, perhaps even, you know, cocking her nose at us, I don't know, but we kept quiet but -- and I think I have seen the statement in my pack.

But I -- and this is the non-verbal stuff. I remember that being read out and I remember the tone of it being it was almost like triumphant and the look from Karen Rees and Alison Kelly almost as if: right, we have got you now.

Okay, you know, maybe -- maybe I am just being lily-livered but it was -- it was very strange because I was thinking: why is this happening now? Why is this happening in this way? And it struck me that that meeting had probably been choreographed in some way and then it went back to around mediation although we were --

Q. Could I pause you there now just for a moment.

So when you were talking about the RCPCH statement you tell us in your written evidence at paragraph 590:

"From early January I spoke on more than one occasion to Ian Harvey as to when we would be allowed to use the RCPH and forensic review reports. He never gave me a clear answer but he suggested that the Trust would make a public statement in February 2017 and I and my colleagues could see the reports after this."

At paragraph 596 you tell us:

"Ian Harvey gave us what he described as some 'headlines' from the reports. He said there was evidence of poor clinical practice that might have contributed to the deaths, evidence of poor team working and evidence to suggest inadequate staffing and higher acuity contributed to the deaths. He said there was no evidence to suggest Letby was related to the deaths and there was 'no smoking gun', which he clarified meant no single causative factor identified, but that were lessons to be learnt and improvements to be made."

Finally at 643 you say:

"It was not made clear that the issues raised in the report about staffing were long-standing issues and pre-dated the rise in a number of deaths. It was also not made clear that these staffing issues were not unique to the NNU and Chester and were common to most

other Level 2 units in the area."

When you were in the moment of course you hadn't seen the report, so when he made those assertions about the impact of staffing, and that the report seemingly might have contributed for some of the deaths, that is how it was being summarised to you, were you in a position to respond on the detail of those points as you are now in the way they have all been set out?

A. At that point, in not as much detail, because although it didn't chime with anything that I had recalled reading in the brief sight of the draft report in November, because had those issues that Mr Harvey was raising been discussed, both myself and Dr Brearey and Anne Murphy would have most certainly noted and commented on them, it didn't also fit with the feedback informally given to me I think on 9 September or 8 September by Mr Harvey, when he had intimated that they hadn't found any significant concerns about clinical practice that needed immediate action. And it didn't also fit with the email that Stephen Cross had sent to the chronology and sent to me where he said in that that the College hadn't identified any significant issues around clinical care.

We didn't again in the meeting query it because we didn't actually have the documents in front of us to

counter it. And at the end of the meeting, we went back to our offices and talked together about how we move forwards and we felt that we couldn't really move forwards without actually seeing the two reports which were being referred to.

Q. Now, can we go, please to INQ0003095, page 1. And this is a letter, 30 January 2017 from paediatricians to Mr Chambers, agreeing:

"... it is appropriate for us to send a letter of apology. Although it was made clear that the Trust board has drawn a line under this issue, we would be grateful for written clarification on the board's understanding on the reason for the increased number of unexpected and unexplained deaths between June 2015 and July 2016 and the actions that you now intend to take."

We understand, so I am just dealing with the grievance point at the moment, how was it you said at this point it is appropriate to send a letter of apology to Lucy Letby? First of all, did you know what you were supposed to be apologising for?

A. Well, no, so we didn't know what we were supposed to be apologising for apart from our bad behaviour but we didn't know what that bad behaviour was. There had been a series of emails between us and also involving Dr Tighe, Consultant anaesthetist, who

was the BAPM local negotiating committee rep, about what we should say.

He had advised -- I think he described as a qualified apology in the sense of we are sorry --

Q. We have heard from Dr Tighe --

A. -- that you felt --

Q. We have seen how you effectively arrive at something that doesn't say that you have done anything?

A. Not admitting any liability but it is very difficult to admit liability when you don't know what you have done.

But we were aware from the tone of that meeting that, you know, these were preconditions for us continuing and we were, you know, continuing in our jobs, continuing doing what we were doing. And also we wanted to move on so that we could start the process of the unit being regraded back up from Level 1 to Level 2.

There was -- it was, if you like, a Cabinet decision. There was disagreement, some Consultants were uncomfortable with that comment about the letter of apology particularly when we didn't know what we were apologising for. But I personally felt, you know, Dr Tighe's advice it would probably be prudent to follow that, if you like, sort of, you know, shorter term pain perhaps, for longer term gain.

Q. 3 February 2017, if I can move forward. We know each Consultant received individual copies of the RCPCH report in sealed envelopes, that is what you tell -- and they had to be collected and signed for from the Executive office; is that right?

A. That's right.

Q. That is quite extraordinary, isn't it, in the modern age?

A. We after the meeting on the 26th wanted to see these reports, we were told: you can see them once we have made our public statement.

We actually -- we were just thought it was completely inappropriate. We actually contacted -- I don't know whether we all did, I know I did and Dr Brearey contacted Sue Eardley from the RCPCH to say: look, you know, they are not letting us see the report you have done on our service and I think -- I don't know what the deciding factor for them to allow us to see them was, but it was I think influenced by Sue Eardley.

Q. Did you see a redacted version? You have now seen through the Inquiry the version --

A. The version --

Q. Disseminated version and the confidential version, so what did you see?

A. The version we got was a redacted version and

it was quite clear really just reading it that there had been redactions. We weren't told it was redacted but it was quite clear I think it was either section 3.10 to 3.11 or 3.11 to 3.12 where the second section, the line started something like "in response to this allegation" but no allegation had been mentioned. So it was clear to us that there had about there had been redactions, but we didn't know and we did point this out.

Q. You have now seen that section about the nurse?

A. Yes.

Q. That whole page, 4.4.1, did you see that?

A. Not at that time, we had to ask specifically for those sections. But we were allowed to see that but they still hadn't released the Casenote Review to us.

Q. Dr Hawdon's review?

A. Dr Hawdon's review, yes.

Q. If we go to INQ0107964, page 77, this is an email, "Dear colleagues", from Mr Chambers on 3 February. We are not currently clear who this goes to, it is the same date you all pick up the report.

Is this with the report or where have you seen this before, if you have seen this before? I mean outside the Inquiry, I know you will have seen it in our process.

A. I don't know whether this was a something to all employees of the hospital, whether it came round in an "all users" email. I don't think it was specifically to us as paediatricians. At this point, what was the date that we had the RCPCH report released to us.

Q. 3 February?

A. So the same day.

Q. Paragraph 630?

A. So it's the same day. You know, he's essentially reiterating what he told us on the -- and Mr Harvey had told us on 26 January; that there's no single cause or factor identified.

Now, I can't disagree with that because actually when we saw the Royal College report it didn't identify a single cause.

So that's not strictly wrong. However, the Royal College report did not address the specific question of our specific concern around Letby and whether her association may have been significant and that, when we finally saw the report, was really worrying because -- and this is before we had seen the Casenote Review from Dr Hawdon's -- it was being interpreted in a way to almost avoid the question that we had asked and actually it was interpreted, I realise now, in a way they took it to, to indicate and prove

that the suspicions and concerns we had had been -- had been -- had been shown not to be correct, whereas actually in my opinion there was a lot of very important observations made in the review which I wouldn't disagree with, but it hadn't addressed that issue one way or the other.

Q. The apology letter now, if we can go to it, INQ00031870001, this is the apology letter that was sent from the Consultants but we have seen from the evidence that the investigation received any inappropriate comments that were made at that time weren't made by any of the people that signed that.

A. No, but I suppose as Consultants we take responsibility for our trainees, or whoever said them.

Q. Dr McCormack found himself sending a letter of apology for something?

A. Yes, I found that bizarre.

Q. Don't worry, I will ask him to comment on that. But there was another Consultant who did the same and he has commented on that. If I can ask you to go to INQ0006424, page 2?

A. I think just to say about this letter of apology, the context of this when we had been told that you are drawing a line under it and if you cross that line there will be consequences was ringing very loudly

in our ears. You know, what -- what those consequence were were never explicitly raised although the talk of GMC and referrals was explicitly raised.

So I think that probably perhaps informed my view on writing some kind of letter at this stage along with Sean Tighe's view on it in that it was a self-protection thing at the time without sort of admitting liability.

Q. So the sequence here is you have raised concerns about baby safety, there's a grievance, and in response to the grievance effectively you are being told there could be a referral to the GMC; I am just trying to understand the HR sequence?

A. Yes.

Q. That is what's happened here?

A. Yes.

Q. Now, if we can just look at this letter.

Mr Harvey says:

"I gather an apology letter was forwarded and would like to thank you for that. I repeat my comments of yesterday that we must separate concerns and reviews from the grievance procedure."

And he says at the end:

"I think this gesture would go a long way to protect you from a possible referral to the GMC from other parties which, having supported many doctors who

have done no wrong even then isn't a comfortable process."

So a suggestion that doctors may be referred to the GMC when they have done no wrong but --

A. I don't think it was so much even if you haven't done anything you would be reported, but doctors do get reported to the GMC and the GMC process, having had friends and colleagues who have been through it, is a deeply unpleasant process and quite often the doctors who have been reported are found to be exonerated.

So I don't -- I don't think he was necessarily saying to me: I know you have done no wrong.

Q. No.

A. But I think what he was suggesting because one of the things that had been discussed amongst other things in yesterday's meeting, which the email refers to, is around the mediation that was being set up.

Q. Well, let's look at the letter at page 1, same enclosure, Mrs Killingback, page 1. This is your response which addresses the mediation issue. You say at bullet point 3:

"We have been asked to engage you and Steve Brearey alone in the mediation process. We suggest all seven Consultants should be part of it."

You say:

"There are still no clear explanations for at least eight of the unexplained collapses and deaths."

You are using "unexplained" and "collapsed" certainly much more clearly by this point, Dr Jayaram --

A. Yes.

Q. -- in terms of your use of "deaths" as opposed to "unexplained deaths". But you are coming back and saying you have no answer for these deaths yet, unexplained deaths?

A. Yes. So the meeting to which this email refers was a meeting with, between myself, Stephen Brearey, John Gibbs, Ian Harvey and Nim Subhedar from Liverpool Women's Hospital and Ian Harvey had arranged the meeting because he had seen -- by this time we had been allowed to look at the Jane Hawdon's Casenote Review and I think Jane Hawdon initial conclusion that she I think explicitly said "there are four cases that I still think are unexplained and need further detail or forensic review", I am paraphrasing a little bit.

When we looked at a group we felt that there were at least another four babies where, in our view, even though Jane Hawdon felt or reported from her analysis that they were explained, that they weren't.

So the meeting that was arranged to which this

email attempts to be a summary was arranged by Ian Harvey because he told certainly me that he had been tasked with feeding back to the Families of the babies whose case notes had been reviewed what the conclusions were from which I assumed that the Families knew that this was happening.

But he wanted sort of guidance from people with experience of neonatology to understand what this meant and what to say and our -- we went through all the cases and we said to him: actually we don't think you can give any firm conclusions to any parents at this point in terms of our interpretation because we still think -- it already says there's four that need further forensic review and to our minds, even thinking about it conservatively there are at least another four where it can't make sense.

So in this email, I --

Q. You say you can't see any effective mediation could take place, I see that in that context.

A. Yes.

Q. Can I ask you to look at this document, please, as well, INQ0107964, page 13. You then write to Sue Hodkinson and tell her, we see it on the screen at paragraph 2:

"The mediator told me this was an entirely

voluntary process and I am under no obligation to engage. This is at odds with the impression given by both Tony Chambers on 26 January when he stated quite clearly that the board had a plan which we expected to follow or would be crossing a line. I have seen no minutes of the meetings [and then you say] now in terms of their depth and also by Ian Harvey who intimated that by not engaging I could increase the chances of being reported to the GMC for whatever I am alleged to have done."

So you take that point up. This is when the mediation was being planned that you begin to appreciate this is voluntary, in fact, with Sue Hodkinson and you ask for a meeting and we see one happens with her on 15 March at 2 o'clock. If we can go to that at INQ0003219, page 1.

Can you see there meeting 13 March and over the page, look at the top?

LADY JUSTICE THIRLWALL: 15 March.

MS LANGDALE: Sorry, 15 March. If we go to page 4, in this conversation, you are discussing your concerns about Letby, you say all circumstantial then you remember three occasions when there were concerns.

What were the occasions that you set out there?

A. Certainly the issue which we discussed earlier

on about the chest drain. I think the first reference is Baby K. I can't remember what the third one was. But it would have been one of the patients I -- I personally was involved with.

Q. Sorry, go on.

A. That was it.

Q. Yes. And another, a valve at a different setting, it was explained it was a mistake when she was looking after the baby?

A. That was -- that is -- that was the discussion around the issue with the closed valve on the chest drain.

Q. Was that Baby H that you discussed earlier, or you can't remember.

A. Yes, the baby we discussed earlier on was Baby H.

Q. And the third?

A. I can't remember which baby that would have been.

Q. Had you had many conversations at all with Sue Hodkinson before in her role as Director of People?

A. I had met her sort of informally at a number of meetings. The first I got in touch with her the main reason, initially I got in touch with her was around my discomfort around the mediation. So when I had been

discussing with Ian Harvey about whether it was appropriate for me to engage with mediation as he had said in his email he strongly advised me because it might reduce the chances of getting referred to the GMC, he mentioned to me that the mediator would be able to advise whether it was appropriate. Now, I really had no understanding of how mediation worked.

In retrospect it was an entirely inappropriate line to go down because mediation is when issues are resolved and it is just for clearing the air, so people can work with each other. But having been advised firmly to engage with the process and I did and of course when I met with the mediator, I forget her name, she was from another NHS Trust, I explained the background of things and why I had concerns around whether this was appropriate and said to the mediator I was told by Ian Harvey that you would be able to advise whether this was appropriate.

She, I think quite rightly I guess from her point of view as a mediator, said no, I cannot advise you, that is not what I am here to do and I said to her: well, that is not what I was told, but then she said it is entirely voluntary. And it was just that whole -- none of this was making sense, you know, it had been suggested by Tony Chambers that we had to engage in this

or there would be consequences.

So the reason I got in touch with Sue Hodkinson was that after that meeting, because I wanted to ask her whether she felt this was appropriate or not and what it was all about and that one-to-one meeting then obviously extended.

Now, I can't recall but I -- I can't recall whether Sue Hodkinson was at that meeting on 26 January or not, so I don't know whether this was the first time that Sue Hodkinson had heard any of this and I had no awareness at this point of Sue Hodkinson's involvement in the matters around Lucy Letby's redeployment and proposed return either.

Q. You emailed her subsequently on 30 March after the mediation INQ0005850, page 3, if we go to page 3/4.

A. So this was following the face-to-face meeting that I had with Letby and the mediator. So just some context. I, after the discussion with Sue Hodkinson, felt on balance I probably ought to engage with that meeting.

I had asked Sue Hodkinson for some detail prior to the meeting of exactly what it is I was supposed to have said or done to indicate the -- the previously described bad behaviour and she had initially agreed to give me some information but actually at another meeting there

was another meeting the evening before this and she said "I will give you some information after that" and she didn't.

Now, actually at the time this meeting took place with Letby there had been a meeting the night before with Ian Harvey and Tony Chambers, the outcome of which I and my colleagues understood was that it -- our concerns would be escalated to the police.

So I came to this mediation meeting knowing that. So the way it worked, I was asked to write a statement to read to Letby. I -- I wrote something, it was probably along the lines of the apology letter I don't have -- it was a handwritten statement, I don't have a copy of it at all.

But what was very interesting are the things that Letby was telling me because she told me that she had evidence from her grievance that myself and a colleague, presumably Dr Brearey, and I have put it in the email, orchestrated a campaign to have her removed; I and a colleague, presumably Dr Brearey, had given an ultimatum to the Trust that if she wasn't suspended we would call the police. And she was telling me that she was coming back next week whether I liked it or not, would I be happy working with her.

And I -- I again it was another meeting where I you

know, it was, it was I know, "Kafkaesque" is over-used but it was a bizarre meeting and I sort of bit my tongue and gave some very non-committal answers. But when I came out -- I -- I don't often get angry but I was angry because I felt that everyone was being misled.

I actually, I can't remember, I think I said to Letby, you know, you are -- you are just being manipulated. But what -- I wanted to know what evidence there was for these things that she was saying I was alleged to have said.

Q. Pausing there, just moving back to the comments. That can come down, that letter.

The meeting you had with Sue Hodkinson, INQ0003219, page 2 you tell her and say to her that you feel the board are more worried about an employment claim worth hundreds of thousands from the member of staff concerned than patient safety and Ms Hodkinson added they are supporting the member of staff to return to the unit.

You say -- it's 0003219, page 2 -- at the bottom you added again that you are:

"... concerned the board has been misled. Have the board been assured that the information is sufficient?"

So you were raising that issue then.

A. Yes.

Q. That can be taken down.

Can I move to a different topic, please, Dr Jayaram it is about information provided to the chronology generally and it may be you can't help very much here, it may be you can I just want take you through some emails. The first is INQ0107964, page 80.

So this is February 2017. You will see there are three deaths in two families that are unascertained.

This is Mr Harvey to you:

"... which is where I think confusion over numbers comes from. Stephen and I are meeting the Coroner tomorrow and it goes without saying that they have to be careful ... any pronouncement of causes whilst Inquests are pending. Ultimately it is for the Coroner to decide cause."

And he continues:

"I have had further correspondence with Jo McPartland and Jane Hawdon re issues such as mottling and air embolism which don't feature in this case review but this will be discussed as part of the meeting. The papers will be available later in the morning."

We also see, so you can comment in one sequence, if you like, Dr Jayaram, INQ0003159, page 1, a letter to you from Mr Chambers. Paragraphs 2 and 3:

"The Trust first advised the Coroner of Cheshire of this matter on Friday, 8 July and has subsequently kept

him informed of developments. I confirm a copy of the report was shared with the Coroner on 20 January 2017 following which a meeting with Mr Rheinberg, the Trust Medical Director and Director of Corporate and Legal Services was held on Wednesday, 8 February to ensure that the Coroner was fully briefed on all matters."

A. So the background to us asking them to talk to the Coroner comes back to post the meeting on 26 January and we how can we escalate this who can we talk to? And one of the things that was discussed, should we go to the police, Dr Tighe suggested that maybe we should ask the Executives to explicitly -- not for us to do it directly, but to ask the Executives to specifically raise our specific concern to the Coroner.

Q. We have got the letter, while you are saying that we can put that on the screen, your letter, INQ0003117, page 1. 10 February.

A. Yes.

Q. So carry on, Dr Jayaram, we see there at paragraph 2:

"... requesting you urgently to ask the Coroner to undertake a full investigation of all..."

A. Yes, and again this was -- we were -- we were struggling to know where to go next. And we thought well, actually the Coroner should have a degree of

independence. Obviously I had been to one Inquest and what we wanted or what we, what we hoped was that if they spoke to the Coroner, when they spoke to the Coroner they would explicitly raise the specific concern that we had been raising about Letby to the Coroner.

And as I say, we have kind of outlined and again this was a letter that was -- had a number of iterations and it was agreed by -- by all seven colleagues. We highlighted the fact that the RCPCH College review was all very well but didn't address the specific issue. We also felt that Dr Hawdon's review which identified four babies that required a broader review we had identified in our view more than that.

I can't remember what the other points we made were.

Q. Don't worry about that.

A. Yes.

Q. It is the Coroner point I am interested in.

A. Yes.

Q. If we can go to the next reference, please, INQ0003395, page 1. This is a letter from Mr Harvey to -- sorry to Dr Brearey, yes, from Mr Harvey. So he confirms:

"... you have each had a letter from Tony Chambers but I was able to give more detail and confirm

Stephen Cross and I had a detailed conversation with both the Coroner and the Deputy."

He continues in that paragraph:

"I was able to confirm that not only had we given the Coroner a copy of the recent letter from you and your colleagues which highlighted your concerns, but Stephen and I also discussed this at length with them."

So this is 6 March, your letter has been sent 10 February:

"The Coroner told us we should not necessarily expect a response from him. He also informed us that his role wasn't to QA hospitals."

Quality assure, is that?

A. Yes, I assume that is what that means.

Q. "I mentioned the conversation with the Coroner because John seemed to get significant assurance from the detail that Stephen and I had gone to with the Coroner when I spoke with him, although I accept that, Ravi, you did not feel the same way."

"John" is presumably John Gibbs?

A. Gibbs.

Q. Mr Harvey told Dr Gibbs and you how much he said to the Coroner. What did you understand had been shared with the Coroner through this?

A. Well, again second-guessing.

Q. Try not to guess, do your best. You have seen the documents, what do you think?

A. No, no, working back from the Coroner's response was: it is not my role to QA hospitals. If the information that was shared with the Coroner to my mind was what we had wanted to be shared with the Coroner, it didn't seem like it was --

Q. Quality assurance?

A. -- an odd -- it didn't seem like it was an appropriate response, which immediately raised the question what was actually shared with the Coroner.

Q. Or what did the Coroner understand from what had been shared?

A. Yes.

Q. But you never had a direct conversation other than this correspondence about what had been shared?

A. No.

Q. You knew there was a meeting, you knew that your letter had been shared?

A. No.

Q. But you had clearly requested that.

Thank you, that can go down.

There's then a meeting, a paediatrics meeting 27 March, INQ0003150, page 1. And you tell us that your understanding of the purpose of this meeting on 27 March

was to give the Consultant paediatricians an opportunity to explain the reasons for their ongoing concerns to Mr Chambers in person with support of the neonatal network.

A. That's correct. So there had been a lot of letters going backwards and forwards. One of the things that I raised in my discussion with Sue Hodkinson earlier in the month was that it would be very useful to actually have a face-to-face meeting to actually in real-time discuss our concerns and get responses.

I remember suggesting that she might be there to mediate, maybe even use a yellow card/red card system to try and keep things on track. I think I also recall saying I would prefer it if Ian Harvey wasn't there because I lost faith in his judgement by this point.

But my understanding of this meeting was that it was set up following my meeting with Sue Hodkinson so that we could in detail discuss our explicit concerns with Tony Chambers, having had the opportunity to digest the Royal College review, the redacted parts, and the Jane Hawdon review as well and we felt that it would be important to have representatives of the neonatal network present as well.

Q. If we look at page 2, we see Dr Subhedar, fifth box down, says very clearly:

"The cluster caused concern, the College review is a service review, not case note and followed up with further detailed review. In-depth review for more than four cases. The standard needs to be external to some degree."

So at the end, page 7, you say in terms:

"We appreciate your time, thank you for listening. one of our colleagues will not have her baby here ... other colleague has expressed concern. We fully understand the implications and impacts."

A. That was with reference to --

Q. You don't have to tell me who or what.

A. Sorry.

Q. The fact is you are now as a group you have brought in somebody external to the network, Dr Subhedar, external to the hospital and you are saying your own colleagues wouldn't want their children delivered in that hospital?

A. That's correct.

Q. That is the force of your level of patient concern?

A. Yes, and --

Q. What -- not looking at the notes but what's the sense? Do you think that's been taken on board, is there real listening to that?

A. So this meeting was -- we were under the impression it was within a few days Letby would be returning to work although it hadn't been confirmed. We decided before this meeting have discussed with colleagues that we would explicitly say we just need to talk to the people who are the only people who can look at this forensically which are the police and if we were able to express what we were concerned about to the police and the police had said no, there's nothing to see here, we don't need to be involved, we would have stopped at that point.

But we just didn't feel at all that to this point, in spite of raising these things over and over again the specific concern had been acknowledged or investigated properly.

Q. We then see at INQ0107964, page 172, Dr Gibbs sends you all an email saying that Mr Harvey had come along to look for you or Dr Brearey but you were both in clinic. Paragraph 2:

"Anyway Ian's message is that discussions about involving the police have been held with a senior criminal barrister, didn't get his name. He would like to meet us to discuss our concerns to advise on how those might be addressed from a legal perspective. He would like to meet as many of us are able to attend."

If we go to INQ0103211, page 1, Dr Brearey responds: there is a degree of urgency about this. Middle of the page:

"The rationale for this meeting that you communicated to me yesterday was so that the barrister can let you know the best way of informing the police after getting a better understanding of the cases from us and not sure therefore why we will all need to be at this meeting."

It is obviously difficult to get you all together and you thought it was about who you should speak to.

You get INQ0107964, page 18. The bottom email, Mr Harvey responds:

"As we discussed, none of us has been in this position before and it about doing it in the best way possible, therefore we consulted with someone experienced and active in criminal law both as barrister and judge. I must stress Mr Medland's independence. I think you will be assured of this when you meet him. It is his advice that he meet with you to fully understand and explore the basis for the concerns to help frame the approach since letters only convey so much."

We then know -- if we can have on the screen, please, INQ0005857, page 1, there is a meeting between

Simon Medland QC, 12 April 2017 and certain Consultants at the hospital. These notes set out his minutes of the meeting. I think the meetings is described somewhere one and three-quarter hours. It is a long meeting, isn't it?

A. It was a long meeting.

Q. We see at paragraph 5:

"The minutes record we all agreed if there was an identifiable common thread between some of the deaths (cf Beverley Allitt) then this would be powerful prima facie evidence that there was potentially a crime or series of crimes which had been committed."

So Beverley Allitt's case was discussed in this meeting?

A. Yes.

Q. Who raised that, can you remember?

A. I can't remember whether it was Mr Medland who mentioned it first or whether one of us made the comparison.

Q. He then gives the advice at paragraph 6, or view:

"The police being strapped for resources can only sensibly investigate cases where there is at the very least reasonable grounds for suspecting that a criminal offence has been committed. He emphasised that this was

very different from there being mere suspicion and also very different from where they were questions about hospital procedures and processes as distinct from criminal actions.

"SM remarked that officially reporting any matters to the police was a [unclear] step which was effectively a public action and would incur adverse publicity and raise matters for the families of the neonates which might be seriously disturbing."

Pausing there, was this given -- that advice given that at the very least reasonable grounds for suspecting criminal offences being committed? Was that what you accepted at the time or thought was the position?

A. Just to roll back a little bit. My understanding and my colleagues' understanding following that meeting at which Nim Subhedar and the other representative from the neonatal networks was present was that we requested that the police be involved and they were going to involve the police. We were then told a week later that a barrister was going to come to talk to us and Ian Harvey had said: it's to help the Trust frame what we say to the police.

We as a group all felt this is just more fudging and avoidance and we -- I think if we go back to the very first or second paragraph of this we said we would

ask Mr Medland before we said anything what he felt his brief was and that was really interesting because what he had been told or what he told us he had been told was very different from what Ian Harvey had suggested to us his role was in that to frame going to the police our interpretation, or certainly my interpretation of what Simon Medland said there was: still don't know if it's worth going to the police, they have asked me to see if there is anything worth going to the police with.

So of course right from the start I think he's starting from a position that there's nothing to see here. So can you go back to the paragraph, sorry, you asked me about?

I mean, I don't think any of us used the word "prima facie"; that is a very legal term.

Q. Don't worry, I am not asking about that.

A. We agreed that, you know, if there was an identifiable common thread, well, there was an identifiable common thread; it was Letby. Which is why we had been raising these concerns all along.

Q. In terms of -- that can come down now, please, and can we have INQ0006136, page 1. This is your email, Dr Jayaram, to Mr Harvey and others expressing what you have just said now, about whilst you agree the minutes you hadn't had that respective understanding of the

purpose of the meeting, you thought it was simply to frame what needed to be said to the police whereas he told you it was to discuss whether there was enough in articulated concerns to make reporting to the police worthwhile.

Either way, it was very soon thereafter that it was reported to the police, wasn't it, and if we see at INQ0107964, page 22, you set out there --

A. So this was in our Consultant WhatsApp group. So Dr Brearey was away and myself and my colleague Dr Susie Holt went to the meeting and this was to summarise to colleagues this was sort of straight out of the -- straight out of the meeting what the outcome had been and my -- my overwhelming I think emotion at this point was relief. I mean, almost bizarrely, you know, a sense of joy because someone had actually taken the trouble to listen to the things we were saying.

Whether we were right or wrong somebody had taken the trouble to listen to what we were saying at the very least felt it was worth looking a bit further to see whether there was anything. And as I said, you know, if this process had happened and then they had said there's nothing, we felt that we would have -- we would have fulfilled our duties of care and it was, it was surreal -- I use that word a lot -- because after this

whole several months of being told that we were the problem, it was the first time that I felt that some progress was being made and I -- I do remember sitting in that meeting with the CDOP team and I just remember Ian Harvey and Stephen Cross sort of the look of shock on their face really because I don't think I can't speak for what they were thinking, but I don't think that they were expecting that to be the outcome of this meeting.

MS LANGDALE: Thank you, Dr Jayaram.

My Lady, this may be a good moment to take the short break.

LADY JUSTICE THIRLWALL: Very well, 10 minutes?

MS LANGDALE: 10 minutes, 20 to 4.

LADY JUSTICE THIRLWALL: So if we could start again please at 20 to.

(3.28 pm)

(A short break)

(3.40 pm)

MS LANGDALE: Dr Jayaram, just a few more questions from me.

INQ0107964, page 0239, please. This is a letter to Mr Chambers from the paediatricians to explain the context, there's been a newspaper article, the police have been brought in at this point, the RCPCH review and this appears, and you all respond to say that the

article reports that Mr Chambers said:

"There was just a few niggles that our clinicians said: look, we think we have got 90% of the answers but there are still bits that we need to in a sense be clear that we have not missed anything."

Well, what was the purpose of that letter? What were you concerned about, all of you?

A. We were concerned -- so I think this was an article in the local paper and a journalist had interviewed Tony Chambers and asked about why the police eventually became involved and this was the reported response.

And given all the concerns that we had raised, the push back that we had, the fact that a police investigation had been going on for several months at this point to describe our concerns as "a few niggles" and we just need to be sure we have not missed anything was insensitive and disrespectful to us and the Families of these babies, because these were not niggles, these were significant concerns and we by this stage were -- the tone had slightly changed in the sense because the police were involved, I think there was an element of Tony Chambers and colleagues perhaps trying to create a picture of saying: we were always going to go to the police anyway, it just needed to take time.

But it was that thing about niggles, it was, it was just -- you know -- absolutely -- I am trying to think of the word -- it was -- it was demeaning. That is not the word I am thinking of, but it was just demeaning to our concerns.

So we wanted to flag this up again as a group and just to sort of really get him to explain why he had used those words that were reported to have been said.

Q. Thank you, that can go down. INQ0107964, page 213. Also February time. This is an email to you from Sir Duncan Nichol:

"However events unfold following today's release, I will be standing with you. I do understand how very difficult this is for you and your colleagues and I want you to know that I am personally here for you, as I will be for any member of the neonatal unit."

What was the release on 8 February, was that that article or is that something else?

A. No, I think that no this is a year before.

Q. Sorry?

A. I think this is when the Trust were making their public statement on the findings of the Royal College review and the Hawdon report.

Q. If we can go to INQ0006681, page 1. 26th:

"Further to your meeting with Ravi Jayaram on

26 February 2018, we remain extremely concerned that our relationship with the Executive Board has deteriorated significantly and no meaningful efforts are being made to repair it. Working in this environment is not conducive to good clinical practice and we would be grateful for the board to acknowledge the problem and take urgent steps to improve this relationship in the interests of patient safety."

Was this the first time this had been put in writing to Sir Duncan, as far as you were aware?

A. I think as a group it's the first time things have been put into writing with Sir Duncan.

Q. When roughly had you first had discussions with Sir Duncan about it?

A. I had -- I had met with Sir Duncan intermittently in 2017, not specifically to discuss this issue.

Q. Doesn't matter if it --

A. I think really from -- I can't remember -- there is a whole series of emails that I've referred to in my statement and the exhibit bundle, but the meeting I had on 26 February was a -- there was -- I can't remember if it was that one. It was a very difficult one where he and I were in my office. It was quite emotional because I articulated to him that I felt that

he had not taken our concerns as seriously as he should have done.

Q. Was that 2017, are you talking about February 2017 or 18?

A. No, I think this was later on.

Q. Later, 18?

A. I can't remember, I would have to refer to my statement. But the meeting referred to here was very much a case of because the police investigation had been ongoing, we had had very little interaction from that point with anybody from the Executive board. Now I appreciate now that it may be that Operation Hummingbird had said to the Executives "don't say anything to the paediatricians for fear of contaminating evidence".

But we also knew that the Executive board or members of the Executive board were having reasonably frequent contact to update members of the nursing staff yet we were getting absolutely nothing and we didn't know where we stood. We wanted to start making moves to think about regrading the unit back-up to Level 2 status again.

We had as a consequence of everything that had happened through June 16 onwards, absolutely no faith or trust in the Executive board. And of course one of the

most difficult things is we -- we go to work every day doing a high risk job and you want to be assured that the people who run the organisation will support you.

Now, doesn't mean cover up for you, obviously, fair's fair, but you want to know that they have got your back. And we, as a group, felt we were in a situation where we were not only walking on eggshells, if the moment anybody put a foot slightly wrong we were potentially at risk of detriment to ourselves.

Q. We see at INQ0107964, page 263, another email from Sir Duncan Nichol to yourself. It looks as though that meeting as you says, is 26 February, was when you met:

"High on my agenda [he says] was concern about the damaging breakdown. So the board understands the problem exists and will press for it to be resolved in the interests of the patients. I welcome an early meeting."

There was a meeting, wasn't there, on 30 April 2018 between Ian Harvey, Mr Cross and the paediatricians?

A. Was that just myself and Dr Brearey? Or was that with all of us?

Q. I think it was just yourself?

A. Yes.

Q. And 26 questions -- actually, I'm not sure

about that, Dr Jayaram. But basically you put 26 questions together, didn't you?

A. Yes.

Q. So there were 26 questions that you wanted answers from that couldn't be given in the meeting and we know subsequently you got answers I think from Mr Chambers and then you did another table with answers to the answers, if I can put it like that?

A. Yes, observations on the answers.

Q. I don't need to take us to those, but your observations.

So there was detailed documentation going backwards and forwards and Stephen Cross asked for an electronic copy which he shared with the Exec Team.

25 May, you tell us in your statement at paragraph 872 you had an informal and unplanned meeting with Sir Duncan.

"I was frank with him at my disappointment that we had not yet had any responses to our 26 questions, that I felt he was sitting on a fence and although he had listened to us I told him that I believed that his ultimate priority was not to ruffle feathers. I also expressed to him I did not believe that Tony Chambers was a fit and proper person to lead any NHS organisation."

A. This was the meeting that I remember as being a very emotional meeting, not the previous one.

Q. So the May 2018 one.

What was his response to that? If it helps there is another email dealing with that and he does express -- I don't need to put it up -- at 0292:

"I want you and Consultant colleagues to know how deeply sorry I am for the personal distress that you have and are all suffering and for my part in not intervening sooner."

Do you remember getting that?

A. Yes, can you remember what date?

Q. Yes 25 May at 5 pm?

A. 25 May. So that was his conciliatory message, as I have described it, in point 873, I think.

Q. Yes.

A. No, I do remember getting that and we then shortly after that got a written reply from Tony Chambers with answers to the questions which we then sat down together, digested and wrote back and then I emailed Sir Duncan, I have here on 4th July, to discuss the concerns we had around Tony Chambers's responses and I think as a group, when we had the responses to our questions, as the document shows, which tabulates it, we have made annotations but most of the

responses weren't -- weren't really answers to the questions that we had. They were -- they were answers to other questions that we hadn't asked or were quite evasive.

Then there was a meeting with Sir Duncan Dr Brearey and myself in early July which was after the first arrest had been made and we as a group at this point were struggling because we did not have faith in Tony Chambers. I articulated it before, and I can't speak for colleagues, but I think we all shared the concern that I had raised previously to Sir Duncan, that he was not a fit and proper person to be running any NHS organisation.

We had started having discussions about the Medical Staff Committee so the Medical Staff Committee is essentially the group of doctors employed by the Trust, mostly Consultants but also career grade doctors, so doctors who aren't in training. And we wanted -- given the confines of the police investigation, we wanted to flag up to colleagues some of the things that had happened and the obstacles that we had run into when we tried to raise concerns, but obviously we had to do that in a way that wouldn't compromise patient confidentiality, wouldn't compromise the police investigation.

And Sir Duncan encouraged us to organise such a meeting. We had correspondence via Paul Jamieson, who was one of the anaesthetists who is Chair of the Medical Staff Committee. He was liaising with the police as to get some guidance as to how much we could disclose.

Ian Harvey retired around this time as well. And I think the meeting took place in September 2024 and we had a lot of discussion as to whether once we'd told our story, and we also wanted to hear of other people's experience as well, whether a vote of no confidence should be considered in Tony Chambers.

But as it was, he stood down on the afternoon that that meeting took place.

Q. Focusing on Sir Duncan again, if I may, INQ0107964, page 0269. An email from Dr Holt. If we look at paragraph 4. She reflects:

"Sir Duncan made it very clear he would not take and no could he/would he get us acknowledgement or apology.

"I feel Sir Duncan was very careful not to promise or suggest he would offer any feedback on their views on the issues discussed. I expect we will hear no more of this."

You had expressed that, now had she. Was there a concern that he wasn't descending into the fray, as it

were, and making decisions or determinations about what was the right thing here?

A. I think he was -- and I can't speak for him but my impression was he was juggling a lot of different priorities that he may have had as Chair of the Trust. I think what I have seen in much of the documentation I have seen as part of this process that I hadn't seen before, there was a lot of -- well, frequent reference to -- to reputational damage to the Trust and I think that that was a -- may be a driving force and I think that was probably one of the issues that sort of equipoise in which he was sitting that led to the discussion on 25 May being quite emotional and heated.

You know, we -- we wanted to make him aware and think we made him aware of the fact that we had absolutely no confidence or faith in the Executive board.

Now, actually the priority here is I don't care who's on the Executive board but I want to know that whoever is sitting on that board that I can trust because it helps me to look after patients safely and properly.

Q. Thank you, that can go down now.

We asked you, Dr Jayaram, as we have everybody for reflections and particularly how babies might be kept

safer in hospital today. You make a number of observations, one of them about whistleblowing at paragraph 944?

A. Sorry, what number was that?

Q. Paragraph 944 of your statement?

A. 944.

Q. You say it became clear to you very quickly following the verdicts in this case:

"It became clear to me very quickly that the behaviour displayed by the Executive Team at the Countess of Chester were by no means unique and that there seemed to be a clear pattern of management behaviours in response to escalating concerns. Initially dismissive responses from managers would be followed up by threats that the complaint was being unreasonable, aggressive or misguided. They were led to believe that they themselves were the problem and were subject to small passive microaggressions, such as, for example, not being offered opportunity for professional development, having theatre lists cancelled or being removed from roles on various hospital advisory committees."

So was that you broadening out your understanding of your own experiences to try and understand other experiences in the NHS?

A. Yes, so -- so following -- following the verdicts from the initial trial, myself and Dr Brearey received an enormous amount of correspondence from not only people who had worked or were working in the NHS but working in other professional organisations as well sharing their experiences of what had happened when they raised concerns. And I think certainly for me, as we were going through the process ourselves, it never occurred to me that -- and again my naivety, that those people in whom I put my good faith to pull in the same direction and do the right thing may not have been -- and it's been quite difficult this afternoon talking about all and reliving it all because I feel a sense of shame that I allowed myself for such a long time to be treated like that because of my -- my misplaced faith and to believe that maybe I was the problem and maybe I was making completely unfounded suggestions.

But when I started hearing from other people it suddenly hit me that there's a pattern and -- and hearing the descriptions of what other people had gone through I suddenly realised I wasn't, you know, although there had been talk of GMC and consequences of crossing lines I suddenly realised that myself and my colleagues had put ourselves professionally and personally at extreme risk and if I had known that, would I have done

the same? Well, yes, because ultimately it is about patient safety and I think what really struck me, and I think this is important, that we were very lucky, I was very lucky to work with a team of Consultants who, yes, we would disagree occasionally but we supported each other and trusted each other.

And I think there were -- and this may come out in your further inquiries, there were attempts to sort of try and divide us and play people off against each other but ultimately it's because there were seven of us who all had the same concern that we managed to stick together.

But I think I never -- I never considered myself a whistleblower and actually I wasn't aware of any formal whistleblowing policies at that time. You know, I was aware vaguely of the existence of Freedom to Speak Up because it had been put in after the Francis report.

I was also aware I think that Alison Kelly was the Freedom to Speak Up Guardian at the time and it never occurred to me, you know, how difficult that might have made things.

So -- sorry, I have completely I have forgotten what the question was.

Q. No, that is fine, you have answered it.

If we can have on the screen finally paragraph 942

of your statement, INQ0107962, page 121. These are your views about how now reports and harm can be investigated.

A. Do you want me to --

Q. It is going to come on the screen?

A. Okay.

Q. I think it will save you going through them Dr Jayaram if you want to add or elaborate on any of them, but you have set them out as clear bullet points here.

A. I think -- I mean, this might potentially be a lot of work but I think the holes in the net need to be as small as possible, so all neonatal deaths should at least be discussed with the Coroner. I think the process for escalating to CDOP needs to be better than it is in terms of just a form being filled in and sent to the designated doctor.

I think if the death is unexplained absolutely the SUDiC process should be involved, because it's quite clear had we done this, had I done this, had colleagues done this, we would have had oversight from other agencies outside of the hospital who would look at it more from a safeguarding point of view.

Now, of course should every death because sometimes they are explained but actually looking back, and this

is important, the way things were happening in 2015 and 2016 almost became our normality; that, you know, these things are happening, they don't happen anywhere else but it happens here and I look back and think it was so unusual and it was so bizarre, you know, and I have thought about this recently -- I am thinking through my whole career and training in paediatrics and doing neonatal jobs, these events just don't happen. I can't think of any events in my training where a baby who is otherwise stable would just suddenly deteriorate for no obvious reason and I kick myself, it was so obvious.

But I think it's -- it's that definition of "unexplained" and I think it's important that non-fatal collapses should be reviewed initially locally and then escalated if there's anything untoward.

I think my next bullet point, I can articulate it a different way.

It's about -- it's about being empowered, firstly, to think the unthinkable. We as human beings, as doctors, as scientists, as people, like to be able to explain things; we don't like uncertainty. And of course as clinicians we are taught to think around natural causes and think common things happen commonly, think of more uncommon things but think right to the edge of the playing field of natural causes.

But we are not empowered to think the unthinkable and actually 99.9% of the time there is no need to think the unthinkable and things like, say, for example that Just Culture document, I think, you know, it is trying to empower to think the unthinkable but it is how, number one, you can empower people, so I think in safeguarding training there needs to be reference to -- was it the Clothier report? -- and the findings of that, I think there needs to be mechanisms at least to prompt people to think about it.

But what's also important is on top of that, there need to be clear processes for what to do if once you have considered the unthinkable and it could be a possibility of how that is then processed be that SUDiC, be it safeguarding referral, be it whatever way but there needs to be clear guidance but most importantly on that point, staff need to be able to work in a culture where they feel that they are going to be listened to and they feel that they can raise potentially what might seem outlandish concerns, without fear of detriment. I think that's really important, not necessarily talking about my experience and my colleagues' experience but what I have heard from lots of other people post the verdicts who have basically been met with a response of: we don't want to know about

this problem we will make you the problem if you don't keep quiet and I think that's really important.

I am not -- you know I am very subjective. I am not going to make judgments about how the people at the top of the organisation may or may not have behaved what their thought processes were but surely everybody who works in healthcare, be they frontline staff, be they administrative staff, be they senior managerial staff it all had has to be about safe patient care and patient safety concerns have to be listened to, however uncomfortable it might make one feel. I think for myself I acknowledge that because I had those concerns and I didn't act on them as soon as I could have done and I will reflect forever on why and it's multi-factorial but I think for the future people need to be able to work in a culture where it is open and I know lip service is paid to being open and everything else, but from what I have heard from other people around, everybody needs to pull in those pull in those directions.

I think with regards to Freedom to Speak Up I think it's certainly better now at the Countess there is much more awareness I still worry about the independence of Freedom to Speak Up Guardians because they are ultimately employees of the Trust. I think the other

important thing is looking at risk and governance departments. I think they are crucial to patient safety and I know there's wide variation in terms of talking to colleagues in other similar hospitals in terms of numbers staff background training of staff as well. I think it's a department and a resource that needs to be prioritised. You need to have the right people with the right training and they need to be visible and there needs to be communication.

MS LANGDALE: Thank you very much, Dr Jayaram.

A. And I think also I think it's a point that you said I think that is really important I do understand that this has changed involvement if you are investigating a clinical incident such as ours in making sure that the parents' opinions and views are represented, and also they are not forgotten about and fed back to. I think it is such an obvious lightbulb moment that I am kind of embarrassed that I have not even thought about it.

MS LANGDALE: Thank you very much. My Lady, there are some questions from Ms Blackwell, from Mr Baker and then Mr Skelton.

LADY JUSTICE THIRLWALL: Very good. Ms Blackwell.

Questions by MS BLACKWELL

MS BLACKWELL: Dr Jayaram, I am Kate Blackwell and

I ask questions on behalf of the former senior managers.
I want to begin, please, by seeking clarification on some evidence that you gave to the Inquiry this morning. In your first Inquiry statement at page 294, you say that you first began having discussions with Consultants about the possibility of deliberate harm by Letby in November of 2015. But in answer to Ms Langdale this morning you said that by that time, the end of 2015, we, I think meaning you and your Consultant colleagues, weren't at those points thinking outside of natural deaths.
So I just want to clarify what you meant by that?
A. So to clarify that I think November it was the first point where I think between us the association of Letby it began to be suggested that it was significant. Now obviously there was no thought about was it well -- was it competence, could it be deliberate.
Q. Yes?
A. But I think the thought at that point about it being deliberate in November it was discussed but as I have said myself I kind of tried to shut it away really and I can't speak for colleagues.
Q. All right.
A. At that point but the association I think from that point was something that we felt was of

significance but we didn't know how.
Q. Thank you. At paragraph 302 of your statement you go on to say that the association with Letby that had been highlighted in the mortality table was being escalated as far as you were concerned to Sian Williams and Alison Kelly and that was being done by Dr Brearey?
A. Yes, there was a series of emails I think Dr Brearey had discussed the mortality table and I think it was an email back from Eirian Lloyd-Powell saying she was escalating it to Sian Williams and Alison Kelly. I think there was an email saying at one point one of them wasn't there or someone was on leave but my understanding was that it had been escalated. I don't know whether it was but my understanding was that it had been.
Q. It wasn't escalated by you?
A. It wasn't escalated by me.
Q. What was your view at that time of Letby continuing to work on the unit?
A. At that time, as I said, we were worried about the association being significant. I at that point did not feel as I was thinking then that there was enough at that point to justify moving her from the unit but I felt there was enough to justify an acknowledgement that this could be significant and work out ways to look

into it further.
Q. All right -- you yourself didn't escalate it or?
A. No, I didn't.
Q. Thank you. By February of 2016, we know that Dr Brearey had conducted the Thematic Review and that that report had been prepared. You were not involved in that, were you, because of clinical commitments I think?
A. Yes.
Q. But you read the report because you say at paragraph 326 in your statement that you noted that the Letby association was not mentioned within the report and you raised that with Dr Brearey who told you that he intended to explicitly discuss your concerns and his concerns about the association with the Medical Director and the Nursing Director. So you noted that that wasn't contained those concerns were not contained within the Thematic Review?
A. Yes, I think the initial mortality review analysis had had her name there.
Q. Yes, that was in an annex wasn't it?
A. Yes.
Q. Yes. Now you said to the Inquiry this morning in justifying your failure to mention your eye witness evidence of Child K to any Executive at the time of the

collapse, in February of 2016, that you were reassured that there was enough in the Thematic Review for senior managers to act.
A. I think there was enough in the Thematic Review to acknowledge that the association was significant.
Q. All right.
A. And my -- the events around Baby K that morning as I discussed I hadn't seen physically doing anything. I note that Alison Kelly made a point that if I had raised with her that Letby might have deliberately silenced the alarms she would have acted. I would contend that -- I don't know whether she would or not -- -- that is something of a straw man argument, to be honest, given from that time and onwards when we did raise concerns the response, particularly when Dr Brearey met with them in the May.
Q. So your evidence remains that you considered there was enough in the Thematic Review to justify you not mentioning to anybody for --
A. I think at that time as I discussed this morning it was, it was an event where -- and again it comes back to the misplaced belief that you had to have evidence.
Q. May I just deal with the chronology please --

A. Yes.
Q. -- because we are going to come to that. The CQC visited the hospital between 16 and 19 February. We know from your witness statement that you had your meeting with the inspectors on 17 February between 2 and 3.00 pm. It was earlier that morning, whilst you were on the ward, in the early hours of the morning that Child K had collapsed.
You had been on shift as we know when the breathing tube was dislodged and you have explained that at that time the nurse tending to Child K was away from the incubator and that you noticed that Letby was there and you were so concerned about her association with other deaths and collapses that you left your chair and went to the incubator to see what, if anything, she was doing and you knew that she was on the ward so is it safe to assume that she knew you were on the ward as well?
A. I would imagine that she knew I was there because I had been there from the moment that Baby K was born.
Q. Thank you. You told the Inquiry this morning that there was speculation or there has been speculation about whether or not the alarm was sounding as you approached the incubator but that's speculation Dr Jayaram has arisen because in your police interview

in April 2018 you said that you couldn't remember if the alarms were sounding?
A. Yes.
Q. But in February 2023 you gave clear evidence that neither the ventilator alarm nor the monitor alarm was sounding.
So had your memory of events in relation to that detail got clearer as time when on?
A. It had I think in that police interview the initial one it was kind of an overarching interview to discuss everything and I have read the transcript. I remember clearly I didn't I wasn't prompted to go into the room because alarms were going off.
Q. Right.
A. But --
Q. Is it your clear memory now that the alarms were not sounding?
A. Yes.
Q. Right and you it was Dr Jayaram who called the transport team?
A. That's correct.
Q. After you tended to Child K for her to be transferred out of Arrowe Park and the written record of that call to the transfer team is that you described what had happened in four words "Baby dislodged the

tube."
A. That is what was recorded so the person I spoke to wasn't a clinical person. It was an administrative person.
Q. So do you remember now what you said?
A. I would almost certainly have said the tube was dislodged.
Q. Tube was dislodged?
A. Yes because it had done it passively.
Q. You gave evidence about these matters at both criminal trials and you accepted that you had not made any clinical notes?
A. I accepted that at the time yes.
Q. Of what you had seen, nor did you compile a Datix report although you agreed with Ms Langdale this morning that the Datix reporting is for when you see something which is a problem or an error. Do you think you should have filled in a Datix form?
A. I think in retrospect because even if there's accidental tube dislodgment it probably should be Datixed because then you look into why the tube may have dislodged. But I didn't.
Q. No. But you agreed in the second criminal trial that it was a shocking discovery of finding her next to the cot. You also agreed with prosecuting

counsel that it was your conclusion that she deliberately dislodged the tube?
A. That was the thought that went through my head there. Again, as I said this morning, in isolation it wouldn't even have crossed my mind but in the context of the other concerns ...
Q. But you didn't mention that to anybody, did you?
A. I didn't because I was as I discussed this morning it was such I think it was the first time it really hit me that you see I had been hoping to walk in and find everything was okay.
Q. Yes?
A. But, as I discussed this morning, this fear of not being believed, this fear of detriment and I acknowledge that as I said I should have had more courage to raise those things.
Q. Were you complying with your duty to public safety in keeping that quiet?
A. Sorry, could you repeat the question?
Q. Were you complying with your duty to public safety to patient safety by keeping that quiet?
A. I'm not sure that I can answer that. I'm not sure that I can answer that.
Q. Well, do you accept this: certainly you didn't

raise any concerns with any Executive about either a concern of neonatal mortality rising, or indeed of any deliberate harm being metered out to any patients?

A. I --

Q. -- please allow me to finish -- until the collapses and deaths of children O and P in 2016?

A. Personally no.

Q. No.

A. But I know that Dr Brearey as neonatal lead had explicitly raise that concern before then.

Q. Had explicitly raised what concern?

A. The association with Letby.

Q. The association but not of deliberate harm?

A. I don't know specifically what he said to them, you will have to ask him.

Q. You were clinical lead for children's services. If you believed that deliberate harm was being used it was your duty was it not to bring that to the attention of the Executive Team?

A. And we did at a point whereas a group we felt that we had enough. Don't forget that even when we raised our concerns in June we were under as I have said, the misapprehension that we needed to have evidence and actually the response we got was: you haven't got any evidence. So actually I didn't know at

the time. Had I raised concerns earlier within even less evidence I can't speculate what the response might have been. I agree that there was, and I have said this already, there was potentially an opportunity to act sooner.

Q. Well, this was eye witness evidence wasn't it of a belief that you had that she was deliberately harming?

A. Well, I didn't see it was more the lack of response to what she was doing. I can speculate on it forever; you are absolutely right, it was an opportunity.

Q. There was a meeting as we know on 11 May of 2016 which you were not at, at which Dr Brearey discussed concerns and we do know that you received an email, you were the first on the list of recipients on 16 May 2016 which we have looked at already today.

And according to that email from Dr Brearey, he said that the 11 May meeting was helpful he was grateful for the work and that effectively all was well. But you gave evidence today that he told you that he had explicitly raised concerns about Letby and was uncomfortable at her continuing to work as of that date?

A. That's correct.

Q. Yes. Did you as a result of your conversation

with Dr Brearey on 16 May raise any further concerns with the Executives at that stage?

A. Not at that point.

Q. All right. We know that there was a meeting with the Executives in Tony Chambers's office on 29 June of 2016. Could I ask, please, that we look at INQ0003371. Now we have looked at this already this morning and we can see who was present on the top line but I would like to go down please to look at your comments towards the bottom of the page.

The first one is entirely subjective "Staff member almost always nurse in charge, babies were stable and then deteriorated, why always this nurse. Babies were unwell but getting better. Babies not getting oxygen then crash babies did not respond as they should."

And then "Steve B disturbing thing ... Twin survived and got better at Arrowe Park. Babies coming back to Countess of Chester. Babies deteriorate. Nurse 7 out of 9 between 12 noon and 4 am."

Can we go over the page, please.

And Steve B more than just an association with this nurse.

And your comments "How: Cannula air embolism crystal ball. Unquestionably got something going on at Countess of Chester but what? Looked at equipment,

looked clinical matters" and then it goes off to Dr Saladi.

So as of 29 June, you were raising serious concerns about Letby being associated and possibly causing the collapses or deaths of some of the babies?

A. That's correct.

Q. Yes. If we go a little further down please to the words attributed to Tony Chambers. It says, "Why did we call the police [I think that should be why did we not call the police] if Twins and Triplets why did the Trust take them on? Can we explore more before the police?"

And Steve B:

"Can we move member of staff? No, should then be police."

And you say:

"Why not earlier? Reviews."

Do you know what those comments relate to?

A. I don't. I think I was probably referring to the reviews, the case reviews that had been done by Steve Brearey and the Thematic Review. I can't think what other reviews I would have been referring to.

Q. No. As of 29 June, were you content that whatever had been raised by the Executives had been treated appropriately and that the reviews that had been

commissioned were the right reviews as of that time?
A. Sorry, can you just repeat that question again?
Q. Yes, of course. The 29 June --
A. Yes.
Q. -- I am asking you whether you viewed at that time that that the pieces of work that had been commissioned by the Executives had been appropriate for the concerns that had been raised at that time?
A. You mean the pieces of work that they commissioned after this meeting in terms of the Royal College? Or --
Q. Well, no. The pieces of work that had already been commissioned, so the Thematic Review and the various internal reviews?
A. Sorry, I don't think any of those reviews were actually commissioned by the Executive Team. They were undertaken by --
Q. Yes, but they come to the attention of the Executive Team, hadn't they?
A. Yes.
Q. And you were content that as of that time those had been appropriate, but that things had developed?
A. I -- I think that the point of the Thematic

Review being sent on to the Medical Director and the Nursing Director and there were the appendices with the Mortality Review on, I think I don't know when they were looked at and how they were interpreted.
But I think up until that point the reviews that had taken place were as far as we could probably go within the department and we had actually had an external neonatologist as well.
Q. Yes, thank you. That can come down. We know that there was another meeting the following day. We have looked at those notes earlier in evidence.
You described the meeting on 30 June as being a strange meeting because in your consideration as at that time the issues around Letby were not being taken seriously.
But following that meeting, the Royal College review was commissioned, wasn't it, and as we know Dr Hawdon's report came through.
As at that time, did you believe that the commissioning of those reports was appropriate?
A. When those -- certainly when the Royal College review was commissioned, and we saw the Terms of Reference, it was essentially a service review but one of the Terms of Reference was specifically to see if -- I forget the exact wording -- to see if there are any

factors that could have contributed and I think it said the "apparent increase" in death rate, but it was the real increase in death rate, and then obviously the Hawdon review was recommended by the College.
Q. Yes.
A. Now, we at this point, when we had the College review -- well, the College review hadn't happened, but when it was suggested we were also expressing our concerns around the continued presence of Letby on the unit.
Q. Well, of course following your meeting on 29 June, and we know that she was on holiday at that time, she never in fact returned to the ward, did she?
A. No.
Q. No.
A. But we were never involved in any discussions around what happened or informed of her move and I think because at that point she was off the unit --
Q. Yes?
A. -- as I mentioned earlier there was a --
Q. A lack of urgency?
A. There was less urgency.
Q. Yes.
A. And because we were under the impression that the RCPCH review and the Hawdon review, as had been

described initially, would be in depth. Now --
Q. Well, we are going to come to the Hawdon review in a second.
A. Okay.
Q. But can I just confirm this; that the reason that I asked whether you thought if things were being generated appropriately at that time is because we know on 24 October of 2016 you spoke to your BMA representative?
A. (Nods)
Q. And said to her that the senior management team took a decision to move Letby to a non-clinical role temporarily and that:
"... we as a group, that's you and the clinicians, are still uncomfortable that our concerns have not been fully addressed but we understand why the Exec body was cautious about escalating things."
So I want to ask you about that, please. Does that accurately reflect your consideration at that time?
A. So I think at that time, it was reassuring that she wasn't in a clinical role. From the discussions with the Executive Team in June and July, we were fully aware, and it's been said and documented, that there they were -- they had concerns about reputational damage.

So when I have said I understood, I didn't say I agreed with their thinking.

Q. Right.

A. But I understood where they were coming from.

Q. Thank you.

A. However, I think the -- I suppose one of the elephants in the room here was that, and looking back, was the fact that all of these actions were predicated on the suggestion from Stephen Cross that involving the police at this stage would not be appropriate.

Q. Yes.

A. And I fell for that. And in the context of that if the legal advisor is telling you that: well, she's off the unit it's being looked at --

Q. Yes.

A. -- that's something. But I am -- I don't think any of us were ...

It was strange. I mean if you're being told by somebody who is a legal adviser and an ex detective that it's inappropriate to call the police I am not in a position to argue however uncomfortable it seems.

Q. Well, by 3 February, you had seen the RCPCH report and by 7 February 2017 you had seen the Hawdon report in which Dr Hawdon had found sub optimal care in the cases that she reviewed at different levels:

significant, major and minor.

And having considered that report, you and your colleagues took the view that in addition to the four cases which she suggested needed a broader forensic review, there were others as well?

A. Yes, that's correct.

Q. And you brought that to the attention of the board, didn't you?

A. That's correct.

Q. Yes. Throughout none of what had taken place since February of 2016, so over the previous 12 months, had you ever brought to anybody's attention your eye witness evidence of Child K, had you?

A. Not at that point. It was only when I was interviewed by the police.

Q. Well, in fact the first person that you spoke to about it in terms of the Executives was Sue Hodkinson on 13 March, wasn't it?

A. Okay, yes.

Q. And we have looked at what you said to her on that date; that this was one of three cases where you had had concerns and you had seen Letby by the cot.

Following that there was a meeting with the Executives on 27 March. Again we have looked at the notes briefly today and you have told the Inquiry that

there had been a lot of letters backwards and forwards in preparation for that meeting. You had requested a face-to-face meeting with the Executives because you had lost faith in Ian's judgment, you said I think today?

A. (Nods)

Q. How had that happened, losing faith in Ian Harvey's judgment?

A. Because firstly, the whole process of how -- the data that Mr Harvey had presented to us in July with his, let's call it his deep dive review which he used to suggest that we were understaffed, more busy, it was entirely plausible that is the reason for the association with Letby.

The fact that -- and we haven't touched on this -- in, in that particular meeting there was, there was there were slides with patient identifiable data including the data of a -- of a colleague which was unforgiveable.

The way that the --

Q. Are you talking about a meeting back in July of 2016?

A. Yes, this is July which I think July 13th or 14th where he presented the data from the deep dive.

Q. All right. Can we have a look at the notes of

this meeting, please of 27 March 2017. They are at INQ0003150, please.

Now, we have already looked at the attendees and we can see that there's a welcome by Tony Chambers and the three items on the agenda which were for discussion.

If we could go to page 2, please. You say at the top of the page:

"As a group of paediatricians we accept the Royal College review, the Casenote Review and Jane Hawdon's review [and identified further ones, that's the further deaths] It's a difficult thing. What level of review do we need to do? We have a collective view that this now needs to be at the level of a rota review, who, where, involved, a forensic investigation. We accept that we may not find a cause. We have our names at the end of the incubator. We need more assurance. The interpretation of reports differs to the board. We were presented with a plan and we have explored every avenue with the BMA."

So you were prepared to accept, it seems from this note, that the Royal College review, the Casenote Review and Jane Hawdon's review had been appropriate in terms --

A. No because if you look at the comment that Steve Brearey's made lower down, and I don't recall

making that comment, and it's quite obvious that we didn't accept the review if you look at the correspondence that had come through since the time we saw the review, I don't think that's -- I don't know who's made these notes.

I think with regards to the RCPCH service review, absolutely some of the recommendations in there were quite clear.

Q. Yes.

A. Absolutely I did not agree -- well, I agreed, what I agreed with with Jane Hawdon's review was that there were definitely at least the four further cases.

Q. Yes. We see that at the bottom of this page --

A. I did not agree -- I did not agree that -- with her conclusion that she made at the time that deficiencies in care were able to explain the deaths.

Q. Yes.

A. And I have said that lower down.

Q. She had found delayed intubation, delayed cord clamping, delayed transfer, delayed attendance by Consultants, hadn't she, and a whole host of things which she suggested may well have contributed to the collapses or deaths?

A. Well, I think in the context of the

information that she was given and the briefing she was given --

Q. Yes.

A. -- I understand that subsequently with more information she's actually disagreed with that.

And as I say our interpretation of the information Jane Hawdon provided even with what she had got we were still concerned that there were further babies in whom --

Q. Yes, of course --

A. -- there was no explanation.

Q. And we see that at the bottom of the page.

Could we move over to the next page, please. Steve Brearey says:

"But we have not interviewed nurses, junior doctors which is really important."

And you say:

"Who could do that level of investigation? Does not look good on the Trust's reputation. As group of clinicians we do not know what to do but all of which are disturbed by this. All unusual ones where they have not responded and should. Board felt reassured, accept inefficiencies."

Then you go on towards the middle of the page:

"Our career would be on the line if we contact

police. It would be whistleblowing. Following BMA advice if there is an alternative of a deeper dive we should go for it, but this is a worry."

So weren't you there suggesting in this meeting that a deeper dive before you go to the police would be appropriate?

A. No because if -- what I was suggesting is if there is any way of doing a deeper dive --

Q. Yes.

A. -- but we didn't feel that there was, absolutely. And I was concerned, you know, already. Don't forget this meeting took place --

Q. 27th --

A. -- a month or so, sorry, two months after we had been told quite clearly about the consequences that would happen if we crossed the line.

I had been told that if I didn't engage with the mediation process, I was at risk of being reported to the GMC. I had been told that there was significant evidence from the grievance process of bad behaviours.

So, absolutely. And, yes, I can argue, you know, my patient safety should come above my career --

Q. Yes.

A. -- absolutely. But also at this point Letby was away from work and actually our purpose of this

meeting, as I understood this meeting, would be an opportunity for us to have a discussion and put down and actually state explicitly, "We don't feel that there is any alternative other than going to the police at this point."

Q. Did you agree that that comment seems to suggest otherwise?

A. No, I said if there is an alternative. But there was no alternative.

Q. All right.

A. There was no other way. We could start looking at the same information over and over and --

Q. Yes.

A. -- over again and still not find anything.

Q. Can we just turn over the page because you do make some more pertinent comments as well. Thank you.

Ian Harvey says:

"There is three options, contact the police, internal with NS support. Other experts conduct further review."

And you say:

"What would be the level of depth?"

Then there is further comments from Ian Harvey:

"We've had the meeting with Jane Hawdon [that was our meeting]. There has been subsequent work done."

And you say:
"We need to speak to all individually. Most of the time they are not on unit. All we want as a group is 1) that we feel assured enough that this cannot be investigated any further and 2) is that the board understand where we are coming from and that there is the board's interpretation. We are now more aware than you guys."
If we can turn over the page, please, you say in the middle of the page there:
"The Consultant body has asked about it a lot. We honestly can't see, get level of detail that's needed. We need the resources and the interest."
And over the page, please.
And you say:
"I agree with NM, the focus needs to be on the babies who have died. We have discussed a lot of implications to the unit, the Trust and parents and colleagues but this is for the greater good, the future. It's a big issue, it's huge."
And then there's a discussion between you and Tony Chambers. He says:
"You absolutely believe we have a criminal behaviour."
And you say:

"We need to clarify it beyond reasonable doubt."
And Steve Brearey says:
"On the balance of probability, words used from the child protection perspective, you say honest answer is we don't know. It's not been sufficiently explored or reassured, there is a subtle distinction."
And Tony Chambers says:
"To get the distinction the only thing is to do a police investigation."
And you seem to agree:
"Not sure anyone can do an investigation like that."
And then finally on this page, you say:
"For me personally I have a vague media profile. Recognise the impact, but so be it. It's for the greater good."
So what were you saying there, Mr Jayaram?
A. I think with that comment, what I meant was I don't think anyone else other than the police can do an investigation like that.
Q. Yes.
A. And actually, you know, if there is an impact on me in other things I do, so be it because we needed to know.
So I -- I, as I said earlier my understanding at

the end of this meeting is that it was accepted that we explicitly said we want to be able to talk to the police.
Q. Yes.
A. And they agreed.
Q. Thank you.
Now, drawing all of that together we seem to have reached this point; that nothing was raised by you until June of 2016. We have looked through the notes of the meetings that took place at the end of that month.
Letby never went back on to a patient-facing role and you expressed in October of 2016 to your BMA representative that you understood why the Executives were cautious to escalate up until that stage.
We have heard this afternoon that following March of 2017, you felt that your relationship with the Executives, and certain of them, had broken down and you were raising that as a problem with Duncan Nichol.
But you don't say, do you, Dr Jayaram, that any reluctance on behalf of the Executives to look into matters prior to June of 2016 causes you any concern and you can't say that because you yourself hadn't raised anything until that date?
A. No, personally I hadn't.

Q. No.
A. But I am concerned that from the time that the Thematic Review was on their radar --
Q. Yes.
A. -- that they didn't feel that the association with Letby was of significance. I don't know whether that is because they hadn't looked at it, wouldn't consider it. But that is --
Q. Well, nobody was saying it was anything other than an association, were they, at that stage?
A. But it's an association in the absence of any other clinical explanations for what was going on.
Q. You were kind enough to provide us an appendix to one of your Inquiry witness statements, the many postings and Tweets and media interviews in which you have engaged and much later in August of 2023 you posted on Facebook the following:
"There are people out there now still earning six-figure sums of taxpayers' money or retired with their gold-plated pensions who need to stand up in public and explain why they did not want to listen and do the right thing, to acknowledge that their actions potentially facilitated a mass murderer and to apologise to the families involved in all of this. However I suspect the response will be fudge and misinformation

and it is now my mission moving forwards to make sure that they are held to account."

You have just agreed that you understood why the Executives were cautious about escalating things. How did their actions potentially facilitate a mass murderer?

A. I said I understood. I didn't say I agreed.

Lucy Letby was on the 27th of March I believe five or six days away from coming back to work --

Q. But she didn't, did she?

A. She didn't --

Q. No.

A. -- because at this meeting we, as consultants and the team from the neonatal network, said we want to speak to the police.

I now understand that Lucy Letby had been led to believe, by Sue Hodkinson, that that meeting on the 27th was actually a meeting at which myself and my colleague Dr Brearey were going to be told that we were going to face disciplinary action.

Now, it's all he said/she said. But there's a clearly a discrepancy between where we are going why, at the meeting on 26 January when we had not had sight of the final Royal College report nor of the Casenote Review, were we told quite explicitly that there's

nothing to see here.

Q. No, this is -- with greatest of respect, Dr Jayaram, this is not about what you were or were not told?

A. No, I am talking about -- about things people could have done differently.

Q. Yes.

A. At that time, why were those interpreted in a way that was clearly to my mind designed to minimise our concerns and bring her back to work? Why was Tony Chambers having conversations with her mother and father? Why was Sue Hodkinson having conversations with her mother and father? Why was the RCN rep?

These are the things I am talking about. And when I talk about people justifying their actions I will put my hands up and I hope I have acknowledged the things I could and should have done differently and better.

Q. Yes.

A. All I meant by those comments -- and bear in mind there was a lot of pent up anger at that point -- all I want is for these people to acknowledge that they too could have done things differently.

Q. Fair enough. You also on the same day said to ITV News:

"The horrible thing to say is I do genuinely

believe that there are four of five babies who could be going to school now who aren't."

Now, given that you have accepted that Lucy Letby never returned to a patient-facing role following your concerns raised to the Executives about deliberate harm, do you still stand by those comments?

A. I would stand by that had she been moved earlier, I think from the time the Thematic Review was on the radar or whether it was considered, I think if, if when the Thematic Review was seen -- and I don't know when it was seen -- but if when it was looked at by the Medical Director and the Nursing Director, had they looked at it and come to us -- and maybe we should have been more proactive and said, "Please can we talk about this with you?" although there were emails to try and get it on the radar --

Q. Yes, but what did you do, Dr Jayaram, about the -- following the Thematic Review to go to the Executives as clinical lead for children's services?

A. As I have said Dr Brearey was running it as neonatal lead.

Q. But you didn't --

A. I personally didn't.

Q. Right. Finally I would like to ask you about Dr Brearey's drawer of doom. He has made an additional

statement to the Inquiry. Have you seen that?

A. I haven't seen the additional statement.

Q. No. Right. Did you ever have sight of Dr Brearey's drawer of doom?

A. I'd never even heard of the concept of a drawer of doom. It seems to come up in a lot of statements.

Q. Yes.

A. I have never heard it referred to as a drawer of doom.

Q. Right. Is it your normal practice to keep one drawer storing important documents dealing with concerns?

A. Certainly not for me. I mean, you'll have to ask Dr Brearey about drawers of doom. I mean, this seems to come up a lot. I --

Q. He never discussed it with you?

A. He discussed all the information he had. I never knew about a drawer of doom or --

MS BLACKWELL: All right. Thank you very much.

LADY JUSTICE THIRLWALL: Thank you, Ms Blackwell. Mr Baker.

Questions by MR BAKER

MR BAKER: Dr Jayaram, I have only got two very brief questions. I represent a number of the Families.

First of all, you were asked some questions about the point at which your belief moved from concern about the possibility of negligent care or deliberate harm into thinking the unthinkable.

Could we go, please, to INQ0102345 and to page 31, please. This may assist your memory. So can you see the bottom left-hand corner. I'm afraid it's very small?

A. Is it possible to enlarge it a little bit.

Q. Yes, here we go.

A. Thank you.

Q. So you are being asked questions here by Mr Myers KC and can you see there a section:

"Question: Right, I am asking you about your state of mind though by the time we get to February the thought had crossed your mind, hadn't it, that she may be deliberately harming babies?"

And you say:

"Unfortunately that unthinkable thought had crossed my mind and other colleagues as well."

A. Yes.

Q. So is it fair to say that by the time we get to February 2016, you and your colleagues have begun to think the unthinkable?

A. Yes. I mean as I discussed, I think

and others did and I suppose I was almost, you know -- I was also aware of the fact that you know maybe I was starting to see things that weren't there.

And it's so obvious now. And yes, I accept that I should have, I should have been -- I should have put my head over the parapet and, and been more --

Q. Thank you.

A. -- explicitly articulated it. And I can only apologise to the parents of the babies that had tragic events after those times.

I can only speculate as to whether had I raised those concerns at that time things might have been different. I honestly don't know.

Q. Well, we are going to look at an email. I think you have been taken to it already. You were asked a question just now:

"As of 29 June, were you content that whatever had been raised by the Executives had been treated appropriately and the review that had been commissioned was the right review at that time?"

If we can go please to INQ0003112 and to page 2 of that document, please. It's the email at the bottom dated 29 June 2016 from Ian Harvey to you.

How did you feel receiving that email from the Chief Executive of the Trust?

by November we were wondering about the significance of the association and as these -- as there were more of these unexpected and unusual events, the -- the thought about deliberate harm had become more prominent.

Q. Yes. So you came back from holiday I think on 5 November 2015 and you were informed about the death of Child I and it's that point where you say in your witness statement concerns began to appear.

And so would it be true to say that between that date and November 2015 and February 2016, those thoughts had coalesced into thinking the unthinkable?

A. As I discussed, I think the November corridor conversations were really the first time that I was aware other colleagues had been having similar thoughts.

I think in that time, absolutely, once you -- once you start having those thoughts it's very, very difficult to ignore them.

But -- and you know I admit I got this wrong, I did my utmost best to hope it wasn't that and it was always there nagging because, yes, I am aware of Beverley Allitt and Shipman and other cases but even now in retrospect it's staring you in the face, it doesn't happen to you, it happens to other people and I -- I talked about courage and I have said that I understand now I -- I, you know, the very fact I had those thoughts

A. Well, from the Medical Director.

Q. Medical Director, sorry, of the Trust?

A. I was familiar with similar emails from Ian Harvey, not to do with this issue, you know Consultants may be moaning about car parking or admin time or something and, and it was not unusual to get an email saying: All emails cease forthwith.

I think the email that I sent to which he sent this response, me suggesting that the Executives didn't seem to have that degree of urgency, was my honest opinion at that time. But of course he hasn't said here it's been discussed and what action is being taken.

And it -- in terms of how it made me feel it just made me feel frustrated and angry really and then obviously he then came down and intimated that they are going to try and get more information and then probably contact the police, which is why I think I sent the subsequent email just after 10 o'clock.

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

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

Questions by MR SKELTON

MR SKELTON: My Lady, I am very conscious of the time and I will try and be as swift as I can.

I appreciate Dr Jayaram has had a very, very long day and I am not going to make it any easier for him.

LADY JUSTICE THIRLWALL: No, all right. Dr Jayaram, would you like another break?

A. No, I'm fine. Let's just carry on.

LADY JUSTICE THIRLWALL: I can't remember, I think you are down for 20 minutes.

MR SKELTON: I am. I will do my best.

LADY JUSTICE THIRLWALL: Yes. Well, I think we have already had a substantial overrun on one of the time estimates. So if you could keep it to 20 minutes.

MR SKELTON: Okay. Dr Jayaram, the duty of candour. Sir Robert Francis defined it as the volunteering of all relevant information to persons who have or may have been harmed by the provision of services whether or not the information has been requested and whether or not a complaint or report about that provision has been made.

I presume you agree with that?

A. I couldn't disagree with it at all.

Q. And it's one of the fundamental axioms of medical practice --

A. Yes.

Q. -- in paediatrics and elsewhere.

You have been asked many times during the evidence

today about the meeting you had with the Executives on 29 June. I won't go into it in any more detail.

But it suffices to say that this was your first direct contact with them in which you laid out your concerns that you thought a nurse, Lucy Letby, was murdering the babies and that was responsible --

A. Potentially yes, yes.

Q. And indeed you speculated in that meeting about the mechanism of murder; possibly air embolism and via a cannula or some other mechanism?

A. (Nods)

Q. You spoke out loud?

A. Yes.

Q. But didn't have the answer?

A. No.

Q. You have also said in your evidence in writing that after that, you thought: I better have a look at this and you found Tanswell and Lee paper --

A. That's right.

Q. -- and we know the history of where that ended up.

A. Yes.

Q. And I think you subsequently said to the Royal College you fund that chilling when you first found that paper?

A. I think when I read the description of the skin changes because it tallied with what colleagues and myself had been aware of.

Q. So that's the end of June. Two months later, or thereabouts, the Royal College actually arrive on site and they speak to you and Dr Brearey and in fact you have a rather similar conversation if not in more detail with the Review Team in which both of you lay out in full and articulately all of your concerns about the mortality, including the fact that a particular nurse was on shift at night when they happened and then when she was moved the collapses and deaths happened on the day shifts as well?

A. (Nods)

Q. And you mention that a lot of information, I won't go through all of it in the interests of time, but one of the things that you mentioned was the unexpected unexplained nature and the failure to respond as you would expect physiologically to standard resuscitation?

A. Correct.

Q. All of which is highly significant because it's unusual and that's correct?

A. That's correct, yes.

Q. And as you had done at the end of June, you

have speculated out loud in front of the reviewers as to how the murders might have been committed and you queried injecting air into babies. Do you remember that?

A. Yes. I think we -- we discussed these are possibilities and we hadn't found any other obvious clinical causes. I don't think I was saying, "This is what's happened", but it -- it was a possibility.

Q. And I think you specifically mentioned Child A in that context?

A. Sorry?

Q. You specifically mentioned Child A?

A. Yes.

Q. As well as the Triplets and others, it's right to say.

And I think you also mentioned the police and the possibility that they could be called which had been discussed with the Executives?

A. Yes.

Q. You may not remember all of that, but have you jogged your memory --

A. Yes, we discussed that and I think I discussed that we'd also been told that it wasn't the right thing to do at that time.

Q. Scroll forward another few months and the

Inquest final arises quite a long time after the death of Child A in respect of his death.

And you must have involved been involved in a number of Inquests over the years sadly?

A. In the past, yes.

Q. And given evidence at them?

A. Yes.

Q. So you were aware of the basic statutory purpose of an Inquest?

A. Yes.

Q. Who the deceased was, how, when and where they came by their death and your bit as the physician is the how bit, the how question: why have they died medically?

A. (Nods)

Q. Yes. You are nodding.

A. Yes.

Q. You are also aware, I would assume, that the coronial system is one of the ways in which this country investigates whether or not something untoward has happened, whether or not a death is unnatural in the sense that there's been foul play?

A. Yes.

Q. And it used to be that they could commit people for trial from Inquests. These days they are linked in with the police and the criminal justice

system and you know that the police will often be involved with Inquests?

A. Yes.

Q. You provided a statement a month or so after Baby A's death in which you dealt with, in a very standard way, with precisely your involvement with his care, so coming on scene, the collapse, the administration of resuscitation and of course his untimely death and that must have been a familiar process for you providing that kind of statement?

A. Yes.

Q. A year or so later, because the Inquest is delayed for many, many months, you -- there are a series of meetings about the Inquest and I think you have now jogged your memory and seen that there is in fact a note of I think possibly a telephone meeting or a direct meeting --

A. Yes.

Q. -- at which you were in fact present.

May I ask you about that insofar as you can now remember having jogged your memory. Was it discussed or did you discuss, or anyone else discuss in any of those meetings the possibility of a criminal act having been committed?

A. I can't remember in that meeting, that

pre-Inquest meeting whether I specifically raised that concern.

Stephen Cross, who was running that meeting, I was aware was fully aware of the specific concern because he had been involved in the meetings in June and July where we -- we discussed it. But in those pre-meetings I didn't specifically raise that.

I had wondered how in a coronial Inquest I could raise that specific concern. Stephen Cross, as we discussed, sent me an email which he had sent to the Coroner saying he had discussed it with the Coroner's assistant before and that the Coroner was fully aware of our concerns.

He also attached to that email the Terms of Reference for Jane Hawdon's Casenote Review that were very detailed and specifically said that this review would be looking for other causes including things such as air embolism. So I guess at the time of the Inquest, my understanding was that the Coroner was fully aware and again when I re-read the email it is an assumption but the Coroner was fully aware of those specific concerns and --

Q. There isn't any evidence in fact that he was, is there, and I don't know whether you have seen his statement but I don't think --

A. No.

Q. -- he was aware. So he hadn't been told by Stephen Cross?

A. No.

Q. And I don't think you proactively said in the conference meeting that you had that you had suspicions, you didn't tell counsel?

A. No.

Q. There may be -- it may be for counsel to answer --

A. Yes.

Q. -- whether he in fact received that information via another source --

A. Yes.

Q. -- such as Mr Cross. But that's not matter for you?

A. Sure.

Q. You don't know if he did or he didn't?

A. Yes.

Q. The GMC's Good Medical Practice at the time, it was the 2013 version, obliges doctors to not deliberately leave out relevant information when they give evidence to legal proceedings. Were you aware of that broadly speaking?

A. Broadly speaking, not the specific clause.

Q. You were called to give evidence at the Inquest in fact twice because there was something of a discussion in respect of the cause of deaths, which required you to come back.

Were you in fact sitting together with Dr Shukla or did you sort of go and sit down and come back up again?

A. Sorry, we went up and then I think I was -- I was in the courtroom.

Q. And then you went back to your seat and then came back up?

A. I think so. I can't -- I don't think I went out of the room and had to come back in. So I think I was ...

Q. The first time you gave evidence, and please in the interests of time I am going try and truncate what you said --

A. Sure.

Q. -- but if I am getting it wrong you must correct me, please.

You said that Child A was stable when you came on shift, you discussed the long line insertion and there's a great deal of analysis of the long line insertion during the Inquest?

A. Yes.

Q. And the administration of dextrose. Again

that's another issue which is discussed in detail.

But you say, quite candidly, that there's nothing you could think of to explain the sudden deterioration and that included the dextrose and the long line?

A. That's correct.

Q. You mention your thought processes at the time, this is back in June. So you are describing what's going through your mind as a senior doctor back in June 2015 when the child collapsed and died and you weren't thinking -- you couldn't think of what had caused it at the time, that's correct?

A. That's correct, yes.

Q. You made it clear that this was an unexplained collapse and that the child hadn't responded in a timely or normal way to resuscitation?

A. That's correct.

Q. And you ruled out the causes I have mentioned but also cardiac arrhythmia, the mother's medical condition and the possibility of a thrombus which could have caused a blockage and led to an arrest. All of those you ruled out clinically?

A. (Nods)

Q. Dr Shukla then gives evidence and he is unable to give a natural or an unnatural cause. He clearly was baffled by why the baby had died. Do you remember that?

A. Yes, and I have seen the summaries as well.

Q. Then you are recalled after that and as you will have seen from the prior's note, which I know you have read because you mentioned it earlier and I think you consider it to be a more accurate note than the other notes we have seen --

A. Yes.

Q. -- your task as recorded in the note is to try and assist with your paediatric knowledge in relation to the circumstances in Dr Shukla, or in other words help Dr Shukla reach a conclusion about the cause of death.

So you have moved slightly from being an expert -- sorry, a witness of fact about your recollection to being something of an expert, trying to explain to the Coroner what might have happened. Did you understand that shift?

A. Not explicitly in -- in those terms, no.

Q. Does it make sense to you, as I put it to you now?

A. It does make sense in those terms, yes.

Q. I mean, to put it bluntly, you are not being asked what you did or thought in June 2015. You were being asked what you think now --

A. Yes.

Q. -- has caused the child's death, how they have

died.

A. Yes.

Q. On those points, in answer to the various questions from the advocates and from the Coroner, you consider the downgrading of the unit and you mention the review, the independent review, and you talk about the initial feedback of the review that nothing had been found systemically with the training practices or equipment.

You mention -- well, this phrase is recorded and I would like to understand what you meant by it:

"A potential issue with staffing."

Now, does that mean understaffing, the classic NHS lament, or does it mean a staff member?

A. That's a really good question. I have to assume that those were the words that I used. I am aware that the kind of hot feedback, if you like, from the College review discussed staffing numbers, but that wouldn't have been what I was referring to because I didn't feel there was that.

And I think it was an oblique reference to an individual member of staff and actually if I -- you know, I've reflected on this for a long, long time, what I was -- and again I guess my response is predicated on an understanding which it seems is not correct; that the

Coroner was aware of our concerns based on what Stephen Cross had told me and that he was aware of the things that were being or were supposed to have been investigated in the forensic review and because of that, I was to an extent slightly surprised that the Inquest was happening when a forensic review was going on. But I -- I didn't query that. But clearly the Coroner didn't have the understanding that I knew.

I -- you are absolutely correct, you know, I am there in a Coroner's court and I should say what I think and again I didn't.

I think and again -- and I, I reach out to Baby A and B's parents for this, and maybe I should have done a supplementary statement or talked afterwards -- I was trying to in my discussion about the fact I couldn't explain this, you know, in the context that my understanding was that the Coroner knew of our concerns I was trying to sort of throw as many breadcrumbs as possible for the Coroner to pick up without explicitly saying what the suspicion was.

Why did I do that? And again -- and I appreciate that this was the wrong judgment -- I had Baby A's parents sitting 10 feet away from me and, yes, absolutely, duty of candour.

I just didn't have the courage to say it and

I think part of this, part of this was already from, you know, I guess being influenced by the -- the pushback that we were getting that, "There's nothing to see here" and, and, I can -- I regret not explicitly saying that then on many, many levels because it should have been said, you know, and I am not going to make excuses. I did have an understanding that the Coroner was aware of our concerns because I interpreted that's what Stephen Cross had told the Coroner and I should have done better.

Q. You should have told the Coroner that a member of staff may have been responsible for the child's death?

A. Yes, I should have done.

Q. And one of the reasons why that was required was not only candour for the parents, mother A was sat there, but also because the Coroner has the equipment and the wherewithal --

A. Yes.

Q. -- to do exactly what you needed to get done?

A. Yes.

Q. The expert investigation, the forensic pathology?

A. Yes.

Q. The radiology review?

A. Yes.

Q. All the things that in fact occurred later on?

A. Yes, absolutely. And, as I say, I am not using this as an excuse at all, but I was under the impression the Coroner was aware of those concerns.

But even if the Coroner was aware of those concerns, I should have still been explicit.

Q. Can I try and deal with Child M as well and --

A. Yes, of course.

Q. And his parents are watching these proceedings. I know you have followed these proceedings and I don't want to assume that you followed them as closely as listening to all of the evidence. But they are particularly concerned that as your concern arose in respect of their child's collapse -- you recall Child M collapsed just like Child A?

A. Yes.

Q. And I think you told the police at one point in 2019 they were the two children who really haunted you --

A. Yes.

Q. -- in effect, those collapses.

You had a chat or you had a discussion with the parents after Child M's collapse. But again you didn't mention your suspicions. And this -- we are now into

2016, well into the terrain, long after the terrain, sorry, long after the suspicion has arisen in your and your colleagues' minds. Why was that?

A. The discussion that I had with Baby M's family after he was resuscitated was I -- I discussed that again I couldn't explain it. It didn't fit with things.

I think I -- I would, I would ask any colleague how, how, to parents sitting there, with the nurse there as well, can I express such, such a concern?

And again at this stage, yes, we were thinking the unthinkable, but it was this issue of not having evidence and I wish I could turn the clock back and wish I could have said it, and I didn't, or later on.

I think it's really difficult to appreciate my thought processes then compared to what I know now, but I think I still probably wouldn't have expressed that concern immediately at that point, but --

Q. You didn't have to, did you? In fact you could have waited until the horror of the situation --

A. Yes.

Q. They were immensely affected by it as you recall?

A. Absolutely.

Q. You could have waited until that had abated somewhat --

A. Yes.
Q. -- and revisited that issue?
A. Yes.
Q. And I have to put to you that candour requires you to at least alert them to the possibility that there was an explanation that hadn't been looked at which needed to be looked at and that included deliberate harm?
A. I don't disagree.
Q. Overall, I think you accept the proposition that once the suspicion arose that Letby was deliberately harming children investigation was required to confirm or rule out that suspicion by hook or by crook?
A. I -- yes, absolutely.
Q. We know from the evidence of you, Dr Brearey and others that discussions occurred internally really from the start of the cluster of deaths in June and continued throughout the next year as to understand why the babies were dying in an increased rate at an increased rate?
A. (Nods)
Q. However, no clear causes or thematic causes were found and you didn't identify the method of crime at any point yourself at that stage?

A. No and I am I wasn't looking for methods of crime at that point. It -- it was -- I wasn't, it was one of the possibilities could these be unnatural events but until June I would say I had not specifically considered how.
Q. To be fair, it wasn't your job to --
A. No, no.
Q. -- investigate a crime?
A. No, absolutely, and, you know, it's my job to raise the concerns.
Q. It is right, and I think you acknowledged today, that there were in fact some significant signs in the records which had a more comprehensive analysis been conducted might have been spotted, the insulin C-peptide results for the two children --
A. Yes.
Q. -- for example and of course Child K about whom you have been asked?
A. Yes.
Q. There were those signals which were slightly more positive than --
A. Yes.
Q. -- inferential.
But the concerns had been raised with Eirian Powell very early on in 2015 and of course you had ultimately

gone to the Executives, they had been alerted to it via Alison Kelly early on and then directly by you in the meetings.
Is it fair to say that you found yourselves -- this is the Consultant body, you, Dr Brearey and your colleagues -- locked into a process of investigation, the Royal College review, the Hawdon review, which wasn't in fact going to answer or confront the question that needed to be confronted: was she harming babies?
A. Yes, so I think in terms of being locked into that process you are absolutely correct. When we had formally raised late June/early July we discussed what the correct -- what the right way forwards we discussed the police, my colleague, Dr Saladi in his email explicitly said he didn't think there was anyone else who could do it, yet we were told explicitly that it would be inappropriate to involve the police at this stage and I remember -- I forget which meeting it was in June/July, we were told that it would be the end of the unit, there would be blue and white tape everywhere, the whole place would be a crime scene, everyone would be a suspect.
Now, I understand this now that that's not how it works when these issues are raised actually, there are actually mechanisms in place for raising these issues

without disruption to service.
I think from that point, because we knew Letby had been moved, as I mentioned I don't think complacency but there was slightly less urgency and I -- I suppose what I can't speak for colleagues, what I anticipated the College review and the Casenote Review would support what had been found by our own Thematic Reviews and at that point the police would be involved.
And there was a delay in us seeing, having access to those -- the information from those and then events went from there and I am, I am glad that we from that point were assertive enough to not accept the Executives' interpretations of what they found, but I do feel we were -- we were locked into that.
Now, could we have actually put our hands up at any point and said: look, this is all very well but this isn't the right thing to do? We could have done.
I think it's very difficult when we have been told by the Executive body, particularly someone who has a legal and policing background, that it is the wrong thing to do and I should have been more curious and challenged it.
Q. Without going into great detail, because I am in danger of going over my time with you, but were you fully aware that the Royal College were never going to

answer the question that you needed to confront, and likewise with Dr Hawdon, in fact; they were really staging posts, as it turned out?

A. I think if I look at the Terms of Reference of the Royal College review, you know, to -- to look for any -- I forget the exact terms but any factors that could have contributed to the deaths.

Q. Yes.

A. And if I look at the Terms of Reference of -- the original Terms of Reference of the Hawdon review, in particular the original Terms of Reference of the Hawdon review, I think either those Terms of Reference would have found something that would have flagged up something unnatural or they wouldn't have and if they had found something unnatural, it would have gone down the police line and if they hadn't, I anticipated that then the next response would be to escalate to the police.

Now, obviously I shouldn't assume what any review is going to find but given that these were paediatricians undertaking these reviews, and I talked to them and my colleagues had talked to them, and they had heard what we had said, I felt at that point although I felt it needed to be escalated and there is an element of -- I think I said it it's minuted

somewhere, that there was part of me that was almost hoping that they would find something explainable and clinical, you know, because that's -- so in many ways, awful as it is, it is so much easier to deal with than the reality of things.

Q. And ordinarily the probability is that they would have done and when you have a cluster of deaths, there usually is a clinical explanation for it?

A. Usually and I think again, you know, this is all about us or me -- I can't speak for others -- trying to make things fit -- and, and not having the courage to think outside the box.

Q. I am not going it take you through all the various committees and groups that existed back in 2015/2016 but I am going to try and deal with it sort of compendiously, if I can.

There clearly was a patient safety issue as suspicions arose in respect of Lucy Letby harming children and there clearly was a parallel safeguarding issue, they are -- in the context, it's the same point, isn't it?

A. Yes.

Q. Safeguarding patient?

A. Yes.

Q. Patient safety.

There was an opportunity to take your concerns and suspicions to the safeguarding team and that opportunity was not taken in terms?

A. Yes. I think by engaging the SUDiC process for the deaths it would have automatically been on the safeguarding radar.

Q. That could have occurred really early on?

A. It could have occurred early on. I don't know whether early on deliberate harm would have been considered but the pattern as things progressed could well have been recognised earlier on.

Q. In terms of the external lifelines, again without discussing them in detail, but trying to deal with them all in one go, there is obviously the CDOP route --

A. Yes.

Q. -- which you have discussed but there is the wider national bodies, the GMC, the NMC the CQC, NHS England and of course you have already talked about the Coroner and the police. But those other bodies, they all have abilities or they all have the capacity to receive concerns or whistleblowing issues and to start to help with them being raised.

As I understand your evidence, really, you didn't feel that any could you really go anywhere outside the

Trust?

A. Yes, I -- I think again speaking for myself but I think I speak for colleagues, we just didn't know where we could go and I think there's some levels, number one about the concern, but also subsequently about the response to concerns when we raised them and I was not aware at the time that all the bodies to whom you refer had processes that we, we could have followed and I will be honest now, I am still not entirely clear specifically what they are.

Q. Did you look at -- I mean, you can type in GMC, NMC, and up come a whole raft of --

A. My understand of the GMC and NMC was again you had to have a degree of evidence.

Q. Well, what they might have done is say: you need to go to the police?

A. Yes.

Q. Any of those bodies in fact may have said this isn't really --

A. Yes.

Q. This isn't really an issue about the adequacy of care; it is not your standard whistleblowing?

A. Yes.

Q. This is much more serious?

A. Yes.

Q. It's criminal.

A. And -- and in many ways I wish somebody had just said that to us, you know. When we initially raised it in June '16 we were told: not the police, when we discussed it with the Royal College reviewers we were told -- why don't you just go to the police. Well, I don't know what the Coroner was told in February 17, I don't know what Simon Medland was briefed, but absolutely.

I think, looking back, we shouldn't have had to have waited for permission to go to the police. We should have just gone.

Q. Because the only way that Lucy Letby was either going to be incriminated or exculpated was by full investigation, of which the police were best equipped?

A. Yes, absolutely and again there was the misapprehension that -- and we thought it was reinforced to us by -- by people in the Trust we raised issues to that: you hadn't got enough evidence to go to the police, which I understand now is absurd because, as you say, the people who find the evidence are the people investigating.

MR SKELTON: Thank you, Dr Jayaram, those are my questions.

So we will rise now and we will start again tomorrow at 10 o'clock.

(5.24 pm)

(The Inquiry adjourned until 10.00 am on Thursday, 14 November 2024)

My Lady, I hope I haven't gone too far over my limit.

LADY JUSTICE THIRLWALL: Thank you very much.

MS LANGDALE: My Lady, I don't think Mr Kennedy has any questions? No, he doesn't and I have no further questions of Dr Jayaram.

LADY JUSTICE THIRLWALL: Very well, and I don't have any questions either, Dr Jayaram, so thank you for bearing with us on a very long day.

A. Thank you, can I just say thank you very much for inviting me here today. Can I say again to the parents of the babies involved that I am sorry for my own personal failings and I apologise for things that I could and should have done better.

I know that my words will never ever help to ease the grief that you feel and I also want to reach out to you and I'm sorry that you are having to go through the external noise that's out there of people taking another view on everything that's happened and I appreciate how painful that must be for you and how insensitive it is of the people who are trying to suggest that other things happened.

And once again, I thank you for your patience with me very much.

LADY JUSTICE THIRLWALL: Thank you, Dr Jayaram.

INDEX