

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

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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?

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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

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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

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1 surgical specialties were Planned Care.

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

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

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

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

25 It also meant that as a specialty, paediatrics and

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1 **A.** No.

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

3 **A.** No, it stayed that way.

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

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

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

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

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

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

15 I think --

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

17 **A.** So in our --

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

20 **A.** Formally --

21 **Q.** Yes.

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

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

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

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

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

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

17 **Q.** Yes, yes.

18 **A.** Just for brevity's sake.

19 I was fully aware of the SUDiC processes.

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

23 **A.** Yes.

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

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

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

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

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

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

20 **Q.** It does.

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

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

3 **A.** It does.

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

6 **A.** Yes.

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

11 **A.** Yes.

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

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

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1 was potential to initiate SUDIc processes in these
2 situations.

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

8 **Q.** We will come to that.

9 **A.** Sure.

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

11 **A.** Yes.

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

16 **A.** Yes.

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

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

25 **A.** Yes, it is.

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1 paediatrician has been informed.

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

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

6 **A.** Yes.

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

9 **A.** Yes.

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

12 **A.** Yes.

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

16 **A.** Yes.

17 **Q.** But Dr Mittal, he is the designated doctor for
18 safeguarding. Did you have any conversations with him
19 or did he approach you to discuss this SUDIc process and
20 whether and if so it should apply to any of the babies
21 --

22 **A.** No, there were no conversations either way.

23 **Q.** Throughout the whole period we are
24 investigating?

25 **A.** Not that I can recall with me specifically.

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

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

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

24 Q. And professionals who listen with
25 a safeguarding perspective?

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

5 A. Yes.

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

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

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

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

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

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1 A. Yes.

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

6 A. Yes.

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

9 A. Completely different yes.

10 Q. And again they had understanding of
11 safeguarding?

12 A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17

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

2 **Q.** That can come down now, thank you.

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

5 **A.** Yes.

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

10 **A.** Yes.

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

15 **A.** I agree.

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

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

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

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1 **A.** Yes.

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

4 **A.** Yes.

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

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

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

24 Now, I am not aware of any -- outside of SUDIc
25 processes of any specific organisational guidance even

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

3 **A.** Absolutely.

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

6 **A.** (Nods)

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

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

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

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

25 **A.** Yes. I was concerned because clinically it

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

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

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

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

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

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

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

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

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

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

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

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

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

23

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

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

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

7 **Q.** That can go down, thank you.

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

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

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

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

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

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

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

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

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

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1 sometimes several days for those results to come back.

2 At the time, there were systems for abnormal
3 results for anything to be flagged up by a phone call
4 from the labs, otherwise paper results come back.

5 I can't explain why this result was not actively
6 chased, although having done these investigations for
7 many years in hypoglycaemic babies invariably the
8 results come back normal or slightly high insulin levels
9 because of Congenital Hyperinsulinism or small for
10 gestational age.

11 And so there's almost an element of well, these
12 results are always normal and I don't know why this one
13 wasn't looked at, whether -- there are a number of
14 things that I think need to be considered; process of
15 handover, is it recorded? We have handover sheets that
16 are updated twice a day, it should have been on the
17 handover sheet as an outstanding result to chase, it
18 should have been in the notes as an outstanding result
19 to chase.

20 I don't know myself whether this result was phoned
21 back and I'm not sure at what point the paper result
22 came back or to whom it came back to.

23 I -- I would say and I don't think any clinician
24 would disagree, that although I was the one that
25 suggested the bloods should be done it was an out of

25

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

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

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

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

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

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

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

27

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

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

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

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

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

21 **A.** Yes.

22 **Q.** -- had taken place?

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

24 **A.** I agree.

25 **Q.** The point of Baby F?

26

1 missed.

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

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

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

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

25 We know of course there was a conviction in

28

1 relation to Baby G for overfeeding with milk?

2 **A.** (Nods)

3 **Q.** And her father gave powerful evidence to the
4 Inquiry about how she vomited and how she presented.

5 You did not have any other clinical involvement but
6 were you involved in any debriefs or discussion around
7 the collapses of Baby G on 7th of the 9th or 21st of the
8 9th?

9 **A.** I don't recall being involved in any of those
10 discussions.

11 **Q.** It's difficult to see indeed if there were
12 discussions around the babies who collapsed or survived
13 from an Inquiry perspective. Can you help us with what
14 the protocol or practice was if a baby survived or
15 recovered from a deterioration, was there due attention
16 given to discussing what may have happened to the baby?

17 **A.** So I think that's a really important question
18 and I will -- I will try and answer it as best I can
19 having thought about things.

20 It would all depend on the circumstances of the
21 event and the collapse. And bear in mind particularly
22 earlier on we were thinking within the realms of, of
23 natural events.

24 So if the baby survived we would often say: well,
25 they were premature, maybe sepsis, but they are fine

29

1 course is when you see something that might be a problem
2 or an error so you Datix that error. The staff error.
3 Of course if we are dealing with a member of staff who
4 is deliberately harming they are not going to self
5 report that and you are not necessarily going to see?

6 **A.** No.

7 **Q.** -- that it is not an error, it is a deliberate
8 act, isn't it?

9 So in terms of how the Datix system might work,
10 simply reporting in the way you are required to report
11 a Sudden and Unexpected Death because it's sudden and
12 unexpected and you don't know what happened, if it's
13 a deterioration that is sudden and unexpected as opposed
14 to a sudden deterioration in a naturally deteriorating
15 baby, do you think that would go some way to triggering
16 the level of discussion? So there isn't a need to own
17 a particular error or mistake in the circumstance; it is
18 just we don't know and actually --

19 **A.** Yes.

20 **Q.** -- this is a problem that we don't know?

21 **A.** Yes, and I agree and I think now my -- my
22 threshold for thinking beyond natural events is -- is --
23 the bar is very low and I do think there is an argument
24 for saying perhaps in these situations if there is no
25 clear explanation, as well as Datixing perhaps even

31

1 now.

2 Now, sometimes these would get Datix reported,
3 particularly if it was clear there had been some kind of
4 error or omission that might have contributed to it, for
5 example a cannula that had tissue or observations to
6 suggest abnormalities, to suggest deterioration that had
7 been missed and if they were Datixed they would have got
8 further review.

9 But there was no standardisation of which ones
10 would be Datixed and again if they weren't Datixed and
11 the babies got better it was kind of, well, thank
12 goodness for that, let's carry on.

13 Now, in retrospect, I do think that if we Datixed
14 every -- and this is where it gets difficult, do you
15 Datix every deterioration, what is the threshold at
16 which point you report? You know, so some babies may
17 deteriorate but not arrest and turn around.

18 Had they been Datixed and -- and one of the things
19 with the perinatal Morbidity and Mortality Meetings is
20 that we would have ordinarily have discussed, been more
21 likely to discuss babies who had had non-fatal
22 collapses. What was happening around this time is that
23 there were so many catastrophic fatal events to discuss
24 that there was almost a lack of time to discuss them.

25 **Q.** Just dealing with the Datix point. A Datix of
30

1 thinking going down the SUDiC line as well. Because it
2 can apply to near misses too.

3 I think in terms of a Datix had some of these
4 non-fatal collapses been Datixed they would have been
5 reviewed but I suspect the outcome of those reviews
6 would have been we can't see any specific clinical issue
7 and it may not have brought us any further forwards
8 because again we are thinking within the confines of
9 natural events.

10 **Q.** Baby H, and if you go to paragraph 279 of your
11 statement, we know you were called in at 0132 hours as
12 Baby H had increasing ventilator requirements for a few
13 hours. She seemed to have stabilised by midnight but
14 had a sudden deterioration at 0114 hours.

15 You say you didn't have specific concerns around
16 the care of Child H or the conduct of Letby at that
17 time.

18 Looking at paragraph 279 and 280, though, you do
19 recall observing to Dr Brearey privately the next
20 morning something. Can you tell us what you said to
21 Dr Brearey?

22 **A.** Yes, I --

23 **Q.** Also your thoughts or observations about the
24 valve on the chest drain --

25 **A.** So having been called in that night and again

32

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

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

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

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

33

1 inadvertent or even deliberate harm.

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

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

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

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

35

1 make of that?

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

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

10 **Q.** You mentioned that you spoke with
11 Sue Hodgkinson about that in March 2017 and we will go to
12 that later, if I may.

13 **A.** Yes.

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

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

21 **A.** So it says:

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

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

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

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

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

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

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

36

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

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

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

9 Baby was stabilised on the neonatal unit, unwell
10 but stable and -- I mean, I will go into the details.

11 They have been widely reported.

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

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

37

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

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

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

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

39

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

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

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

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

38

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

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

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

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

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

21 **A.** I can't remember.

22 **Q.** Okay.

23 **A.** When we come to it.

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

40

1 about Baby K at the time or not?

2 **A.** I -- I can't remember in detail. I think
3 I sort of mentioned it in the sense another event had
4 happened and Letby was there but I don't think
5 I specifically articulated the thought processes I was
6 having at 3 o'clock in the morning.

7 **Q.** So did you articulate those thought processes
8 that you were having at 3 o'clock in the morning, you
9 say, with anyone in the hospital?

10 **A.** I think between ourselves not at that point,
11 there was a -- and as time went from February 16
12 onwards, there was an increasing feeling between all of
13 us that, however unlikely, unwanted, abominable the
14 thought of Letby causing deliberate harm could be, that
15 elephant in the room was becoming bigger and bigger and
16 we -- we felt completely impotent to know how to deal
17 with it. We knew that the Thematic Review had been done
18 and hadn't identified any obvious clinical causes.

19 And I assume colleagues were also aware that that
20 Thematic Review had been escalated through to the
21 Medical Director and the Director of Nursing with
22 a request for a meeting. I naively -- I am going to use
23 the word "naively" quite a lot I think today -- assumed
24 that the Nursing Director and the Medical Director would
25 look at that and see the pattern and act.

41

1 **Q.** Did you at that time not understand mere
2 suspicion is enough? I know -- we will come to the
3 Execs, they were looking for proof and what was your
4 evidence and all that stuff, that comes out repeatedly.
5 Mere suspicion is enough, that is not what you
6 appreciated?

7 **A.** Yes, no, I just didn't understand, I don't
8 think any of us understood that at the time,
9 particularly in this situation involving a member of
10 staff.

11 And of course when you think about safeguarding in
12 other situations, for example a child who has come in
13 with unexplained bruising.

14 **Q.** You know mere suspicions --

15 **A.** Of course suspicion is more than enough to
16 trigger the process.

17 **Q.** Child M. You say the presence of Letby at the
18 unexpected collapse of Baby M added to your concerns and
19 that is at paragraph 361 of your statement.

20 If we can go, please, to your police statement at
21 INQ0001982, page 11, Child M, at the bottom if you go
22 over to page 12.

23 You attended after he had collapsed. Resuscitation
24 was under way; displayed the same type of unusual
25 blotching as Child A:

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1 And maybe I was reassured that, you know, there is,
2 there is enough there for people to act anyway. But,
3 yes, I -- I can't really articulate more about Baby K.

4 **Q.** Well, again I suppose picking up on what you
5 said about speaking to CDOP it depends who you are
6 giving that information to someone with a safeguarding
7 perspective --

8 **A.** Yes.

9 **Q.** -- had that information by this point there
10 had been a number of collapses a number of
11 deteriorations and you were saying they are sudden and
12 unexpected leaving aside a member of staff?

13 **A.** (Nods) And I think it's also and again this is
14 my misunderstanding at the time, I understand entirely
15 now that having enough grounds for suspicion is enough
16 to escalate and I think for example had I walked in with
17 Baby K and witnessed something then that would have been
18 very easy, you know, that's -- that's a no-brainer but
19 I think this was all -- you know, it was all very
20 circumstantial and I think we felt or we believed
21 because it was such an outlandish and unlikely
22 possibility that we -- you know, did we need more to
23 raise it?

24 And of course it took us in the end until the third
25 week of June in 2016 to feel we had enough to raise it.

42

1 "Didn't fit with anything I had ever seen before."

2 You tell us in your statement that you went on to
3 discuss this with Dr Brearey.

4 So you had seen these patches, blotches again that
5 were odd. What were you thinking at that point, what
6 did you start to think about?

7 **A.** Again, I hadn't at that point, although myself
8 and colleagues were -- had begun to wonder about the
9 possibility of Letby deliberately doing something, we
10 hadn't really started actively thinking about what might
11 be being done.

12 And again in these situations Letby was there, it
13 was an unusual, very unusual collapse and this unusual
14 discolouration. Again we are thinking along the lines
15 could this be sepsis? But it doesn't quite seem to
16 quite fit, could this be some kind of cardiac event
17 didn't seem to quite fit.

18 And when I discussed with Dr Brearey essentially
19 I mentioned, you know, it was another one with the
20 blotching but in this situation we actually had
21 a successful resuscitation.

22 **Q.** So again -- that can come down, thank you --
23 the pressure fell off that the child resuscitated well?

24 **A.** Yes.

25 **Q.** And it wasn't something there was debriefed,

44

1 discussions?

2 **A.** It sounds awful to say, had the outcome been
3 different it might well have triggered a more in-depth
4 response.

5 **Q.** You say at paragraph 374 of your statement:
6 "An event such as that around Child M might usually
7 have been discussed at the [Perinatal Mortality
8 Meetings]. However, given the number of deaths there
9 had been there was not the capacity in the scheduled
10 three monthly meetings to discuss the non-fatal
11 collapses."

12 We see in fact Baby E isn't even reached in one of
13 the meetings that Baby E is supposed to be being
14 discussed.

15 Just dealing with those meetings generally, having
16 reviewed a number of notes of the meetings, they
17 don't -- usually because the postmortem comes in
18 later -- usually review postmortem and clinical findings
19 at the same time in great detail from the ones we have
20 seen for the babies of the indictment?

21 **A.** Yes.

22 **Q.** Is that your experience more generally of
23 them?

24 **A.** So ideally by the time a baby is discussed at
25 the Perinatal Mortality Meeting we would like to have

45

1 I don't think in that meeting it's something that would
2 have necessarily been on anyone else's radar.

3 **Q.** Before we even get to deliberate harm, what
4 was necessary was that the doctors and the nurses and
5 the parents in some cases -- let's be clear, the parents
6 had key information to provide?

7 **A.** (Nods)

8 **Q.** -- particularly the Mother E in relation to --

9 **A.** Yes.

10 **Q.** -- her baby. They all needed to be in the
11 same spot discussing this, didn't they, to share their
12 own observations about who had seen what, because the
13 meetings are dependent on the notes that arrive there --

14 **A.** Yes.

15 **Q.** -- and the people who attend?

16 **A.** Yes.

17 **Q.** We haven't seen notes of meetings with all the
18 various people who make observations, for example, on
19 Baby A or Baby C or Baby D all in the same room
20 discussing it with a postmortem report where the
21 contradictions and inconsistencies can be fleshed out?

22 **A.** Yes.

23 **Q.** It is not possible, is it, in the context of
24 meetings with only one of the doctors who wasn't there?

25 **A.** I think that's a really important observation.

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1 the postmortem back and, you know, the pathologist will
2 come down and discuss.

3 This was -- there were -- this wasn't happening as
4 frequently, so babies were often being discussed without
5 the postmortem findings. Ideally, when the postmortem
6 findings were back, they would -- they should have been
7 rediscussed. I don't think that was happening
8 consistently just due to time constraints.

9 **Q.** We have seen the records of those.

10 **A.** So to an extent the value of the Perinatal
11 Mortality Morbidity Meetings was not as effective as it
12 might have been without those.

13 I think the important thing about those meetings as
14 well -- and I have thought long and hard about this --
15 as to whether they would have been a forum to flag up
16 the specific concern about deliberate harm. Again, it's
17 very much like a lot of the meetings looking at systems,
18 looking at processes, looking at what was done, how it
19 was done, was it done at the right time, was it the
20 right thing, was it too late?

21 It -- I don't think it is a forum where it would
22 have taken -- if I may use the analogy of the Emperor's
23 new clothes, you would have needed somebody with the
24 courage of the little boy to actually put their head
25 over the parapet and say, "There is no clothes" and

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1 So even in terms of Perinatal Mortality Meetings,
2 the doctors, nurses, midwives involved wouldn't
3 necessarily be available or free to attend the Perinatal
4 Mortality Meetings at that time.

5 The rapid reviews that were undertaken by the
6 neonatal lead, the neonatal ward manager and the risk
7 facilitator did not routinely have people in attendance
8 who were there at the time. If it was escalated to
9 a higher level they might be there if there was
10 a Level 2 investigation and you made a really important
11 point which I had never considered before, yet it is so
12 obvious: parents' observations need to be included in
13 these as well, every time, you know, not necessarily
14 present, but, you know, information from the parents
15 needs to be there.

16 **Q.** You either have everybody who's present
17 writing things down, which of course they eventually did
18 in a police station investigation, giving statements to
19 the police for that perinatal or neonatal mortality
20 meeting to discuss, or you have to have them there but
21 would you agree with me, certainly in the babies we have
22 been looking at, they were relatively superficial
23 analyses and refer a lot to obstetric care, antenatal
24 care --

25 **A.** Yes.

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1 Q. -- things like delayed cord clamping,
 2 important but not what this was about?
 3 A. Yes, no, I agree.
 4 Q. They can in some sense give a false
 5 reassurance. You see a load of documents and think:
 6 well, that was considered then. Well, not really for
 7 the information that we are analysing.
 8 A. Yes, yes, and I think -- I suppose if you
 9 don't ask the right questions you are not going to find
 10 the important answers.
 11 Q. And if you have a set process, you are not
 12 going to?
 13 A. No.
 14 Q. If you just follow a set process you are not
 15 going to get the important answers?
 16 A. No, I agree.
 17 Q. You refer to a Level 2 investigation, I don't
 18 know what that means, but if something's really odd,
 19 actually having a debrief, hot debrief -- I don't know
 20 what you call it in the NHS -- but everyone around
 21 a table to discuss it --
 22 A. Yes.
 23 Q. -- is what was required.
 24 Is there room for that thinking outside the box or
 25 the processes?

49

1 Letby's notes and Mother E's evidence?
 2 A. Yes.
 3 Q. So again having everybody there can still be
 4 useful?
 5 A. Yes, yes, and it depends on the level of
 6 detail in the discussion as well. But, yes, absolutely,
 7 I couldn't disagree.
 8 Q. Child L was another child that you had
 9 actually recommended changes to fluid management for and
 10 requested blood tests, same as my questions earlier
 11 about Child F. Obviously that insulin test result
 12 wasn't appreciated at the time. Missed opportunity,
 13 would you say? As you have said before, that should
 14 have been picked up.
 15 A. Yes. So I am aware with -- sorry, it was
 16 Child L, wasn't it?
 17 Q. Yes.
 18 A. I am aware with Child L that when the insulin
 19 C-peptide result came back, it was documented in the
 20 notes by one of the junior paediatricians in training.
 21 I wasn't clear when I saw the notes whether those
 22 results had been discussed with anyone more senior, but
 23 an impression was given that the result was back and
 24 I think the error carried forward that there was nothing
 25 abnormal.

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1 A. So in terms of debriefs, a hot debrief is
 2 sitting down immediately afterwards and, you know, does
 3 anyone -- is everyone okay? Any thoughts about what's
 4 happened? What can we do differently?
 5 A cold debrief is more when the dust has settled,
 6 there is time to think -- there may or may not be
 7 postmortem findings, to have a think through what we did
 8 well, what we could have done better, what for the
 9 future can we do.
 10 Now, I think those are important, essential.
 11 I think interestingly had those debriefs happened
 12 and -- and they tend to be the hot, the cold debriefs
 13 are usually planned to try and find a time where the
 14 majority of staff involved can be present. Now, of
 15 course in these situations Letby would have been present
 16 as well.
 17 So I can only speculate on again whether those
 18 discussions might have been more revealing, but I do
 19 think that even with her present there's an opportunity
 20 for the -- for everybody to express -- I suppose to say
 21 this doesn't make sense and it triggers an opportunity
 22 to look further.
 23 Q. Well, Letby's presence might have been helpful
 24 to the extent that, for example, discussing the medical
 25 notes around Baby E, there was a direct conflict between

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1 Now, interestingly, at the time of the episode of
 2 hypoglycaemia, it was the same day as the baby's Twin
 3 had the non-fatal collapse and had problems with
 4 resuscitation.
 5 One of the things with this baby's hypoglycaemia is
 6 that I was not at the time -- even with Letby being
 7 present, I was not at the time concerned about anything
 8 unnatural going on and to the extent that we know that
 9 premature babies who are on the smaller side can become
 10 hypoglycaemic, again if they are hypoglycaemic, we need
 11 to do the investigations to exclude other things, but
 12 the amount of glucose that was needed to maintain normal
 13 blood sugars, although higher than a normal healthy
 14 baby, was not at a point beyond what I had seen in
 15 babies in similar situations with natural reasons for
 16 hypoglycaemia.
 17 So I saw this little one a few days later on a ward
 18 round on a weekend, and I think I wrote in the notes
 19 "resolved hypoglycaemia". I wasn't prompted to look to
 20 see whether the investigations had come back.
 21 So I didn't look back in the notes. One of the
 22 reasons I guess I didn't look back is the hypoglycaemia
 23 had resolved. Secondly, I hadn't had a suspicion that
 24 there was anything unnatural going on. Thirdly, and to
 25 be honest, I will be honest, I don't recall whether

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

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

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

14 Child O and P, you were away from the hospital on
15 23 June and you became aware of O's death on 24 June and
16 you deal with this at paragraph 392 of your statement
17 and the Inquiry has heard evidence from both
18 Karen Townsend and Karen Rees about this.

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

23 **A.** Karen Townsend or ...?

24 **Q.** Townsend, sorry, first.

25 **A.** So Karen Townsend was the Divisional Director

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

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

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

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

25 So that's my recollection of the conversation.

55

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

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

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

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

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

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

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

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

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

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1 Please do something.

2 I could have been more forthright. I could have
3 said specifically, "You must remove her from the unit"
4 and I didn't say that.

5 **MS LANGDALE:** Thank you, Dr Jayaram.

6 I think that's a good moment to take a break. May
7 I suggest a 11.35 return?

8 **LADY JUSTICE THIRLWALL:** Yes, thank you,
9 Ms Langdale. So, doctor, we are going to take a break
10 and we will start again at 25 to 12.

11 (11.17 am)

(A short break)

13 (11.40 am)

14 **LADY JUSTICE THIRLWALL:** I'm sorry to have kept you
15 all waiting. Ms Langdale.

16 **MS LANGDALE:** Dr Jayaram, may I move now to the
17 Inquest for Baby A in October 2016, so we are moving on
18 in time.

19 You prepared your statement to the Inquest back in
20 July 2015. In common with your medical notes at the
21 time, that doesn't make reference to the rash and you
22 tell us because at the time of events when you did the
23 Coroner's statements in your notes, you didn't
24 appreciate the significance of that?

25 **A.** No, and I can't remember writing the statement

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1 the people listed, so Stephen Cross, legal,
2 Louis Browne, Queen's Counsel, yourself, Dr Saladi,
3 Dr Harkness and a Dr MacCarrick.

4 If we go to page 10 we see noted Louis is
5 explaining the Inquest, the objective of the Inquest,
6 pointing out -- someone is pointing out PM
7 unascertained, the postmortem says unascertained death.
8 Cross pulmonary arteries, no suggestion it played a part
9 in the death.

10 Dr Harkness makes contributions.

11 Then if we go to page 11, Dr Jayaram: still to this
12 day Ravi doesn't know why this happened. 27 years in
13 paediatrics, never seen this kind of situation.

14 Did you say that in the meeting or is that --

15 **A.** I probably said words to that effect, that,
16 you know, I couldn't -- I still at this stage couldn't
17 explain what had happened and it ...

18 **Q.** If we go to page 12, Dr Saladi, Coroner -- he
19 says if the Coroner asks -- it looks as though it says
20 if the Coroner asks how did it inform future practice --
21 and I don't know who says this, do you know who says:

22 "Review Royal College of Paediatrics, pattern of
23 deaths appear unusual, further inquiry required,
24 forensic review"?

25 Then there is a reference:

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1 but it -- it really wasn't in my mind at that time.

2 **Q.** When you write a statement we have heard from
3 some of the junior doctors you sort of get a pack about
4 what's required or what's to be done. Did you get
5 anything about guidance on putting statements together?

6 **A.** I don't recall getting anything specifically
7 on this occasion. I had written statements previously
8 for safeguarding proceedings and things.

9 **Q.** Dr Lambie told us she understood it had to be
10 factual about your involvement in the baby --

11 **A.** Very much so and we are always told that you
12 should not speculate but just stick to facts.

13 **Q.** The Inquiry has a notebook from a paralegal
14 called Josh Swash about meetings around that time
15 between Execs and legal department. If I can ask for
16 INQ0108406; page 9. This is a telephone conference on
17 the morning. It looks like there was a meeting earlier
18 with some of the doctors and but you weren't at that,
19 Dr Jayaram.

20 Were you invited to an earlier meeting, do you
21 remember?

22 **A.** Yes, I recall that there were two dates,
23 I think the first one I had other clinical commitments
24 and couldn't go.

25 **Q.** So you attend for this telephone call between

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1 "If review is outside of the remit of your
2 knowledge, then say so."

3 Just to anchor us in time, it says the review is
4 ongoing. At this point, the Royal College review has
5 been received but you haven't seen the Royal College
6 review but someone has spoken to you about it; is that
7 right?

8 **A.** Yes, so at this stage my understanding of
9 where things were up to is as follows: the Royal College
10 review had taken place, I had had if you like a hot
11 debrief from Ian Harvey a few days after they had been
12 to feed back to me what they had fed back to the
13 Executive board.

14 **Q.** What was that?

15 **A.** So essentially that we were told that they
16 hadn't identified any significant issues with clinical
17 practices, that there were a number of recommendations
18 around team working and leadership although he didn't
19 specifically say what areas, and that they had
20 recommended a forensic -- full forensic Casenote Review
21 and I think at the time he came to see me I actually
22 sent an email to colleagues summarising his conversation
23 pretty much contemporaneously of what he had said was
24 due to happen and it was a full forensic review
25 involving neonatologists, pathologists, all the notes,

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1 all the staffing patterns.

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

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

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

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

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

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

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1 **A.** Yes.

2 **Q.** It says here:
3 "If review is outside of the remit of your
4 knowledge, say so. Don't say anything unless you know."

5 Do you know who was saying that?

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

9 **Q.** Louis Browne?

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

13 **Q.** Yes, that is the page before?

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

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

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

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

22 "Dear Mr Rheinberg."

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

25 "You will recall that in your absence I advised

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

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

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

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

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

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

11 Then the next page:

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

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

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

22 **Q.** To Dr Hawdon or the Royal College?

23 **A.** The one to Dr Hawdon.

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

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1 "Dear Louis,
2 "Thanks for the case conference, most helpful.
3 "Further to our conversation regarding disclosure
4 to the Coroner regarding the current review being
5 undertaken, please see email below. I attach for
6 information our letter of instruction regarding the
7 continuation of the review."

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

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

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

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

25 **Q.** Aware of reviews going on --
65

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

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

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

17 **A.** Yes.

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

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

3 **A.** Aware of our specific concern about an
4 individual.

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

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

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

18 "Mr Rheinberg moved on to questioning Dr Jayaram."

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

23 Then we also see if we go to page 8, you are
24 recalled by the Coroner to assist with knowledge of the
25 circumstances concluding with any cause of death and you
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1 family. However, as he pointed out, it is the Executive
2 board's decision. He has to confirm, however, that the
3 events that happened to Child A do not make any clinical
4 sense to him at all."

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

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

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

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

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

24 I was trying to make it clear to the Coroner that
25 I did not understand what was going on here and
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1 I couldn't think of a clinical explanation and there had
2 been other things like this as well. But I didn't
3 explicitly say that.

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

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

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

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

16 I am now going to move to a different topic,
17 Dr Jayaram, of the discussions of concerns amongst
18 doctors themselves. So we will go back in time again to
19 2015 and if we can go to INQ0003110, page 1.

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

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

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

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

6 **Q.** Dr Gibbs says:

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

9 And he says candidly to you and his fellow
10 Consultants:

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

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

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

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

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

25 The email further below:

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

3 **A.** I would agree.

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

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

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

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

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

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

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

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

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

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

9 **A.** Yes.

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

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

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

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

25 When I was sent this email it was my first

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

7 **Q.** We can pick that up with Dr Brearey but if you
 8 look at the top, the last email at the very top, I don't
 9 think -- Dr Brearey says:
 10 "I don't think they warrant a presentation for all
 11 three yet. I would rather discuss Child A in detail.
 12 Not sure who's presenting that."
 13 Of course viewing them together as a cluster would
 14 have been very helpful, wouldn't it?

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

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

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1 **Q.** If we go to 0005580, page 1, it's an email
 2 from Dr Brearey attaching his summary and data on 1 July
 3 --
 4 **A.** Yes.

5 **Q.** -- for a meeting. And you are cc'd with this
 6 so in fact stuff was being done?
 7 **A.** Yes.

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

11 **Q.** Felt we have seen their evidence, of course,
 12 about how shocked they were?
 13 **A.** Yes.

14 **Q.** Out of blue.
 15 Very helpful information to have to assist the
 16 thinking of senior Consultants, wasn't it?
 17 **A.** Yes, I agree.

18 **Q.** So we see he attaches a summary. One of the
 19 pieces of information that appears to be put together
 20 quite early on, if we go to 0003191, page 3, is the
 21 business of pattern, the pattern of those three deaths.
 22 So Dr Brearey has pulled together the neonatal
 23 mortality deaths. I am assuming it is him, we will
 24 check with him, but in his review of those years
 25 previously and there's three in three weeks.

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1 Dr Brearey is not there but you are present for
 2 this one and there is discussion about the business case
 3 for paediatric Consultants and if we go overleaf to
 4 page 2, on the fourth paragraph:
 5 "There was also an issue raised around the fact
 6 that with the three recent neonatal deaths Registrars
 7 had been quite worried and feel that nothing is being
 8 done.
 9 "Behind the scenes reviews are going on but it was
 10 felt that formal debriefs should probably take place
 11 rather than any specific meeting to discuss all three."
 12 Can you even remember that being discussed now?
 13 **A.** I can't, I can't remember the meeting. I --
 14 I probably put this record together. I don't remember
 15 the discussion. I can't remember whether Steve Brearey
 16 was at this meeting or not. Sorry, can you go back?
 17 **Q.** No, he wasn't. If you go back to page 1 he's
 18 not?
 19 **A.** But I think that the discussion that had taken
 20 place on email might have contributed to that, but first
 21 of all I can't remember the discussion, I can't remember
 22 what the pros and cons discussed of discussing them
 23 together or separate debriefs was and how that
 24 conclusion was made and I don't know whether those
 25 debriefs then took place.

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

5 **Q.** That can go down, please. We then have
 6 an illustration but I think you accepted this earlier,
 7 a discussion at the neonatal mortality meeting 0003228,
 8 page 1. Dr Brearey's has emailed a number of people to
 9 request at short notice another neonatal mortality
 10 meeting on Thursday, that is not the right one.
 11 0003288, page 1.
 12 We see there Child I, this is the discussion for
 13 Child I and considering the circumstances awaiting the
 14 PM, there is not much that can be presented or in the
 15 learning there. And we see the attendees at the top, do
 16 you agree?
 17 **A.** Yes.

18 **Q.** I think Dr Neame, to be fair, was involved in
 19 Child I but in terms of setting out clinical findings
 20 against pathology, need for review. It's not very
 21 detailed, is it, for --
 22 **A.** Not on these minutes, no.

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

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1 page 1. We see Dr Subhedar has said one additional
2 comment:
3 "You might consider adding somewhere that relates
4 to the theme of some of the cases involving babies that
5 suddenly and unexpectedly deteriorated and whom there
6 was no clear cause for the deterioration/death
7 identified at PM".

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

12 **A.** Yes.

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

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

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

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

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

8 **A.** By this stage, yes.

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

11 **A.** I was aware because there had been in the
12 mortality table and the review that it was unusual that
13 these things were happening at this time. I was also
14 aware that Letby's presence was a consistent finding as
15 well. And in conjunction I think if you look at points
16 1 and 2 together, that's sort of two massive red flags
17 for indicating things need to be looked at in far more
18 detail.

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

20 **A.** Can I just comment as well?

21 **Q.** Yes.

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

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

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

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

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

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

23 **A.** Yes.

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

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

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

7 This email is sent -- and you are cc'd -- by

8 Dr Brearey. It is after Baby M, before Baby N saying:

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

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

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

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

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

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

25 **A.** (Nods)

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

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

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

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

4 **A.** Yes.

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

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

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

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

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

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

5 **A.** Okay.

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

7 **A.** Sorry.

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

13 18 June 2015, if we go to INQ0004235, page 3, we
14 see at the top the Datix of Child A being referred to.
15 Documentation excellent, multi-disciplinary working was
16 excellent, clear reviews etc, etc.

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

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

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1 up or fleshed out?

2 **A.** So the Women and Children's Governance Board
3 was a monthly meeting. It's -- there are Terms of
4 Reference for it, but it very much was a forum that took
5 an overview of things so rather than actually
6 investigating things itself reports should have been
7 brought to it. Having said that, I am fully aware that
8 later on Datix reports of other babies who died were not
9 brought to the meeting.

10 Usually what would happen if something had been
11 identified that required a change in practice, a change
12 in systems, any kind of -- or any kind of quality
13 improvement, it would be brought and then that quality
14 improvement plan, action plan, would then be monitored
15 here and signed off when it was done.

16 Again, is this a forum where -- two things, really.

17 Had each of the reported deaths been discussed at
18 this meeting or even flagged up at this meeting, it
19 might have caused other people to ask the question and
20 raise concerns. The second question is: was it a forum
21 where the specific concern about a member of staff could
22 be explicitly raised? I would think probably not.

23 **Q.** Pausing there, I am not suggesting that should
24 have happened?

25 **A.** Sorry.

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1 there was a lot of stuff to be covered, a lot of it was
2 almost more process: we have to talk about this, we have
3 to talk about this.

4 **Q.** So it is process-driven?

5 **A.** It is very process --

6 **Q.** What you are required to talk about rather
7 than --

8 **A.** Yes, in my -- in my view it was very
9 process-driven and I think it was therefore difficult to
10 make it more reactive. I think as well in terms of this
11 being a forum for -- I think it could have been flagged
12 up, that these were sudden and unexpected, in terms of
13 it being a forum for discussing therefore potential
14 cause, I'm not sure I would usually be -- myself or
15 Dr Brearey would only -- would usually be the only
16 paediatric medical person there and there may be one or
17 two people from the paediatric nursing background.

18 However, I do think if they had been flagged up,
19 then it may have been spotted.

20 Now, the thing I was never sure of is how these
21 minutes were then escalated and this is one of the
22 difficulties when we had the division of Women and
23 Children's, there were much clearer lines.

24 They would have been I think since the Urgent Care
25 governance board and the Planned Care governance board

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1 **Q.** Just that the death was sudden and unexpected?

2 **A.** Yes.

3 **Q.** If you take us back to our beginning
4 conversation, if everybody understood "sudden
5 unexpected" triggers investigation?

6 **A.** Yes.

7 **Q.** Concern, what can I add, is there something of
8 importance here? Just the description, a Datix doesn't
9 really cover it, does it, we know why the Datix was
10 completed?

11 **A.** Yes.

12 **Q.** It doesn't really cover what the central issue
13 is. And just if I may continue, Dr Jayaram, we know
14 nothing of notice in relation to these babies 30 July
15 meeting or 19 November. And I think the 16 June 2016 is
16 the next time we see reference and that's at INQ0004308,
17 page 5.

18 As that document's being called up, Dr Jayaram,
19 I think there are 18 attendees listed, most give
20 apologies and seven attend.

21 So what's the reality on the ground for these
22 larger meetings, seven out of 18 doesn't sound great to
23 me, but is that typical?

24 **A.** Yes. I think that the trouble with these
25 meetings is that the agendas were very, very large,

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1 but I don't know how they would have been slated beyond
2 that.

3 **Q.** It says on page 1 how they are escalated, it
4 says:

5 "Alison Kelly receives minutes for escalating to
6 Trust board"?

7 **A.** Okay.

8 **Q.** So if she chooses to, they can be escalated to
9 the Trust board?

10 **A.** Okay.

11 **Q.** Just going back to your answer, it was
12 process-driven. Do you mean this committee, do you mean
13 governance generally in the hospital?

14 **A.** I think this meeting was, was very, very
15 process driven. I can't speak for other governance
16 meetings across the Trust but I do -- and I don't think
17 this just applies to the Countess, I think this is an
18 NHS-wide thing, I think there are a lot of processes
19 that are put in place that are there to help to achieve
20 an outcome, but sometimes or not infrequently the
21 process, if you like, becomes more important than the
22 outcome, because it --

23 **Q.** And they become superficial?

24 **A.** It becomes easier to monitor the process and
25 to actually try and change the process is -- is

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1 difficult.

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

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

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

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

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

24 **Q.** Yes.

25 **A.** And of course as a consequence, we were in
89

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

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

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

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

19 **Q.** Thank you, that can go down.

20 CQC visit briefly.

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

24 You tell us you don't recall discussing the numbers
25 of neonatal deaths with the CQC inspectors and you
91

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

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

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

10 **A.** Yes.

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

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

19 **Q.** 21 July 2016.

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

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

25 **A.** No, no.
90

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

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

6 **Q.** Yes.

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

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

14 **A.** No.

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

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

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

22 "... subsequently learnt that the inspectors were
23 told that as a group of Consultants we felt that we were
24 struggling to be heard in raising patient safety
25 concerns and not being listened to, although I was not
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1 aware they had been told this at the time. We were also
2 at that time still waiting for the two new consultant
3 posts that had been approved to be advertised and
4 continuing to regularly act down to cover middle-grade
5 gaps as well as dealing with a significantly more
6 intense workload on the NNU."

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

10 **A.** Yes.

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

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

19 **Q.** Yes.

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

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

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

8 **A.** Well --

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

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

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

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

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

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

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

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

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

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

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

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

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

9 "Dear Steve ..."

10 If we can get that on the next page.

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

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

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

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

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1 I don't know.

2 **Q.** Let's go to INQ0003114, page 1. Mr Harvey
3 suggests whether it can be joined up with the obstetric
4 review when it's signed off at governance board. We
5 know the Brigham review had been conducted?

6 **A.** Yes.

7 **Q.** Which was very much an obstetric review, not
8 a neonatal review.

9 **A.** Yes.

10 **Q.** We see at the top there an email to you and
11 Eirian.

12 "I think we still need to talk about Lucy, maybe
13 when you are back and free the three of us can meet to
14 talk about it."

15 So at the same time, Dr Brearey is suggesting you,
16 Eirian and he speak about Letby. Did a meeting as far
17 as you recollect happen around then to discuss Letby
18 herself?

19 **A.** There was never a meeting between myself
20 Steve Brearey and Eirian Lloyd-Powell that took place.
21 I think that various people were on leave at different
22 times but I was never part of a specific meeting and
23 I think shortly after this was when Letby was moved from
24 nights to days. I can't remember, I think it wasn't
25 long after this, but I wasn't part of that --

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1 to Alison Kelly by Eirian Lloyd-Powell was the review
2 that had been sent to Ian Harvey in the February,
3 correct me if I am wrong --

4 **Q.** We will follow that up with them.

5 **A.** I don't know.

6 **Q.** I am just asking your understanding, if I can?

7 **A.** Okay.

8 **Q.** So if we look at this, we see an email from
9 Dr Brearey to Alison Kelly:

10 "I am hoping Karen has spoken to you about our
11 mortalities last week. We are going to discuss the
12 matter at our senior paediatricians' meeting on Monday.
13 I was wondering if it might save time if you and Ian
14 could join us to discuss the ongoing issues."

15 If we go back to page 1, Karen did discuss -- the
16 reply comes:

17 "Karen did discuss this with me last week. I am
18 looking to touch base with her again. I will discuss
19 with Ian this AM re trying to attend your meeting. from
20 our previous meeting held several weeks ago we agreed we
21 would meet in July anyway so the timing is appropriate."

22 So in the May meeting, agreed to meet in July.

23 Was there any ability just to create informal
24 meetings or immediate meetings depending on the
25 circumstances or the level of concern?

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1 **Q.** That is April, yes?

2 **A.** -- decision-making process.

3 **Q.** If we can go please next, Dr Jayaram, to
4 INQ0003089, page 2. We see there at the bottom you are
5 cc'd into this, an email between Eirian Powell and
6 Alison Kelly asking to arrange a meeting to discussing
7 how to move towards with regards to findings of the
8 review.

9 At the top another email reply from Alison Kelly:

10 "Thanks for the update. Could you please send Ian
11 and I the report? Once we have reviewed this I think it
12 would be good for me, you, Ian, Steve and Ravi to meet
13 and discuss."

14 Did you ever have such a meeting around them?

15 **A.** No. No and I was never -- I was never invited
16 to a meeting and certainly a meeting with myself,
17 Dr Brearey, Eirian Lloyd-Powell, I think the meeting
18 that eventually took place was the one that was referred
19 to earlier in May 2016, which was some time after the
20 initial request.

21 **Q.** There's another request for a discussion if we
22 go to INQ0003142, page 2. Later on in time,
23 sometimes --

24 **A.** Another observation, sorry, is that this was
25 sent on 17 March. But I am assuming that what was sent

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1 **A.** I suppose there's always an ability to create
2 an immediate meeting if people are free and there is
3 a high level of concern. We knew that we were going to
4 have all the other relevant people in the room on -- so
5 I think that email that Steve Brearey initially sent to
6 Alison Kelly was actually sent on a Sunday so we knew
7 that we would have everybody in the room on the Monday
8 lunchtime, or the majority of the people in the room on
9 the Monday lunchtime for the senior clinicians' meeting
10 which is why I think Steve Brearey has invited them to
11 come to that meeting.

12 **Q.** We then see an email from Dr Brearey
13 INQ0005749, page 3. If we go to the next page, please.

14 We need to go to page 3, sorry, thank you:

15 "There has been a watchful waiting approach since
16 our last meeting with Ian and Alison in March. Since
17 the episodes and deaths last week there was a consensus
18 at the senior paediatricians' meeting. We felt on the
19 basis of ensuring patient safety this member of staff
20 should not have any further patient contact."

21 And conclusion to this email:

22 "I understand Ian and Alison met with Eirian and
23 Ann yesterday and the outcomes from that meeting don't
24 entirely fit with what was suggested at our senior
25 paediatricians' meeting hence it would be helpful to

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

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

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

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

17 **A.** Yes.

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

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

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

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1 was it that you --

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

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

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

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

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

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

24 **Q.** You sent that at 10.24?

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

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1 need to go to INQ0003112, page 3.

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

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

7 We see your response above:

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

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

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

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

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

22 Then we see at page 1 at the top your response.

23 Can you tell us from Dr Saladi's email and yours what
24 had happened in the day that arrived at you sending that
25 email or whether you already knew that was the case, how

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

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

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

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

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

24 **Q.** Page 2. Comments attributed to TC,

25 Tony Chambers. Why did we call the police? Presumably

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

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

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

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

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

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

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

24 **Q.** Paragraph 465, you do say:

25 "I recall Mr Chambers explicitly saying in one of
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1 "I appreciate we don't want to cause alarm but
2 people aren't daft, they will immediately ask why. The
3 absence of any reasons makes it look like we are trying
4 to hide something."

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

9 **A.** Yes.

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

14 **A.** Sorry?

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

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

21 But there was no, there didn't appear to be any
22 sort of reasoning given behind it and I just, I just
23 felt and again it was my, my view that it would probably
24 although the statement I believe properly in good faith
25 was put out to sort of smooth calmed waters, there was
111

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

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

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

13 **A.** Yes.

14 **Q.** -- the day job.

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

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

25 You say:

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1 the risk that it would actually cause more
2 consternation.

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

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

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

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

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

23 **A.** I -- I can't -- I can't remember whether it
24 was this. I think it was this one because there was
25 another meeting the next day, but looking at the --
112

1 I think -- does it mention it in the minutes?

2 **Q.** You tell us the meeting the next day we know
3 was an extraordinary Board of Directors.

4 **A.** So I think this meeting was where he presented
5 those graphs and interpreted the data as I guess what --
6 what we were being told is the data suggests that it's
7 chicken and egg; you have had a higher acuity of babies
8 and therefore you have been more busy and therefore the
9 staff have been busier, it's inevitable that a full-time
10 nurse who's done the intensive care course is more
11 likely to be involved with any of these babies because
12 she is there more for them and therefore really that --
13 and there were graphs presented, I think, that were
14 interpreted as suggesting acuity had gone up, intensity
15 had gone up --

16 **Q.** I'll come to those in a moment. If you just
17 look at page 5 at the bottom. Somebody has asked the
18 question about what would we do if this was a doctor?
19 How would we deal with it? It's Mr Chambers. And you
20 say at the bottom:

21 "Doctor would have been suspended."

22 **A.** Yes. It was, it was -- it was a strange, it
23 was a strange comment --

24 **Q.** Yes.

25 **A.** -- because it doesn't matter whether, you
113

1 anything else? Did you have any idea how this was put
2 together?

3 **A.** No. I think this was BadgerNet and NNAP data,
4 I think. It says it uses BadgerNet data. Badger is the
5 neonatal database. All neonatal units enter data into
6 Badger

7 **Q.** So if we just pause for a second only, please,
8 Mrs Killingback, on each page 2, 3, 4, 5, 6, 7.

9 **A.** So this -- this is the striking one where it
10 basically very clearly demonstrates what we'd been
11 saying: there had been a quite marked and obvious uptick
12 in deaths on the neonatal unit since 2015.

13 **Q.** Yes.

14 **A.** Now, this was an interesting graph because
15 there are -- again, my interpretation of it -- there are
16 dots that are coloured in red.

17 But it doesn't to my eyes -- and maybe that's
18 because I don't want to see a trend, I don't know -- it
19 doesn't show a trend. If I look back at 2014, I could
20 colour in some of those dots red as well.

21 And of course we were -- we did have more activity
22 because we had sicker babies, but we had sicker babies
23 for reasons that we know about.

24 I think that that's also -- care days, of course if
25 you've got sicker babies you are going to have more care
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1 know, if you're a doctor or a nurse or a physio or
2 a ward clerk, or any other person working in a hospital,
3 if there are suspicions about you causing deliberate
4 harm you would be suspended.

5 And I have realised, again subsequently having seen
6 other documents, that there was a suggestion that
7 because the individual we were worrying about was
8 a member of nursing staff we were reacting very
9 differently. And the suggestion I -- I think here was
10 if this was a doctor, we wouldn't be suggesting all of
11 these things, you know, and I think the suggestion was
12 if it was a doctor, you would -- you would perhaps be
13 more nurturing and not as -- not as accusatory.

14 And, I think the other point I made here is
15 Ian Harvey's data's all very well, but it doesn't
16 actually address the specific issue of these babies
17 suddenly deteriorating.

18 **Q.** Let's quickly have his presentation on the
19 screen please, INQ0002837, starting at page 2. Page 1
20 actually tells you how it's summarised.

21 That's what it purports to do. Did you know if
22 there had been consultation with any of the neonatal
23 network or others?

24 **A.** Not that I was aware of.

25 **Q.** Or if it had been taken from MBRRACE or
114

1 days. Now, if you then look at that -- and again,
2 sorry, can you go back to that one?

3 If you go back to 2014, I could have put some red
4 dots in there as well. But of course care days were
5 going up because we had sicker babies and those sicker
6 babies, you know, chicken and egg were effect, in
7 retrospect, rather than cause.

8 Then of course the next one looking at acuity.
9 Yes, of course acuity was going up because we were
10 having -- we were having sicker babies.

11 And I think there -- was there one more about
12 staffing as well?

13 **Q.** What do you mean when you say "sicker babies"?

14 **A.** Well, we were having babies who were more
15 unwell because what we know now is they were being made
16 more unwell.

17 **Q.** So you weren't saying constitutionally you
18 were getting iller babies?

19 **A.** No, no.

20 **Q.** You were saying that the ones were
21 presenting --

22 **A.** There wasn't a trend of smaller babies, more
23 premature babies. The babies that we had were babies
24 that we had previously always looked after as you can
25 see from the data from previous years.
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1 But again the reason that acuity was going up was
2 because of what was happening to these babies and of
3 course because of that, of course there were going to be
4 more intensive care and high dependency, high dependency
5 days. And again if you look back at November 13 and
6 January 14, May 14 there's been troughs and peaks
7 throughout.

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

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

15 **A.** Well --

16 **Q.** -- or required scrutiny for each of the
17 babies --

18 **A.** No.

19 **Q.** -- who died or collapsed?

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

23 **Q.** Let's just -- two more documents before we
24 break, if I may. The first is the extraordinary
25 Board of Directors meeting, minutes of meetings held on
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1 something that you say -- you state what you are going
2 to say was confidential and not to be minuted?

3 **A.** I think I explicitly stated the concern about
4 Letby.

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

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

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

16 "The actions are proportionate as a holding measure
17 ..."

18 Is this the instruction for the RCPCH?

19 **A.** Yes, the RCPCH and the regrade.

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

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

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

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

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

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

16 **A.** Yes, and I think there's -- there's data from
17 NNAP that actually suggests that although we were not
18 100% compliant with British Association for Perinatal
19 Medicine standards for staffing in terms of the skill
20 mix, we were not an outlier by any means compared to any
21 other organisations. We were bang in the middle for
22 average. And those also were not new circumstances.
23 There hadn't been a sudden change in terms of where we
24 were with our staffing compliance.

25 **Q.** Sorry, over the page, page 4, you say
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1 remember whether it was this meeting or another meeting.

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

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

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

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

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

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

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

22 **MS LANGDALE:** 5 past 2.

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

25 (1.15 pm)

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1 (The luncheon adjournment)
 2 (2.05 pm)
 3 **MS LANGDALE:** Dr Jayaram, you tell us at
 4 paragraph 518 of your statement that you requested
 5 a meeting with Ian Harvey to update you with verbal
 6 feedback from the RCPCH review panel:
 7 "... and also to explain to me why the adverts for
 8 the two new Consultant posts that had been approved
 9 earlier in the year, had been delayed."
 10 The meeting took place at 4 o'clock on 8 September.
 11 The Inquiry has heard evidence, Dr Jayaram, from
 12 the RCPCH interviewers and I don't need to ask you about
 13 the fact that you made it clear as was described at some
 14 times with emotion in your voice about what was worrying
 15 you and your concerns including about a nurse and about
 16 Letby.
 17 So you clearly set that out yourself with
 18 Dr Brearey in those interviews.
 19 In your meeting with Ian Harvey we see you
 20 subsequently emailed your colleagues on
 21 9 September 2016, at INQ0103167, page 3. So that would
 22 begin -- if we had gone to the previous page which we
 23 don't need to -- to say, "I met with Ian Harvey
 24 yesterday afternoon, this is a distilled summary of
 25 things discussed."

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1 that the immediate feedback from the team had been that
 2 there were no issues around the service itself that
 3 needed urgent attention. He told me that they had noted
 4 our plan to appoint two new Consultants ...
 5 And:
 6 "He used the words 'no smoking gun' [being]
 7 identified to explain the increase in death rates but
 8 didn't detail what data had been looked at to make this
 9 conclusion."
 10 Is that right?
 11 **A.** That's correct, yes.
 12 **Q.** And when you asked if they had addressed
 13 specific concerns around Letby's potential link, and he
 14 told you they had not investigated this specifically but
 15 had recommended a detailed independent forensic review
 16 be undertaken; yes?
 17 **A.** That's correct, yes.
 18 **Q.** So going then to this letter on the screen.
 19 When you received that, what did you think was going on
 20 and in particular what did you think paragraph 2
 21 represented, if anything?
 22 **A.** I was surprised to receive this, to put it
 23 mildly. I think it came via email. Now, by this point,
 24 I was aware that Letby was not working on the unit and
 25 I had been made aware at some point prior to this,

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1 Then we see you say:
 2 "They did acknowledge the concerns we raised over
 3 foul play and recommended a forensic detailed
 4 independent review of all the cases.
 5 "This would be far more detailed than the Thematic
 6 Review and be conducted by two teams independently. Sue
 7 Eardley gave four names to Ian."
 8 You weren't, at this time, shown the report, were
 9 you?
 10 **A.** No, we, we weren't shown the report. I mean
 11 actually, at this stage, I didn't even assume that any
 12 kind of written draft report would have been available
 13 because I think this was only a week or so after the
 14 two days of the RCPCH visit.
 15 So this was a summary of -- of my interpretation or
 16 my recollection about what Ian Harvey had told me at the
 17 meeting that I had with him on the day before.
 18 **Q.** Thank you. That can go down.
 19 Moving to October and the grievance, can we see
 20 please INQ0107964, page 43. Sorry -- before we go to
 21 that, Dr Jayaram, I should ask you to confirm,
 22 paragraph 520, you say at that discussion with
 23 Ian Harvey that we have just looked at:
 24 "The first issue discussed was the RCPCH Review
 25 Team feedback, he did not give much detail but suggested

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1 I can't remember when, that she was working in the risk
 2 and governance department.
 3 When I received this, my first reaction was
 4 surprise and -- and anxiety, really. Because I --
 5 I appreciate it's probably a formal template kind of
 6 letter, but it was the line about, "anything I say not
 7 only will form part of this investigation and may be
 8 presented in disciplinary hearings should this be
 9 necessary".
 10 Now, up to this point -- not even up to this point,
 11 even now I am not -- I wasn't sure whether I had done
 12 anything or said anything out of place or that was
 13 potentially going to get me in trouble. As we discussed
 14 before lunch, I had been quite cautious to an extent
 15 asking for things not to be minuted for fear of some
 16 kind of come-back.
 17 And I think as well, it -- I think it recommended
 18 bringing a Union representative. Now, I have been
 19 a member of the BMA from the time I qualified as
 20 a doctor, never really had to use them for very much.
 21 But the very fact it said that just filled me with quite
 22 a lot of uncertainty and concern and so, as
 23 a consequence, I contacted my BAPM representative.
 24 But I actually I think my reply to Dr Green when he
 25 sent this email saying "can you set up a date?" was

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1 "yes, I think that's fine but can you tell me what it is
 2 I am supposed to have done?"
 3 **Q.** We have seen those can I take you firstly to
 4 INQ0004356, page 3. You are asking your Union
 5 representative about it. If we go to page 3, and the
 6 advice in short, they suggest to you:
 7 "You request a copy of the grievance policy and an
 8 agenda. Inform the Trust you have sought BMA advice and
 9 will return contact when you can establish the
 10 availability of your representative. Forward all
 11 correspondence to myself along with a copy of your
 12 contract policy and agenda as soon as you receive these
 13 pieces of information."
 14 And we know you in fact, not with this person who
 15 advised you, attended with another BMA representative on
 16 the day of the interview and you are expressing here,
 17 aren't you, at the top:
 18 "We as a group are still uncomfortable that our
 19 concerns have not been fully addressed but understand
 20 why the Exec body is being cautious about escalating
 21 things. My worry about this HR meeting is what I will
 22 be asked and how I reply. Clearly if I am asked 'did
 23 I have any concerns?' I can only give a subjective view
 24 and if I raise the possibility of deliberate harm, am
 25 I putting myself at all sorts of risk? Although I stand
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1 services."
 2 As you say, that was an Executive decision, wasn't
 3 it? You made representations about your concerns but
 4 you weren't writing letters removing her?
 5 **A.** No, so -- so at the meetings in June and July,
 6 we asked them to do something about our concerns around
 7 Letby working unsupervised and we discussed CCTV, there
 8 was one-to-one supervision discussed. No conclusions
 9 were made in any of the meetings that I was in
 10 attendance at with the Executive board at all and
 11 I subsequently heard through a grapevine, really, at
 12 some point in the next few weeks that she had been moved
 13 to Risk and Patient Safety. And I think that's
 14 important because, again, it seems to be a recurring
 15 theme that there was some kind of ultimatum put by
 16 myself and my colleagues that, "if she's not moved we
 17 will call the police".
 18 And I am not really quite sure where that's come
 19 from. But we were --
 20 **Q.** I just need to ask you one thing about that;
 21 did you ever say "threaten to call the police"?
 22 **A.** No, no, I don't.
 23 **Q.** So I need to ask you --
 24 **A.** Others may recollect differently I do not
 25 believe at all, at any point an ultimatum was given that
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1 by the fact that we ..."
 2 **A.** It should say "escalated".
 3 **Q.** -- yes, "escalated and therefore fulfilled
 4 a duty of care".
 5 You also, if we can go to a second document,
 6 INQ00063110001, asked Mr Cross, the internal -- well,
 7 did you see him as the internal person to go to for
 8 legal adviser support?
 9 **A.** Yes, I mean the irony of this now is not lost
 10 on me that he was the Trust's legal advisor and I wanted
 11 some kind of advice as to how much I -- how much detail
 12 I could give about our specific concern, given this was
 13 an investigation of a grievance.
 14 And I in the back of my mind had a concern that
 15 this could be used against me and you know I am, I --
 16 I sort of facepalm and laugh at myself that the person
 17 I asked was Stephen Cross, in retrospect.
 18 **Q.** You are saying very clearly the Trust and, as
 19 you say, he is legal adviser for the Trust:
 20 "... but we are sure that one of the questions will
 21 concern why we had concerns about X. As you know we had
 22 noticed the association between unexplained collapses in
 23 the presence of X, felt it was a matter of patient
 24 safety until this had been looked into further. We were
 25 not involved in the decision to move her to non-clinical
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1 "if you don't move Letby we will call the police".
 2 **Q.** Perhaps you wish there had been now --
 3 **A.** Had we given that ultimatum -- actually,
 4 I wish we had done, but we didn't because we were trying
 5 to remain as respectful as possible.
 6 So all we wanted was to be reassured that Letby was
 7 either practising in a supervised way or other actions
 8 would be taken.
 9 **Q.** Looking at the second paragraph of your email
 10 to Mr Cross:
 11 "If we are asked what concerns we had how should we
 12 play this? I think we should make it clear that the
 13 whole Consultant body had concerns about patient safety
 14 and these concerns were escalated appropriately and
 15 leave it at that. Inferences may or may not be drawn
 16 but if put on the spot and asked directly, specifically
 17 what duplicate asked directly, specifically what the
 18 concern was, it would be wrong not to be explicit. This
 19 however could unleash a whole other cascade of events.
 20 Advice gratefully received"
 21 Your meeting had been brought forward that
 22 Thursday.
 23 We have seen from emails, Dr Jayaram, that
 24 Claire Raggett emailed you and asked you to phone him.
 25 You say you did phone him, but don't recall the
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1 conversation now?

2 **A.** No, I have absolutely no recollection.

3 **Q.** Do you think you did definitely call him?

4 **A.** I -- if I did I can't remember.

5 **Q.** Okay.

6 **A.** It would seem there was an arrangement made to
7 have a call, I cannot remember whether I spoke or not.

8 **Q.** You certainly can't remember advice that shed
9 light on the problems that you are identifying --

10 **A.** No.

11 **Q.** -- both to your Union rep and to him.

12 **A.** No.

13 **Q.** So when you go into the grievance interview
14 have you had any satisfactory answer to what you should
15 be saying or not, about the suspicions or concerns?

16 **A.** So my BMA rep said "see what the question is
17 like" but essentially said "don't say anything
18 speculative" and they were with me and said that they
19 would intervene if they felt the line of questioning was
20 inappropriate for the purpose of the meeting.

21 **Q.** Let's go to the meeting then that you are in,
22 INQ0002879, page 47.

23 **A.** I think, before the meeting as well, I had
24 some communication with the HR representative to ask
25 whether I was there as a witness or as somebody who was

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1 and needed to look at why. It was raised to the
2 Executive board about increase in death rates, also
3 reviewed individual cases internally. Stephen Brearey
4 organised a Thematic Review with external reviewers.
5 There didn't appear to be anything in terms of clinical
6 practice equipment or the environment that was relevant.
7 There did appear to be an association with Lucy Letby,
8 either looking after or being present at the time of the
9 deaths. Discussed with the obstetricians, we were all
10 concerned we were potentially putting babies at risk
11 when there was something that might have been a factor
12 concerns were raised with the Executives."

13 Two answers down you also refer to an incident with
14 the Triplets "babies who were getting better, were
15 stable, who suddenly collapsed".

16 Those, you make clear, they were stable, suddenly
17 collapsed and the same at the top, you make clear, they
18 are not babies you'd have predicted to collapse. You
19 don't say "sudden and unexpected with no explanation",
20 you know we were dealing with that term earlier?

21 **A.** Yes.

22 **Q.** You do, when you read it as I have, see that
23 you said they were stable and then they suddenly
24 collapsed?

25 But other than that in that paragraph, do you think

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1 potentially being investigated and I recall the reply

2 that came back was that I was there as a witness --

3 **Q.** Witness, that's right?

4 **A.** -- at that time.

5 **Q.** So you had got that back from her -- that was
6 Lucy Sementa I think -- that you were a witness.

7 Then we see the first question from Dr Green.

8 First of all, did you know Dr Green at all?

9 **A.** Yes, in fact I was actually on one of the
10 informal interview panels on the day he was appointed to
11 Director of Pharmacy. I didn't have a particularly
12 close working relationship with him, he was fairly quiet
13 and I didn't really have much occasion to have much to
14 do with him but I had met him on several occasions.

15 **Q.** So no bad blood, no good blood, as it were --

16 **A.** No. There were no issues, there were no axes
17 to grind from my side.

18 **Q.** If we look here, your paragraph 1, you set
19 out:

20 "Premature babies are at high risk, our rate
21 comparable to neighbouring units. There was a rise in
22 mortality and they were not the babies you would have
23 predicted. None of these babies responded to timely
24 resuscitation manoeuvres. As a group of Consultants, we
25 were very concerned that the babies were deteriorating

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1 that's a fair summary of the concern for the babies:
2 that they had collapsed and weren't being --

3 **A.** I think so, yes.

4 **Q.** Do you think retrospectively, again flagging
5 up sudden and unexpected, well, deteriorated when we
6 didn't expect them to, might have made that it wasn't
7 simply the association of the nurse around a death, it
8 was the association around unexpected inexplicable
9 deaths with no medical cause identified by the
10 paediatricians?

11 **A.** I don't know whether in this forum, in the
12 grievance investigation with Dr Green, specifically
13 saying that would have made a difference. Those words
14 had already been used explicitly with the Executive Team
15 who commissioned, presumably, Dr Green to do this and
16 I don't think Dr Green's investigation here was
17 specifically to consider what was happening with the
18 babies. It was very much around Letby's grievance.

19 So I think in my opinion, using those words, in
20 what's documented in the first paragraph of this
21 transcript, probably wouldn't have made a difference.
22 And, okay, I'll put myself out here, one of the reasons
23 I also think it wouldn't have made a difference is that
24 my subjective view, with a little bit of evidence behind
25 it, is that the findings of this grievance process -- or

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

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

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

9 If we look at page 48, Dr Green says:

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

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

15 He says that:

16 "That's not a yes or no."

17 You say:

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

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

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

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1 we would raise concerns but that would be speculation."

2 And he says:

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

8 And you make the point:

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

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

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

25 And I suppose looking at the transcript now,

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

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

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

14 **Q.** The next Dr Green question:

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

17 You say:

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

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

22 You say:

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

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

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

14 **A.** Yes, I did.

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

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

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

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

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

7 **A.** Yes, of course.

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

11 **A.** Okay.

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

15 "There has been a number of behaviours on the ward
16 that do not reflect too well. I had to go and speak to
17 RJ that some of the trainees had been making reference
18 to 'angel of death' but no specific person was named.

19 There was behaviour in the clinic it being heard talking
20 about killing babies on the unit. I had to speak to
21 Ravi about comments about killing babies. This was not
22 denied and Ravi Jayaram did accept that it was
23 inappropriate."

24 **A.** I mean --

25 **Q.** Also before you comment on that can I show you
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1 in a public area saying what Eirian Lloyd-Powell was
2 told I had said, explicitly someone is killing babies.

3 **Q.** Yes.

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

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

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

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

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

23 **Q.** When you say "that epithet"?

24 **A.** The angel of death.

25 **Q.** We have heard Nurse Death, was angel of death
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1 both, because there's another one at 0038:

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

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

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

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

24 **A.** So the first thing I will say is, although
25 I can sometimes have a big mouth, I wouldn't have been
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1 something that you --

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

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

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

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

21 **Q.** Going back to page 10, which is Mr Harvey's
22 discussion he says he's had with you, so let's look at
23 that box again about what he says to Dr Green. Do you
24 now remember him speaking to you about comments he says
25 about killing babies?
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1 A. No. I don't remember, I remember him talking
2 about the comments of the "angel of death". I don't
3 remember him talking about me apparently explicitly
4 using those words in clinic. And I certainly wouldn't
5 have in a -- you know, in a, in a -- even if I was in
6 a clinic room, there's people walking past, there is
7 a lot of traffic I wouldn't have used those words.

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

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

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

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

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

24 He sets out:

25 "We need to remind ourselves how we got into the
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1 So the New Year came. I -- I repeatedly asked
2 Ian Harvey could we see them and so this meeting on
3 26 January was arranged. So we were told that we would
4 get feedback from the reports and an account of what the
5 Trust's plan moving forwards would be.

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

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

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

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

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

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

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

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

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

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

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

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

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

25 Q. So it moved from this report of the RCPCH

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1 conclusions or highlights from Mr Harvey straight into
2 what --
3 **A.** Yes.
4 **Q.** -- they had to say to Letby and her family and
5 what you should be saying?

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

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

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

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

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

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

9 At paragraph 596 you tell us:

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

20 Finally at 643 you say:

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

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

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

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

18 Okay, you know, maybe -- maybe I am just being
19 lily-livered but it was -- it was very strange because
20 I was thinking: why is this happening now? Why is this
21 happening in this way? And it struck me that that
22 meeting had probably been choreographed in some way and
23 then it went back to around mediation although we were
24 --

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

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1 other Level 2 units in the area."

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

9 **A.** At that point, in not as much detail, because
10 although it didn't chime with anything that I had
11 recalled reading in the brief sight of the draft report
12 in November, because had those issues that Mr Harvey was
13 raising been discussed, both myself and Dr Brearey and
14 Anne Murphy would have most certainly noted and
15 commented on them, it didn't also fit with the feedback
16 informally given to me I think on 9 September or
17 8 September by Mr Harvey, when he had intimated that
18 they hadn't found any significant concerns about
19 clinical practice that needed immediate action. And it
20 didn't also fit with the email that Stephen Cross had
21 sent to the chronology and sent to me where he said in
22 that that the College hadn't identified any significant
23 issues around clinical care.

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

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

6 **Q.** Now, can we go, please to INQ0003095, page 1.

7 And this is a letter, 30 January 2017 from
8 paediatricians to Mr Chambers, agreeing:

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

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

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

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

6 **A.** That's right.

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

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

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

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

22 **A.** The version --

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

25 **A.** The version we got was a redacted version and

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

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

5 **Q.** We have heard from Dr Tighe --

6 **A.** -- that you felt --

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

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

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

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

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1 it was quite clear really just reading it that there had
2 been redactions. We weren't told it was redacted but it
3 was quite clear I think it was either section 3.10 to
4 3.11 or 3.11 to 3.12 where the second section, the line
5 started something like "in response to this allegation"
6 but no allegation had been mentioned. So it was clear
7 to us that there had about there had been redactions,
8 but we didn't know and we did point this out.

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

11 **A.** Yes.

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

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

16 **Q.** Dr Hawdon's review?

17 **A.** Dr Hawdon's review, yes.

18 **Q.** If we go to INQ0107964, page 77, this is
19 an email, "Dear colleagues", from Mr Chambers on
20 3 February. We are not currently clear who this goes
21 to, it is the same date you all pick up the report.

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

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

6 Q. 3 February?

7 A. So the same day.

8 Q. Paragraph 630?

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

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

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

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

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

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

13 A. Yes.

14 Q. That is what's happened here?

15 A. Yes.

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

17 Mr Harvey says:

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

22 And he says at the end:

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

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

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

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

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

17 A. Yes, I found that bizarre.

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

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

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

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

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

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

13 Q. No.

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

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

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

25 You say:

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1 "There are still no clear explanations for at least
2 eight of the unexplained collapses and deaths."
3 You are using "unexplained" and "collapsed"
4 certainly much more clearly by this point, Dr Jayaram --
5 **A.** Yes.
6 **Q.** -- in terms of your use of "deaths" as opposed
7 to "unexplained deaths". But you are coming back and
8 saying you have no answer for these deaths yet,
9 unexplained deaths?
10 **A.** Yes. So the meeting to which this email
11 refers was a meeting with, between myself,
12 Stephen Brearey, John Gibbs, Ian Harvey and Nim Subhedar
13 from Liverpool Women's Hospital and Ian Harvey had
14 arranged the meeting because he had seen -- by this time
15 we had been allowed to look at the Jane Hawdon's
16 Casenote Review and I think Jane Hawdon initial
17 conclusion that she I think explicitly said "there are
18 four cases that I still think are unexplained and need
19 further detail or forensic review", I am paraphrasing
20 a little bit.
21 When we looked at a group we felt that there were
22 at least another four babies where, in our view, even
23 though Jane Hawdon felt or reported from her analysis
24 that they were explained, that they weren't.
25 So the meeting that was arranged to which this

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1 voluntary process and I am under no obligation to
2 engage. This is at odds with the impression given by
3 both Tony Chambers on 26 January when he stated quite
4 clearly that the board had a plan which we expected to
5 follow or would be crossing a line. I have seen no
6 minutes of the meetings [and then you say] now in terms
7 of their depth and also by Ian Harvey who intimated that
8 by not engaging I could increase the chances of being
9 reported to the GMC for whatever I am alleged to have
10 done."
11 So you take that point up. This is when the
12 mediation was being planned that you begin to appreciate
13 this is voluntary, in fact, with Sue Hodkinson and you
14 ask for a meeting and we see one happens with her on
15 15 March at 2 o'clock. If we can go to that at
16 INQ0003219, page 1.
17 Can you see there meeting 13 March and over the
18 page, look at the top?
19 **LADY JUSTICE THIRLWALL:** 15 March.
20 **MS LANGDALE:** Sorry, 15 March. If we go to page 4,
21 in this conversation, you are discussing your concerns
22 about Letby, you say all circumstantial then you
23 remember three occasions when there were concerns.
24 What were the occasions that you set out there?
25 **A.** Certainly the issue which we discussed earlier

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1 email attempts to be a summary was arranged by
2 Ian Harvey because he told certainly me that he had been
3 tasked with feeding back to the Families of the babies
4 whose case notes had been reviewed what the conclusions
5 were from which I assumed that the Families knew that
6 this was happening.
7 But he wanted sort of guidance from people with
8 experience of neonatology to understand what this meant
9 and what to say and our -- we went through all the cases
10 and we said to him: actually we don't think you can give
11 any firm conclusions to any parents at this point in
12 terms of our interpretation because we still think -- it
13 already says there's four that need further forensic
14 review and to our minds, even thinking about it
15 conservatively there are at least another four where it
16 can't make sense.
17 So in this email, I --
18 **Q.** You say you can't see any effective mediation
19 could take place, I see that in that context.
20 **A.** Yes.
21 **Q.** Can I ask you to look at this document,
22 please, as well, INQ0107964, page 13. You then write to
23 Sue Hodkinson and tell her, we see it on the screen at
24 paragraph 2:
25 "The mediator told me this was an entirely

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1 on about the chest drain. I think the first reference
2 is Baby K. I can't remember what the third one was.
3 But it would have been one of the patients I --
4 I personally was involved with.
5 **Q.** Sorry, go on.
6 **A.** That was it.
7 **Q.** Yes. And another, a valve at a different
8 setting, it was explained it was a mistake when she was
9 looking after the baby?
10 **A.** That was -- that is -- that was the discussion
11 around the issue with the closed valve on the chest
12 drain.
13 **Q.** Was that Baby H that you discussed earlier, or
14 you can't remember.
15 **A.** Yes, the baby we discussed earlier on was
16 Baby H.
17 **Q.** And the third?
18 **A.** I can't remember which baby that would have
19 been.
20 **Q.** Had you had many conversations at all with
21 Sue Hodkinson before in her role as Director of People?
22 **A.** I had met her sort of informally at a number
23 of meetings. The first I got in touch with her the main
24 reason, initially I got in touch with her was around my
25 discomfort around the mediation. So when I had been

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

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

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

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

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

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

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

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

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1 or there would be consequences.

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

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

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

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

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

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

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

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

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

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

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

23 So you were raising that issue then.

24 **A.** Yes.

25 **Q.** That can be taken down.

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

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

8 This is Mr Harvey to you:

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

15 And he continues:

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

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

24 "The Trust first advised the Coroner of Cheshire of
25 this matter on Friday, 8 July and has subsequently kept
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1 independence. Obviously I had been to one Inquest and
2 what we wanted or what we, what we hoped was that if
3 they spoke to the Coroner, when they spoke to the
4 Coroner they would explicitly raise the specific concern
5 that we had been raising about Letby to the Coroner.

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

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

16 **Q.** Don't worry about that.

17 **A.** Yes.

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

19 **A.** Yes.

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

24 "... you have each had a letter from Tony Chambers
25 but I was able to give more detail and confirm
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1 him informed of developments. I confirm a copy of the
2 report was shared with the Coroner on 20 January 2017
3 following which a meeting with Mr Rheinberg, the Trust
4 Medical Director and Director of Corporate and Legal
5 Services was held on Wednesday, 8 February to ensure
6 that the Coroner was fully briefed on all matters."

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

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

18 **A.** Yes.

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

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

23 **A.** Yes, and again this was -- we were -- we were
24 struggling to know where to go next. And we thought
25 well, actually the Coroner should have a degree of
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1 Stephen Cross and I had a detailed conversation with
2 both the Coroner and the Deputy."

3 He continues in that paragraph:

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

8 So this is 6 March, your letter has been sent
9 10 February:

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

13 Quality assure, is that?

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

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

20 "John" is presumably John Gibbs?

21 **A.** Gibbs.

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

25 **A.** Well, again second-guessing.
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1 Q. Try not to guess, do your best. You have seen
2 the documents, what do you think?

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

8 Q. Quality assurance?

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

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

14 A. Yes.

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

17 A. No.

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

20 A. No.

21 Q. But you had clearly requested that.

22 Thank you, that can go down.

23 There's then a meeting, a paediatrics meeting
24 27 March, INQ0003150, page 1. And you tell us that your
25 understanding of the purpose of this meeting on 27 March
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1 "The cluster caused concern, the College review is
2 a service review, not case note and followed up with
3 further detailed review. In-depth review for more than
4 four cases. The standard needs to be external to some
5 degree."

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

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

11 A. That was with reference to --

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

13 A. Sorry.

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

19 A. That's correct.

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

22 A. Yes, and --

23 Q. What -- not looking at the notes but what's
24 the sense? Do you think that's been taken on board, is
25 there real listening to that?
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1 was to give the Consultant paediatricians an opportunity
2 to explain the reasons for their ongoing concerns to
3 Mr Chambers in person with support of the neonatal
4 network.

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

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

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

24 Q. If we look at page 2, we see Dr Subhedar,
25 fifth box down, says very clearly:
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1 A. So this meeting was -- we were under the
2 impression it was within a few days Letby would be
3 returning to work although it hadn't been confirmed. We
4 decided before this meeting have discussed with
5 colleagues that we would explicitly say we just need to
6 talk to the people who are the only people who can look
7 at this forensically which are the police and if we were
8 able to express what we were concerned about to the
9 police and the police had said no, there's nothing to
10 see here, we don't need to be involved, we would have
11 stopped at that point.

12 But we just didn't feel at all that to this point,
13 in spite of raising these things over and over again the
14 specific concern had been acknowledged or investigated
15 properly.

16 Q. We then see at INQ0107964, page 172, Dr Gibbs
17 sends you all an email saying that Mr Harvey had come
18 along to look for you or Dr Brearey but you were both in
19 clinic. Paragraph 2:

20 "Anyway Ian's message is that discussions about
21 involving the police have been held with a senior
22 criminal barrister, didn't get his name. He would like
23 to meet us to discuss our concerns to advise on how
24 those might be addressed from a legal perspective. He
25 would like to meet as many of us are able to attend."
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1 If we go to INQ0103211, page 1, Dr Brearey
2 responds: there is a degree of urgency about this.
3 Middle of the page:

4 "The rationale for this meeting that you
5 communicated to me yesterday was so that the barrister
6 can let you know the best way of informing the police
7 after getting a better understanding of the cases from
8 us and not sure therefore why we will all need to be at
9 this meeting."

10 It is obviously difficult to get you all together
11 and you thought it was about who you should speak to.

12 You get INQ0107964, page 18. The bottom email,
13 Mr Harvey responds:

14 "As we discussed, none of us has been in this
15 position before and it about doing it in the best way
16 possible, therefore we consulted with someone
17 experienced and active in criminal law both as barrister
18 and judge. I must stress Mr Medland's independence.
19 I think you will be assured of this when you meet him.
20 It is his advice that he meet with you to fully
21 understand and explore the basis for the concerns to
22 help frame the approach since letters only convey so
23 much."

24 We then know -- if we can have on the screen,
25 please, INQ0005857, page 1, there is a meeting between
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1 very different from there being mere suspicion and also
2 very different from where they were questions about
3 hospital procedures and processes as distinct from
4 criminal actions.

5 "SM remarked that officially reporting any matters
6 to the police was a [unclear] step which was effectively
7 a public action and would incur adverse publicity and
8 raise matters for the families of the neonates which
9 might be seriously disturbing."

10 Pausing there, was this given -- that advice given
11 that at the very least reasonable grounds for suspecting
12 criminal offences being committed? Was that what you
13 accepted at the time or thought was the position?

14 **A.** Just to roll back a little bit. My
15 understanding and my colleagues' understanding following
16 that meeting at which Nim Subhedar and the other
17 representative from the neonatal networks was present
18 was that we requested that the police be involved and
19 they were going to involve the police. We were then
20 told a week later that a barrister was going to come to
21 talk to us and Ian Harvey had said: it's to help the
22 Trust frame what we say to the police.

23 We as a group all felt this is just more fudging
24 and avoidance and we -- I think if we go back to the
25 very first or second paragraph of this we said we would
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1 Simon Medland QC, 12 April 2017 and certain Consultants
2 at the hospital. These notes set out his minutes of the
3 meeting. I think the meetings is described somewhere
4 one and three-quarter hours. It is a long meeting,
5 isn't it?

6 **A.** It was a long meeting.

7 **Q.** We see at paragraph 5:

8 "The minutes record we all agreed if there was
9 an identifiable common thread between some of the deaths
10 (cf Beverley Allitt) then this would be powerful prima
11 facie evidence that there was potentially a crime or
12 series of crimes which had been committed."

13 So Beverley Allitt's case was discussed in this
14 meeting?

15 **A.** Yes.

16 **Q.** Who raised that, can you remember?

17 **A.** I can't remember whether it was Mr Medland who
18 mentioned it first or whether one of us made the
19 comparison.

20 **Q.** He then gives the advice at paragraph 6, or
21 view:

22 "The police being strapped for resources can only
23 sensibly investigate cases where there is at the very
24 least reasonable grounds for suspecting that a criminal
25 offence has been committed. He emphasised that this was
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1 ask Mr Medland before we said anything what he felt his
2 brief was and that was really interesting because what
3 he had been told or what he told us he had been told was
4 very different from what Ian Harvey had suggested to us
5 his role was in that to frame going to the police our
6 interpretation, or certainly my interpretation of what
7 Simon Medland said there was: still don't know if it's
8 worth going to the police, they have asked me to see if
9 there is anything worth going to the police with.

10 So of course right from the start I think he's
11 starting from a position that there's nothing to see
12 here. So can you go back to the paragraph, sorry, you
13 asked me about?

14 I mean, I don't think any of us used the word
15 "prima facie"; that is a very legal term.

16 **Q.** Don't worry, I am not asking about that.

17 **A.** We agreed that, you know, if there was an
18 identifiable common thread, well, there was
19 an identifiable common thread; it was Letby. Which is
20 why we had been raising these concerns all along.

21 **Q.** In terms of -- that can come down now, please,
22 and can we have INQ0006136, page 1. This is your email,
23 Dr Jayaram, to Mr Harvey and others expressing what you
24 have just said now, about whilst you agree the minutes
25 you hadn't had that respective understanding of the
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1 purpose of the meeting, you thought it was simply to
2 frame what needed to be said to the police whereas he
3 told you it was to discuss whether there was enough in
4 articulated concerns to make reporting to the police
5 worthwhile.

6 Either way, it was very soon thereafter that it was
7 reported to the police, wasn't it, and if we see at
8 INQ0107964, page 22, you set out there --

9 **A.** So this was in our Consultant WhatsApp group.
10 So Dr Brearey was away and myself and my colleague
11 Dr Susie Holt went to the meeting and this was to
12 summarise to colleagues this was sort of straight out of
13 the -- straight out of the meeting what the outcome had
14 been and my -- my overwhelming I think emotion at this
15 point was relief. I mean, almost bizarrely, you know,
16 a sense of joy because someone had actually taken the
17 trouble to listen to the things we were saying.

18 Whether we were right or wrong somebody had taken
19 the trouble to listen to what we were saying at the very
20 least felt it was worth looking a bit further to see
21 whether there was anything. And as I said, you know, if
22 this process had happened and then they had said there's
23 nothing, we felt that we would have -- we would have
24 fulfilled our duties of care and it was, it was
25 surreal -- I use that word a lot -- because after this

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1 article reports that Mr Chambers said:

2 "There was just a few niggles that our clinicians
3 said: look, we think we have got 90% of the answers but
4 there are still bits that we need to in a sense be clear
5 that we have not missed anything."

6 Well, what was the purpose of that letter? What
7 were you concerned about, all of you?

8 **A.** We were concerned -- so I think this was an
9 article in the local paper and a journalist had
10 interviewed Tony Chambers and asked about why the police
11 eventually became involved and this was the reported
12 response.

13 And given all the concerns that we had raised, the
14 push back that we had, the fact that a police
15 investigation had been going on for several months at
16 this point to describe our concerns as "a few niggles"
17 and we just need to be sure we have not missed anything
18 was insensitive and disrespectful to us and the Families
19 of these babies, because these were not niggles, these
20 were significant concerns and we by this stage were --
21 the tone had slightly changed in the sense because the
22 police were involved, I think there was an element of
23 Tony Chambers and colleagues perhaps trying to create
24 a picture of saying: we were always going to go to the
25 police anyway, it just needed to take time.

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1 whole several months of being told that we were the
2 problem, it was the first time that I felt that some
3 progress was being made and I -- I do remember sitting
4 in that meeting with the CDOP team and I just remember
5 Ian Harvey and Stephen Cross sort of the look of shock
6 on their face really because I don't think I can't speak
7 for what they were thinking, but I don't think that they
8 were expecting that to be the outcome of this meeting.

9 **MS LANGDALE:** Thank you, Dr Jayaram.

10 My Lady, this may be a good moment to take the
11 short break.

12 **LADY JUSTICE THIRLWALL:** Very well, 10 minutes?

13 **MS LANGDALE:** 10 minutes, 20 to 4.

14 **LADY JUSTICE THIRLWALL:** So if we could start again
15 please at 20 to.

16 **(3.28 pm)**

(A short break)

17 **(3.40 pm)**

18 **MS LANGDALE:** Dr Jayaram, just a few more questions
19 from me.

20 INQ0107964, page 0239, please. This is a letter to
21 Mr Chambers from the paediatricians to explain the
22 context, there's been a newspaper article, the police
23 have been brought in at this point, the RCPCH review and
24 this appears, and you all respond to say that the

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1 But it was that thing about niggles, it was, it was
2 just -- you know -- absolutely -- I am trying to think
3 of the word -- it was -- it was demeaning. That is not
4 the word I am thinking of, but it was just demeaning to
5 our concerns.

6 So we wanted to flag this up again as a group and
7 just to sort of really get him to explain why he had
8 used those words that were reported to have been said.

9 **Q.** Thank you, that can go down. INQ0107964,
10 page 213. Also February time. This is an email to you
11 from Sir Duncan Nichol:

12 "However events unfold following today's release,
13 I will be standing with you. I do understand how very
14 difficult this is for you and your colleagues and I want
15 you to know that I am personally here for you, as I will
16 be for any member of the neonatal unit."

17 What was the release on 8 February, was that that
18 article or is that something else?

19 **A.** No, I think that no this is a year before.

20 **Q.** Sorry?

21 **A.** I think this is when the Trust were making
22 their public statement on the findings of the
23 Royal College review and the Hawdon report.

24 **Q.** If we can go to INQ0006681, page 1. 26th:

25 "Further to your meeting with Ravi Jayaram on

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1 26 February 2018, we remain extremely concerned that our
2 relationship with the Executive Board has deteriorated
3 significantly and no meaningful efforts are being made
4 to repair it. Working in this environment is not
5 conducive to good clinical practice and we would be
6 grateful for the board to acknowledge the problem and
7 take urgent steps to improve this relationship in the
8 interests of patient safety."

9 Was this the first time this had been put in
10 writing to Sir Duncan, as far as you were aware?

11 **A.** I think as a group it's the first time things
12 have been put into writing with Sir Duncan.

13 **Q.** When roughly had you first had discussions
14 with Sir Duncan about it?

15 **A.** I had -- I had met with Sir Duncan
16 intermittently in 2017, not specifically to discuss this
17 issue.

18 **Q.** Doesn't matter if it --

19 **A.** I think really from -- I can't remember --
20 there is a whole series of emails that I've referred to
21 in my statement and the exhibit bundle, but the meeting
22 I had on 26 February was a -- there was -- I can't
23 remember if it was that one. It was a very difficult
24 one where he and I were in my office. It was quite
25 emotional because I articulated to him that I felt that

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1 most difficult things is we -- we go to work every day
2 doing a high risk job and you want to be assured that
3 the people who run the organisation will support you.

4 Now, doesn't mean cover up for you, obviously,
5 fair's fair, but you want to know that they have got
6 your back. And we, as a group, felt we were in
7 a situation where we were not only walking on eggshells,
8 if the moment anybody put a foot slightly wrong we were
9 potentially at risk of detriment to ourselves.

10 **Q.** We see at INQ0107964, page 263, another email
11 from Sir Duncan Nichol to yourself. It looks as though
12 that meeting as you says, is 26 February, was when you
13 met:

14 "High on my agenda [he says] was concern about the
15 damaging breakdown. So the board understands the
16 problem exists and will press for it to be resolved in
17 the interests of the patients. I welcome an early
18 meeting."

19 There was a meeting, wasn't there, on 30 April 2018
20 between Ian Harvey, Mr Cross and the paediatricians?

21 **A.** Was that just myself and Dr Brearey? Or was
22 that with all of us?

23 **Q.** I think it was just yourself?

24 **A.** Yes.

25 **Q.** And 26 questions -- actually, I'm not sure

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1 he had not taken our concerns as seriously as he should
2 have done.

3 **Q.** Was that 2017, are you talking about
4 February 2017 or 18?

5 **A.** No, I think this was later on.

6 **Q.** Later, 18?

7 **A.** I can't remember, I would have to refer to my
8 statement. But the meeting referred to here was very
9 much a case of because the police investigation had been
10 ongoing, we had had very little interaction from that
11 point with anybody from the Executive board. Now
12 I appreciate now that it may be that
13 Operation Hummingbird had said to the Executives "don't
14 say anything to the paediatricians for fear of
15 contaminating evidence".

16 But we also knew that the Executive board or
17 members of the Executive board were having reasonably
18 frequent contact to update members of the nursing staff
19 yet we were getting absolutely nothing and we didn't
20 know where we stood. We wanted to start making moves to
21 think about regrading the unit back-up to Level 2 status
22 again.

23 We had as a consequence of everything that had
24 happened through June 16 onwards, absolutely no faith or
25 trust in the Executive board. And of course one of the

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1 about that, Dr Jayaram. But basically you put 26
2 questions together, didn't you?

3 **A.** Yes.

4 **Q.** So there were 26 questions that you wanted
5 answers from that couldn't be given in the meeting and
6 we know subsequently you got answers I think from
7 Mr Chambers and then you did another table with answers
8 to the answers, if I can put it like that?

9 **A.** Yes, observations on the answers.

10 **Q.** I don't need to take us to those, but your
11 observations.

12 So there was detailed documentation going backwards
13 and forwards and Stephen Cross asked for an electronic
14 copy which he shared with the Exec Team.

15 25 May, you tell us in your statement at
16 paragraph 872 you had an informal and unplanned meeting
17 with Sir Duncan.

18 "I was frank with him at my disappointment that we
19 had not yet had any responses to our 26 questions, that
20 I felt he was sitting on a fence and although he had
21 listened to us I told him that I believed that his
22 ultimate priority was not to ruffle feathers. I also
23 expressed to him I did not believe that Tony Chambers
24 was a fit and proper person to lead any NHS
25 organisation."

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1 A. This was the meeting that I remember as being
2 a very emotional meeting, not the previous one.

3 Q. So the May 2018 one.

4 What was his response to that? If it helps there
5 is another email dealing with that and he does
6 express -- I don't need to put it up -- at 0292:

7 "I want you and Consultant colleagues to know how
8 deeply sorry I am for the personal distress that you
9 have and are all suffering and for my part in not
10 intervening sooner."

11 Do you remember getting that?

12 A. Yes, can you remember what date?

13 Q. Yes 25 May at 5 pm?

14 A. 25 May. So that was his conciliatory message,
15 as I have described it, in point 873, I think.

16 Q. Yes.

17 A. No, I do remember getting that and we then
18 shortly after that got a written reply from
19 Tony Chambers with answers to the questions which we
20 then sat down together, digested and wrote back and then
21 I emailed Sir Duncan, I have here on 4th July, to
22 discuss the concerns we had around Tony Chambers's
23 responses and I think as a group, when we had the
24 responses to our questions, as the document shows, which
25 tabulates it, we have made annotations but most of the

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1 And Sir Duncan encouraged us to organise such
2 a meeting. We had correspondence via Paul Jamieson, who
3 was one of the anaesthetists who is Chair of the Medical
4 Staff Committee. He was liaising with the police as to
5 get some guidance as to how much we could disclose.

6 Ian Harvey retired around this time as well. And
7 I think the meeting took place in September 2024 and we
8 had a lot of discussion as to whether once we'd told our
9 story, and we also wanted to hear of other people's
10 experience as well, whether a vote of no confidence
11 should be considered in Tony Chambers.

12 But as it was, he stood down on the afternoon that
13 that meeting took place.

14 Q. Focusing on Sir Duncan again, if I may,
15 INQ0107964, page 0269. An email from Dr Holt. If we
16 look at paragraph 4. She reflects:

17 "Sir Duncan made it very clear he would not take
18 and no could he/would he get us acknowledgement or
19 apology.

20 "I feel Sir Duncan was very careful not to promise
21 or suggest he would offer any feedback on their views on
22 the issues discussed. I expect we will hear no more of
23 this."

24 You had expressed that, now had she. Was there
25 a concern that he wasn't descending into the fray, as it

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1 responses weren't -- weren't really answers to the
2 questions that we had. They were -- they were answers
3 to other questions that we hadn't asked or were quite
4 evasive.

5 Then there was a meeting with Sir Duncan Dr Brearey
6 and myself in early July which was after the first
7 arrest had been made and we as a group at this point
8 were struggling because we did not have faith in
9 Tony Chambers. I articulated it before, and I can't
10 speak for colleagues, but I think we all shared the
11 concern that I had raised previously to Sir Duncan, that
12 he was not a fit and proper person to be running any NHS
13 organisation.

14 We had started having discussions about the Medical
15 Staff Committee so the Medical Staff Committee is
16 essentially the group of doctors employed by the Trust,
17 mostly Consultants but also career grade doctors, so
18 doctors who aren't in training. And we wanted -- given
19 the confines of the police investigation, we wanted to
20 flag up to colleagues some of the things that had
21 happened and the obstacles that we had run into when we
22 tried to raise concerns, but obviously we had to do that
23 in a way that wouldn't compromise patient
24 confidentiality, wouldn't compromise the police
25 investigation.

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1 were, and making decisions or determinations about what
2 was the right thing here?

3 A. I think he was -- and I can't speak for him
4 but my impression was he was juggling a lot of different
5 priorities that he may have had as Chair of the Trust.
6 I think what I have seen in much of the documentation
7 I have seen as part of this process that I hadn't seen
8 before, there was a lot of -- well, frequent reference
9 to -- to reputational damage to the Trust and I think
10 that that was a -- may be a driving force and I think
11 that was probably one of the issues that sort of
12 equipoise in which he was sitting that led to the
13 discussion on 25 May being quite emotional and heated.

14 You know, we -- we wanted to make him aware and
15 think we made him aware of the fact that we had
16 absolutely no confidence or faith in the Executive
17 board.

18 Now, actually the priority here is I don't care
19 who's on the Executive board but I want to know that
20 whoever is sitting on that board that I can trust
21 because it helps me to look after patients safely and
22 properly.

23 Q. Thank you, that can go down now.

24 We asked you, Dr Jayaram, as we have everybody for
25 reflections and particularly how babies might be kept

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1 safer in hospital today. You make a number of
2 observations, one of them about whistleblowing at
3 paragraph 944?

4 **A.** Sorry, what number was that?

5 **Q.** Paragraph 944 of your statement?

6 **A.** 944.

7 **Q.** You say it became clear to you very quickly
8 following the verdicts in this case:

9 "It became clear to me very quickly that the
10 behaviour displayed by the Executive Team at the
11 Countess of Chester were by no means unique and that
12 there seemed to be a clear pattern of management
13 behaviours in response to escalating concerns.
14 Initially dismissive responses from managers would be
15 followed up by threats that the complaint was being
16 unreasonable, aggressive or misguided. They were led to
17 believe that they themselves were the problem and were
18 subject to small passive microaggressions, such as, for
19 example, not being offered opportunity for professional
20 development, having theatre lists cancelled or being
21 removed from roles on various hospital advisory
22 committees."

23 So was that you broadening out your understanding
24 of your own experiences to try and understand other
25 experiences in the NHS?

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1 the same? Well, yes, because ultimately it is about
2 patient safety and I think what really struck me, and
3 I think this is important, that we were very lucky,
4 I was very lucky to work with a team of Consultants who,
5 yes, we would disagree occasionally but we supported
6 each other and trusted each other.

7 And I think there were -- and this may come out in
8 your further inquiries, there were attempts to sort of
9 try and divide us and play people off against each other
10 but ultimately it's because there were seven of us who
11 all had the same concern that we managed to stick
12 together.

13 But I think I never -- I never considered myself
14 a whistleblower and actually I wasn't aware of any
15 formal whistleblowing policies at that time. You know,
16 I was aware vaguely of the existence of Freedom to Speak
17 Up because it had been put in after the Francis report.

18 I was also aware I think that Alison Kelly was the
19 Freedom to Speak Up Guardian at the time and it never
20 occurred to me, you know, how difficult that might have
21 made things.

22 So -- sorry, I have completely I have forgotten
23 what the question was.

24 **Q.** No, that is fine, you have answered it.

25 If we can have on the screen finally paragraph 942

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1 **A.** Yes, so -- so following -- following the
2 verdicts from the initial trial, myself and Dr Brearey
3 received an enormous amount of correspondence from not
4 only people who had worked or were working in the NHS
5 but working in other professional organisations as well
6 sharing their experiences of what had happened when they
7 raised concerns. And I think certainly for me, as we
8 were going through the process ourselves, it never
9 occurred to me that -- and again my naivety, that those
10 people in whom I put my good faith to pull in the same
11 direction and do the right thing may not have been --
12 and it's been quite difficult this afternoon talking
13 about all and reliving it all because I feel a sense of
14 shame that I allowed myself for such a long time to be
15 treated like that because of my -- my misplaced faith
16 and to believe that maybe I was the problem and maybe
17 I was making completely unfounded suggestions.

18 But when I started hearing from other people it
19 suddenly hit me that there's a pattern and -- and
20 hearing the descriptions of what other people had gone
21 through I suddenly realised I wasn't, you know, although
22 there had been talk of GMC and consequences of crossing
23 lines I suddenly realised that myself and my colleagues
24 had put ourselves professionally and personally at
25 extreme risk and if I had known that, would I have done

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1 of your statement, INQ0107962, page 121. These are your
2 views about how now reports and harm can be
3 investigated.

4 **A.** Do you want me to --

5 **Q.** It is going to come on the screen?

6 **A.** Okay.

7 **Q.** I think it will save you going through them
8 Dr Jayaram if you want to add or elaborate on any of
9 them, but you have set them out as clear bullet points
10 here.

11 **A.** I think -- I mean, this might potentially be
12 a lot of work but I think the holes in the net need to
13 be as small as possible, so all neonatal deaths should
14 at least be discussed with the Coroner. I think the
15 process for escalating to CDOP needs to be better than
16 it is in terms of just a form being filled in and sent
17 to the designated doctor.

18 I think if the death is unexplained absolutely the
19 SUDIc process should be involved, because it's quite
20 clear had we done this, had I done this, had colleagues
21 done this, we would have had oversight from other
22 agencies outside of the hospital who would look at it
23 more from a safeguarding point of view.

24 Now, of course should every death because sometimes
25 they are explained but actually looking back, and this

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1 is important, the way things were happening in 2015 and
 2 2016 almost became our normality; that, you know, these
 3 things are happening, they don't happen anywhere else
 4 but it happens here and I look back and think it was so
 5 unusual and it was so bizarre, you know, and I have
 6 thought about this recently -- I am thinking through my
 7 whole career and training in paediatrics and doing
 8 neonatal jobs, these events just don't happen. I can't
 9 think of any events in my training where a baby who is
 10 otherwise stable would just suddenly deteriorate for no
 11 obvious reason and I kick myself, it was so obvious.

12 But I think it's -- it's that definition of
 13 "unexplained" and I think it's important that non-fatal
 14 collapses should be reviewed initially locally and then
 15 escalated if there's anything untoward.

16 I think my next bullet point, I can articulate it
 17 a different way.

18 It's about -- it's about being empowered, firstly,
 19 to think the unthinkable. We as human beings, as
 20 doctors, as scientists, as people, like to be able to
 21 explain things; we don't like uncertainty. And of
 22 course as clinicians we are taught to think around
 23 natural causes and think common things happen commonly,
 24 think of more uncommon things but think right to the
 25 edge of the playing field of natural causes.

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1 this problem we will make you the problem if you don't
 2 keep quiet and I think that's really important.

3 I am not -- you know I am very subjective. I am
 4 not going to make judgments about how the people at the
 5 top of the organisation may or may not have behaved what
 6 their thought processes were but surely everybody who
 7 works in healthcare, be they frontline staff, be they
 8 administrative staff, be they senior managerial staff it
 9 all had has to be about safe patient care and patient
 10 safety concerns have to be listened to, however
 11 uncomfortable it might make one feel. I think for
 12 myself I acknowledge that because I had those concerns
 13 and I didn't act on them as soon as I could have done
 14 and I will reflect forever on why and it's
 15 multi-factorial but I think for the future people need
 16 to be able to work in a culture where it is open and
 17 I know lip service is paid to being open and everything
 18 else, but from what I have heard from other people
 19 around, everybody needs to pull in those pull in those
 20 directions.

21 I think with regards to Freedom to Speak Up I think
 22 it's certainly better now at the Countess there is much
 23 more awareness I still worry about the independence of
 24 Freedom to Speak Up Guardians because they are
 25 ultimately employees of the Trust. I think the other

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1 But we are not empowered to think the unthinkable
 2 and actually 99.9% of the time there is no need to think
 3 the unthinkable and things like, say, for example that
 4 Just Culture document, I think, you know, it is trying
 5 to empower to think the unthinkable but it is how,
 6 number one, you can empower people, so I think in
 7 safeguarding training there needs to be reference to --
 8 was it the Clothier report? -- and the findings of that,
 9 I think there needs to be mechanisms at least to prompt
 10 people to think about it.

11 But what's also important is on top of that, there
 12 need to be clear processes for what to do if once you
 13 have considered the unthinkable and it could be
 14 a possibility of how that is then processed be that
 15 SUDIc, be it safeguarding referral, be it whatever way
 16 but there needs to be clear guidance but most
 17 importantly on that point, staff need to be able to work
 18 in a culture where they feel that they are going to be
 19 listened to and they feel that they can raise
 20 potentially what might seem outlandish concerns, without
 21 fear of detriment. I think that's really important, not
 22 necessarily talking about my experience and my
 23 colleagues' experience but what I have heard from lots
 24 of other people post the verdicts who have basically
 25 been met with a response of: we don't want to know about

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1 important thing is looking at risk and governance
 2 departments. I think they are crucial to patient safety
 3 and I know there's wide variation in terms of talking to
 4 colleagues in other similar hospitals in terms of
 5 numbers staff background training of staff as well.
 6 I think it's a department and a resource that needs to
 7 be prioritised. You need to have the right people with
 8 the right training and they need to be visible and there
 9 needs to be communication.

10 **MS LANGDALE:** Thank you very much, Dr Jayaram.

11 **A.** And I think also I think it's a point that you
 12 said I think that is really important I do understand
 13 that this has changed involvement if you are
 14 investigating a clinical incident such as ours in making
 15 sure that the parents' opinions and views are
 16 represented, and also they are not forgotten about and
 17 fed back to. I think it is such an obvious lightbulb
 18 moment that I am kind of embarrassed that I have not
 19 even thought about it.

20 **MS LANGDALE:** Thank you very much. My Lady, there
 21 are some questions from Ms Blackwell, from Mr Baker and
 22 then Mr Skelton.

23 **LADY JUSTICE THIRLWALL:** Very good. Ms Blackwell.
 24 Questions by MS BLACKWELL

25 **MS BLACKWELL:** Dr Jayaram, I am Kate Blackwell and
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1 I ask questions on behalf of the former senior managers.
 2 I want to begin, please, by seeking clarification
 3 on some evidence that you gave to the Inquiry this
 4 morning. In your first Inquiry statement at page 294,
 5 you say that you first began having discussions with
 6 Consultants about the possibility of deliberate harm by
 7 Letby in November of 2015. But in answer to Ms Langdale
 8 this morning you said that by that time, the end of
 9 2015, we, I think meaning you and your Consultant
 10 colleagues, weren't at those points thinking outside of
 11 natural deaths.

12 So I just want to clarify what you meant by that?

13 **A.** So to clarify that I think November it was the
 14 first point where I think between us the association of
 15 Letby it began to be suggested that it was significant.
 16 Now obviously there was no thought about was it well --
 17 was it competence, could it be deliberate.

18 **Q.** Yes?

19 **A.** But I think the thought at that point about it
 20 being deliberate in November it was discussed but as
 21 I have said myself I kind of tried to shut it away
 22 really and I can't speak for colleagues.

23 **Q.** All right.

24 **A.** At that point but the association I think from
 25 that point was something that we felt was of

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1 into it further.

2 **Q.** All right -- you yourself didn't escalate it
 3 or?

4 **A.** No, I didn't.

5 **Q.** Thank you. By February of 2016, we know that
 6 Dr Brearey had conducted the Thematic Review and that
 7 that report had been prepared. You were not involved in
 8 that, were you, because of clinical commitments I think?

9 **A.** Yes.

10 **Q.** But you read the report because you say at
 11 paragraph 326 in your statement that you noted that the
 12 Letby association was not mentioned within the report
 13 and you raised that with Dr Brearey who told you that he
 14 intended to explicitly discuss your concerns and his
 15 concerns about the association with the Medical Director
 16 and the Nursing Director. So you noted that that wasn't
 17 contained those concerns were not contained within the
 18 Thematic Review?

19 **A.** Yes, I think the initial mortality review
 20 analysis had had her name there.

21 **Q.** Yes, that was in an annex wasn't it?

22 **A.** Yes.

23 **Q.** Yes. Now you said to the Inquiry this morning
 24 in justifying your failure to mention your eye witness
 25 evidence of Child K to any Executive at the time of the

199

1 significance but we didn't know how.

2 **Q.** Thank you. At paragraph 302 of your statement
 3 you go on to say that the association with Letby that
 4 had been highlighted in the mortality table was being
 5 escalated as far as you were concerned to Sian Williams
 6 and Alison Kelly and that was being done by Dr Brearey?

7 **A.** Yes, there was a series of emails I think
 8 Dr Brearey had discussed the mortality table and I think
 9 it was an email back from Eirian Lloyd-Powell saying she
 10 was escalating it to Sian Williams and Alison Kelly.
 11 I think there was an email saying at one point one of
 12 them wasn't there or someone was on leave but my
 13 understanding was that it had been escalated. I don't
 14 know whether it was but my understanding was that it had
 15 been.

16 **Q.** It wasn't escalated by you?

17 **A.** It wasn't escalated by me.

18 **Q.** What was your view at that time of Letby
 19 continuing to work on the unit?

20 **A.** At that time, as I said, we were worried about
 21 the association being significant. I at that point did
 22 not feel as I was thinking then that there was enough at
 23 that point to justify moving her from the unit but
 24 I felt there was enough to justify an acknowledgement
 25 that this could be significant and work out ways to look

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1 collapse, in February of 2016, that you were reassured
 2 that there was enough in the Thematic Review for senior
 3 managers to act.

4 **A.** I think there was enough in the Thematic
 5 Review to acknowledge that the association was
 6 significant.

7 **Q.** All right.

8 **A.** And my -- the events around Baby K that
 9 morning as I discussed I hadn't seen physically doing
 10 anything. I note that Alison Kelly made a point that if
 11 I had raised with her that Letby might have deliberately
 12 silenced the alarms she would have acted. I would
 13 contend that -- I don't know whether she would or not --
 14 -- that is something of a straw man argument, to be
 15 honest, given from that time and onwards when we did
 16 raise concerns the response, particularly when
 17 Dr Brearey met with them in the May.

18 **Q.** So your evidence remains that you considered
 19 there was enough in the Thematic Review to justify you
 20 not mentioning to anybody for --

21 **A.** I think at that time as I discussed this
 22 morning it was, it was an event where -- and again it
 23 comes back to the misplaced belief that you had to have
 24 evidence.

25 **Q.** May I just deal with the chronology please --

200

1 A. Yes.

2 Q. -- because we are going to come to that. The
3 CQC visited the hospital between 16 and 19 February. We
4 know from your witness statement that you had your
5 meeting with the inspectors on 17 February between 2 and
6 3.00 pm. It was earlier that morning, whilst you were
7 on the ward, in the early hours of the morning that
8 Child K had collapsed.

9 You had been on shift as we know when the breathing
10 tube was dislodged and you have explained that at that
11 time the nurse tending to Child K was away from the
12 incubator and that you noticed that Letby was there and
13 you were so concerned about her association with other
14 deaths and collapses that you left your chair and went
15 to the incubator to see what, if anything, she was doing
16 and you knew that she was on the ward so is it safe to
17 assume that she knew you were on the ward as well?

18 A. I would imagine that she knew I was there
19 because I had been there from the moment that Baby K was
20 born.

21 Q. Thank you. You told the Inquiry this morning
22 that there was speculation or there has been speculation
23 about whether or not the alarm was sounding as you
24 approached the incubator but that's speculation
25 Dr Jayaram has arisen because in your police interview
201

1 tube."

2 A. That is what was recorded so the person
3 I spoke to wasn't a clinical person. It was an
4 administrative person.

5 Q. So do you remember now what you said?

6 A. I would almost certainly have said the tube
7 was dislodged.

8 Q. Tube was dislodged?

9 A. Yes because it had done it passively.

10 Q. You gave evidence about these matters at both
11 criminal trials and you accepted that you had not made
12 any clinical notes?

13 A. I accepted that at the time yes.

14 Q. Of what you had seen, nor did you compile
15 a Datix report although you agreed with Ms Langdale this
16 morning that the Datix reporting is for when you see
17 something which is a problem or an error. Do you think
18 you should have filled in a Datix form?

19 A. I think in retrospect because even if there's
20 accidental tube dislodgment it probably should be
21 Datixed because then you look into why the tube may have
22 dislodged. But I didn't.

23 Q. No. But you agreed in the second criminal
24 trial that it was a shocking discovery of finding her
25 next to the cot. You also agreed with prosecuting
203

1 in April 2018 you said that you couldn't remember if the
2 alarms were sounding?

3 A. Yes.

4 Q. But in February 2023 you gave clear evidence
5 that neither the ventilator alarm nor the monitor alarm
6 was sounding.

7 So had your memory of events in relation to that
8 detail got clearer as time when on?

9 A. It had I think in that police interview the
10 initial one it was kind of an overarching interview to
11 discuss everything and I have read the transcript.
12 I remember clearly I didn't I wasn't prompted to go into
13 the room because alarms were going off.

14 Q. Right.

15 A. But --

16 Q. Is it your clear memory now that the alarms
17 were not sounding?

18 A. Yes.

19 Q. Right and you it was Dr Jayaram who called the
20 transport team?

21 A. That's correct.

22 Q. After you tended to Child K for her to be
23 transferred out of Arrowe Park and the written record of
24 that call to the transfer team is that you described
25 what had happened in four words "Baby dislodged the
202

1 counsel that it was your conclusion that she
2 deliberately dislodged the tube?

3 A. That was the thought that went through my head
4 there. Again, as I said this morning, in isolation it
5 wouldn't even have crossed my mind but in the context of
6 the other concerns ...

7 Q. But you didn't mention that to anybody, did
8 you?

9 A. I didn't because I was as I discussed this
10 morning it was such I think it was the first time it
11 really hit me that you see I had been hoping to walk in
12 and find everything was okay.

13 Q. Yes?

14 A. But, as I discussed this morning, this fear of
15 not being believed, this fear of detriment and
16 I acknowledge that as I said I should have had more
17 courage to raise those things.

18 Q. Were you complying with your duty to public
19 safety in keeping that quiet?

20 A. Sorry, could you repeat the question?

21 Q. Were you complying with your duty to public
22 safety to patient safety by keeping that quiet?

23 A. I'm not sure that I can answer that. I'm not
24 sure that I can answer that.

25 Q. Well, do you accept this: certainly you didn't
204

1 raise any concerns with any Executive about either
2 a concern of neonatal mortality rising, or indeed of any
3 deliberate harm being metered out to any patients?

4 **A.** I --

5 **Q.** -- please allow me to finish -- until the
6 collapses and deaths of children O and P in 2016?

7 **A.** Personally no.

8 **Q.** No.

9 **A.** But I know that Dr Brearey as neonatal lead
10 had explicitly raise that concern before then.

11 **Q.** Had explicitly raised what concern?

12 **A.** The association with Letby.

13 **Q.** The association but not of deliberate harm?

14 **A.** I don't know specifically what he said to
15 them, you will have to ask him.

16 **Q.** You were clinical lead for children's
17 services. If you believed that deliberate harm was
18 being used it was your duty was it not to bring that to
19 the attention of the Executive Team?

20 **A.** And we did at a point whereas a group we felt
21 that we had enough. Don't forget that even when we
22 raised our concerns in June we were under as I have
23 said, the misapprehension that we needed to have
24 evidence and actually the response we got was: you
25 haven't got any evidence. So actually I didn't know at
205

1 with Dr Brearey on 16 May raise any further concerns
2 with the Executives at that stage?

3 **A.** Not at that point.

4 **Q.** All right. We know that there was a meeting
5 with the Executives in Tony Chambers's office on 29 June
6 of 2016. Could I ask, please, that we look at
7 INQ0003371. Now we have looked at this already this
8 morning and we can see who was present on the top line
9 but I would like to go down please to look at your
10 comments towards the bottom of the page.

11 The first one is entirely subjective "Staff member
12 almost always nurse in charge, babies were stable and
13 then deteriorated, why always this nurse. Babies were
14 unwell but getting better. Babies not getting oxygen
15 then crash babies did not respond as they should."

16 And then "Steve B disturbing thing ... Twin
17 survived and got better at Arrows Park. Babies coming
18 back to Countess of Chester. Babies deteriorate. Nurse
19 7 out of 9 between 12 noon and 4 am."

20 Can we go over the page, please.

21 And Steve B more than just an association with this
22 nurse.

23 And your comments "How: Cannula air embolism
24 crystal ball. Unquestionably got something going on at
25 Countess of Chester but what? Looked at equipment,
207

1 the time. Had I raised concerns earlier within even
2 less evidence I can't speculate what the response might
3 have been. I agree that there was, and I have said this
4 already, there was potentially an opportunity to act
5 sooner.

6 **Q.** Well, this was eye witness evidence wasn't it
7 of a belief that you had that she was deliberately
8 harming?

9 **A.** Well, I didn't see it was more the lack of
10 response to what she was doing. I can speculate on it
11 forever; you are absolutely right, it was
12 an opportunity.

13 **Q.** There was a meeting as we know on 11 May of
14 2016 which you were not at, at which Dr Brearey
15 discussed concerns and we do know that you received
16 an email, you were the first on the list of recipients
17 on 16 May 2016 which we have looked at already today.

18 And according to that email from Dr Brearey, he
19 said that the 11 May meeting was helpful he was grateful
20 for the work and that effectively all was well. But you
21 gave evidence today that he told you that he had
22 explicitly raised concerns about Letby and was
23 uncomfortable at her continuing to work as of that date?

24 **A.** That's correct.

25 **Q.** Yes. Did you as a result of your conversation
206

1 looked clinical matters" and then it goes off to
2 Dr Saladi.

3 So as of 29 June, you were raising serious concerns
4 about Letby being associated and possibly causing the
5 collapses or deaths of some of the babies?

6 **A.** That's correct.

7 **Q.** Yes. If we go a little further down please to
8 the words attributed to Tony Chambers. It says, "Why
9 did we call the police [I think that should be why did
10 we not call the police] if Twins and Triplets why did
11 the Trust take them on? Can we explore more before the
12 police?"

13 And Steve B:

14 "Can we move member of staff? No, should then be
15 police."

16 And you say:

17 "Why not earlier? Reviews."

18 Do you know what those comments relate to?

19 **A.** I don't. I think I was probably referring to
20 the reviews, the case reviews that had been done by
21 Steve Brearey and the Thematic Review. I can't think
22 what other reviews I would have been referring to.

23 **Q.** No. As of 29 June, were you content that
24 whatever had been raised by the Executives had been
25 treated appropriately and that the reviews that had been
208

1 commissioned were the right reviews as of that time?
 2 **A.** Sorry, can you just repeat that question
 3 again?
 4 **Q.** Yes, of course. The 29 June --
 5 **A.** Yes.
 6 **Q.** -- I am asking you whether you viewed at that
 7 time that that the pieces of work that had been
 8 commissioned by the Executives had been appropriate for
 9 the concerns that had been raised at that time?
 10 **A.** You mean the pieces of work that they
 11 commissioned after this meeting in terms of the
 12 Royal College? Or --
 13 **Q.** Well, no. The pieces of work that had already
 14 been commissioned, so the Thematic Review and the
 15 various internal reviews?
 16 **A.** Sorry, I don't think any of those reviews were
 17 actually commissioned by the Executive Team. They were
 18 undertaken by --
 19 **Q.** Yes, but they come to the attention of the
 20 Executive Team, hadn't they?
 21 **A.** Yes.
 22 **Q.** And you were content that as of that time
 23 those had been appropriate, but that things had
 24 developed?
 25 **A.** I -- I think that the point of the Thematic
 209

1 factors that could have contributed and I think it said
 2 the "apparent increase" in death rate, but it was the
 3 real increase in death rate, and then obviously the
 4 Hawdon review was recommended by the College.
 5 **Q.** Yes.
 6 **A.** Now, we at this point, when we had the College
 7 review -- well, the College review hadn't happened, but
 8 when it was suggested we were also expressing our
 9 concerns around the continued presence of Letby on the
 10 unit.
 11 **Q.** Well, of course following your meeting on
 12 29 June, and we know that she was on holiday at that
 13 time, she never in fact returned to the ward, did she?
 14 **A.** No.
 15 **Q.** No.
 16 **A.** But we were never involved in any discussions
 17 around what happened or informed of her move and I think
 18 because at that point she was off the unit --
 19 **Q.** Yes?
 20 **A.** -- as I mentioned earlier there was a --
 21 **Q.** A lack of urgency?
 22 **A.** There was less urgency.
 23 **Q.** Yes.
 24 **A.** And because we were under the impression that
 25 the RCPCH review and the Hawdon review, as had been
 211

1 Review being sent on to the Medical Director and the
 2 Nursing Director and there were the appendices with the
 3 Mortality Review on, I think I don't know when they were
 4 looked at and how they were interpreted.
 5 **Q.** But I think up until that point the reviews that
 6 had taken place were as far as we could probably go
 7 within the department and we had actually had an
 8 external neonatologist as well.
 9 **Q.** Yes, thank you. That can come down. We know
 10 that there was another meeting the following day. We
 11 have looked at those notes earlier in evidence.
 12 **Q.** You described the meeting on 30 June as being
 13 a strange meeting because in your consideration as at
 14 that time the issues around Letby were not being taken
 15 seriously.
 16 **Q.** But following that meeting, the Royal College
 17 review was commissioned, wasn't it, and as we know
 18 Dr Hawdon's report came through.
 19 **Q.** As at that time, did you believe that the
 20 commissioning of those reports was appropriate?
 21 **A.** When those -- certainly when the Royal College
 22 review was commissioned, and we saw the Terms of
 23 Reference, it was essentially a service review but one
 24 of the Terms of Reference was specifically to see if --
 25 I forget the exact wording -- to see if there are any
 210

1 described initially, would be in depth. Now --
 2 **Q.** Well, we are going to come to the Hawdon
 3 review in a second.
 4 **A.** Okay.
 5 **Q.** But can I just confirm this; that the reason
 6 that I asked whether you thought if things were being
 7 generated appropriately at that time is because we know
 8 on 24 October of 2016 you spoke to your
 9 BMA representative?
 10 **A.** (Nods)
 11 **Q.** And said to her that the senior management
 12 team took a decision to move Letby to a non-clinical
 13 role temporarily and that:
 14 "... we as a group, that's you and the clinicians,
 15 are still uncomfortable that our concerns have not been
 16 fully addressed but we understand why the Exec body was
 17 cautious about escalating things."
 18 **Q.** So I want to ask you about that, please. Does that
 19 accurately reflect your consideration at that time?
 20 **A.** So I think at that time, it was reassuring
 21 that she wasn't in a clinical role. From the
 22 discussions with the Executive Team in June and July, we
 23 were fully aware, and it's been said and documented,
 24 that there they were -- they had concerns about
 25 reputational damage.
 212

1 So when I have said I understood, I didn't say
2 I agreed with their thinking.
3 **Q.** Right.
4 **A.** But I understood where they were coming from.
5 **Q.** Thank you.
6 **A.** However, I think the -- I suppose one of the
7 elephants in the room here was that, and looking back,
8 was the fact that all of these actions were predicated
9 on the suggestion from Stephen Cross that involving the
10 police at this stage would not be appropriate.

11 **Q.** Yes.

12 **A.** And I fell for that. And in the context of
13 that if the legal advisor is telling you that: well,
14 she's off the unit it's being looked at --

15 **Q.** Yes.

16 **A.** -- that's something. But I am -- I don't
17 think any of us were ...

18 It was strange. I mean if you're being told by
19 somebody who is a legal adviser and an ex detective that
20 it's inappropriate to call the police I am not in
21 a position to argue however uncomfortable it seems.

22 **Q.** Well, by 3 February, you had seen the RCPCH
23 report and by 7 February 2017 you had seen the Hawdon
24 report in which Dr Hawdon had found sub optimal care in
25 the cases that she reviewed at different levels:

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1 there had been a lot of letters backwards and forwards
2 in preparation for that meeting. You had requested
3 a face-to-face meeting with the Executives because you
4 had lost faith in Ian's judgment, you said I think
5 today?

6 **A.** (Nods)

7 **Q.** How had that happened, losing faith in
8 Ian Harvey's judgment?

9 **A.** Because firstly, the whole process of how --
10 the data that Mr Harvey had presented to us in July with
11 his, let's call it his deep dive review which he used to
12 suggest that we were understaffed, more busy, it was
13 entirely plausible that is the reason for the
14 association with Letby.

15 The fact that -- and we haven't touched on this --
16 in, in that particular meeting there was, there was
17 there were slides with patient identifiable data
18 including the data of a -- of a colleague which was
19 unforgivable.

20 The way that the --

21 **Q.** Are you talking about a meeting back in July
22 of 2016?

23 **A.** Yes, this is July which I think July 13th or
24 14th where he presented the data from the deep dive.

25 **Q.** All right. Can we have a look at the notes of
215

1 significant, major and minor.

2 And having considered that report, you and your
3 colleagues took the view that in addition to the four
4 cases which she suggested needed a broader forensic
5 review, there were others as well?

6 **A.** Yes, that's correct.

7 **Q.** And you brought that to the attention of the
8 board, didn't you?

9 **A.** That's correct.

10 **Q.** Yes. Throughout none of what had taken place
11 since February of 2016, so over the previous 12 months,
12 had you ever brought to anybody's attention your eye
13 witness evidence of Child K, had you?

14 **A.** Not at that point. It was only when I was
15 interviewed by the police.

16 **Q.** Well, in fact the first person that you spoke
17 to about it in terms of the Executives was Sue Hodgkinson
18 on 13 March, wasn't it?

19 **A.** Okay, yes.

20 **Q.** And we have looked at what you said to her on
21 that date; that this was one of three cases where you
22 had had concerns and you had seen Letby by the cot.

23 Following that there was a meeting with the
24 Executives on 27 March. Again we have looked at the
25 notes briefly today and you have told the Inquiry that
214

1 this meeting, please of 27 March 2017. They are at
2 INQ0003150, please.

3 Now, we have already looked at the attendees and we
4 can see that there's a welcome by Tony Chambers and the
5 three items on the agenda which were for discussion.

6 If we could go to page 2, please. You say at the
7 top of the page:

8 "As a group of paediatricians we accept the
9 Royal College review, the Casenote Review and
10 Jane Hawdon's review [and identified further ones,
11 that's the further deaths] It's a difficult thing.
12 What level of review do we need to do? We have
13 a collective view that this now needs to be at the level
14 of a rota review, who, where, involved, a forensic
15 investigation. We accept that we may not find a cause.
16 We have our names at the end of the incubator. We need
17 more assurance. The interpretation of reports differs
18 to the board. We were presented with a plan and we have
19 explored every avenue with the BMA."

20 So you were prepared to accept, it seems from this
21 note, that the Royal College review, the Casenote Review
22 and Jane Hawdon's review had been appropriate in
23 terms --

24 **A.** No because if you look at the comment that
25 Steve Brearey's made lower down, and I don't recall
216

1 making that comment, and it's quite obvious that we
2 didn't accept the review if you look at the
3 correspondence that had come through since the time we
4 saw the review, I don't think that's -- I don't know
5 who's made these notes.

6 I think with regards to the RCPCH service review,
7 absolutely some of the recommendations in there were
8 quite clear.

9 **Q.** Yes.

10 **A.** Absolutely I did not agree -- well, I agreed,
11 what I agreed with with Jane Hawdon's review was that
12 there were definitely at least the four further cases.

13 **Q.** Yes. We see that at the bottom of this
14 page --

15 **A.** I did not agree -- I did not agree that --
16 with her conclusion that she made at the time that
17 deficiencies in care were able to explain the deaths.

18 **Q.** Yes.

19 **A.** And I have said that lower down.

20 **Q.** She had found delayed intubation, delayed cord
21 clamping, delayed transfer, delayed attendance by
22 Consultants, hadn't she, and a whole host of things
23 which she suggested may well have contributed to the
24 collapses or deaths?

25 **A.** Well, I think in the context of the
217

1 police. It would be whistleblowing. Following BMA
2 advice if there is an alternative of a deeper dive we
3 should go for it, but this is a worry."

4 So weren't you there suggesting in this meeting
5 that a deeper dive before you go to the police would be
6 appropriate?

7 **A.** No because if -- what I was suggesting is if
8 there is any way of doing a deeper dive --

9 **Q.** Yes.

10 **A.** -- but we didn't feel that there was,
11 absolutely. And I was concerned, you know, already.
12 Don't forget this meeting took place --

13 **Q.** 27th --

14 **A.** -- a month or so, sorry, two months after we
15 had been told quite clearly about the consequences that
16 would happen if we crossed the line.

17 I had been told that if I didn't engage with the
18 mediation process, I was at risk of being reported to
19 the GMC. I had been told that there was significant
20 evidence from the grievance process of bad behaviours.

21 So, absolutely. And, yes, I can argue, you know,
22 my patient safety should come above my career --

23 **Q.** Yes.

24 **A.** -- absolutely. But also at this point Letby
25 was away from work and actually our purpose of this
219

1 information that she was given and the briefing she was
2 given --

3 **Q.** Yes.

4 **A.** -- I understand that subsequently with more
5 information she's actually disagreed with that.

6 And as I say our interpretation of the information
7 Jane Hawdon provided even with what she had got we were
8 still concerned that there were further babies in
9 whom --

10 **Q.** Yes, of course --

11 **A.** -- there was no explanation.

12 **Q.** And we see that at the bottom of the page.

13 Could we move over to the next page, please.

14 Steve Brearey says:

15 "But we have not interviewed nurses, junior doctors
16 which is really important."

17 And you say:

18 "Who could do that level of investigation? Does
19 not look good on the Trust's reputation. As group of
20 clinicians we do not know what to do but all of which
21 are disturbed by this. All unusual ones where they have
22 not responded and should. Board felt reassured, accept
23 inefficiencies."

24 Then you go on towards the middle of the page:

25 "Our career would be on the line if we contact
218

1 meeting, as I understood this meeting, would be
2 an opportunity for us to have a discussion and put down
3 and actually state explicitly, "We don't feel that there
4 is any alternative other than going to the police at
5 this point."

6 **Q.** Did you agree that that comment seems to
7 suggest otherwise?

8 **A.** No, I said if there is an alternative. But
9 there was no alternative.

10 **Q.** All right.

11 **A.** There was no other way. We could start
12 looking at the same information over and over and --

13 **Q.** Yes.

14 **A.** -- over again and still not find anything.

15 **Q.** Can we just turn over the page because you do
16 make some more pertinent comments as well. Thank you.

17 Ian Harvey says:

18 "There is three options, contact the police,
19 internal with NS support. Other experts conduct further
20 review."

21 And you say:

22 "What would be the level of depth?"

23 Then there is further comments from Ian Harvey:

24 "We've had the meeting with Jane Hawdon [that
25 was our meeting]. There has been subsequent work done."
220

1 And you say:

2 "We need to speak to all individually. Most of the
3 time they are not on unit. All we want as a group is 1)
4 that we feel assured enough that this cannot be
5 investigated any further and 2) is that the board
6 understand where we are coming from and that there is
7 the board's interpretation. We are now more aware than
8 you guys."

9 If we can turn over the page, please, you say in
10 the middle of the page there:

11 "The Consultant body has asked about it a lot. We
12 honestly can't see, get level of detail that's needed.
13 We need the resources and the interest."

14 And over the page, please.

15 And you say:

16 "I agree with NM, the focus needs to be on the
17 babies who have died. We have discussed a lot of
18 implications to the unit, the Trust and parents and
19 colleagues but this is for the greater good, the future.
20 It's a big issue, it's huge."

21 And then there's a discussion between you and
22 Tony Chambers. He says:

23 "You absolutely believe we have a criminal
24 behaviour."

25 And you say:

221

1 the end of this meeting is that it was accepted that we
2 explicitly said we want to be able to talk to the
3 police.

4 **Q.** Yes.

5 **A.** And they agreed.

6 **Q.** Thank you.

7 Now, drawing all of that together we seem to have
8 reached this point; that nothing was raised by you
9 until June of 2016. We have looked through the notes of
10 the meetings that took place at the end of that month.

11 Letby never went back on to a patient-facing role
12 and you expressed in October of 2016 to your
13 BMA representative that you understood why the
14 Executives were cautious to escalate up until that
15 stage.

16 We have heard this afternoon that following March
17 of 2017, you felt that your relationship with the
18 Executives, and certain of them, had broken down and you
19 were raising that as a problem with Duncan Nichol.

20 But you don't say, do you, Dr Jayaram, that any
21 reluctance on behalf of the Executives to look into
22 matters prior to June of 2016 causes you any concern and
23 you can't say that because you yourself hadn't raised
24 anything until that date?

25 **A.** No, personally I hadn't.

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1 "We need to clarify it beyond reasonable doubt."

2 And Steve Brearey says:

3 "On the balance of probability, words used from the
4 child protection perspective, you say honest answer is
5 we don't know. It's not been sufficiently explored or
6 reassured, there is a subtle distinction."

7 And Tony Chambers says:

8 "To get the distinction the only thing is to do
9 a police investigation."

10 And you seem to agree:

11 "Not sure anyone can do an investigation like
12 that."

13 And then finally on this page, you say:

14 "For me personally I have a vague media profile.
15 Recognise the impact, but so be it. It's for the
16 greater good."

17 So what were you saying there, Mr Jayaram?

18 **A.** I think with that comment, what I meant was
19 I don't think anyone else other than the police can do
20 an investigation like that.

21 **Q.** Yes.

22 **A.** And actually, you know, if there is an impact
23 on me in other things I do, so be it because we needed
24 to know.

25 So I -- I, as I said earlier my understanding at

222

1 **Q.** No.

2 **A.** But I am concerned that from the time that the
3 Thematic Review was on their radar --

4 **Q.** Yes.

5 **A.** -- that they didn't feel that the association
6 with Letby was of significance. I don't know whether
7 that is because they hadn't looked at it, wouldn't
8 consider it. But that is --

9 **Q.** Well, nobody was saying it was anything other
10 than an association, were they, at that stage?

11 **A.** But it's an association in the absence of any
12 other clinical explanations for what was going on.

13 **Q.** You were kind enough to provide us an appendix
14 to one of your Inquiry witness statements, the many
15 postings and Tweets and media interviews in which you
16 have engaged and much later in August of 2023 you posted
17 on Facebook the following:

18 "There are people out there now still earning
19 six-figure sums of taxpayers' money or retired
20 with their gold-plated pensions who need to stand up in
21 public and explain why they did not want to listen and
22 do the right thing, to acknowledge that their actions
23 potentially facilitated a mass murderer and to apologise
24 to the families involved in all of this. However
25 I suspect the response will be fudge and misinformation

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1 and it is now my mission moving forwards to make sure
2 that they are held to account."

3 You have just agreed that you understood why the
4 Executives were cautious about escalating things. How
5 did their actions potentially facilitate a mass
6 murderer?

7 **A.** I said I understood. I didn't say I agreed.

8 Lucy Letby was on the 27th of March I believe five
9 or six days away from coming back to work --

10 **Q.** But she didn't, did she?

11 **A.** She didn't --

12 **Q.** No.

13 **A.** -- because at this meeting we, as consultants
14 and the team from the neonatal network, said we want to
15 speak to the police.

16 I now understand that Lucy Letby had been led to
17 believe, by Sue Hodgkinson, that that meeting on the 27th
18 was actually a meeting at which myself and my colleague
19 Dr Brearey were going to be told that we were going to
20 face disciplinary action.

21 Now, it's all he said/she said. But there's
22 a clearly a discrepancy between where we are going why,
23 at the meeting on 26 January when we had not had sight
24 of the final Royal College report nor of the Casenote
25 Review, were we told quite explicitly that there's

225

1 believe that there are four of five babies who could be
2 going to school now who aren't."

3 Now, given that you have accepted that Lucy Letby
4 never returned to a patient-facing role following your
5 concerns raised to the Executives about deliberate harm,
6 do you still stand by those comments?

7 **A.** I would stand by that had she been moved
8 earlier, I think from the time the Thematic Review was
9 on the radar or whether it was considered, I think if,
10 if when the Thematic Review was seen -- and I don't know
11 when it was seen -- but if when it was looked at by the
12 Medical Director and the Nursing Director, had they
13 looked at it and come to us -- and maybe we should have
14 been more proactive and said, "Please can we talk about
15 this with you?" although there were emails to try and
16 get it on the radar --

17 **Q.** Yes, but what did you do, Dr Jayaram, about
18 the -- following the Thematic Review to go to the
19 Executives as clinical lead for children's services?

20 **A.** As I have said Dr Brearey was running it as
21 neonatal lead.

22 **Q.** But you didn't --

23 **A.** I personally didn't.

24 **Q.** Right. Finally I would like to ask you about
25 Dr Brearey's drawer of doom. He has made an additional

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1 nothing to see here.

2 **Q.** No, this is -- with greatest of respect,
3 Dr Jayaram, this is not about what you were or were not
4 told?

5 **A.** No, I am talking about -- about things people
6 could have done differently.

7 **Q.** Yes.

8 **A.** At that time, why were those interpreted in
9 a way that was clearly to my mind designed to minimise
10 our concerns and bring her back to work? Why was
11 Tony Chambers having conversations with her mother and
12 father? Why was Sue Hodgkinson having conversations with
13 her mother and father? Why was the RCN rep?

14 These are the things I am talking about. And when
15 I talk about people justifying their actions I will put
16 my hands up and I hope I have acknowledged the things
17 I could and should have done differently and better.

18 **Q.** Yes.

19 **A.** All I meant by those comments -- and bear in
20 mind there was a lot of pent up anger at that point --
21 all I want is for these people to acknowledge that they
22 too could have done things differently.

23 **Q.** Fair enough. You also on the same day said to
24 ITV News:

25 "The horrible thing to say is I do genuinely
226

1 statement to the Inquiry. Have you seen that?

2 **A.** I haven't seen the additional statement.

3 **Q.** No. Right. Did you ever have sight of
4 Dr Brearey's drawer of doom?

5 **A.** I'd never even heard of the concept of a
6 drawer of doom. It seems to come up in a lot of
7 statements.

8 **Q.** Yes.

9 **A.** I have never heard it referred to as a drawer
10 of doom.

11 **Q.** Right. Is it your normal practice to keep one
12 drawer storing important documents dealing with
13 concerns?

14 **A.** Certainly not for me. I mean, you'll have to
15 ask Dr Brearey about drawers of doom. I mean, this
16 seems to come up a lot. I --

17 **Q.** He never discussed it with you?

18 **A.** He discussed all the information he had.

19 I never knew about a drawer of doom or --

20 **MS BLACKWELL:** All right. Thank you very much.

21 **LADY JUSTICE THIRLWALL:** Thank you, Ms Blackwell.
22 Mr Baker.

Questions by MR BAKER

24 **MR BAKER:** Dr Jayaram, I have only got two very
25 brief questions. I represent a number of the Families.

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1 First of all, you were asked some questions about
2 the point at which your belief moved from concern about
3 the possibility of negligent care or deliberate harm
4 into thinking the unthinkable.

5 Could we go, please, to INQ0102345 and to page 31,
6 please. This may assist your memory. So can you see
7 the bottom left-hand corner. I'm afraid it's very
8 small?

9 **A.** Is it possible to enlarge it a little bit.

10 **Q.** Yes, here we go.

11 **A.** Thank you.

12 **Q.** So you are being asked questions here by
13 Mr Myers KC and can you see there a section:

14 "Question: Right, I am asking you about your state
15 of mind though by the time we get to February the
16 thought had crossed your mind, hadn't it, that she may
17 be deliberately harming babies?"

18 And you say:

19 "Unfortunately that unthinkable thought had crossed
20 my mind and other colleagues as well."

21 **A.** Yes.

22 **Q.** So is it fair to say that by the time we get
23 to February 2016, you and your colleagues have begun to
24 think the unthinkable?

25 **A.** Yes. I mean as I discussed, I think
229

1 and others did and I suppose I was almost, you know --
2 I was also aware of the fact that you know maybe I was
3 starting to see things that weren't there.

4 And it's so obvious now. And yes, I accept that
5 I should have, I should have been -- I should have put
6 my head over the parapet and, and been more --

7 **Q.** Thank you.

8 **A.** -- explicitly articulated it. And I can only
9 apologise to the parents of the babies that had tragic
10 events after those times.

11 I can only speculate as to whether had I raised
12 those concerns at that time things might have been
13 different. I honestly don't know.

14 **Q.** Well, we are going to look at an email.

15 I think you have been taken to it already. You were
16 asked a question just now:

17 "As of 29 June, were you content that whatever had
18 been raised by the Executives had been treated
19 appropriately and the review that had been commissioned
20 was the right review at that time?"

21 If we can go please to INQ0003112 and to page 2 of
22 that document, please. It's the email at the bottom
23 dated 29 June 2016 from Ian Harvey to you.

24 How did you feel receiving that email from the
25 Chief Executive of the Trust?
231

1 by November we were wondering about the significance of
2 the association and as these -- as there were more of
3 these unexpected and unusual events, the -- the thought
4 about deliberate harm had become more prominent.

5 **Q.** Yes. So you came back from holiday I think on
6 5 November 2015 and you were informed about the death of
7 Child I and it's that point where you say in your
8 witness statement concerns began to appear.

9 And so would it be true to say that between that
10 date and November 2015 and February 2016, those thoughts
11 had coalesced into thinking the unthinkable?

12 **A.** As I discussed, I think the November corridor
13 conversations were really the first time that I was
14 aware other colleagues had been having similar thoughts.

15 I think in that time, absolutely, once you -- once
16 you start having those thoughts it's very, very
17 difficult to ignore them.

18 But -- and you know I admit I got this wrong, I did
19 my utmost best to hope it wasn't that and it was always
20 there nagging because, yes, I am aware of
21 Beverley Allitt and Shipman and other cases but even now
22 in retrospect it's staring you in the face, it doesn't
23 happen to you, it happens to other people and I --
24 I talked about courage and I have said that I understand
25 now I -- I, you know, the very fact I had those thoughts
230

1 **A.** Well, from the Medical Director.

2 **Q.** Medical Director, sorry, of the Trust?

3 **A.** I was familiar with similar emails from

4 Ian Harvey, not to do with this issue, you know
5 Consultants may be moaning about car parking or admin
6 time or something and, and it was not unusual to get
7 an email saying: All emails cease forthwith.

8 I think the email that I sent to which he sent this
9 response, me suggesting that the Executives didn't seem
10 to have that degree of urgency, was my honest opinion at
11 that time. But of course he hasn't said here it's been
12 discussed and what action is being taken.

13 And it -- in terms of how it made me feel it just
14 made me feel frustrated and angry really and then
15 obviously he then came down and intimated that they are
16 going to try and get more information and then probably
17 contact the police, which is why I think I sent the
18 subsequent email just after 10 o'clock.

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

21 **LADY JUSTICE THIRLWALL:** Thank you, Mr Baker.
22 Mr Skelton.

23 Questions by MR SKELTON

24 **MR SKELTON:** My Lady, I am very conscious of the
25 time and I will try and be as swift as I can.
232

1 I appreciate Dr Jayaram has had a very, very long
2 day and I am not going to make it any easier for him.

3 **LADY JUSTICE THIRLWALL:** No, all right.

4 Dr Jayaram, would you like another break?

5 **A.** No, I'm fine. Let's just carry on.

6 **LADY JUSTICE THIRLWALL:** I can't remember, I think
7 you are down for 20 minutes.

8 **MR SKELTON:** I am. I will do my best.

9 **LADY JUSTICE THIRLWALL:** Yes. Well, I think we
10 have already had a substantial overrun on one of the
11 time estimates. So if you could keep it to 20 minutes.

12 **MR SKELTON:** Okay. Dr Jayaram, the duty of
13 candour. Sir Robert Francis defined it as the
14 volunteering of all relevant information to persons who
15 have or may have been harmed by the provision of
16 services whether or not the information has been
17 requested and whether or not a complaint or report about
18 that provision has been made.

19 I presume you agree with that?

20 **A.** I couldn't disagree with it at all.

21 **Q.** And it's one of the fundamental axioms of

22 medical practice --

23 **A.** Yes.

24 **Q.** -- in paediatrics and elsewhere.

25 You have been asked many times during the evidence

233

1 **A.** I think when I read the description of the
2 skin changes because it tallied with what colleagues and
3 myself had been aware of.

4 **Q.** So that's the end of June. Two months later,
5 or thereabouts, the Royal College actually arrive on
6 site and they speak to you and Dr Brearey and in fact
7 you have a rather similar conversation if not in more
8 detail with the Review Team in which both of you lay out
9 in full and articulately all of your concerns about the
10 mortality, including the fact that a particular nurse
11 was on shift at night when they happened and then when
12 she was moved the collapses and deaths happened on the
13 day shifts as well?

14 **A.** (Nods)

15 **Q.** And you mention that a lot of information,
16 I won't go through all of it in the interests of time,
17 but one of the things that you mentioned was the
18 unexpected unexplained nature and the failure to respond
19 as you would expect physiologically to standard
20 resuscitation?

21 **A.** Correct.

22 **Q.** All of which is highly significant because
23 it's unusual and that's correct?

24 **A.** That's correct, yes.

25 **Q.** And as you had done at the end of June, you

235

1 today about the meeting you had with the Executives on
2 29 June. I won't go into it in any more detail.

3 But it suffices to say that this was your first
4 direct contact with them in which you laid out your
5 concerns that you thought a nurse, Lucy Letby, was
6 murdering the babies and that was responsible --

7 **A.** Potentially yes, yes.

8 **Q.** And indeed you speculated in that meeting
9 about the mechanism of murder; possibly air embolism and
10 via a cannula or some other mechanism?

11 **A.** (Nods)

12 **Q.** You spoke out loud?

13 **A.** Yes.

14 **Q.** But didn't have the answer?

15 **A.** No.

16 **Q.** You have also said in your evidence in writing
17 that after that, you thought: I better have a look at
18 this and you found Tanswell and Lee paper --

19 **A.** That's right.

20 **Q.** -- and we know the history of where that ended
21 up.

22 **A.** Yes.

23 **Q.** And I think you subsequently said to the

24 Royal College you found that chilling when you first

25 found that paper?

234

1 have speculated out loud in front of the reviewers as to
2 how the murders might have been committed and you
3 queried injecting air into babies. Do you remember
4 that?

5 **A.** Yes. I think we -- we discussed these are
6 possibilities and we hadn't found any other obvious
7 clinical causes. I don't think I was saying, "This is
8 what's happened", but it -- it was a possibility.

9 **Q.** And I think you specifically mentioned Child A
10 in that context?

11 **A.** Sorry?

12 **Q.** You specifically mentioned Child A?

13 **A.** Yes.

14 **Q.** As well as the Triplets and others, it's right
15 to say.

16 And I think you also mentioned the police and the
17 possibility that they could be called which had been
18 discussed with the Executives?

19 **A.** Yes.

20 **Q.** You may not remember all of that, but have you
21 jogged your memory --

22 **A.** Yes, we discussed that and I think I discussed
23 that we'd also been told that it wasn't the right thing
24 to do at that time.

25 **Q.** Scroll forward another few months and the

236

1 Inquest final arises quite a long time after the death
2 of Child A in respect of his death.

3 And you must have involved been involved in
4 a number of Inquests over the years sadly?

5 **A.** In the past, yes.

6 **Q.** And given evidence at them?

7 **A.** Yes.

8 **Q.** So you were aware of the basic statutory
9 purpose of an Inquest?

10 **A.** Yes.

11 **Q.** Who the deceased was, how, when and where they
12 came by their death and your bit as the physician is the
13 how bit, the how question: why have they died medically?

14 **A.** (Nods)

15 **Q.** Yes. You are nodding.

16 **A.** Yes.

17 **Q.** You are also aware, I would assume, that the
18 coronial system is one of the ways in which this country
19 investigates whether or not something untoward has
20 happened, whether or not a death is unnatural in the
21 sense that there's been foul play?

22 **A.** Yes.

23 **Q.** And it used to be that they could commit
24 people for trial from Inquests. These days they are
25 linked in with the police and the criminal justice

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1 pre-Inquest meeting whether I specifically raised that
2 concern.

3 Stephen Cross, who was running that meeting, I was
4 aware was fully aware of the specific concern because he
5 had been involved in the meetings in June and July where
6 we -- we discussed it. But in those pre-meetings
7 I didn't specifically raise that.

8 I had wondered how in a coronial Inquest I could
9 raise that specific concern. Stephen Cross, as we
10 discussed, sent me an email which he had sent to the
11 Coroner saying he had discussed it with the
12 Coroner's assistant before and that the Coroner was
13 fully aware of our concerns.

14 He also attached to that email the Terms of
15 Reference for Jane Hawdon's Casenote Review that were
16 very detailed and specifically said that this review
17 would be looking for other causes including things such
18 as air embolism. So I guess at the time of the Inquest,
19 my understanding was that the Coroner was fully aware
20 and again when I re-read the email it is an assumption
21 but the Coroner was fully aware of those specific
22 concerns and --

23 **Q.** There isn't any evidence in fact that he was,
24 is there, and I don't know whether you have seen his
25 statement but I don't think --

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1 system and you know that the police will often be
2 involved with Inquests?

3 **A.** Yes.

4 **Q.** You provided a statement a month or so after
5 Baby A's death in which you dealt with, in a very
6 standard way, with precisely your involvement with his
7 care, so coming on scene, the collapse, the
8 administration of resuscitation and of course his
9 untimely death and that must have been a familiar
10 process for you providing that kind of statement?

11 **A.** Yes.

12 **Q.** A year or so later, because the Inquest is
13 delayed for many, many months, you -- there are a series
14 of meetings about the Inquest and I think you have now
15 jogged your memory and seen that there is in fact a note
16 of I think possibly a telephone meeting or a direct
17 meeting --

18 **A.** Yes.

19 **Q.** -- at which you were in fact present.

20 May I ask you about that insofar as you can now
21 remember having jogged your memory. Was it discussed or
22 did you discuss, or anyone else discuss in any of those
23 meetings the possibility of a criminal act having been
24 committed?

25 **A.** I can't remember in that meeting, that

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1 **A.** No.

2 **Q.** -- he was aware. So he hadn't been told by
3 Stephen Cross?

4 **A.** No.

5 **Q.** And I don't think you proactively said in the
6 conference meeting that you had that you had suspicions,
7 you didn't tell counsel?

8 **A.** No.

9 **Q.** There may be -- it may be for counsel to
10 answer --

11 **A.** Yes.

12 **Q.** -- whether he in fact received that
13 information via another source --

14 **A.** Yes.

15 **Q.** -- such as Mr Cross. But that's not matter
16 for you?

17 **A.** Sure.

18 **Q.** You don't know if he did or he didn't?

19 **A.** Yes.

20 **Q.** The GMC's Good Medical Practice at the time,
21 it was the 2013 version, obliges doctors to not
22 deliberately leave out relevant information when they
23 give evidence to legal proceedings. Were you aware of
24 that broadly speaking?

25 **A.** Broadly speaking, not the specific clause.

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1 Q. You were called to give evidence at the
 2 Inquest in fact twice because there was something of
 3 a discussion in respect of the cause of deaths, which
 4 required you to come back.
 5 Were you in fact sitting together with Dr Shukla or
 6 did you sort of go and sit down and come back up again?
 7 A. Sorry, we went up and then I think I was --
 8 I was in the courtroom.
 9 Q. And then you went back to your seat and then
 10 came back up?
 11 A. I think so. I can't -- I don't think I went
 12 out of the room and had to come back in. So I think
 13 I was ...
 14 Q. The first time you gave evidence, and please
 15 in the interests of time I am going try and truncate
 16 what you said --
 17 A. Sure.
 18 Q. -- but if I am getting it wrong you must
 19 correct me, please.
 20 You said that Child A was stable when you came on
 21 shift, you discussed the long line insertion and there's
 22 a great deal of analysis of the long line insertion
 23 during the Inquest?
 24 A. Yes.
 25 Q. And the administration of dextrose. Again

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1 A. Yes, and I have seen the summaries as well.
 2 Q. Then you are recalled after that and as you
 3 will have seen from the prior's note, which I know you
 4 have read because you mentioned it earlier and I think
 5 you consider it to be a more accurate note than the
 6 other notes we have seen --
 7 A. Yes.
 8 Q. -- your task as recorded in the note is to try
 9 and assist with your paediatric knowledge in relation to
 10 the circumstances in Dr Shukla, or in other words help
 11 Dr Shukla reach a conclusion about the cause of death.
 12 So you have moved slightly from being an expert --
 13 sorry, a witness of fact about your recollection to
 14 being something of an expert, trying to explain to the
 15 Coroner what might have happened. Did you understand
 16 that shift?
 17 A. Not explicitly in -- in those terms, no.
 18 Q. Does it make sense to you, as I put it to you
 19 now?
 20 A. It does make sense in those terms, yes.
 21 Q. I mean, to put it bluntly, you are not being
 22 asked what you did or thought in June 2015. You were
 23 being asked what you think now --
 24 A. Yes.
 25 Q. -- has caused the child's death, how they have

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1 that's another issue which is discussed in detail.
 2 But you say, quite candidly, that there's nothing
 3 you could think of to explain the sudden deterioration
 4 and that included the dextrose and the long line?
 5 A. That's correct.
 6 Q. You mention your thought processes at the
 7 time, this is back in June. So you are describing
 8 what's going through your mind as a senior doctor back
 9 in June 2015 when the child collapsed and died and you
 10 weren't thinking -- you couldn't think of what had
 11 caused it at the time, that's correct?
 12 A. That's correct, yes.
 13 Q. You made it clear that this was an unexplained
 14 collapse and that the child hadn't responded in a timely
 15 or normal way to resuscitation?
 16 A. That's correct.
 17 Q. And you ruled out the causes I have mentioned
 18 but also cardiac arrhythmia, the mother's medical
 19 condition and the possibility of a thrombus which could
 20 have caused a blockage and led to an arrest. All of
 21 those you ruled out clinically?
 22 A. (Nods)
 23 Q. Dr Shukla then gives evidence and he is unable
 24 to give a natural or an unnatural cause. He clearly was
 25 baffled by why the baby had died. Do you remember that?

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1 died.
 2 A. Yes.
 3 Q. On those points, in answer to the various
 4 questions from the advocates and from the Coroner, you
 5 consider the downgrading of the unit and you mention the
 6 review, the independent review, and you talk about the
 7 initial feedback of the review that nothing had been
 8 found systemically with the training practices or
 9 equipment.
 10 You mention -- well, this phrase is recorded and I
 11 would like to understand what you meant by it:
 12 "A potential issue with staffing."
 13 Now, does that mean understaffing, the classic NHS
 14 lament, or does it mean a staff member?
 15 A. That's a really good question. I have to
 16 assume that those were the words that I used. I am
 17 aware that the kind of hot feedback, if you like, from
 18 the College review discussed staffing numbers, but that
 19 wouldn't have been what I was referring to because
 20 I didn't feel there was that.
 21 And I think it was an oblique reference to an
 22 individual member of staff and actually if I -- you
 23 know, I've reflected on this for a long, long time, what
 24 I was -- and again I guess my response is predicated on
 25 an understanding which it seems is not correct; that the

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1 Coroner was aware of our concerns based on what
 2 Stephen Cross had told me and that he was aware of the
 3 things that were being or were supposed to have been
 4 investigated in the forensic review and because of that,
 5 I was to an extent slightly surprised that the Inquest
 6 was happening when a forensic review was going on. But
 7 I -- I didn't query that. But clearly the Coroner
 8 didn't have the understanding that I knew.

9 I -- you are absolutely correct, you know, I am
 10 there in a Coroner's court and I should say what I think
 11 and again I didn't.

12 I think and again -- and I, I reach out to
 13 Baby A and B's parents for this, and maybe I should have
 14 done a supplementary statement or talked afterwards --
 15 I was trying to in my discussion about the fact
 16 I couldn't explain this, you know, in the context that
 17 my understanding was that the Coroner knew of our
 18 concerns I was trying to sort of throw as many
 19 breadcrumbs as possible for the Coroner to pick up
 20 without explicitly saying what the suspicion was.

21 Why did I do that? And again -- and I appreciate
 22 that this was the wrong judgment -- I had Baby A's
 23 parents sitting 10 feet away from me and, yes,
 24 absolutely, duty of candour.

25 I just didn't have the courage to say it and
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1 A. Yes.

2 Q. All the things that in fact occurred later on?

3 A. Yes, absolutely. And, as I say, I am not
 4 using this as an excuse at all, but I was under the
 5 impression the Coroner was aware of those concerns.

6 But even if the Coroner was aware of those
 7 concerns, I should have still been explicit.

8 Q. Can I try and deal with Child M as well and --

9 A. Yes, of course.

10 Q. And his parents are watching these
 11 proceedings. I know you have followed these proceedings
 12 and I don't want to assume that you followed them as
 13 closely as listening to all of the evidence. But they
 14 are particularly concerned that as your concern arose in
 15 respect of their child's collapse -- you recall Child M
 16 collapsed just like Child A?

17 A. Yes.

18 Q. And I think you told the police at one point
 19 in 2019 they were the two children who really haunted
 20 you --

21 A. Yes.

22 Q. -- in effect, those collapses.

23 You had a chat or you had a discussion with the
 24 parents after Child M's collapse. But again you didn't
 25 mention your suspicions. And this -- we are now into
 247

1 I think part of this, part of this was already from, you
 2 know, I guess being influenced by the -- the pushback
 3 that we were getting that, "There's nothing to see here"
 4 and, and, I can -- I regret not explicitly saying that
 5 then on many, many levels because it should have been
 6 said, you know, and I am not going to make excuses.
 7 I did have an understanding that the Coroner was aware
 8 of our concerns because I interpreted that's what
 9 Stephen Cross had told the Coroner and I should have
 10 done better.

11 Q. You should have told the Coroner that a member
 12 of staff may have been responsible for the child's
 13 death?

14 A. Yes, I should have done.

15 Q. And one of the reasons why that was required
 16 was not only candour for the parents, mother A was sat
 17 there, but also because the Coroner has the equipment
 18 and the wherewithal --

19 A. Yes.

20 Q. -- to do exactly what you needed to get done?

21 A. Yes.

22 Q. The expert investigation, the forensic
 23 pathology?

24 A. Yes.

25 Q. The radiology review?
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1 2016, well into the terrain, long after the terrain,
 2 sorry, long after the suspicion has arisen in your and
 3 your colleagues' minds. Why was that?

4 A. The discussion that I had with Baby M's family
 5 after he was resuscitated was I -- I discussed that
 6 again I couldn't explain it. It didn't fit with things.

7 I think I -- I would, I would ask any colleague
 8 how, how, to parents sitting there, with the nurse there
 9 as well, can I express such, such a concern?

10 And again at this stage, yes, we were thinking the
 11 unthinkable, but it was this issue of not having
 12 evidence and I wish I could turn the clock back and wish
 13 I could have said it, and I didn't, or later on.

14 I think it's really difficult to appreciate my
 15 thought processes then compared to what I know now, but
 16 I think I still probably wouldn't have expressed that
 17 concern immediately at that point, but --

18 Q. You didn't have to, did you? In fact you
 19 could have waited until the horror of the situation --

20 A. Yes.

21 Q. They were immensely affected by it as you
 22 recall?

23 A. Absolutely.

24 Q. You could have waited until that had abated
 25 somewhat --
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1 A. Yes.
 2 Q. -- and revisited that issue?
 3 A. Yes.
 4 Q. And I have to put to you that candour requires
 5 you to at least alert them to the possibility that there
 6 was an explanation that hadn't been looked at which
 7 needed to be looked at and that included deliberate
 8 harm?
 9 A. I don't disagree.
 10 Q. Overall, I think you accept the proposition
 11 that once the suspicion arose that Letby was
 12 deliberately harming children investigation was required
 13 to confirm or rule out that suspicion by hook or by
 14 crook?
 15 A. I -- yes, absolutely.
 16 Q. We know from the evidence of you, Dr Brearey
 17 and others that discussions occurred internally really
 18 from the start of the cluster of deaths in June and
 19 continued throughout the next year as to understand why
 20 the babies were dying in an increased rate at
 21 an increased rate?
 22 A. (Nods)
 23 Q. However, no clear causes or thematic causes
 24 were found and you didn't identify the method of crime
 25 at any point yourself at that stage?

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1 gone to the Executives, they had been alerted to it via
 2 Alison Kelly early on and then directly by you in the
 3 meetings.
 4 Is it fair to say that you found yourselves -- this
 5 is the Consultant body, you, Dr Brearey and your
 6 colleagues -- locked into a process of investigation,
 7 the Royal College review, the Hawdon review, which
 8 wasn't in fact going to answer or confront the question
 9 that needed to be confronted: was she harming babies?
 10 A. Yes, so I think in terms of being locked into
 11 that process you are absolutely correct. When we had
 12 formally raised late June/early July we discussed what
 13 the correct -- what the right way forwards we discussed
 14 the police, my colleague, Dr Saladi in his email
 15 explicitly said he didn't think there was anyone else
 16 who could do it, yet we were told explicitly that it
 17 would be inappropriate to involve the police at this
 18 stage and I remember -- I forget which meeting it was in
 19 June/July, we were told that it would be the end of the
 20 unit, there would be blue and white tape everywhere, the
 21 whole place would be a crime scene, everyone would be
 22 a suspect.
 23 Now, I understand this now that that's not how it
 24 works when these issues are raised actually, there are
 25 actually mechanisms in place for raising these issues

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1 A. No and I am I wasn't looking for methods of
 2 crime at that point. It -- it was -- I wasn't, it was
 3 one of the possibilities could these be unnatural events
 4 but until June I would say I had not specifically
 5 considered how.
 6 Q. To be fair, it wasn't your job to --
 7 A. No, no.
 8 Q. -- investigate a crime?
 9 A. No, absolutely, and, you know, it's my job to
 10 raise the concerns.
 11 Q. It is right, and I think you acknowledged
 12 today, that there were in fact some significant signs in
 13 the records which had a more comprehensive analysis been
 14 conducted might have been spotted, the insulin C-peptide
 15 results for the two children --
 16 A. Yes.
 17 Q. -- for example and of course Child K about
 18 whom you have been asked?
 19 A. Yes.
 20 Q. There were those signals which were slightly
 21 more positive than --
 22 A. Yes.
 23 Q. -- inferential.
 24 But the concerns had been raised with Eirian Powell
 25 very early on in 2015 and of course you had ultimately

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1 without disruption to service.
 2 I think from that point, because we knew Letby had
 3 been moved, as I mentioned I don't think complacency but
 4 there was slightly less urgency and I -- I suppose what
 5 I can't speak for colleagues, what I anticipated the
 6 College review and the Casenote Review would support
 7 what had been found by our own Thematic Reviews and at
 8 that point the police would be involved.
 9 And there was a delay in us seeing, having access
 10 to those -- the information from those and then events
 11 went from there and I am, I am glad that we from that
 12 point were assertive enough to not accept the
 13 Executives' interpretations of what they found, but I do
 14 feel we were -- we were locked into that.
 15 Now, could we have actually put our hands up at any
 16 point and said: look, this is all very well but this
 17 isn't the right thing to do? We could have done.
 18 I think it's very difficult when we have been told
 19 by the Executive body, particularly someone who has
 20 a legal and policing background, that it is the wrong
 21 thing to do and I should have been more curious and
 22 challenged it.
 23 Q. Without going into great detail, because I am
 24 in danger of going over my time with you, but were you
 25 fully aware that the Royal College were never going to

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1 answer the question that you needed to confront, and
2 likewise with Dr Hawdon, in fact; they were really
3 staging posts, as it turned out?

4 **A.** I think if I look at the Terms of Reference of
5 the Royal College review, you know, to -- to look for
6 any -- I forget the exact terms but any factors that
7 could have contributed to the deaths.

8 **Q.** Yes.

9 **A.** And if I look at the Terms of Reference of --
10 the original Terms of Reference of the Hawdon review, in
11 particular the original Terms of Reference of the Hawdon
12 review, I think either those Terms of Reference would
13 have found something that would have flagged up
14 something unnatural or they wouldn't have and if they
15 had found something unnatural, it would have gone down
16 the police line and if they hadn't, I anticipated that
17 then the next response would be to escalate to the
18 police.

19 Now, obviously I shouldn't assume what any review
20 is going to find but given that these were
21 paediatricians undertaking these reviews, and I talked
22 to them and my colleagues had talked to them, and they
23 had heard what we had said, I felt at that point
24 although I felt it needed to be escalated and there is
25 an element of -- I think I said it's minuted

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1 There was an opportunity to take your concerns and
2 suspicions to the safeguarding team and that opportunity
3 was not taken in terms?

4 **A.** Yes. I think by engaging the SUDIc process
5 for the deaths it would have automatically been on the
6 safeguarding radar.

7 **Q.** That could have occurred really early on?

8 **A.** It could have occurred early on. I don't know
9 whether early on deliberate harm would have been
10 considered but the pattern as things progressed could
11 well have been recognised earlier on.

12 **Q.** In terms of the external lifelines, again
13 without discussing them in detail, but trying to deal
14 with them all in one go, there is obviously the CDOP
15 route --

16 **A.** Yes.

17 **Q.** -- which you have discussed but there is the
18 wider national bodies, the GMC, the NMC the CQC,
19 NHS England and of course you have already talked about
20 the Coroner and the police. But those other bodies,
21 they all have abilities or they all have the capacity to
22 receive concerns or whistleblowing issues and to start
23 to help with them being raised.

24 As I understand your evidence, really, you didn't
25 feel that any could you really go anywhere outside the

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1 somewhere, that there was part of me that was almost
2 hoping that they would find something explainable and
3 clinical, you know, because that's -- so in many ways,
4 awful as it is, it is so much easier to deal with than
5 the reality of things.

6 **Q.** And ordinarily the probability is that they
7 would have done and when you have a cluster of deaths,
8 there usually is a clinical explanation for it?

9 **A.** Usually and I think again, you know, this is
10 all about us or me -- I can't speak for others -- trying
11 to make things fit -- and, and not having the courage to
12 think outside the box.

13 **Q.** I am not going to take you through all the
14 various committees and groups that existed back in
15 2015/2016 but I am going to try and deal with it sort of
16 compendiously, if I can.

17 There clearly was a patient safety issue as
18 suspicions arose in respect of Lucy Letby harming
19 children and there clearly was a parallel safeguarding
20 issue, they are -- in the context, it's the same point,
21 isn't it?

22 **A.** Yes.

23 **Q.** Safeguarding patient?

24 **A.** Yes.

25 **Q.** Patient safety.

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1 Trust?

2 **A.** Yes, I -- I think again speaking for myself
3 but I think I speak for colleagues, we just didn't know
4 where we could go and I think there's some levels,
5 number one about the concern, but also subsequently
6 about the response to concerns when we raised them and
7 I was not aware at the time that all the bodies to whom
8 you refer had processes that we, we could have followed
9 and I will be honest now, I am still not entirely clear
10 specifically what they are.

11 **Q.** Did you look at -- I mean, you can type in
12 GMC, NMC, and up come a whole raft of --

13 **A.** My understand of the GMC and NMC was again you
14 had to have a degree of evidence.

15 **Q.** Well, what they might have done is say: you
16 need to go to the police?

17 **A.** Yes.

18 **Q.** Any of those bodies in fact may have said this
19 isn't really --

20 **A.** Yes.

21 **Q.** This isn't really an issue about the adequacy
22 of care; it is not your standard whistleblowing?

23 **A.** Yes.

24 **Q.** This is much more serious?

25 **A.** Yes.

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1 Q. It's criminal.
 2 A. And -- and in many ways I wish somebody had
 3 just said that to us, you know. When we initially
 4 raised it in June '16 we were told: not the police, when
 5 we discussed it with the Royal College reviewers we were
 6 told -- why don't you just go to the police. Well,
 7 I don't know what the Coroner was told in February 17,
 8 I don't know what Simon Medland was briefed, but
 9 absolutely.

10 I think, looking back, we shouldn't have had to
 11 have waited for permission to go to the police. We
 12 should have just gone.

13 Q. Because the only way that Lucy Letby was
 14 either going to be incriminated or exculpated was by
 15 full investigation, of which the police were best
 16 equipped?

17 A. Yes, absolutely and again there was the
 18 misapprehension that -- and we thought it was reinforced
 19 to us by -- by people in the Trust we raised issues to
 20 that: you hadn't got enough evidence to go to the
 21 police, which I understand now is absurd because, as you
 22 say, the people who find the evidence are the people
 23 investigating.

24 MR SKELTON: Thank you, Dr Jayaram, those are my
 25 questions.

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1 So we will rise now and we will start again
 2 tomorrow at 10 o'clock.
 3 (5.24 pm)
 4 (The Inquiry adjourned until 10.00 am
 5 on Thursday, 14 November 2024)
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1 My Lady, I hope I haven't gone too far over my
 2 limit.
 3 LADY JUSTICE THIRLWALL: Thank you very much.
 4 MS LANGDALE: My Lady, I don't think Mr Kennedy has
 5 any questions? No, he doesn't and I have no further
 6 questions of Dr Jayaram.
 7 LADY JUSTICE THIRLWALL: Very well, and I don't
 8 have any questions either, Dr Jayaram, so thank you for
 9 bearing with us on a very long day.
 10 A. Thank you, can I just say thank you very much
 11 for inviting me here today. Can I say again to the
 12 parents of the babies involved that I am sorry for my
 13 own personal failings and I apologise for things that
 14 I could and should have done better.
 15 I know that my words will never ever help to ease
 16 the grief that you feel and I also want to reach out to
 17 you and I'm sorry that you are having to go through the
 18 external noise that's out there of people taking another
 19 view on everything that's happened and I appreciate how
 20 painful that must be for you and how insensitive it is
 21 of the people who are trying to suggest that other
 22 things happened.
 23 And once again, I thank you for your patience with
 24 me very much.
 25 LADY JUSTICE THIRLWALL: Thank you, Dr Jayaram.

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