Tuesday, 19 November 2024

(10.00 am)

LADY JUSTICE THIRLWALL: Ms Langdale.

MS LANGDALE: May I call Dr Brearey?

LADY JUSTICE THIRLWALL: Yes, Dr Brearey, come forward, please.

DR STEPHEN BREAREY (sworn)

Questions by MS LANGDALE

LADY JUSTICE THIRLWALL: Thank you, Dr Brearey, do sit down.

MS LANGDALE: Dr Brearey, you have been a Consultant paediatrician at the Countess of Chester Hospital since March 2008, a neonatal unit Lead Clinician from March 2008 to July 2020. You have provided us with three statements to the Inquiry dated July 2024, September and November 2024.

Can you confirm the statements are true and accurate as far as you are concerned?

A. Yes.

Q. Before I begin to ask you questions, Dr Brearey, I understand you want to say something.

A. Yes, I would like to speak to the Families.

Sorry. Sorry for my part in not being able to protect your babies. I can just say that I tried my best and I acknowledge that at times my best was not

enough.

This apology is to the parents in the indictment but also parents who are involved in the ongoing police investigation. I hope that you all get the truth and justice that you deserve.

Q. Dr Brearey, I am going to ask you questions today under different themes, there is obviously a long period of time you were involved in different aspects with raising concerns to Execs, conversations amongst medical staff, so I am going to break topics down, if we may. So occasionally we might move back slightly in the chronology or forwards, but I think this might assist understanding for those who are less familiar with every document, as you and I both are by now.

First of all, if we can turn, please, to guidance that is relevant to Sudden and Unexpected Deaths and if I can ask Ms Killingback, please, for INQ0014165, page 33.

Dr Brearey, I would like to trace through with you what was prevalent then, what you deal with now, and safeguarding generally and your understanding at the time about who to contact, what to do.

A. Okay.

Q. So this first piece of guidance is a Countess of Chester policy and it's section 6 that deals with

Sudden and Unexpected Deaths in Infancy and we see how that is defined at the top of the page. So Sudden and Unexpected Death, unexpected in the 24 hours prior to death, of a child under the age of 24 months irrespective of the place of death, so at home or in the community, in the hospital emergency department or ward. And a SUDiC should be managed in accordance with the SUDiC guidelines.

You tell us in your statement, Dr Brearey and perhaps you could expand on it, that you interpreted it as referring to a cot death scenario rather than an unexpected death in a healthcare environment.

Was that your understanding at the time of this policy?

A. My understanding was that it was certainly treated as, as such, yes; that it's predominantly written for guidance regarding children or babies that had died unexpectedly from a community home setting rather than a hospital setting.

And it was even more detached in a way from the reality of working on a neonatal unit, where you could argue that any -- any baby who died in the first 24 hours of life you might not have expected that to happen and, you know, because there might be maternal reasons for the cause of death.

So already there's -- there's scope for misinterpretation, really, on a neonatal unit.

Q. Would most babies that died early on from natural causes, would that natural cause be evident? Even if it was unexpected for a parent or even if it was sudden for a healthcare professional, you could understand a naturally evolving cause?

A. Not always, no, and actually the one death that we have had since 2016 -- I don't want to go into the details.

Q. Please don't.

A. But that did involve a diagnosis that was established after postmortem and after specialist had assessed the case, that that family certainly, certainly weren't aware of until afterwards and, you know, considered the baby as healthy until the baby is born.

Q. Was a SUDiC process followed for that to get the proper forensic investigation or medical testing in a clinical --

A. There wasn't a SUDiC process triggered for that, yes.

Q. So in terms of at the time, and the number of unexpected and unexplained deaths that you were dealing with, was it a deliberate decision to effectively ignore this guidance, was that consciously decided upon at any

level within the hospital or how was it from your perspective?

A. I can't remember a discussion with colleagues that it should have been a SUDiC process or any of these cases should have been a SUDiC process, really, over the course of 2015 and 2016.

Q. Did you ever speak to Dr Mittal? We know that Dr Mittal and Dr Gibbs had a conversation about Baby C.

A. Yes.

Q. And although it wasn't a SUDiC process there is a document that looks as though there is a meeting between Dr Gibbs and somebody who deals with safeguarding, a safeguarding manager, but it wasn't referred as a SUDiC and somehow he was in that meeting?

A. No.

Q. So you yourself, would you have had a conversation with Dr Mittal at any point about these deaths or the processes?

A. Well, he worked in the same building, but I can't remember any specific conversations with him regarding whether SUDiC should be followed with any of these cases but I always got the impression that he felt that neonatal deaths weren't in this remit of SUDiC or CDOP actually at the time as well, they weren't included.

Q. What gave you that impression? You said he worked in the same building, what was your sense that that was what he thought?

A. Well, the Form A for CDOP, Form A and Form Bs that we had to complete after deaths went through him to CDOP. So I was assuming he would have been aware of the deaths.

Q. Why would you assume that, did you have any conversations with him about it? We know Dr Gibbs referred Baby C and spoke to him about Baby C.

A. Well, those -- those forms are completed after every death and -- and he's on the CDOP panel and he would see what's been submitted to the CDOP panel.

Q. So even without the SUDiC process you think there is a form that is filled in for every death?

A. Yes, the Form A, Form B.

Q. Form A/Form B?

A. Yes, yes.

Q. Did you ever fill any of those in? Who was expected to fill those in?

A. I would have filled one in for a non-indictment baby that died in September.

Q. Okay. So that was a Form A, you think, or B, you can't remember?

A. It starts with Form A which is the immediate

form and there is a little bit more time to fill in the details of the Form B form.

Q. So irrespective of SUDiC that form gets filled in and did you understand where that ended up?

A. I knew it is for CDOP processes. We don't -- the process of CDOP takes a little while to filter down before the panel discuss things at a regional level and then we would get feedback some time after that about lessons learned that are quite general, really, rather than anything specific to any babies.

Q. What about referral to the Coroner for a death, did the doctor phone the Coroner or how was that done?

A. The Consultant who was in the hospital covering the neonatal unit at the time of death would normally be expected to phone the Coroner or the Coroner's officer to notify them of the death.

Q. If we can go, please, to INQ0108408.

LADY JUSTICE THIRLWALL: While that's going up, I wonder if I just might observe that everyone who's speaking is competing with a quite a loud fan which is off to my right and it may be that people are struggling a bit to hear, notwithstanding the microphones, so if you could both remember that.

A. Okay.

LADY JUSTICE THIRLWALL: I think it's probably because it was very cold in here yesterday so the heating is on, but it's obscuring your voices a bit.

MS LANGDALE: Noted, thank you, my Lady.

Actually I think the reference may not be that if that can come down. If we go to INQ010848. And it's page 41 of that document, thanks, Mrs Killingback. 10848, page 41. Can we try again, it may be you exhibited it Dr Brearey, INQ0108408. And it's page 41.

It's the checklist you provided us, Dr Brearey, while it's coming up?

A. Okay.

Q. You say this is what you have to complete now?

A. Yes.

Q. You say from your own experience, completing this child death guideline requirements took you about six hours to complete?

A. Mm-hm, yes. So this is our current guidance at the Countess of Chester Hospital in which one of my colleagues has tried to make it as simple a process as possible for what to do in the event of a death, child death or a neonatal death and I felt it was important to share with -- with the Inquiry really to highlight it's not a simple process and I think colleagues and myself find it quite onerous to do.

You -- you are having to deal with the fall out from a death in terms of family and staff and talking to them. There's obviously involvement with other agencies possibly. The -- I think the fifth line from the bottom of the first table, the Form A and B is now changed to an e-CDOP referral, so that is a slight change from 2016.

But the SUDiC paperwork in itself was the majority of that work, really. Included in this form would be a debrief with staff and the six hours it took me to complete the -- the actions needed in this case was excluding the debrief which a colleague from the emergency department undertook in the case that my most recent memory, which is last month.

Q. When you comment on the time presumably you are not commenting on the purpose which is effectively to notify external agencies and I think we probably agree at the outset if more external agencies --

A. Yes.

Q. -- had been involved in events we are examining --

A. Yes.

Q. -- there would have been greater forensic scrutiny earlier, wouldn't there, of the deaths?

A. Yes, yes.

Q. So is it the process that it's bureaucratic or do you think the information is necessary if you are going to catch those cases like the ones we are examining, where it really did need a forensic --

A. I am not questioning the need for any of the statutory processes that need to be taking place, that is absolutely essential. But I am also minded that Inquiries can add to the requirements of clinicians and I wouldn't want to make something more complicated or more onerous when actually it feels like it could be simplified as well.

Q. How could that be simplified, do you think -- two options, isn't there: fewer questions raised, but maybe you wouldn't get your purpose fulfilled; or other people supporting in the hospital to fill them in, Risk Teams and the like? Does it need to be a doctor that puts this information in and does it?

A. It doesn't need to be a doctor. No.

I think as well, you know, I have mentioned in my main statement that dealing with this sort of thing out of hours in the middle of the night after a traumatic event isn't very conducive to making the right decisions sometimes, immediate decisions, you know, nought to four hours after the death, and that actually, you know, if any of these tasks can be shifted to the next working

day and be done in a more sort of collegiate thoughtful way, then that's probably more likely to lead to the right decisions and referrals being made.

Q. We see at page 45 of this guidance Learning from Child Deaths, it states: no meetings should take place without the presence of an acute paediatric Consultant with knowledge of the case.

You reflect there, Dr Brearey, that, perhaps the next day, having the essential people in the room that were involved in the case may lead to better decision-making and the provision of the best information within any form than one person doing it on their own within nought to four hours?

A. Absolutely, yes.

Q. So would your suggestion be if this system of referral has value, which you don't seem to question, it needs to be factored into the time and effort and quality of information that can be put into the referral in the first place?

A. Yes, yes. And I recognise the difficulties in that because people have got to factor in, you know, these deaths don't happen in a -- in an arranged way, so they can happen any time of day at night, at weekends, and, you know, the important people need to be at those sort of subsequent meetings.

But I think, you know, today's age of Teams and that sort of thing, I think it is easier than it has been, certainly.

Q. The Inquiry legal team, Dr Brearey, has prepared a document it's INQ0108517, with the assistance of legal representatives from other Core Participants, particularly the Countess of Chester lawyers. So I am not asking you to comment on the detail of this now, Dr Brearey, but by all means when you leave today and at any time that is convenient to you if you notice something that you think should be there, do let us know.

But within this document, we set out an index to all the reviews conducted in respect of the indictment babies and if we look at 0108517000, we see there is a section halfway along the table, a bit further, "Sudden and Unexpected Deaths in Infancy and Childhood" and we see if we scroll through the table that in fact none of the babies on the indictment go through that process of referral.

We do see for Baby D there is a STEIS referral and we will come to that later when we look at documents and scrutiny, Dr Brearey.

But it's quite stark, isn't it -- it's not appendix 1, we need to go further up, please, if we

could, to the STEIS Level 2 report. We are looking at those two columns of Sudden and Unexpected Deaths in Infancy and the STEIS Level 2 report. It's very stark when you see it on a single table like this, the absence of scrutiny in this way, independently through other agencies, isn't it --

A. Mmm, yes.

Q. -- for all of the babies or even a majority of the babies who died?

A. Yes.

LADY JUSTICE THIRLWALL: Sorry, Ms Langdale, so we are looking at two column headings are we? Sudden Unexpected Death in Infancy and Childhood?

MS LANGDALE: Yes, and the STEIS.

LADY JUSTICE THIRLWALL: And then further along STEIS. Thank you.

MS LANGDALE: We see next to the babies on the indictment there is no, no, no and we see for Baby D there is a reference to a STEIS referral in her case which of course involves NHS England, automatically brings the parents in.

A. Yes.

Q. Different process?

A. I mean, there's a few things I would like to say about Sudden and Unexpected Death in Infancy

guidance at the time and why we didn't.

I mean, it's worth pointing out that nobody was suggesting at the time who were aware the deaths that were happening, people like Dr Subhedar from the Liverpool Women's Hospital, when he did the Thematic Review, didn't make any suggestions that we should have been doing that.

I think still today there's some uncertainty about whether to refer for a SUDiC or not. I -- I have read some of Dr Garstang's evidence and I think she stated that one -- one baby might be referred for a SUDiC in the West Midlands every year I think was the rough numbers she was talking about from a neonatal unit. And I think if you are using the strict definition of -- of unexpected death and not being aware that that baby was going to die or having any clues to that 24 hours beforehand, I think those numbers were probably going to be larger so it suggests to me that I don't think people were following the strict definition still.

I have become a part of the working group for the British Association for Perinatal Medicine for governance for child deaths because I feel that I have had some experiences that I can add to that, that work process. That's chaired by Dr Eleri Adams, who is the President of BAPM. She opened, in the first meeting we

had as a working group, to explain why that working group was happening. I think this -- these events obviously might have triggered things but she actually said that they, they -- she polled members of BAPM, who are predominantly neonatal doctors and nurses, as to what the members wanted from BAPM in terms of guidance and clearly death governance was one of the top things that was asked for.

So that is immediately telling me that the neonatal workforce generally have difficulties with this sometimes.

Q. You say in your statement that you were involved in a peer review programme since these events and --

A. Yes.

Q. -- able to discuss with other neonatal networks how they were dealing with deaths as well or Sudden and Unexpected Deaths?

A. Yes, yes, so that was -- I can't remember the year precisely. I don't know what year I might have put it in my statement, I think it was 2017 or 18.

Q. You said that, yes.

A. So there was an NHS England quality surveillance programme peer review that entailed every neonatal unit in the country being visited by the

reviewers with one peer reviewer from another neonatal unit, so I participated in that and peer-reviewed three hospitals in the south west of England.

The format of the review was quite structured with certain questions and standards to meet and mortality processes weren't one of the questions that were asked, but obviously I was interested in this with our own experiences and -- and the doctors I spoke to in those peer reviews really stated that they didn't have a child death policy in -- in their hospital for their neonatal unit.

It struck me firstly because the reason for that was that the number of the deaths were so few which obviously made me reflect on we could have missed our -- our sort of issues for so long.

But secondly, it struck me that I don't think we were out of the ordinary in terms of a neonatal unit at the time in terms of what we were doing and the processes that we had. I -- I think we were doing the same as our peers, really.

Q. Indeed when you raised the point about how striking it was I think Beverley Allitt, it was between February and April in 1991, and the rise in deaths and the suspicions and ultimately an insulin result as well.

It was far too long, wasn't it? I mean, any death

was bad, but the period of time before which this was detected was -- well, how would you describe it, really?

A. Yes, yes, and that's why we are here, I suppose, to work that out. Yes.

Q. If we can take that down, please, and put up INQ0108346, page 45, 0045 and it should be a flowchart that was alluded to yesterday.

You made reference to Dr Mittal being in the building and indeed everyone else and of course we know Alison Kelly was involved in your discussions with Eirian Powell early on and the charts highlighting Letby and the like.

So people with safeguarding responsibility, certainly Ms Kelly, and I doubt she was alone, are looking at this, knew about these deaths and suspicion and concern and Eirian Powell conceded in evidence the fact she was pulling the tables together in the end, looking back, there was suspicion about: could someone always be there that was causing this?

If we look at this flowchart, we heard evidence yesterday from Paula Sindall, who I think was Paula Lewis at the time. Was this readily apparent? We were told this was around the hospital and indeed in the neonatal unit, this flowchart was on the wall, sort of Working Together-type approach where you make it clear

who you speak to, try and make it direct.

Do you remember seeing that around the unit?

A. I can't remember seeing it on a wall or a -- you know, anywhere in a clinical area but, you know, I was aware of it because I attended the safeguarding updates and training every year, yes.

Q. You would have known the people involved anyway. Dr Mittal you have already referred to and we know --

A. Yes.

Q. Dr Howie Isaac, I think, shared a room with Dr Holt, who was of course involved later on with the paediatric discussions around everything. So we will come to this later but broadly, how aware were the hospital, firstly about the concerns within the hospital that you had and, later on, how you and the other doctors felt victimised and pressured by the -- by the Executives? How widely were those two issues; they are very separate? The first is suspicions about a member of staff and the second is how you were being treated as doctors.

Were you quite open about -- certainly in the latter about how you were being treated as doctors? We know Dr Tighe was involved and other people. Did you speak widely about that?

A. Can you just clarify the question?

Q. Yes, when you were going through the grievance and you were asked to do the letter of apology and you were asked to do mediation with Letby, were you very open with colleagues about all of that stuff?

A. Open about our concerns?

Q. Not concerns about Letby, but about how you were being treated. We will come to how you treated your concerns and suspicions about Letby, but in terms of the second part of that, how you were treated as a consequence, were you open with people about that?

A. I think we made it very clear to Executives that we didn't feel we were being treated appropriately with this.

Q. To other members of staff, I am thinking safeguarders are the people who --

A. Well, the -- the flowchart that's in front of me is really what to do if you are worried a child is being abused. So I don't think the escalation names on this list would be relevant to what to do if you feel you are being victimised by some Executives.

Q. Sure, definitely not. My question is really if you knew these people and were talking to them, because we can speak of roles, can't we, but often the same person occupies a number of roles and

responsibilities so I am just trying to get an understanding of how many medical colleagues you would have discussed how you were being treated with, we will come on to how that was or wasn't later?

A. I thought it was quite important -- I think the team felt it was quite important throughout this process that we were, we were confidential about our concerns because it involved a member of staff and quite significant concerns and we didn't think that discussing that with anybody and everybody was, was appropriate, really.

So we tried to limit our discussions to the group of paediatricians who had the concerns and to the Execs that we were talking to predominantly.

Q. That can come down, please, and if we can go to the policy for reporting of incidents which is INQ0006466, page 1. If we just flick through this guidance, Dr Brearey, we see at page 3 what should be reported as an incident, near misses. Over the page, how to report an incident.

Then over the page, Never Events. Over the page, 7, how -- sorry back to 6, sorry, point 7, how staff can raise concerns, for example whistleblowing, open disclosure, et cetera.

Was this a policy that you ever sat down with

anyone in Risk or elsewhere or any of the Executives as events were unfurling with the deteriorations of babies in some cases, deaths of others, did anyone discuss with you how these should be reported and how they might be escalated and triangulated and brought together?

A. No.

Q. Was this a policy you would even have looked at at the time?

A. I would have been aware of it, but I -- it wasn't committed to memory and I wouldn't be referring it on a frequent, referring to it on a frequent basis.

Q. What was your understanding about when Datix were completed, for example we know the Datix for Baby D was completed around a delayed giving of antibiotics. So with everything else going on it was the delayed antibiotics that actually triggered the Datix, not other suspicions or concerns. What did you understand a Datix needed to be completed for and did you think it was a useful process?

A. From -- from my memory I think more than one Datix was -- was submitted on Baby D. I think one was for the delay in antibiotics, one was for the delay in reviewing the baby and admitting to the neonatal unit, but -- just from memory, that is.

But I was the neonatal Risk Lead so it was my job

to encourage a healthy, risk aware neonatal unit and I was trying my very best at that and I think I was relatively successful. I think the staff were all aware of their requirement to report a Datix incident, no matter how significant, whether they felt any problem with the care of the baby might have been compromised.

Q. And indeed that's right for Baby A, the context of the Datix report said "drug administration error, sudden and unexpected deterioration and death".

For Baby C, "sudden deterioration and death, delay in receiving documentation regarding the death". And for Baby D, "baby required resuscitation after delivery and death".

So they were being completed at the time, weren't they --

A. Yes.

Q. -- in those cases? What --

A. So there was --

Q. Sorry.

A. There was a dual process for the Datix reporting really because you would be reporting an incident if you felt there had been a problem with the care of the -- of the baby. But it's also the policy at the time to report the death per se and I think that's where some confusion in terms of the grading of the

incidents came in some cases, when -- when it was a death of a baby but it was designated low harm because they were just following the process of reporting the death as opposed to reporting a problem with the care that the baby had received.

And -- and therefore the grading becomes a little bit confused because the person completing the form isn't sure -- obviously, you know, it's significant harm because the baby has died but they are being asked about whether there's an event that caused that harm or -- in terms of clinical incidents in addition to that. I think that's sometimes why the grading was variable.

Q. Can that document come down, please, and can we have INQ0001954, page 17. This is a paragraph from the RCPCH report, which we'll come on to later and its wider purpose and effect. But if we just look at this 4.4.9, please.

So one of the recommendations was that:

"The death near miss reviews process requires further strengthening to involve the Risk Management Team systematically and to follow corporate process. All deaths should be raised as in a Serious Incident ... the case reviewed promptly by paediatrician, Risk Midwife, neonatal nurse and obstetrician and then either stood down or investigated informally."

That sounds a sensible recommendation. Did you think that was, in the light of what we now know and have seen?

A. Well, there's certain parts of it I would agree and disagree with. I would agree that the deaths should be raised as an SI and the cases reviewed promptly by a paediatrician and Risk Midwife and neonatal nurse and obstetrician.

In terms of the Serious Incident, the process would be if the Datix is completed and the case is discussed at the Neonatal Incident Review Group, the Risk facilitator would then take that information to the Risk and Governance Team who would then classify it as an SI or not.

I think actually it was Debbie Peacock that would submit the SBAR form to the SI Panel to decide on whether it was an SI or not. So the decision for an SI was really out of my remit, but clearly it seems sensible to suggest that every -- every death's an SI.

Q. What would you say now -- and if you can't say it now and you would rather do a further statement later that is fine, Dr Brearey, it may require thought and you might want to look at that document first.

But looking back, how should the deaths have been reported as far as you are concerned, the Sudden and

Unexpected Deaths and the deteriorations to encourage that early capture of what was going on?

A. I think what happens now would be that the Serious Incident Panel would sit and decide this.

I think then the, I mean, in retrospect, looking at the final deaths of the two Triplets, I think there's an argument -- there's a very strong argument then that we should have triggered a SUDI protocol for them with the concern that we had as well, although, you know, we decided to escalate it quite significantly at that time anyway.

Q. So when you say the Serious Incident Panel would deal with the others, so what would you envisage if you were -- if this happened now with Baby A, just think of the exact cases.

A. So it would depend on the gestation of the baby. So if it was a term baby that died now, that would prompt what used to be HSIB but now is MNSI, Maternity Neonatal Safety Investigation, which is a nationally mandated process where external reviewers would come in and review the care that that baby received. But that only applies to term babies, not preterm babies.

For preterm babies, there will be the Perinatal Mortality Review tool which was being developed in 2016

but not completely embedded and established then. And that involves a multi-disciplinary review of the case as described in 4.4.9 with an external clinician and an external midwife to review those cases. Yes, so that that would be the process as it stands at the moment.

Q. Thank you. That document can go down and I am going to turn now please, if we can, Dr Brearey, to the individual babies and your involvement with them at the time.

We will move on subsequently to the Thematic Review and the like, so we will confine ourselves to the chronology of events and the babies as far as you were involved.

So we begin with Child A. And we know of course Letby had taken over his care at 8 o'clock and within half an hour he was apnoeic.

You were not involved or responsible for his care at any point?

A. No.

Q. Dr Jayaram was and told us that he didn't put in the notes at the time about the rash, the unusual rash when he wrote his notes up that he had seen. Child B arrested the day after and if we can go, please, to INQ000698, page 28, so these are medical notes from Child B.

Dr V's note. And we know before this note, I'm not going to put all the notes up, Dr Brearey, but Dr Lambie had recorded widespread discolouration of skin with white patches and a gradual reduction in heart rate.

Dr V then notes:

"Soon thereafter went apnoeic suddenly, purple blotching of body all over with slowing of heart rate."

If we go to the next page, page 29, near the bottom:

"Purple discolouration almost resolved ?? cause."

You tell us you did see those notes at paragraph 90, you say you reviewed both sets of case notes and read Dr V's record of purple discolouration which had almost resolved. You can't remember talking to Dr V directly about it.

When you came to do case notes, do you think it would have been helpful now to have gone to speak to both Dr Lambie and Dr V about what they had seen?

A. Yes.

Q. Child C died on 14 June. You don't recollect when you were informed about Child C's death. You address that at paragraph 92 of your statement but you say it's likely Dr Gibbs informed you as he was Child C's Consultant, and we know Eirian Powell held a debrief on the morning of 2 July, so a couple of weeks

later. So if we could look at that please at INQ000010827 [page 27].

This is the debrief on 2 July so it's Dr Gibbs, Eirian Powell, some nurses, Mel Taylor, Kathryn Davis, Sophie Ellis and also Lucy Letby. What was the purpose of these debriefs? They are not hot debriefs, it is not the same day or the day after, this is a couple of weeks later, what is your understanding of the purpose of this?

A. There's no strict sort of definite guidance for this nationally and I know hospitals and individuals treat these debriefs slightly differently. I think the predominant thing for me in these debriefs is to get the team together to run through the events again, and to allow time for staff to sort of reflect on the event and feel that, get any feedback from the -- any provisional postmortem results, to have an opportunity to thank their colleagues if they were particularly supportive or helpful and to, if anybody had has got any concerns that they don't think has been addressed in any way, to raise those as well.

But I think from my point of view they are more of a mentoring, learning, supportive environment-type debrief rather than a strict more analytical look at the care that was received and any deviation from what

should have happened. But clearly somebody taking this sort of debrief, it is a bit clearer now that the people that take these debriefs tend to be the ones that aren't or it's encouraged they are not the people that are involved in the actual case at the time, somebody independent would hold this debrief at this time and go through those things.

Then if there was anything significant, other than things I have talked about, then they can take that to the reviewers after that.

Q. We see here Dr Gibbs has included at the beginning:

"Events leading up to arrest, did not seem unwell. Active."

Et cetera.

A. Yes.

Q. You say in your statement at paragraph 95 you have a number of reflections. You also say that Dr Gibbs, at paragraph 92, presented the case of Baby C at a Perinatal Morbidity Meeting and the two issues that struck you following his presentation were the completely normal and stable observation chart in the 12 hours before the sudden collapse of Child C and continuing to make some respiratory effort after resuscitation had been stopped.

So that -- that point was made clear to you when you were watching his presentation?

A. Yes, yes. The -- he did two presentations, I think he did one as a Neonatal Mortality Meeting earlier in 15 and then one in January 16 with the obstetric team in the Perinatal Mortality Meeting. And through -- through all of this you question yourself about what you are thinking at the time but there was a definite acknowledgement that in neonates babies can desaturate and -- and deteriorate suddenly without much warning and I was aware that, you know, people were making efforts to try and prevent that happening and the thought was sometimes that the observation charts that you have on a neonatal unit when a nurse just ticks a box every half hour or 10 minutes to say what the blood pressure, heart rate and temperature and those sort of things are is a fairly crude way of doing things these days.

Liverpool Women's Hospital had developed something called the HeRO system which takes on a number of metrics from the monitor, including heart rate variability, for example, and will give the clinical staff a score of sickness in that baby and the thought was that if the HeRo score would get to a certain level then that baby would be screened for infection and have

a medical review and that would pick up babies with sepsis, for example, earlier than it would do if you are just doing a traditional observation chart.

So those are the discussions I had with Dr Dewhurst at Liverpool Women's Hospital after Dr Gibbs' presentation with a mind of thinking: well, were we missing something with this completely normal set of observations? And were they just too crude to pick up Baby C's deterioration? Obviously in retrospect we know what the answer was, but it -- I am trying to demonstrate to you that, you know, natural causes were still very much in my mind but at the same time certainly at that stage when we are discussing it in January, I think 2016, Professor Dixon-Woods mentioned soft signals, you know, that would be one of those soft signals to me at the time that was -- was making me feel slightly uncomfortable.

Q. You say at paragraph 95 of your statement:

"All of the postmortem examinations for babies in the indictment were done on the assumption of a natural cause of death."

You have just set that out yourself looking at it thinking of a natural cause of death until something forced you to think otherwise?

A. Yes.

Q. Would that be a fair assessment of what you have just said?

A. I think everybody was -- was working on that premise and I think that's -- that's generally the case for ...

Q. You also say none were forensic postmortems. What's the significance of that?

A. Well, I am not a paediatric pathologist so, you know, I wouldn't be able to answer that detail with -- with much confidence. But a forensic postmortem would -- would be looking at toxicology, for example, and have two pathologists present, one of which is a forensic pathologist used to detecting or expert in detecting the possibility of intentional harm.

Q. Would you accept that when they were instructed to do those postmortems, none of those pathologists were given the details that they could have been subsequently of the rashes, the unexpected nature, the response of staff, various suspicions that might have assisted in looking at the cause of death?

A. Well, they were given a clinical background in the pro forma that they are given prior to the postmortem, so they would have had some clinical details --

Q. Yes, some clinical details?

A. -- about sudden collapse and that sort of thing.

Q. Yes, but not the detail, for example, for Baby A in the notes; the rash doesn't appear, does it?

A. Yes -- no. Yes. I mean, my own reflections about the comments about the rash, rashes, from the babies in June was that it's not unusual sometimes for a sick baby to be mottled for example and it's trying to equate what, what is a normal, if you like -- I know none of it's normal, but what's mottling in terms of a sick baby with -- with sepsis or some other illness and with the case of Child A and B, it was known that *(redacted)* which can cause rashes as well and whether, you know, *(redacted)* might in some way have caused a rash in the babies and obviously this was early, you know, in -- in all of these cases and intentional harm was very low down on -- on the list of differential diagnoses and on anybody's radar, really.

So I think most of the clinicians who -- who noticed those rashes at the time either thought they were a septic rash or maybe mottling or may be associated with mum's *(redacted)* rather than considering something a little bit more sinister.

LADY JUSTICE THIRLWALL: I think in terms of reporting of the information that you have just given,

the Inquiry has taken the approach of talking about a medical condition but no more than that, so there must be no reporting of the nature of the medical condition and it will be redacted from the transcript.

MS LANGDALE: Dr Brearey, can I ask you to speak up as well?

A. Okay sorry.

Q. We are competing with background noise I think but if you are properly heard at the back, that would be helpful.

A. Okay.

Q. Child D. You don't have any recollection of exactly when you were informed of Child D's death but you reviewed the case with Eirian Powell on 22 June 2015, so can we have a look please at INQ0003110, page 1.

We see you send to Dr Jayaram, you have met with Eirian and reviewed the case notes of Child D. And over the page, if we can go to page -- the action plan at the bottom of that page. You have agreed an action plan:

"Review Child C case notes in detail this week and I will review Child A."

You didn't at that time add Child B who had had that collapse, the Twin of Child A. Looking back, do you think it would have been helpful? And dealing with

the rashes point for example you would have had more evidence of those four babies together, A, B, C, D, wouldn't you, that might have caused you concern?

A. I was already very aware of Child B, I had seen Child B clinically and scanned Child B's heart and I was aware of the discussions that were going on between the clinical team and the experts in Liverpool Women's Hospital and Alder Hey Hospital haematology experts. I think there were some discussion as well with the team in London.

So I was already very familiar with Child B, so although it's not mentioned in this email, I don't think if I had included a review of Child B it would have added any extra information that I didn't know already.

Q. If we can go, please, now to INQ0025743, page 2. This is an email from Dr Gibbs reflecting on Dr Lambie coming to visit him. To put it in context, these events have all happened between 8 June and 22 June with A, B, C and D; it is a lot, isn't it?

A. Yes.

Q. Dr Lambie gave evidence to the Inquiry about how anxious coming into night shifts people were, thinking: is something going to happen? Or, you know, worried about coming to work, really.

If we look at Dr Gibbs' email, it sets out

Registrars are very concerned about the recent neonatal deaths and collapses and in the last paragraph he says:

"I have mentioned we are looking into this. I'm not sure exactly how this is being done but I didn't say this to Rachel."

Just curious that in terms of Consultants and junior -- or Registrars, is there any reason not to say: we don't know what's being done yet, it's happened so quickly, to be more open than that, than ...

A. Well, I think of all us would like to think we are quite approachable as a team of Consultants and it was nice the Registrars were coming to us and asking and mentioning their worries. I can't remember this conversation on email but --

Q. Let's go to page 1, the page before, because it flows up and you can see your responses?

A. Yes.

Q. So Dr Newby comes in at the bottom of the page, you have to go backwards in the way of the world to see the sequence:

"I agree. I have just been grilled by Dave Harkness. This is causing a lot of concern/upset."

Then your email to Dr Newby gives and others, Dr Murphy, Dr Jayaram:

"I have reviewed Child D's care with Eirian and

looked to see if there are any common threads in the deaths. I emailed an action plan to Ravi yesterday. Child D's death appears to be due to an early neonatal sepsis after PROM."

And you say:

"PMM tomorrow afternoon. Please encourage all juniors and nurses to attend and discuss in this forum rather than ... privately."

Then as we go further up, Dr Newby suggests he is "happy to put a quick presentation so we can discuss all three together, I presume you were due to discuss the other two anyway". And you say:

"I would rather discuss Child A and don't warrant a presentation for all three yet."

Clearly Dr Newby thought it might be a good idea and a Registrar had been worried. Would that have been a good idea straight away to get people together, the people in the room, Dr Newby, Dr Lambie, the people that were concerned about different things, it would appear?

A. Obviously in retrospect, yes. However, you know, it was -- it was felt at the time that the three different deaths were different in terms of their nature in that we had a maternal illness for Child A, we had a very small poorly grown baby in Child C and we had a more mature baby with sepsis from birth in Child D and

my interpretation of the concerns that were being raised it's an impression that I had at the time was it was more to do with the lack of knowledge of what was going on with Child A and B rather than a sort of generic overall concern about all three babies had died.

I -- I may have been mistaken with that.

And the Perinatal Mortality Meetings, they only occur four of five times a year and we were having one the following day and I thought, and -- and we are very open in terms of discussions and that sort of thing. So if the junior doctors that were there that wanted to discuss the other babies in that perinatal meeting they would have been quite welcome to do so if they felt there was a link between all the babies.

And that is an open, you know, collegiate type meeting where different specialties are there and can add their opinions so I didn't think it was unreasonable at the time to use that as a forum to discuss these cases if needed, we needed to formally review so many babies at every perinatal meeting, so Child A wasn't the only baby we discussed at that meeting, there were two others.

Q. We are going to come to the meeting, so let's pause there, we are going to do Perinatal Mortality Meetings and Neonatal --

A. But what I am saying is that --

Q. Yes

A. -- you know, there was a restriction in the numbers we could -- we could discuss in one meeting and the two babies that weren't mentioned here that had to be discussed at that meeting were also very important to discuss and -- and had waited longer, if you like, for it -- for that discussion to happen.

So --

Q. Dr Newby had offered to pull the presentation together. I appreciate that doing one at a time allows a very careful going through the notes. But what was being expressed to Dr Gibbs was a worrying spate of deaths and collapses; it was a bigger picture thinking, wasn't it, it wasn't looking at each one necessarily as you described now. It like, what's happened there, that is an unusual three weeks?

Looking back, did anybody talk to you about how the three weeks felt for them at the time? You know, like I have given you Dr Lambie's evidence coming to the Inquiry about that and others who were becoming worried.

What -- did anyone say to you at the time they were feeling like that?

A. I -- I can't remember any specific conversations. But I can remember a general sort of

confusion in terms of particularly Child A and B and what was going on certainly. And clearly it's worrying that we had three deaths in such a short period of time which is why we triggered a meeting with the Risk Team and Alison Kelly, the Director of Nursing, to discuss those cases in more detail.

Q. And one of the doctors I think had some time off, didn't he, because he was so shocked? You refer in your statement to the psychological shock of a death of a neonate for --

A. Yes.

Q. -- first of all their parents but for staff with them, working with the neonates, it can be hard, can't it?

A. Absolutely.

Q. So you were sensitive then to how people felt around you or may have felt around you at that time?

A. Yes. But I was -- I was interpreting the -- the discomfort people had as a sort of lack of knowledge particularly in Child A and B --

Q. And you were thinking natural causes?

A. Yes.

Q. And you weren't particularly worried with your experience about the natural causes presentation, as far as you were concerned?

A. At that time no.

Q. There is a senior clinicians meeting, if we can go to INQ0036166, page 1. You are not there, I am only going to refer you to one paragraph of it. Dr Jayaram is there, Dr Newby, Eirian Lloyd-Powell Dr Saladi and Dr Gibbs.

If we go to the second page, this is the senior clinicians' meeting and:

"There was an issue raised around the fact that at the three recent neonatal deaths, the Registrars had been quite worried and feel that nothing is being done. Behind the scenes reviews are going on but it was felt formal debriefs should probably take place rather than any specific meeting to discuss all three."

So your email exchange on the 23rd to say let's deal with one, and we are getting there, didn't seem to allay concerns, did it, that they felt nothing, the Registrars, was being done?

A. I -- I don't, I don't know whether that's -- minutes of that meeting referring to the concerns we have already talked about or whether those concerns were ongoing. It's -- it's not clear and I wasn't at the meeting, I can't really comment on that.

Q. But it does sound as though they had a sense that something may very well be wrong at a time that you

were thinking those deaths at the time were pointing towards natural causes. Looking back, do you think that was a moment for a sense check? Just because we are more experienced doesn't necessarily mean we have the right sense check at every time, does it? Might there have been some value in that sense check from the Registrars?

A. Possibly.

Q. I mean, it is quite an email to send, isn't it, from Dr Lambie to Dr Gibbs and then for Dr Harkness to say, you know, Dr Newby referred to other concerns being grilled?

A. Yes.

Q. I mean, they are clearly at the time writing that they feel like that and presumably speaking like that too, if anyone is asking them?

LADY JUSTICE THIRLWALL: I think Dr Lambie went to see Dr Gibbs, didn't she?

MS LANGDALE: Yes, Dr Lambie went to see him as well.

A. But it was at a time when we were still information gathering, if you like. You know, we didn't have the postmortem results. The review in July with Alison Kelly hadn't happened yet, you know, it hadn't been discussed at that level, which was effectively --

Q. About to happen?

A. The sense check meeting, if you like. But I -- I take the point that that would have been the meeting without the input of the Registrars and that might have been helpful.

Q. So you arranged for the 2 July to have a meeting to discuss the three deaths and if we go to INQ0103164, page 2, we see there an email from you attaching your summary and data to Debbie Peacock. You are emailing Dr Jayaram and if we can go to your summary, please, we see that at INQ0003191, page 1.

You summarise the case of Child A, Child D, and at page 2 you set out learning, there we are, of these cases:

"Notable excellence in practice and record-keeping. Surely it appeared to be excellence in record-keeping at these stages. It is just a point we notice going through all the reviews about excellent record-keeping and of course we come to Baby E where the record-keeping is by Letby and it is not accurate, is it? Evidence given about -- from Mother E about that note-keeping not being accurate.

So when you are reviewing it, how do you know if it's excellent if you don't know what's happened to the baby? I mean, you have got to compare the two things,

haven't you, what someone is writing and what's happening?

A. Well, you can't criticise an omission of something if you can only make a critique of what's written in the case notes and there are a set of standards in case notes that doctors have to follow like any other professional to make them contemporaneous, to record the date and the time, to sign them appropriately and to describe what happened in a -- in a manner that is appropriate and thorough.

So that would be the critique that I was commenting on there.

Q. You say in your statement that in retrospect you regret not paying more attention to the description of the rashes and skin abnormalities and you have explained now that some of the doctors had described or explained them as a sign of sepsis although it is clearer now they weren't typical of that.

Does that just indicate the limitations of a Casenote Review and that you need to talk to people really, that sitting back and reading and going through the case notes isn't as effective as bringing the people together and speaking to them and getting a real flavour of what they are telling you?

A. Yes. And, you know, the systems we have in

place now would have -- would be more likely to involve a discussion with clinicians concerned, although not always.

Q. And later in your statement you are critical of Dr Hawdon for doing just that, a Casenote Review, and it doesn't even look like she had all the case notes and some of the material.

A. Exactly, yes

Q. It can be quite high-handed and a bit aloof, can't it, looking at things like that and giving comments to those who may have more information on the ground?

A. Certainly, you know, it's more helpful, yes.

Q. You at page 3 set out neonatal mortality data in this first document that you put together. Why do you do that? First of all, do you have to look them up and why do you put that in to this summary?

A. Because it was in anticipation with the meeting with Ruth Millward and Alison Kelly that we had in early July and I think I might have had a discussion with Eirian Powell, the unit manager, prior to that meeting, regarding what information we would bring to that meeting and knowing what our annual mortality rate is historically obviously informs Alison Kelly, who's the Executive lead for patient safety, as to how

significant three babies dying in that short period of time was.

Q. You don't provide comment on that, you just provide the data for that. Is there a reason for that? Did you have a comment on that, did you have a thought about it?

A. Well, it was for bringing to the meeting to -- to explain and then obviously I would -- I would comment at the meeting. It was -- it was just the raw data.

Q. What's the data that you include at page 4 and 5?

A. So that was information regarding -- can I just have time to digest this?

So that is number of admissions to neonatal units in the Cheshire and Merseyside Neonatal Network in the period from 1 January to 30 June, for the first six months of 2015. And the purpose of that table would have been along with mortality data to see how we compare to other units in terms of admissions. If we were -- sorry, I haven't -- I am not too familiar with this document. Did I follow with anything on this or is this the last part of the --

Q. No, you just have 5, 6. This is your summary?

A. Okay. So I have got a table of the admissions, I have got a table of the deaths --

Q. Yes.

A. -- for the network.

Q. And gestation at page 5.

A. Yes, by gestation between 22 and 31 weeks.

Q. And survival percentages if you are born at those weeks?

A. Exactly, yes.

Q. So you have pulled that together and then we know on 2 July you meet with Alison Kelly and others. If we can have INQ0003530, page 1. You tell us at paragraph, the bottom bits can be removed, it is just that top bit relating to Child D -- you say at 114:

"The reason for the meeting was to meet with Alison Kelly and describe the events and what had been done since. I anticipated Alison Kelly would then advise us as to any actions that were needed. I was reassured that we could share everything with her."

What did you mean "reassured we could share everything with her"?

A. I'm not sure whose notes these were because I have seen Alison Kelly's notes of this meeting which are a little more detailed than this.

Q. Do you remember the meeting, just tell us --

A. I do, yes.

Q. -- about the meeting. That can come down.

Just tell us about the meeting and what was discussed. Do you know how long it was roughly, first of all?

A. I -- I can't remember but it was, it was at least an hour, I would imagine. We discussed with Alison Kelly that we had had three -- three deaths in a short period of time, this was unusual. This amounted to what would be our normal annual mortality rate in -- in that short period of time and I discussed the cases and reviews that we had undertaken already regarding the three babies.

And I discussed with the group where I felt there might be any deficiencies in care that we could be, could be improved on, and following the sort of specific discussion regarding the babies, then we discussed other factors in terms of what might link these three deaths together, so we were thinking of that and Eirian Powell had done a number of things which included looking at the spaces where the babies were cared for, whether there was one common incubator or cot space that was common to the three babies, whether there was any microbiology evidence linking the three babies together, always a concern if that is the case. But there wasn't any microbiology evidence that there was any -- any links.

There's already also a consideration of the IV

fluids that Baby D had had, because we were buying a commercial product for parental nutrition for use in preterm babies and obviously there was a thought whether that might be contaminated or not. But only two of the babies had TPN and Baby D wasn't on TPN at the time so that was excluded.

And finally, we looked at staffing or I say -- Eirian Powell looked at staffing, nurse staffing, and had identified that one member of staff was present for all three of the -- of the cases.

Q. And you say in your statement at 116:

"Towards the end of the meeting Eirian Powell raised the observation that Lucy Letby had been on the NNU on the three occasions when the three babies had collapsed. My first reaction was to say 'not Lucy, not nice Lucy' as before this meeting I was unaware of which Nurse Eirian Powell had identified."

Is that what you said?

A. Yes.

Q. Later on I think in the grievance there is a reference to Eirian Powell that you said something about Mel Taylor being nice, "not nice Mel Taylor", did you ever use that phrase in relation to her as well at any point?

A. I have no recollection of that and I think the

accusation that I said it didn't refer to this meeting anyway.

Q. No, I just wondered if at any point you had, while it is in your mind?

A. No.

Q. So you didn't refer to that, but you said that about Lucy Letby. What made you say that? Why -- why would you say that, why would you comment on that at that point?

A. It was a spontaneous comment that came when her name came out and it didn't necessarily sort of signify anything. And I think with all of this, there is a little bit of denial going on, isn't there, of the cause for everything?

The -- the whole of the nursing team that we worked with were, you know, I believed to be good people, so I probably would have said that for any of the -- any of the nursing staff to be honest. Yes. That's it.

Q. You say:

"Although the association was significant enough to remain in my mind following the meeting I was not overly concerned at that stage."

A. Yes.

Q. So was your superficial impression of Letby -- I say superficial in the sense of she is a colleague,

you don't know her really well, do you at this point?

A. No, no.

Q. So was that falsely reassuring in some way at the time?

A. I -- I don't think it was reassuring or not. I -- I didn't have -- you know, I was more interested in the facts, really, and I felt at the time that it was a small unit, there were, you know, 13 members of nursing staff around, maybe less than that, sometimes on the workforce and I didn't think it was particularly unusual that a member of staff might condense their shifts into a period of time like this, you know, to allow for holidays and other commitments and staff did do that at times.

So over, you know, a two-week period somebody might work a good number of those shifts. So I didn't see it as being overly concerning that she was present at all, on all three occasions.

And I was aware that sometimes you do get clusters in, in medicine, in neonatology, where your, your deaths for a year won't be spread out evenly. You know, there will be times when you have more than others and, and I thought that wasn't within the realms of, you know, it didn't strike me as -- you know, obviously it's something to concern and consider the factors we

concerned.

But once you have, you have done the things that we were doing, there -- there was nothing too concerning at that stage for me.

Q. You say that Alison Kelly's reaction to the association with Letby was to say, "We will have to keep an eye on it".

Do you remember her saying, "We will have to keep an eye on it"?

A. Keeping an eye on it, as in keeping an eye on the mortality cases, I thought that was more to do a generic thing rather than keeping an eye on her.

I think she was alluding to the fact that, you know, we would have to keep our eye on things going, going forwards in the future.

Q. Did the meeting discuss how you would keep an eye on it?

A. No.

Q. We see INQ0003625, page 1:

"Hi Steve, just wanted to thank you for your contribution. Reassuring to know each case has been looked at in such detail and we recognise some areas required further review. I know it's been a particularly challenging few weeks for all the team. I am mindful that currently Ian Harvey is on leave but

if you wanted to discuss anything outside of the unit then I am happy to meet with you."

Had you had dealings with Alison Kelly before this meeting?

A. No.

Q. That seems a very open email saying: If you want to discuss anything. Did you take it as that? Did you think you could follow that up with her?

A. I didn't exactly understand what she was trying to get at really because I didn't know what she was referring to when she said "outside the unit".

Q. Might that just mean physically not in the unit? I don't know. What did you think of it?

A. I don't know either actually.

Q. But did you see it as an invitation? She said, you say, keep an eye on it, the situation. She is recognising this has been a challenging few weeks. If you want to discuss further, come, do discuss with me. It looks like you don't leave with a plan at the meeting?

A. Yes.

Q. So was that keeping a dialogue open or not? How did you view that at the time?

A. I think, in retrospect, it was an opportunity where I could have come back to her with, you know,

a suggestion of how we are going to keep an eye on it going forwards, yes.

Q. Did you choose to do that or not?

A. No.

Q. Child D. We know Child D was referred to STEIS. I think was that a decision of -- you say that Alison Kelly decided that Baby D should be the subject of a STEIS report and she was. We have seen the STEIS report.

My question, please, would it have been appropriate, do you think, to undertake a Serious Incident Review in respect of the cluster of the deaths A, C and D. I know you say you were familiar, you might get clusters. But they are a cluster, aren't they, and there could be all manner of things that that kind of scrutiny might throw up at an early stage.

Do you think that would have led to greater scrutiny?

A. It would have led to greater scrutiny, certainly. As I say, the -- the Serious Incident classification wasn't usually a decision that I would make certainly alone and usually through the SI panel and I wasn't overly familiar with the criteria for an SI. You know, you would always have a fairly confident idea which ones were and weren't, but ...

Q. You weren't the only one in the meeting. So others --

A. Yes.

Q. -- could have thought of that too?

A. Yes.

Q. But it would have led to greater scrutiny, wouldn't it, and family involvement?

A. Yes.

Q. And external reporting?

A. Yes.

Q. Increased objectively. We know as we move forward it's you and Eirian Powell are looking at what's happening on a unit where you both work and a nurse that she backs, openly backs all the time, through this?

A. It certainly would have done that and there was the Head of Risk at the meeting with the Head of -- Safe Executive lead for the Trust there as well.

Q. Moving on to Child E. You had no clinical involvement with Child E yourself, but you did a review of Child E, didn't you, which we find at INQ0003296, page 1.

So this is an incident review you undertake October 2015. We know the SUDiC procedure that should have been initiated wasn't and there wasn't a postmortem required in this case, accordingly.

And the working diagnosis for Child E before their death and for you was necrotising enterocolitis; is that right?

A. That's correct, yes.

Q. We see at the summary, page 3, again:

"Neonatal care was appropriate. Record-keeping of a high standard possible learning points are described below. Unlikely any changes in management would have prevented this sad outcome."

As I indicated earlier, we know that Mother E had substantial evidence to bring to the care of Baby E arriving as she did with expressed breast milk for her baby and seeing blood on his lips and realising when she saw the medical notes that Letby had covered her tracks with the timings on those notes.

Reflecting there, this kind of review, did you think to speak to the parents or to see what they had to say about their understanding? And do you think that was an opportunity missed to do so, particularly with Baby E?

A. I think what I was doing at the time with these reviews was in line with what neonatal teams across the country would be doing for similar cases.

I don't think the way we were doing it was -- was much different to any other hospitals and I think I --

I agree with you, it would have been really helpful to have the parents there but it just wasn't the process at the time.

Q. Other hospitals weren't having this rapidity of unexpected unexplained deaths. Did that cause you to pause and think: I need to speak to people around and see if they have got any relevant information?

A. It's quite difficult to pause in the job that we are doing actually and it -- it's an exceptionally busy job anyway at the best of times and -- and when you are getting these through, there is a rate you are talking about then obviously that adds another workload as well and obviously a clinical workload that I shared with all my colleagues.

So the -- the capacity to even -- even do this in more detail including families takes time, more time, and obviously it's another sort of soft indicator that things were getting busier and harder to fulfil. But I -- I think with the -- with the resource that I had and the resource of time that I had at the time, it would have been very difficult to -- to spend enough time reviewing these cases adequately in the way that you suggest.

Q. Did you feel able at the time to express that time was pressured and we understand you had four hours,

Dr Jayaram said four hours --

A. Yes.

Q. -- for admin time effectively?

A. Yes.

Q. So did you have more than that when this was happening?

A. No. Yes. The Trust's financial situation was such that I knew what the answer would be if I did ask for -- for more time and I don't -- I didn't think my position at that time was any different to any of the other neonatal lead Consultants in other local neonatal units in the region.

I did bring it up at network level, the workload for neonatal leads, and it became a standing item for the board meetings for a period of time before they took it off but there was no actual action to improve that and shortly after these -- the deaths in the indictment occurred, we had approval for more hours for a Risk Lead Consultant to help with the role and she had four hours of her job plan designated for managing risk so that I could concentrate on the other parts of the neonatal lead role.

So it was being talked about, identified, that even without these -- these deaths, the workload was excessive and close to unmanageable. But at the time,

I just did the best that I could do with the resources available.

MS LANGDALE: Dr Brearey we will take a break now and resume at 11.45.

A. Okay, thanks.

LADY JUSTICE THIRLWALL: Very good, we will start at 11.45.

(11.31 am)

(A short break)

(11.45 am)

LADY JUSTICE THIRLWALL: Ms Langdale.

MS LANGDALE: Thank you, my Lady.

Dr Brearey, I have just asked you about Baby E.

Which point is it that you say you were concerned that Letby may be deliberately harming babies, at which baby or point in time? You said you weren't thinking about it for A, C, D, but as we will move forward now, when were you thinking that was a possibility or you were suspicious about it?

A. Well, obviously I was aware of her association from the first three and it was more of a growing nagging concern rather than any one seminal moment.

I can remember a conversation with Dr ZA --

Q. Yes.

A. -- after I came back from leave who actually

did mention that.

Q. When was that? Orientate us in time, when would that be?

A. It would have been August, late August, maybe early September when she mentioned the death of Baby E and mentioned that Letby was present but reassured me that she felt there the cause of the death was natural. She didn't use those words, I think she said it was quite clearly a small baby with IUGR and probable necrotising enterocolitis.

So I was reassured by her somewhat and reassured by the review that I did as well. Obviously there were -- there were further deaths in September that weren't in the indictment that did have medical diagnoses which reassured me at the time. I can't remember knowing at the time whether Letby had been present or not.

Q. Let's go through the babies one by one. I thought you might on reflection be able to say X or Y?

A. Yes.

Q. Let's stay with where we were in the chronology.

So Baby E, you said at the time you thought natural causes, but you were also aware of Letby's presence?

A. Yes.

Q. When you made the comment in the meeting in

the Serious Incident meeting "oh no, not nice Lucy", what was the point of the "oh no"? What was the link that was being made in your mind, why would it be an "oh no"?

A. Well obviously some -- some part of my mind was thinking that -- the worst really.

Q. Yes, suspicion?

A. Yes.

Q. "Oh no, it's her, it can't be"?

A. Yes.

Q. So in that meeting, and keep an eye on it, there was suspicion and concern -- I am not putting it higher than that, but suspicion and concern -- and Eirian Powell had identified that was the person who was the link at that point, if anyone was?

A. I don't think "suspicion" would be the right word at that time. But concern, yes.

Q. Your mind jumped to something to say "oh no", didn't it?

A. Yes.

Q. What did it jump to?

A. The concern that there might be somebody harming babies.

Q. Yes. So you leave the meeting with that concern in your mind and Alison Kelly says: let's watch

the situation, discuss with me if you want to.

Then Baby E happens and you have the conversation with Dr ZA.

She gives you from your perspective reassuring information about Baby E.

A. Mm-hm.

Q. What do you tell her? Do you tell her you have met with Ms Kelly, Ms Powell and you have been drawing up a link with a member of nursing staff or not at that time, when she tells you about Baby E?

A. Not at that time I was still quite firmly in my mindset that these were natural and this is me just being paranoid, if I was even getting that far as to thinking -- thinking it through that -- that much in the front of my head.

Q. So Alison Kelly knows you are thinking that, Eirian Powell knows you are thinking that and you are having those conversations together at that Serious Incident time.

Is there anyone else, who are you speaking to first about that? Just those two at the point of Baby E?

A. I don't have any specific memories of talking to colleagues about it, but I must have done because Dr ZA was aware enough to talk to me about it.

Q. She would tell you about a death, wouldn't

she, she's telling you about the death of E, so she would have to talk to you about that?

A. Yes.

Q. Did she mention Letby being there, in a suspicious way or not?

A. No, no.

Q. Just a factual way?

A. Yes.

Q. So from her point of view she is telling you a baby has died and the nurse on shift, but she is not communicating concern about that association herself, in any way, at that time, is she?

A. Exactly.

Q. You don't tell her you have got a concern because you say it's evolving in your mind at that time?

A. Well, for her to tell me would have meant that she would have been aware of the association in -- in June.

Q. Or that she was just caring for her, it is an assumption to make, isn't it, because if she was just telling you who is looking after her?

A. No, because it followed after her telling me of the -- the presence of Letby but I am quite happy that this baby died of necrotising enterocolitis; one followed the other in our discussion.

Q. Babies F and L, we know you were given the task of reviewing the care in the police investigation and you came across those insulin results at that time and the police were informed both in relation to Child F and Child L.

Your reflections in your statement about this, if we can go to your statement, INQ0103104, page 24, paragraph 149. While we are finding that, Dr Brearey, you say in your statement to the Inquiry prior to this you had been told by the Executives there is no smoking gun, and when you saw these results, both you and I think you say Dr Holt were looking at those results, it was a moment, wasn't it, where you realised what had been missed and the importance of them?

A. Yes.

Q. Do you share Dr Gibbs' reflection upon that, that that was a collective failure of the paediatricians not to note those results at the time and to potentially appreciate their significance?

A. It was a collective failure of the paediatricians and the labs, in Chester and Liverpool, and the system generally in terms of flagging what should have been a Never Event. Yes.

Q. Dr ZA's evidence about the results of Baby F at the time was saying she discounted insulin poisoning

as "so fantastical and unlikely".

Looking back, do you think if you had shared your suspicions or the thought, the concern, however you want to put it, that you had in that Serious Incident meeting: oh no, that there was a concern about someone or that something might be happening, her reaction may have been different to that or not because fantastical and unlikely at a time when you have got someone saying "we will watch and see", and the meeting you have had?

A. I don't think Dr ZA's knowledge or view was any different to mine at that time in that she would have known the same association as me, not thought that it was particularly worrying at that time.

So I don't think there's any -- any provenance in terms of sharing information either way with -- with her. I think we were both in a position where we, we couldn't quite believe that something like this was, might have been happening.

Q. Were you familiar with the case of Beverley Allitt and the learning around that?

A. Yes.

Q. You were?

A. Yes, yes.

Q. When did that case in your presence, the Allitt case, when was that first discussed at any time

between whoever?

A. I- I can't remember discussing it with colleagues because I -- I think we all were aware of the case historically. It was there and might have been the reason why I said "not nice Lucy" in June.

I think we all would have been aware of it historically but there's one thing to be aware of it historically; another thing to be considering that it's -- it might be happening on your unit.

Q. You set out at paragraph 149 your reflections regarding the insulin and you have listed thoughts about how it might be avoided in the future at A and B and you also say -- we don't need to turn to it:

"NHS should consider making a blood test result from a baby on NNU of a raised insulin and low C-peptide level and Never Event. This would mandate an urgent Serious Incident Review in all cases."

We looked at the Serious Incident reporting guidance earlier. So the Never Event, set out what the significance of the Never Event is and why you suggest it should be a Never Event?

A. Well, Never Events as -- as described really they are, they are stated, there's a list of them in the guideline. That includes taking out the wrong organ, for example, leaving in metal equipment in surgery

things that should never happen and when they do happen, mandate a Serious Incident and comprehensive review and the Trust reporting to national bodies to say that they have taken steps to make sure they never happen again.

So, yes, I mean, if it had been a Never Event, then, you know, that would have triggered a significant review and a look into this and more -- more thought would have obviously gone into the results than went into the results at the time.

Q. Can we go to paragraphs 158 and 159 of your statement, please, which addresses Baby G.

We know of course that Letby was convicted of attempted murder of Baby G with the method of attack being excessive volume of feed and air via nasogastric tube.

You say at paragraph 158:

"I have never heard of air or milk being forced into a baby's stomach and it didn't cross my mind this might have caused Child G's collapse. In retrospect and prior to the trial, what struck me as being very abnormal was the amount of gas or fluid that was aspirated from Child G's stomach ..."

Was that something -- one of the matters the Inquiry is exploring is what the parents have been told at various times. Was that something that you discussed

with the parents of Baby G at any time, the amount of gas or fluid that was aspirated? I don't need to take you to the notes of that.

A. *(Redacted)*

But in response to your question, the significance of what you have just read out wasn't as clear to me then as it is now and, yes, if it had that significance at the time then certainly I -- I think it would have been appropriate to discuss it with Baby G's parents.

Q. That can come down, please. Child H.

You say in your statement you can remember Dr Jayaram talking to you about Child H in late September.

"This was regarding the unusual nature of her pneumothoraces and need for more than one chest drain but I don't recall anyone at the time raising concerns regarding the conduct of Letby during Child H's care."

You say you:

"... became more aware of the unusual nature of Child H's care later, probably in late 2016/2017, when the team of Consultants were trying to recall unusual events that had occurred in relation to Letby."

So you have commented in that earlier paragraph we had on the screen that there were so many deaths that actually looking at the deteriorations or other events

or the babies who did not die you didn't have as much time as you might have liked.

It certainly does appear that there wasn't at the time sufficient gathering of people who might have information about deteriorations and discussion to reflect on those at the time of the events occurring, would you agree with that?

A. Yes, that's correct, yes. Yes, you know if you compare it to today, I mean not only have we got more people doing the job that I was doing but the perinatal Morbidity and Mortality Meetings will be entirely meetings to discuss morbidity because we don't really have any deaths at the moment.

So we have time to go into those in more detail and -- and gain learning from them. And the fact that those meetings in 2015 and 16 were taken up with Mortality Reviews meant that we didn't have that time to discuss morbidity in the form of a perinatal meeting that I have described.

Obviously there's other opportunities to review these cases and obviously if staff feel an incident is, is significantly unusual or significant then they can Datix those, those incidents in which they will be reviewed appropriately as well.

But there's -- there's also issues in terms of how

you define a collapse, for example, when you are dealing with patients and babies who are known to have apnea of prematurity which is, you know, a well-known sort of thing with preterm babies, that they can stop breathing briefly for a time. Or, you know, if they did have a blocked tube when they are on a ventilator. That's not necessarily an incident, it's secondary to care and you would have to change that tube and the baby might deteriorate before, you know, you realise that's the case.

So there are some things that might be considered to be normal practice or -- or normal care where a baby might deteriorate that -- so the point I am saying is that which ones become an incident and which ones don't and I think in retrospect, although I thought our reporting systems -- our reporting culture on the unit was good, and that staff were very aware to report things when they thought things went wrong I think some of the incidents occurring in the indictment period, and probably before the indictment period, were babies that deteriorated that could have been -- could have triggered an incident and on reflection I think it's, it's likely that Letby didn't start becoming a killer in June 2015 or didn't start harming babies in June 15 and I think it's likely that she -- her actions prior to

then over a period of time changed what we perceived to be abnormal.

Q. Can I ask you now please to go to paragraph 170. Perhaps have it on the screen 170, 171 and 172, and this is detailing events around Child I.

Dr Jayaram's evidence was that he, after Child I, became suspicious of the link between Letby and that she was deliberately harming babies and that he remembers saying to you about Child I: Letby was present again or some reference to her presence.

Do you have, before we go to the detail and the documents, a sense of that around Child I thinking this is a real suspicion that she's doing something now of deliberate harm?

A. It was certainly a significant moment that raised my level of concern quite considerably. The -- the nature of her care, having come from Liverpool Women's Hospital, being relatively mature when she arrived with us, then having abdominal problems and having to go back to Liverpool Women's Hospital with assumed necrotised enterocolitis where she stabilised for a week, then coming back to Chester and then deteriorating on a number of occasions, before going to Arrowe Park, recovering very quickly and coming back to Chester again, before having the same problems again,

and collapsing and dying, to me set a few alarm bells going. Yes, yes.

Q. If we go, it is INQ0103104, page 28 for those paragraphs in his statement, thank you, Mrs Killingback.

Her death is 23 October 2015. You say at paragraph 170 you were emailed by Eirian Powell giving her views about Child I's care and attaching a staffing analysis of the deaths, including Child I.

Eirian Powell throughout all of this, all the way through, was a defender of Letby, wasn't she, didn't believe she was capable or had done these things but she was still giving you the staffing analysis that pointed out it was Letby who was present and seems to here straight away let you know that it was Letby who was present; is that fair?

A. Yes.

Q. When you gave her the tasks, right from that early action plan, what's supposed to be done around the incubator, she does -- she goes off and faithfully sends you the material back?

A. Yes.

Q. Her analysis of it is different, very different from yours but she is giving you the information and tells you there is an association and you say:

"I was keen to talk about Letby with Eirian Powell because I felt we both needed to acknowledge the association between her presence on the NNU when these deaths occurred. I didn't feel completely reassured by Powell's assertions that all the cases were different."

We will come to those assertions later. But at this point, you are sent that staffing association. We know Dr Gibbs holds a debrief and refers to the multiple transfers, you set that out at 171, we don't need to go to that.

You say there is discussions with the surgical team, Professor Kenny who had -- the transfers had taken place and there was a discussion that there should be a tabletop to review her care.

You also produce a document, 31 October 2015, if we can go to it please, INQ0003286, page 1, Mortality Review for Child I. If we go over the page, the summary of page 3.

So we know you discussed the association at this point with Eirian Powell, Alison Kelly previously, Dr Jayaram, mentioned Dr ZA in August. So you have discussed with a number of people the association of Letby and this summary doesn't mention that at all, does it? Any concerns about it being an unexpected -- Sudden and Unexpected Death, multiple transfers and who might

have been involved?

A. The -- the purpose of these reviews is to review the care the baby received. That was my -- my role in terms of -- and I think this is the expert witnesses previously have stated that the NHS isn't particularly -- the way that risk management is -- is set up isn't particularly good at picking out bad apples and, you know, we are very focused on reviewing these deaths, the care that was received without actually looking at a possible cause because it's assumed that the cause will come out in the postmortem and various investigations.

So the focus of all these reviews was on -- on the care that was received, not a forensic look at staffing associations and things like that. The purpose for this was not for me to say this is the cause of death or it isn't.

Obviously I had a concern but I also had a duty to consider other things as well and the other things that were thought to have that were being talked about at the time more predominantly firstly was the fact that there had been a lot of input with the surgical team at Alder Hey, and you can see higher up on that page, the surgeon saying possible chronic stricture and I think -- sorry, excuse me --

Q. But you don't refer, when you refer to the transfers and the surgical team there, to what you said earlier that it was concerning she kept needing to be transferred out and she had come back and then the same was happening?

A. Yes, so --

Q. That is the key importance in terms of what was happening to Baby I?

A. But if you look at -- I am sure if you look at the case notes and the -- the discharge letters, they will say there is a possible abdominal pathology going on here, possible NEC, possible something surgical in terms of the abdomen. And I think the clinicians in Liverpool, at Arrowe Park and in Chester thought that was what they were treating when she went to those hospitals.

Q. You go beyond a differential diagnosis in this, though, don't you? You say a baby is likely to have died. You are not saying this is an option, it is unexpected, we are not clear, we are getting more information. If you were reading that as a standalone, do you think that might be more reassuring than your thoughts were at that time?

A. Yes. I would -- I would take that and as I say, my concerns were being raised and I can't say

precisely at the point that, you know, I -- I sort of flipped to thinking this is more likely than not.

Q. Did you think to email Alison Kelly straight after Baby I and say: this has happened?

A. I think my -- I considered my role at the time was to look at the other factors that might be responsible because if -- if the postmortem came back as this baby having necrotising enterocolitis or having a chronic abnormality that caused her collapse, then you have got a natural cause for the death and there will be no reason to go to Alison Kelly at that stage.

Q. Well, really, because you have already said that those postmortems were conducted on the basis that they were looking for natural causes? They weren't forensic postmortems. Had anyone known you were suspicious of a nurse, it would be different?

A. No, what I am saying is I am saying if there was a clinical concern of an abdominal pathology, prior to death, then you are not obliged to wait until that natural diagnosis is confirmed on postmortem before you start having concerns about a member of staff being present.

Q. You do, as you say -- INQ0103121, page 1. It is an email that you send to Dr Subhedar and Caroline Travers. You say:

"I think her care ought to be reviewed by these centres and the surgical team. Parents have spoken to the Consultant here and feel the same way. I was wondering whether the different teams could review their own contribution before we discuss it at the next Network Mortality Review."

Then if we can go please to INQ0103135, page 1, this is the tabletop review meeting which was held on 26 February at Alder Hey Hospital to discuss the case of Child I.

Now, you are listed as attending but you say you didn't go to that meeting?

A. That's correct, I wasn't there.

Q. Why didn't you go to that meeting?

A. Because the network administrator that was organising the meeting forgot to copy me in to some of the emails when they were organising it and I only found out about the meeting I think just over a week beforehand and I wasn't able to attend.

Q. Do you think it would have been important for you to attend and to express your concern to this meeting and suspicion at that point?

A. I think given the timings of the meeting which was after the Thematic Review it would have been useful; it would have been more useful for me, though, to know

what the postmortem result was that was completed in February 2016 because if -- if that had said that the there was no abdominal pathology in the postmortem, that would have been more significant in terms of the presence of Letby.

I didn't actually know the postmortem result until June 30 2016.

Q. Thank you. That can be taken down. Could we please have INQ0103104, page 31, your statement, paragraph 186 about Baby J.

While that's coming up, we know that you take over the care of Baby J in the morning when she is stable and Dr Gibbs had been called in in the early hours to assist with J when she had collapsed and the jury couldn't reach a verdict in relation to whether that collapse was an attempted murder.

Did you nevertheless ask Dr Gibbs much about the deterioration in the night or what happened or try and find out who was there, anything like that, given where you were in the chronology by this point?

A. No.

Q. Why not?

A. It's -- you know, it's -- you are describing one baby and one item of care in -- in many that we would have been discussing frequently every day on the

unit and on the children's ward.

Baby J or Child J was a baby with known abdominal surgery and stomas, and I think the deterioration overnight with Dr Gibbs had been put down to a seizure. He was the epilepsy Consultant expert at the Trust at the time. You can have electrolyte disturbances with babies who have stomas and at the time I didn't see it as overly concerning in terms of again the categorisation of what represents normal care and expected deteriorations or unexpected deteriorations, if you like.

So no, it wasn't considered that for every patient that might need an escalation of care that I -- you know, that was asking people who was the nurse looking after them overnight when that happened. No, that wasn't something I considered at the time.

Q. That can come down now, thank you.

It appears that with the deaths you were suspicious and looking for an association and arrived would you say, as Dr Jayaram did, with concerns by Baby I that there was deliberate harm, potentially being caused here; is that fair?

A. Sorry, can you --

Q. By the time of Baby I, you thought that there was deliberate harm maybe being caused here?

A. Yes, there was considerable concern at that stage, yes.

Q. Even before then at the meeting of the Serious Incident back in July when you said "oh no", a causal link was made that somebody could be doing this --

A. Mmm.

Q. -- in bad faith?

A. Yes.

Q. How is it then if you thought somebody could be killing babies in bad faith or harming them you didn't make a link with deteriorations or, what we now know, attempt murders to think: what are the cause for those? Because they do seem to have been treated very separately in your mind and in terms of how you review yourself, even if there are only Casenote Reviews reviewing them?

A. Yes, and I -- I accept that, that it wasn't in my mind and it's something that I have obviously reflected on and thought I should have been and -- and again I think it probably comes down to the workload and the time that I had in doing this -- you know, most -- most of the reviews you are talking about, you know, the documents here were done out of hours.

You know, the -- dealing with the mortality on -- on their own was, was quite a considerable workload

along with my other duties and I do on reflection feel that there was a lot of clues and incidents in terms of the morbidity side of things that would have brought us to the conclusion that earlier -- that something was -- was wrong.

Q. I am just looking for an email that you send, Dr Brearey, saying that you wish to be notified about any deteriorations. So it's --

A. That was in May 2016.

Q. So it's INQ0103144. So this is you in May, as you say:

"Keeping close eye. If you do come across a baby who deteriorates suddenly or unexpectedly or needs resuscitation, please could you let me and Eirian know."

Did anyone respond to you as a consequence of this email?

A. No.

Q. Pardon?

A. No.

Q. Pursuant to that email, one of the babies on the indictment, Baby N, is a child you attended I think on 15 June, I don't need it on screen, but if you look at paragraph 235 of your statement, Dr Brearey.

You arrive and you are solely focused on his airway management and you don't recall seeing Letby. You can't

recall a discussion regarding the cause for the need for intubation other than the possibility of sepsis and Dr Saladi was the Consultant in charge and you say.

"I can't recall when I was told about subsequent events regarding his care. Colleagues had been discussing his management and his difficult intubation. In retrospect, I can see these two clinical problems completely blinded me and colleagues to considering the reason for the need to intubate him in the first place and the difficulties staff encountered due to Letby's actions."

And you can't recall:

"... anyone talking to me regarding concerns about Letby or involvement with Child N."

One doctor, they have been ciphered, a trainee doctor, said when you asked them about Child N and whether they had noticed anything unusual, they said that they mentioned Letby's strange behaviour in that she was agitated when staff arrived from other departments in Alder Hey.

Do you remember that doctor saying that to you or discussing anything about Letby with that doctor? You say you didn't, around the time of Child N?

A. Doctor S?

Q. Yes?

A. I can remember that doctor.

Q. Can you remember this conversation --

A. No.

Q. -- about Child N and them saying to you something about Letby being agitated -- strange behaviour, agitated when other medics or staff arrived from other departments in Alder Hey?

A. I can't remember that conversation at all.

Q. I think you say you didn't -- you don't remember any conversations until after Baby P with that doctor?

A. Exactly, yes.

Q. But they recollect that. Were people discussing with you by this time concerns or anything about Letby?

A. I -- I can't, certainly no junior doctors were discussing any concerns with me. There is likely to have been private conversations between Consultants in that time period, but nothing formal or of that nature.

Q. Which Consultants? Because it looks as though Dr Jayaram early on and Dr Saladi and Dr Newby, perhaps because she was involved in Child D, are on your emails but the list expands further down, doesn't it?

A. Yes.

Q. So what was your thinking about who you could

talk to about this suspicion or concern and who you couldn't talk to about it?

A. The -- you know, it -- it was a significant thing to be thinking about, wasn't it? It's not something that you can just sit and, you know, chat informally to people outside of the tight circle of the Consultants with certainly -- you know, I discussed it with Eirian Powell fairly regularly and -- and her view was quite clear and most of the conversation she tried to close down.

But outside that, I didn't share it with any junior doctors or any more junior nurses than the --

Q. Generally, your working relationship with Eirian Powell up until then was a positive one, wasn't it?

A. It was, yes, yes.

Q. So when she tried to shut it down or said to you: that is not going to be the case, she's great, she is excellent, whatever she said, did that influence your own thinking?

A. It naturally -- if somebody has a completely opposing view of things, then clearly that, you want to reflect on that and challenge yourself as to whether your -- your opinion is rational or not.

There were soft sort of concerns that were creeping

through in that time period. I mean, more -- there was -- I can remember Dr Mayberry, for example, in the corridor just notifying me of one of the deaths and I can't remember which one it was, but in the way that gave me a few concerns.

There was a doctor from Liverpool Women's who arrived for something unrelated and mentioned, "You are having a bad run, aren't you?" So there were those sort of soft indicators that something wasn't right.

But you know, I could, so I was questioning my views. I felt that those soft indicators were literally that; just soft. And looking in retrospect, I could see that Eirian Powell had this, this cultural entrapment, if you like, of her views and didn't want to move on from that.

Q. What do you mean "cultural entrapment"?

A. I think Dr Dixon-Woods explained that as -- if somebody is raising concern and that concern is so significant that the hearer the receiver of that information can't believe it and -- and it creates this credibility gap and that hearer has got that entrapment and can't move on and that's obviously made worse by denial and -- and that sort of thing.

Q. Did you feel it became nurses versus doctors further down the line with this, with Karen Rees,

Eirian Powell's views, your views?

A. I had worked with Eirian Powell for three or four years by then as the -- the unit manager and I thought we -- we had a reasonably good and positive relationship. I considered her to be a friend, really. We -- we had been to different parts of the country and to Germany planning the new neonatal unit that was going to be built, so -- and the reason for escalating in the way that we did was -- was -- that I said at the time was to try and preserve that working relationship that we had which -- which made it quite surprising and upsetting when she acted in the way that she did with the help of Karen Rees.

I didn't know Karen Rees. I hadn't knowingly attended any meetings with her prior to June and she was the nursing lead for a big division and we just -- our paths hadn't crossed. So I think Karen was -- was working from a point of not knowing me and not knowing the -- the Consultant team and not having the confidence and relationship in that team that maybe a senior nurse in a Women and Children's division might have had previously. And I think the combination of Karen Rees' behaviours and Eirian Powell's denials created certainly what we felt was a nurse v the Consultant body relationship, which wasn't helpful.

Q. That can come off the screen now, please, and if we can have paragraph 238, 239 and 240 of your statement on screen, which is INQ0103104, page 42. So we know, Dr Brearey, you were asked by Dr U to assist with Child O's intubation.

You did note what appeared to be the purpuric rash on the right side of his chest, but with otherwise normal perfusion.

You say you were very worried at this stage. Can you tell us what you thought when Child O died and then we will move on to discuss or ask you about the conversations that you had with Karen Rees and the one Karen Townsend says she had with you. So do you want to in your own words tell us -- you no doubt remember, do you, those two days and what happened?

A. So the conversation that I had with Karen Rees was following the death of Child P.

Q. Yes. So deal with O first.

So when Child O died, what did you think?

A. I was exceedingly worried. Although we were talking about this in the morning, the -- the rashes that you talk about had been mentioned in June 2015 and hadn't been a huge topic of conversation in the intermediate time.

So I clearly had enough memory to think that this

rash was unusual and might have been similar to previous ones that had been noted in 2015 and it was -- I was present at the resuscitation with Dr Gibbs and Dr U and as far as resuscitations go, everything was done smoothly and efficiently and well, in -- in my opinion.

And the baby just didn't recover from -- from all our resuscitation efforts.

The parents were present but I can remember Child O's grandmother being present as well.

Q. You say you were worried, you were very worried, at paragraph 239 and you intended to discuss with Eirian Powell as soon as possible with an intention to escalate to the Executives --

A. Yes.

Q. -- and request action to make the NNU safe.

You didn't know that Letby was returning to work, you couldn't conceive senior nursing staff would allocate her to care for the surviving Triplets.

Did you say that to anyone as soon as Child O had died: do not allocate her to any of the Triplets or don't have her in the unit? As soon as Child O had died?

A. I mean, the -- the normal processes following a death would have happened but I can't recall any conversation and I can't -- the, I can't think of the

timings of when it happened but I think it was, it was early evening time when most sort of senior people would have not been in the hospital.

So, yes, I was worried. I did think it needed escalating. Eirian Powell wasn't present, other Consultants, other than the ones involved with the care, weren't present and it was something I wanted to address as soon as possible the following day and obviously I regret waiting until the following day to act.

It would have been far more appropriate to trigger something on that Thursday evening rather than wait to the following morning.

Q. You set out at 241 and 242 of your statement that on the morning -- just the top two paragraphs, please, just 241 and 242, you say that you were asked to undertake an echocardiogram for Child P on the 24th. When you returned Child P had died and Dr Oliver Rackham was leading a debrief.

Karen Townsend gave evidence that she spoke to you on this day and spoke to you in terms where you described having a "drawer of doom". You have provided the Inquiry with a third statement detailing your clinical moments and where you were on that day.

So ignoring the movements and the events that you have set out for us, what do you remember or not

remember about meeting with Karen Townsend on that day?

A. It's Karen Rees.

Q. Sorry, Karen Rees.

A. So after Child P died -- I will go back to the beginning -- as in my supplementary statement, I was in clinic all morning on the Friday morning doing a cardiology clinic that involved echocardiograms and one of the junior doctors came to me during the clinic to ask for an urgent echo on Child P.

I had to finish the clinic first, which I did, and then I went directly from the clinic to the neonatal unit. The -- in my supplemental statement I have, I have given you the times of the scans that I did in that clinic and on the neonatal unit and the time between the last image being stored in the clinic and the time between the first image being stored on the neonatal unit, seven minutes, so in that time I would have had to finish the consultation with the patient in clinic and explain to them what the follow-up would be and that sort of thing.

Close the scanner down, pack up my notes, walk out of the clinic, walk to the neonatal unit, reboot the scanner, take a handover from the staff about what was happening with Child P and find an appropriate time to do the scan. So it tells you the urgency of what I was

doing in the -- seven minutes doesn't seem like a lot of time to do all those actions. And I am only giving that detail because Karen Rees has given evidence saying that she was waiting for me in the clinic and then walked back to my office with me for a discussion which I have no memory of.

So --

Q. Is a "drawer of doom" anything that you would have said, you say very clearly you didn't say anything on that day. Would you comment on having a drawer of doom to anyone?

A. As I have said in my supplemental statement, I -- I have a memory of saying it may be on one occasion to somebody informally. I don't think there's anything really too exciting about saying this and as I have explained in my statement, most Consultants will have a drawer they keep important files, medico-legal files, files from Inquests and I had a drawer in which I would keep my reports of the babies who had died and those important sort of documents there.

Q. Who do you remember using that phrase to, "drawer of doom", at some point in time?

A. I -- I -- it's a difficult memory because I didn't -- I didn't know Karen Rees at the time and if she had spoken to me without introducing herself

I wouldn't have known who she was. I had only recognised her name on emails, for example, at that stage. But I think the conversation I can vaguely remember with that was with somebody who was standing in the doorway talking. I don't know whether it -- it's hard to imagine that it could have been on that day, but the point I was trying to make was that normally that drawer is fairly unused.

Q. We have got the point, and there were more deaths and more events; yes?

A. So it was -- it was getting full and then I think the way that that phrase has been used by Karen Rees and was used by others in the following year or so was, it was belittling the concerns that we had and distracting from the concerns that we had and that seemed to be an issue with other behaviours from that level of management at the time, in that, you know, they felt there was no evidence and that the Consultants were acting inappropriately and to mention things like the drawer of doom seemed to hold some significance to them that was really just distracting from what the important question was, which was why these babies were dying.

Q. You do remember speaking with Karen Rees later that day as you tell us that you phoned the switchboard on the evening of 24 June and asked to speak to the duty

Executive who happened to be her. Can you tell us how that conversation went?

A. Well, I knew that it was -- it was by chance that I was speaking to her because the switchboard put me through, I didn't ask to speak to her specifically.

But when I realised that's who I was talking to, and she was at home at that time, I let her know that Child P had died. I let her know that all the Consultants had concerns regarding Letby and that I had just been told that Letby was going back to work the following day on the Saturday during the debrief that occurred after the death and that I wanted the neonatal unit to be safe and the only way for us to be sure that it was safe at that stage was for her not to come to work the following day.

Karen Rees then as I have described previously said no to this. She said that I had no evidence, was quite categorical. I said: well, if you are saying "no", does that mean that you -- that you are happy to take responsibility if anything were to happen on the following day with any further babies and override the wishes of seven Consultants? And she said "yes" to both of these.

And the call ended shortly afterwards.

Q. That can come down now. Thank you.

Dr Brearey, moving on to meetings that were held to discuss the deaths of babies and what could or could not be ascertained from them.

The Neonatal Mortality Meeting record, please, if we can have INQ0003297, page 1. I am not going to take you to all of these, Dr Brearey, just an example. This is the type of discussion that was held. Who decides who are the attendees?

A. Well, the -- the dates for the Perinatal Mortality Meetings were given in advance and scheduled as half days so everybody would know that that schedule beforehand had been told by email. The difference with the Neonatal Mortality Meeting was that we -- we didn't have capacity in the Perinatal Mortality -- scheduled Perinatal Mortality Meetings to discuss all the babies that we needed to discuss which again is -- is a sign in itself, isn't it?

But I wanted to discuss these in a timely fashion, so organised a Neonatal Mortality Meeting. The difference being that because of the short notice organisation of it, it wasn't a joint meeting with the obstetric team, it was just the paediatric and neonatal team and neonatal nurses that would have been invited.

Q. So we don't have Dr Jayaram there who of course would have known about the rash on Child A, if

C and D were being discussed, because you are dealing with individual babies at these meetings, yes?

A. Yes, so the whole team would have been notified beforehand, but the other problem with arranging meetings outside the -- the perinatal meetings is that it was held at a lunchtime session that would normally be scheduled for teaching, so normal clinical activities wouldn't be cancelled for it. So people attended that meeting in addition to the clinical work that day.

Q. Are these meetings for mortality, discussions around mortality limited when you don't have any postmortem findings and when you don't have a discussion about what type of postmortem is indicated?

A. Yes. But there is still something to be learned from them. You know, they are -- they are educational meetings in the main and a chance for the doctors involved to present what they did that day and any reflections they have on them but also an opportunity for the people attending the meeting to critique what went on and maybe suggest things they might have done differently.

And that's all of benefit without the knowledge of the postmortems and at the time it was taking us six to 12 months for the postmortem results to come back anyway

and you couldn't wait a year to have a meeting like this. You had to do the meeting without the PM results most of the time.

Q. Would you automatically schedule one when the PM results were back in for a mortality meeting? It might be more meaningful around cause of death to have those reports and reflection together about pathology and clinical findings.

A. Yes, in the ideal world it would have been good to have a further meeting down the line to update that meeting. But again, this meeting was primarily for learning and education and rather than a governance risk procedure, where you are identifying the cause of death, which -- which is obviously down to the Coroner and that sort of thing.

Q. You also say that in relation to the Neonatal Perinatal Morbidity and Mortality Meetings if we can go to INQ0005445, page 1, you say of these meetings the Perinatal Morbidity and Mortality Meetings that they were for learning and discussion rather than governance?

A. That is what I have just explained, yes.

Q. Yes, so it is the same for these?

A. Yes.

Q. So in terms of understanding risk to babies, I can see there is discussion about care and staff

learning about delayed cord clamping, for example, in one of them. But in terms of babies' safety, are these the events we are looking at, are these able to drill into the matters that we are examining? Governance, risk, elevated risk? Decisions that indicated to be made wider than the neonatal staff? HR decisions about moving someone off a unit?

A. Clearly particularly the Consultant body who would have attended all these or been invited to all these meetings and would have received all the minutes, they will be getting a theme if they are attending these meetings of how many babies are dying and a feeling for the overall trend, as I was, for the junior doctors who do six-month stints here, I think purely sort of learning and education benefit. But in answer to your question, no, they are not particularly helpful in terms of risk and governance and identifying a bad apple, if you like.

Q. If we can have, please, INQ0005449, page 1 on the screen. This is obstetrics, neonatology and midwifery meeting and you tell us in paragraph 140:

"It was not an appropriate forum to discuss confidential concerns regarding a member of staff and I cannot recall anyone discussing this or the number of deaths that had occurred on the NNU. However, all the

paediatric Consultants would have been aware of the number of deaths."

That does sound artificial, that you are having a meeting where not even the number of unexpected deaths can be referred to, even if you are feeling protective about the name of the nurse or that a nurse is suspected, not even the number of deaths are being raised? What's the point?

A. I think the point is looking at the individual cases, if somebody had brought something like that up, it would have been acknowledged and I am sure it was acknowledged in the room informally on a number of occasions. But in -- in terms of where you can take it from there in this meeting with junior members of staff, nursing and medical staff, so that people were clearly able to express opinions and comments there, but as -- as a forum for discussing an association with one member of staff, it would have been inappropriate.

Q. There were also Neonatal Incident Review Groups, weren't there, and if we can on screen please INQ0010005, page 1 the Neonatal Incident Review Group before each meeting a list of the NNU Datixes for the period to be considered was circulated by Debbie Peacock and then the Datix were discussed at the meeting and although there is no minutes or notes for the meetings

you would circulate a newsletter to NNU staff afterwards; have I summed that up correctly?

A. Debbie Peacock would minute the meetings on the Datix system and the actions from each case but yes, I would generate this neonatal incident newsletter for all staff as soon as I could after the -- the meeting to disseminate learning to clinical staff.

So, for example, in this case in July 15, you know, it was -- the top learning in terms of any neonatal sepsis was I think in reference to Baby --

Q. Don't worry about which baby. We are not worried about which baby.

A. Child D, it was --

Q. Yes.

A. -- because of the --

Q. Let's, let's not worry about that --

A. -- delay in antibiotics.

But, I mean, generally you can see from the sentence at the bottom, which is me encouraging people to report on the Datix system and the more reports raised, the better, more risk aware unit it was generally accepted, is that the case.

So it was for learning generically without pinpointing any members of staff and it was to encourage people to use that system and --

Q. Would you ever --

A. -- seek feedback from it.

Q. Sorry. Would you ever complete Datixes yourself as a doctor --

A. Yes.

Q. -- or was it for nurses to do? You did do it?

A. Yes, yes.

Q. Thank you. That can go down.

A. I thought the -- the incident reporting culture and rate in the neonatal unit was -- was good and comparable to others and that was supported by network reports, other incident reporting that we had to feed back to as well.

Q. You then have Clinical Effectiveness Group meetings. That's -- if we can have on screen INQ0005531, page 1.

While that comes up, you tell us in paragraph 61 of your statement that this group met every three months until September 2015 and then every two months thereafter and it was attended by the neonatal Lead Clinician and nurse manager from the nine neonatal units in the region along with the network clinical lead, nurse lead and administrator, serious incidents of mortality would be discussed as well as quality improvement and educational initiatives.

And if we look at this document, over the page, we see the list of attendees. So you have got paediatricians from surrounding hospitals.

If we go to page 5, mortality for Countess of Chester, three deaths under review will be discussed at subsequent Clinical Effectiveness Groups.

By the date of this meeting of course E had died on 4 August, so it might well have been four that was referred to there. But the number, did any of your colleagues just reporting -- first of all, how was that reported? Mortality, it doesn't say "Sudden and Unexpected Deaths", for example?

A. This system with this group that had been developed in 2015, it was new, and the -- the network would give you three-month windows to report on and a deadline for when to submit your -- your reports.

So for this meeting -- sorry, in September, it would have been the -- I think it was May, June, July, but it was a three-month period that only covered the three deaths that we had in June which is why only three deaths are reported at this time.

It was the requirement at the meeting that the deaths in that time period were -- were discussed at this meeting.

Q. This wasn't a meeting where you raised either

suspicions about a nurse or, on the face of it, suspicions and concerns about Sudden and Unexpected Deaths, a number of Sudden and Unexpected Deaths; is that fair? Looking at the notes or the records of the babies on the indictment and discussions, we don't see in-depth discussion about concerns about any aspect and I just wonder what was it about this forum that didn't encourage that?

A. It was -- you know, these discussions had -- the reporting from the -- from the CEG, the purpose of it was for learning lessons following on from -- from reviews of -- of deaths and to disseminate learning to other neonatal units.

I -- I -- the -- certainly in September I didn't think it appropriate to talk and share with clinicians from around the region that there was a commonality between one nurse.

Q. Well, at any time, never mind September, the whole period of the indictment babies?

A. Yes, I just didn't think it was the forum for that with the -- you know, something which is so grave is the sort of worry that was developing to share that with people that go back to work in every hospital in the region, I didn't think appropriate.

But I did -- I can remember at this meeting

discussing with Dr Subhedar at the end of the meeting privately that we had had some more deaths in addition to the three that were discussed in the meeting.

Q. At that meeting, did you tell him, was that adding Baby E, as I have said that would have happened by September?

A. I didn't tell him that association with Nurse Letby, but I did tell him that we were having more than expected and I can't remember the precise response but it was more or less well, you know, just keep us informed and we will just go through the normal process of -- of what's described in the meeting.

Q. Why didn't you tell him about the concerns at that point about a nurse?

A. Because they weren't at a level that I felt I needed to talk to him about at that time.

Q. Just one more question before we break again, please, Dr Brearey, a brief topic: the CQC.

It looks clear that no doctor raised the issue of Sudden and Unexpected Deaths and collapses in 2016 at that February 2016 CQC visit, that nobody said as you are saying now at that point in February you were concerned about three deaths.

Is that the kind of issue that you think should be capable of being raised with the CQC? Did you think

about raising it with the CQC? And if you didn't, why didn't you raise it with the CQC?

A. Well, we had had the Thematic Review meeting the week beforehand in February and I had provided a draft report from that meeting and I sent that to Ian Harvey, the Medical Director, with a request for an urgent meeting to discuss and I was very keen to get that to him prior to the CQC inspection because I felt it was important to do that, with his knowledge, because I was really expecting the CQC to ask us about mortality and to tell them that I've taken these actions and escalated to the Medical Director would have been the appropriate thing to do.

But there was a bit of an internal dialogue going on with myself in terms of what -- what to say to the inspectors because if he can, effectively I would be raising concerns to the CQC before I raised concerns to the Medical Director. I was expecting an urgent meeting within a week or two with him to discuss the report and to discuss the concerns and I -- so I was in a little bit of a dilemma about it.

I think I came to the conclusion that if asked, I would talk about it but otherwise I would leave it to a discussion with the Medical Director which I assumed was going to be imminent at that time and -- and

obviously assumed at the time that the response would be appropriate as well.

Knowing what I know now, we should have discussed it.

Q. Would you have to have been asked? You say you would have only said anything if you were asked the question, what would the question had to have been: have you had a number of deaths that you are worried about in the unit and are you worried about anyone? I mean, how specific did it need to be?

Just in terms of the learning, I suppose, moving forwards for the CQC and generally what kind of question would have made you in conscience answer as you knew to be the case at that point?

A. I think that the first thing would be whether the CQC actually knew about mortality or not already and I was assuming they did but I -- I don't know whether they did or they didn't.

Therefore, the flagging up that problem then I would be to be honest with you and say that this is what we have done and we have done a Thematic Review.

In terms of what sort of question I think any probing question into mortality that went deeper than: when are your meetings? would have sort of been enough really.

Q. You said in a statement you had no opportunity to speak with the inspectors confidentially, you were obviously in a group, but even if you had been are you saying you would need to have specific questions to know what you should be saying?

A. That was the point I was -- at the time because I had some confidence in -- in getting the Thematic Review to Mr Harvey and him taking the appropriate action soon.

Q. Can we look please at INQ0103141, page 1. That's a letter from the CQC Compliance Lead Risk and Patient Safety Team within the Countess of Chester Hospital?

A. Yes.

Q. It looks like Gill Mort has explained:

"You would like to attend the CQC interview to represent neonatal care. While I understand you would be able to answer any specific neonatal questions I think this interview is aimed at being an overview of children's services and that any specific questions will be dealt with during the rest the inspectors'.

"I am conscious that there are quite a few individuals already attending the interview so perhaps the best thing would be if you arrive at the interview and ask the inspector if they would like you to join

them."

So how did this work when you got to this? Were you expected, not expected?

A. I think the -- the background was that we were asked if anybody wanted any individual conversations with the inspectors and I thought one with me would have been helpful. So again it sort of reflects that it was in my mind that I am likely to have to share this information and it was turned down, wasn't it? It was, it was turned down and that opportunity went basically for me to have a one-to-one with them, the inspectors.

MS LANGDALE: Thank you, my Lady, this might be a good time to break. Would it be possible to take a slightly shorter break than usual?

LADY JUSTICE THIRLWALL: Yes. 45 minutes?

MS LANGDALE: Thank you.

LADY JUSTICE THIRLWALL: So we will rise now and start again at 10 to 2.

(1.05 pm)

(The luncheon adjournment)

(1.50 pm)

MS LANGDALE: Dr Brearey, I am going to turn now to the Thematic Review and lead up to that meetings after your Thematic Review. If we could have on the screen, please, INQ0005643, page 1.

This is an email from you on 22 January to Debbie Peacock and others. Have a read of that now and let ...

(Pause)

You have had a conversation with Dr Subhedar about increased mortality. It looks like you have asked him if he would be an external member for a Mortality Review, he was a little reluctant to commit to that.

So your thinking around the Thematic Review in January, what -- how did it come about who was involved and what you did? Who did you have discussions with apart from Dr Subhedar about that?

A. Well, I had an increasing level of concern about the mortality, about the association with Letby and the -- I felt there was a need for some external objectivity from somebody outside the hospital to sense-check, if you like, where we were at that time.

I thought it was as relevant to show what we had done so far and the way we had looked at all the cases and excluded any significant sort of problems in terms of care and there were -- and that we had learned as we were going that year various things and improved the care that we were giving babies generally and I think it was at a time that needed somebody external to just validate everything that had been done so far and help

us regarding any suggested next steps.

Q. If we can have, please, INQ0003251, page 1, this is your Thematic Review. It's actually the final version that was circulated, 2 March, even though the date stays there, 8 Feb. So we know you had circulated a draft and the final version on 2 March.

Looking at the attendees, as far as you were concerned then were all these people involved in the Thematic Review and where does Dr Green fit in as "apologies from pharmacy" on that list?

A. So I wanted to be as inclusive as possible in terms of people that were attending in terms of the expertise that was there so we had some medical attendance, myself and Dr V and obviously medical help with Dr Subhedar from Liverpool Women's Hospital, we had some nursing input from Eirian Powell and Anne Murphy and Laura Eagles that was deputising for a deputy, Yvonne Griffiths, I think, we had somebody from governance and --

Q. Debbie Peacock is from governance?

A. From governance and Chris Green was the Director of Pharmacy.

Q. Did he ever come to a meeting or have anything to do with it?

A. He didn't -- he was invited to the meeting,

but didn't attend.

Q. Yes. So in terms of active engagement with the topic clearly Eirian Powell, Dr Subhedar you are talking to and he is the only external one. Who on that list was the most useful to you in terms of input in what we read in this document, I will go to bits of what we read, but who actually assisted with that? The reviews themselves, the comments in the document?

A. Well, the people that were reviewing the deaths were usually myself, Eirian Powell and Debbie Peacock -- Debbie Peacock, the governance facilitator.

Q. So three of you were the essential drivers of this?

A. Yes, yes.

Q. Why was it done in this way, a Thematic Review, rather than a Serious Incident Investigation which would have followed more recognised methodology, involved other people and would have been disclosed to parents?

A. I wasn't aware that the Serious Incident methodology could be applied to a group of cases like this.

Q. Did you ever think about the sharing of this review or information with parents when you had taken

effectively your own route of a Thematic Review as a Trust? Did you think about who should see it and when?

A. I mean, in terms of duty of candour, that was really sort of focused on the individual reviews themselves rather than doing this as a collective. So I think clearly if something had come out of these reviews that changed our opinion regarding the care that the babies received, then that would clearly be something that you would want to share with parents, certainly.

Q. If we look at page 7. Themes identified. You have got the sudden deterioration and I think Dr Subhedar says "add suddenly and unexpectedly", you know that' --

A. Yes, yes.

Q. -- clearer, isn't it, than just talking about neonatal deaths because death can be natural causes sudden and unexpected needs investigation; that is the difference between just describing a neonatal death and a Sudden and Unexpected Death, isn't it, there is a need for investigation in one for sure?

A. Yes, yes, they were investigated but, yes.

Q. You comment "timing of arrests between midnight and 4 am". But you don't include as a common

theme a member of staff, even if you didn't want to say who it was, a nurse or a doctor or their name, you don't say "timing of arrests and a member of staff".

That is the pattern that you have identified, isn't it?

A. Yes.

Q. You have identified midnight to 4 am, you say why that is unusual. Were it to be natural causes you wouldn't expect that and you have identified and indeed one of the reasons for doing it is your cause for concern about Letby. So why isn't that there as a common theme?

A. So I was aware of Eirian Powell's feelings about this in terms of it not being significant. I wanted some objectivity from Dr Subhedar and Dr Subhedar wasn't aware of the connection, the correlation with Letby at the time when we went through the care of each baby because I didn't want to affect his -- his judgment of -- of those case by case but at the end of the meeting we discussed the association with Letby and there was some discussion, there was a pause whilst he took on that information.

Q. Which meeting are you saying with Dr Subhedar you discussed the association with Letby?

A. The one -- the Thematic Review meeting.

LADY JUSTICE THIRLWALL: Was it a single meeting, the Thematic Review meeting?

A. Yes, the Thematic Review meeting on 8 February.

LADY JUSTICE THIRLWALL: 8 February?

A. Yes, yes. So from that there was an agreement to do another review of the babies 12 hours prior to their collapse to see if there was anything we missed. Essentially that was myself and Eirian Powell going through the records and the observation charts again to try and exclude anything that might have been missed from that respect and I think that might have been suggested by Dr Subhedar after we had had the discussion regarding Letby.

But there was no other suggestions from him following that discussion, so again, in retrospect I wish I had put the association with -- with Letby in at this stage. I think at the time my thinking was that I'm not sure Eirian Powell would have been particularly keen to put it in.

Q. Was that a determining factor, timing of arrests and a member of staff --

A. Yes.

Q. -- would have highlighted something very clearly, wouldn't it?

A. It would have been but I -- I thought this was concerning enough already for somebody to read this in terms of the fact that we hadn't found any other common themes, the numbers, the sudden deterioration, the timing of the arrests and the report did have a name by every baby bar one --

Q. On reflection --

A. -- in the appendix.

Q. Sorry, Dr Brearey, but on reflection, do you think that because the concerns were obvious to you because you were steeped in it and you may even have been occupied in many of your thoughts about it, that you overestimated what someone would take from that without knowing all that you and Eirian Powell knew at that time?

A. I -- I did under-estimate because I would have thought from just reading it that it would have warranted more in-depth reading because I think anybody who would read all of it would have seen the association with -- with Letby.

Q. Let's have a look at an email that indicates what you have just said about Eirian Powell's views. INQ0005609, page 1.

A. It's worth pointing out as well, that I asked for an urgent meeting with Ian Harvey and

Alison Kelly --

Q. No, no, we will come --

A. -- to discuss.

Q. -- to the stuff about meetings but look at this.

This is after Baby I, so Eirian Powell adjusts that document that shows very clearly now Letby's presence at I as well and the death. She says:

"I designed the document to reflect the information clearly. It is unfortunate she was on, however each cause of death was different. Some were poorly prior to their arrival and other were [query] NEC or gastric bleeding/congenital abnormalities."

So that is what she is saying to you but in the end you are the Consultant, you have found that link and she's clearly defending her member of staff, her nursing staff member on the ward there.

So was it really the case that that strength of feeling was so clear to you that you thought Eirian Powell would object to it if you added it as a theme, or was there something in addition to that, for example worrying about whether you should be even mentioning a category of staff on a document that would be circulated more widely?

A. In reference to this email, it felt important

to -- to get that postmortem result because she's questioned NEC here as a cause but at the time when she wrote the email we didn't know that for sure, although it was suspected by the clinical teams.

So it was important for me to try and exclude, you know, if we were going down the route of trying to confirm the submissions are founded, of her being involved. If it was proved that NEC occurred in Baby I, then clearly that would be reassuring.

Q. If we go to one of your emails, please, INQ0003114, page 1. You are emailing the summaries the reviews and the Thematic Review report, the report includes a summary of the cases discussed:

"Themes identified [we have just looked at those] and an action plan. The appendix has embedded documents of all the previous reviews prior to the Thematic Review."

Ian Harvey asks if it can be joined up with an obstetric review, we know that doesn't happen.

Then above the email that you send just to Eirian:

"I think we still need to talk about Lucy. Maybe when you are back and free, the three of us can meet to talk about it, Dr Jayaram and [Eirian]."

So you are sending the report to everyone, but only that to her?

A. And Dr Jayaram.
Q. And Dr Jayaram, yes.
If it was significantly important to have further conversations, do you think on reflection when you circulated that report it should have been much clearer and if you had put "member of staff" without saying who, where or what, it would have if you were concerned about anonymity have dealt with that, or were you really worried about offending Eirian Powell in this?
A. I wasn't worried about offending her and it's quite difficult to offend her generally. But the -- the purpose of sending the report to everybody was -- or those people that contributed to it, including risk leads and obstetricians, so they are aware of the report. The purpose of sending it to Alison Kelly and Ian Harvey was to talk about Letby's association and I didn't think it was appropriate to open up that conversation to the -- the larger list of recipients of the email on 2 March.
Q. We then see emails, if we can, on INQ0003089, page 2.
LADY JUSTICE THIRLWALL: Ms Langdale, I wonder if I might ask a question for clarification while we wait for that to come up.
Just really to ask you to make sure I have

understood this correctly. There was the schedule prepared by Eirian Powell which showed Lucy Letby against most of the -- most of the babies. That document went, did it, with the Thematic Review to all these people?
A. It was an appendix, yes.
LADY JUSTICE THIRLWALL: Yes.
A. It was in that document, yes, the -- the staffing that said "Letby" next to the allocated nurse or whatever it was.
LADY JUSTICE THIRLWALL: Yes, thank you.
A. That was in there, yes.
MS LANGDALE: If we look at this email at the bottom, Eirian Powell to Alison Kelly:
"I was hoping that we could arrange a meeting to discuss how to move forward with regards to our findings: High mortality ... a commonality that a particular nurse was on duty either leading up to or during. This particular nurse commenced working in January 2012 without incident. Doctor was also identified as a common theme."
That is how Eirian Powell summarises that.
Alison Kelly says:
"Thanks for the update."
Then if we go back to page 1:

"Hi Alison,
"I was wondering what your thoughts were after going through the Thematic Review. I notice the Thematic Review did not include the medical team that were involved, I have therefore attached ..."
Did you have cause to have a conversation with Eirian about the tone or content of either of those emails that she sent then or not?
A. I can remember -- sorry, excuse me -- talking to Eirian wondering when we were going to have the meeting with Alison Kelly and Ian Harvey because as far as I was concerned, we had -- we had asked for it some time earlier and there was a degree of urgency about this. But in terms of the content of her email, no.
Q. What did you make of the one -- I notice it didn't include the medical team. What do you think the purpose of that addition is or do you think it in any way impacts on the commonality that you have identified or she's identified thus far of Letby?
A. That had been agreed following the Thematic Review that we had put the names of the doctors in to her table and as far as I was concerned, we had done that. But maybe the copy that she sent to Alison Kelly hadn't included the most up-to-date one with the medical staff. But I am recall fairly sure that we did that as

an action following the Thematic Review in February.
Q. If we go, please, to INQ0003115, page 1.
There's a meeting on 2 May and there are a number of documents, Lucy's shifts and mortality document, continued NNU monitoring process and a neonatal unit review assurance document.
This states:
"Obviously we would like to have a meeting with Alison Kelly and Ian Harvey as a matter of urgency, primarily for reassurance and to ensure that we have covered all the relevant actions."
You don't go to the meeting I think on 2 May; is that right?
A. That's correct, yes.
Q. But they -- you are suggested as having gone but you say that's inaccurate, you weren't at that meeting?
A. No.
Q. The meeting you say was Ms Powell, Ms Rees, Ms Murphy but not you?
A. That's correct. Well, I mean I can't say who was at the meeting but I certainly wasn't there.
Q. The neonatal assurance or review assurance document, can we have a look at that please INQ0003243, page 1.

A. So I wasn't aware of the meeting and I wasn't aware of these documents and the email until after the meeting we had with Alison Kelly and Ian Harvey on 11 May, I think I was a hot week Consultant the week when these meetings happened, so I was busy clinically and didn't get a chance to read them but when I did, I was quite surprised by the content.

Q. Did you feel Eirian Powell had strayed into areas of expertise that were not her own in this document?

A. Yes.

Q. Would you like to highlight where that was done and why you say that?

A. Well, the first sentence saying there is no evidence whatsoever other than coincidence overlooks the timing of the deaths and the sudden/unexpected nature of the deaths. The increase in numbers above anything we'd expected and the rashes that we have discussed already, although that wasn't at the forefront of my mind at the time.

The second sentence says there was no performance management issues and no members of staff have complained to me about her regarding performance, we now know about the -- I didn't know at the time, about the morphine overdose or any other issues that have come to

rise since then because during risk management meetings we don't identify the member of staff that have made those mistakes in the meeting. It is up for the unit manager and senior nursing staff to address that with the individual member of staff.

So I wasn't aware of her name with that one. But clearly there were performance issues, so 3:

"I found LL to be diligent and of excellent standards within the clinical area."

Well, I couldn't really argue with her at the time which made it more worrying in a way that if there was no concerns regarding her clinical competence, what was the cause of her association with the deaths?

Number 4:

"Whilst our mortality rate has risen in January 15 to January 16 we have had three mortalities from January 16 to date. Two have died due to congenital abnormalities."

I mean, the babies had congenital abnormalities but the point and the level of concern was that it wasn't clear from the postmortem results that those congenital abnormalities led to the sudden collapses.

Dr H and Dr G is Dr Harkness and Dr Gibbs, appear to be involved in many mortalities. Well, they were involved more than some of the other doctors but it was

still less than half of the episodes that Letby had been involved with. And I did explain in the meeting on May 11th regarding the fact that Consultants tend to come along towards the end of a resuscitation or certainly not at the beginning, when -- when juniors have escalated concerns to us and we are attending, so it makes it less likely that even if Dr Gibbs is there on a number of occasions he was actually there at the beginning when the collapse occurred.

So that didn't seem to make any sense.

Number 6:

"Cheshire and Mersey Transport Service have been involved in a few of these mortalities and they may have survived if the service was running adequately."

I don't think there was any evidence that a delay in a transport caused a death or led to a death; that was established with all the cases and obviously the transport service had problems to all the other neonatal units in the region who hadn't seen an increase in our mortality.

7:

"Alder Hey Children's Hospital's failures in facilitating a cot also add to the complexities of these mortalities. If there been a bed sooner, the infant may not have died."

I don't think there was any evidence for that in any of the cases.

Number 8, "some of the issues related to midwifery problems." Well, there were some items of care that might have been improved on in terms of midwifery but certainly none that related to something that might have caused a mortality.

Number 9:

"Two of the babies' postmortems diagnosed congenital pneumonia."

And it's attributed to transport team issue. I don't actually understand what she's trying to get at with that and the children with congenital pneumonia were improving and stable and getting better a number of days after treatment before they collapsed and died.

Number 10: four babies had congenital abnormalities. It's a repeat of point 4 which I have mentioned already.

Number 11 on maternal syndrome, I am assuming that was the mother of Child A and B., where we may have been still waiting for the Coroner's Inquest for that baby but certainly not a common theme at all.

Point 12, two with possible necrotising enterocolitis. We had one without a PM with this and Child I must have been the other one, but we didn't have

a PM result by then, well, I did not, I didn't have sight of it, although it had actually been completed in February 2016.

Q. Was this list discussed with you --

A. No.

Q. -- at all in advance?

A. No, no.

Q. So you say to us that after learning of that meeting, you felt:

"... let down by Eirian Powell and very disappointed she had not invited me to the meeting and she didn't feel able to talk to me herself about these opinions without going to a senior manager ..."

Meaning Karen Rees.

A. Yes.

Q. About them. You had very little contact with Karen Rees before then and knew that she would be relatively unfamiliar with the events on NNU since June 2015 and you weren't sure whether she had any neonatal experience or expertise.

When you look at that document, when you looked at it then and certainly when you look at it now, should that have communicated to you a lack of objectivity and yet she was so firmly involved with yourself in this ongoing evaluation or watching, as you might have

described it, did that concern you?

A. It did concern me, and it did show a lack of objectivity and I was concerned that she had developed this document for assurance with Karen Rees with her lack of neonatal expertise and without discussion with any of the Consultants and the -- the arguments and the summary of this report was essentially what was used in the meeting that we had with Alison Kelly and Ian Harvey the following week on 11 May at which point I did obviously have a chance to argue the case in terms of why I wasn't reassured by any of these items.

Q. The reassurance case had been put first, as it were, before 11 May --

A. Yes.

Q. -- with the documents.

Let's have a look at Alison Kelly's note of that, INQ0003181, page 1. This is the meeting on 11 May that you have, Alison Kelly, Anne Murphy, and yourself and Ian Harvey. You tell us in your statement that you said at the meeting that the number of deaths in 2015 and early 2016 were exceptional and you raised the common theme: the association with Letby on duty.

What do you remember about that meeting? You set it out at 230 to 232 of your statement but what was your impression of the response particularly from

Alison Kelly and Ian Harvey?

A. Well, I put forward the results of the Thematic Review, the association with Letby, the concerns of myself and my colleagues about this and how we were worried. The new information at the meeting was that Letby had been moved on to day shifts as well in April for a matter of mentoring reasons and support and that there had been no collapses or deaths at night between the beginning of April and this meeting which was further weight to everything.

And I was trying to be objective and measured and stating the facts and essentially I was interrupted by Anne Murphy and Eirian Powell with quite a forceful view expressed by both of them with a fair amount of emotion, essentially saying this was wrong, and it's just coincidence that, you know, there is no evidence, these are our assurances, as mentioned in that document.

Q. Was that document available before that meeting? We know it was done on 5 May by Eirian Powell?

A. It was, it was sent before the meeting, yes, but I hadn't had a chance to -- I hadn't had a chance to read it personally. But --

Q. You had or hadn't?

A. Hadn't. No.

Q. So when did you first read that?

A. I read it after this meeting.

Q. After the 11 May meeting or after 5 May meeting?

A. After the 11th meeting, it was sent on the day after the 5th meeting, I think.

Q. So you got that, you had got the Letby association with the staff association document?

A. Yes. So, I mean, essentially the Thematic Review I felt had enough information in it to take some action and the assurance document that had been created by Eirian Powell and Karen Rees essentially with a sort of counter to it, if you like, that they created the week before and it got quite heated, the meeting.

I was taken a little bit surprised because I hadn't read their document beforehand and Ian Harvey and Alison Kelly were quite passive throughout the whole meeting, really and they didn't interject too much with things.

I made it very clear it wasn't just my own individual view, it was the views of my -- all my colleagues, concerns about this and I was very much hoping that the Executives in the room could bring some oversight and objectivity to the discussion.

Q. And we see on Ms Kelly's notes absolutely no issues: nurse circumstantial?

A. So if you -- if you are going through that document, the bit above that, most of that is in relation to how I started talking about concerns. Obviously it's -- it is her record and in my memory I would have said much more than that but from absolutely no concerns and circumstantial that's her documenting Eirian Powell and Anne Murphy's point of view at the time --

Q. You say -- sorry. You say they countered your concerns quite forcibly and with great emotion?

A. That's correct, yes.

Q. What action did you think was necessary to make the unit safe at this point? What do you think in retrospect you might have been saying at that meeting?

A. I -- I thought that the Execs should have been discussing it outside the hospital with -- with experts, whether that be safeguarding experts or the police or NHS England, whoever. It just felt like so much of a significant concern that doing nothing didn't seem to be an option.

Q. What did you think was going to be done after that meeting? Did you chase for anything to be done from Mr Harvey or Ms Kelly?

A. Well, Ms Kelly asked about Letby towards the end of the meeting. So there was no doubt about what

concerns I was raising, both myself and on behalf of my colleagues, and the note at the bottom of that record saying "trained at Chester" suggests she was inquiring regarding the background of Letby at the time -- sorry, I can't remember what your original question was.

Q. Yes, what action you wanted, what did you want done when you were at that meeting?

A. As I say, something significant in terms of sort of escalation and assurance of safety. Obviously, the --

Q. Were you relying on the Executives attendant to say what should be done next?

A. Well, I was really hoping they would or at least give us some fairly solid guidance about what to do next, yes.

Q. Because you had reached a point where you and Eirian Powell had a different view, certainly, of the involvement of Letby?

A. Yes.

Q. You are still both working on the ward with very different views about a member of staff on that ward?

A. Yes.

Q. Was that acknowledged in the meeting, the difficulty of that, that you have got a neonatal lead

and a ward manager have a completely different view and how this might impact on safety?

A. No. No.

Q. If we can go, moving forward in time and away from that meeting to an email you sent to Ms Kelly and others on 28 June now, INQ0005749, page 3. This is after the deaths of O and P. Is that what made you next write to an email to Ms Kelly, those deaths of O and P?

A. The discussion I had had with Karen Rees on the Friday, where she refused to take Letby off -- off the unit.

Q. Yes.

A. And an anxious weekend when Child Q also collapsed and ...

Q. Let's have a look at this email and --

A. Yes, yes, so --

Q. -- focus on what you say here. 28 June in the third paragraph.

"There's been a watchful waiting approach since our last meeting with Ian and Alison in March. However, since the episodes and deaths last week, there was a consensus at the senior paediatricians' meeting. We felt on the basis of ensuring patient safety on NNU this member of staff should not have any further patient contact."

A. Yes.

Q. If we go to page 2 we see a response to Karen Rees and then above an email from you:

"Just to confirm you are happy for LL to work on the NNU in the same capacity as last week despite the paediatric Consultant body expressing our concerns this may not be safe and that we would prefer her not to have further patient contact."

A. So this is Karen Townsend, who is the divisional manager, rather than Karen Rees.

Q. Yes, sorry.

A. And following the weekend I had emailed Alison Kelly on Sunday to say can we meet early on Monday, we are having a Consultant meeting at lunchtime programmed anyway, if you and Ian Harvey wanted to attend that to make it easier for us to all be together, that would be fine. She said she couldn't meet at the lunchtime meeting.

When we had the lunchtime meeting, without the Execs, the Consultants agreed that it would be appropriate for me to approach Ian Harvey and insist that Letby was removed from the unit to assure safety until further actions could be taken.

Ian Harvey agreed to that removal of Nurse Letby and I was reassured by that. However, I understand,

reading some of the documents, that Eirian Powell then had a meeting with Alison Kelly and Anne Murphy, I believe, on the Monday afternoon, where Alison -- sorry, Eirian Powell and Anne Murphy had been present at the lunchtime meeting, where we had agreed that Letby should be removed from the unit. But then on meeting outside the Consultants' sphere, if you like, on their own with Alison Kelly, they must have provided some reassurance -- I think Karen Townsend might have been there as well -- that Nurse Letby could continue working on the unit and therefore a decision was made for her to continue working on the unit that week despite Ian Harvey agreeing to take her off that day.

These emails follow on the 28th I think is a Tuesday, when we -- I was -- I was learning that Nurse Letby was still on the unit. This meeting had taken place, and that Karen Townsend was then notifying me of the decisions made on the meeting on the Monday afternoon without us, regarding what the Trust were doing in regard to our concerns which didn't now include taking Letby off the unit.

Q. We know she was subsequently moved to the Risk and Patient Safety Team?

A. Yes.

Q. Were you involved in any discussion about that

placement or anything like that?

A. No, none at all, no, I wasn't.

Q. Whose decision was it where she went to?

A. I wasn't informed of the decision, I don't know what made the decision, I only found out secondhand later.

Q. We know around this time, 29 June, there is various emails between the Consultants, we don't need to take you to them, where Dr Saladi is saying isn't this time for external investigation, we need help from outside agencies and the discussion between you.

Then there is a meeting on 29 June, if we can go, please to INQ0003371, page 1.

It's a meeting with the Executives at 10 past 5 on Wednesday, 29 June. While we are finding that, you recollect in your statement at paragraph 266 that:

"Mr Chambers explained we were very lucky to have Stephen Cross involved because of his experience as the head of CID in Chester and Stephen Cross explained the implications of calling the police."

First of all, what did you know about his career? Did you think he had been an experienced police officer or what did you know about that, if anything?

A. We, we knew he was an ex-policeman but we didn't know anything else other than that at the time,

it's only later that I found out that although he had been the head of CID as they had mentioned in terms of talking about his credibility, I understood that he had been demoted from the rank of Chief Inspector to Police Constable, I understand.

Q. When did you find that out?

A. About two years ago.

Q. Right. So at the time, when he was working there, you didn't know that?

A. No.

Q. And you were being told --

A. No.

Q. -- he has experience of this capacity, "and Stephen Cross explained the implications of calling the police".

What do you say -- we have got the note here. What do you say Stephen Cross said about that?

A. I think it's quite well described in the handheld note -- handwritten note, sorry, of -- I think it was Sue Hodkinson, the HR Director. She's more or less dictated it verbatim but essentially it was saying that the unit would be closed, it would be made a crime scene, there would be arrests, there would be people called for questioning and it would be a very upsetting for the Families and a disaster for the Trust's

reputation.

Q. What did you say it that given your level of concern? And we see if we look at these notes on page 2 --

A. Well --

Q. -- Dr Jayaram says something: how? can the air embolism. All sorts of things are being discussed, Dr Saladi: babies don't suddenly deteriorate and collapse.

Mr Chambers looks like he may have said something to the effect of: why did we not call the police?

Then at the bottom, Mr Chambers:

"Issues cannot explain is this suspicious, criminal or are we missing something, some causal link? Causal link, nurse."

Over the page, 3:

"Concern, shut unit, commission a review then police or police and consequences. Balance needed."

Et cetera.

A. It's worth pointing out this these are the notes of Stephen Cross who I have just mentioned and, you know, sometimes they don't always give a fully sort of accurate impression of everything that's discussed.

Q. Lorraine Burnett's evidence to the Inquiry was at this meeting no one wanted the police to be called

and her recollection was that everyone was open to a number of explanations and getting more information to inform the next steps?

A. No, I wouldn't agree with that. I wouldn't agree with that at all really. The -- my response to the original question about Stephen Cross' comment and how the unit would be treated was so be it, really. You know, if that's what's needed and that makes things safe, that's fine.

It was clearly having a major factor in terms of the way the Executives were seeing things and --

Q. We --

A. I can also remember in the, in the meeting trying to reassure Tony Chambers regarding the unit itself and the quality of the care that we -- we were able to give and my confidence in -- in the unit and the quality of the staff and, you know, definitely comparable to other -- other units in the region because obviously --

Q. Was that because shutting the unit was an option at that meeting?

A. No. It was trying to reassure him because clearly by them thinking that coming to the conclusion that the police -- it wasn't appropriate to go to the police they, the alternative suggestion was that there

is some other alternative cause for these deaths and one of those being practices on the unit, staffing, all those sort of things and acuity and I can even -- I can remember at that time even suggesting, you know, this is -- this is not an issue and -- on our unit.

Q. Did you think you need the permission of the Executives to go to the police, would you have thought: I will go and just contact someone via CDOP or a police officer via the local authority's safeguarding process? I don't know if you ever had experience of contacting the police in the context perhaps of a suspicion of a family member. Have you ever had to deal directly with the police in your work as a paediatrician over the years?

A. It wasn't something that we considered was the right thing to do at the time. I thought the right thing at the time was to engage with the Executives and persuade them this was the right thing to do and to do this together because it is a big step to make.

No is the answer to your other question about contacting police directly. I have got experience of child protection cases where -- where children have been harmed intentionally.

Q. Have you had to call the police then because paediatricians sometimes have to, don't they, from

hospitals?

A. The scenarios that happens in either the child or the baby comes to A&E collapsed and usually the police are already there with the family and the child and the ambulance and they all arrive together almost.

So most instances like that, there's no contact with the police needed. If you admit a child on to the ward who, for example, has been bruised and you are investigating for possible non-accidental injury, then your first port of call is emergency social care worker. So no is your answer, I had never contacted the police directly before and would have been uncomfortable doing it or knowing who to contact and at this time, I felt that she had been removed from the neonatal unit, we were in a position of safety and there was some breathing space to get a collective view on this and agreement on it.

Obviously in retrospect, knowing now how the Trust responded and the Executives responded I think actually picking up the phone would have been a much easier and quicker way to get things done.

Q. There was then a meeting on 30 June, if we can go to INQ0003362, page 1. And you tell us at paragraph 271:

"[Your] recollection of the meeting was that

Executives were looking for reasons to either not go to the police or to defer this decision. Tony Chambers opened the meeting and explained the Trust had commissioned an external review and that the NNU would be regraded in the meantime."

You also tell us at paragraph 271 that -- you say:

"I can remember us raising our concerns regarding the possibility of Letby harming the babies in the meeting. Tony Chambers answered by saying 'that would be convenient'."

What did you think that meant if that was said? Can you remember it being said?

A. I can remember it vividly, yes. It really struck me and it -- it struck me that he had formed his opinions already. Whether they were his own or whether they were put to him by people around him, I don't know.

But the impression that we were getting already three or four days into this escalation was that Mr Chambers and his colleagues felt that our actions in highlighting the commonality of Letby and asking to be removed from the unit was a convenient, in his words, way of maybe hiding our own failings. I don't know, you would have to ask him.

Q. Page 6 of this meeting, there is a point Karen and Steve Brearey:

"Apologies of aggressive defensive, Karen.
"Steve Brearey: apologies if defensive."
Can you remember what that was about? Was that to do with the email you had sent about just to be clear or what was that about?
A. Well, most of the meetings Karen Rees was -- was attending she would normally raise her voice from across the table telling me that there was no evidence repeatedly and it didn't strike me that she understood that the evidence was in the Thematic Review and I think that was enough evidence to escalate things to another level and that, you know, you didn't have to witness somebody pulling a tube out or, you know, injecting something to have enough evidence to go to the police.
I thought we had enough concern evidence at that stage to do it and clearly Karen with her limited understanding of neonatology felt otherwise.
Q. Can we go now, please, to INQ0103147. That's a press release and you comment in your statement I think you were only involved in one early press release. The usual process is somebody asks people, don't they, for somebody who knows the content, the doctors in this case or the Execs and they pull it together and a media team put something out, is that how it worked? Early on there was a discussion we know

around what should be put together for this press release around downgrading.
You tell us you were concerned about any implication that the increased mortality rate was related to the most poorly babies and those under 32 weeks gestation because this was not the case?
A. That's correct. This was the only communication I had with the Trust comms, Gill Golt was the communications -- one of the communications team at the time who I was helping when she was trying to draft this, all further communications none of the paediatric team had any input in.
But even with this input, I felt that the third paragraph talking about the poorly babies was -- was misleading because it seemed to suggest that the unit was struggling with the smaller babies that were the focus of the rise in mortality and that clearly wasn't the case and I think over half the babies who, who died in that 13 months were of a gestation or age where we would have been looking after them in our changed designation from looking after 32 weeks and above.
So I -- I felt that was misleading.
Q. So the combination poorly and/or the gestation?
A. Yes.

Q. That can come down, please, and can we have INQ0003365, page 9. You are unable to attend a meeting on 13 July where Dr Saladi, Dr Jayaram, Dr Gibbs, Dr ZA and the Execs meet and it looks like Ian Harvey has a catch-up with you afterwards.
"Update following meeting: Steve Brearey still concerned but is mindful to follow his colleagues in the decision not to report to the police. Trust are taking the matter seriously. Nurse to be supervised."
Effectively there's discussion around the RCPCH as well subsequently, isn't there, about them being instructed instead of going to the police?
A. Mm-hm.
Q. Can you remember this conversation with Mr Harvey?
A. No, no. I mean, the reason why I didn't attend the meeting was I was in clinic that afternoon, so my colleagues attended. So by the timing of things in that document, it would suggest that he must have come to me in clinic to talk to me and I don't have any memory of that conversation and I can remember going to the meeting, the board meeting the following day and --
Q. We are going to go to that.
A. -- the information that was put to me being new.

So if -- if there was a conversation there's really no substance to it, but I really can't remember it and would have been busy in clinic all afternoon anyway, certainly at that time.
Q. The board minutes or the meeting on 14 July we have at INQ0004216, page 1. I think you say you hadn't seen these minutes and you doubt their accuracy in part I think at some point --
A. I think they were drafted some months after the actual meeting, I think at least six months afterwards, I understand.
Q. How do you know that, what's your understanding for that?
A. From -- I think it might have been even later than that. I'm not sure whether we even received them prior to Susan Gilby starting in the Trust which is 2018, certainly not in that year, we didn't receive them that year at all.
Q. There was a handwritten note we know of Stephen Cross, it is just a page and there is these typed notes but either way this isn't something that was circulated and that you saw at the time.
We know -- perhaps we should go to the PowerPoint instead, INQ0002837, page 1. We know that Mr Harvey presented a PowerPoint presentation and you say in your

statement:

"My impression of the presentation was that it was of poor quality and didn't show any data that might explain the rise in mortality we had seen."

We see page 1 -- page 2, sorry, there we are.

What comment do you have on this slide, if anything? And also on the one on acuity on page 5?

A. I -- from memory I don't think this set of PowerPoint slides are the ones that Ian Harvey presented.

Q. You don't think that?

A. I don't think they are the same ones that were presented at the board meeting to us that -- that afternoon.

Q. Why's that? Why do you think that?

A. Well, I don't -- firstly I don't recognise some of the slides. I do remember one slide he presented with three dots on them showing a trend that he said was a trend in increasing acuity that clearly isn't in this PowerPoint presentation.

Q. Right.

A. And I also remember him putting up a spreadsheet of late pregnancy losses/early stillbirths which he had factored into his -- his internal review as well and this wasn't a summary slide with information

like this; that was a slide he had -- it was almost like he had screenshotted an Excel spreadsheet with the mother's names and baby and mother's details on that PowerPoint slide which obviously included patient identifiable information, one of which included a colleague.

Q. Could it have included these plus those or do you think they didn't look like these at all?

A. From memory I don't think this is the PowerPoint presentation that we looked at. There was some similarity in terms of his arguments and his presentation in terms of the acuity and activity. The first slide you showed that there was certainly the -- the argument he was putting forward to the board that day but I am pretty confident these aren't the slides that he presented that day.

Q. We know subsequent to that meeting, Dr Jayaram -- we don't need to take you to the email -- suggests to Mr Harvey and Ms Kelly that the network has a very large pool of data it collects on a daily basis and suggests they have a role here and you are asked, aren't you, to provide various documents?

If we look at INQ0103148, page 1. This is you sending to Ruth Millward embedded documents for each baby's review and I think you tell us you were being

asked now to give information because Mr Harvey was collecting or doing his own analysis, is that the position?

A. Yes, so the decision in the meeting in the week following the Triplets' deaths was that Letby would go on leave for two weeks, that was planned leave already, and in that two-week period, then Ian Harvey would do a forensic drill-down, I think the decision was, was made to do -- to investigate all factors and then report back to the board before she was due back off her holiday so they could make a decision on whether she was going back to work or not and what other actions were needed.

So Ian Harvey set about that. There was a Silver Command created with data analysts and risk facilitators and various people pulling that data for him to analyse. And it's really striking that he was doing that on his own in terms of medical expertise. There was -- he had asked John Gibbs to provide some information regarding babies that had been transferred out of the hospital that he did with Anne Martyn, one of the sisters on the children's ward, but I was completely excluded from any of those investigations as far as Ian Harvey was concerned.

However, the information that he was requesting

went to people in the Trust who then asked me for the information because, you know, I was the neonatal lead and I had most of it at hand on my computer, and it just felt ridiculous actually and I had expressed to him concerns that he trained as an orthopaedic surgeon and he was taking on a review of these -- this very complex case with hardly any neonatal experience.

And it was fine if you wanted to exclude me, clearly at that point, even at that point we sort of understood that, you know, they were treating us as potentially part of the problem, so I -- that is when I indicated to Mr Harvey that he should seek the help of the Neonatal Network, Nim Subhedar I mentioned. But, you know, it wouldn't be appropriate for him to do this internal review looking at all these things without some neonatal expertise and the -- just the PowerPoint slide you showed before in terms of acuity and activity levels in which he was trying to argue to the board that those were a factor, negated two really important things that would have been picked up by a neonatal specialist: firstly he was just noting changes within the hospital without any reference to other hospitals and other neonatal units.

Q. I am going to come to that later when we look at the audit for your hospital.

A. Yes, yes.
Q. But yes, didn't pick up relevant data?
A. The other factor was that acuity goes up when babies start collapsing and dying. You know, a baby who's in special care cot area who suddenly collapses and needs intubation and ventilation immediately becomes an ITU baby who needs one-to-one nursing, so that instantly increases a unit's acuity for that shift and also reduces the likelihood of -- of the nursing staff on that shift being able to meet the -- the staffing standards set by BAPM, both of which he was saying was a cause for the deaths rather than actually them causing the lack of compliance. And he just didn't have that insight or perspective that you would have if you had been in neonates for a year or two.
Q. Understood. You then -- INQ0006769, page 1, I don't want to spend much time on these, Dr Brearey, but you send an email to Ruth Millward, we see there at the bottom of the page, moving on to the next page.
A. So this is as I have already described in a way that Ruth Millward, the Head of Risk, or actually she was -- she was asking for information regarding baby deaths over a time period going back from 2010. So I was having to give that to -- to her for this internal review that Ian Harvey was -- was doing without any

expertise from the network.
And it was a point of frustration from me because of the reasons I have given in the email really; that, you know, I was still very concerned about the -- all the babies' deaths, particularly after Baby O and P, but I was expressing my concern regarding the support the Risk Department had given me over the preceding certainly six months.
Q. If we go back to page 1, please, we see Mr Harvey's email to you cc'ing the others:
"I am also not in the habit of sending angry emails. I will in recognition of the strain that everyone is under at the moment resist the temptation now. I will, however, say that I am disappointed at the tone and some of the phrases of your email to Ruth which is, as I read it, simply a request for copies of existing reviews, not a request to undertake fresh reviews. If you are going to get angry at anyone then aim it at me. I have requested the Invited Review and ... responsible for needing this data."
You were required in September, I think, to mediate or it was suggested you should mediate as a consequence of this email?
A. Yes, yes. So the -- I think the phrase when -- I use in the second paragraph of my email saying

that is I was completely "underwhelmed by the support your department has provided this year" was the pretext to the mediation process.
Considering the stress we were under and the level of support I had received from the Risk Department that year, I thought it was quite restrained, to be honest. Yes.
Q. And --
A. And it was also interesting to know why firstly Ian Harvey didn't act on any of my concerns about the Risk Department that I had mentioned in that email, which I thought was more important than the -- than the -- whether it --
Q. Just dealing with that, we see that the successor David Semple, INQ01031341, it is an email?
A. So Mr Semple was a Consultant obstetrician who took over a role at quite a high level in risk after Ruth Millward left and his summary is there, really, of the issues that himself and Julie Fogarty, the ex head lead midwife but then Associate Director of Risk and Safety found, including previous poor leadership, members of the Risk Team on short-term secondments, a lack of communication, no feedback on Datix reports, no feedback on incidents, no feedback on Never Events, no training for clinicians to lead investigations --

Q. We can see it, Dr Brearey, we see it.
A. Yes, it is all there.
Q. My question was going to be this: how widely is that circulated, I am seeing all Consultants as groups but how widely has this been circulated by Mr Semple?
A. He sent it to every Consultant in the Trust.
Q. Every Consultant?
A. Yes. He wasn't put into mediation with anybody.
Q. All right. Thank you, that can come down and I want to move to a different topic, the RCPCH report.
We know from paragraph 331 of your statement that Ian Harvey's secretary sent an email to you on 23 November requesting a meeting with you and Ms Hodkinson.
When you arrived, Ms Hodkinson was recording everything that was said. Do you mean recorded as in tape recorded, or just writing?
A. Hand -- handwritten notes, yes.
Q. Making a note.
Yes. You had I think before then been one of the Consultants, it was you, Dr Jayaram and it was also Anne Murphy who had had sight of a redacted copy of the RCPCH report; is that right?

A. That's correct, yes.

Q. You turned up, read it, realised it was redacted. How did you realise it was redacted, briefly?

A. There was black ink over the lines that we couldn't read, yes.

Q. You came to a meeting -- while you are telling us about the meeting, perhaps we can have on the screen INQ0003094, page 1. It looks as though you -- well, tell us what they wanted to discuss with you?

A. So we had had the meeting, we were only allowed an hour to read the draft report or the College report and obviously it was redacted. We made comments about some changes and factual inaccuracies there. I asked Ian Harvey towards the end of the meeting what his thoughts were about sharing what we had read with others, he didn't really give any straight answer actually and wasn't categorical anyway.

Staff were really keen to hear what the results of the report were because this was December by now. The review had happened in September.

People wanted to get back to the previous designation of the unit and find out the results and we were also waiting for the Hawdon report as well.

So I was on leave and contacted and asked by the secretary for a meeting, we were waiting for the Hawdon

report then he hadn't seen a draft report or any report of and I thought it may be related to that or something more significant in terms of deciding about the police.

So I cancelled things and anyway turned up at the meeting and was a little bit surprised to find Sue Hodkinson there with Ian Harvey in which he said that I had -- I had talked to members of staff on the unit about the draft report and when I shouldn't have done against his instructions and, you know, I wasn't to do this.

I explained to him that he hadn't given me an answer when I had asked him when I had read the draft and he was very clear that, you know, if this was to happen again, there would be consequences and he would be following this up with a letter. Sue Hodkinson left the meeting after she had finished recording all of this but we were both still in his office for a short time as I was walking towards the door and it was then that he -- he was saying that I ought to be very, very careful, that his office was a funnel, a receptacle of information from lots of different areas including the neonatal unit and yes, that I should be very careful.

I think in the -- in the context of that meeting it should be accepted that we had, we had just come out of the grievance procedure as well which had felt very

adversarial and felt that we were being accused of mistreating a nurse and very one-way conversations with Chris Green in the grievance procedure and obvious with the -- with the mediation with Ruth Millward on what seemed to be fairly minimal grounds.

It felt very hot to me that, you know, I -- personally I was being pressurised, really, with all of this information and probably being portrayed as somebody who was being unreasonable and irrational and unprofessional and that it felt like this was part of that process.

Q. What did you make of "we expect a factual response as above", the last paragraph? Did you think that was controlling?

A. Yes.

Q. Did you understand why there needs to be controlling?

A. Well, he had talked about that everything, it was an intensely frustrating period of time because of the lack of communication we were having from him about the College review, about anything, really, and, you know, his term of trimming the grapevine really was just making everything as confidential as possible and not letting out any information.

And I accept that, you know, there's degrees of

confidentiality. We weren't sharing information about our concerns about Letby but, at the same time, it -- the -- it was combined with the lack of urgency as well, you know, that why you know in December had we not seen both reports, you know, when the College report had been in September it just felt -- I mean, I think I mentioned in my statement obfuscation and delay and secrecy seemed to be the theme of those months.

Q. If we could please have on the screen INQ0103159, page 1, it is an email you write some time later in 2018 but closer to the events than now. So INQ0103159, page 1.

You are summarising or commenting with your colleagues on the RCPCH report and the Hawdon report. We see at the bottom the letter:

"Fundamentally, the Execs treated the service review as a review of mortality and treated the Hawdon report as a robust review which it wasn't at her own admission then used the grievance procedure as evidence suggested or triangulated in IH's words. This was all very incompetent and misleading."

Is that broadly your view of the reports that were commissioned and the --

A. And that's what we kept putting to Executives particularly in 2017, after they told us of their plans,

yes.
Q. That can come down and can I ask you about another document, please. INQ0103210, page 1. This is going to be a Countess of Chester neonatal unit annual report, January to December 2016. It's an annual audit report and if we go, please, to page 4. Who's responsible for compiling the data for this?
A. The -- the information historically used to be a nurse collecting data on the neonatal unit but actually for most of these years of the indictments it came from something called BadgerNet which is a computer -- national computer system which all neonatal units enter data for across the country and is amalgamated so that we can interrogate the data on a Trust basis.
Q. So we see at paragraph 2 the outcome and activity data showing your admissions. Decreased from 2014, it looks like, in 2015, slightly up in 2016.
If we can work through it, please, and get to page 15 of the document. Annual admissions by gestation 2012 to 2016.
Were you ever asked in any meeting to get this data together or did anyone ever actually get this BadgerNet data together?
A. This is freely available to anybody with access to BadgerNet within the Trust.

Q. Right.
A. But I'm not sure whether Ian Harvey was even aware of it when he was doing his internal review. The reason why we did that annual report, it was one of the suggested recommendations from the RCPCH College review that we should be doing an annual report. So this was the first one that I wrote.
But all data, as I say is -- is pulled from BadgerNet.
Q. When did you pull that together in the period --
A. That would have been late in 2016 -- sorry, 2017 for the year before.
Q. The report received by the clinical audit group of yours in 2015, if we can have a look at that briefly, INQ0103194, page 1.
This is timeframe 1 January to 31 December and overleaf a shorter report than the other one. Go to page 2. Thank you. So a different format. Were you developing the formats of these audit reports?
A. No. Normally the -- the statistics and the data by the time it becomes available it's about a nine-month lag from the previous year. So for 2015 data it would have been available towards the end of 2016 and there is a National Neonatal Audit Programme

that measures audit standard you can see on the left-hand side, quality measures for neonatal care and we would be report -- the Trust would have a report of it -- its performance regarding those standards through the NNAP programme and I would be expected to produce a report for sign-off with the Executives to inform them of the results of the report effectively.
So the first -- this one was -- was the format of me reporting the NNAP results, but in the 2016 annual report that was done on the recommendation of the College reviewers and it incorporated all the information I would normally put in this anyway, so the annual report replaces this but also adds the recommendations of the College review.
Q. That can go down, please, and if we can now have INQ0003357, page 51?
A. It's worth adding that our National Neonatal Audit Programme results for the years 15, 16 before and after were all very positive, all above usually above the -- the mean for the local neonatal units both regionally and nationally and there were never really any significant outliers in terms of our results NNAP although it didn't include mortality.
Q. We have here Dr Hawdon's recommendation. Just number 5, you point out as does Dr Subhedar in an email

I am going to go to next, that there was no case that Dr Hawdon was reviewing of undiagnosed pneumothorax or duct dependent congenital heart disease and that that recommendation seemed irrelevant to the deaths reviewed?
A. That's correct.
Q. You had tried to assist, hadn't you, that can come down, in an email if we look at INQ0103171, page 1, you had tried to assist the process of Dr Hawdon actually getting meaningful records or notes to conduct a Casenote Review, I think we can all agree how limited casenote reviews are anyway by their nature --
A. Yes.
Q. -- compared with speaking to people but you had flagged up the need to have the reviewer having access to BadgerNet, some of the X-rays' importance and "let me know if I can be of any help". You sent that to Mr Harvey?
A. Yes, it is worth noting as well in this last but one sentence I am talking about reviewers will need access to BadgerNet. I was assuming that there would be more than one reviewer as recommended by the College. It seemed to me that it was going to be more than just one person doing Casenote Review.
Q. Can we look, please, at INQ0103192, page 1 and this is a letter to Mr Harvey from Dr Subhedar where he

says the same as you on a number of things about the RCPCH report.

"The unit in Chester is by no means and outlier either of terms of processes around Mortality Reviews or Consultant presence and supervision on the neonatal unit. The COCH team's commitment to the Network Steering Group and Clinical Effectiveness Group is exemplary ... demonstrates a commitment to improving safety and quality of neonatal care."

So you had been having at least one external -- not external to the region but external to the hospital, commenting and seeing the Hawdon report as well and feedback -- providing feedback to Mr Harvey?

A. Yes.

Q. Can we turn now please to the grievance, just briefly. You were sent a letter, INQ0004349, page 1, in October 2016. What did you think when you got that?

A. So this is preceding the grievance procedure?

Q. Yes.

A. That took place where Chris Green, Head of Pharmacy, had been instructed to undertake.

Q. We know the background. Don't worry, we know this very well.

A. So essentially --

Q. What did you think when you got it? What did

you think you needed to turn up for?

A. It wasn't clear what the grievance procedure was for and the paragraph at the end is talking about bringing a representative -- sorry, it is the second paragraph, isn't it, bring a representative. Worried -- worried us both, actually, myself and Dr Jayaram, I didn't get a chance to talk to Dr McCormack about it because, as I say, the -- the impression that we had since July was this seemed to be turning into a narrative against us rather than concentrating on the cause of the deaths and it did worry me, yes.

Q. Of course. You were worrying about your position, your job?

A. Well, yes, yes. I mean, I wanted to focus on the -- on the babies and the cause of death but there was an escalating amount of pressure I felt along with Dr Jayaram that yes, it was -- it felt intimidating.

Q. Yes. INQ0005341, page 3. Dr Green emailed you both saying it is for him as investigating officer to establish the facts leading up to the removal of Lucy Letby from the neonatal unit and subsequently to that in terms of her continued redeployment in the Risk Team he says he understands you need to -- you wish to be accompanied by your Union representative. You both go and consult with Union representatives and you attend

with yours. Jenny Bremner, I think --

A. That's correct.

Q. -- is your Union representative?

We understand that in your conversations with her, you had discussed going to the police but that you were concerned about adverse consequences and felt the Executives needed to be doing it; is that the case?

A. I can't remember specifically talking to her about the police actually and I know her record was from memory, wasn't it, recently. And we talked about a lot of things in terms of everything around this grievance and the worries we had. I can't specifically remember a discussion about the police one way or another, to be honest, but yes, she was certainly aware of all of our concerns, yes.

Q. She was aware of all your concerns and did she suggest contacting a local Member of Parliament or suggesting the parents do that, was there any way of her -- any suggestion she made of pushing through your concerns to get them reported externally, however that might have been?

A. She -- I think I remember her discussing going through the parents to contact the MPs, but as I say I can't remember making a suggestion regarding the police.

Q. What did you think the parents had been told at this point?

A. Well, nothing in terms of -- of this and -- and everything that had gone on since July, really.

Q. And was that troubling you as well?

A. It was. It was. I can remember having a conversation with some parents of a baby who died who wasn't in the indictment and it was -- it was because in my position as neonatal lead because the baby's Consultant, Dr Newby, had already left the Trust to go and work at another Trust so I took on the role of talking to them at their request about the care their baby's received, and feeling quite awkward about it, to be honest.

And the -- the concerns they had I could easily answer in terms of specifics. It's almost they could tell that something wasn't quite right but they didn't quite have, you know, their senses were up but they didn't know the specifics or the worries that we had

So I could reassure them about the care their baby received and their concerns and reassure them about that but it didn't sit with me at all well and I felt very uncomfortable doing it but I didn't feel in a position to let them know that I -- I was worried about a nurse murdering their baby as well as others, I didn't

think -- because then it would be in the public domain.
So I spoke to Ian Harvey after that discussion and told him of my discomfort, if you like, at the discussion I had just had and how I didn't really feel it was appropriate to be doing this and he said basically: don't worry, I will take over the care of or take over the role of speaking to the Families.
Q. When was that, roughly?
A. I think -- I think it was some time in 2017, I can't remember for sure, but, yes.
Q. If we can go to the grievance interview please, INQ0103176, page 3. We see the interaction here with Chris Green's question at the end:
"Was there any suggestion of foul play in any way relating to the babies' deaths?
"Suggestion from whom?" Says your Union rep.
"From the Consultants."
The Union rep:
"Can't speak for other Consultants, only for yourself.
"No, I wasn't directly involved with the Triplets' deaths.
"Just answer the question, only answer the question.
"What was the question? Can you repeat the

question?
"It's been suggested [Chris Green says] it's been said that there was a suggestion of air embolism and twisting of tubes that led to babies' deaths? Was that on the table as the cause of death?"
Overleaf you say:
"I have never come across a case of air embolism before."
Were you aware that Eirian Powell had forwarded the email that had gone through the Consultant group about the links to air embolus; in other words, the Consultants had Eirian Powell as a ward manager on your own email groups for some time?
A. Yes.
Q. That had been sent to Dr Green. Had you any idea he had got that email?
A. I didn't, no, no.
Q. When you look back and there was conversations happening between you about where's this information coming from or how do they know this, as things got more factioned between the doctors and the Execs, looking back now does it surprise you that something you are circulating in that way ends up being used by Dr Green in a grievance?
A. Not really by the way that everything else was

happening around us at the time and I talked about the incident discussing something with a -- with a nurse. The only thing that I actually discussed with that nurse when I was called into the office with Ian Harvey and Sue Hodkinson was I mentioned the College's agreement that we needed two new Consultants before going back to a Level 2 unit, I think that was the only definite comment that I had made which I didn't think was very contentious or in depth at the time.
But -- and the warning I had been given by Ian Harvey after that, clearly there seemed to be a source of information coming out of the unit that would feed into Execs' ears and help sort of carve a narrative that we were being unreasonable and often taken out of context. It felt sometimes as if I was working in North Korea or, you know, the old DDR or something. You know, it was, it was that level of -- we should probably not have this open conversation with a nursing colleagues as we normally would really in that situation which is really sad and took a lot of working on afterwards to get trust back on both sides.
Q. So how would you describe at that time the culture on the neonatal unit in terms of relationships between the doctors, doctors and nurses, doctors and Execs, you know, just across different groups generally?

A. Well, I thought we managed it as a -- as a team quite professionally in terms of patient-facing contact and I think a lot of junior doctors at the time had no idea all of this was going on and said so afterwards.
Some of them are Consultant colleagues now. So from a junior nursing/junior doctor point of view, I thought we managed it reasonably well in that respect. But I think a lot of the nursing staff had been given a narrative as well by Executives during this period, and that seemed to be sticking the blame on us for things without knowledge of what concerns we had which was quite hard to -- to manage on a day-to-day basis for us.
I thought the teams as a whole, you know, were professional enough to cope with that and just concentrate on either the best care we could deliver to the babies or concentrate on the concerns we had outside the unit when it was confidential.
Q. There was a meeting between the Executives and paediatric Consultants on 26 January, INQ0003523, page 1. This is 26 January 2017. Dr Tighe we know is in attendance and Mr Harvey had told you to ensure fair play. What did you make of that?
A. I-I didn't know what to make of it, really.

We had been told we are going to be given an opportunity to read the College report and the Hawdon report. I -- I had a clue as to it being slightly more different to that when I had a discussion with Mr Semple that we mentioned before in the delivery suite, when he's in his new risk role, I think he had a one-to-one meeting with Tony Chambers and Mr Semple warned me that -- to be very careful at the meeting on 26 January. He said that if you are going to do anything, do it together, because he mentioned the word "decapitation" in terms of the consequences of anybody speaking on their own out of turn in that meeting. So that was my expectation going into the meeting, I shared that information with colleagues and we all agreed before the meeting that if there was anything significant to say we should probably hold off for the time being, unless we absolutely had to.

Q. If we look at page 2 of the meeting, in terms of the RCPCH Mr Harvey said it was:

"... not about raising concerns, that's fine, but the review by a high-powered team does not call out a criminal act. It does raise other issues. There is a need to draw a line under the Lucy issue".

First of all, had you seen the unredacted version at that point about the section on the nurse and

Lucy Letby?

A. No.

Q. Secondly, you say in your statement the tone of the meeting was aggressive, intimidating and direct.

We know a statement was read out at that meeting from Letby by Karen Rees; is that right?

A. That's correct, yes.

Q. What did you make of that at the time?

A. It felt -- the whole meeting felt choreographed and -- and Ms Rees was quite dramatic in her reading of it. We were all quite stunned, really. As a sort of synopsis of Executive behaviour, I can't imagine there's an example of anything more incompetent in the history of the NHS. How you can start a meeting saying you followed Speak Out Safely practices and then tell seven Consultants who all have significant concerns like this that they are to apologise to the person and that she would be going back to work or else there will be consequences, was quite -- quite striking and surprising and quite upsetting for -- for most people there.

Q. You said in your statement, if we could have on the screen please INQ0103104, page 64, beginning at 354, if we go down -- to the next page. You say at paragraph 358:

"... concerned at the discrepancy between what I read and the negative way it had been portrayed at the meeting 26 January. No mention by Ian Harvey of the cohesive and enthusiastic group of paediatricians and a nursing complement that well led and supportive ... good engagement with network colleagues, trainees positive about their experience or that morale had remained robust with generally good communication between teams."

A. I think that's true. There was lots of positive in it. But actually the -- the whole nature of the meeting on the 26th was Ian Harvey trying to pick out the negatives to make them triangulate as he said when all he was representing was -- was a grievance procedure that didn't actually look into the cause of the deaths, a College report that was a service review and didn't adequately look at the deaths and a Hawdon report that I thought was overly critical and not what had been recommended by the College and somehow he had managed to create a narrative that ignored so much positives -- so many positives regarding the neonatal unit, our practices, and falsely represent the investigations that had been done to date.

Q. That can come down now, thank you.

We know that you were involved, just as Dr Jayaram

and other Consultants were, in a series of letters in January and February, pressing your concerns with the Consultants and there was discussion around the Coroner, the Coroner was and wasn't told. So I don't need to ask you about any of those letters or communications.

You do receive one letter from Mr Harvey, INQ0103207, page 1. This is at a time when the apology letter has been forwarded to Lucy Letby, I don't need to ask you about that and how the wording was arrived at. But look at the second paragraph:

"Can I counsel you [Mr Harvey says] to make every effort to attend the preliminary meeting with the facilitator. It is an initial meeting just with the facilitator to enable you to address some of the issues that were called out yesterday."

You in fact pulled out of this, Dr Jayaram went and he said he felt he was hung out to dry. Very briefly, why did you not go and why did you think it was inappropriate?

A. Well, I did attend, I attended two sessions which were the two sessions prior to the third session which would have been the meeting with Letby.

Q. So with the pre --

A. Yes, and I did that because I felt under threat of GMC referral. I know it's only implicit in

the email but, you know, I think the tone of everything that had gone on beforehand is very clear as to what he was getting at and the first meeting with the mediator said it was confidential, voluntary and I could pull out at any stage.

I explained to her that I didn't think it was voluntary for reasons I have just explained and after the second meeting, it was put to me what I would like it say to Letby and I told her I didn't have anything to say to her because I didn't think it was appropriate and things still needed further investigation and at that impasse she agreed to put things on hold. And before I got back to my office I had a phone call from Sue Hodkinson saying: I hear you pulled out of the mediation process, which clearly then it wasn't confidential or --

So yes, I engaged as far as I could in terms of avoiding GMC referral and -- and stopped.

Q. There was a meeting on 27 March with the paediatricians and Mr Harvey, Mr Chambers, if we look at INQ0004407, page 1, you tell us:

"This meeting took place on 27th. Attending were Tony Chambers, Ian Harvey, Dr Jayaram, Dr Subhedar, Julie Maddox, Sue Hodkinson and myself. Stephen Cross was on leave and Sue Hodkinson might have been

responsible for taking the minutes."

You say:

"I can't locate emails or discussion prior to the meeting. However the situation for Consultants was becoming more desperate. Colleagues felt their jobs and careers were under threat, the prospect of LL returning to work on NNU seemed imminent and we had done everything reasonable to raise our concerns within the Trust without success."

LADY JUSTICE THIRLWALL: I wonder -- I'm sorry to interrupt, Ms Langdale, I just noticed the time and the shorthand writer has been going a long time. I wonder if we might just take a break. Would 15 minutes be acceptable? Yes, sorry.

MS LANGDALE: Not at all.

LADY JUSTICE THIRLWALL: You can repeat the question when we get back. So 10 to 4, please.

(3.34 pm)

(A short break).

(3.50 pm)

MS LANGDALE: Dr Brearey, we were looking at INQ0004407, page 1, and it was the meeting that took place on 27 March and you say and tell us:

"... colleagues felt their jobs and careers were under threat, the prospect of [Letby] returning to work

on the neonatal unit seemed imminent and we had done everything reasonable to raise our concerns without success."

You said:

"Also I was considering going to work at another hospital and I could then raise concerns from outside the Trust."

Just tell us what that pressure was like and how it was being exerted or why you thought it was being exerted?

A. Well, we -- we had the sort of direct threat from Mr Chambers in January -- 26 January you know "or else there will be consequences, do not cross a line".

We -- we had the sort of imminent threat of GMC referral and there is a prospect of her coming back to work on the neonatal unit, which scared us all really. The more we thought about it, the -- the more concerned we got about some of the cases and some of the morbidity cases that we had overlooked earlier on were coming to the fore in terms of our thinking.

The results of the work that John Gibbs had done eventually came back to us so we are a little bit more aware of the morbidity cases as well as that.

So our sort of concerns were coming to a head, clinically, but the pressure on us to comply from the

point of view of the -- that pressure was becoming greater as well in terms of the mediation and --

Q. The letter of apology?

A. The letter of apologies, the three letters we had had to send, yes, it was -- it was -- it was all there and my colleague, Dr Gibbs, there is a few emails there where he is starting to waiver a little bit when he had been approached by Ian Harvey on his own at the end of a very long day where he thought maybe we have got as far as we could go. So you could feel the cracks in the team and the cohesion of the seven of us, you know, one of my colleagues who was *(redacted)* at the time was *(redacted)* at the prospect of Letby coming back and I just felt that we were reaching the end of the line in terms of what else we could do.

And --

Q. Was it ever suggested to you that somebody might go to the GMC about you, did you -- was that suggested to you or not?

A. Yes, I -- I picked up on -- it's hard to get an aspect of what it was like at the time because obviously subsequent to all of this, you know, I learned about the sort of suggestion that, you know, we were going to be subject to some disciplinary sort of procedure for all of this from the -- the senior

managers and Executives who were -- were following that narrative.

But I can't remember anything directly specifically at that time, although it was very clear, what -- what was being inferred and what the likely consequences were and it wasn't that I wanted to stop raising my concerns, it just wasn't a safe environment to be working in and, you know, through all of this we are having to look after children and babies on a daily basis.

Q. What does your working week look like? How many hours are you working a week at this point?

A. I am contracted for 40 hours a week of which 75% of that will be clinical work -- probably over 40 hours of a week will be clinical work and -- and -- the extras are extra, if you like.

So and that's -- you know, I don't mind that, you know, it is a good job.

Q. You have done all this stuff, these admins, these emails, these meetings, these responses, just getting a sense, how many hours were you working outside the clinical hours at this time?

A. My colleague Dr Gibbs always had the reputation for leaving the office last and, you know, he was sending emails at half past midnight on one occasion and it wouldn't be uncommon for him to be leaving at

say, 11 o'clock, 10 o'clock in the evening most days, and a lot of the time it would be just me and him in the office talking from across the corridor really with the doors open, when the cleaners are coming round and that sort of thing. Yes.

Q. Taking yourself back to that level of worry. How worried were you about all of it, not just your own job but the babies and Letby coming back and what was that like, in that time?

A. It was extremely worrying because, you know, I sorted of committed to working in Chester and it's -- it is -- there is some wonderful people that work there and wonderful clinical staff. And, you know, I still enjoy working there and doing my job, but the -- it was a fairly intolerable pressure that we were under and it -- there's always a risk of overspill into your own clinical practice if you are under that pressure in the non-clinical work that, you know, that's going to spread to the clinical work really and that is quite a stress for medical professionals to -- raising concerns to have to sort of counter, you know that you -- if you did make a mistake it is likely you are not going to be supported in a fair way given everything else that's going on.

So yes, I did worry about that and hence the job application to another hospital.

Q. We know that there was then a suggestion that you as Consultants meet with a barrister, then Simon Medland QC, if we can have the minutes on the screen, his minutes INQ0005857. If we go to page 1 and then sit at page 2. First of all, what did you think the purpose of the meeting was, what did you think you were all being invited to meet with him for?

A. Well, going back to your previous slide, that meeting was a meeting where we directly told or asked the Chief Executive Tony Chambers to go to the police. I don't think that was the intention of the meeting. The meeting was talking about the reviews and what further forensic work was needed.

It was a meeting that we asked for Nim Subhedar and Julie McCabe, the Director of the North West Neonatal ODN, to be at and before discussions at a meeting the sort of point of desperation had been reached and I had agreed that I would just go to the meeting and say: you have just got to go to the police.

So that was the previous meeting that you just had a slide up for which I think was some time in late March -- was it 27th, I think?

Q. Yes.

A. And after a fairly heated meeting -- interestingly Stephen Cross wasn't at that meeting and

it felt like we had ambushed Tony Chambers and Ian Harvey a little bit, but they agreed to go to the police in that meeting. But then -- and Tony Chambers said "Clear your diary for the week, this is what we will be doing", you know, his comment was, and we thought we had finally made some progress.

And then I got an email a week later from Nim Subhedar saying: what's going on, have you heard anything? Because we hadn't heard anything and we only heard an email from Tony Chambers saying: your absolute discretion and confidentiality is needed. So we weren't updated at all in that time and the first we knew of anything then was Ian Harvey approaching us over a week later saying that they still intended to go to the police but this is an unusual step and we have asked a very experienced barrister to advise us on the best way of doing it and he would like to meet you and I was obviously keen to get this rolling.

So we offered early dates for a meeting with myself and Dr Jayaram and he says no, it has to be all of you, all seven Consultants, because you all raised concerns and wrote to us. So we had to wait even further, you know, for a meeting where all seven of us were available with Mr Medland. So that was our understanding going into the meeting; that -- I did have some suspicions

that I had been misled a little bit because Mr Harvey had verbally told us about the reason for this meeting individually, together -- individually at separate times and when he suggested it had to be the seven of us I did try and clarify in an email saying can you, can you confirm this is because email and he wasn't specific in his response to that either.

Q. This is an hour and a half, this meeting, wasn't it, we see from the minutes?

A. With Mr Medland?

Q. Mr Medland, yes.

A. Yes, he started saying so, you know, "the purpose of this meeting, I have been asked is to clarify whether there's enough evidence to go to the police". And we had to point out to him at the beginning of the meeting that was not the reason we had been given for why we were having this meeting and he -- he said "that's not a very good start, is it?" And then we cracked on with the rest of it really, yes.

Q. It looks as though paragraph 5 of these minutes:

"We all agreed that if there was an identifiable common thread between some of the deaths [cf the Beverley Allitt] this would be powerful prima facie evidence that there was potentially a crime or series of

crimes which had been committed."

Who mentioned Beverley Allitt or spoke about that case, can you remember now?

A. Sorry, I didn't hear.

Q. Who spoke about Beverley Allitt's case, the significance of that?

A. I think he -- he might have mentioned it. But I can't remember off the top of my head.

Q. He then says:

"In [his] view the police being strapped for resources in any event can only sensibly investigate cases where there is at the very least reasonable grounds for suspecting that a criminal offence has been committed ... different from there being mere suspicion."

Then did he say:

"Reporting the matter to the police was a condign step which was effectively a public action and would incur adverse publicity and raise matters for the families, which might be seriously disturbing"?

A. Yes. He was very clear about the negative consequences of the police investigation and the high, high bar needed to initiate one and the fact that it would upset families. He even put it to us -- I'm not sure it's mentioned in these minutes -- that if we had

similar concerns about a medical colleague, we wouldn't have, be doing this or making these concerns which I thought was quite offensive.

Q. The next paragraph, 7, he records:

"There was a commonality of concern amongst the Consultants; they all felt although these matters expressed in different ways, that this matter had not in some significant respects been dealt with happily by the hospital. They felt that they had sometimes been excluded from a frank and inclusive discussion of the deaths and had been told different things by different people. They all felt there had been an unacceptable delay of nine months when little seemed to have happened."

Then the barrister emphasises:

"It was the first order of importance [at paragraph 9] that the hospital and the Consultants work together on this issue and that positions did not become entrenched or opposed."

He advised at paragraph 12, he made the point:

"As things stand [he] did not see there was such material as might give rise to reasonable grounds for suspecting that a criminal offence had been committed. He expressed the view that it was important to remember that such a step may well have far-reaching

ramifications and should not be taken lightly."

At paragraph 13:

"... posited a situation where a member of staff who might come under very damaging suspicion was not a nurse but was a Consultant, no doubt that Consultant would only want the matter to be put into the hands of the police after very serious thought about potential consequences of such a step and where the evidence justified such a step."

What did you make of that observation?

A. I am not quite sure what he's trying to say actually. So again --

Q. Paragraph 13, I am asking you about?

A. Yes, I think he is trying to suggest that we wouldn't make that step unless we were clear about our concerns and that we were aware of the potential consequences of that step.

Q. Would that make any difference whether it was a nurse or a Consultant?

A. None at all, no.

Q. That's what I am asking, the question. How did you receive that piece of advice or comment?

A. I thought it was -- it was fairly judgmental and untrue, really. There was -- and, you know, we would be in the same position if we had a -- had

a concern about a colleague. You know, our concern was about patient care and safety of babies, full stop.

Q. What he does suggest at paragraph 14 is that:

"The Consultants should make short notes setting out their best points those matters which they say most clearly indicate in their minds reasonable grounds for suspecting that a criminal offence has been committed. This would help to crystallise matters and push them forward to a sensible conclusion. It would help everyone to deal with the matter head on in an inclusive collegiate way which included taking the views of the Consultants and including them in the decision-making process."

He also set out at paragraph 15 the possibility of a private discussion with Detective Chief Superintendent Wenham, because he is a senior officer, independent and experienced and he has sat on CDOP.

That document can go down now please.

That's in fact what happened, wasn't it, we see a series of emails pursuant to that meeting between the Consultants, thinking between themselves and going through INQ0103217 onwards, and if we could have on the screen please INQ0011915, page 1.

A. I mean, it struck me that his recommendation to have a -- put our points down on paper of key points

and have a discussion in an inclusive and collegiate way was exactly what had been missing over the last nine months, really. There had been no -- nothing like that at all and, you know, obviously that was the opportunity back in July 2016, when Ian Harvey was tasked to do this deep dive is just sit down and understand the Consultants' concerns. I think that was one of the actions from one of those meetings anyway, and there was nothing inclusive or collegiate about anything that followed really. Yes.

Q. Indeed, that was going to be my question, Dr Brearey: had this been done earlier what in fact Mr Medland advised and the culmination of communication between doctors and generally this document --

A. Yes.

Q. -- going to the police --

A. Yes.

Q. -- of course meant there was a police investigation because matters had been pulled together in this way?

A. Yes, there is nothing materially different in this document to the concerns we were raising nine months earlier. The only difference is the morbidities that we had added which was Dr Gibbs' work that fed into Ian Harvey's work that hadn't been shared with us for,

you know, a good period of time until 2016 --

Q. And the formality of putting it together, you had also, if we go to the end of it, dealt with the acuity and staffing point in this document INQ0103225, page 1.

A. Because obviously Ian Harvey had argued about acuity and activity, so we were keen to include we thought was relevant data that came from BadgerNet and had come from the network which would hopefully reassure the police that mortality, acuity and staffing wasn't an issue contributing to the mortality of all these babies.

So, you know, summarising there that nursing staffing in the unit was above the national average, yes it was below BAPM levels, the percentage of shift staff to BAPM standards -- if you can scroll down to the next slide, this is a basically a synopsis of where we were as a unit -- sorry it is the following one.

Q. Page 3?

A. It is the funnel plot.

So if you -- this would apply to Chester in a number of different areas. I know there is staffing here but this is the percentage of eligible shifts on the Y axis so the orange line there is the national average, so nationally 58% of shifts were staffed to

BAPM standards for all neonatal units. The yellow dots represent larger neonatal intensive care units and the green dots represent local neonatal units like ours and you can see there is a fair spread of staffing there and the pink dot is the Countess of Chester which again is above the national average, not the best, but above the average and certainly not an outlier. And I could show you graphs like this for most other audit measures for the neonatal unit in terms of our compliance with retinopathy screen for bronchopulmonary dysplasia, for most other national audit standards that we -- we were doing okay, other than mortality.

And that was the point of this slide, or these, these graphs and data, to reassure the police that the impression that Ian Harvey and his previous reviews had done were skewed and irrelevant relevant.

Q. And indeed Eirian Powell's assurance, NNU reassurance document that we went to --

A. Exactly, yes.

Q. -- earlier that repeats those comments?

A. Yes.

Q. Finally, Dr Brearey we know that there was at this point a breakdown between the Executives and the Consultants and there was correspondence with Sir Duncan Nichol about that, certainly between he and

Ravi Jayaram. You also attended a meeting I think on Monday, 9 October with a Rachel Hopwood, who had been appointed Children's Champion. Can you say anything about that role for us, the Children's Champion role that was then created, how effective was that?

A. Some Trusts had incorporated Children's Champion -- I can't remember the exact document or body that recommended it but having a Children's Champion at board level to concentrate on the wishes of children and children's services and we hadn't had a Children's Champion up until that point and it was a recommendation from the College review that was then put in place in October or -- later that year.

And Rachel Hopwood had been present at the meeting on 26 January when we were told not to cross the line, although I think she said she couldn't remember that meeting. But the meeting that you are describing where we were introduced to her with Ian Harvey and she described her reason for wanting to do this role, I think, for *(redacted)* who had received paediatric services in the past --

Q. Yes.

A. -- and was very positive about the department.

Q. Was it positive, the role moving forwards, did you find that a useful role to have a Children's

Champion or did it not impact, it is really the --

A. Well, after that meeting with her I didn't see her again and I can't remember ever seeing her on the ward or the neonatal unit and I think it's difficult for a Non-Executive Director to have a meaningful influence on the affairs of the hospital and the paediatric service, I think it needs to be somebody at Executive level who's there every day, or knows the people involved.

Q. INQ0006681, page 1, on 29 March 2018 we see as Consultants you email Sir Duncan expressing that you remain extremely concerned that the relationship with the Executive board has deteriorated significantly and that no meaningful efforts are being made to repair it.

We can see what you say there, Dr Brearey, and we know you send a list of concerns, you get a response from the Execs and you as paediatricians respond to their responses?

A. (Nods)

Q. That all is from this point onwards. But a question here: in terms of Sir Duncan Nichol, how useful did you find his intervention or involvement at this stage when you have written that letter?

A. Well, he seemed to be supporting the Executives through most of the issues up to May 17,

before the police investigation started. I know he had some private issues he was trying to get over at the same time.

But it was only really when Mr Harvey left the Trust and Susan Gilby took over that Sir Duncan seemed to realise maybe what had been going on at Executive level and started -- you got the impression he started to feel that he might have been misled at times and his input at this time, which I think was just before Mr Harvey left, was to try and build bridges and try and repair the damage that had been done.

There was nobody at Executive level that was, was really doing that. There was no communication that we had with the Executives after the police investigation started. It's all very cursory and the impression we were given always was that the police investigation would come to nothing and, you know, it would take a long time to prove a negative, in Mr Harvey's words.

So Sir Duncan I think was trying to build bridges at this time in communicating with us and because I don't think the Executives were prepared to.

Q. Thank you. That can come down.

Finally reflections, Dr Brearey. We see in the Countess of Chester Hospital records a reflective note, I don't need to put it on the screen now. It says "CPD

activity", hone dated 31 October and one 2016, and one slightly earlier, 1 March 2016. Were those personal reflection documents things that you do at the time as part of HR?

A. Yes. So every Consultant has a revalidation and annual appraisal that keys into the revalidation.

So you would meet with an appraiser annually and present a portfolio of your achievements and challenges that year and that would normally be -- you would expect to have a couple of reflections in that appraisal, sometimes about difficult cases. But in both these case I was reflecting on my role as the neonatal lead in the years 2016/2017 I think.

Q. You commented earlier that with the CQC you didn't speak to the inspector in a confidential setting I think you may have had a one-to-one with a Dr Odeka in February 2016; can you remember that?

A. That's correct, yes.

Q. So you did have a meeting but you didn't mention it in that one-to-one?

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

Q. CCTV. In your statement, you make an observation about you do see a use for video cameras to be used during resuscitations. At paragraph 453 you say:

"I know that this is practised in some other hospitals and countries. It would be a useful tool to promote learning for staff for medico-legal use and might also be useful for the very rare occasions of intentional harm. As with all cameras in clinical areas there are data protection laws that need to be adhered to."

So are you thinking sort of almost bodycam footage for the doctors or above the scene or what? We know the police work with bodycams now which they wouldn't have imagined a decade ago but they do?

A. I think my understanding of where they are used in other hospitals would be, obviously with the consent and all the information governance problems overcome, they would be attached to what's call the Resuscitaire, which is the device trolley, if you like, on the side of the delivery suite where the baby would go to full resuscitation. So it is from the top there, so you would just be filming as the baby came on to the Resuscitaire and that resuscitation effort really, although equally it could be used in the intensive care incubators from a sort of bird's eye perspective from the top really, which obviously staff I think would feel a little uncomfortable with at the beginning but I think research shows that people get used to it and it can be

helpful in feeding back information about resuscitation procedures and learning from it, yes.

Q. One other observation you make in your second statement relates to data systems and reliable signals being triggered and you say at paragraph 31 of your second statement:

"Rather than MOS running in parallel to MBRRACE UK, the two systems would be better integrated together earlier and more reliable signals could be triggered if preterm and term babies were analysed together. I think this is vital for a neonatal alerting system.

"Obstetric care metrics such as stillbirths and hypoxic brain damage, should be analysed separately as well as part of the wider measures of perinatal care."?

A. So the MOS system which is in a prototype, if you like, was developed as a result of the East Kent Inquiry which was predominantly obstetric and midwifery care that was the problem, so the markers for that were term babies dying or term babies with brain damage and it didn't include and the MOS that is devised doesn't include any preterm babies or babies over 28 days of age.

So it would exclude most of the babies in the indictment, for example, and wouldn't be particularly helpful for neonatologists, it might be more helpful for

maternity services, for example. And the problem with the MBRRACE data is that it -- although it is a real-time system it doesn't -- it doesn't have any statistical tools to let you interpret the data and it can include babies that are born in Chester, for example, stabilised in Chester, moved to Alder Hey for cardiac surgery, then died following surgery. So that would be still attributed to Chester and likewise it also includes babies who might not be of viable gestation who have signs of life after birth that die who didn't die on the neonatal unit, but died on the delivery suite.

So the data for neonatal doctors for MBRRACE isn't particularly useful at the moment even though they have got the real-time reporting now and MOS, as it's proposed at the moment, wouldn't cover all the babies in this indictment either and sort of going back to what I was saying with SUDiC processes and things like that that what we want is something simpler that is overarching rather than another system to add on to other systems that aren't perfect.

It's easy for me to say, I know it is a complicated process to do that, but ideally to have a combination of MOS and MBRRACE that covers more babies, more gestations and to include some metric of babies who die on

a neonatal unit rather than including others I am sure would be quite helpful, yes.

MS LANGDALE: Thank you, Dr Brearey those are my questions. My Lady, Ms Blackwell, followed by Mr Baker, Mr Skelton and Mr Kennedy at the end if he has anything to ask.

LADY JUSTICE THIRLWALL: Very well. Ms Blackwell.

Questions by MS BLACKWELL

MS BLACKWELL: Good afternoon, Dr Brearey.

A. Hello.

Q. I ask questions on behalf of the former senior managers. As you have acknowledged this morning in answer to questions from Ms Langdale we are here partly at least to work out why it took so long to detect the level and cause of the deaths on your unit and I have some questions about what was or wasn't known by the senior managers at what time.

You told us first of all this morning about a meeting on 2 July of 2015 and that was a meeting you remember lasting about an hour?

A. Mm-hm.

Q. During which you discussed the deaths of Child A, Child C, and Child D and you had prepared a summary of the cases in preparation for that meeting. You told us that during the meeting you discussed the

fact that there had been three deaths in a short space of time which was unusual for your unit and you felt that there may have been deficiencies in the cases that could be improved on, but you were looking for what might link the three deaths.

You also told us that Eirian Powell had done a number of things before the meeting. She had looked at spaces, microbiology links and also the possibility of fluid contamination?

A. (Nods)

Q. Yes. Now, it was put to you by Ms Langdale that those deaths were unexpected and unexplained and that might well be the narrative and the understanding now. But will you take it from me, Dr Brearey, that nowhere in your summary document are the words "unexpected" or "unexplained" and I want to suggest to you that those were not words that were used during the course of the meeting. Would you agree with that?

A. No. But -- I mean, yes, they weren't explicitly said but at the same time the timelines for each events were talked about and it was very clear that the babies collapsed suddenly as described in the narrative of all three cases. So obviously that is the sudden side of things.

We had -- we didn't have an explanation for Child A

and we didn't have an explanation for Child C at that stage, so they were unexplained. Whether those words were explicitly used, I can't say one way or another if there's no record of them. But it was very clear from those cases that of the sudden nature of -- of their deaths and the unexplained nature of two of the deaths, yes.

Q. All right. I would like you to look, please, at a paragraph in your witness statement which again was put to you by Ms Langdale this morning. It is at INQ0103104, paragraph 116, please. I don't have the page, I'm afraid.

LADY JUSTICE THIRLWALL: 17.

MS BLACKWELL: 17. Thank you, my Lady, it is page 17. Thank you.

Here you are recorded as saying:

"Towards the end of the meeting Eirian Powell raised the observation that Lucy Letby had been on the NNU on the three occasions when the babies the three babies had collapsed. My first reaction was to say 'not Lucy, not nice Lucy' as before this meeting I was unaware of which Nurse Eirian Powell had identified. Although the association was significant enough to remain in my mind following the meeting I was not overly concerned at that stage."

Now, your evidence this morning was that sometimes you do get clusters of deaths in neonatology and there was nothing too concerning, certainly not suspicion that was crossing your mind at that time of deliberate harm; is that right?

A. Although we had done a staffing analysis, hadn't we? We -- as I said, Eirian Powell had done a staffing analysis.

Q. Yes.

A. So that had been some degree of cognitive process to do that.

Q. Yes.

A. And then comment on it, yes.

Q. All right. Julie Fogarty has given evidence to this Inquiry that she was very clear that Lucy Letby's name was not discussed during that meeting and Eirian Powell has given evidence to the Inquiry that she has no recollection of being at the meeting.

I want to, please, now look at INQ003530, which is the note of the meeting to see if this assists you in terms of who was present. INQ0003530. Thank you. When it comes up, we can see top right-hand corner the initials of those present, Julie Fogarty, Ruth Millward, yourself, Alison Kelly, Sian Williams and Debbie Peacock.

Do you agree, Dr Brearey, that Eirian Powell's initials don't seem to be in that list?

A. Debbie Peacock?

Q. Yes.

A. And I don't know who the one is before that.

Q. Sian Williams. Alison Kelly, Sian Williams, Debbie Peacock.

A. It's also got the details of an obstetric secondary review for Child D, hasn't it, a bit later?

Q. Yes. But this is the -- this is the reference to who was present and Eirian Powell's initials don't seem to be there, do they?

A. You know, it's a three-page record and I don't know whose record it is.

Q. Might it be, Dr Brearey, that you are wrong that Eirian Powell mentioned Lucy Letby's name at this meeting?

A. Absolutely not, no, because where else would I have got that information from?

Q. Well, it may have come to you in another meeting or in a discussion with Eirian Powell?

A. No, no.

Q. But what I want to suggest to you is that Eirian Powell and Julie Fogarty are right that Eirian Powell wasn't there and Lucy Letby's name wasn't

mentioned?
A. Well, Eirian Powell was there because she presented those -- those, that data to me. I am absolutely sure and I think you are saying that she's right but actually she can't remember, did you say?
Anyway the meeting happened, we had that review.
Q. Yes.
A. And I don't know whether you have asked Debbie Peacock about it as well to confirm your suspicion because as far as I am concerned that meeting definitely happened and her name was definitely mentioned.
Q. There's no other person who was present there who confirmed that Lucy Letby's name was mentioned or that Eirian Powell was there?
A. I'm sorry, it happened.
Q. All right. It was put to you by Ms Langdale as a fact that Alison Kelly knew that you were thinking that there had been deliberate harm to Letby in this meeting. That is not right, is it? You -- you agreed with me that even you weren't thinking in the realms of deliberate harm?
A. Yes, yes.
Q. Thank you. You say at paragraph 121 in your statement that you felt uneasy with the decisions made

at the meeting. But we know that following the meeting, Alison Kelly, as you have accepted, invited you to contact her with anything you wanted to discuss, and you didn't take her up on that invitation?
A. Mmm.
Q. You were then taken through the chronology of deaths and you were asked by Ms Langdale to indicate when you became convinced that deliberate harm may have been carried out to some of the children on your unit and you told us that certainly by the time of Child I's death in October of 2015, there were a lot of clues and incidents which would have brought you to the conclusion that something was wrong.
But that indicated that you were ruminating on it but not raising it, certainly not with any Executives at that stage?
A. I had raised it with Eirian Powell who had written the email to me saying that she is going to raise it with Alison Kelly on Monday.
Q. But you didn't email Alison Kelly or contact her?
A. No, no.
Q. And in fact the next emails that you sent to Ian Harvey and Alison Kelly were around the time of the Thematic Review, weren't they?

A. Yes.
Q. We looked at the final report of the Thematic Review earlier today but I would like to look, please, very briefly at the draft report, the first version, which is at INQ0003217, at page 7, please. Eventually, the themes identified were amended in the final report to add sudden deterioration and timings of arrest to the top of the list, weren't they?
A. Yes.
Q. But in its original iteration, we can see that you had placed delayed cord clamping in preterm deliveries as the number one theme identified. What caused you to amend that?
A. I wanted to put them in order of importance in the final version of the report.
Q. Well, in fact in this first draft, I don't think that sudden deterioration appeared at all, did it, as a theme?
A. No, it was a suggestion from Dr Subhedar, as we have discussed already.
Q. Now, you have dealt with the fact that there is no mention in the body of the report of Lucy Letby as a theme?
A. Mmm.
Q. Or as any nurse being a commonality and you

have explained that you regret not putting her presence or the presence of a nurse in that list?
A. Although her name was in the --
Q. In the appendix.
A. -- table with all the cases.
Q. Yes.
I would like to ask you please -- we can take that down, thank you -- about the sharing of the Thematic Review because your evidence today is that you sent it to Ian Harvey and asked him for an urgent meeting?
A. Yes.
Q. Now, could we look, please, at the email thread that's relevant to this. It is INQ0003140 and if we can go to the bottom of the thread first, please. Thank you. This is an email from Ian Harvey to you.
"Am I correct in thinking that you commissioned an external review of recent neonatal deaths? If so, is there any early feedback ahead of this week's visit."
He is referring there to the CQC visit, isn't he?
A. Yes.
Q. If we go to the next page up, we can see that was sent to you by Ian Harvey on the morning of 15 February and your response is above, you respond within the hour explaining that it wasn't an external review but that you had invited neonatologists from

Liverpool Women's Hospital to join and you attach the draft minutes, which is in fact the draft report, isn't it?

A. Yes.

Q. Yes. Do you agree then that it was as a result of Ian Harvey asking you about the Thematic Review that you sent to him that you had cause to send him the report?

A. I -- the plan had been to send it to him anyway.

Q. Yes.

A. He might have pre-empted me sending it but it would have gone to him anyway before the CQC inspection no matter what.

Q. You, I know, Dr Brearey have searched for the email that you say you sent to Ian Harvey asking for an urgent meeting?

A. Yes.

Q. And you can't find it?

A. No.

Q. Is it possible that you are wrong in your recollection about asking for a meeting with him?

A. I don't think so, no.

Q. All right. Well, I just want to come away from the Thematic Review for a moment to ask you about

your knowledge of Child K because we know that by the time you met with the CQC in the presence of Dr Jayaram there were -- there was a group of you, wasn't there, that was at the CQC meeting?

A. Mm-hm.

Q. Yes, that earlier that day Dr Jayaram had witnessed Child K's collapse and had concluded that it was a shocking event, and that the dislodging of the breathing tube had been deliberate. Did he mention that to you either before or around the time of your CQC meeting?

A. I can't remember him mentioning it, no.

Q. No. If he had mentioned that to you, what would you have done with that information?

A. Well, I would have instigated a review of the case and spoken to him in detail and if I was concerned, I would have shared that with others.

Q. Yes, you would have brought it to the attention of the Executives, wouldn't you?

A. Yes.

Q. Yes. Because in his evidence at the criminal trial, INQ10309 I don't ask that we look at that now, he said he didn't make a note of it in his clinical notes for Child K, but it was one of the things that we discussed as a team together and added to the list of

concerns we already had and escalated it to the senior management at the hospital.

If he's right about that, you were not a member of the team for that discussion and you didn't escalate it to the management, did you?

A. Well, that statement isn't dated, is it, so I don't know what date he's referring to that because clearly we escalated our concerns of the morbidity cases when we were presenting the evidence to the policy inventory.

Q. Yes well, we know from his evidence that he didn't mention it to any Executive for 13 months until his meeting with Sue Hodkinson on 17 March of 2017.

When do you say you became aware of his conclusion that Letby had deliberately dislodged Child K's breathing tube?

A. I -- I can't remember and from -- from my impression of his recollection of it, it was, it was something that stuck with him and I think all of us had these moments and I think parents as well where they experienced something that is abnormal such as an abnormal cry or a light not being on when it should have been, which on its own at that time might not trigger an immediate action but stays in somebody's mind and I don't know whether that's because you can't quite

believe what you are trying to think or whatever.

Q. But I am asking when you became aware of it --

A. I can't remember.

Q. -- Dr Brearey. All right.

Could we put up, please, INQ0003089. You have been taken to one of the emails in this chain already this morning by Ms Langdale. It's an email from -- if we could scroll down to the bottom, please, thank you very much. And then the next page up.

17 March in the afternoon, Eirian Powell is emailing Alison Kelly:

"I have been informed [she says at the bottom of the email] that Ian Harvey is aware that we have had an external Thematic Review."

Alison Kelly's response on 21 March that lies above is:

"Could you please send Ian and I the report in the first instance, then once we have reviewed it I think it would be good for me, you, Ian and Steve and Ravi to meet to discuss."

That is 21 March?

A. Mmm.

Q. So six weeks or so after you had prepared the draft Thematic Review and it's being -- the final version is now being sent to Alison Kelly.

Do you think that that's the first time that any meeting between yourself and the Executives was being first raised as a possibility?

A. No, no. Both myself and Eirian Powell were asking for meetings much earlier than that.

Q. I want to now take you to the meeting of 11 May which you have been asked about. You tell us that what you sought from the meeting on 11 May as well as discussing your Thematic Review was the need for guidance on how to take things forwards?

A. Mm-hm.

Q. You described Eirian Powell and Anne Murphy's behaviour during the course of that meeting as countering your concerns forcibly and with great emotion and you also said that they were emotionally driven and seemingly in denial of the facts?

A. Mm-hm.

Q. What was the relevance of the fact that they were in your opinion, Dr Brearey, acting with emotion?

A. Because I thought that their -- certainly Eirian's relationship with Letby was getting in the way of her objective analysis of the facts.

Q. Did you tell her that --

A. Yes.

Q. -- at that meeting?

A. I made it very clear to them at that meeting yes.

Q. Right. Now, Eirian Powell had brought with her the document that she had prepared following your meeting of 5 May, hadn't she?

A. Yes.

Q. And that document had been emailed to you well in advance of this meeting?

A. Yes.

Q. Yes, but you tell us today that you were too busy to read it?

A. Yes.

Q. A few moments ago, towards the end of your evidence, you were questioned about Simon Medland, Queen's Counsel, as he then was, and the advice that he gave to you about listing your best points.

Isn't that what Eirian Powell was doing here?

A. Do you mean that Eirian Powell was listing her best points?

Q. The best points as far as her argument was concerned about Lucy Letby?

A. Well, to create a document at a meeting without the clinicians isn't very collegiate, as Simon Medland has suggested, or inclusive.

Q. I'm sorry to interrupt you, but my point is

this: you could have -- you could have prepared your own document, couldn't you, and taken it to the meeting or you could have prepared a document after the meeting and sent it to the Executives?

A. Well, the best points document was the Thematic Review report which I produced and asked for a meeting with the Executives with. That was the best point, and that was the inclusive collegiate meeting with nursing staff and medical staff and external doctor to come up with the best points that came up, with the -- all the themes that I have mentioned in terms of sudden and unexpected collapse and timing of the deaths and -- and the fact that we couldn't identify any natural cause or care problems that might have been responsible.

They were the best points for that meeting. It had already been sitting there waiting for that meeting for two or three months.

Q. Yes. And you say that you were disappointed with the outcome?

A. Well, I was worried by the outcome. Yes, certainly.

Q. Worried and disappointed?

A. Yes.

Q. Yes. All right, let's look at your response,

please, at INQ0103144. This is the email that you sent five days after the meeting to Dr Jayaram and other Consultants and you also copied in Eirian Powell and Anne Murphy:

"Eirian, Anne and myself met Ian Harvey and Alison Kelly last week to discuss the rise in neonatal mortality last year. It was a helpful meeting and they were grateful for the work we have done in the various reviews and involving an external clinician."

Nothing there about you being disappointed?

A. I -- I have said in my statement that I didn't think there was anything helpful in the meeting at all and I regret writing that and wrote it in a -- in an attempt to try and be positive about a meeting that there really wasn't anything to be positive about.

Q. You are asking your colleagues to keep a close eye on things and if they do come across a baby who deteriorates suddenly or unexpectedly or needs resuscitation on your unit, could they let you or Eirian know?

A. Mm-hm.

Q. We know that you were aware of Child N's collapse on 15 June of 2016 and you tell us that you planned to review that but you didn't get round to reviewing it before the collapse and death of Child O

and Child P?
A. Yes.
Q. Did you discuss your concerns about Child N with Eirian Powell?
A. No.
Q. We also know that Doctor S says that --
A. It is worthwhile saying that Child N was a morbidity case and I have said in my statement as well, that I was -- I was blinded by the medical issues in the case in terms of the haemophilia that Child N had and the difficulty with the airway that was -- was encountered which blinded me to the actions of Letby.
So in my mind, it didn't trigger the response that I would have expected in terms of the previous email, raising concerns for a sudden collapse.
Q. Doctor S has given evidence that on 16 June, they spoke to you about strange behaviour which Letby had exhibited. You have no recollection of that --
A. No, no.
Q. -- conversation?
A. But I can, I can remember her talking to me on the neonatal unit when, when Child O and P died, which was a similar conversation and I do wonder whether she's got those two cases mixed up.
Q. Right. If she did tell you that before the

collapse and death of Child O and Child P what would you have done about that information?
A. Well, I would have shared it with Eirian Powell and obviously it's hard to say now, but I would have liked to think that I would have shared it with the Executives as well.
Q. Right. Thank you. We know the interaction and involvement that you had with Child O and Child P and I just want to ask you, please, about your conversation, if indeed there was one, overnight between 23 and 24 June with Dr Jayaram?
A. I can't remember having a conversation with him.
Q. Well, Karen Townsend has given evidence that the following morning she met Dr Jayaram in the cafeteria and she discussed several issues with him including the third in a list of three was the NNU Triplets.
And it's during that conversation that Karen Townsend said that Dr Jayaram told her about the drawer of doom; the collated evidence that was in your office. Karen Townsend then went to speak to Karen Rees about it which is what prompted her to come and speak to you, to find you in the clinic and walk back to your office with you. And we know that Karen Rees's evidence

of that conversation includes her asking to see what was in the drawer and you refusing her access to it.
Now, your evidence is that none of that happened?
A. No. And the timings don't entirely fit either because that suggests that Karen Rees already knew I was calling it the drawer of doom before we had -- I'd had that meeting with her that afternoon, whereas my understanding of her statement is that she said I mentioned it then and that's what she remembers. But that was after, after she had been tasked by Karen Townsend to go. So the timings don't add up, do they?
Q. Did you speak to anybody on the night of 23 June about your concerns in terms of Letby?
A. I honestly can't remember whether I did or not.
Q. All right. But you did speak to Karen Rees on the evening of 24 June?
A. Yes.
Q. And it was during that conversation, I suggest, that she asked you again for evidence of your concerns about Letby and said in the absence of evidence she couldn't take her off the rota for the following day?
A. As I have explained already, firstly, I don't

think that conversation happened and Karen Rees's repeated comments about "there's no evidence", really, were based on the fact that I think she assumes that the evidence we, somehow, were hiding was some event in which we witnessed harm being done and we were hiding that from her.
Actually, the evidence was quite clearly and it was all in the Thematic Review: the evidence of Letby's association; the sudden and unexpected nature of the collapses; the timings of the collapses; the numbers of the collapses; the fact there was no other explanation for this, that was the evidence. And again, you know, she was entrapped in those thoughts having spoken to Eirian Powell who was also in that position and unwilling to consider the concerns we were raising.
Q. Right. But finally this, please, Dr Brearey: the meeting with the Executives on 30 June of 2016, you have told the Inquiry that Tony Chambers accused you of your concerns about Letby being a convenient way of hiding your own failings.
I have to suggest to you that he didn't use those words, he didn't express that sentiment and there's no reference in the meeting notes to suggest the same?
A. Well, I have explained already that I don't think the meeting notes are particularly reliable

anyway.
Q. Stephen Cross' notes?
A. Yes.
Q. Yes.
A. I specifically remember him saying it, I can specifically remember talking to colleagues at Alder Hey that same summer; senior colleagues at Alder Hey, talking about our problems and mentioning what he said and their reaction being similar to ours, really.
If you would like to corroborate that with them I am quite happy for you to give them the names and you can talk to them, you know, to corroborate that. He definitely said "that would be convenient", he definitely looked away and said it, yes.
Q. You express that you were irritated with Karen Rees's interjections during the course of that meeting and in your view, you didn't need evidence of someone pulling out a tube or injecting something in order to take matters further?
A. Well, I think the evidence that we did have was enough to escalate it to another agency.
Q. Yes. Interesting, if I may make this point, that you chose those two examples because of course Dr Jayaram did have evidence where he had concluded that the breathing tube of Child A had been deliberately

taken out and, of course, Dr ZA had noticed that the insulin levels were suggestive on another child of external provision.
But neither of those two matters were brought to the attention of the Executives at that stage?
A. Well, we weren't aware of the insulin at that stage --
Q. Yes?
A. -- and Dr Jayaram didn't witness her taking the tube out of the baby.
Q. But concluded that that is what had happened?
A. Well, he -- he witnessed her coming to the side of the cot side as described in the court case.
Q. Yes.
A. Yes.
Q. Thank you?
A. So as you -- that would be the epitome of "no evidence" but actually it turned out on further that it was.
MS BLACKWELL: Thank you, Dr Brearey. My Lady, that is all I ask.
LADY JUSTICE THIRLWALL: Thank you very much indeed, Ms Blackwell.
Mr Baker.

Questions by MR BAKER

MR BAKER: Thank you, Dr Brearey. I ask questions on behalf of a number of Families including the Family of Child G.
A. Okay.
Q. You deal with Child G from paragraph 155 of your witness statement and you have given already some evidence about Child G and your interactions with her parents and you have expressed your views on her parents and the quality of care that they provide?
A. Yes.
Q. You had some involvement with Child G at or about the time of her collapse in September 2015?
A. Yes.
Q. Now, your opinion initially about the cause of that collapse was that it was caused by sepsis but the condition of Child G up until that point had actually been very good considering that she had been born a little under 24 weeks?
A. Yes.
Q. By this point she was the equivalent of about 37 weeks gestation and you describe how, in your witness statement, she was very different to the other babies on the indictment?
A. Yes.
Q. She was much bigger, more robust, she was

drinking milk, she was interacting with her parents?
A. Yes.
Q. Her parents' view -- and they expressed this to you -- was that there was a remarkable change between how she was prior to this incident in September and how she was afterwards?
A. Yes.
Q. And you were also shown MRI scans from Arrowe Park?
A. Mm-hm.
Q. Those scans taken after the collapse, again, showed a profound change in the appearance of Baby G's brain?
A. Yes.
Q. And from that point onwards she appeared to develop evolving signs of cerebral palsy?
A. Well, obviously, over a longer period of time.
Q. Yes, and you say in your witness statement that her mother and father, in effect, said to you that there was a profound change in her condition. In effect, the progress that she had made to that point had been lost and they attributed the signs of evolving cerebral palsy to the collapse in September and you say in your witness statement that you don't regard that as being unreasonable?

A. Yes.
Q. There will have come a point -- although you initially believed that this collapse was caused by sepsis -- there will have come a point where you began to us suspect that Child G may have been one of the victims of Lucy Letby?
A. Mmm.
Q. And the reason for that was that her observations prior to the collapse were all normal and then they changed profoundly with the collapse and from that point onwards; that's correct, isn't it?
A. Yes.
Q. The signs that you had attributed to sepsis, raising the CRP which rose after the collapse, the metabolic acidosis which appeared after the collapse, and fact that she needed anatropic drugs to maintain her blood pressure after the collapse were not concordant with the usual appearance of sepsis which leads to a which involves the development of prodromal symptoms leading to a collapse; it was out of the blue?
A. I wouldn't completely agree with that statement. The CRP test doesn't -- doesn't always reflect what's happening at the time when the blood's taken.
Q. There is a lag with CRP?

A. There is a lag, isn't there?
Q. Yes.
A. So the fact that the CRP was raised within the 24 hours of her collapsing --
Q. If I put it this way --
A. -- might indicate on its own -- you know, I am not arguing with you in terms of the neurological sort of outcomes for this, but I think the team in Chester and the team at Arrowe Park I think where she went to subsequently, felt the blood tests were -- were indicative of infection but seeing, seeing it with a different perspective now and knowing more about some aspects of her care which I might not have felt was as important at the time in terms of the quantity of milk that was vomited, then obviously clearly, you know, we accept now there was a different cause for it.
But at the time I don't think it was unreasonable is given at the time for infection as well as collapse.
Q. Can I just come back to the milk?
A. Yes.
Q. Because there was a very substantial vomit?
A. Yes.
Q. I think it was described by Mother and Father G as "flying across the room"?
A. Yes.

Q. After that vomit, there was an attempt to aspirate fluid and gas --
A. Yes.
Q. -- from Child G's stomach and Child G had 100 millilitres still inside her stomach?
A. Yes.
Q. Later that again appeared to you to be odd given the fact that Child G's stomach capacity as a baby would be relatively small?
A. Yes.
Q. She had had a large vomit and why would she still have 100ml of fluid in her stomach after such a large vomit?
A. Yes.
Q. That taken with the suddenness of the collapse and the fact that it came out of the blue later caused you to suspect that there might have been a connection with Lucy Letby?
A. It was unusual, certainly, and the reason for us to list her as one of the babies that we had concerned about to the police, I don't -- I don't think our -- my level of forensic knowledge limited my understanding any further than that and I wouldn't want to step into an area, you know, that I am not an expert in.

But it would certainly reach the threshold at which we thought it was appropriate to refer to the police, certainly.
Q. Yes. You had a number of consultations with Mother and Father G and Child G?
A. Yes.
Q. And Father G recalls at one of those consultations you showed him the observations for Child G and you said to him these were entirely normal up until the point of the collapse and then there's the collapse and everything changes. Were you trying to tell him something?
A. I can't remember that specific part of the conversation. But I -- I don't think so, no. No.
Q. You described how you had to sit with parents knowing what your suspicions were and not being able to tell them and how difficult you found that.
A. Yes.
Q. There must have come a time when you were doing that with Family G?
A. I can't -- I can't recall the dates exactly but -- and obviously I was focused on the mortality more than morbidities for most of the time after we escalated our concerns. And yes, we did include Baby G in that, but it was a relatively late decision about that and,

and --
Q. The first Father G found out about that, the inclusion in effect was the arrest?
A. Right.
Q. What concerns him and what he wants to clear the air about --
A. Yes.
Q. -- because you still see each other regularly --
A. Yes, yes.
Q. -- is why couldn't you tell him before then about your suspicions?
A. Yes. I mean, I can't remember whether my suspicion with Baby G was -- was very high or I really can't remember where I was in my mind process about the concerns for her at the time. I certainly wouldn't have been in a position to or want to mislead any Family in any way, certainly not -- not her Family and -- and if -- I ever did, I am sincerely sorry for that, really.
But it didn't remind me of the conversation with the other set of Families where I did feel very uncomfortable with it and it -- and as I have said before, once you -- once you share a concern like that with a parent, you are effectively putting your concerns into the public domain before a police investigation has

evidence and, you know, we needed help with it.
So that's -- that's why we -- we asked for that support and advice.
Q. The way you describe things in your witness statement, and in particular it's paragraph 265, from 265 onwards this is describing the meeting in June 2016.
At paragraph 266 you say there were concerns about the NNU being closed and made a crime scene and the publicity that would follow would be a disaster for the Trust?
A. That is what we were told, yes.
Q. Did you have a sense that the concerns were being put to one side because of worries about reputation and reputational harm to the Trust?
A. Well, that was certainly put to us; that that would be one of the reasons why not to because of the reputation of the Trust. I -- having lived through all this, I am a little bit sceptical as to whether that was a true concern or whether it was more on an individual basis, the people making that decision looking after themselves and trying to protect themselves through this, particularly if they had not responded to our concerns as early as they should have done.
Q. I take it your evidence is that it's as true in June 2016 as it would be earlier in the year

even started which is -- is difficult to feel is -- is appropriate, you know, I had never been in this situation before, I have always tried to be as honest as I can with any set of parents and if I did mislead them and I was thinking of concerns at that time, I sincerely apologise for that. But that certainly wasn't anything malicious or intentional.
Q. Thank you. Can I move on to a slightly different issue. You were interviewed by The Guardian for an article that was published in August 2023 and I just want to take a couple of points out of that and into what you were saying in your evidence.
You were quoted in that article as saying that Executives at the Trust should have contacted the police in February 2016 when concerns were first raised following the Thematic Review?
A. Mm-hm.
Q. Is it your evidence that a position had been reached following the Thematic Review that the threshold had been crossed and that the police needed to be called?
A. I think that was the most likely outcome of escalating it to the Executives when I did then. But, you know, we had circumstances shall evidence, worrying really what I felt was quite convincing circumstantial

following the Thematic Review, that the appropriate action should have been to call the police to investigate a potential crime and allow their forensic skills to take over?
A. Yes.
Q. Another thing you say in The Guardian article, or are quoted as saying, that you felt there was an anti doctor agenda amongst some of the Trust's senior leaders?
A. Yes.
Q. Could you explain first of all if that is something you said, and secondly, expand upon it?
A. Well, Mr Chambers made something of him being a nurse and having worked as a nurse and generally speaking, the Consultant body in the Trust at the time, their morale was low and they didn't feel particularly listened to, there were a number of sort of issues that contributed to that.
There is a Consultant body within the Trust called the Medical Staff Committee, which represents all the Consultants in the Trust and the head of the Medical Staff Committee normally had an advisory role within the Executive board but that I believe Tony Chambers dropped that role, Mr Chambers dropped that role so that the spokesman for the Consultant body no longer had a voice

at Executive level.

And yes, I think generally speaking, the Consultant body's morale was low, you might have heard it from other -- other Consultants from the Trust, but yes, I think that was a perception that was shared amongst a number of Consultants.

Q. Do you feel it had an impact upon the way that your concerns were received?

A. I think it allowed the Executive body, particularly Mr Chambers, to give more credibility to the views of some senior nursing staff, such as Eirian Powell and Anne Murphy and Karen Rees in preference to the Consultant body's concerns and I think in addition to that, the concerns of Letby's parents and Letby herself above our concerns.

Q. Finally, can I ask you about another issue. Can we go, please, to INQ0012979, please, and to page 23.

This is your Facere Melius interview and your discussion, you are discussing the choice of Mr Medland as a -- to be involved by Stephen Cross and can you see at the bottom it says Darren Thorne, so it is a distraction, Stephen convinces Tony, that is Tony Chambers, and there's a rationale written down as to why they shouldn't go to the police, Stephen has

influenced Tony's thinking, convinced him because we shouldn't go to police as it's not a criminal investigation, there's no criminality to this and what they do is they go instead to a QC who Stephen knows and you say:

"Has anybody mentioned the Freemasons to you?"

Darren Thorne says:

"Nobody has mentioned to me before in terms of [if we go over the page, please] it's all hearsay but it wouldn't surprise me too that there is a Freemasons connection of a number of high ranking people in the hospital and elsewhere for this and I am sure that's where his friend is from, that is where Simon came from, and no one has mentioned it to us yet, and it's useful that you have. But I was intending to ask a question of one of the other interviewees who has previously been told was threatened not to do certain things. So yes there will be an undercurrent. Did you have anything ever said to you?"

You say:

"It is all rumours and hearsay."

Could you expand upon what message you are trying to get across there?

A. Well, I mean after Stephen Cross came to the Trust, I understand he -- he rose from quite a junior

position to a senior position at Executive level quite quickly within six or seven years, I think to corporate affairs.

We were also always given the impression that he was a sort of fixer of problems within the Executive body and they relied on him a lot like that and it questions whether any processes were followed by the Trust in terms of fit and proper candidate for Executive roles because, you know, subsequently I think probably after this interview I found out about Stephen Cross' demotion to the -- in the police service, which would fit with the rumours and hearsay that I mentioned here, that maybe some of the conversations he had and some of the people he dealt with had split loyalties, really I suppose is the word.

Q. You had had a sense that there might be some deals going on behind the scenes, some element perhaps of corrupt behaviour?

A. People had that impression and certainly there were rumours of that kind, certainly, yes.

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

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

Questions by MR SKELTON

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

You made a comment earlier in your answer to some questions from Ms Langdale that on reflection, you thought it's likely that Lucy Letby didn't start becoming a killer in June 2015. Baby A was murdered on 8 June. Is it your view that she had murdered or assaulted children in your hospital prior to that date?

A. I think that's -- that's likely, yes.

Q. On reflection now, do you look back and see a number of unexpected collapses or deaths which with information now available to you appears suspicious?

A. Yes.

Q. On reflection now, do you recall having any concern about those collapses or deaths at the time, or did your colleagues?

A. No. As far as I am aware, neither me or my colleagues had concerns at the time. We just thought we were going through a busy patch or a particularly difficult patch at times.

Q. So the kind of factual investigation which this Inquiry is conducting from essentially June 2015 to the police being called a couple of years later, that kind of factual analysis, those meetings, those reviews, those investigations, was not occurring in the hospital

prior to that date?
A. Well, those reviews, mainly Mortality Reviews that we talked about and, you know, you have seen our mortality numbers prior to this, were fairly stable but I -- you know, on reflection I think events were happening that were unusual and I think the context of why I said it was because, if you like, we had a thermostat for a level of work and a number of events that we can't quite understand, you know, I think it was turned up over those years so that our perception of what is normal for a neonatal unit in terms of the number of collapses that, you know, you might expect in a week a month or a year had changed and I think that was the case for doctors and nursing staff.
Q. One of the effects of normalising the abnormal is that when abnormalities occur, you don't react as you should?
A. Yes.
Q. You don't recognise it and you don't take appropriate action, is that a reflection which resonates with you?
A. I think so, yes. I think -- and also people try and rationalise reasons and, you know, coming out and sort of criticising, you know, there were -- we were working that NHS, it's not perfect, there's lots of

rational ways of trying to explain it away which at the time really we, you know, looking back on it wouldn't have made sense, blaming the transport service or, you know, blaming another Trust for maybe sending babies back when they weren't completely stable, rather than sort of taking a step back and thinking: well, you know, what's happening here? Certainly, yes, yes.
Q. I will come back to that, if I may, at the end I have only got, I'm afraid, 20 minutes?
A. Okay.
Q. I have got a quite a few things I need to get through.
Can I clarify this before I move on: did anyone in your hospital suspect Lucy Letby was harming children prior to June 2015?
A. No.
Q. Child A. He had an unusual rash which has been talked about a lot at this Inquiry, and likewise other children in that cluster of deaths had unusual rashes, his sister did, for example, as well, as you know.
There is an email, I can take you to it if you would like me, where the Registrars' concerns about those rashes are being voiced by Dr Gibbs; do you remember that?

A. Yes, yes.
Q. And in your statement you say at paragraph 88 that you weren't aware of the concerns about the rashes, do you think on reflection having seen that email from 23 June that that was --
A. Obviously, yes, I mean, I can't remember that email chain but I must have been notified, yes.
Q. Do you think looking back that it would have been appropriate to have try and done a serious incident investigation of that cluster of deaths and thereby captured a theme that turned out to be significant such as the rashes?
A. I think that's a reasonable thing to say in retrospect, but I still think at the time, you know, our job is dealing with uncertainty and there is many a time in paediatrics and in neonatology where you don't have the answer immediately and although Child C had a rash and Child A had a rash, and B, obviously who survived -- the [redacted] that mother had for Child A and B swayed me towards a natural cause which we hopefully were going to get an answer from either with investigations with Child B or the postmortem and we were waiting for the postmortem for Child C which we hoped might give us an explanation which is clearly a different case.
And I don't think the description of the rashes in

the case notes when I was reviewing them were did enough to really trigger my concern and clearly the email as well didn't do that and the perinatal meeting that followed the following day that I described for the junior doctors to discuss their concerns I -- I found that presentation from Dr Lambie about Child A's care from that perinatal meeting, I submitted it to Hill Dickinson at the weekend when I was going through my bundle I had been given on Friday, with the emails in and it's a six-slide presentation of Child A's care, but it didn't include any mention of the rash in her presentation.
And it might have been mentioned in the presentation, I can't remember everything about it at the time, but it just adds to the -- my general feeling that I just considered these to be separate events and natural events and my -- my radar for something harmful was -- was it wasn't picking up anything at the time.
Q. Mother A would like to have known about the rash because it clearly had caused some concern to some of the doctors?
A. Yes.
Q. She wasn't told, do you recognise it's the kind of thing when she was looking and she was desperate to get an answer for why her son had died that it could

have been mentioned to her?
A. Yes, yes.
Q. Just following forward into the chronology of the investigations, a postmortem took place and obviously that takes a period of time and was available later in the year and then there is of course the Inquest and all the way up and including the Inquest, Baby A's death was unascertained?
A. (Nods)
Q. That's correct, isn't it?
A. Yes.
Q. So your initial concern that it might have been something to do with the condition the mother had was in fact excluded and you couldn't find the medical cause of his death?
A. Exclusion is different from saying there was a connection, if you know what I mean. You know, sometimes you don't know and you can't confirm anything, even if the cause is natural.
So yes, I -- I take your point. I understand that it was unascertained.
Q. By the time the Inquest took place the Coroner was relying on a document that you had produced in part which was a single page analysing the potential causes of death which included the mother's condition, but in

fact things had moved on, hadn't they, because by that time the Inquest took place, you didn't think it was necessarily that cause?
A. Mmm.
Q. Do you recall that?
A. I don't because after my initial review like that in terms of certainly the Inquest preparation I wasn't involved with the Inquest preparation, I know Dr Jayaram was and maybe other Consultants.
Q. Dr Saladi, for example?
A. Yes, but I didn't have any input prior to the Inquest.
Q. Did you talk to either of those Consultants or indeed anyone else about the Inquest that was taking place and whether or not your concerns or suspicions about a member of staff needed to be told to the Coroner?
A. I can remember Dr Jayaram being very worried about it in terms of what he would what he could say at the Inquest because obviously we had raised concerns at that stage.
Q. Worried specifically about that concern and whether or not he could say that about Letby?
A. Yes, yes. And he was seeking advice from Stephen Cross at the time about that.

Q. Was it your understanding that Stephen Cross advised him not to mention it?
A. That -- that was my understanding. I can't recall whether that's something that Dr Jayaram has told me since then or at the time when it happened, but, yes, that was, that's certainly my understanding now.
Q. Can I turn briefly to Child I, please.
She had a series of collapses and repeatedly left your hospital and went into care in other NHS hospitals and then returned and then eventually she had a final and fatal collapse in October 2015.
How unusual did you find that pattern of collapses in your unit: recovery elsewhere, return and collapses again in your unit?
A. Well, it was unusual and it struck me and it increased my level of concern at the time and triggered things afterwards, particularly in terms of the Thematic Review.
But without going through everything again, I can't say that those -- not exact events happened previously but I know Eirian Powell felt very strongly that particularly Arrowe Park Hospital were sending some patients back too early and I can't remember which cases she was referencing to that and whether they are children in the indictment or not.

But certainly that seemed to be a theme for a while, that concern. Yes.
Q. But specifically in relation to her, she had a pattern of deterioration at the Countess?
A. Are you talking "her" as in Child --
Q. Child I.
A. Child I, yes.
Q. Yes. Which was highly unusual, wasn't it?
A. Yes.
Q. Did that up the index of suspicion or concern, as far as you were concerned?
A. It did, yes.
Q. I will come back to that at the end.
A. But the rider on that, as I have said already, was that the -- the consensus amongst medical professionals in a number of hospitals at the time was that she had some abdominal pathology going on which was causing her collapses and we didn't have the postmortem result.
So it would have been nice for me to have received the postmortem result in February around about the time of the Thematic Review and we -- postmortem reports aren't shared with paediatricians directly once they are produced. They go to the Coroner and I think they go to the GP.

So there was some delay in me seeing that report, it was June before I saw it because that obviously would have informed me more in February in the Thematic Review, had I known that there is no abdominal pathology going on and there are these strange events happening --

Q. Is that something that should be improved that you should receive them really as soon as they are available?

A. Yes, I don't understand why they are not shared with the paediatricians and neonatologists in a timely fashion.

Q. Can I turn to Child M, please.

LADY JUSTICE THIRLWALL: Just before you do, Mr Skelton I'm sorry to interrupt you. There have been a couple of references to Mother A's medical condition this afternoon.

A. Sorry.

LADY JUSTICE THIRLWALL: As I said this morning, they must not be reported.

MR SKELTON: Thank you, my Lady. Child M had been born in good condition, no concerns again for him and he suffered a serious collapse on 9 April 2016.

You have said previously that you thought that was very unusual and worrying?

A. Yes.

A. Yes.

Q. You could have written that email months before in fact and started to collate the data about the collapses in order to bring together the information. Why didn't you?

A. Yes. Because I think the -- it may have been those events in April might have triggered people's thoughts into thinking -- starting to think along that line, really, as the Consultant body.

I can't remember precisely the dates we started to sort of start to think about the morbidity cases in addition to mortality cases, but it was certainly around that time. I can't say and obviously with the volume of work in terms of looking at the mortalities, I accept that it was very hard to get a grip of the morbidity cases as well and yes, certainly that was a missed opportunity.

Q. Can I ask the similar line of questions in respect of Child N?

A. Mm-hm.

Q. In respect of Child N's deteriorations, he was found -- Lucy Letby was found guilty of attempting to murder him on 3 June 2016, but in fact the parents weren't aware of that collapse that was an attempted murder.

Q. The nature of his collapse, and I think Dr Jayaram shared a degree of perplexity too about that; is that correct?

A. Yes.

Q. Did either of you think to connect it with your already existing concerns about Lucy Letby?

A. No. I have to say and I don't know why, I know I was very focused on mortality and it looking back on it, it's just one of those moments you think why, why, why didn't we? And it wasn't something that struck -- clearly, you know, there should have been a link there and it didn't and I can't go back and tell you what I was doing at the time or what work I was doing or whether I was in hospital or not in hospital or what conversations went on.

But certainly that was a moment I felt that, you know, there was an opportunity to link some events like that.

Q. Can you explain why you didn't in a bit more -- with a bit more clarity because only a month later on 16 May, you are writing an email around to the staff saying --

A. Yes.

Q. -- Eirian and I need no know about these collapses?

Again, that is the sort of thing that they should have been alerted to, shouldn't they?

A. Yes.

Q. Can you explain why that wouldn't have happened, or didn't happen?

A. Well, I wasn't the Consultant caring for Baby N, I was obviously involved in some of the airway issues that we had. And -- and again, we were blinded a little bit by the medical issues, the haemophilia and the blood coming up the airway which -- and the difficult airway problems which distracted me and others from thinking about the cause of the collapse really and the collapse happened in -- in theatres when people were preparing for intubating Child N in the presence of Letby.

So I think a lot of different things were going on all at the same time with that because you had a team from Alder Hey an ENT surgeon, a PICU anaesthetist, the surgeon prepping for a surgical airway if needed. There was the issue of getting the correct fact rates for the baby in view of the haemophilia and I think all those obviously they had to deal with emergency at the time in terms of intubation and stabilising the baby which clearly takes priority over informing parents if you have got limited staff available. But I accept that

they should have been notified at the earliest opportunity.

Q. And should his deterioration, the unexpected deterioration that he suffered have been captured by your own request as one of those cases --

A. Yes.

Q. -- that needed to be drawn together?

A. Yes, yes.

Q. And likewise presumably the rash that he demonstrated as well which was recognised to be unusual could have been captured and linked with the previous children?

A. So the review for Child N, the events with Child O and P meant that those happened before we got a chance to review Child N's death, you know, appropriately. So those events didn't get reviewed before Child O and P died sadly.

So -- and then we are on the rails of escalating the concerns to Executives and everything that went on that week and the following week. So yes, I am sorry that, you know, I didn't look at Child N's care earlier or in more depth and I should have done at the time but there was a lot going on.

Q. Do you think the same -- broadly the same conclusion applies to Child Q, who of course

deteriorated after the death of the first -- the two deaths from the Triplets --

A. Yes.

Q. -- while Letby was still on the unit just before she was excluded? Again do you think that needed to have been looked at and the parents spoken to?

A. Yes, I mean, we were in so many meetings the following week after Child Q's collapse that, you know, naturally those events or those reviews were delayed, yes.

Q. Taken in the round, the Families clearly were unaware that there was this growing concern amongst the doctors that had treated their children over the course of 2015 and 2016, that in fact their children had been harmed and in some cases killed?

A. Mmm.

Q. Can you see that asymmetry of knowledge in professionals in whom they must put their Trust --

A. Yes.

Q. -- is invidious?

A. It's -- it's it was really hard for -- for -- it's one the hardest things I have dealt with through all of this including, you know, the dealing with all the managers, it just goes against the grain of the way you are trained and -- and supposed to behave and it was

really hard. Really hard. You talked about, you know, existing patients in clinic and Child G's parents aren't the only ones that, you know, I look after in clinic and even after these events it's very hard to talk about that in a 10 or 15 minute consultation.

But, you know, before we escalated concerns it was very hard. And there's, there's no guidance for this; you know, you can't look up a GMC manual and say, you know, well, concerning -- if you are concerned about criminal activity, that's an unproven concern, you know, is it, is it right that you tell every Family before it's been appropriately investigated, you know, with the appropriate authorities? And --

Q. Dr Brearey, I have to put to you that it is right that transparency and openness and simply respect for those Families requires you to tell them?

A. You know, I -- I accept that, but it was not clear at the time and the consequences of talking to them about concerns that you had got about circumstantial evidence that's unproven and putting that in the public domain and the harm that that might incur on parents if those concerns are incorrect and unfounded is also there.

You know, the last thing I wanted to do was, was conceal anything to anybody. At the same time, you

know, you have to be sensitive to the fact that, you know, if this wasn't correct and this did prove to be nothing the damage you can do as well.

It's really hard and if I got it wrong, I'm sorry.

Q. Can I ask more generally about your response to concerns. As I understood your evidence this morning to Ms Langdale, the meeting you had on 2 July 2015 in which you made the "not nice Lucy" comment, was the first time when you had a concern about her causing harm to those babies?

A. That was the first time it was -- it was raised as a commonality, yes.

Q. And I think you said there was part of your mind thinking the worst. From that time onwards, 2 July, part of your mind thinks the worst?

A. It was in the back of my mind, obviously trying to rationalise it and go through all the thought processes and denial and questioning that my colleagues went through at different times, yes.

Q. What is the difference between a concern that a member of staff is harming babies and a suspicion?

A. To me, you know, a concern is, is something that's on a differential, you know, that you can, you can have a number of possibilities of cause and you don't know which one it would be or which is the most

probable. And I think a suspicion is a little bit more definite in your thought processes as to what the cause is.

Q. Not much difference?

A. Not much, but significant.

Q. Further babies collapsed, as we well know, and further babies died over the course of 2015.

By the end of that year, certainly by the time Baby I died, you were aware of the unusual number of deaths, you were aware of that they were unexpected and unexplained in many cases medically, and there weren't certain causes of death that had been identified.

Dr Jayaram also mentioned in his evidence the fact that babies didn't respond appropriately to resuscitation when they collapsed. So you piled in and did all the things that you as paediatricians will do to bring a baby back from a collapse, but they didn't respond to the drugs, to the interventions in the normal way and you had identified very early on Letby's presence at those collapses and deaths.

A. (Nods).

Q. And hadn't found, on investigation, an alternative medical explanation, is that fair?

A. Mm-hm.

Q. You wrote a letter in 2017, a report rather,

with the other Consultants raising the six points I have just mentioned to you. They were in fact in place in 2015, weren't they, just fewer numbers?

A. Yes.

I mean obviously, as time went on, we consolidated those thoughts, yes. But, yes, the facts were all there, yes.

Q. All of those facts were in place in 2015?

A. Yes, yes.

Q. But at that stage there were just fewer deaths and collapses?

A. Yes. I mean, I think it's worth pointing out that it was quite a lonely place to be as well because you have got those thoughts going on in your head, but, you know, normally in this line of work you are bombarded with requests, actions, various things to do on a fairly regular frequent basis and to respond to in terms of patient safety concerns, national alerts, that sort of thing and there was nothing.

There was no external or internal people alerting us to say, "What are you doing about this mortality?" and the nursing staff were very adamant that there was no problem, which ends up with you questioning yourself as well.

So, you know, that credibility gap was there and

pushing me in one direction. But weirdly it felt that there was, there was, other than colleague, Consultant colleagues, there was no other push or request to do anything. I mean it, you know, it, it -- it felt a bit isolating to be honest.

Q. But shouldn't you have named your concerns and your suspicions when they grew in the clearest and most explicit terms because what one sees in your emails --

A. Yes.

Q. -- in your meeting notes, "We need to talk about Lucy", a Thematic Review that doesn't mention Lucy Letby or the suspicions that she may have murdered children. It's all euphemistic, it's all implicit and it needed to be clear and explicit and it never was?

A. Yes. And, you know, if I was writing a guideline for how to do this for future doctors, you know, I would -- I would be happy to, you know, include that.

But, you know, with the environment in the Trust and the feeling of the nursing staff and the lack of worry from anywhere else in the organisation then, I felt I had to be categorical in, in -- in naming and being very clear about the concerns that we had and even when we did raise concerns with even more evidence in June '16 we were still accused of picking on a nurse

and victimising her and treated in the way that we have described.

And, you know, if we had raised those concerns and been very explicit about her name and naming her earlier, then I sort of suspect the treatment we had regarding us victimising her would have been even stronger.

MR SKELTON: But the Thematic Review which you judged as being something of a watershed moment --

LADY JUSTICE THIRLWALL: Sorry, Mr Skelton. I'm sorry to interrupt you, Mr Skelton. I certainly will allow to you ask the questions you want to ask, but the shorthand writer has been going now for nearly two hours, so I think we will have a 10-minute break, just for her to recover.

MR SKELTON: Certainly, my Lady.

LADY JUSTICE THIRLWALL: We will take 10 minutes and come back in just before five to.

(5.42 pm)

(A short break)

(5.50 pm)

LADY JUSTICE THIRLWALL: Mr Skelton.

MR SKELTON: Earlier you explained to Ms Langdale the Thematic Review you reviewed as being a key moment where the Executives might understand that the police

needed to be called, is that correct?
A. Yes.
Q. Why is it though that within that Thematic Review, you don't make clear Lucy Letby's -- your suspicions about Lucy Letby or the view, which was shared I think by the Consultants, that the police needed to be called? Why didn't you make those things explicit?
A. The evidence was circumstantial, but concerning and significant, I -- as I said to Ms Langdale before I regret not putting her as a commonality in the theme.
But at the time we had to agree a draft before it was finalised and I didn't think that the nursing staff would be happy with me doing that particularly when they had criticised me already for not including all the doctors being present for all the events.
And it was the intention to meet with Executives as early as possible to discuss the report with them, in which case it would have been mentioned explicitly in that meeting and we could have discussed the appropriate action.
It was never my intention that that meeting was delayed until May 11th that I asked for in February. So it was really to -- probably a feeling of appeasing some

of the members of the group which undertook the Thematic Review so that we could agree the final report and get it out and request the meeting, not to do that.
And as I say, you know, in retrospect now knowing what followed I regret doing it --
Q. But also --
A. -- or omitting to do it.
Q. -- knowing what you knew at the time because the situation was actually rather urgent, wasn't it?
A. Yes.
Q. Lucy Letby had been actively harming children for seven, eight months by this stage?
A. Yes.
Q. And there was no action being taken to stop her?
A. Yes.
Q. At all?
A. And --
Q. And so you couldn't actually guarantee the safety of the patients on the unit unless urgent action was taken and it wasn't?
A. And again I was, I was looking for guidance from an external neonatologist as well and certainly if he'd told me, "Go to the police" or go -- you know, anything, you know, I would have followed his advice for

that. But I didn't get anything explicit from him at that meeting to suggest that I should do so.
Q. This is?
A. Dr Subhedar.
Q. Who's giving evidence tomorrow.
A. Yes.
Q. You had at least three options open to you. One was to raise a safeguarding concern?
A. Yes.
Q. One was to contact the police yourself or insist that someone did so?
A. Mm-hm.
Q. And the third was to tell the Coroner the concerns or to insist someone did so. Those really are the three urgent and immediate options, aren't they, that needed to be implemented by someone?
A. Yes.
Q. And you talked about the sort of index of concern, the spectrum perhaps?
A. Yes.
Q. Bearing in mind what you were thinking by the time Baby I died, which is when you and Eirian Powell put together the table which identified Lucy Letby, and you were already aware of her from July?
A. Yes.

Q. So this is several months afterwards, so we are talking October, November 2015; that was the time to take those steps, wasn't it?
A. As I say it was, it was -- it was a relatively lonely place and with every -- after every death there was, you know, obviously excepting the Triplets, there was a pause in, in the -- in the death rate, well, you know, I think some of my emails surmise as much when I put the draft of the Thematic Review out, "Well, you know, here's hoping for a better year this year."
I was, I was, you know -- it was always a little bit in your head thinking, you know, I am being paranoid here and, you know, and that was supported by some people, that view, and, you know, things might get better and there was always a period of time where you thought, well, that might be the case.
Obviously now, you know, I would have liked to act earlier certainly.
Q. Sorry, I didn't catch -- obviously now... I'm sorry, I didn't catch that very last bit you said.
A. Obviously now I, you know, accept that I should have acted earlier.
Q. Or someone else should have done. Really --
A. Yes.
Q. -- from the moment Lucy Letby was suspected of

harming and killing babies --
A. Yes.
Q. -- action needed to be taken, not further internal investigations, meetings, notes and reviews, but actual action involving external help?
A. Yes, and, and clearly, you know, we asked for -- I asked for advice about that with an external doctor and, and again there was no advice pushing me that way and, yes, there was no ...
To give you an example of, you know, the -- the Executive body, they weren't problem sensing and they were comfort finding and the previous Medical Director to Mr Harvey was Virginia Clough, and a very good Medical Director, and I can remember her calling me in to ask me about an episode where some of our babies were colonised with MRSA, which is a bacteria that was, was passed on to them either through the mother or from infection in another Trust before they came to us.
Those babies didn't have an MRSA infection as such that needed antibiotic treatment. They were colonised with it on the screening swabs we do when the babies arrive on the unit. So we felt that we had things covered. But she, she politely and firmly approached me as the neonatal lead and Eirian, the unit manager, to enquire about why we had three cases of MRSA on our

unit.
She didn't ask for me to volunteer that information. She, she came to us about it because she's the Medical Director and she was -- she was problem sensing as Executives ought to be and, you know, I -- I didn't feel offended by her challenge. You know, it was a reasonable question and, and we assured her that we were taking the appropriate steps and did some actions that she recommended as well.
But that's that -- that problem sensing behaviour was never there at Executive level and when, when the lines of escalation are blurred, you know, we chose to skip most of them and go direct to the Executive because we knew that the, you know, the process of going through various things within the Trust was -- would only sort of delay things further.
You know, I've -- I was just limited by what I could do at the time. As I say, I was trying to do my best in very difficult and unusual circumstances and naturally looking back at the end result there are times when I could have been more explicit with the concerns that we had and there are times when I feel that we could have pushed a little harder. You know, but that's in retrospect and, you know, I was just doing what I could at the time, really.

Q. Just finally in respect of the Executives who you've mentioned a number of times.
A. Yes.
Q. I have asked you about that report, which you and your fellow Consultants wrote in May 2017, which had that summary of six points, which I put to you earlier, the unexpected nature of the collapses, the failure to respond normally to resuscitation and so on?
A. Yes.
Q. At what point in time do you think the Executives were aware of those points? Was it -- are you clear in your mind that it was prior to the deaths of the first two, the two Triplets?
A. Yes. That -- they were -- that was -- most of that information was in the Thematic Review. All of it was given to them when we escalated to them at the end of June 2016.
You know, the, you know -- the myth that we were bashed with during the grievance procedure, that we are somehow withholding information, was literally that; it was just a myth and, you know, we were in a grievance procedure where we were made to feel as though we were on trial and we weren't -- I was keen not to sort of hypothesise about mechanisms for, for injury because I thought the evidence that we had in terms of

everything that you have described was enough to escalate and I thought hypothesising about air embolus or whatever would actually just be outside my area of expertise and distract from the significant -- we had concerns with evidence we had already albeit circumstantial.
Q. So as far as you are concerned, if you try and get the timing pinned down from the time of the Thematic Review --
A. Yes.
Q. -- from your perspective, the Executives had sufficient information to take immediate action should they have chosen to do so?
A. Yes.
MR SKELTON: Thank you.
LADY JUSTICE THIRLWALL: Mr Kennedy.
Questions by MR KENNEDY
MR KENNEDY: My Lady, can I just indicate before I ask any questions that the PowerPoint presentation of Dr Lambie on Child A has been provided to the Inquiry?
LADY JUSTICE THIRLWALL: I think it already has been.
MR KENNEDY: It has been, yes.
LADY JUSTICE THIRLWALL: Yes.
MR KENNEDY: But I don't think it's made its way

any further than that.

LADY JUSTICE THIRLWALL: I made an enquiry about it during the hearing. Thank you.

MR KENNEDY: Very well. I am behind the pace.

Dr Brearey, I just want to deal with three brief matters and depending on how we are doing for time I may just trim that to two.

The first is you have been asked a lot of questions about the nature of your concerns and the timing of your concerns. You have been asked by both Ms Blackwell and by Mr Skelton about 2 July. I am not going to ask you about that again.

You were asked a question by Counsel to the Inquiry about 23 October 2015, so immediately after Child I's death, and the preparation by Eirian Powell of the table?

A. Mm-hm.

Q. She asked you a question about which was premised on what Dr Jayaram was thinking at that time. I just want to ask you to consider what he said in evidence and just assist the Inquiry with what your -- what was the state of play as far as you were concerned.

So he was asked a question and my Lady it's on page 35 of his at line 16. He was -- he gave an answer having said that there were informal conversations and

informal conversations which included you. He also said that he thinks that or thought that Dr Newby had been involved and Dr Gibbs had been involved. These were what he referred to as corridor conversations.

To start with, does that accord with your recollection that there were at that stage four of you or does that not accord with your recollection?

A. That's seems a reasonable thing. I mean I haven't got, any you, know explicit memory as such. But, you know, certainly we were talking about things round about that time, yes.

Q. Okay. So this is as I say 23 October. He then said this: that he couldn't remember specific conversations, but his impression was that all of us had begun to consider whether her [so that's Letby] Letby's presence was a significant -- was of significance rather than just coincidental and bad luck.

So dealing with that. Where were you in terms of your thought process using that perhaps as a guide?

A. Again, it was, it was a significant step up in concern. But in the back of my mind, I was thinking, well, if this is, we need to ensure that we haven't overlooked anything significant here, hence the reason for the tabletop review of the transport service issues and the other hospitals and, and the need to see the PM

results that were sort of critical in -- in sort of validating those concerns really because, you know, if there had been an abdominal issue then we could step down from those concerns a little at that stage.

Q. Very well. He went on to say this. He said:

"I don't know whether all of us had genuinely begun to consider: could she be potentially be causing deliberate harm?"

So he went on to consider that, to say that?

A. Yes.

Q. Again, where were you in relation to that proposition in late October 2015?

A. Well, I suppose it's implicit if you have excluded all the other possibilities and there's this one association that you are worried that she might be harming those babies.

Q. All right. So if one looks at a range from simple association --

A. Yes.

Q. -- perhaps through a competence question to deliberate harm, where on that, if that's a legitimate range, tell me if it's not, but where on that range were you?

A. I think that it's too simplistic because --

Q. All right.

A. -- again, you know, it's -- it's the natural cause of death exclusion that would push you further along past halfway in your scale before I could come to that conclusion really. So -- and obviously if you are going to be in a position where you are presenting your concerns to Executives, police, whoever, you need to be sure that your own house is in order and that, you know, natural causes of death have been excluded to have that level of concern.

And so that's where I was at. I mean, yes, worrying. But then still in my head there was a feeling that we needed the PM and the other things sorted for this baby first.

Q. Okay. So association, yes?

A. Yes.

Q. Whether I need to be worried?

A. Yes.

Q. Whether that is for competence reasons or more sinister reasons, I'm still uncertain?

A. Well, I don't think we were ever concerned about competency issues.

Q. Very well.

A. Which is obviously a concern in the other direction. So it was really just natural causes or and -- you know, I think by the time we had finished the

Thematic Review, you know, most of the other things that you might want to consider I felt had been excluded and, you know, in medicine we'd call it a diagnosis of exclusion. You know, that you've ruled out everything else and you are just left with this, this one probable even though, you know, in legal terms it was still circumstantial.

Q. Okay. So as at October, we have association?

A. Yes.

Q. But you are still on the route to where you get to at the Thematic Review?

A. Yes, yes.

Q. Okay. In relation to the Thematic Review, you explained that it was Dr Subhedar's intervention that caused you to add "sudden deterioration" to your list of themes?

A. Mmm, I think he actually emailed after the meeting actually.

Q. Very well.

A. I think there might be a copy of that email somewhere in the pack, but when I sent the draft out and obviously after the discussion we had had about her association at the end of the meeting he emailed back and suggested putting in "sudden and unexpected" as a theme.

Q. You put in "sudden deterioration" into the final draft?

A. Yes, yes. Yes.

Q. We can bring it up if -- we can bring the two versions up if we need to, but I anticipate everybody has them well in mind now.

But one of the other differences between version 1 and version 2 is the timing of events comes up in the list of themes?

A. Yes.

Q. Was there any significance to that, question one?

A. Well, yes, because, you know, again that balance that I had in terms of the members of the -- in the meeting and accepting the draft and getting it out and, you know, we have talked already about why I didn't put the staff association in, but one thing I could do if I wasn't putting that in is put what I felt to be the most important factors and common themes at the top of the list, hence both of those going to the top.

Q. All right, so that was conscious?

A. Yes.

Q. That was my first question?

A. Yes.

Q. I think you have answered my second question

which was: why or whose decision was it?

A. It was my --

Q. I take from your answer it was your decision?

A. My decision, yes.

Q. Okay. The action that was to be taken in relation to the question of timing of events was the same, so it read the same, so that you and Eirian Powell to review these cases focusing on the nursing observations in the four hours before the arrests and then you say:

"... aim to identify if unwell babies could have been identified earlier."

And then you say this:

"... identify any medical or nursing staff association with these cases."

A. Mm-hm.

Q. And that was the --

A. Inclusion of the medical staff in the staffing analysis that Eirian had created yes.

Q. Okay but appended to both version 1 and version 2 was Eirian Powell's analysis which set out the association in fact of Letby with all of the -- well, with the cases?

A. Yes.

Q. Okay.

The third point I just wanted to ask you about was, was this: you have said on a number of occasions that you were -- and this is my expression, that you were hampered by the volume of work that you had to do in terms of -- in terms of working on the mortality cases to the detriment of the morbidity cases in the 2015/2016 period?

A. Yes.

Q. Do you recall that?

A. Yes.

Q. I think you explain that of the 40 hours that you were due to work each week 75%, so 30 hours, was allocated to clinical tasks?

A. Mm-hm.

Q. Was the balance your function as neonatal lead?

A. Well, no, I mean the -- in the job plan -- I mean, the job plan didn't really resemble what I was doing anyway because I was doing way over 40 hours of clinical work anyway. But the two-and-a-half sessions which is 10 hours a week that was allocated to non-clinical work, four hours of that was allocated to the neonatal lead work, and the other time was allocated to other non-clinical work that I was doing in terms of work with the College supervision of trainee doctors,

appraisals, that sort of thing.
Q. So just so we understand. The work that you did reviewing deaths, did that fall within the --
A. Neonatal lead role.
Q. It fell within the neonatal lead role?
A. Yes, yes.
Q. All right.
A. I mean, nobody was counting, you know, it just needed doing and I just did it. Yes.
Q. You also explained and I am not quite clear in terms of timing, but you explained that there was -- a Risk Management Consultant was allocated some time and I am not clear whether that was relevant to the issues that the Inquiry is looking into.
A. Well, only relevant in so much that it sort of emphasised the workload that was on me and other neonatal leads at the time --
Q. Okay.
A. -- really.
Q. Did it take any of the work off your shoulders?
A. Absolutely, because obviously risk was a huge part of my neonatal lead role so the Consultant -- I think she started doing this in 2017 -- would have four hours allocated --

Q. All right. So for the 2015/2016 period --
A. Yes.
Q. -- you were on your own?
A. It was just me, yes.
Q. Okay. Where I wanted to get to was this, you are no longer the neonatal lead, I think that's now Dr McGuigan?
A. No, he was the paediatric lead equivalent to Dr Jayaram at the time.
Q. Forgive me --
A. The neonatal lead at the moment is Dr Guratsky.
Q. Okay. Is the allocation of time as far as you are aware any better than it was in 2015 between clinical responsibilities and the time -- the time that the neonatal lead has to has available to devote to tasks such as Mortality and Morbidity Meetings?
A. Yes. You know, you always look back on what you are doing and think that the people at the moment have got it slightly easier but actually they are working very hard and they are still stretched in their role, requirements always evolve and increase in terms of risk management and the Trust is -- the Trust Risk Department has obviously developed a lot since then as well.

But I still see colleagues who are working very hard trying to fulfil risk and governance roles probably beyond the scope of the hours they are given for those, those roles. It's still a demanding job, despite the extra resource.
Q. So there's extra resource which assists the neonatal lead?
A. Yes.
Q. My question was more to do is more time carved out of the neonatal lead's hours to allow him or her to commit to this type of work? If you don't know the answer, please say so?
A. No, it would still fall on the Risk Lead Consultant's --
Q. Very well, all right --
A. -- workload for doing this.
MR KENNEDY: Thank you.
My Lady, thank you, those are my questions.
LADY JUSTICE THIRLWALL: Thank you very much indeed, Mr Kennedy. Dr Brearey, I have no additional questions. They have all been dealt with. Thank you very much indeed for coming today, I know it's been a very long session but it does mean that you don't have to come back tomorrow, so thank you very much. And we will rise now until 10 o'clock tomorrow morning. I'm

sorry, Ms Langdale, I didn't ask you?
MS LANGDALE: No further questions.
LADY JUSTICE THIRLWALL: We will rise now.
(6.19 pm)
(The Inquiry adjourned until 10.00am on Wednesday, 20 November 2024)

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