1 Wednesday, 20 November 2024
2 (10.00 am)
3 **LADY JUSTICE THIRLWALL:** Mr De La Poer.
4 **MR DE LA POER:** My Lady, our first witness is
5 Dr Subhedar and I wonder if he might come forward to the
6 witness box, please.
7 **LADY JUSTICE THIRLWALL:** Do come forward.
8 DR NIMISH SUBHEDAR (affirmed)
9 Questions by MR DE LA POER
10 **LADY JUSTICE THIRLWALL:** Do sit down.
11 **A.** Thank you, yes.
12 **MR DE LA POER:** Please could you state your full
13 name?
14 **A.** Nimish Subhedar.
15 **Q.** Dr Subhedar, is it correct that you provided
16 to the Inquiry a witness statement dated 20 June of this
17 year?
18 **A.** That's correct.
19 **Q.** Is the content of that witness statement true
20 to the best of your knowledge and belief?
21 **A.** Yes, it is.
22 **Q.** Did you qualify as a medical doctor in 1988?
23 **A.** That's right.
24 **Q.** Did you become a Fellow of the RCPCH in 1998?
25 **A.** That's correct.

1 **Q.** Was it that same year that you were appointed
2 as a Consultant neonatologist at Liverpool Women's
3 Hospital NHS Foundation Trust?
4 **A.** Yes.
5 **Q.** Does your work there involve you working
6 across two sites?
7 **A.** That's right, yes.
8 **Q.** One of those being Liverpool Women's Hospital,
9 the other Alder Hey Children's Hospital?
10 **A.** Yes, that's right.
11 **Q.** For the period 2010 to 2024, were you the
12 Clinical Lead for Cheshire and Merseyside Neonatal
13 Network?
14 **A.** Yes, I was.
15 **Q.** In terms of the workload of that role,
16 approximately how many hours per week or month did you
17 devote to it?
18 **A.** It was a role that required one session a week
19 which is four hours per week on average.
20 **Q.** Did you find that that was sufficient time for
21 you to discharge your duties under that role?
22 **A.** The weekly work was longer than four hours but
23 yes, I was able to do that, that work in my working
24 week.
25 **Q.** Dr Subhedar, I wonder if I could just invite

1 you to move very slightly closer to the microphone; that
2 would be kind, thank you very much.
3 **A.** Is that better?
4 **Q.** Yes, thank you.
5 In practical terms, what did the role of clinical
6 lead for the network mean?
7 **A.** Yes, I was offering clinical support to
8 members of the network as -- as a practising
9 neonatologist who had experience of neonatal care.
10 Specifically my roles within the network were that
11 I would chair the Clinical Effectiveness Group meetings,
12 I was a member of the Neonatal Steering Group, the
13 Network Steering Group, but I didn't chair those
14 meetings, I was a -- one of the members of that, that
15 group.
16 **Q.** I think your colleague Dr Yoxall was the chair
17 of that group; is that correct?
18 **A.** No, it was someone called Julie Maddocks who
19 was the network director who chaired the Neonatal
20 Steering Group.
21 **Q.** So far as the meeting that you chaired, the
22 Clinical Effectiveness Group, what was the function of
23 that group?
24 **A.** The primary role of that group was sharing and
25 learning, really. Learning from Incident Reviews and

1 Mortality Reviews that were conducted by neonatal unit
2 providers and sharing best practice.
3 So that might mean learning that came from those
4 reviews, it might mean setting up audits, creating
5 guidelines, those sort of things.
6 **Q.** How frequently would that group meet?
7 **A.** That was a bi-monthly meeting.
8 **Q.** So that we are clear, because different people
9 mean different things, every two months?
10 **A.** Held every two months.
11 **Q.** Every two months?
12 **A.** Yes.
13 **Q.** In terms of the structure of the network, is
14 it right to say that it consisted of nine neonatal
15 units?
16 **A.** So the -- there are differences in terms of
17 what people mean by "networks". There was the
18 overriding, overarching operational delivery network
19 which was across the North West but within that network
20 there are three locality networks. Cheshire and
21 Merseyside was one of those three locality networks and
22 within Cheshire and Merseyside, there were nine neonatal
23 units -- nine neonatal provider units.
24 **Q.** So is a correct description the local network
25 to mean --

1 A. We sometimes call it the locality network.
2 Q. The locality network. By that we mean the
3 Cheshire and Merseyside Neonatal Network, the network
4 you were the clinical lead for?
5 A. That's correct.
6 Q. And the network which had the Clinical
7 Effectiveness Group meetings that we have talked about?
8 A. Yes, that is right.
9 Q. Well, please help us to understand where, if
10 it is the operational delivery network we are talking
11 about, that that is made clear.
12 Now, within the locality network of nine neonatal
13 units, one of them was the Countess of Chester?
14 A. That's correct.
15 Q. Is that correctly described as a Level 2 unit?
16 A. People used to describe it as a Level 2 unit
17 or that was a previous classification. More recently
18 around this time it would have been termed a local
19 neonatal unit, which is distinguished from a neonatal
20 intensive care unit which is, if you like, the old
21 Level 3 unit and beneath that would be a special care
22 unit of which there weren't any in Cheshire and
23 Merseyside at that time.
24 Q. Well, we have seen used around this time talk
25 about the classification of Level 2 and Level 1. We

1 have seen a press release from 2016 that talks in those
2 terms, so if we can, we will just refer to those terms
3 I think we are all very familiar with them.
4 A. Okay, that's fine.
5 Q. Was it the case that in the event that
6 a Level 2 unit had a particular baby that had needs that
7 they could not address adequately that they would
8 transfer such babies to the Level 3 units?
9 A. That's right. That would be called an uplift
10 in care and there was set criteria. So, for example,
11 a Level 2 unit would only be able to provide short term
12 intensive care, so if it was anticipated that a baby may
13 only need intensive care for a day or two then it would
14 be acceptable for a local neonatal unit, a Level 2 unit,
15 to look after that baby but if it was clear that this
16 baby was going to need ongoing intensive care it would
17 be transferred to a neonatal intensive care unit.
18 Q. Was there also advice sought from Level 3
19 neonatologists by those working in the Level 2 care
20 centres?
21 A. Yes, that -- that happened not infrequently.
22 Q. Now, if we return to the subject of the
23 Clinical Effectiveness Group meetings and just look in
24 a little bit more detail at the sort of things that were
25 discussed every two months at these meetings.

1 Is it right that Mortality Reviews that were
2 conducted at the hospital level would be brought to
3 those meetings for discussion?
4 A. That's correct, yes, yes.
5 Q. Was there an expectation that every Mortality
6 Review would be brought for discussion or only those
7 that the hospital doctors thought ought to be shared
8 with the wider group?
9 A. No. All Mortality Reviews would be expected
10 to be discussed at some level at the Clinical
11 Effectiveness Group but we would have spent more time
12 talking about those where the reviews had identified
13 deficiencies in care and learning and perhaps new ways
14 of working, changes in practice.
15 Q. Now, you have had an opportunity to look at
16 the minutes of the three Clinical Effectiveness Group
17 meetings in particular?
18 A. (Nods)
19 Q. I will just give the dates of those
20 16 September, 12 November both of 2015 and
21 21 January 2016.
22 A. Yes.
23 Q. One of the things you tell us in your witness
24 statement that you looked for was whether Mortality
25 Reviews from the Countess of Chester were brought to any

1 of those meetings?
2 A. I did, yes.
3 Q. As you acknowledge candidly in your statement
4 you don't in fact have a recollection of some of the
5 detail that you have seen in the minutes but you have
6 been able to check them for us?
7 A. That's right, I relied on the minutes
8 themselves and the information contained therein.
9 Q. So if we go to the Clinical Effectiveness
10 Group meeting for 16 September 2015, what you tell us in
11 your witness statement is that Dr Brearey informed the
12 meeting that there were three deaths under review to be
13 presented at a subsequent meeting?
14 A. Yes. I'm assuming it was Dr Brearey who
15 brought that information it doesn't actually say that in
16 the minutes but I would expect that if he was there, he
17 would have been the one bringing that information to the
18 group and the minutes suggest that there were three
19 deaths that were notified and it was said that they
20 would be brought back at the next meeting once reviews
21 had been completed.
22 Q. Now, I don't know whether you will be able to
23 help with this, but I will ask you in any event. We
24 understand that those deaths related to Child A, Child C
25 and Child D, deaths which occurred in June of 2015. Do

1 you know whether that detail is correct or not?
2 **A.** Sorry, I can't confirm that, but I can say
3 that we didn't have any patient identifiers brought to
4 us when cases were presented, we were just told that
5 there were deaths and some basic information about those
6 deaths.
7 **Q.** I am sure there will be a different way for us
8 to check that and that's certainly the present
9 understanding. But at all events, three Mortality
10 Reviews acknowledged as being in process, but not
11 presented at that meeting for the stated reason that
12 they weren't yet ready to be presented?
13 **A.** That's correct.
14 **Q.** What you tell us is that it wasn't unusual to
15 expect the review at the local level to be completed
16 before it reached the locality network?
17 **A.** That's -- that's correct. Usual process would
18 have been that we would have been notified that those
19 babies had died or we might have already known that
20 because we would have had that data at network level so
21 that list of babies who had died would have been
22 compiled together with the -- the local neonatal unit.
23 And then we would have expected them to go away, do
24 the review, wait until perhaps a postmortem was done or
25 if it went to be a Coroner's case, to see what the

1 Coroner said and then come back with a focus on the
2 learning and whether there was any change in practice
3 that was put in place which may have had a wider message
4 for other local neonatal units, other neonatal units
5 full stop, yes.
6 **Q.** So that brings us to the meeting of
7 12 November of 2015. Again you have considered the
8 minutes for us and you tell us that three Mortality
9 Reviews were presented and discussed?
10 **A.** That's right.
11 **Q.** We will come to a little bit more about that.
12 But in terms of those three, do you know whether it was
13 the three that were trailed in the previous meeting or
14 whether it was one or two of those or none of those
15 three or again are you not able to say because of the
16 lack of detail?
17 **A.** Well, I am unable to say but I would have
18 expected it to have been those three but at that time at
19 network level we didn't keep a log of exactly which
20 cases we were expecting to have presented at future
21 meetings. I mean, that does happen now, there's a far
22 clearer way of logging which babies have died, whether
23 they have been notified at CEG and whether then the
24 review has been completed. So that level of detail is
25 available now, but it wasn't then.

1 **Q.** Do you think it's a fair criticism to say that
2 it was a shortcoming of the system that was being
3 operated by the locality network at that time that such
4 audit was not so readily straightforward?
5 **A.** I think -- I think that's fair but it's fair
6 to understand that was an evolving process around that
7 time so it was -- I agree with what you have said that
8 it wasn't as robust as it could have been.
9 **Q.** So by November of 2015, so far as the network
10 is concerned, three cases have been brought to it from
11 the Countess of Chester and they have been discussed
12 with the object that you have described, namely to
13 derive learning, particularly learning that might assist
14 other units?
15 **A.** That's right. I think if I remember correctly
16 two of the cases involved babies who had had congenital
17 malformations, so to a certain extent were expected to
18 die. But there was a third where a postmortem report
19 was still awaited, so that couldn't have been reviewed
20 in full because we didn't have all of the information.
21 **Q.** Now, the Inquiry knows that by November 2015,
22 there had been significantly more than three deaths on
23 the neonatal unit and if I just work through them?
24 **A.** (Nods)
25 **Q.** There were the three deaths of A, C and D in

1 June of 2015. The death of Child E in August of 2015.
2 There were then two non-indictment baby deaths in
3 September of 2015 and then the death of Child I towards
4 the end of October 2015.
5 Now, at this meeting, the Network Clinical
6 Effectiveness Group were discussing three deaths. Would
7 you have expected the fact that those three sat as part
8 of an expected increase in the mortality rate to be
9 raised in the discussion that was taking place?
10 **A.** No, not necessarily. And I say that because
11 the focus of the Clinical Effectiveness Group was that
12 of learning from reviews that had been completed,
13 identifying any changes in practice the local neonatal
14 unit had recommended, and then to disseminate that
15 information to other local neonatal units.
16 So the purpose of CEG wasn't to monitor rates of
17 death and numbers of death, more to receive information
18 once the reviews had been completed and that could come
19 back to CEG -- that sort of information could come back
20 to CEG in piecemeal fashion sporadically depending on
21 when the reviews had been completed, when the postmortem
22 results were available and, if necessary, when the
23 Coroner's Inquest had taken place.
24 **Q.** Acknowledging what you say about the big
25 picture not being for this particular group, but just

1 adding a little detail to what I have told you already.
2 We also know at the end of October of 2015, Dr Brearey,
3 who was the lead for the neonatal unit, had had
4 a discussion with Eirian Powell and I think both of
5 those people were present at this November meeting; is
6 that right?
7 **A.** I would have to consult the minutes again but,
8 yes, my understanding is there were.
9 **Q.** And as a result of that discussion, we know
10 that Eirian Powell produced a spreadsheet, or a table,
11 which contained a total of eight neonatal deaths and
12 that that table had analysed which of the nursing staff
13 were present and you saw a later iteration of that table
14 so you know what I am talking about because it was
15 appendixed to the Thematic Review?
16 **A.** Yes.
17 **Q.** Now, that occurred on the day of Child I's
18 death and so it would appear, and the Inquiry has
19 already received evidence about this, that there was
20 some consideration of the big picture and in particular
21 what -- whether a staffing feature may be relevant to
22 the mortality of each of those babies?
23 **A.** Okay.
24 **Q.** Bearing in mind that that work was done, just
25 two or three weeks before the meeting that you had,

1 would you have expected any mention of that to be
2 raised, acknowledging that you are looking at individual
3 cases but those individual cases had been part of that
4 analysis before your meeting?
5 **A.** I don't know. I don't think so. I don't
6 think it would necessarily have been relevant to the
7 purpose of the Clinical Effectiveness Group in the sense
8 that at that point there wasn't -- if there was any
9 learning, specific elements of learning that were
10 relevant to other local neonatal units, I think I would
11 have expected them to have been brought back but the
12 fact there was some sort of attempted overview of the
13 deaths this had occurred I don't think that was
14 necessarily the role of CEG.
15 **Q.** If I just put it directly, it is my last
16 question on the topic. In the case of each of those
17 three babies that you were discussing, consideration was
18 being given for each of those three deaths as to whether
19 or not a staffing factor may be relevant to the death?
20 **A.** (Nods)
21 **Q.** So setting aside the big picture in the case
22 of the case that was being discussed, that was under
23 active consideration it would appear at that time.
24 Again, might that be something to be mentioned as
25 part of the review; that this is something that we are

1 considering at the moment for that child?
2 **A.** No, I would have been surprised if anyone had
3 said that at that meeting only because I'm not sure --
4 again, focus on learning and sharing, I don't think that
5 was relevant to that.
6 But, yes, so I -- I wouldn't have expected that
7 level of detail and especially how sensitive that would
8 have been to come across at the Clinical Effectiveness
9 Group.
10 **Q.** Just help us because we have heard that
11 phrase, or a variant on it, a number of times, you say
12 given how sensitive that is, what do you mean by that
13 and how does that sensitivity prevent or inhibit
14 discussion?
15 **A.** So the sensitivity because individual staff
16 members are being scrutinised, if that was the case.
17 Therefore the care that they were being -- the care that
18 they were providing for babies who had died would have
19 been scrutinised and that is sensitive in the sense
20 that, you know, people don't like to -- to talk about
21 that because it makes for uncomfortable listening and
22 hearing.
23 Also in terms of the Clinical Effectiveness Group,
24 that doesn't really impact on other units and what they
25 should be doing. So that's why I don't think it was

1 necessarily relevant to bring that to the Clinical
2 Effectiveness Group meeting.
3 **Q.** Do you think that in general terms that
4 sensitivity prevents discussion happening when it should
5 happen?
6 **A.** I think it probably does. People do feel
7 nervous about attributing poor care to an individual or
8 groups of individuals and especially when a baby has
9 died, to -- to think that that might have been because
10 of the care that was provided by -- by staff members.
11 That is uncomfortable and people do feel sensitive about
12 talking about that.
13 **Q.** Do you think that that is a feature of the
14 culture that needs to change in the interests of the
15 patient?
16 **A.** I think we need to be open, especially when
17 there are concerns like that. But equally we need to be
18 fair to individuals involved as well and there needs to
19 be due process. But if it means that care will be
20 improved and if we are more open, and talk about
21 individuals and groups of individuals, teams, giving
22 best quality of neonatal care yes, I think that could be
23 improved.
24 **Q.** The final meeting to ask you about is the
25 21 January and at this meeting, you say that the minutes

1 record that one death was presented?
2 **A.** (Nods)
3 **Q.** So it would appear that up to the date of
4 21 January 2016, four of the deaths which occurred on
5 the neonatal unit at the Countess of Chester had been
6 brought to the Clinical Effectiveness Group.
7 Now, you tell us in your statement that this is the
8 first time that you had a conversation with Dr Brearey
9 about the mortality rate; is that correct?
10 **A.** As far as I can recall, yes, that is correct.
11 **Q.** And was there any particular reason why you --
12 your recollection is that it's that meeting in January
13 as opposed to, for example, the November meeting?
14 **A.** It's because I have read the email that
15 Steve Brearey had sent to colleagues which was in my
16 initial bundle of information, which referred to him
17 having spoken to me after that meeting. So that email
18 was dated on the 22nd.
19 **Q.** We are certainly going to have a look at that
20 email, but that's how you root yourself in time?
21 **A.** Yes, yes.
22 **LADY JUSTICE THIRLWALL:** Is there a dispute about
23 that?
24 **MR DE LA POER:** I don't believe that there is,
25 my Lady. At one time there may have been.

1 **LADY JUSTICE THIRLWALL:** Thank you.
2 **MR DE LA POER:** Certainly no dispute about the
3 email.
4 So just tell us as far as you can recall what it
5 was that Dr Brearey told you?
6 **A.** So I can't, I can't remember exactly what he
7 said at that time, but my recollection in general terms
8 is that, that he -- that there were a number of deaths
9 that had occurred at Chester, that they had reviewed
10 those deaths and would I act as someone external, in my
11 role as clinical lead for the network, to come and look
12 at those their review of deaths and they hadn't been
13 able to identify any clear cause of death and could
14 I be, if you like, a second pair of eyes looking at, at
15 all of those deaths again and giving my view.
16 **Q.** And was there any discussion between the two
17 of you on 21 January about a particular staff member
18 being associated with those deaths?
19 **A.** No, no, I cannot recollect that at all.
20 **Q.** So we are going to come now to the Thematic
21 Review, but before we get to the detail of that and the
22 email that you have told us about already, what was your
23 impression of the culture of the Countess of Chester's
24 neonatal unit?
25 **A.** So the people I had most dealings with were

1 Dr Brearey and Eirian Powell because they are the ones
2 who represented Chester at either the Clinical
3 Effectiveness Group meetings or the Neonatal Network
4 Steering Group meetings and I had always respected
5 Dr Brearey in the -- in terms of his dedication and
6 diligence in his duties and his engagement with the
7 neonatal network.
8 My view of the neonatal service at Chester was that
9 they operated well, that they had good clinical
10 governance underpinning their activities. They
11 contributed to network activities such as guidelines,
12 incident reviews, they represented their unit regularly
13 attendance at either steering group or Clinical
14 Effectiveness Group wasn't mandated and yet they were
15 there reliably on just about every meeting.
16 **Q.** So let's look at the email that you have told
17 us about, INQ005643. So the email we are looking at is
18 as you have told us the day after that Clinical
19 Effectiveness Group meeting, but before we look at the
20 detail of this I would just like to look at the
21 preceding email in the chain which you are not sent
22 directly but which is forwarded to you.
23 So we can see that was sent three days earlier and
24 it's from Eirian Powell to Dr Brearey, copying in two
25 nurses, the deputy unit manager and the head of the

1 children's service and we can see that what Ms Powell is
2 talking about is that she has:
3 "... amended the last list to ensure we have
4 included all babies that have died on the unit within
5 this timeframe"?
6 **A.** Yes.
7 **Q.** Now I have told you already that there was
8 a first version of that list created which had eight
9 babies on it; that was in October 2015. This is the
10 updated list which had 10 babies on it and so that's the
11 email which --
12 **A.** Yes.
13 **Q.** -- Dr Brearey replies to but he has a number
14 of other people added to this email. Is this the email
15 that you received?
16 **A.** No, I don't think I was on the circulation
17 list, but I have seen that because it appeared in my
18 bundle of information.
19 **Q.** Right. And we can see that you don't appear
20 to be indicated as one of the recipients but so far as
21 our purpose is concerned, we see that Dr Brearey is
22 saying that he discussed increased mortality with you
23 after the network meeting yesterday and that you would
24 be happy to be an external panel member for a Mortality
25 Review but seemed a little bit reluctant to commit more

1 than half a day. He thought some of his colleagues
2 would be willing or he could ask outside the network.
3 He goes on to attribute a number of other things to
4 you. In the second paragraph:
5 "He suggested [so that's you] maybe just reviewing
6 the cases we are uncertain about the diagnosis for."
7 And he makes a point about a particular case which
8 is not an indictment baby, saying he doesn't think it
9 will help to review that again.
10 He comments about having already reviewed Child A,
11 C and D in some detail and being dubious about the
12 benefit of that and goes on to say that the focus would
13 then be on six babies to review.
14 Now, did you know any of the detail -- that detail
15 at the time of your discussion or was it simply as he's
16 recorded it here; that you made a suggestion that there
17 needed to be focus in the meeting because it was only
18 going to be half a day?
19 **A.** I don't recall the details of our
20 conversation, certainly not numbers and individual
21 cases. But I can imagine saying that, that I could
22 offer half a day just because of other work pressures
23 and that we needed to be focused about what exactly they
24 were asking and whether we could rationalise the number
25 of cases to -- to discuss, yes, I can -- I can imagine

1 saying that.
2 **Q.** Now, if we just bring up the document which is
3 attached to this as a convenient way of addressing this
4 issue, so the attachment to this forwarded email and
5 indeed to Ms Powell is INQ0003190. This is a document
6 I think you have been shown by the Inquiry; is that
7 right?
8 **A.** I have seen a number of versions of this.
9 I did want to emphasise that the version that I had
10 didn't have names highlighted in red, but it was
11 certainly dated 19 January.
12 **Q.** So the same date as this but as it appears on
13 the screen, no -- no names highlighted in red as we can
14 see here?
15 **A.** Correct.
16 **Q.** Thank you, we can take that down.
17 Now, as I understand it, you were sent a version of
18 that document. Was that ahead of the meeting or on the
19 day of it?
20 **A.** No, no, it was a few days ahead of the
21 meeting.
22 **Q.** Did it just come as that table or was it
23 attached to any other document?
24 **A.** It was attached to an email, I think.
25 **Q.** So it was an attachment to an email but it

1 wasn't part of a larger document, it was just that
2 table?
3 **A.** I think it was that, I think it was the
4 three-page table.
5 **Q.** And did you consider that document before the
6 meeting?
7 **A.** I am -- I would have looked at it, yes.
8 **Q.** And when you saw that document and saw that it
9 was only looking at nursing staff and that it was
10 differentiating between those who were allocated to the
11 baby and those who were on duty at the time, did it
12 occur to you to wonder why that was being provided to
13 you?
14 **A.** To be honest, I wouldn't have paid much
15 attention to that. I think I would have been focused on
16 the embedded documents of the reviews and I would have
17 focused on -- on those in particular. So I don't
18 recollect paying any specific attention to the columns
19 with the names on them.
20 **Q.** You were being invited to a Thematic Review
21 meeting?
22 **A.** (Nods)
23 **Q.** Would it ordinarily be the case that a chart
24 with staffing would form part of that Thematic Review?
25 **A.** No. With the benefit of hindsight it does

1 seem a bit strange that there were names of individual
2 staff members included in that table, but again my focus
3 was trying to find out whether the causes of death as
4 attributed and the findings of the each individual
5 review were appropriate or not. So hence my focus away
6 from those columns.
7 **Q.** Do you think you should have been more curious
8 about why you were being sent that document to try and
9 understand what the thinking that lay behind it was?
10 **A.** Of course with the benefit of hindsight now
11 looking at it, it does seem curious that those names
12 were there. But at the time, I didn't think anything of
13 it. It didn't occur to me as being really unusual that
14 those were there.
15 **Q.** So we come to the meeting itself and we have a
16 record of the meeting but I just wish to seek your
17 impressions before we go to the detail of it.
18 **A.** Yes.
19 **Q.** Was it a good and effective constructive
20 meeting from your point of view?
21 **A.** As far as I remember, yes, I don't recollect
22 the details of exactly what happened but I would have
23 thought that each case was presented in, you know, an
24 overview of the case rather than a blow-by-blow account.
25 We weren't expected to review all of the case with all

1 of the case notes there and -- and repeat the review,
2 but to get some sort of overview of each case and
3 whether we -- whether I -- I was obviously a panel
4 member, I didn't convene the meeting and didn't chair
5 the meeting but whether I agreed with their conclusion
6 in each case.
7 **Q.** Was there any discussion of the version of
8 that document, the staffing table, at the meeting?
9 **A.** Not that I recollect, I don't remember any
10 discussions about staff members, if that is your
11 question.
12 **Q.** Well, firstly staffing in general, whether
13 that was discussed?
14 **A.** No, no. I can't -- I don't remember it being
15 discussed, no.
16 **Q.** Did anybody at any stage say that they were
17 concerned or had noticed an association between one
18 member of staff and the babies who died?
19 **A.** Not in such stark details, but at some stage
20 I became aware that they were concerned about staff,
21 a staff member or staff members because between the end
22 of that Thematic Review and by the time that
23 Steve Brearey had emailed me with the draft report,
24 I obviously wanted to emphasise an aspect that I thought
25 was important, which was the unexpected and unexplained

1 deaths and the fact that I believed that a more detailed
2 review was required, but I don't remember exactly the
3 point at which I became aware that they were concerned
4 about a staff member.
5 **Q.** Are you able to say with any certainty whether
6 it was during the meeting itself when everybody was
7 sitting in the room together?
8 **A.** No, no. I can't remember that. I think that
9 would have been unusual, possibly noteworthy, if they
10 had mentioned that. I -- I am aware that either in
11 Dr Brearey's statement or his evidence yesterday that he
12 said that he had mentioned after the meeting to me that
13 there were concerns about a staff member and that it
14 could have been then. I think it's more likely it was
15 then.
16 **Q.** That was what I was going to say. Is that the
17 probability that that --
18 **A.** I think -- I think so.
19 **Q.** When you were told about his concern, as you
20 just told us about the sudden and unexpected
21 deteriorations and -- and deaths, and the association,
22 if that's a fair way of neutrally describing what he was
23 suggesting to you, was that something that gave you
24 cause for concern?
25 **A.** It -- yes, it would have done, yes. It would

1 have concerned me, but I think at that time I would have
2 still wanted to press for a detailed review of broader
3 staffing flows, for want of a better word, because
4 clearly there was only -- it was only a summary of the
5 nursing staff members that were on duty at the point at
6 which various babies died, there wasn't any mention of
7 medical staff, there wasn't any mention of who had cared
8 for babies in 12 or 24 hours prior to that, all of those
9 I think were relevant.
10 **Q.** He has told you those two facts that he's
11 worried about: the sudden and intended deteriorations
12 and deaths and that there is a member of staff who
13 appears to be associated with all in fact bar one
14 according to the chart.
15 I mean, did you understand at the time that that
16 implied that there was a possibility at least, in
17 Dr Brearey's mind, that that member of staff may be
18 responsible for the deaths because otherwise it's
19 a meaningless additional fact, isn't it?
20 **A.** I think I would have been aware of that. But
21 it's not something that was top of one's list when you
22 are considering why babies might have died.
23 It's -- there are other explanations including
24 perhaps individuals giving care that wasn't of the
25 standard rather than wilfully doing any harm to babies.

1 And from time to time, there are cases where a death
2 occurs in a neonatal unit and we have got no good
3 explanation for. It doesn't automatically mean that
4 there is someone trying to do harm to that baby.
5 **Q.** No, but the fact that it's a possibility,
6 doesn't that raise a safeguarding issue?
7 **A.** Yes, if -- if an individual is concerned that
8 someone is harming a baby, yes, it does raise
9 a safeguarding issue.
10 **Q.** And -- and did you say to Dr Brearey, "Isn't
11 this a safeguarding issue, don't you need to raise it as
12 such?"
13 **A.** No, I didn't say that to him. If he had been
14 concerned I would have expected him to have raised
15 a safeguarding issue at a local level, at the Trust
16 level and followed safeguarding, their safeguarding
17 policy. But I didn't specifically say that to him, no.
18 **Q.** Do you think that's something that you should
19 have said to him? Based -- not with the benefit of
20 hindsight but based on the fact that he is telling you
21 that he's worried about these deaths, the fact he has
22 drawn to your attention there is an association which
23 implicitly carse the possibility that that individual is
24 deliberately causing harm, isn't that enough to say:
25 this is safeguarding, we need to engage those

1 mechanisms?
2 **A.** I suppose it is. I would say that I would
3 have expected him, if he had that level of concern, to
4 have triggered the safeguarding policy that was in
5 operation.
6 My view was the pressing need for more information
7 in terms of a detailed staffing review.
8 **Q.** But seeking more information, do you agree,
9 doesn't keep babies safe in the meantime?
10 **A.** No, I agree, that doesn't. But I suppose
11 I would want more information about why he was concerned
12 about an individual and whether that was an appropriate,
13 was the appropriately -- it was appropriate to be
14 concerned about one individual when a detailed review of
15 other individuals who had been providing care at that
16 time hadn't been conducted.
17 **Q.** Did you seek to explore it with him any
18 further than you have just described?
19 **A.** No, I -- I didn't, except to say that in the
20 draft report that he sent me I asked for greater
21 emphasis to be put on the fact that there were a series
22 of unexplained and unexpected deaths and that would
23 provide justification for this internal review that
24 I expected was one of the action points.
25 **Q.** Let's just work through the documents briefly.

1 We will start with the first draft of the Thematic
2 Review and we have looked at it many times, we can just
3 go quite surgically to particular parts of it,
4 INQ0003217 and if we go to page 7, please.
5 We can see at item 4 in this draft is the timing of
6 the arrests. Do you recollect a discussion in the
7 meeting about the timing?
8 **A.** I'm afraid I don't recollect that, no.
9 **Q.** So that didn't stand out for you if it was --
10 if it was discussed?
11 **A.** I don't remember it being discussed, but I can
12 see that it's there in as an identified theme so it's
13 quite possible we discussed it, yes.
14 **Q.** In connection with the timing, the action
15 point is:
16 "To review focusing on nursing observations in the
17 four hours before arrest, aim to identify if unwell
18 babies could have been identified earlier."
19 And then finally this:
20 "Identify any medical or nursing staff association
21 with these cases."
22 Do you recall that action point being discussed in
23 the meeting as you were all present?
24 **A.** I can't personally recollect that but, you
25 know, I accept that that was one of the themes that was

1 identified, so it probably was discussed. But I don't
2 think it just applies to those babies, it applies --
3 I would say it applies to all of the babies that -- in
4 whom there was an unexpected and unexplained collapse.
5 **Q.** So you were expecting that to go beyond the
6 babies listed that had been discussed at the meeting and
7 up?
8 **A.** I think so, yes. Yes, I don't see why it
9 should just apply to those babies that died in that
10 four-hour window.
11 **LADY JUSTICE THIRLWALL:** Sorry, I think you might
12 be at cross-purposes.
13 So because it says six babies had arrests, and then
14 there is the reference to reviewing all these cases, are
15 you reading that as meaning only the six rather than all
16 the cases?
17 **A.** Yes, I thought that was the question. But
18 I am saying that it should have been extended to all.
19 **LADY JUSTICE THIRLWALL:** All the ones you were
20 reviewing.
21 **A.** Yes, well, all the ones we were reviewing
22 where there wasn't an explanation for.
23 **LADY JUSTICE THIRLWALL:** Yes, thank you.
24 **MR DE LA POER:** Thank you, my Lady. Now, appended
25 to this draft report is that table which appears to be

1 a table identifying the nursing staff association, do
2 you agree?
3 **A.** Well, I haven't got it in front of me but yes,
4 I am familiar with the table, yes.
5 **Q.** You are familiar?
6 **A.** With those columns.
7 **Q.** Was that the sort of thing that you were
8 expecting would be produced as a result of this action
9 point?
10 **A.** Well, in part. But also medical -- similar
11 I think all people, all staff members, be they nursing
12 or medical, who had cared for those babies at around the
13 time of death and in the hours preceding that is what
14 I would have suggested.
15 **Q.** Thank you, we can take that down.
16 Then we come to the email that you have referred
17 to, INQ0102684, and we go to page 214 for this, please.
18 So down one more page. So we can see quite late at
19 night on 8 February, Dr Brearey sends out the draft and
20 invites suggestions and you reply on 10 February to say
21 this:
22 "One additional comment that you might consider
23 adding somewhere that relates to the theme of some of
24 the cases involving babies that suddenly and
25 unexpectedly deteriorate and in whom there was no clear

1 cause for the deterioration/death identified at
2 postmortem."
3 You attach a paper. Is that -- is that paper
4 anything to do with your preceding comment or is that
5 something else that was discussed at the meeting?
6 **A.** Something else that was discussed and
7 I promised to forward on.
8 **Q.** Fine. So in terms -- and you have told us
9 something about this already, in terms of your thinking
10 behind adding that just, just work us through exactly
11 why you thought that that needed to be added?
12 **A.** Well, the purpose of me being there and for us
13 to be having that Thematic Review was to confirm the
14 suspicion in Chester, when they had done their reviews
15 that there were still some cases where there was no
16 clear explanation for a baby's collapse and/or -- and/or
17 death. I think what we decided at Thematic Review was
18 that was correct that there were certain cases that were
19 -- remained unexplained and yet in the draft that
20 Dr Brearey had created it didn't spell that out so
21 I felt it was important to highlight that.
22 Because one of the actions that came from that was
23 this in-depth review and there needed to be some
24 justification for why there was going to be that
25 in-depth review.

1 **Q.** When you say the in-depth review, what exactly
2 were you expecting would be done and by whom?
3 **A.** Well, it was this medical and nurse staffing
4 review, a more detailed review about which members of
5 not just nursing staff, not just those who were
6 allocated, who were actually delivering care at the time
7 and perhaps in the preceding shift, something like that.
8 **Q.** What was your expectation that if that review
9 was conducted and that one member of staff who was
10 identified right at the start of your understanding
11 about what Dr Brearey was concerned about, remained the
12 only member of staff associated, what would you expect
13 to happen at that point?
14 **A.** Well, I think that would escalate the level of
15 concern, had I been Dr Brearey, for example, that the
16 level of concern in my own mind about my concern about
17 the care that is being provided, whether intentionally
18 or unintentionally, that that staff member was providing
19 for the babies at the time.
20 **Q.** And -- and on your understanding of what you
21 were told, does it at that stage reach the safeguarding
22 threshold?
23 **A.** I think it does, yes. At that point, when you
24 have excluded other possibilities, I think that -- and
25 you are concerned about an individual's care for a --

1 for a baby, yes, that, that does.
2 **Q.** Now, somebody who hadn't participated in the
3 conversations that you had had with Dr Brearey may not
4 immediately understand your thought process behind that;
5 do you see that? That by adding that phrase you are not
6 saying -- associating it with the staffing analysis, do
7 you see what I mean?
8 **A.** Right. Possibly, it was my intention to link
9 the two, yes, but I can understand that it may not have
10 been clear.
11 **Q.** So we can have a look at INQ0006817 and again
12 we can go to page 7. So we can see that this is the
13 version that it is finally circulated. Your entry now
14 takes number one spot. But there's no action associated
15 with it. The action continues to be as it was in the
16 draft against timing of arrests.
17 So do you think that there has been
18 a miscommunication between you and Dr Brearey in terms
19 of what you were intending to be linked and to be
20 justified in a particular way and what actually appears
21 in the final version?
22 **A.** I appreciate that it looks as if there is no
23 action from point number 1 on that, on that page. But
24 I think the action under point 2 encompasses both points
25 1 and 2 or at least that would have been my intention

1 and I think there is an action plan that goes along with
2 this document which --
3 **Q.** Yes.
4 **A.** -- also summarises that action.
5 So while I appreciate that it doesn't explicitly
6 say what the action from point 1 is, I think it's
7 encompassed under point 2.
8 **Q.** Because of course this was a document that you
9 understood would be -- would have a wider audience?
10 **A.** Well, yes, I didn't know who this would have
11 been circulated to, but yes.
12 **Q.** But it wasn't just being held within the group
13 of you who had discussed it. This was -- this was --
14 **A.** No, probably not, no.
15 **Q.** So we can look at that action, page 10. Is
16 this the action list that you were referring to?
17 **A.** That's right, yes, it's at the bottom there.
18 **Q.** We can see that it's marked as complete as
19 at -- this will be 2 March of 2016.
20 **A.** Yes, well I can see that it's marked as
21 complete, yes.
22 **Q.** And so, I mean, in your mind this was
23 an important action that needed to have a proper
24 justification. When that was sent to you, did you have
25 a look to see where Dr Brearey had got to with the issue

1 that he raised with you he was concerned about and that
2 you had given had him advice about and that had led to
3 the amendment of the draft?
4 **A.** So I -- this is the first time I have noticed
5 that that says "complete", it's not something that's
6 occurred to me previously. This is the final draft of
7 the action plan that comes from the Thematic Review so
8 I wouldn't have really expected any of these actions to
9 be properly complete and I don't think that between the
10 review and receiving the final draft that all of the
11 actions would have been completed. So that's probably
12 why I didn't see that and make any -- I didn't look at
13 the word "complete" and think that: oh, yes, all of
14 that's completed now.
15 **Q.** Did you ever follow up with Dr Brearey about
16 the advice you had given him and the sudden collapses
17 and the staffing analysis to say: Dr Brearey, did you
18 ever put to bed that worry that you had, or is it still
19 a concern?
20 **A.** No, not -- I didn't personally follow that up
21 until many months later when we had meetings with the
22 team at Chester because I was under the impression, and
23 I think this is supported by an email that Dr Jayaram
24 had, that I have seen, which said that there was some
25 sort of internal review. So I assumed that there was

1 some sort of internal review that was ongoing.
2 **Q.** So that internal review doesn't start, if it's
3 the same one, until July. Do you think you should have
4 followed up -- given that Dr Brearey had raised this
5 with you, do you think you should have followed up
6 to say what was the final conclusion of the Thematic
7 Review about the staffing analysis?
8 **A.** I think again with the benefit of hindsight
9 I wish I had done that but that was really -- it was the
10 ownership of this document and the action plan was the
11 team at Chester is how I saw this, that they had
12 a number of actions that they should complete and that
13 was one of them.
14 **Q.** But this one was slightly different, do you
15 agree, to others in the sense that you would actually
16 encourage an amendment to the report in order to provide
17 a robust justification for it?
18 **A.** Yes, yes, I would accept that, yes.
19 **Q.** Do you think the Thematic Review should have
20 been more explicit about the concern which existed at
21 the time that it was undertaken about a particular
22 member of staff. When I say the Thematic Review I mean
23 the report itself.
24 **A.** Well, as I said before I don't think we
25 discussed a member of staff at the Thematic Review, so I

1 don't think it would have been correct to state in those
2 plain terms that there was concern about the care
3 provided by a single member of staff seeing as we hadn't
4 discussed it in any detail in the -- in the meeting
5 itself.
6 **Q.** But the document itself says that no themes
7 were identified but in fact you knew that a theme,
8 a particular member of staff, had been identified at the
9 time of the meeting?
10 **A.** No, that's not quite correct. Well, not
11 during the meeting but I understand that Steve had
12 expressed -- Dr Brearey had expressed concern after the
13 meeting about a member of staff which he told me
14 informally.
15 **Q.** Well --
16 **A.** But I don't think that was discussed at the
17 meeting itself. In fact, I don't remember any
18 discussions about staffing at the meeting.
19 **Q.** Again just looking at it from the point of
20 view of you know that this is a document that's going to
21 go into wider circulation. Doesn't the reader need to
22 have that spelt out for them? Instead of as the reader
23 would: "there was no common theme identified in all
24 cases"?
25 **A.** Sorry, I haven't got that page in front of me,

1 so I can't --
2 **Q.** It's page 7.
3 **A.** I mean, it does say there was no common theme
4 identified in all the cases and I have -- I have said
5 some of the babies suddenly and unexpectedly
6 deteriorated. I think those are consistent, although
7 I hear what you are saying, a very important theme that
8 was identified was the sudden deterioration and a very
9 important action that followed that theme was the review
10 of medical and nursing staffing, so if your question is
11 should we have made it clearer, should it have been
12 clear, I think you are probably right, it should have
13 been.
14 **Q.** The Inquiry has received evidence that this
15 document was taken at its face as saying there was no
16 common theme.
17 **A.** Well, if you read the first sentence and the
18 first sentence only, then -- then that would be correct.
19 But in the context of the first theme that was
20 identified, it may not have been common to all of the
21 babies but it is the first theme that says sudden
22 deterioration and -- and that there was no clear cause
23 for the deterioration or -- or collapse or death.
24 So I think in that respect it's clear.
25 **Q.** I think in fairness to you, Dr Subhedar,

1 I just want to acknowledge you and I have both been
2 working on this being the version sent to you but I have
3 noticed as we were flicking on the previous page that
4 there was a date of April 2016 which postdates the
5 version. So can I just give you this undertaking that
6 we will double-check the version that you were sent in
7 terms of whether that action was marked as complete at
8 the time it was sent. I just want to acknowledge that
9 to you in fairness to you?
10 **A.** Okay, thank you. I do appreciate there are
11 a number of different versions there and I can't
12 remember which one I received.
13 **Q.** Well, we will be able to find it.
14 So I would like to move on from the Thematic
15 Review, so please could we take that down and just
16 briefly summarise your understanding of the second half
17 of 2016.
18 Were you aware of the downgrading of the unit in
19 July of 2016?
20 **A.** Yes, I was.
21 **Q.** Were you aware that the Royal College was
22 commissioned to undertake a review?
23 **A.** I -- I was aware of that but fairly close to
24 the point at which the review was going to happen
25 because I didn't have enough time to change my diary and

1 I was away at that time so I couldn't participate in
2 that.
3 **Q.** There was an idea that you might participate
4 in the Royal College's review; is that right?
5 **A.** There was -- I was invited to fairly late on.
6 I couldn't go but the director of the network,
7 Julie Maddocks, did attend on behalf of the network.
8 **Q.** Bearing in mind -- and this isn't a criticism
9 of your unavailability, but bearing in mind that you had
10 been involved in the Thematic Review and so and you had
11 had those conversations with Dr Brearey about this very
12 topic, do you think it would have been better if the
13 Royal College had spoken to you?
14 **A.** Possibly. But the network director,
15 Julie Maddocks, I had had discussions prior to the
16 Thematic Review about Chester wanting me to attend and
17 we had agreed that that was reasonable and I would have
18 spoken to her in the intervening months about -- about
19 what was happening at Chester and the fact that the
20 RCPCH review was happening, she would have been aware of
21 that.
22 So I think she could have deputised but I can see
23 some benefit of me having been there, yes.
24 **Q.** Were you aware of Dr Hawdon or perhaps just
25 a neonatologist being instructed to conduct a detailed

1 forensic Casenote Review?
2 **A.** I was, but I -- I don't know when that would
3 have been. Some time in the autumn perhaps, so later on
4 in 2016.
5 **Q.** Did any of those events give you cause for
6 concern or cause you to think that on behalf of the
7 network you needed to find out what was going on at the
8 Countess of Chester?
9 **A.** Not cause for concern, quite the opposite.
10 I would have been pressing for a more detailed review,
11 so I welcomed the reviews that were ongoing. We weren't
12 party to the Terms of Reference of either review. But
13 I was grateful for there being external scrutiny and
14 what I hoped was a more detailed review which is
15 something we had been asking for from the point of the
16 Thematic Review onwards.
17 **Q.** Now, the Inquiry knows that the Consultant
18 body, particularly Dr Brearey and Dr Jayaram, said in no
19 uncertain terms that they -- to the Executives in June
20 of 2016, that they were concerned that Letby may be
21 murdering babies. They said as much again in September
22 to the Royal College.
23 Was that a concern that the network should have
24 been notified about?
25 **A.** I don't know. I was -- I have never been in

1 that position before. I'm not sure that was necessarily
2 the network's role but I know that when the
3 paediatricians at Chester asked for us to attend
4 meetings with the Chief Exec -- with the Executive Team
5 at Chester, we were happy to do so but more in terms of
6 providing support for the paediatricians rather than
7 having an independent role ourselves.
8 **Q.** Now, that brings us to February 2017. The
9 Royal College report was published on the Internet. Did
10 you have an opportunity to read it?
11 **A.** I read it because it was sent to me by
12 Julie Maddocks and I think she received it from Chester
13 at that point. But it hadn't been shared prior to -- to
14 then.
15 **Q.** Now, you will have noted that there was
16 recommendation to the network within that report, wasn't
17 there?
18 **A.** There was. Sorry, you would have to remind me
19 of what the recommendations were specifically?
20 **Q.** I certainly can, although perhaps the detail
21 isn't important, but you have asked so INQ0001954,
22 pages 21 and 22.
23 **A.** Thank you.
24 **Q.** So this is in relation to the transport
25 service which is operated at a network level?

1 **A.** That's right.
2 **Q.** Now, there is evidence to suggest that this
3 report was finalised in this form in November of 2016.
4 Should you have been told about this as soon as that
5 report was finished?
6 **A.** I think we should have been and I don't know
7 whether that's the responsibility of the Executive Team
8 at Chester or the College to have given us access to
9 that report but, yes, if there were recommendations for
10 the network, we should have seen it.
11 **Q.** Well, the transport service continued to
12 operate in the period November to February. If there
13 were improvements presumably you would want to know
14 about those as soon as possible?
15 **A.** Yes, that's -- that's true.
16 **Q.** Now, thank you, we can take that down.
17 You also received Dr Hawdon's report and we don't
18 need to go to the document, but did you reply to the
19 email from Ian Harvey that sent that to you enquiring
20 about Dr Hawdon's Terms of Reference?
21 **A.** I did.
22 **Q.** Why did you want to know Dr Hawdon's Terms of
23 Reference?
24 **A.** I wanted to -- I wanted to know what she had
25 been asked to do and what information she had been able

1 to access and -- and to whom she spoke to, to be able to
2 compile her report.
3 **Q.** One of her Terms of Reference which in fact
4 she said she couldn't undertake but it was there on the
5 face of the Terms of Reference was she was asked to
6 consider which staff had access to the neonatal unit.
7 So not just who's supposed to be caring for the baby but
8 who had access.
9 Is that the sort of enquiry that a neonatologist
10 would be expected to be able to answer?
11 **A.** I'm not sure I understand what that term
12 means, having access to the neonatal unit. That
13 suggests on the face of it people who can literally get
14 into the neonatal unit, that doesn't sound like a job
15 for a neonatologist and I am confused by why that would
16 be in the Terms of Reference stated as such.
17 **Q.** Did you ever receive a response from
18 Ian Harvey in relation to your request to clarify the
19 Terms of Reference from Dr Hawdon?
20 **A.** No, I didn't.
21 **Q.** Now, having considered Dr Hawdon's report, did
22 you conclude that there were -- as it was presented to
23 you there were four cases that she said further forensic
24 review should take place in relation to. Did you
25 identify three more?

1 **A.** Yes, I did.
2 **Q.** And we don't need to go into the medicine.
3 But in simple terms, why do you think that there were
4 three additional cases that were requiring further
5 investigation, what was it about them?
6 **A.** Again because they were unexpected and
7 unexplained.
8 **Q.** Was that particular feature something that you
9 would ordinarily look for or was it something that you
10 had in your mind from the Thematic Review that you had
11 already participated in?
12 **A.** I think it must have been from the Thematic
13 Review but also I wasn't clear whether Dr Hawdon had
14 been able to -- had been given access to all of the
15 cases that we had been concerned about following the
16 Thematic Review.
17 **Q.** You attended a meeting on 28 February. That
18 meeting included a number of paediatricians and
19 Ian Harvey; is that right?
20 **A.** That's correct.
21 **Q.** What was the tone of that meeting?
22 **A.** I think one of concern that was expressed by
23 the paediatric Consultants at Chester. I think it was
24 a perfectly civil meeting, I don't think there was any
25 unpleasantness, for want of a better word. But yes,

1 that's my recollection of it.
2 **Q.** Was there discussion in the meeting about the
3 Consultants' concerns about an individual member of
4 staff?
5 **A.** I can't remember. I -- I can't remember if
6 that was the meeting where there were minutes but if
7 there were minutes I would like to have a look at them
8 to -- to remind myself whether that was discussed.
9 **Q.** There were emails exchanged about this meeting
10 that you were copied into. The one email I would like
11 to take you to is the one that you sent following the
12 meeting, INQ000 -- I will start that again. INQ0006105.
13 So Dr Brearey at the start of this had sent you
14 a summary of the meeting which is just over the page.
15 **A.** Yes.
16 **Q.** We will see that in a different context.
17 Dr Gibbs has gone through it and amended it and your
18 response above the page is to say that you are not going
19 to co-sign it but you would like an addition and if
20 I can summarise this, I hope I do so completely, your
21 position was the Countess of Chester was not an outlier
22 from an acuity or staffing perspective as compared to
23 the network?
24 **A.** That's correct.
25 **Q.** So insofar as it may be suggested that that

1 could explain the increase, you were giving a bigger
2 picture to say to your mind it couldn't?
3 **A.** That's correct. Just to -- just to be clear,
4 at that time, most neonatal units weren't compliant with
5 the national standards for nursing numbers and ratios,
6 but Chester didn't -- wasn't an outlier compared to
7 other local neonatal units within the network.
8 **Q.** We see that that text was included in the
9 email sent, INQ0003395. The email summarising the
10 position is over the page and your text was included,
11 I think it's the next page down. There we are, the
12 final substantial paragraph lifted into Dr Brearey's
13 email and we can see that what Dr Brearey is saying is
14 if we go back up the page, that there are eight babies,
15 so four started with Dr Hawdon, you in fact thought it
16 was seven, Dr Brearey is now saying eight.
17 The only question I want to ask you about this is
18 what Ian Harvey says in response to the paragraph that
19 you added in --
20 **A.** Yes.
21 **Q.** -- which is on the page above. And in the --
22 I think it's the fourth paragraph --
23 **A.** Yes.
24 **Q.** -- where Ian Harvey comments -- and I'm sorry,
25 I have just lost my place, forgive me.

1 **LADY JUSTICE THIRLWALL:** It is the third paragraph.
2 **MR DE LA POER:** It is the third -- three lines down
3 the paragraph beginning "Contrary"?
4 **A.** Yes.
5 **Q.** He agrees that you did say that, but then goes
6 on to say:
7 "I have seen no evidence to confirm this nor have
8 I seen anything to indicate that there was the same
9 trajectories that we had in the period leading up to
10 2015/16."
11 Now, did Ian Harvey ever ask you for data or to
12 assist him further?
13 **A.** No, he didn't.
14 **Q.** Was the network data available?
15 **A.** Yes. Staffing occupancy levels, all of that
16 sort of data is included in an annual report that the
17 network provided called -- we call it the ACD report,
18 the Activity Capacity Demand report, which contains
19 those that sort of level of information.
20 **Q.** And had you effectively as clinical lead
21 summarised that information as you understood it into
22 that paragraph that you drafted?
23 **A.** Yes, I had.
24 **Q.** Thank you very much. The final meeting to ask
25 you about is on 27 March 2017. There is a record made

1 of this meeting.
2 **A.** Yes.
3 **Q.** I don't think because there is only one matter
4 in particular that I want to ask you about that's
5 recorded in the minutes that you refer to in your
6 statement, it's recorded that Dr Brearey said the matter
7 needs to be escalated to the police.
8 Do you have a recollection of a discussion about
9 whether or not the police should be contacted at that
10 meeting?
11 **A.** Not a detailed recollection but I am aware
12 that the -- a referral to the police was discussed at
13 that meeting.
14 **Q.** What was your impression of Ian Harvey's --
15 who I think was also present at that meeting -- reaction
16 to that?
17 **A.** Sorry, I can't remember exactly what his
18 reaction was, him personally.
19 **Q.** Do you recall whether the meeting ended with
20 a plan to call the police or was that still an open
21 question or had a decision been made not to do that?
22 **A.** No, as far as I remember, there wasn't a firm
23 decision made that they were going to go away and
24 consider it.
25 **Q.** You were invited to meet Simon Medland QC, as

1 he was, the barrister instructed by the Trust, but you
2 decided to decline that invitation; is that right?
3 **A.** That -- that's correct, yes.
4 **Q.** Why did you think it wasn't appropriate to go?
5 **A.** I discussed it firstly with Julie Maddocks,
6 the network director, and we came to the conclusion that
7 whatever decision they -- the team at Chester came to
8 would be their decision and I didn't want the network --
9 we didn't want the network -- to be supporting
10 a decision which, whichever way they -- they went
11 because if we had been attending the meeting then by
12 virtue of the fact that we were there it would have
13 suggested the network was supportive of whichever
14 direction Chester took following that meeting, whether
15 to involve the police, which is what we were pushing for
16 or equally not to involve the police at that time.
17 **Q.** Finally this. You reflect in your statement
18 and I will just read it out to you:
19 "I believe the overall role and performance of the
20 locality network in relation to monitoring and oversight
21 of neonatal mortality in 2015/16 could have been
22 improved."
23 Can you tell us why you say that and what
24 improvements you think there may be?
25 **A.** Yes. So the way I see the role of the network

1 is in part to -- to provide the best quality of care for
2 babies who are being looked after in that region and
3 also to monitor performance which means not only
4 activity and staffing levels but also outcomes and
5 benchmarking outcomes and the starting point for that is
6 to collect and report data, good quality data,
7 consistently, and I think we failed in that -- in that
8 role because in the Neonatal Network Steering Group
9 meetings we didn't provide that data.
10 To be fair, it was an evolving process and I think
11 that we at that time and in the years that followed, the
12 North West operational delivery network as a whole was
13 ahead of other networks, so we weren't the only network
14 who didn't provide good quality data but given that that
15 was part of our Terms of Reference, that's what we
16 should have been producing and we didn't.
17 So I would apologise for that because I think that
18 is a weakness, a failing, of the network's role.
19 **MR DE LA POER:** Dr Subhedar, there will be some
20 further questions but, my Lady, I wonder if this might
21 be a convenient moment for a break?
22 **LADY JUSTICE THIRLWALL:** Very well. We will take
23 a break of 15 minutes and we will start again at 25 to
24 12.
25 **(11.19 am)**

1 **(A short break)**
2 **(11.35 am)**
3 **LADY JUSTICE THIRLWALL:** Ms Rong.
4 Questions by MS RONG
5 **MS RONG:** Dr Subhedar, I ask questions on behalf of
6 two of the Family groups and just want to explore a few
7 issues that are of particular interest to them.
8 You have already given evidence this morning that
9 your involvement in the chronology of events that
10 concerns this Inquiry was in your role as the clinical
11 lead of the neonatal network; that's correct, isn't it?
12 **A.** That's correct, yes.
13 **Q.** As part of the overall structure or function
14 of the network, there is the Clinical Effectiveness
15 Group and a steering group?
16 **A.** That's correct.
17 **Q.** Now, first of all let's look at the Clinical
18 Effectiveness Group Terms of Reference. If I could have
19 INQ0102684, page 4, please.
20 Thank you. Section 2.1, second section on this
21 page, the vision statement, it explains:
22 "To be clinically driven and operate within and
23 support a culture of collaboration; to engage and
24 interact with other stakeholders, member organisations
25 and families, to deliver agreed outcomes".

1 So that is the Terms of Reference for the CEG?
2 **A.** (Nods)
3 **Q.** Let's now turn to page 10, please, which is
4 part of the Terms of Reference for the steering group.
5 And it's page 10. Thank you.
6 Section 2.2, it explains the operating principles
7 for the neonatal ODN and says they are adapted and
8 adopted from NHS England values.
9 So these are core NHS values, do you agree?
10 **A.** Yes.
11 **Q.** I just want to take you to two specific
12 principles in that list, the first item, first bullet
13 point:
14 "We will put the interests of patients and their
15 families and carers at a centre of our activities."
16 The third bullet point:
17 "We will be clinically led with an equal voice for
18 babies, their families and carers alongside clinicians
19 and managers."
20 So it is clear from these Terms of Reference that
21 the babies and the families who have received care and
22 treatment within the network is at the centre of what
23 you do?
24 **A.** I would agree with that, yes.
25 **Q.** The guiding principle is that they should have

1 an equal voice alongside clinicians and managers within
2 the Trust, would you agree?
3 **A.** Yes.
4 **Q.** Now, we know that from the evidence you gave
5 this morning, Dr Brearey first brought to your attention
6 his concerns after the CEG meeting on 21 January 2016,
7 we know that because we have seen the email
8 correspondence and he asked for your input and I think
9 you put it this morning as a second pair of eyes or
10 a fresh pair of eyes to essentially sense-check whether
11 their concerns that there were unexplained, unexpected
12 deaths on the unit was confirmed, was something that was
13 accurate?
14 **A.** Yes, that's right.
15 **Q.** You thereafter, we know, attended a Thematic
16 Review meeting on 8 February 2016 and you gave evidence
17 this morning that shortly afterwards there was I think
18 you say a separate conversation you had with Dr Brearey
19 when the nursing concern or the association with
20 a member of staff were discussed?
21 **A.** That's right.
22 **Q.** Now, the takeaway from those discussions, by
23 which I mean the Thematic Review meeting and the
24 subsequent discussion you had with Dr Brearey, was that
25 there were internally within the Countess of Chester NNU

1 concerns that they were having increased numbers of
2 deaths, but not just that, that those deaths were
3 unexplained and unexpected?
4 **A.** I only knew that Steve was -- when you say
5 "internal concerns", I only knew that Dr Brearey was
6 concerned and that he was concerned about some of the
7 deaths that were unexplained and unexpected.
8 **Q.** That's the reason why he came to you in the
9 first place?
10 **A.** Well, yes.
11 **Q.** Yes?
12 **A.** Yes.
13 **Q.** That was your view after the Thematic Review,
14 you agreed with him: yes, what you are concerned about
15 is valid?
16 **A.** Yes.
17 **Q.** Based on a clinical review, I appreciate it
18 was only a brief discussion in that meeting, but from
19 what you were aware of, from the point of view of the
20 network, you did not think any other factors such as
21 acuity or level of activities on the NNU or any nursing
22 competency issue could immediately explain those
23 concerns?
24 **A.** At the Thematic Review some of those things
25 you have mentioned weren't discussed. It was the

1 clinical care stuff such as an individual nurse's
2 competency, broader staffing factors. Those weren't --
3 those weren't discussed at the review.
4 **Q.** They were or were not?
5 **A.** Were not.
6 **Q.** Were not. But nothing that was brought to you
7 or you had seen around that time, both in the meeting
8 itself and during your subsequent discussion with
9 Dr Brearey, it wasn't -- okay, we have identified the
10 reason now, it's acuity, it's nursing competency;
11 nothing --
12 **A.** That's correct.
13 **Q.** -- to explain it away?
14 **A.** That's correct.
15 **Q.** And that was not an acceptable state of
16 affairs, by which I mean there was clearly a patient
17 safety issue that needed further investigation, further
18 review; that was your view, was it not?
19 **A.** It was, yes, that -- that needed further
20 detailed review, yes.
21 **Q.** Now, Dr Brearey's evidence to the Inquiry
22 yesterday was that as far as he was concerned, by the
23 end of that Thematic Review, you had or he had looked at
24 most of the other things you might wish to consider and
25 those things have already been excluded.

1 Now, I do not know of course whether he expressed
2 those thoughts to you at the time, but when you gave
3 evidence this morning when asked when the threshold
4 would be reached to escalate the level of concern, and
5 your answer was: when you excluded other possibilities?
6 **A.** Yes, yes.
7 **Q.** So if that was the frame of mind for the
8 paediatricians, Dr Brearey in particular at the end of
9 the Thematic Review, you would expect escalation at that
10 point, would you not? That threshold has been crossed?
11 **A.** If an individual believes that there is no
12 other explanation then that threshold would have been
13 crossed.
14 **Q.** If we take a step back, your recommendation
15 was we need to look at it further, that's the action
16 plan that was drafted by Dr Brearey afterwards to see
17 whether there was a theme regarding staffing issue, but
18 those reviews take time and when we are in a state of
19 affairs where there was a concern, a valid concern, we
20 do not know what it was, it might take time to get to
21 the bottom of it, does patient safety not demand
22 immediate action to protect the patients whilst those
23 reviews are ongoing?
24 **A.** Well, I think it does. But we have to ask --
25 you can't put safeguards if you don't know what the

1 problem -- where the problem lies, so you have to go
2 through a process and that's what I was asking for that,
3 a detailed review needed to be performed to get to the
4 point at which you conclude there are no other
5 explanations here and that it is perhaps a staff member
6 and the care that that staff member is delivering,
7 either intentionally or unintentionally, to that baby
8 that's causing the problem.
9 So you can't jump to that conclusion without having
10 gone through that process.
11 **Q.** But the unit didn't jump to that conclusion.
12 Work had already been done before they came to you.
13 Now, I am not suggesting for a moment that you
14 ought to act alone and put in measures, it wasn't your
15 job but they had already reviewed, they have raised
16 a concern, they have confirmed with a fresh pair of eyes
17 that that was a valid concern.
18 So whilst whatever further work might be
19 undertaken, might be required to confirm or exclude that
20 factor, immediate action needed to be taken, did it not?
21 **A.** Well, again, if that individual was convinced
22 that there was no explanation then to protect patient
23 safety, yes, action will have needed to be taken. The
24 difficulty is knowing what action in those circumstances
25 and I can't answer that question because I wasn't in

1 that position with the benefit of the knowledge to have
2 made that decision.
3 **Q.** One of the options would be to involve the
4 police and when you gave evidence earlier, when in the
5 context of explaining why you declined the invitation to
6 take part in the meeting with Simon Medland QC, in
7 April 2017, and your answer towards the end was: you
8 didn't want to give credit to or legitimise any
9 decisions that they may make, one of which might be to
10 involve the police, and you said "which is what we were
11 pushing for".
12 Now, when you refer to "we" in that sentence, to
13 whom are you referring, is it the paediatricians, the
14 network, who was pushing for involvement of the police?
15 **A.** So I was referring to the meeting that we had,
16 I can't remember the date, I'm afraid, with the
17 Executive Team where Dr Brearey and his colleagues were
18 suggesting that this needed to be escalated to
19 a referral to the police.
20 **Q.** That is the March 17 meeting?
21 **A.** Yes. So we were there to support their view
22 and from a network point of view we were still demanding
23 a more in-depth detailed review, however that was
24 conducted and by whomever that was conducted.
25 So really I suppose what I am saying is we were

1 supporting the paediatricians in their view that this
2 needed to be escalated to a police matter.
3 **Q.** But the features which were pointing, as far
4 as the paediatricians were concerned, towards calling
5 the police or involving the police at that stage, all of
6 those factors, save for the number of babies who had
7 already been killed or harmed at that stage, were
8 already present by the time they sought your advice in
9 January 2016, were they not?
10 **A.** Well, I don't know that because I -- I can't
11 speak to that because I wasn't aware of all of the
12 information that they had available. Potentially, yes.
13 **Q.** Now let me deal with very quickly with the
14 parents' involvement and taking a step back in terms of
15 looking at the lessons that can be learned from all of
16 this.
17 Going back to the Terms of Reference that we looked
18 at earlier, giving parents a part, giving them an equal
19 voice, now, would you agree that when concerns were
20 identified regarding the care that the babies on the
21 unit had received, the parents ought to have been
22 consulted from the point of view of provision and
23 gathering of information.
24 Let me expand on that.
25 There are two parts to it. The first is to be

1 notified or to be informed that there might be an issue
2 with the care their children had received?
3 **A.** So at that point where there is concern and
4 the process has been completed, in terms of gathering
5 the information, then yes, I think we as professionals
6 have a duty of candour, a responsibility to let parents
7 know and that's true for -- this -- only when a death
8 has occurred, when significant harm has occurred in
9 whatever setting.
10 **Q.** There doesn't have to be confirmed -- the
11 cause doesn't have to be confirmed. All that requires
12 or triggers the duty of candour is there might have been
13 gaps in the provision of care, there might have been
14 shortcomings in the provision of care, would you agree?
15 **A.** Yes, but that would apply -- at the moment I'm
16 aware that the duty of candour responsibility is --
17 needs to be discharged when there is at least moderate
18 harm and clearly all deaths would -- would qualify for
19 that which means that you would have to go through
20 a process like that for every baby that's died prior to
21 any review having been conducted.
22 **Q.** But apart from provision of information, the
23 other element or the side of the coin which is equally
24 important is the gathering of information because we are
25 not talking about adult patients where you can take the

1 history directly from them, the parents whose children
2 these were, they might and it's reasonable to expect,
3 have valid and useful information to contribute towards
4 the process of investigation; would you agree?
5 **A.** Yes, I would agree with that. And you are
6 right that that didn't happen during this process and as
7 far as I know doesn't happen regularly. There is
8 a little bit of involvement with -- with respect to
9 parents, in PMRTs, which are Formal Mortality Review
10 processes now, where parents are asked have they got any
11 specific questions they would like addressed during
12 those meetings.
13 But in terms of gathering information, for example,
14 when there has been an incident that doesn't involve
15 parents at the moment.
16 **Q.** No, but when we are talking about the history
17 of care with these babies being on units, some of them
18 for weeks, that they might have information to give?
19 **A.** Yes.
20 **Q.** Some of the evidence given by other witnesses
21 to this Inquiry I think it is the approach of: we don't
22 want to upset parents, we don't want to tell them
23 anything until we knew. But that is not the right
24 approach because the parents, if I can put to you, one
25 has a right to know; and two, might have their own input

1 in what investigations they want taken, what
2 information, for example, records they want to seek,
3 what independent advice they want to seek themselves if
4 they are not happy with the hospital's approach, would
5 you agree with that?
6 **A.** Yes, yes, I would agree with that. I think we
7 have to take into account the anxiety and distress that
8 some parents might experience.
9 But equally I don't think we can take
10 a paternalistic view and say we are trying to protect
11 them from that and therefore we should exclude them from
12 those reviews.
13 **Q.** The clinicians or the Execs shouldn't say "we
14 know better"?
15 **A.** Correct.
16 **Q.** And that, would you agree -- and again I am
17 not suggesting you have spearheaded some sort of
18 communication plan alone, but this -- looking back on
19 the chronology of events in this case, that
20 patient-centered approach was lacking in this case, was
21 it not, such that the parents were left on the outside
22 of the perimeters of investigation until very, very late
23 in the day?
24 **A.** Yes, I agree with you that the parents weren't
25 involved in any of the reviews or those discussions,

1 yes, I agree.
2 **MS RONG:** Thank you. Thank you, my Lady.
3 **LADY JUSTICE THIRLWALL:** Thank you, Ms Rong.
4 Mr Skelton.
5 Questions by MR SKELTON
6 **MR SKELTON:** Dr Subhedar, I ask questions on behalf
7 of all of the Family groups.
8 Can I ask you first about your background and
9 expertise. In your statement you mention your posts
10 within your hospital but you don't mention I think that
11 you are clinical lead, I think for risk management and
12 clinical governance; is that right?
13 **A.** I was lead for clinical for, for clinical
14 governance and risk management about until about around
15 this time, I think. It was the last few years that
16 I haven't been so, probably from about 2017 I think
17 I might have stepped down from that role within out
18 Trust.
19 **Q.** So at the time that you and Dr Brearey were
20 dealing with the issues you have been talking about
21 today you were clinical lead?
22 **A.** I would have to check but yes, I think
23 I probably was at that time.
24 **Q.** Is it right you also have a special clinical
25 interest in patient safety?

1 **A.** Twinned with that role as safety lead within
2 the -- within the Trust, yes, I had a had an interest in
3 patient safety.
4 **Q.** If in 2015 a child had died unexpectedly
5 without immediate medical explanation in your unit, what
6 investigations would you have initiated?
7 **A.** There would have been a review process that
8 would have been undertaken which is the same as for all
9 deaths and then if we had concluded that there was an
10 unexpected and unexplained death in 2015, if it was
11 an isolated incident, I think that happens from time to
12 time, I don't think it would have necessarily taken --
13 gone -- been taken any further.
14 At the time, sort of in real-time, I think that
15 a Coroner might be involved. I think I would have
16 expected if there was the clear cause of death we would
17 have made a referral to the Coroner.
18 **Q.** What about the SUDiC process?
19 **A.** The SUDiC process to my mind at that time
20 wasn't relevant to babies who died in neonatal intensive
21 care. It was the sort of thing that was triggered if
22 a baby died at home as a cot death, I am pretty sure
23 that the national guidance at that stage referred to
24 Sudden Unexpected Postnatal Collapse in individuals at
25 term, babies at term who were born in a good condition

1 and then secondarily collapsed.
2 So I don't think -- I am pretty sure we weren't
3 using the SUDiC protocol in neonatal intensive care.
4 **Q.** Were you aware that Dr Garstang who gave
5 evidence about her experience in a similar setting not
6 too far from your hospital, thought that SUDiC was
7 appropriate for deaths in hospital, for sudden --
8 **A.** I wasn't aware of that, no.
9 **Q.** If you suspected that a member of staff had
10 harmed a patient, what was the process that you would
11 have initiated as the safeguarding lead in your own
12 hospital?
13 **A.** Depends on my level of concern but the way you
14 state it, if I was really concerned that someone had
15 harmed a baby --
16 **Q.** Murdered?
17 **A.** Well, that would have been a very serious
18 event, obviously, I would have involved the safeguarding
19 team and taken advice about involving the police there
20 and then.
21 **Q.** It's right, isn't it, that one of the
22 axiomatic principles of safeguarding is that it's
23 everyone's responsibility?
24 **A.** Yes, it is.
25 **Q.** Not one person; every one that's aware of that

1 information, that concern, has a responsibility to act?
2 **A.** Yes, I would agree with that.
3 **Q.** As I understood your evidence, you had been
4 provided with the mortality table in early 2016 which
5 listed the deaths that were going to be considered by
6 the review and also the staff allocation and people who
7 were present, the staff members present?
8 **A.** Yes.
9 **Q.** Again as I understood your evidence earlier,
10 it was unusual to have the staffing as part of the
11 information provided into an investigation into
12 a child's death?
13 **A.** I think I said that with the benefit of
14 hindsight it was unusual. Looking back now, I would
15 wonder why those names were there.
16 **Q.** Why didn't you ask?
17 **A.** I didn't really pay much attention to those
18 columns with the names in there. I was focused on the
19 embedded documents which was the summary of the clinical
20 case and the causes of death.
21 **Q.** Dr Brearey's evidence, have you read his
22 principal statement to the Inquiry?
23 **A.** I have, yes.
24 **Q.** So his evidence at paragraph 199 is that
25 during the Thematic Review meeting that you attended,

1 Lucy Letby was not discussed. He didn't want to
2 introduce any bias into the process of discussing the
3 children, the individual babies, and then he says that
4 after he discussed, or:
5 "... we had discussed every case, I then raised the
6 issue of the staffing analysis and association with
7 a nurse. We also discussed that six of the nine babies
8 had collapsed between the times of 0000 to 0400 hours."
9 So his recollection in his statement, which he then
10 reaffirmed yesterday, was that there was a discussion at
11 that meeting of the staff association that had been
12 identified in the table.
13 Is your recollection that you can't remember that
14 or you are sure that he didn't do that, say that?
15 **A.** Would you mind bringing that up, so I could
16 have a look at that part of his statement.
17 **Q.** The statement, yes, it's -- give me one second
18 for the reference --
19 **A.** Because I would like to read the context.
20 **Q.** It's INQ0103104. And if we could go to
21 page 33, please, which is the section where he deals
22 with this meeting. So at the bottom, you can see there
23 is a heading "Thematic Review" and you can see that you
24 are listed as one of the attendees along with
25 Steve Brearey --

1 **A.** Yes.
2 **Q.** -- Dr V, Eirian Powell Anne Murphy, Ms Eagles
3 and Ms Peacock?
4 **A.** Yes.
5 **Q.** Then if we go on to the next page, the
6 paragraph I read out if you want to just take a moment
7 to have a look at it, it's paragraph 199.
8 **A.** Yes.
9 **Q.** So essentially it seems there are almost two
10 parts to the meeting, there is the first part where you
11 discuss the babies without mentioning the staff. Then
12 at the end of that discussion, it appears that he raises
13 the staffing issue, which of course was already embedded
14 within the table that you had received that you hadn't
15 analysed.
16 Do you remember that?
17 **A.** I don't remember that but I can see that he's
18 stated that and I know that around that time, whether it
19 was during the meeting or immediately after the meeting,
20 I think either in his statement somewhere or perhaps in
21 his evidence yesterday he talked about speaking to me
22 after the meeting to let me know about the concerns
23 about an individual.
24 So I'm not sure exactly when that was but
25 I understand that around that time, he must have made me

1 aware or I was made aware that there were concerns about
2 a member of staff.
3 **Q.** Did you say to him: Steve, do you think the
4 staff has negligently harmed these children or are you
5 saying it was intentional or are you thinking it was
6 intentional as a possibility?
7 **A.** I didn't say either of those things.
8 **Q.** Do you recognise that you should have done?
9 **A.** I recognise that what was important was to
10 understand why he was concerned about a member of staff
11 and why that would have been a particular nursing member
12 of staff when I don't see that there was any review of
13 other staff members delivering care to -- to those
14 babies such as medical staff.
15 I think that's why we concluded that an in-depth
16 review of all staff was important.
17 **Q.** But in respect of the single staff member that
18 he mentioned at the meeting or at that time to you, why
19 didn't you ask: what do you think she's done?
20 **A.** No, I -- well, it didn't occur to me that
21 anyone would want to wilfully harm babies, that the most
22 likely explanation, if anything, was that the care that
23 was being provided for that -- for those babies wasn't
24 of a high standard, whatever that might mean from
25 a nursing perspective.

1 But it didn't occur to me that I needed to ask in
2 such explicit terms to why he was concerned, at least
3 until a review had been undertaken of all the staffing
4 members.
5 **Q.** It may be right that it's more likely that
6 a staff member is negligent than criminal. But it was
7 a possibility, wasn't it?
8 **A.** Yes, it was -- well, especially with the
9 benefit of hindsight yes, of course it was
10 a possibility. But we wasn't thinking that way at that
11 time.
12 **Q.** Without the benefit of hindsight, if a nurse
13 is associated with a large number of child deaths, it is
14 possible that is because of deliberate conduct?
15 **A.** Yes, of course it's possible.
16 **Q.** That is a matter that needs to be ruled out
17 for patient safety reasons urgently?
18 **A.** Yes, I would agree with that, that it needs to
19 be ruled out after a proper review, but an urgent
20 review, yes.
21 **Q.** You, over this period of time, and indeed
22 before this period of time, and throughout 2016 and
23 2017, are the wise person to whom Steve Brearey is
24 going, the person outside his own hospital, for advice.
25 Can you explain why you didn't ask him about his concern

1 about this nurse or advise him to trigger the usual
2 processes that would apply?
3 **A.** I was asked as someone external to that
4 neonatal unit to provide an overview, Thematic Review,
5 and to look at all of those cases and that's what
6 I believe I did as part of the Thematic Review. I think
7 it was reasonable to suggest a detailed staffing review.
8 I highlighted the concerns that were expressed during
9 that review, during the Thematic Review of the fact that
10 there were some unexplained and unexpected deaths and
11 I think that was the right thing to do.
12 **Q.** But you didn't really follow that up, did you?
13 I mean, the detailed staffing analysis demonstrated that
14 she was in fact present?
15 **A.** Well, that's not what I meant by a detailed
16 staffing analysis. It was more than just having names
17 who were looking after that baby at that time.
18 There was names, it was flows of staff, both
19 medical and nursing, at the time and prior to that time
20 as well which was important. I didn't have that level
21 of detailed information.
22 **Q.** But as far as you were aware, after the --
23 after this Thematic Review meeting, did the
24 investigations that you set in motion or assisted to set
25 in motion ever identify a common cause for these

1 children's deaths?
2 **A.** I knew that there was a review ongoing or
3 I suspected there was a review ongoing. I wasn't party
4 to what the review found. So I can't -- I'm not sure
5 I can answer that question.
6 **Q.** Well, the answer's no, isn't it? As far as
7 you were aware, there was no common cause identified
8 medically to explain these children's deaths?
9 **A.** There was no common cause found medically,
10 yes, that's correct.
11 **Q.** How had you in your mind excluded the
12 possibility that the nurse had acted criminally?
13 **A.** I wasn't able to do that. I wasn't in
14 a position to do that. I was asking for a detailed
15 review to be done of -- of all staff at that time and
16 I didn't know whether that was being done or whether it
17 had been done and that had resulted in concerns about
18 a single member of staff or continued concerns about
19 a single member of staff.
20 **Q.** But if this had happened in your hospital,
21 many more children than usual dying, no identifiable
22 common medical cause, exclusion of the usual causes but
23 a commonality of a single member of staff, you would
24 have acted with urgency, wouldn't you?
25 **A.** If all of those things that you have said were

1 in place, yes.
2 **Q.** But you never advised Steve Brearey to do
3 that?
4 **A.** I didn't know all of those things were in
5 place. All of those things that you have mentioned
6 about a single member of staff being identified after
7 a thorough review, if that had happened in my hospital
8 we would have demanded a thorough review, first of all,
9 there would have been an urgent review and if at the end
10 of that review there was only one member of staff that
11 was still implicated then, yes, that would have demanded
12 further action.
13 **Q.** When do you say Steve Brearey or anyone else
14 first made it clear to you that the suspicion was in
15 fact of deliberate harm, murder, by that nurse? When in
16 this whole chronology did that occur?
17 **A.** That was, those words were never used by
18 Dr Brearey to me. There was -- I was aware of a concern
19 about an individual, I didn't know specifically the
20 level of concern and so, for example, I didn't know
21 whether that was about clinical care or whether it was
22 actively wanting to harm babies.
23 So -- but I knew that there was concern. What had
24 prompted such concern I wasn't aware of.
25 **Q.** Throughout the entire time into 2017?

1 **A.** Well, by -- by the time we met with the Exec
2 Team at Chester and Dr Brearey and the team were
3 concerned enough to want to involve the police, I knew
4 at that stage that there were -- there were concerns
5 about a member of staff having murdered babies. But,
6 but not before then.
7 **Q.** When you found that information out, did you
8 think to say to Steve who you knew very well,
9 professionally: why didn't you tell me? Why am I only
10 finding out now in 2017 that you suspected this nurse
11 for two years?
12 **A.** I didn't ask him that specific question, no.
13 **Q.** Why not?
14 **A.** Because I knew there was a process that was --
15 well, I assumed that there was a process that had been
16 followed with external reviews. What I didn't know was
17 whether an internal review had been undertaken and what
18 that had shown and whether there were other events that
19 had prompted their concern, but I was aware of their
20 concern.
21 **Q.** Do you recognise now that a series of reviews
22 that drifted into weeks to months to years was not the
23 appropriate response to a concern of that gravity?
24 **A.** Yes, I -- I would accept that. I think it
25 demanded an urgent detailed review with -- by either an

1 external body or something similar which had some
2 independence and that should have been done much more
3 quickly.
4 **MR SKELTON:** Thank you, thank you my Lady.
5 **LADY JUSTICE THIRLWALL:** Thank you, Mr Skelton.
6 **MR DE LA POER:** My Lady, I have no questions
7 arising.
8 **LADY JUSTICE THIRLWALL:** I have no questions either
9 so thank you very much indeed, Dr Subhedar, you are free
10 to go.
11 **A.** Thank you very much.
12 **MR DE LA POER:** My Lady, our next witness is
13 Dr Mittal. I wonder if he might come forward, please.
14 DR RAJIV MITTAL (affirmed)
15 Questions by MR DE LA POER
16 **LADY JUSTICE THIRLWALL:** Do sit down.
17 **MR DE LA POER:** Please could you state your full
18 name?
19 **A.** Rajiv Mittal.
20 **Q.** Dr Mittal, you provided to the Inquiry
21 a statement dated 7 June of 2024?
22 **A.** That's correct.
23 **Q.** I understand that there is a correction that
24 you wish to make before you confirm its content to be
25 true. I think it's paragraph 16 that you want to take

1 us to, so I wonder if you might just do that now and
2 just explain to us what it is that you wish to correct?
3 **A.** So, my Lady, the paragraph 16, there were no
4 formal minutes of that meeting which were shared with
5 me. After looking at the minutes from Mr Stephen Cross'
6 statement, I realised that there are a few things which
7 are incorrect in my statement, so it was not Dr Brearey,
8 it was Dr Susie Holt who was in that meeting.
9 **Q.** If I can just pause you there, just so that we
10 all know, those who don't have your statement in front,
11 you are speaking about a meeting on 27 April of 2017; is
12 that right?
13 **A.** That's correct.
14 **Q.** It's a meeting that you deal with at
15 paragraph 16. You have just told us that you have seen
16 Stephen Cross' notes of that meeting which were not
17 a document that you had access to at the time that you
18 made your witness statement?
19 **A.** (Nods)
20 **Q.** You have told us that you are correcting your
21 recollection that it was not as you say in your
22 statement Dr Brearey, but instead it was Dr Holt who was
23 present.
24 Is there any other matter within your paragraph 16
25 that you wish to correct?

1 **A.** And also there was a mention of a member of
2 the staff linked to deaths in that meeting so that was
3 the first time this was mentioned in that meeting. So
4 this is -- in correcting my statement.
5 **LADY JUSTICE THIRLWALL:** So your statement says
6 there was no mention, but --
7 **A.** Sorry, my Lady?
8 **LADY JUSTICE THIRLWALL:** Is what you are correcting
9 the first line on page 3?
10 **A.** And then the second one there was a mention of
11 the involvement of a member of staff in that meeting
12 definitely.
13 **LADY JUSTICE THIRLWALL:** So should we delete the
14 word "no"?
15 **A.** Yes, yes, my Lady.
16 **LADY JUSTICE THIRLWALL:** Thank you.
17 **MR DE LA POER:** Thank you, Dr Mittal, we will come
18 to that meeting in the course of your evidence but
19 taking into account the corrections that you have just
20 made about paragraph 16, is the statement otherwise
21 correct to your knowledge and belief?
22 **A.** Yes, my Lady.
23 **Q.** Now, Dr Mittal, this isn't dealt with in your
24 statement but can you just give us some idea of when you
25 qualified as a doctor?

1 **A.** So I qualified -- I had completed my MBBS in
2 1992 and since 1992 I have been working as
3 a paediatrician in various roles.
4 **Q.** You became a member of the RCPCH in 2009; is
5 that correct?
6 **A.** In 2003 I became a member of the Royal College
7 of Paediatrics and Child Health.
8 **Q.** Thank you. Did you join the Countess of
9 Chester Hospital in 2009?
10 **A.** That's correct, I joined Countess of Chester
11 in March 2009.
12 **Q.** Was that as a Consultant paediatrician?
13 **A.** That's correct.
14 **Q.** Was your area of work the community?
15 **A.** That's right, so I am a neuro-developmental
16 paediatrician and I mainly do ADHD autism assessments
17 and cerebral palsy and children with development delay.
18 **Q.** Can I ask you just to slow down very, very
19 slightly, I think that will just help with the echo.
20 **A.** Sure.
21 **Q.** Now, as part of your role, did you also become
22 what is known as the designated doctor?
23 **A.** That's correct, my Lady, yes.
24 **Q.** Now, we need to be clear about where you were
25 the designated doctor of. Were you the designated

1 doctor for Cheshire West and Cheshire Vale Royal?
2 **A.** From 2009 I had been working as a Designated
3 Doctor for Safeguarding and Designated Doctor for Child
4 Deaths.
5 **Q.** For Child deaths, but was that for the
6 Countess of Chester that you were working in that
7 designated doctor role or was it for a wider area?
8 **A.** My Lady, that was for ICB. It used to be
9 called CCG before, Clinical Commissioning Groups, and
10 now they are called ICB, Integrated -- Integrated --
11 **LADY JUSTICE THIRLWALL:** Care Board.
12 **MR DE LA POER:** Care Board.
13 **A.** Integrated Care Board, so they are the same
14 but yes, that was on behalf of them.
15 **Q.** So were they funding that part of your job?
16 **A.** Yes. My Lady. So I get four hours of my
17 which is one session per week which is paid by ICB for
18 my Designated Doctor for Child Death role.
19 **Q.** Just to look at it in a practical real world
20 context, if there was a safeguarding issue at the
21 Countess where you were a Consultant paediatrician,
22 would you be the person to be spoken to about that or
23 was there another person who should be spoken to?
24 **A.** So, my Lady, it would be the named doctor for
25 safeguarding which is Dr Howie Isaac. She would be

1 contacted first and I would be contacted if it is in the
2 local authority in different hospitals or GPs or health
3 visitors, they would contact me, if it is outside the
4 hospital.
5 **Q.** But presumably the Countess of Chester fell
6 within the area that you had responsibility for. So
7 just as other hospitals might have a named doctor for
8 the hospital, your responsibility for the -- at the CCG
9 level included the Countess of Chester?
10 **A.** That's correct, my Lady.
11 **Q.** So does it follow that in terms of
12 a safeguarding issue that was raised with you, because
13 that's being raised at a CCG level, you aren't in fact
14 answerable to anybody at the Countess of Chester in
15 terms of how you deal with that; is that right?
16 **A.** That's correct, my Lady, so for my -- this
17 role, there is a director of quality in ICB, she is
18 called Paula Wedd, she is my immediate manager for this
19 role.
20 **Q.** Now, as far as the SUDiC process was
21 concerned, what was your understanding in 2015/16 as to
22 whether SUDiC applied to unexpected deaths of neonates
23 who were born in hospital and were moved to the NNU?
24 **A.** So, my Lady, I would like to just spend
25 a couple of minutes on SUDiC process because this has

1 evolved from 2004. Originally it was only for infants
2 up to two years of age, it was only for infants who died
3 at home unexpectedly, so this process was started in
4 2004 because only for those babies.
5 So gradually the remit has increased and it
6 increased from up to two years to 18 years of age.
7 Previously it was only like for deaths which were
8 outside the hospital but gradually it has included any
9 death anywhere in the hospital or outside in the
10 community; if it is unexpected, then a SUDiC process
11 should be initiated.
12 **Q.** So you have described an evolution which
13 I think brings us up to the present day; is that right?
14 **A.** That's right.
15 **Q.** So the resting position today is that SUDiC
16 applies to every death regardless of where it takes
17 place and regardless of the circumstances?
18 **A.** Just I would like to make one comment here
19 my Lady, that this is a process. So the way it is
20 followed is still like Dr Subhedar also mentioned. It
21 is still people think that if a death is outside the
22 hospital in community, then SUDiC process is followed.
23 If it is an in-hospital death although for unexpected
24 in-hospital deaths SUDiC process should be followed, but
25 it is still people's presumption that in-hospital death

1 there is a separate process, so SUDiC is not followed.
2 And in 2015 again like people thought again it's
3 a training issue and it is a national issue, so in my
4 15 years in the Countess of Chester Hospital I haven't
5 come across a single death where we have done a SUDiC
6 meeting for in-patient hospital deaths. And I was
7 reading our expert Dr Garstang's statement and she was
8 saying last year, which is 2023, in Birmingham, which
9 deals with a much larger population and much larger
10 neonatal deaths, she said out of 18 neonatal deaths, she
11 was only involved in one death, one neonatal death,
12 which was an in-hospital neonatal death, where SUDiC
13 process was initiated.
14 So it is unusual still and I -- I agree that it
15 should have been initiated but it is more like
16 a training issue and practice issue and it is a national
17 thing. This is being discussed in the national meetings
18 as well, that people are really not following the SUDiC
19 for in-hospital deaths.
20 **Q.** Dr Mittal, I just want to get down to, as my
21 question began, with what your understanding you have
22 described how your colleagues who are not necessarily
23 specialists in SUDiC may have misunderstood it and you
24 have been very clear about that. But you are the
25 designated doctor for the CCG, as it was then.

1 In 2015, did you think that SUDiC applied to
2 unexpected deaths in hospital?
3 **A.** Yes, my Lady.
4 **Q.** You did?
5 **A.** Yes.
6 **Q.** So if any Consultant paediatrician in the
7 Countess of Chester had told you that they had an
8 unexpected death of a neonate, would you have advised
9 them to initiate the SUDiC process?
10 **A.** So I would just like to explain a bit more
11 about answer to this question. So in my Designated
12 Doctor for Child Deaths role there are two ways I get
13 information. First is like the Form A which has been
14 mentioned which is a notification form which is for all
15 deaths, all routine deaths.
16 In 2015, it used to come to me, either via phone or
17 in a paper copy or it could be an email. So the process
18 was not very structured and it could be sometimes a
19 couple of days before the information came to me, in
20 2015.
21 The system has changed now but at that time it was
22 very -- it was not very systematic at that time. So
23 this is for all deaths.
24 But if there is a SUDiC death I get phone call from
25 the police officer, if it is in community the police

1 officer will ring me directly or if it is a health
2 professional they are not sure whether the SUDiC should
3 be started or not, they would come to me, they will come
4 to me, they will contact me if it is a paediatrician or
5 A&E Consultant, they will come to me and then they ask
6 me whether we should be doing a SUDiC for this death or
7 not.
8 **Q.** Dr Mittal, my question just to ask you to
9 focus on it, please, was if you had been asked for your
10 advice, that would have been --
11 **A.** Yes.
12 **Q.** -- if this is an unexpected death, we need to
13 initiate the SUDiC protocol which would involve using
14 the language of 2015 a Rapid Response Meeting which
15 would be multi-agency; is that correct?
16 **A.** That's correct, yes.
17 **Q.** Now, did any of your colleagues at the
18 Countess ask you about any of the deaths that they dealt
19 with whether or not the SUDiC protocol applied?
20 **A.** No.
21 **Q.** Now, you have told us that you saw the
22 Form As, we are not going to look at the detail of any,
23 but in terms of your responsibility if any of those
24 Form As mentioned that the death was unexpected, did you
25 have a responsibility to notice that and to go back to

1 the neonatal unit to say: has this death been considered
2 for SUDiC?
3 **A.** So, my Lady, there are three different types
4 of forms. The Form A which is a notification form, it
5 just states that so and so baby has died and these were
6 the problems.
7 It doesn't mention much in detail whether it was
8 unexpected or unexplained. That is in the Form B or
9 which is a reporting form.
10 So the Form A notification form comes straight away
11 within 24 to 48 hours of the death, although it was
12 coming late at that time because the system was not very
13 structured but the details about the death they come in
14 the Form B, which is like four to six weeks after the
15 death that Form B comes. But for SUDiC, if anybody
16 wants us to initiate the SUDiC, coming to me for SUDiC
17 means that we are involving the police and it should --
18 they should be coming straight because SUDiC needs to be
19 initiated within 72 hours to five working days, we
20 cannot wait later than that so that's the guideline.
21 **Q.** So you, if I may say so, Dr Mittal, appear
22 very clear in your own mind about what should have
23 happened in 2015 in the case that a Consultant
24 paediatrician identified that the death was unexpected.
25 And you have described that it is a training issue if

1 somebody didn't realise that they needed to contact you.
2 Whose responsibility was it to ensure that the
3 Consultant paediatricians at the Countess of Chester
4 were properly trained?
5 **A.** So, my Lady, just -- just to clarify. It
6 was -- the way the SUDiC was followed up all over the
7 country, just not -- Countess was not an outlier in
8 that, so it was the whole country.
9 **Q.** Dr Mittal, we have had that point very
10 clearly.
11 My question is about who had responsibility to
12 ensure that the Countess of Chester Consultant
13 paediatricians knew which process they should follow?
14 **A.** So there was an overlap at that time because
15 there was no named doctor for child death in the
16 Countess at that time. Now, they have appointed a named
17 doctor for child death who's paid by Countess to look
18 into the child death process but at that time I was only
19 person, all the Countess was not paying me for this
20 role, I was the only named person in the hospital
21 because I was employed by Countess and my role was to
22 check that Countess is doing this or not.
23 So I was delivering training but it was ad hoc, it
24 was not like every three months I was doing, so I was
25 delivering training to paediatricians and other

1 Consultants in the hospital.
2 **Q.** So we know that the first death of a child
3 named on the indictment was towards the start of
4 June 2015 and the final death was in June of 2016.
5 Were you delivering training to the Consultants at
6 the Countess of Chester during that year-long period?
7 **A.** So it is difficult for me to remember when
8 I delivered the training. It was more like an ad hoc
9 thing that in the departmental meeting I used to deliver
10 some training about CDOP in that, in the meeting. And
11 I used to call Mrs Sharon Dodd, who is -- who used to be
12 our named nurse for CDOP. She used to join me for
13 delivering those sessions to paediatricians or to A&E
14 but I don't remember the dates when I delivered those
15 trainings.
16 **Q.** We know now, and it's clearly established from
17 documentation at the time, that the Consultant
18 paediatricians did identify a number of these deaths as
19 being unexpected and you have told us none of them
20 contacted you.
21 This is over a period of a year --
22 **A.** (Nods)
23 **Q.** -- and it's across the Consultant body at the
24 Countess. Do you think you have a responsibility for
25 failing to ensure that those Consultants knew which

1 process they should follow?
2 **A.** I would accept that there is some -- some
3 responsibility on my part and for not being clear at
4 that time that in-hospital deaths should be followed
5 with the same rigorous way, the way we used to follow
6 the out of hospital deaths for initiating the SUDiC
7 process.
8 But I was only getting one session of four hours
9 for dealing everything doing everything in addition to
10 delivering training.
11 **Q.** So is your position, just to summarise what
12 you have just told us, that you accept that that was
13 a failure on your part, but that you are drawing
14 attention to the amount of time that you had and that
15 that is an explanation or part of the explanation for
16 why you think you failed to ensure they knew what to do;
17 is that fair?
18 **A.** Also like I was employed by ICB which was CCG.
19 So Countess was not paying me for to do this role so
20 actually I was supposed to check on Countess to make
21 sure that the paediatricians are doing -- they know
22 about the -- this training and everything else. So it
23 should be Countess engaging somebody to do this, to pay
24 somebody to deliver that training. But because I am
25 based in Countess, that is why I also take

1 responsibility that I should have also delivered that.
2 **Q.** Another way of looking at it is that you had
3 a responsibility to ensure that everybody within your
4 area, including the Countess, understood which way which
5 process to follow in those circumstances?
6 **A.** That's correct.
7 **Q.** So is that a fair way of looing at it?
8 **A.** That is a fair way, yes.
9 **Q.** Now, the RCPCH report, just staying with the
10 topic of SUDiC, made a recommendation, I am sure you
11 will remember it, that the SUDiC process needed to be
12 improved. That report was published in February of
13 2017.
14 Was that a recommendation that you needed to know
15 about as soon as it was made?
16 **A.** So, my Lady, I was called by the RCPCH team to
17 speak to them. They never asked me much, they were more
18 interested in knowing my role what I do.
19 **Q.** Dr Mittal --
20 **A.** But it was not shared with me formally.
21 **Q.** No, no and I was not seeking to suggest
22 otherwise. If you just listen to my question.
23 The report contained a recommendation that the
24 SUDiC process at the Countess of Chester needed to be
25 improved. That report was published in February of

1 2017. Nobody is suggesting that you were told that
2 before that.
3 My question was: was that a recommendation by the
4 Royal College that you needed to know as soon as
5 possible?
6 **A.** Yes, my Lady, I should have but I don't think
7 that I really followed that or really like did anything
8 for that.
9 **Q.** Now, the subject of SUDiC was raised at
10 a number of the CDOP meetings, the Child Death Overview
11 Panel meetings?
12 **A.** (Nods)
13 **Q.** We will just bring, up focusing at this stage
14 just on SUDiC, INQ00178115, and we will go to page 2.
15 What you are going to see, Dr Mittal, is the
16 26 September 2016 meeting. It's a document you have
17 seen before.
18 So that is the meeting as we will see on page 2
19 that you were asked to chair in the absence of the
20 independent chair, Ms Frame, and she's already given us
21 some evidence about that. So page 2, please.
22 We can see that marked towards the top left-hand
23 corner. If we look at the third action, we can see that
24 one of the matters discussed at the meeting to be added
25 for the November meeting was asking if the panel

1 consider that unexpected death in hospitals should be
2 referred for a Rapid Review Meeting.
3 So it would appear that at a meeting that you
4 chaired dealing with the whole area covered by the CDOP,
5 the Pan Cheshire area, that this was something that the
6 panel was discussing; is that right?
7 **A.** So, my Lady, from my recollection there are,
8 there are two parts of this meeting, so one part is
9 a clinical meeting where we discuss cases and the second
10 part of the meeting is a business meeting where we
11 discuss if there are any issues around this.
12 So this was discussed in the second part of the
13 meeting and it was because I was called by the Royal
14 College of Paediatrics team, that's why I raised this
15 here as well; that -- and I have raised this so many
16 times in various fora that in-hospital patient deaths
17 should be dealt with the same vigour as out of hospital
18 deaths. So this is what I -- I think I raised it,
19 because I had -- fresh from the -- from meeting the
20 Royal College team.
21 **Q.** Yes. And so does it follow then that in
22 September of 2016, you knew that there was a problem at
23 the Countess, because that is where the Royal College
24 had been, about the SUDiC process?
25 **A.** It was more about the cluster of deaths

1 which -- which happened in the neonatal unit and that
2 was the main reason why I was saying that cluster of
3 unexplained deaths and nothing has been happened nothing
4 has happened and this has not been raised to us.
5 **Q.** We are going to come to the wider CDOP picture
6 in terms of the death. Just finishing this point.
7 I mean, it's been pushed down the road, this discussion,
8 because it's not being discussed at this meeting, it's
9 been pushed off to November. But is this fair,
10 Dr Mittal: in fact, it is very simple, you have just
11 told us in a sentence SUDiC applies in hospital?
12 **A.** Yes.
13 **Q.** There's no discussion to be had, is there;
14 that is what the protocol was at the time?
15 **A.** (Nods)
16 **Q.** You understood that?
17 **A.** Yes.
18 **Q.** So why wasn't that just -- the item just put
19 to bed there and then in September, you are the
20 designated doctor, you are the chair of the meeting:
21 this is the position, we don't need to discuss it any
22 more, everyone needs to get on with it?
23 **A.** So, my Lady, the SUDiC meetings happen within
24 72 hours to the five days, within the five working days.
25 So this was too late and we didn't have any facts at

1 that time. So usually we do not initiate SUDiC meetings
2 if a year or two years after the death.
3 **Q.** Forgive me, Dr Mittal, I wasn't suggesting
4 that the SUDiC discussion needed to be focused upon the
5 deaths that were mentioned by the Royal College. This
6 appears to be of general application to the whole area
7 and instead of just saying: this is very
8 straightforward, everybody, I am the designated doctor,
9 it applies in hospital, everybody here needs to know
10 that and tell everybody about it ... you seem to just be
11 passing the issue on to the next meeting as if there's
12 some legitimate debate to be had about it?
13 **A.** So I would say a couple of things here like
14 I am not the only designated doctor in this panel, there
15 are two more designated doctors who have neonatal
16 responsibilities, whereas I do not go to the neonatal
17 units in my clinical role.
18 So they also attend this meeting and we all knew
19 that this is a national problem so the reason why I was
20 raising here was to raise awareness and to raise this
21 issue that in hospital deaths should be dealt in the
22 same rigour as out of hospital deaths to initiate SUDiC
23 meetings, so that was the reason I raised this in the
24 meeting.
25 **Q.** Well, the way the action is phrased is asking

1 if the panel consider that the unexpected deaths in
2 hospital should be referred to. The way it's phrased
3 suggests that there is some legitimate debate to be had
4 one way or the other rather than you just saying: this
5 is how it is. Do you know why it's phrased in that way,
6 as if there is a discussion to be had about it?
7 **A.** So I'm not sure how this has been phrased like
8 this. But it was more about raising awareness about
9 this issue. That was the reason why we discussed it in
10 there.
11 **Q.** We don't need to go to it, but I am sure you
12 can confirm the subject of SUDiC was discussed at the
13 November meeting, wasn't it?
14 **A.** Yes.
15 **Q.** We see also that it came up again at the March
16 meeting?
17 **A.** (Nods)
18 **Q.** Thank you very much indeed, we can take that
19 down.
20 The final question that I have for -- topic of
21 questions that I have for you about SUDiC is about
22 a form that was filled in about Child C.
23 I wonder if we can bring that up, please, and it is
24 very important that we don't bring up anything other
25 than this page, INQ0000108 and we are going to go to

1 page 178, 178, please.
2 Now, again, just refamiliarise yourself with this.
3 The heading of it is "Sudden Unexpected Death in Infancy
4 and Childhood Initial Strategy Meeting".
5 Now, does that heading -- ignore for a moment what
6 the content is and who attends this, just that heading.
7 Is that the meeting, the initial strategy meeting, that
8 would that you would expect would take place with you as
9 the designated doctor?
10 **A.** So, my Lady, this is a template for the SUDiC
11 meeting but it looks like Dr Gibbs has used this
12 template for SUDiC meeting to discuss this case with the
13 --
14 **Q.** Dr Mittal, I'm sorry to cut across you, you
15 are doing what we will come to, which is you are looking
16 at the text which I have asked you to ignore. Just
17 focus, please, on the heading, the "Sudden Unexpected
18 Death in Infancy and Childhood Initial Strategy
19 Meeting", would that be the meeting that would take
20 place with you, that is what you would expect under the
21 SUDiC as designated doctor?
22 **A.** That's correct. That is the template for the
23 SUDiC meeting.
24 **Q.** Exactly. So the circumstances in which you
25 would expect this form to be used as designated doctor

1 is once the paediatrician has phoned you said that we
2 have had an unexpected death, we need to within that
3 initial two to five hour window, I think you told us; is
4 that right?
5 **A.** That's correct.
6 **Q.** Have a meeting, obviously you need to make
7 record of that meeting and this is the template which
8 would be followed at that meeting?
9 **A.** And there is usually 10 to 15 people in that
10 meeting, so there are only two people in this meeting.
11 **Q.** Yes.
12 Now, Dr Gibbs has given evidence broadly along the
13 lines that you have just told us, which is that this
14 absolutely was not a SUDiC meeting as far as he was
15 concerned, that he just used this form as a record for
16 what happened?
17 **A.** (Nods)
18 **Q.** From your point of view as a designated
19 doctor, do you regard that as something which shouldn't
20 have happened, that we shouldn't have forms for such
21 a serious meeting being used to record for a different
22 purpose?
23 **A.** So, my Lady, this form is public so it is
24 everywhere like online, on the website, on the Countess
25 internet website, so it is for people to -- again

1 I cannot say why this form was used, but this form is
2 easily available on Internet.
3 **Q.** But what you can say, perhaps Dr Mittal, is as
4 the designated doctor, this form should not be used for
5 anything other than a meeting with you?
6 **A.** That's correct.
7 **Q.** Dr Gibbs spoke to some of the content, in fact
8 he candidly drew attention to one part of the form so
9 let's have a look at it, over the page, please. We can
10 see that as part of the meeting that you would expect to
11 have with you looking at the template, that there is
12 a discussion about the strategy and Dr Gibbs has
13 recorded a strategy meeting was not held.
14 We can see that there is a discussion about what
15 agencies have been involved. 6 requires consideration
16 of safeguarding issues for surviving children and then
17 we have a section for the Coroner.
18 In terms of helping us to understand how these
19 meetings should happen, not the way that Dr Gibbs was
20 running it, but would they run through this template
21 having a discussion at each and every stage about each
22 of the boxes and what needs to be said and populated?
23 **A.** That's correct, my Lady, this is a very
24 structured meeting and all these headings we covered in
25 the meeting.

1 **Q.** So we can take that down, thank you very much
2 indeed.
3 Now, we are going to widen the questioning not just
4 to SUDiC but to the CDOP role and all child deaths and
5 return to an answer you gave us a moment or two ago
6 which is that all of the Form As with limited
7 information, as you have told us, passed through your
8 hands?
9 **A.** Yes.
10 **Q.** Now, we know from contemporaneous
11 documentation that the mortality rate on the neonatal
12 unit was between two and three per year up to June of
13 2015?
14 **A.** (Nods)
15 **Q.** We know that there was a very significant
16 increase in that and it depends on how you identify the
17 period whether you do it by annual year or you work from
18 a different number. But we are at a level of somewhere
19 around 17 or 18 deaths which then occur in the following
20 year and so that's a very significant increase in the
21 number of Form As, isn't it?
22 **A.** So can I elaborate this further?
23 **Q.** If it's relevant to answering my question then
24 of course you must say?
25 **A.** So just to give a bit of background about

1 this. So not all deaths -- like we have about 20 deaths
2 per year in the Cheshire area. Out of 20 deaths, about
3 50% are neonates but most of these deaths happen in
4 Liverpool Women's Hospital so they don't happen in
5 Countess, so Countess there are only two to three deaths
6 per year. but the Countess babies they are transferred
7 to Liverpool Women's and then the babies die elsewhere.
8 So the number of neonatal deaths are more than two to
9 three per year but they don't happen in the hospital,
10 so -- because the sick babies they are transferred to
11 patient centres and then deaths happen there. But they
12 constitute the majority of the deaths in Chester. So
13 out of 20 deaths, more than 10 deaths, they are neonatal
14 deaths every year.
15 So yes, I agree that in that year, in 2015 and 2016
16 over the two financial years, the number of deaths in
17 Countess were much more than what we would normally
18 expect in a year.
19 **Q.** Was that something that you noticed, bearing
20 in mind that you were looking at each of these Form As?
21 **A.** In hindsight I should have but I did not --
22 not notice at that time.
23 **Q.** You didn't at the time but you accept you
24 should have?
25 **A.** Yes, and I can give some reasons as well.

1 **Q.** Please?
2 **A.** Because the way they come to me is like
3 I didn't record them anywhere on my system for these
4 deaths. So all these deaths were recorded by
5 Sharon Dodd, so I didn't have an admin or secretary who
6 should be recording all these deaths. So all these
7 forms were going to secretary who was based with the
8 Mrs Sharon Dodd in Cheshire Wirral Partnership.
9 So the system was not very structured. It has
10 changed a lot. But every two months or one month I will
11 get an email or a phone call or like informing me
12 different ways, then it used to go to the admin in
13 Cheshire Wirral Partnership to Mrs Sharon Dodd's office.
14 So there was no structured way -- I admit that
15 I should have looked at the pattern but because they
16 were coming from all over like some deaths were in
17 Liverpool Women's, some were in Arrowe Park Hospital and
18 some were in Manchester, there was one death in
19 Manchester. And -- so there was no structured way for
20 me to look at because I didn't have a database in the
21 hospital to look at this. So I did not recognise the
22 trend until I was called by the Royal College about that
23 cluster of deaths.
24 **Q.** So your recollection is the first time you
25 became aware of the fact that there had been an increase

1 in the number of neonatal deaths was in September 2016?
2 **A.** I was aware that the number of deaths are more
3 and I think Mrs Dodd also said in her evidence to the
4 Inquiry that we had some discussion what's happening,
5 why there are so many babies dying. So it was more like
6 ad hoc discussion in one of the meetings but we didn't
7 go anything further, it was just saying that the numbers
8 are more than what we normally -- would normally deal
9 with, that's all we discussed. We didn't go any further
10 than that.
11 **Q.** Where were you physically based at this time?
12 **A.** So I was based in the Countess and Mrs Dodd is
13 based in a different --
14 **Q.** Were you based on the same corridor as the --
15 **A.** Yes.
16 **Q.** -- other Consultant paediatricians?
17 **A.** That's right.
18 **Q.** So having had this conversation with Ms Dodd
19 about there's been an increase, I wonder what's
20 happening, did you go and ask any of your colleagues
21 what is happening on the neonatal unit, we have noticed
22 an increase?
23 **A.** I -- I don't think that I went to any of the
24 Consultants to ask specifically for this.
25 **Q.** Given your role as designated doctor and given

1 that the Countess fell within that, and given that as
2 you have told us that you wondered about it and noticed
3 it and discussed it with Ms Dodd, do you think you
4 should have gone to ask your Consultant colleagues who
5 were on the same corridor what's happening?
6 **A.** In hindsight, yes, I should have.
7 **Q.** Well, I mean, at the time didn't you have
8 enough information to make that judgement?
9 **A.** No.
10 **Q.** Why?
11 **A.** I just knew that the number of deaths are more
12 because of the notification forms but I didn't have any
13 -- any other information.
14 **Q.** But the people who could have given you that
15 information were just next door, weren't they?
16 **A.** Yes, but in hindsight I think I should have
17 explored these more. But I don't think that at that
18 time I went to the Consultants and asked them: okay,
19 what's happening?
20 **Q.** We are going to have a look at an email.
21 INQ0103110. This is an email in September 2015, it is
22 an exchange between you and Dr Gibbs about filling in
23 forms?
24 **A.** Yes.
25 **Q.** I am sure you will recognise it when it comes

1 up.
2 And so the email thread starts at the bottom with
3 Dr Gibbs raising a concern about the effectively
4 excessive paperwork and if I summarise what he says, so
5 we don't need to look at it, what he is saying is we are
6 filling out the same information in multiple places, is
7 that the thrust of it?
8 **A.** That's correct, yes.
9 **Q.** So information that needs to go in the Form B
10 is having to be typed out elsewhere as well and --
11 **A.** Yes.
12 **Q.** -- that is plainly not very efficient?
13 **A.** That's correct.
14 **Q.** And so you reply but before we get to that.
15 Let's just have a look at the very first line of his
16 email that we can see. We have had another neonatal
17 death, he says.
18 So I appreciate you have made your own observation
19 from the number of forms. But do you agree this appears
20 to be an occasion when Dr Gibbs is drawing your
21 attention to the fact -- well, that there appears to be
22 a developing trend is one inference from him having
23 started an email with that fact, do you agree?
24 **A.** Yes.
25 **Q.** Do you think that that was a sufficient prompt

1 for you as designated doctor to be curious about it and
2 say: do you think we need to have a chat about what's
3 going on on your unit?
4 **A.** In hindsight, yes, yes.
5 **Q.** That statement he makes is not something that
6 you respond to in your email but what you do say is that
7 effectively to make the form filling easier, that
8 information populating a letter can just be copied
9 across into the Form B; that is the thrust of it, isn't
10 it?
11 **A.** That's correct.
12 **Q.** That is you effectively trying to make the
13 admin less onerous?
14 **A.** That's correct.
15 **Q.** On that topic, do you think the administrative
16 burden from your point of view as designated doctor is
17 too great on Consultant paediatricians?
18 **A.** I would say yes because admins, they don't get
19 that much admin support, so yes, there is a lot of
20 burden on Consultant paediatricians.
21 **Q.** So this was clearly your attempt in 2015 to
22 ease that burden, so far as your particular area of work
23 is concerned?
24 **A.** That's correct.
25 **Q.** Are there further improvements that can be

1 made to that?
2 **A.** So yes, my Lady, now everything has become
3 electronic, so they get an email directly from -- so
4 there is a central admin for CDOP and then the emails
5 come directly from there and then they just need to
6 complete the online form and it automatically goes back
7 to CDOP. So I don't get involved in this, it directly
8 goes to CDOP.
9 **Q.** So as things stand now, you wouldn't get the
10 Form A?
11 **A.** So the Form A goes to many people.
12 **Q.** Yes.
13 **A.** But it -- there is a central place now in the
14 CDOP office where they are the main people who look at.
15 I get a copy of the Form A as well so it goes to many
16 people like the named nurse for child death and also to
17 me. But there is a central office now in CDOP where
18 electronically all notifications go and then they look
19 at everything now.
20 **Q.** Just to invite you to consider another event.
21 We can take that down, thank you very much indeed.
22 We know that the neonatal unit was downgraded in
23 July of 2016, to use the language of the time, to
24 a Level 1 unit from a Level 2?
25 **A.** That's right.

1 **Q.** Was that something that you were aware of at
2 the time?
3 **A.** Yes, I knew.
4 **Q.** At the time did you understand that that was
5 because of an increase in the mortality rate?
6 **A.** That's correct.
7 **Q.** So again if we think about when you were aware
8 of the mortality rate, we have got your observations, we
9 have got Dr Gibbs's email which appears to refer to it
10 directly. Obviously at the other end we have got the
11 Royal College, when you are meeting them in September,
12 but in July as well, quite a dramatic step from the
13 point of view of a hospital to downgrade its unit
14 because of an increase in mortality, would you agree?
15 **A.** That's correct. Yes.
16 **Q.** And do you think that that was a prompt for
17 you to go or should have been a prompt for you to go and
18 find out what was going on with your colleagues on that
19 corridor?
20 **A.** In hindsight, yes.
21 **Q.** Did you do that?
22 **A.** No.
23 **Q.** And why do you think that you didn't seek to
24 find out more about why the unit had been downgraded and
25 what the concerns were?

1 **A.** I don't think I have an answer for that.
2 **Q.** Now, we know that at the end of June 2016 and
3 at the beginning of September 2016, firstly to the
4 Executives and secondly to the Royal College, concerns
5 were raised by your Consultant colleagues that they
6 thought a member of staff may be murdering babies?
7 **A.** (Nods)
8 **Q.** And that that was the explanation, or might be
9 the explanation for the increase in mortality.
10 When did you first learn of those concerns?
11 **A.** So this was kept very confidential from me
12 because they knew that the moment I get involved, the
13 police will be involved and because the first --
14 **Q.** Can I just stop -- can I just stop you there.
15 Is that your assumption that as soon as --
16 **A.** That's my assumption.
17 **Q.** That's your assumption. No one has ever told
18 you that that's the reason you weren't told?
19 **A.** No, no. That's an assumption because the way
20 we work for SUDiC or the way we work because I am an
21 outsider basically, because I am from CCG or ICB looking
22 at. For this role, I am not part of the paediatricians,
23 I am an outsider or like my role is to scrutinise the
24 work which is done there.
25 So everything was kept very confidential from me

1 and I was not involved in any of those discussions.
2 **Q.** Was a consequence of you being outside of the
3 management structure of the Countess that insofar as you
4 were concerned, it wouldn't matter whether the
5 Executives did or didn't want to involve the police; you
6 would make your own judgment about that as designated
7 doctor and if you thought the police should be called,
8 you would call the police?
9 **A.** Could you please ask me the question again?
10 **Q.** Of course. Was one of the effects of you
11 being outside of the management structure, just picking
12 up on your answer a moment ago about you would call the
13 police, that it wouldn't matter to you or it wouldn't
14 determine your decision if the Executives didn't want to
15 call the police; you are independent of them for this
16 purpose, you are there representing the CCG, if you want
17 to call the police, you'll call the police?
18 **A.** Yes, after establishing the facts, and if I am
19 concerned that, yes, there is something like this, yes,
20 I would speak to them.
21 **Q.** So just going back to my question. When do
22 you think the first time you became aware of the concern
23 that a member of staff may be responsible for the
24 deaths?
25 **A.** So from my recollection the first time

1 I became aware of this was in that meeting in April
2 2017, which was in the CEO's office.
3 **Q.** That was the meeting at which a police officer
4 attended?
5 **A.** That's right.
6 **Q.** Well, we will get to there shortly.
7 But let's just look at what's happening in the CDOP
8 and in particular two meetings before we get to that
9 point. So the first meeting is the September one. We
10 have already looked at one aspect of this, this is
11 INQ00178115.
12 This is the meeting that you chaired and Child I's
13 case we know was considered at this meeting.
14 If we go to page 2, we can see above the action
15 that we previously looked at, so this is action
16 number 2:
17 "Child's details to be sent to Coroner for review
18 of case notes. The child's case to be referred to once
19 the Royal College report is presented by Dr Mittal."
20 A reference to you. All of that detail follows the
21 assertion "closed case". Do you see that?
22 **A.** Yes.
23 **Q.** So was the case of Child I closed so far as
24 the CDOP was concerned at this meeting?
25 **A.** So, my Lady, the way the system works -- again

1 I am just explaining it from my recollection -- one
2 thing is although I was chairing the meeting, but there
3 are other designated doctors as well who have got more
4 neonatal experience; they were there in the meeting as
5 well.
6 The other thing is there was nothing in the
7 paperwork, you know, the Form Bs which are completed by
8 the paediatricians about clinical management to be
9 suspicious about. And this baby had medical problems
10 already, like lots of comorbidities were already there
11 in this baby.
12 So the way which I think must have happened at that
13 time is -- so we have an action log for CDOP like
14 actions to be completed, so we put that as an action in
15 that action log, and then we might have agreed at that
16 time that we should close the case.
17 I agree, in hindsight, we shouldn't have done that.
18 **Q.** Well --
19 **A.** But that's what I think must have happened at
20 that time.
21 **Q.** On the face of it, of this record, there was
22 to be a further investigation into Child I's death in
23 the form of the College report?
24 **A.** (Nods)
25 **Q.** In addition, as we can see from the following

1 action, we know that there was concern about whether
2 SUDiC had been followed in relation to the cohort that
3 the RCPCH were looking at. That's why you have told us
4 you brought it up --
5 **A.** So can I just clarify this point here?
6 I think the way this has been done or taken is not the
7 correct way. So basically this was a general discussion
8 about in hospital deaths, whether RRM should happen or
9 not, not specifically related to this case.
10 But I do not know why this has come up here as like
11 this. But the discussion was not specifically related
12 to this case because we do not do Rapid Response
13 Meetings like straight away.
14 **Q.** Let --
15 **A.** So it was a general discussion about in
16 hospital deaths, why we are not doing this, but not
17 specifically related to this case.
18 **Q.** But did you know from the Royal College that
19 their review had identified that SUDiC hadn't been
20 followed in relation to the deaths that they had looked
21 at?
22 **A.** So I -- the report, at this stage the report
23 was not shared with me at that time.
24 **Q.** And they hadn't said anything to you about it?
25 **A.** No, not to me.

1 **Q.** But at all events, Child I's case is recorded
2 as being closed, when it shouldn't have been.
3 I mean, Ms Frame has told us about the very
4 substantial backlog -- I think she used the phrase "huge
5 backlog" -- that she inherited in 2015.
6 Did you feel under pressure to close cases as
7 quickly as possible so as to be able to set the
8 committee on its right footing?
9 **A.** So, my Lady, I was not the only one. Like it
10 is always a unanimous decision in the panel. Like,
11 I was just one of the member. So it was everybody in
12 the panel because there was nothing suspicious in the
13 Form B from the hospital and because it was a neonate
14 and then we thought that, like, we are not picking up
15 anything, any theme from that. That's why the panel
16 agreed.
17 **Q.** Dr Mittal --
18 **A.** Let's close the case and keep it as and action
19 for later on.
20 **Q.** You will forgive me, I hope, for interrupting
21 you.
22 My question was whether you felt under any pressure
23 to close cases quickly as part of the effort to clear
24 the backlog; that's the question.
25 Did you or did you not feel under that pressure?

1 **A.** It's difficult for me to remember, but I think
2 it was one of the pressure at that time, that we had too
3 many cases pending.
4 **Q.** Now, the final matter to deal with just before
5 I ask the Chair to consider taking a lunch break is
6 evidence that we received from Dr Isaac.
7 Are you aware of what Dr Isaac told the Inquiry on
8 Monday?
9 **A.** Not fully.
10 **Q.** No. Well, let me -- let me help you.
11 Dr Isaac told the Inquiry that in February of 2017,
12 having become aware at a time earlier than that of the
13 concerns of Dr Brearey, that she drafted a letter as the
14 named doctor for safeguarding for the hospital that she
15 was intending to send to the Executive lead,
16 Alison Kelly, and she told us that she didn't send that
17 letter and part of her reason was that there was
18 a culture of fear?
19 **A.** (Nods)
20 **Q.** That's what she told us. Did you know
21 anything about Dr Isaac intending to intervene in what
22 was going on between the Consultant paediatricians and
23 the Executives?
24 **A.** I had some, some impressions, so not --
25 I didn't know exactly the full facts, but I had some

1 inkling that there is something going on.
2 **Q.** Doing the best you can, was that around early
3 2017 --
4 **A.** Yes.
5 **Q.** -- does it seem to you?
6 **A.** Yes.
7 **Q.** So about the time that she's contemplating.
8 Did you know that she was thinking about writing
9 a letter?
10 **A.** I think she did mention to me that, yes, she
11 want to contact.
12 **Q.** And did she ever tell you whether she had sent
13 that letter?
14 **A.** Not exactly, but I knew that there is
15 a tension going on between the paediatricians and the
16 management because people were applying for jobs
17 elsewhere at that time.
18 **Q.** Wasn't that a very significant red flag for
19 you as the designated doctor for the area? You've got
20 the named doctor for safeguarding thinking about,
21 talking to you about intervening, you have got an
22 apparent breakdown in relationships such that people are
23 thinking about moving. Isn't that a very significant
24 concern or shouldn't it be a significant concern for
25 you?

1 **A.** In hindsight, yes. In hindsight, yes.
2 **Q.** And did Dr Isaac tell you what she was going
3 to put in the letter?
4 **A.** Not specifically what she was going to put in
5 the letter.
6 **Q.** But it would, given that she was named doctor,
7 it would be to raise a safeguarding issue, is that
8 right?
9 **A.** That's right, yes.
10 **Q.** Did you think it was important that as the
11 named doctor for safeguarding that she should act
12 fearlessly and raise any concerns that she had?
13 **A.** Yes, she should.
14 **Q.** Did she tell you that she didn't send the
15 letter?
16 **A.** So NHS, like it's a very hierarchical
17 structure. So --
18 **Q.** Can I just ask you to focus on my question.
19 Did she tell you that she hadn't sent the letter?
20 **A.** No.
21 **Q.** Did she tell you about what factors she was
22 weighing in the balance in terms of whether she would or
23 wouldn't send the letter?
24 **A.** I didn't know exactly what was ...
25 **Q.** Well, did you understand that she was fearful

1 about the consequences to herself?
2 **A.** Must -- that must be one of the reasons, yes.
3 **Q.** So you knew that?
4 **A.** Yes.
5 **Q.** And did you say, "It is your responsibility,
6 as named doctor for this hospital, that you do something
7 if you are worried, nevermind the consequence to you"?
8 **A.** From recollection, I said, "You need to speak
9 to Alison Kelly", who is the head of safeguarding,
10 because that's our immediate line manager. So "Speak to
11 her about your concerns".
12 **Q.** Now, Dr Isaac is telling you that she is
13 unsure what to do. Did you follow up with her to make
14 sure that she had been brave and raised the safeguarding
15 concern that she was thinking about?
16 **A.** No, I didn't.
17 **Q.** Bearing in mind that Dr Isaac sat within the
18 management structure of the Countess and you did not, so
19 far as being designated doctor, wasn't that the moment
20 for you to say, "Tell me what you are worried about,
21 I will go and raise it. I am the designated doctor.
22 They can't do anything to me"?
23 **A.** In hindsight, I should have.
24 **Q.** Did you even speak to the Consultant
25 paediatricians at that time that she had been speaking

1 to to find out what they were worried about?
2 **A.** I didn't do it at that time.
3 **Q.** Dr Mittal, just being blunt about it, was that
4 a significant failing on your part, not to intervene at
5 that stage?
6 **A.** In hindsight, like with all this awful tragedy
7 which has happened, I should have been more proactive at
8 that time.
9 **Q.** Isn't the point of view -- I know you've
10 hindsight and we know that their fears were justified --
11 but in safeguarding, you never know whether the fears
12 are justified, do you, but you act anyway?
13 **A.** That's right.
14 **Q.** Is that fair?
15 **A.** Yes.
16 **Q.** And in a sense from a safeguarder's
17 perspective, it doesn't matter whether it's true. What
18 matters is that patients are protected from a risk?
19 **A.** Yes, that's correct.
20 **Q.** And so again, setting aside hindsight, was
21 that a significant failure on your part not to intervene
22 at that time?
23 **A.** I would say, yes, I should have intervened at
24 that time.
25 **MR DE LA POER:** Yes. Well, Dr Mittal, I have

1 a small amount of further questions for you, but,
2 my Lady, I wonder given the time whether that would be
3 a convenient moment.
4 **LADY JUSTICE THIRLWALL:** Yes, thank you. So we
5 will take a break and we will start again at 5 past 2.
6 **(1.05 pm)**
7 **(The luncheon adjournment)**
8 **(2.04 pm)**
9 **LADY JUSTICE THIRLWALL:** Mr De La Poer.
10 **MR DE LA POER:** My Lady, thank you. Dr Mittal, we
11 have just looked at the meeting of the CDOP --
12 **A.** Yes.
13 **Q.** -- in September of 2016 and discussed the
14 letter that Dr Isaac wrote but didn't send in February
15 of 2017.
16 Another event in February 2017, as we have already
17 touched upon, was the publication of the RCPCH report.
18 Now, the Inquiry knows that there are two versions
19 of that, one confidential which mentions the
20 Consultants' concerns about Letby, and the other marked
21 the dissemination copy and that's the one that was
22 published on the Internet.
23 Did you ever see a copy of the confidential version
24 of the RCPCH report?
25 **A.** This was never shared with me.

1 **Q.** Now, as the designated doctor and person
2 responsible for the area in which the Countess fell in,
3 should you have been provided with a copy of that
4 confidential report?
5 **A.** So it should be as a panel like we should have
6 chased it from the panel as well.
7 **Q.** You should have chased it --
8 **A.** Yes.
9 **Q.** -- from the CDOP panel?
10 **A.** From the hospital yes.
11 **Q.** So is it your view that not only as the
12 designated doctor but also that the CDOP panel needed to
13 see the confidential version?
14 **A.** Yes.
15 **Q.** Is that right?
16 **A.** That's right, yes.
17 **Q.** Did you know that there was a second version
18 of the report?
19 **A.** I was never aware that there were two versions
20 of the report.
21 **Q.** This brings us now in the timeline to the CDOP
22 meeting in March of 2017. If we bring that up
23 INQ0001953. We will go to page 3, please.
24 Now, at the September meeting, when Child I's case
25 was closed, there was a note indicating that there would

1 be a return to Child I's case when you make
2 a presentation about the RCPCH report and this here is
3 your presentation about the RCPCH report; is that right?
4 **A.** I wouldn't say that this is a presentation for
5 RCPCH report. This is more like a general discussion in
6 the business meeting about the same issue again, about
7 SUDiC meetings for in-hospital deaths.
8 **Q.** We can see that it's focused upon the
9 substance of the RCPCH report which obviously had been
10 published just a month or so before. I suppose another
11 way of asking the question is: did the panel ever go
12 back to Child I's case as seemed to be indicated in
13 September once the RCPCH report was published?
14 **A.** From recollection I don't think we looked at
15 that again.
16 **Q.** And do you know why?
17 **A.** I'm not sure about that.
18 **Q.** Was it a -- I mean, on the face of the notes
19 from September, you have seen them just before lunch?
20 **A.** Yes.
21 **Q.** It appeared that there was an intention to go
22 back to that case even though it was closed. But
23 an oversight by the panel, a failure to do what it set
24 out to do, can you offer any different explanation?
25 **A.** I don't have any explanation for that.

1 **Q.** Now, we also know that Child A's case was
2 discussed and we will bring up the detail. It's
3 page 10. So the case at the top there is Child A's
4 case. Now, as we can see from the record of the
5 meeting, Child A's case was closed at this meeting.
6 Now, at the time that the panel closed Child A's
7 case, did you know that Dr Hawdon, a neonatologist, had
8 conducted a review following the RCPCH and had concluded
9 that Child A's case needed further investigation?
10 **A.** We didn't have that detailed information at
11 that time.
12 **Q.** Did you know because on the face of the RCPCH
13 report there was a recommendation that a Casenote Review
14 --
15 **A.** Yes, I knew that.
16 **Q.** So you knew there was a Casenote -- did you
17 ever find out what the Casenote Review concluded?
18 **A.** I didn't know specifically about the case like
19 which cases were reviewed by her. But I only knew that
20 following the report a neonatologist has been instructed
21 to look into some cases in more detail.
22 **Q.** From a CDOP point of view isn't it quite
23 important if there is to be another investigation that
24 you know whether any of Dr Hawdon's cases are those
25 going before CDOP so that you can find out what she said

1 about them?
2 **A.** In hindsight we should have done that.
3 **Q.** Because in fact although CDOP closed this, as
4 at the date that CDOP closed it, Dr Hawdon's view was
5 that Child A's case needed further investigation and
6 that shouldn't happen, should it?
7 **A.** That's right yes.
8 **Q.** CDOP should be the end of the process of
9 investigation, not part way through it?
10 **A.** I agree, yes.
11 **Q.** Now, we can see the cause of death here is
12 given as unascertained and if we go to the Form C for
13 Child A, INQ0001944, we will get a little bit more
14 detail. So we can see the case summary and from the
15 narrative we are given, it appears there is no
16 expectation that Child A was going to collapse --
17 **A.** Yes.
18 **Q.** -- do you agree?
19 **A.** Yes.
20 **Q.** And so on the face of it we have a child who
21 has unexpectedly collapsed in circumstances where the
22 cause of death is unascertained. Now let's have a look
23 if we may, please, at page 5 of this. We can see there
24 is a category for such children, which is category 10,
25 Sudden Unexpected Unexplained Death. Do you agree the

1 information presented to the panel means that that
2 category could be ticked?
3 **A.** So, my Lady, we were falsely reassured at that
4 time that because we were not the expert -- because CDOP
5 is not an investigative panel.
6 **Q.** Well --
7 **A.** It is more about learning the trends and in
8 the panel we were reassured that because the Countess is
9 looking into this and neonatologists are looking into
10 this and nothing has come to us so we wanted reassurance
11 from Countess but we were not thinking the unexpected;
12 which is Sudden Unexpected Death.
13 So that may be the reason which, from my
14 recollection, that we didn't pick number 10 because
15 there is nothing in the records at that time which were
16 in front of us which were pointing towards Sudden
17 Unexpected Deaths.
18 **Q.** Well, my question was: do you agree from the
19 information you were presented with that box 10 could
20 have been ticked?
21 **A.** In hindsight, yes.
22 **Q.** The box that was ticked was 8, perinatal
23 neonatal event. Ms Frame, the independent chair, told
24 us when I asked her about this that lay members of the
25 panel were quite dependent upon the clinicians for their

1 interpretation of the medicine to help fill in this form
2 and is that a fair observation by her?
3 **A.** That's correct, yes.
4 **Q.** So what category A requires is that death
5 related to a perinatal event and examples are given.
6 Now, if we go back to page 1, just to help us from
7 a clinical perspective how this information would be
8 analysed, are you able to identify for us what the
9 perinatal event was from the description that you are
10 given?
11 **A.** So the perinatal event is like at the time of
12 death and immediately after birth within a week --
13 **Q.** Yes.
14 **A.** -- if there is any event---
15 **Q.** An event, yes.
16 **A.** -- which is responsible for the death.
17 **Q.** Yes.
18 **A.** So when this baby was born, there was -- this
19 baby was given inflation breaths, the baby was preterm,
20 the weight was low and this baby had -- had CPAP and
21 lines.
22 So this baby had co-morbidity as a preterm and also
23 in the records which were in front of us, there was no
24 such suspicion from the paediatricians that they were
25 thinking that it could be something else because these

1 are the common scenarios which we have in panel, the
2 neonatal deaths are the commonest.
3 So I am just assuming because there were three
4 designated doctors in the panel and I am the one who
5 doesn't deal with neonates, there are two who deal with
6 neonates, and everybody agreed that, yes, we can close
7 it. So that's my assumption.
8 **Q.** Just to help us, bearing in mind the Coroner
9 who has had a postmortem and investigated it at an
10 Inquest has concluded the cause of death is
11 unascertained, isn't that an indication -- you tell us
12 -- that really perinatal event can't be said to be
13 related to the death?
14 **A.** So, my Lady, like just from my recollection
15 I am not the neonatologist, but there are many deaths
16 where we see unascertained from the Coroner and we still
17 we don't tick them in Sudden Unexpected Death, we still
18 tick them in other categories but it all depends on the
19 scenario, on the context.
20 So certainly like in hindsight now what we know
21 about this case, yes, it should be in number 10. But at
22 that time, we didn't think about that this should go in
23 number 10.
24 **Q.** Of course your evidence this morning was that
25 as at the 24 March, you did not know about the concerns

1 of your Consultant colleagues?
2 A. That's right, yes.
3 Q. The final question about this particular
4 meeting is we know that the Inquest hearing for Child A
5 took place on 10 October. Do you know why it took until
6 March for this case to get before the panel?
7 A. So the way the panel works is we need
8 everything in front of us, like the case has to be
9 prepared with all information, if there is any inquiry
10 or any investigation going on everything should be
11 complete. Only then CDOP is the final end. So my only
12 guess is that it must have taken that much time to
13 prepare the case by the admin team and that's why it
14 took so long to come to the panel.
15 Q. We can take that down and I just have one
16 final general question about CDOP. Thank you. We have
17 looked at Child I, we have looked at Child A, we have
18 seen both cases are closed. There is some commentary
19 associated particularly with Child I.
20 How long in this meeting is the discussion about an
21 individual case before a conclusion is reached?
22 I appreciate it will be case-specific, but is it as
23 little as a minute sometimes and as much as an hour?
24 What's the sort of time range that is spent in this
25 meeting going through each of these cases and deciding

1 closed or not closed?
2 A. So, my Lady, it depends upon the case. Like
3 there are some cases we spend sometimes up to an hour or
4 like 40 minutes and some cases like we close them within
5 a minute or within two minutes. So it all depends on
6 the context and it depends on the information which is
7 in front of us.
8 So it is difficult to give a definite or general
9 answer that every death we spend that much time. It all
10 depends on the paperwork which is in front of us. But
11 we rely on the professionals completing those forms and
12 sending information to us.
13 Q. Is the material available to the panellists
14 ahead of the meeting?
15 A. Yes.
16 Q. And is there an expectation that every
17 panellist will read all of the information provided to
18 them?
19 A. Yes, yes.
20 Q. Looking -- you have told us already that you
21 had limited time, was that something that you were
22 always able to do, to read the entirety of a pack for
23 every meeting before it?
24 A. I always tried to do it but, yes, sometimes
25 there are some times like I may not have read the full

1 papers. But I do try my best to read all the papers.
2 Q. Now, we have heard from Ms Frame that
3 following this meeting there was contact with Ian Harvey
4 and that led to an invitation for her to a meeting and
5 she's told us that she invited Detective Chief
6 Superintendent Wenham to come with her.
7 Now, you were at the meeting on 27 April 2017 at
8 the Countess; is that right?
9 A. So I was not formally invited by the -- they
10 didn't think that I should be there but it is our chair,
11 she thought that it would be better that I accompany her
12 to support her. So it was at her request I went with
13 her to the meeting, but I was not invited for that
14 meeting.
15 Q. Now, your initial recollection as recorded in
16 your witness statement, we dealt with this right at the
17 beginning, was that there was no mention at that meeting
18 of the involvement of a member of staff in the increased
19 mortality, that is what you believed when you wrote your
20 statement and you have since seen the records which
21 demonstrate that that issue plainly was raised.
22 Do you agree it's quite a significant thing to be
23 said in a meeting, "I think a member of staff might be
24 involved in the deaths of these babies"?
25 A. (Nods)

1 Q. So given that you agree that, why do you think
2 that you had forgotten that that was said in this
3 meeting, are you able to help us with that?
4 A. So from my recollection in that meeting a very
5 small amount of time was spent on that part and more
6 discussions were: what should we do next? So that's all
7 I can remember, I don't know why I missed that in my
8 recollection.
9 But it was only like brief, like not a significant
10 part of the meeting was spent on the staff involvement.
11 Q. Going out of the meeting, what did you think
12 was going to happen?
13 A. So in the meeting only like we are going to
14 hear from Mr Wenham, so there was a discussion whether
15 there should be SUDiC or it should be -- it was asked to
16 me whether the SUDiC should be started on this and
17 I said that now that the police is involved, it should
18 be -- SUDiC is separate from criminal investigations.
19 So that's why like they were thinking more about
20 criminal investigations.
21 Q. So was it your expectation at the end of the
22 meeting that the police were going to have a think about
23 what they wanted to do --
24 A. Yes.
25 Q. -- with that information?

1 **A.** Yes.
2 **Q.** So that is what the police are doing.
3 Now, you are the only safeguarder at this meeting;
4 is that right?
5 **A.** That's right, yes.
6 **Q.** You had been invited effectively in that role
7 to the meeting. The Consultants' concerns as they were
8 reported to you in that meeting were a safeguarding
9 issue, do you agree?
10 **A.** Yes.
11 **Q.** And whilst the police are going to take it
12 away and think about what they are going to do and that
13 will take as long as it takes, do you agree there was
14 still an issue for the hospital from a safeguarding
15 perspective?
16 **A.** In hindsight, yes. But at that time because
17 the police was involved and such a high level meeting
18 was there, so I thought it is now for the higher
19 authorities to now address this. This is a very
20 sensitive issue and it should be dealt with at high
21 level.
22 **Q.** But --
23 **A.** But I agree that yes, there is a safeguarding
24 as well in this.
25 **Q.** Let's just untangle that, Dr Mittal. You

1 operate at a high level, you represent the CCG?
2 **A.** Yes.
3 **Q.** What the police are not doing in the early
4 stages as they think about what they are going to do
5 from a police investigation, is making sure that babies
6 were safe. That wasn't what they were telling you they
7 were going to do, they were going to go away and think
8 about it?
9 **A.** (Nods)
10 **Q.** So I think you have agreed with this: didn't
11 there need to be a safeguarding response from you in
12 this meeting?
13 **A.** Can you clarify what exactly from a
14 safeguarding perspective?
15 **Q.** Well, a discussion saying: this is
16 a safeguarding issue, we need to understand how we are
17 going to keep babies safe in the future, we need to
18 contact the LADO, to make sure the LADO knows about it,
19 and we need to think about any formal action we need to
20 take in relation to the member of staff that the concern
21 is about to make sure that any risk that that person may
22 pose is prevented from occurring?
23 **A.** So, my Lady, at that stage I thought it is
24 being now at much higher level than -- this should --
25 I should have thought about this in February but not

1 because in April it was like CEO of the hospital,
2 Medical Director of the hospital and the police and then
3 the chair of the CDOP there.
4 So I thought that this has now gone at a higher
5 level. So I didn't even think at that time that
6 I should be dealing with it at safeguarding level --
7 **Q.** Do you agree you should have been thinking --
8 **A.** Yes, I agree that, yes, I should have.
9 **Q.** Now, the final topic is the safeguarding
10 report of 2017. It's INQ0004715, and we will go
11 straight to page 19, where we will see your name.
12 So at item 11.5 you are providing a Child Death
13 Overview Panel update, do you see that?
14 **A.** Yes.
15 **Q.** I am not by any means trying to take a cheap
16 point here, Dr Mittal, it may just be a matter of
17 formatting.
18 But under that heading, albeit in bold, we see the
19 Countess of Chester neonatal unit investigation added.
20 So it isn't marked out as a separate item, it appears to
21 fall under the item, but as I say it's not intended as
22 a cheap point. The heading is CDOP.
23 My question is: were you responsible or taking
24 responsibility for the addition Countess of Chester
25 neonatal unit investigation?

1 **A.** I was not taking any responsibility for
2 neonatal investigation. This was following this meeting
3 and once the police decided to take it further, I was
4 asked by the police for Operation Hummingbird, so any
5 neonatal death in the hospital I need to ring 101 and
6 inform the police and Alison Kelly asked me to fill
7 a Datix form for every death after. But this all
8 happened after this meeting. Not before that.
9 So that is what is here that until end of 2017
10 I was informing the police and to the Exec of any death
11 which I come across.
12 **Q.** So you didn't type this or have anything to do
13 with the wording, is that right, or did you?
14 **A.** It might be me. But I can't really -- I can't
15 be sure.
16 **Q.** You see, this is a safeguarding report.
17 I mean, it mentions the fact that the police are
18 involved, but it doesn't actually say anything about
19 what the safeguarding response is and I am just
20 wondering if you were the author of that, as it seems to
21 have been inserted into your section, that this was
22 an opportunity to reflect on the need for a safeguarding
23 response to make sure that any risk that the member of
24 staff may pose was being addressed at a safeguarding
25 level?

1 **A.** So if I remember, this report is after that
2 meeting, after that high-profile meeting.
3 **Q.** It is, yes, yes. And we can see that because
4 it begins in the first sentence with mentioning the fact
5 that there's an investigation started by Cheshire Police
6 which only happened after -- after that meeting?
7 **A.** Yes. So usually our named nurse Karen Milne
8 used to ask me if something needs to go in this or not.
9 So I used to send her information from the CDOP report,
10 but I can't remember specifically what information
11 I sent at that time. But I used to provide information
12 for the annual report from -- from the CDOP annual
13 report to the safeguarding report in Countess.
14 **Q.** Bearing in mind what was known by you at the
15 time of this report, do you think there in fact should
16 have been more information provided in this -- in this
17 report, or do you think it was adequate just to describe
18 it in that way?
19 **A.** I was not sure whether it should be me or it
20 should be from somebody else who should be talking more
21 about once the police has taken over this investigation.
22 **MR DE LA POER:** Thank you, that can come down.
23 Dr Mittal, thank you for answering my questions.
24 My Lady, those are all the questions I have for
25 Dr Mittal and although permission was granted, it has

1 just been communicated to me that there are no questions
2 from Core Participants.
3 **LADY JUSTICE THIRLWALL:** All right. Very good.
4 I have no questions for you, Dr Mittal. Thank you
5 very much indeed, you are free to go now.
6 **A.** Thank you.
7 **LADY JUSTICE THIRLWALL:** I was asked if we would
8 take a break --
9 **MR DE LA POER:** Yes.
10 **LADY JUSTICE THIRLWALL:** -- before the next
11 witness, although I think it was thought we were going
12 to be a bit longer with the last one. So shall we say
13 10 minutes, come back in at 20 to.
14 **(2.30 pm)**
15 **(A short break)**
16 **(2.39 pm)**
17 **MS LANGDALE:** Mr Wenham, please.
18 FORMER DETECTIVE CHIEF SUPERINTENDENT NIGEL WENHAM
19 (sworn)
20 Questions by MS LANGDALE
21 **LADY JUSTICE THIRLWALL:** Do sit down.
22 **MS LANGDALE:** Mr Wenham, you have provided
23 a statement to the Inquiry dated 20 June 2024. Can you
24 confirm whether the contents are true and accurate as
25 far as you are concerned?

1 **A.** Yes.
2 **Q.** Do you have it in front of you?
3 **A.** I do, yes.
4 **Q.** You tell us you commenced your career as
5 a police officer in 1989 and retired on 22 April.
6 During the timeframes that are relevant for the
7 purposes of this Inquiry, between 2015 and 2017 you
8 worked as a Detective Superintendent and Detective Chief
9 Superintendent. You also, in November 2012, were
10 promoted to Detective Chief Inspector and became head of
11 the Constabulary Strategic Public Protection Unit, you
12 tell us that at paragraph 5. It was in that context
13 that you became involved in the Pan Cheshire Child Death
14 Overview Panel, is that right, in that role?
15 **A.** That's correct, yes.
16 **Q.** In January 2015 you were temporarily promoted
17 into the role of Detective Superintendent and deputy
18 head of the PPD. Can you tell us something about the
19 PPD, please, Public Protection Directorate?
20 **A.** PPD stands for Public Protection Directorate.
21 At that time within Cheshire Constabulary that was an
22 area of business with about 400 officers and staff that
23 looked after all areas of vulnerability and risk, for
24 example child protection, child abuse, rape, sexual
25 abuse.

1 **Q.** Indeed at paragraph 10 you set out what that
2 PPD was responsible for and it's a wide range of multi
3 discipline meetings, for our purposes including Local
4 Safeguarding Children Boards and the Child Death
5 Overview Panel.
6 Can we perhaps have paragraphs 23 and 24 on the
7 screen of your statement, please, INQ0102367, page 6, so
8 that everyone can follow.
9 While we are retrieving that, Mr Wenham, you say
10 that the purpose, at paragraph 23, of the police
11 representative role at CDOP was to represent the police
12 and to fulfil the police roles and responsibilities
13 outlined in the protocol and the police representative
14 would have been there in a position of rank that
15 empowered them to take responsibility to make
16 appropriate decisions.
17 So what are you referring to there? What kind of
18 decisions in all of these various meetings where
19 a police representative is present might be being taken?
20 **A.** Yes, it's so the individual is empowered to
21 actually make the decisions on behalf of the
22 Constabulary, so that he can answer yes or no to
23 something that a decision needs making and you don't
24 take to take that decision back within the Constabulary
25 in order to get that issue resolved.

1 **Q.** This is rich coming from me, but you might
2 need to go a bit slower if you can?
3 **A.** Okay.
4 **Q.** So if you look at paragraph 24 --
5 **A.** Yes.
6 **Q.** -- you set out how cases were reviewed and the
7 subject of reviews each month in CDOP and that:
8 "The cases were fairly old in terms of the actual
9 date of death and the date of review. It is not unusual
10 for cases to be reviewed that were sometimes over
11 12 months or longer. Neither I nor Cheshire Police had
12 any involvement or responsibility identifying the cases
13 that would be reviewed at each CDOP. I do recall the
14 issue of the delays of these cases being brought to CDOP
15 and raised on several occasions in order to try and
16 narrow the time from the death to the review."
17 Do you consider when you look at that, or did you
18 consider at the time, it was therefore ineffective in
19 identifying patterns of unexpected or unexplained deaths
20 because of the manner in which cases were brought to it
21 and considered?
22 **A.** It was recognised -- through the period I was
23 present and attending CDOPs it was recognised that there
24 was an issue with delays by the chairs and they did try
25 to take steps through the CDOP, through the business

1 support, in order to try and improve the timeliness.
2 Some of the issues that caused the delays were outside
3 of the CDOP's control. For example, they could be
4 waiting on Inquests or other factors relating to that
5 individual case. So many issues were probably related
6 to process within the relevant local safeguarding local
7 authority areas and some of the issues may be to do with
8 the business side of the CDOP but the chair recognised
9 that and particularly Hayley tried to reduce the delays
10 and I think she did achieve some success in that.
11 **Q.** That can come down thank you. Paragraph 33 of
12 your statement. You say:
13 "I was not made aware during my attendance at the
14 CDOP from 2015/2016 that there had been an increase in
15 the number of deaths at the Countess of Chester neonatal
16 unit. Any increase in neonatal deaths would be unlikely
17 to have been identified from the CDOP as a standalone
18 process."
19 You say:
20 "Again, I don't think so that the structure of the
21 meetings and reviews would have made it easy to identify
22 that there had been an increase ... several reasons for
23 this assertions."
24 You have just set out some, are there any more
25 reasons you would identify? For example you say the

1 number of cases that are listed for review for each
2 meeting would frequently be into double figures. so how
3 much time does that give you with each case?
4 **A.** The CDOP meetings were generally a full day,
5 the first -- it was Part A or a Part B. Part A was
6 generally the policy strategy steering exercise and
7 governance for the meeting and that was normally in the
8 morning and Part B was the case reviews. At any one
9 time there could be anything from 10 to 20 cases to be
10 reviewed on a particular meeting.
11 I remember frequently the panel members would sit
12 through the lunch and eat their lunch whilst they were
13 reviewing the cases because there was such a large
14 volume to get through.
15 But each case could be discussed from anything from
16 15 minutes to maybe an hour on an individual case so if
17 there is 15, 16 cases, it would be four to five hours
18 that afternoon reviewing all the cases.
19 **Q.** You also say in this paragraph that each of
20 the cases were mostly reviewed in isolation from each
21 other.
22 **A.** The cases would have been listed without any
23 correlation or relation to each other. My understanding
24 is the cases would be managed through the business
25 support for the CDOP and the cases listed on the basis

1 of: the ready to be listened and presented to CDOP. So
2 my understanding there was no -- no reason why we would
3 consider there is an immediate relationship between any
4 of those cases that are being discussed unless there was
5 something obvious standing out. For example, if we had
6 done some research and a family and we knew there was
7 a familial link between a case, we would disclose that
8 on the form and that would be discussed in the meeting.
9 **Q.** You tell us at paragraph 35:
10 "I can be very clear and specific when I first
11 became aware of the increase in the number of deaths on
12 the Countess of Chester neonatal unit. It was
13 effectively 24 March 2017 ..."
14 You say prior to that meeting you weren't aware of
15 any increase in the number of infant deaths or any other
16 issues.
17 Should we go to that meeting note, please, on the
18 screen, INQ0012008, page 3. So just to orientate
19 yourself, Mr Wenham, when it comes on the screen this is
20 an extract of the minutes of that meeting and item 5,
21 Countess of Chester Neonatal Review. So have a look at
22 that top paragraph.
23 "The Countess of Chester has carried out a review
24 of the neonatal department following a cluster of deaths
25 over a 16-month period."

1 Now, we heard evidence from Sharon Dodd yesterday
2 who was a member of CDOP and she had become aware
3 because of the forms that are filled in that there were
4 13 deaths in the period that we are concerned with. She
5 was aware of 13 neonatal deaths in between June 2015 and
6 June 2016.
7 Do you remember if a number or figure was raised in
8 this discussion? It is not minuted but there's
9 reference to a cluster of deaths over a 16-month period.
10 Do you remember how big or significant a number it was?
11 **A.** I can't remember that being specifically
12 mentioned. It possibly was because if you read the
13 report that was presented which I would have read prior
14 to the meeting and at the meeting, I think it makes
15 reference to 13 or 11.
16 **Q.** Yes, yes.
17 **A.** So I would have had knowledge of it but I am
18 surprised it isn't referenced specifically in the
19 meeting but whoever has wrote them minutes at the time.
20 **Q.** But you were aware, as you say, someone there
21 had that number and you have seen that's in the errata,
22 so you wouldn't be surprised if that was mentioned. Do
23 you remember if there was any discussion about how that
24 featured, set against previous years -- would you have
25 understood what 13 represented in terms of a change in

1 significance from previous years or not?
2 **A.** From recollection -- I mean, I clearly left
3 that meeting with some concerns. But from recollection,
4 I can't remember if that was discussed specifically
5 other than what the contents of the report was that was
6 presented.
7 **Q.** Was the report provided to you, had you seen
8 the RCPCH review, we assume they are referring to there.
9 Did you ever see a Royal College report on paediatric
10 child health?
11 **A.** I saw the one that was part of the minutes --
12 sorry, part of the agenda, because the papers are
13 provided in advance.
14 **Q.** Yes. And that version that you saw, did it
15 contain any reference to a nurse or concerns about
16 a nurse and an HR process being necessary? Did you get
17 the version with that in it or was that redacted and not
18 available to you?
19 **A.** I -- I think the version that came to the CDOP
20 was not -- did not make any reference to the -- to the
21 nurse.
22 **Q.** If it had made a reference to a nurse and
23 concerns about a particular nurse, what, if anything,
24 would you have thought about that in the context of
25 everything else you were being told here?

1 **A.** Well, my concerns were raised anyway because
2 of the content of the nature of the report as it was, it
3 was presented. If it had also included the redacted or
4 the -- the unpublished version, then my concerns
5 possibly would have been even more heightened and
6 increased.
7 **Q.** In terms of the CDOP process, and making
8 contact with the police, at an earlier meeting, I don't
9 think you were present at it, but I am going to ask for
10 it to go on the screen so you can see the issue readily.
11 So that can come down, please, and can we have instead
12 INQ0017817, page 2. This is an earlier meeting,
13 20 November, there is an R next to your name. Is that
14 when someone else comes to represent instead of you?
15 **A.** Yes.
16 **Q.** So you weren't there but there is clearly
17 a discussion about SUDiCs generally, you see there
18 number 4:
19 "SUDiC within the hospital."
20 "Should a Rapid Response Meeting be held each time
21 there is a Sudden Unexpected Death within a hospital.
22 The meeting felt that the response should be on
23 a case-by-case basis and the safeguarding doctor should
24 be involved in the discussion with the designated doctor
25 and a Rapid Response should be arranged if deemed

1 appropriate. The meeting felt this process should be
2 reflected in our procedures with clarification of best
3 practice.
4 "Action: ensure that when the Pan Cheshire
5 procedures are reviewed Sudden Unexpected Deaths in
6 hospital are identified".
7 So there seems to be a discussion about the
8 suitability or otherwise of Sudden Unexpected Deaths
9 procedures, when babies die in hospital and we know they
10 weren't used in this case in these neonatal deaths.
11 Were you aware in the other child protection work you
12 were doing across other committees and generally that
13 there are close liaisons sometimes between for example
14 local authorities and the police where there is an
15 officer from the force and somebody from the local
16 authority who can readily reach out to each other at an
17 early stage for guidance or just to discuss things if
18 they are worried about them.
19 Do you think that kind of process whether you call
20 it a Rapid Response Meeting but something with the
21 police early on would be useful to have a conversation
22 with a liaison officer?
23 **A.** Can I just clarify exactly, are you talking in
24 specifically around individual cases of a death or in
25 general?

1 **Q.** In individual cases of Sudden Unexpected
2 Deaths in hospital. So a baby dies in hospital, the
3 SUDiC form and process wasn't used and assume for
4 a moment it is bureaucratic in part. Is there another
5 way of communicating directly with the police at the
6 time that might be useful outside the processes that
7 clearly were proving challenging for a number of people?
8 **A.** At the time, I felt as though across Cheshire
9 we had a really strong partnership at a safeguarding and
10 child protection level, both local safeguarding children
11 boards, and a range of other partnership structures
12 where we were able to work together effectively.
13 There were -- there was always that opportunity to
14 engage with another professional from another agency all
15 the time. It was just a case of the willingness of
16 those individuals involved just to reach out and engage
17 with those other professionals.
18 **Q.** Did that include doctors or people within the
19 hospital? I mean I understand when there's deaths in
20 the community and suspicious deaths in the community but
21 in terms of dealing with hospitals where there were
22 concerns about a member of staff in a hospital would it
23 be the same ease of reference who you should contact or
24 who you might contact?
25 **A.** I am a bit unclear in terms of are you -- are

1 you suggesting whereby it's -- a doctor's got concerns
2 about a particular individual?
3 **Q.** Or just the circumstances of a death, a Sudden
4 and Unexpected Death, they are not quite sure what
5 happened. They don't at that stage know what's happened
6 but they want to share any information they have about
7 it.
8 **A.** Then the answer to that would be pick up the
9 phone and contact the police and a professional police
10 officer will attend and normally from the specialist
11 department. You know, we are there all the time to
12 respond.
13 It obviously leads into the -- the understanding
14 around the Sudden and Unexpected Death in Infants and
15 Child protocol or procedures that were in place around
16 that time.
17 **Q.** We know that following that 27 March meeting,
18 soon after that, in April, if we go to INQ0102758,
19 page 4, Mr Harvey is asking Hayley Frame for a meeting
20 as soon as possible and has invited her to attend.
21 If we go to page 3, the page before. He suggests
22 you might like to invite others and we see at the top
23 Hayley Frame says:
24 "I wonder whether we should invite Nigel from
25 Cheshire Police and Gill Frame, independent chair of

1 Chester. Please can you canvas Mr Harvey's views."
2 Page 2. Mr Harvey agrees they should be invited:
3 "Would you be able to arrange this with them as
4 I don't have contact details?"
5 Then over the page, page 1, you are invited and you
6 confirm that you will attend and so there is a meeting
7 on 27 April, which you address at paragraph 50 of your
8 statement. The emails can go down now, thank you.
9 You say at 51:
10 "I recall I would have been involved in the
11 planning of the meeting but I cannot recall or don't
12 have access to how precisely this was done or if there
13 were formal minutes from the meeting."
14 You set out, and again it might be useful to have
15 your bullet points of your notes from your statement,
16 INQ0102367, at page 13, the bullet points you identify
17 from the meeting. If we just have the bullet points at
18 the end there, please and the two -- that is helpful
19 thank you -- or three on the next page.
20 You have looked at the key points of the discussion
21 and these are the key points. If we could now go to the
22 meeting notes of Mr Cross, and I can just ask you to
23 pick up a couple of matters that you have identified
24 there, but I will give people a chance to read those.
25 So the meeting then, please, is INQ0102292,

1 starting at page 2, and this meeting of course is
2 a combination -- you have got Stephen Cross, Ian Harvey,
3 this is a meeting that's a combination of doctors, the
4 paediatricians and the Executives.
5 So if we go to page 2 first. You have Dr Jayaram
6 referring to "one member of staff. Concern
7 Beverley Allitt". Can you see at the beginning?
8 **A.** Sorry I missed that.
9 **Q.** Halfway down, "Association of one member of
10 staff. Concern Beverley Allitt" in that middle section.
11 So on the one hand you have got a doctor there at the
12 beginning telling you clearly that that's what the
13 doctors are worried about and then straight underneath
14 you have got Mr Harvey saying:
15 "Nurse. Full-time, overtime, allocated sick and
16 poorly babies."
17 Then you have got at page 3, at the top,
18 Dr Jayaram:
19 "Particular nurse days and nights. [More of]
20 nights and then no incidents on nights."
21 **LADY JUSTICE THIRLWALL:** "Moved off nights".
22 **MS LANGDALE:** "Moved off nights", thank you:
23 "... then no incidents on nights."
24 "Since level change no real incidents."
25 We have got Mr Harvey talking about very hot unit,

1 staff working under pressure.
2 If we go over the page to page 4. That reference
3 at the top:
4 "NW reports: Royal College -- Dr Hawdon not widely
5 shared."
6 Had you seen the Dr Hawdon report? It appears to
7 be you that's commenting on that, but I don't know if
8 you remember whether you commented on things not being
9 widely shared?
10 **A.** I think at that point I hadn't seen it. The
11 only report that we had had sight of was the RCPCH one.
12 **Q.** The redacted version?
13 **A.** Which went to the CDOP and one of the actions
14 that came out of this meeting was for the
15 professionals -- sorry, the Executive Team to share
16 those reports with the police.
17 **Q.** Did you have a sense, you have got a doctor
18 telling you "Beverley Allitt", you have got a Medical
19 Director saying "this is a busy unit, this is a hot
20 unit", et cetera. What was the impression you got in
21 the meeting, did you appreciate the width of opinion
22 between them or not?
23 **A.** It's quite difficult trying to reflect back
24 because it was obviously some time ago. At the time,
25 I just remember those present, I think I put it in my

1 statement that those individuals were professional, they
2 were engaging, and there was -- there were, I think it's
3 reflected in the information that's been shared, there
4 was a difference in terms of interpretations and
5 concerns.
6 So maybe the Executive Team were a bit more
7 satisfied things were being managed, whereas the -- some
8 of the doctors present were clearly concerned and that's
9 reflected my notes at the time which I have documented.
10 And that clearly informed my mindset moving out of that
11 meeting for the next steps.
12 **Q.** If we look at page 7 of this meeting, we have:
13 "Ian Harvey: Grievance -- HR process.
14 Recommendation of mediation. Behavioural issues. No
15 previous ..."
16 I don't know what that means afterwards, on:
17 "... nurse skills or ... Trust criticised for what
18 we did ... to be reintroduced."
19 What do you remember them saying about the
20 grievance HR process and behavioural issues?
21 **A.** My notes are fairly detailed and I haven't got
22 reference to that so I can't remember that specifically
23 being discussed. Clearly it was. But it would have
24 been part -- part of that discussion around when the
25 nurse was being discussed by those present but I don't

1 disagree that it would have been discussed, I just can't
2 remember that specific point.
3 **Q.** Did you get an impression or not about what
4 the Executives thought about the behaviour of
5 Consultants?
6 **A.** Not from that meeting, no.
7 **Q.** If we go over the page to page 8, there's
8 reference to under "Ravi: blue and white tape
9 everywhere".
10 Do you remember how it was described that the
11 police might become involved and the way they might
12 becoming involved if they were contacted?
13 **A.** Sorry, can you repeat the question, please?
14 **Q.** Yes. Were you aware of any description of how
15 if the police became involved, there would be blue and
16 white tape everywhere, it would be disruptive for the
17 unit, that that was discussed in some way, the concerns
18 about how the police would manage an investigation or
19 being invited in to look at the situation?
20 **A.** I can't remember the detail. I am just trying
21 to reflect my statement what I recorded because it would
22 have been reflected in some of my notes.
23 **Q.** Do you mean your statement of the meeting?
24 **A.** Yes, my statement that I have written for the
25 Inquiry which would have been drafted --

1 **Q.** Okay --
2 **A.** -- Using reference to my notes.
3 **Q.** Let's go to a different question or
4 a different way of approaching it.
5 Would it be a realistic expectation at this time,
6 when you are discussing it, that if the police were
7 contacted about allegations that a nurse had harmed
8 babies on a neonatal unit, that they would come in and
9 close the unit, tape it off and be very visible in their
10 investigative work to staff and families trying to use
11 the hospital? How would the police go about it?
12 **A.** No, in terms of I -- I would have reflected
13 what our response would have been, but I would have been
14 very cautious in that meeting about --
15 **Q.** Sorry, that is not you. I am not suggesting
16 you said anything about blue and white tape at that
17 meeting?
18 **A.** Right.
19 **Q.** I am saying if somebody said -- the Inquiry
20 has heard evidence that Mr Cross, who had worked with
21 the police --
22 **A.** Yes.
23 **Q.** -- had said or made reference to blue and
24 white tape and how the hospital might face the reality
25 of an investigation on a neonatal unit. So you don't

1 remember that being referred to, whatever this note says
2 about blue and white tape, so forget that and I am just
3 asking you now: how did in fact the hospital go -- how
4 did the police go about the investigation and was there
5 blue and white tape and was the unit shut?
6 **A.** When the decision was made to launch the
7 investigation, the key focus was immediately round the
8 needs of the families and communication, engagement and
9 support to the Families.
10 We also then focused on the needs of the
11 individuals working in the hospital to ensure their
12 welfare was addressed and those individuals were
13 supported. But that would have been all covered by the
14 SIO, the senior investigating officer, as part of the
15 investigation plan, investigation strategy.
16 But there would have been an assessment around it
17 I think I have made some reference to this in one of my
18 notes that the unit had been risk-assessed and managed
19 and in terms of the individual who was felt to be the
20 risk had been removed, then the operational activity at
21 the Countess could continue. So it wasn't a case of the
22 police going in, sealing things off, crime scenes. It
23 was a case of support, engagement, gathering evidence,
24 gathering files, securing information, because a lot of
25 the information was two to three years old and it's not

1 just at the Countess, it was in pathology, it was in
2 postmortems, it was in, you know, other, other
3 hospitals.
4 **Q.** And plain clothes officers?
5 **A.** Sorry?
6 **Q.** Plain clothes officers going into the
7 hospital?
8 **A.** Well, it had been detectives generally who
9 would lead them or carry out the enquiries, yes. But it
10 would have been very much initially a low-key -- not
11 a visible investigation. It would have been sitting in
12 the background of the work going on at a pace. But very
13 much focused around initially engaging with the Families
14 because once that decision -- once we made the decision
15 to go live with the investigation, we didn't go public
16 for 36 hours because the next day, it was a family
17 liaison strategy and engaging and knocking on the doors
18 of all those Families, you know, to bring the news of
19 what was happening.
20 **Q.** So the suggestions around how it might have
21 been done were simply wrong, this blue tape?
22 **A.** It could be seen as scaremongering, I suppose
23 now, looking back with hindsight. You know, but --
24 **Q.** To put people off wanting to go?
25 **A.** Potentially looking at it now with fresh eyes

1 but at the time if it was said I would have just
2 dismissed it and again remained very professional and
3 outlined exactly what our processes would have been in
4 reality, not like what you see on the TV.
5 **Q.** That can come down, thank you.
6 If we go back to your statement, Mr Wenham, at
7 paragraph 68, you move on from that meeting we have just
8 been looking at, 27 April, and refer to another meeting
9 on 5 May, which you and other police colleagues had with
10 Tony Chambers, Stephen Cross and Ian Harvey.
11 You say at paragraph 69 you would have briefed your
12 colleague:
13 "... and we would have agreed the need for this
14 meeting in order to continue to gather further
15 information regarding events at the Countess of
16 Chester."
17 The meeting notes, if we can go to them, please,
18 are INQ0102298, beginning at page 2. You have again
19 done notes, Mr Wenham, at the time, but I am going to
20 the ones that are longer, if that's okay?
21 **A.** (Nods)
22 **Q.** So we see attending at the meeting
23 Tony Chambers, Stephen Cross, Ian Harvey. At that time,
24 this is solely Executives. Is there a reason for going
25 just to the Executives at this point, is that because

1 they are the decision-makers or why -- why is it that we
2 see no doctors or Execs at this meeting?
3 **A.** I suppose the best way to describe this is
4 post the CDOP. The Constabulary was on a sort of a
5 journey to gather information and the ultimate goal was
6 to lead to a decision and to get to that point of
7 decision-making was meeting with some individuals who
8 had relevant information. And I think from my
9 recollection certainly with the assistant chief
10 constable who chaired and led the meeting, it would have
11 been around the Constabulary to meet with those involved
12 at an Executive level from the Countess and I think it
13 was the right thing to do.
14 **Q.** If we look at page 3, let's see some of the
15 things that you were told there. So the reviews --
16 the Families are all aware two reviews have been
17 conducted, the Dr Hawdon review and the Royal College
18 review. Had you seen those yet, do you remember, or
19 not? You have seen the redacted RCPCH one but do you
20 think by this point you have seen the other one or not?
21 **A.** I would have to check the timeline but they
22 would have been shared because they were asked for by
23 myself to Ian Harvey after the meeting on the 27th and
24 I -- I think, I think, I'm not sure, but in the meeting
25 prior to this which I would have had with -- in house

1 effectively within the Constabulary I think we discussed
2 some of these documents because we had more knowledge at
3 that point.
4 So those I am going to say I am reasonably
5 confident that at that point those documents would have
6 been in the Constabulary but not the Letby -- not the
7 one with reference to Letby. I never seen that, never.
8 **Q.** You see further down it says:
9 "A criminal QC was instructed by the Trust who
10 after consideration of the relevant papers advised that
11 there was no evidence to suggest criminal activity."
12 What weight would that have, what weight would you
13 have given that at the time if you are being told
14 a criminal QC has looked at the relevant papers and said
15 no evidence to suggest criminal activity?
16 **A.** I think it's relevant information for those to
17 have shared to the Constabulary. In terms of the
18 weight, we would make our own decision and I would
19 suggest not be influenced by that specific piece of
20 information.
21 **Q.** But when it says after consideration of the
22 relevant papers, did you think that they had just had
23 the same as you or they might have had more or did you
24 not really give further thought to that at the time?
25 **A.** I can't remember in terms of these because

1 these are the minutes which are from that meeting and it
2 is reasonably detailed and I just can't remember.
3 **Q.** And we see at the bottom:
4 "Nurse. As part of the reviews, staffing was
5 looked at. There was a notable high statistical
6 relationship between a member of the nursing staff and
7 babies deterioratingn in the unit. There is no evidence
8 other than coincidence."
9 If we go over the page to page 4:
10 "She had been moved from nights to days, redeployed
11 off the unit whilst the review was taking place for her
12 protection. The nurse has a 'Qualification in
13 Specialty' so was therefore more likely to be caring
14 after the sickest babies on the unit."
15 And then we see the summary:
16 "If Cheshire Constabulary are involved it would be
17 deemed an 'investigation'. COCH would need to assist
18 with clinical expertise, guidance. An investigation
19 would be to identify, gather facts to evidence
20 and establish cause of death. Also if applicable
21 identify any criminal activity. There are no
22 significant concerns to suggest any unlawful acts, it
23 appears a series of anomalies that needs to be
24 investigated further."
25 So that was your impression or the group's

1 impression after the meeting with the Executives
2 recorded there?
3 **A.** Yes, I mean that's the closing statement well
4 the closing record from the Chair of the meeting as, as
5 documented. But again I would emphasise that I think
6 there was an -- still an element of caution in terms of
7 the Constabulary. It was a case of let's just slowly,
8 slowly gather this information. And when I say "slowly,
9 slowly" let's get the information at the Constabulary so
10 we can make this decision. Because again if you look
11 below that there is a reference to drafting a Terms of
12 Reference for an investigation. Now we wouldn't be
13 drafting a Terms of Reference for an investigation if we
14 were thinking there isn't going to be an investigation
15 because my view is we were very much moving in that
16 direction and that was the direction we were -- we were
17 going.
18 **Q.** You then tell us at paragraph 73 of your
19 statement, and we will put them up, that you received
20 an email from Dr Ravi Jayaram. So that document can
21 come off the screen, please, and instead please can we
22 have INQ0102300, page 3.
23 We see at the bottom:
24 "Confidential. Hello, Superintendent Wenham.
25 "I met you a couple of weeks ago at the Countess

1 during our discussions about the unexplained neonatal
2 deaths and collapses. I am aware the Trust have sent
3 you copies of the RCPCH report and the Independent
4 Casenote Review from Jane Hawdon as well as the results
5 of internal reviews ..."
6 Pausing there. When did you meet Ravi Jayaram
7 two weeks before? Was that you and Hayley Frame having
8 a conversation with him?
9 **A.** No that would have been the meeting at
10 27 April at the Countess.
11 **Q.** So the 27 April meeting. So he has sent this
12 to you. If we go overleaf, documents data from the
13 regional neonatal network report looking at intensity
14 staffing and mortality in the period January 2015 to
15 July 2016. And if we see what he attaches please at
16 INQ0102301, page 2, we see this is reasons for concerns.
17 They have put together the Consultants, their concerns.
18 If we trace through the document, please. They
19 list various babies, concerns, when we get to page 12,
20 survival graph from the Office for National Statistics.
21 Move through the document. They have their unit
22 staffing levels finishing on page 7.
23 Were you expecting that level of information back
24 from Dr Jayaram having --
25 **LADY JUSTICE THIRLWALL:** Sorry, Ms Langdale,

1 I think we might have gone backwards -- forwards and
2 backwards, you said concluding on page 7 and that sounds
3 like a different document.
4 **MS LANGDALE:** I think it may be. So if we could
5 put up instead, please, INQ0102303, so that document can
6 come down, that is the first document and then another
7 document that you have exhibited for us, Mr Wenham, is
8 a separate document then that was also attached
9 I assume. INQ0102303, page 3.
10 This as well was sent to you, the Inquiry has seen
11 this before from Dr Brearey but it was the data pulling
12 together information. Was that the level of information
13 that you were expecting to get from Dr Jayaram at that
14 time?
15 **A.** I'm not sure how detailed the information was
16 going to be, but it was -- overall collectively the
17 three documents were incredibly powerful and important
18 in terms of how we moved forward.
19 **Q.** That can come down. Can we please have
20 a different document on the screen, which relates to
21 a meeting on 12 May. So that's INQ0102306, page 2.
22 While that's coming up, Mr Wenham, so you have received
23 that from Dr Jayaram and then you have a meeting on
24 12 May. You have had an internal meeting before that to
25 the police and as you say, you are considering what you

1 are going to do and who you are going to interview or
2 speak with, I should say.
3 And there's a second meeting that takes place on
4 12 May with the Executives again. Do you know again why
5 you had only the Executives at this meeting? I know
6 what happened subsequently and you arrange a meeting
7 with Dr Jayaram, but you only have Executives at this
8 12 May meeting.
9 **A.** I -- I can't recall why that was decision was
10 made just to keep it at Executive level.
11 **Q.** So if we go to --
12 **A.** But -- sorry, but I think we had, I think we
13 had the premeet and we had already had -- I think there
14 was a plan already to meet with the paediatricians who
15 had written the email and the letter so we had gone into
16 that meeting with that plan.
17 **Q.** You seem to have responded on the emails we
18 looked at earlier to Dr Jayaram to agree to meet but
19 let's have a look at this meeting here, page 4. If we
20 see "Situational review", you have shared presumably the
21 information you have received from the doctors with them
22 at this point, because Tony Chambers is commenting on
23 that under this heading situation review and says:
24 "TC stated there's nothing new in the email review
25 from Dr Jayaram that has not already been shared with

1 the Royal College of Paediatrics and Child Health and
2 all the inquiries that have gone on."
3 Did you share the documents I have taken you
4 through on screen, the ones that you exhibited to your
5 statement, had they seen those before this meeting,
6 because it appears that that's what's being commented
7 upon here?
8 **A.** I don't think -- sorry, just let me read.
9 **Q.** Just read it.
10 **A.** I am sure I would remember some reference to
11 it that the documents hadn't been shared by -- to
12 Executive level?
13 **Q.** Yes.
14 **A.** Yes, I don't think they had been shared at
15 that point.
16 **Q.** Well, what's he commenting on then because it
17 looks like you are asking them their views and TC stated
18 there's nothing new in the email review from Dr Jayaram
19 that's already been shared?
20 **A.** Sorry, I might be misleading there. I --
21 I don't think they had been shared prior to the meeting,
22 they were discussed in the meeting.
23 **Q.** Right --
24 **A.** So the contents of the email and the report
25 would have been discussed in the meeting so they would

1 have got knowledge of it there but I can't remember if
2 it was shared before.
3 **Q.** So it might not have been before but would you
4 have taken them to the meeting because the email itself
5 is very short, isn't it? The email simply refers you to
6 the document, and then the documents are as you have
7 attached for us, the reports relating to various babies
8 on the indictment and other babies and also the graph.
9 But it looks as though -- it's said here:
10 "It reads in a fairly unbalanced way and it needs
11 to be looked at in the context of all of the information
12 that COCH can share with Cheshire Constabulary."
13 Did you have any memory now what was being referred
14 to, what material was being referred to there by
15 Mr Chambers?
16 **A.** Is it the same highlighted section?
17 **Q.** Yes, yes.
18 **A.** So the question you are asking is?
19 **Q.** What did you think Mr Chambers had seen before
20 he made that observation at the meeting, it reads in
21 a fairly unbalanced way, what were you discussing with
22 him?
23 **A.** I can't remember. I can't remember if the
24 contents of the email that Dr Jayaram had provided to
25 the Constabulary had been shared prior to the meeting or

1 not.
2 Q. It looks like --
3 A. It looks like he's got reference to it so
4 I would say he must have seen it.
5 Q. Further up it looks like it does say, doesn't
6 it:
7 "This document has now been shared with the COCH
8 Executive Team."
9 A. Where's that?
10 Q. Just further up, if we can go three boxes up
11 and you gave an overview, so on 10th of the 5th an email
12 was sent:
13 "Documents now have been shared with the Executive
14 Team. NW gave an overview of the contents."
15 Can we see, it is just three paragraphs down?
16 A. Yes, it says:
17 "There was no personal information sent within the
18 email and it was felt appropriate Executive Team were
19 made aware of this."
20 Q. Mm-hm.
21 A. So it looks like the timeline is the email's
22 come in, a discussion maybe taken place between myself
23 and the ACC.
24 And then it says:
25 "This led to a further telephone conversation

1 between DM [which was the ACC] and SC Stephen Cross on
2 11th of the 5th to make him aware of [the] email."
3 So it looks like the ACC has communicated with him
4 the day before, so yes.
5 Q. Yes, so they have got it?
6 A. Yes.
7 Q. We see if we go down to the bottom of the page
8 again it's expressed:
9 "It is disappointing that it does feel that, as
10 a group of clinicians, they have not moved on."
11 If we go to page 5 of this note, please. We see in
12 the second box, second paragraph:
13 "[Mr Chambers] shared the same concerns [as DM]
14 regarding putting the families through a process that
15 feels unnecessary. [Mr Chambers] would be comfortable
16 to pause at this point, but equally would be comfortable
17 to see what level of enquiry could be done that would
18 not necessitate an open transparent conversation with
19 the families."
20 And if we look further down the page, the last but
21 one paragraph:
22 "[Assistant constable] questioned if there is any
23 scope for an external review".
24 And Mr Chambers replies:
25 "In the first instance the body would be the Royal

1 College of Paediatrics and Child Health. They would
2 identify the [Terms of Reference] which were structured
3 in a way that all concerns would have been in scope and
4 any environment/behaviour concerns. RCPCH would
5 constitute a review panel consisting of two experienced
6 neonatologists, one senior nurse and a barrister."
7 So they are relying, are they, in the meeting or
8 referring to the RCPCH report being conducted by
9 a number of professionals as described there. Do you
10 remember that, them saying they had done that review?
11 A. Yes, I mean I can only say, I can only go by
12 what's written in the minutes here in front of me --
13 I can't remember.
14 Q. Okay the next page, then, page 6, you may not
15 remember this either, the third bullet point at the top:
16 "QC -- purpose to involve was to help clinicians
17 understand the difference between what they thought was
18 criminal evidence and something that may not constitute
19 as criminal evidence."
20 So what was the tone -- do you remember anything
21 now about the tone of this meeting and what the
22 Executives were encouraging or thought should happen?
23 A. It's interesting now, sitting here looking
24 back at the minutes as you have pointed out and
25 identified and highlighted because when I was in the

1 middle of this, I genuinely -- my mindset was this was
2 on a path to an investigation and there was a lot of
3 external noise going on round here but I felt this was
4 where it was going and that was where we would end up
5 but when you read some of the comments now it's like
6 indeed doors are trying to be shut, that is the way
7 I feel as though it's presented, if that makes sense.
8 Q. It does. If you look at page 6, the last but
9 one paragraph, this is an officer -- assistant chief
10 constable clarifying:
11 "... there was nothing new that had come out of the
12 email that [Countess of Chester] were not already aware
13 of, and nothing contained in email that makes specific
14 allegation, which would cause COCH to believe that
15 potential criminal offences have been committed.
16 [Mr Chambers] and [Mr Harvey] both agreed there was
17 nothing to suggest this and nothing new within email."
18 If we go to page 7, and look at the last three
19 paragraphs, please:
20 "[Mr Chambers] stated it would become a wider GMC
21 issue as there becomes a point where a group of
22 clinicians who are not prepared to take the
23 recommendation of the RCPCH are blocking the ability to
24 move forward which creates a more difficult and
25 dangerous environment for sick babies."

1 Next, he says:
2 "[He] added the Consultants have made their points
3 and they have been seen and not judged as sufficient to
4 warrant a police-led investigation, looking at how close
5 it constitutes as a criminal act. There was a need to
6 explore to ensure Countess of Chester have not missed
7 anything but there is also a need to move on. It will
8 become a GMC issue, likewise if the media are involved.
9 This is for the Countess of Chester to manage
10 appropriately.
11 The Assistant Chief Constable replies:
12 "If Countess of Chester's position is that they are
13 satisfied where they are and there is nothing of
14 anything that would cause to believe potentially
15 criminal offences have been committed which may warrant
16 a police investigation, then this needs to be placed in
17 writing."
18 So that's what the Assistant Chief Constable says,
19 "it needs to be placed in writing".
20 And over the page he asks that:
21 "The [Countess of Chester] need to be clear what
22 their expectations are of Cheshire Constabulary if
23 a criminal investigation is required, and equally [the
24 Assistant Chief Constable] needs to document back to the
25 Countess of Chester what Cheshire Constabulary's

1 position is. This is to ensure a clear audit trail of
2 what the information was, the decision-making and the
3 grounds for those decisions, should anything arise in
4 the future."
5 You further down in the last five paragraphs say:
6 "NW added an observation that Dr Jayaram has sent
7 the email directly to the police and bypassed the
8 Countess of Chester Executive Team. Cheshire
9 Constabulary are duty-bound to respond to Dr Jayaram on
10 behalf of the clinician team. It might be appropriate
11 to have a conversation with Dr Jayaram around the
12 content of the letter and gain a feel of anything else
13 that they may wish to disclose, which would add some
14 value to the contents of the letter."
15 Again two paragraphs down, the assistant chief
16 constable clarified what you are articulating:
17 "That there could potentially be allegations of
18 bullying, intimidation on the part of the Countess of
19 Chester. It seems reasonable as they have written to
20 have a conversation with Dr Jayaram to clarify there is
21 nothing else sat behind the letter which has not been
22 disclosed."
23 When you were hearing reference to the GMC and the
24 referrals, you are planning to meet Dr Jayaram anyway
25 but had you already as police discussed that before,

1 that there potentially could be other allegations or was
2 that something that emerged during this meeting?
3 **A.** It will have been something that's just
4 emerged from that meeting.
5 **Q.** You agreed with your colleague that Cheshire
6 Constabulary should speak to Dr Jayaram to give the
7 clinicians an independent voice?
8 **A.** Yes.
9 **Q.** Mr Chambers clarified whether it's possible to
10 have a conversation with the clinicians without
11 involving the Families as the clinicians would value the
12 conversation with a police officer. So recognition by
13 Mr Chambers there that the clinicians might like to
14 speak or would like to speak with a police officer?
15 **A.** Yes, I mean, I was quite clear that we needed
16 to go and meet with those doctors and make sure that
17 they were able to speak freely without any external
18 influences and we had actually given them a voice so
19 they were listened to.
20 **Q.** You then -- or it is documented, rather, on
21 page 9 of the bullet points under:
22 "DM reiterated what has been agreed ..."
23 Crucially a meeting will be held on 15 May with
24 Dr Jayaram.
25 That document can go down now. You in fact invite

1 Dr Jayaram to bring a couple of people with him if he
2 would like to and I think it's Dr Holt and Dr Brearey
3 who attend?
4 **A.** (Nods)
5 **Q.** You tell us at paragraph 90 of your statement,
6 Mr Wenham:
7 "This meeting was in my view the most critical and
8 important event following the CDOP meeting on
9 24 March 2017."
10 You say:
11 "I can still recall how these clinicians presented.
12 They were completely professional in their presentation
13 and they were knowledgeable and passion in that about
14 their work with the neonatal unit. There was some
15 degree of frustration in where they felt this situation
16 had reached and I felt that they were relieved that they
17 could speak to the police about their concerns.
18 "Following this meeting, my own personal assessment
19 was that this further reinforced my view that this was
20 now going to progress to a criminal investigation. It
21 was my responsibility to communicate this to the chief
22 officer level ... to inform future decisions."
23 So if we could go, please, to the notes of that
24 meeting, INQ0102309, page 2, and we see at page 3 at the
25 top, Dr Jayaram in that second paragraph, specifically

1 mentions forensic review and the fact is these babies
2 would not be the ones you would have expected at the
3 point they collapsed and they did not respond
4 physiologically to the treatment as expected.
5 Dr Brearey says:
6 "Of those nine we reviewed six out of nine
7 collapsed between midnight and 4 which was highly
8 unusual."
9 Dr Jayaram further down:
10 "At the point of the collapse the nurse was present
11 at that time in close proximity. This has not happened
12 to other staff."
13 A bit further down he says:
14 "There is perception that we are on campaign. This
15 is not the case. Other Consultants and junior doctors
16 had come to the same view. It got to the point that
17 when the nurse was on duty we feared something would
18 happen."
19 Over the page, page 4, six paragraphs up:
20 "Concern we have is could something being done
21 deliberately to harm them.
22 "We don't know. I don't know if this is something
23 we just have to live with. We would rather there was
24 some explanation. Our concern is to have enough
25 questions being asked. Can we be satisfied we have done

1 all we can to confirm if there is something more going
2 on."
3 He says:
4 "Nobody's talked to junior doctors who have been
5 involved. We appreciate that a lot of time has passed
6 since these" events, presumably. "We at the end of the
7 day are responsible for patient safety on the ward, the
8 buck stops with us."
9 Of course when the investigation did take place all
10 of the junior doctors were spoken to, weren't they, and
11 the evidence was collated?
12 **A.** Yes.
13 **Q.** We see at page 5:
14 "Survival rate for babies over 32 is nearly 100%.
15 For six of our babies to have died who are over 32 weeks
16 to die is not right."
17 Reference to the Thematic Review.
18 Over the page at page 6, Dr Brearey repeating at
19 the top, "most babies were at gestation would not expect
20 these sorts of things happening". Dr Jayaram: "these
21 babies simply did not respond as expected."
22 Then in the closing comments on page 7, the
23 highlight, the death of two Triplets: "there was no
24 explanation, she was the named nurse".
25 "Duty Exec was happy for nurse to remain on duty at

1 that time. When expressed our concerns we don't think
2 the Executives have understood our concerns."
3 Further down, Dr Jayaram:
4 "I don't want the obvious fractious relationship
5 between us and the Executive, this is not why we want
6 you here. We are not sure of the process, reports have
7 asked the right questions."
8 I mean:
9 "We are not sure whether the process, reports has
10 asked the right questions, We want to exclude is there
11 anyone who is deliberately harming these babies?"
12 And:
13 "Speaking for myself, we are not comfortable as
14 worried about safety of our patients."
15 You may not have been aware, Mr Wenham, but at this
16 point, certainly back at the end of March there was
17 discussion about Letby coming back on to the wards to
18 work with babies. You say these doctors impressed you
19 as professional in that meeting.
20 Why was that? How was that that they impressed
21 you?
22 **A.** The meeting was -- I can't describe how
23 powerful it was. They were knowledgeable, they spoke
24 from the points of view whereby they were dealing with
25 these things real-time and the -- they have had -- they

1 have had -- they have lived and are breathed these
2 events for the last several years and I just felt for
3 those professionals there, they had an opportunity now
4 to just speak to someone and be listened to and believed
5 what they were saying. And it felt as though that we
6 weren't just going to push them away like they had been
7 in the past or threatened or intimidated, which is what
8 the perception is they had.
9 They were just very powerful in what they were
10 saying and committed and, you know, I think we all owe
11 them a great deal for coming forward and speaking out
12 the way they did.
13 **Q.** That document can come down now.
14 At paragraph 94 of your statement, you say on
15 15 May, telephone meeting with the Executive Team. You
16 had made the decision to launch the criminal
17 investigation, a telephone meeting arranged with the
18 Executives from the Countess of Chester and
19 Cheshire Police.
20 We know at paragraph 95, you recall a discussion
21 regarding a strategy to support the Families and issues
22 regarding the impending Inquest.
23 At paragraph 96 you say:
24 "The initial plan was to visit and provide
25 one-to-one briefings to all of the families and it was

1 finalised during the evening of 15 May and the visits to
2 the families started early the following day, 16 May."
3 Do you know sitting there now what information
4 the Families were provided with at that time?
5 **A.** I can't remember, it was subject to a -- we
6 have a tiered approach to family liaison so you have
7 a co-ordinator and then you have family liaison officers
8 so we would have put a strategy in place but it would
9 have been directed by the senior investigating officer,
10 but it would have been very factual, it would have been
11 concise and it would have been probably fairly narrow at
12 that point because we didn't really know -- so it would
13 have been very specific to those individuals, those
14 Families and to give them some reassurance and a contact
15 within the Constabulary.
16 **Q.** At that stage when you are just beginning an
17 investigation, are you able to say that you have
18 suspicions or concerns about an individual or what?
19 I mean, what's the balance between giving information
20 and protecting the investigation and not prejudicing any
21 trial when you get there in terms of how you share
22 information?
23 **A.** At that point there wouldn't have been any
24 public comment or statements regarding any individual
25 because the investigation from the outset would have

1 been approached with a very open mind. So it would have
2 been a case of going out, gathering information,
3 bringing that information into the system and then
4 making assessments from there. But clearly the
5 investigating team couldn't avoid the fact, you know,
6 the nurse had been mentioned and was a significant
7 individual involved in these events. But you would have
8 had a very open mind in terms of the investigation from
9 the outset.
10 **MS LANGDALE:** Thank you those are my questions,
11 Mr Wenham. I think both Mr Baker and Mr Skelton have
12 some questions, my Lady.
13 Questions by MR SKELTON
14 **MR SKELTON:** Mr Wenham, I ask questions on behalf
15 of one of the Family groups. Can I ask you first of
16 all, just a bit of a recap about your service in
17 Cheshire Police.
18 I think you spent 30 years in the Constabulary, so
19 your entire career?
20 **A.** 30 years, yes.
21 **Q.** You started in uniform and went on to become
22 a DC fairly early on, a detective constable; is that
23 right?
24 **A.** Yes, I was a detective sort of most of my
25 career, yes.

1 **Q.** Retired at the rank of detective chief
2 superintendent?
3 **A.** That's correct.
4 **Q.** So you spent most of your career in CID?
5 **A.** CID is a specific area of business, criminal
6 investigation, also the area of safeguarding and public
7 protection which is another specialist area of
8 investigation and also homicide and murder
9 investigations as well.
10 **Q.** You were a homicide SIO, senior investigating
11 officer; is that right?
12 **A.** Yes, between 2009/10 and 13.
13 **Q.** Would that have been at the rank of
14 a detective inspector?
15 **A.** Detective inspector, yes.
16 **Q.** While you were in Cheshire Police, did you
17 come across Stephen Cross?
18 **A.** No, I think he was a little bit possibly
19 before my time or because we are geographically based
20 I think he may have worked at the West and I never
21 really worked in the West as a geographical area
22 personally until that meeting, I don't think I have ever
23 met him.
24 **Q.** Were you aware that he was a senior or had
25 been a senior officer?

1 **A.** I may have been told at some point but it may
2 -- probably after that meeting because he attended that
3 meeting and I didn't know who he was, I didn't know who
4 Ian Harvey was. Obviously I knew the positions they
5 held, but I didn't know who they were.
6 **Q.** Did you subsequently find out what rank he had
7 been?
8 **A.** I'm not sure.
9 **Q.** Dr Brearey yesterday mentioned the fact that
10 he thought that he had been demoted from a fairly senior
11 rank to being a constable again. Do you know anything
12 about that?
13 **A.** I can say I have got no direct knowledge of
14 that.
15 **Q.** Ms Langdale asked you about SUDiC. Was it
16 your expectation that all deaths that occurred -- child
17 deaths that occurred in hospital would result in the
18 SUDiC process?
19 **A.** If you take that term in its broadest terms,
20 yes, if you are following the procedure as in -- it's
21 outlined but in the broadest terms of the hospital
22 setting. Generally it, it's interpreted, I think now
23 reflecting back, as in an A&E or someone's being from an
24 A&E into a ward. I think there was possibly -- well,
25 there was a lack of understanding in terms of the

1 compliance with the policy and in a neonatal unit.
2 **Q.** Do you think you appreciated that lack of
3 understanding when you were in post at the time in CDOP?
4 **A.** Did I appreciate it or understand it?
5 **Q.** That difference between types of death of
6 children? In the community, sudden death would
7 inevitably be SUDiC; coming into A&E I think you are
8 saying then transferred to a ward and dying, that might
9 be SUDiC.
10 But being admitted, say, for several weeks wouldn't
11 necessarily be SUDiC; is that the difference?
12 **A.** Yes, certainly from my experience and you have
13 outlined my background, I have never had any knowledge
14 of being notified of a death within a neonatal unit from
15 a police perspective.
16 **Q.** So far as the CDOP is concerned, as
17 I understand your evidence from your statement, you on
18 CDOP were completely unaware of the neonatal increase in
19 deaths in 2015 and following until very late on in the
20 process?
21 **A.** From a personal perspective?
22 **Q.** Yes.
23 **A.** I wasn't aware until 24 March but I understand
24 the CDOP had references to it before then as a group or
25 in minutes.

1 **Q.** If someone had come to a CDOP meeting in 2015
2 or 2016 and said: we have had what we perceive to be
3 a significant increase in the number of deaths, how
4 would you have thought CDOP should respond?
5 **A.** It depends on the circumstances. I think it's
6 a really difficult or impossible question to answer.
7 Because it could well be that I am thinking from just
8 from a police perspective, "is there something criminal
9 going on here", as opposed to a CDOP perspective around
10 that multi-agency work and is there something criminal
11 and I would probably pick it up and run with it like
12 I did with this to understand what's going on.
13 But I can't answer that because obviously it's
14 so -- it's difficult to answer because that scenario
15 just didn't happen.
16 **Q.** Can I put a bit more flesh on the information.
17 So if someone had come to CDOP and said: The number of
18 deaths has increased to an unusual degree, the deaths
19 appear to be unexpected in that we weren't expecting the
20 children to die and we can't find a clinical explanation
21 for team that's obvious, the cause of death is uncertain
22 for a number of the babies, the babies didn't seem to
23 respond as we would expect when we tried to resuscitate
24 them after their collapses. We have identified that one
25 member of staff appears to have been present during each

1 of the collapses and deaths and our investigations that
2 we have conducted haven't yet revealed a medical cause
3 or any other cause that links the deaths... Presented
4 with that information, what would you have been
5 thinking?
6 **A.** In effect, you've just outlined where we were
7 on 15 May.
8 **Q.** I have.
9 **A.** So we know what happened at 15 May. We
10 launched a criminal investigation. So -- but clearly
11 I just can't relate that back to a different time and
12 a different space because I don't know and also, in
13 terms of the timeline of the events at what point
14 were -- would these concerns have been raised? So --
15 **Q.** Well, is there any --
16 **A.** Does that make -- do you understand what I'm
17 saying?
18 **Q.** Indeed. But is there any reason to think --
19 the number of deaths would obviously have been fewer the
20 further we go back. But is there any reason to think
21 that if the Consultants or a person, a clinician, had
22 brought you that information in 2015 and 2016 that the
23 same kind of response wouldn't have occurred?
24 **A.** From -- individually or CDOP?
25 **Q.** CDOP.

1 **A.** If it had been a little bit more specific
2 around the points you've just raised, then I would
3 expect CDOP as a group and the chair to raise some
4 questions and ask some questions around that, that
5 scenario you have presented.
6 Now, how that -- how they would go about that as
7 a group would have to be assessed at that time. You
8 know, it might well be that sometimes -- it doesn't,
9 this doesn't sound right -- but the CDOP would maybe set
10 up like a little task and finish group to go and look at
11 something.
12 So it could well be some -- you know, it could be
13 a case of three or four individuals just go and gather
14 more information and then go and make an assessment.
15 But I can't really answer that. It's too broad
16 a question.
17 **Q.** If a clinician, or any member of staff, had
18 said to you in the formal meeting or outside the formal
19 meeting: I'm concerned we have got a number of
20 unexpected deaths and I suspect a member of staff may be
21 harming children, what would you have done?
22 **A.** I would have -- I would've clearly listened to
23 them and took some steps to gather some further
24 information, whether it's just through that individual
25 or by speaking to other individuals within the

1 organisation, bring in more information into -- and
2 knowledge into my -- into my domain so we can make
3 a decision.
4 **Q.** Would you have recognised if the individual
5 that was the subject of the suspicion was still working
6 that there was a degree of urgency required?
7 **A.** If that information had been provided,
8 clearly, yes.
9 **Q.** Can I ask you about recommendations and
10 whether you have any views on some of the issues that
11 this Inquiry is looking at.
12 Obviously there is the issue of SUDiC and CDOP and
13 its application, but that's a general national policy
14 issue, which is probably outside of your remit as it
15 were, but just in terms of -- for healthcare staff
16 understanding what to do if they suspect their fellow
17 members of staff, do you think more guidance is needed
18 about what to do from a safeguarding perspective?
19 **A.** From a -- from a safeguarding perspective
20 the -- the guidance is fairly clear. If someone's got
21 any concerns regarding any safeguarding issues, then
22 they should speak out and speak up.
23 But individuals did that in that case, but weren't
24 listened to and that, that creates a problem in itself
25 because we're in at an Executive level. If that starts

1 to get shut down, that creates a problem. So
2 individuals should have confidence and trust within
3 their organisation that they can speak out and be
4 listened to. So that, that in itself is challenging if
5 the culture within that organisation doesn't allow that.
6 **Q.** What about the question of reporting
7 externally. Obviously you have rightly said you would
8 expect -- implicitly said you would expect people to
9 raise things internally within their safeguarding team
10 or via the other processes CDOP, SUDiC and so on.
11 But what about external communication? Do you
12 think there is a case for there being some guidance on
13 healthcare staff being able to contact the police for
14 example, directly without fear of unleashing awful
15 consequences upon themselves or others?
16 **A.** I mean, individuals can do that now. They,
17 they can contact an organisation the police, and, and
18 speak in confidence around any issues or concerns they
19 have got.
20 The police, I mean I've been out of policing for
21 six years, but as an organisation we would always listen
22 to people, we will treat that information with
23 confidence and respond accordingly as to what we are
24 told. But you'd have to make an assessment of what that
25 information is. If there are any immediate safeguarding

1 issues we would have to address that, whether it's
2 safeguarding in relation to an individual or to do with
3 children or a family we would respond and address that.
4 **Q.** So could a doctor have called the police in
5 2015 and not given their name and not given any details
6 but alerted the police to the possibility that somebody
7 was murdering children?
8 **A.** Well, clearly the answer to that would be yes
9 and we would -- someone would have responded to that and
10 made an assessment of that piece of information.
11 I was asked to comment in my statement whether, you
12 know, the police should have been notified at an earlier
13 stage and clearly with hindsight and looking back the
14 obvious answer to that is yes. You know, we should have
15 been notified and engaged with earlier.
16 I think looking at the scenario and the events as
17 we know a lot of those doctors involved did raise the
18 concerns repeatedly and continued to raise those
19 concerns and they were shut down, sadly.
20 **MR SKELTON:** Thank you, Mr Wenham. Thank you,
21 my Lady.
22 **LADY JUSTICE THIRLWALL:** Thank you, Mr Skelton.
23 Mr Jamieson.
24 **Questions by MR JAMIESON**
25 **MR JAMIESON:** My Lady, through you, may I make the

1 enquiry of the shorthand writer whether she is content
2 to continue. I have 10 minutes.
3 **LADY JUSTICE THIRLWALL:** Yes. Thank you,
4 Mr Jamieson.
5 **MR JAMIESON:** Yes, I have 10 minutes but lawyers'
6 time estimates have not always been accurate.
7 Mr Wenham, I ask you questions also on behalf of
8 The Families.
9 Most of the topics I would have covered have
10 already been and so please excuse me if this is a little
11 staccato.
12 **A.** Okay.
13 **Q.** Can we start with CDOP, please, and may we
14 have a document on the screen that I don't think we have
15 looked at yet. It's the protocol that you provided us
16 with, so it's INQ0102288 and may we start at page 2,
17 please.
18 So this was the governing protocol for the
19 Pan Cheshire CDOP. The date of the document that we can
20 see that it was in force is at the bottom of the
21 page 2014 and you have provided in your statement that
22 this was the one in force in 2017?
23 **A.** It says July -- oh, yes, yes.
24 **Q.** Yes. So it was supposed to be reviewed
25 in '15, that doesn't always happen, does it, it was the

1 one that was being used in 2017?
2 **A.** I understand this was the one because
3 obviously I was asked to provide a statement and I have
4 gone back retrospectively to try and confirm which
5 protocol was the relevant one.
6 **Q.** Okay. Well, if anything turns on it we will
7 hear about it, but I doubt it frankly.
8 Can we go forward to page 5, please, which is the
9 introduction to this document and what I just wanted to
10 draw out is if we could crop in on the bottom half of
11 the page, please. So under "Introduction", this is the
12 first guidance that's given to the readers of this
13 document. It's really that underlined text that's put
14 there in the first paragraph:
15 "As highlighted in the guidance it is vitally
16 important that local safeguarding children boards
17 establish mechanisms for appropriately informing and
18 involving parents and other family members in both Child
19 Death Overview and the Rapid Response process."
20 And there "Rapid Response process", is that a type
21 of SUDiC, is that what that's talking about?
22 **A.** Yes, the Rapid Response process a stage in the
23 SUDiC protocol.
24 **Q.** Yes, so it's the initial stage.
25 **A.** It's an initial meeting -- well, the initial

1 meeting would take place within the first few hours.
2 But a Rapid Response Meeting would generally take place
3 within 72 hours --
4 **Q.** Yes.
5 **A.** -- or up to five days maximum from the events.
6 **Q.** And what this guidance is telling you, and
7 everybody else on the CDOP right at the start, is that
8 it is vitally important that families are both informed
9 and involved in the process?
10 **A.** Yes.
11 **Q.** When you sat on the CDOP meetings and
12 considered the cases, did families ever attend? Were
13 they ever invited to attend?
14 **A.** I'm -- I'm not aware of that. That was part
15 of the process of the group for third parties to attend,
16 families or external.
17 **Q.** I mean, if we just go, sorry to jump around,
18 but if we go to page 13 of this document, just how that
19 is supposed to be achieved I think is identified for us.
20 Can you see there 4.6, "Involvement of parents and
21 family members." So having highlighted at the start
22 that it's important, this is how it's supposed to happen
23 and what it comes to -- please do take a moment to read
24 the paragraphs if it's helpful -- but essentially they
25 get a letter that tells them about the process and it

1 will be hand-delivered to them by a co-ordinator who
2 will be in a position to answer their questions, but
3 that's it?
4 **A.** Yes. What -- what that's referring to is the
5 process around the rapid response meeting. So the rapid
6 response meeting would normally be chaired, if it was
7 for example a death of an infant or a child in the
8 community and went to A&E, then a detective inspector
9 from the police would attend and within the time period
10 of 72 hours a professional meeting would be held.
11 That's the rapid response meeting. And one of the
12 things covered in that rapid response meeting is
13 communication and engagement with the family.
14 **Q.** Okay.
15 **A.** So that would involve who is -- who's in
16 contact with the family, who is the liaison and covering
17 the CDOP aspect of that to make them aware of the CDOP
18 process.
19 **Q.** Okay.
20 **A.** That's my understanding of where that sits.
21 **Q.** Okay. So because I suppose what could be said
22 is delivering a letter that might deal with informing,
23 but it's not going to involve --
24 **A.** No.
25 **Q.** -- a parent. But if a police officer is going

1 to go talk to them and start that dialogue --
2 **A.** Yes.
3 **Q.** -- that might be how that occurs?
4 **A.** Yes, and delivering a letter there it sounds
5 quite clinical.
6 **Q.** It does.
7 **A.** -- and very transactional.
8 **Q.** It does.
9 **A.** -- whereas it's actually more of a -- it's a
10 process where the family is engaged by either the best
11 person who's working with that family. Because bearing
12 in mind a lot of investigations we decide at that
13 meeting: is it criminal, or is it safeguarding or is it
14 none, none of those two things or is it one or the
15 other.
16 **Q.** Yes.
17 **A.** So for example if it wasn't criminal, then it
18 might well just be who's the lead professional. So
19 who's the best -- who's already working with that family
20 and that person may already be the link and do the CDOP
21 process.
22 **Q.** But in that circumstance that you are talking
23 about, where you are having that discussion, is that one
24 of those cases where there has been a rapid review, ie
25 we are on the SUDiC route rather than the CDOP Form A

1 and Form B route?
2 A. Well, they both -- they both run tandem with
3 each other. So this is the SUDiC process in which you
4 have a rapid response meeting within 72 hours of the
5 death or the event.
6 Q. Yes.
7 A. And part of that then the CDOP process runs
8 off that because the professionals have to complete the
9 relevant documentation and notifications to CDOP.
10 Q. Yes.
11 A. Does that make sense?
12 Q. It does.
13 A. Yes.
14 Q. And I think what I'll say to you is that's how
15 it is supposed to work.
16 A. Yes. And also invariably in the community
17 setting or in an A&E, that would work. What we know now
18 is within a neonatal setting it hasn't worked
19 effectively.
20 Q. May I just pick up something with you while
21 I'm here. Can you see just at the very bottom of this
22 page, it says "Bereavement Support Services" and it
23 says:
24 "The role of the Pan Cheshire CDOP is to question
25 whether bereavement services were offered to the parents

1 at the time of the child's death and if not to establish
2 the reasons for this."
3 Now, one of the recurring features for The Families
4 in this case is that they did not receive adequate
5 bereavement services. Now, I know not all of them came
6 to the CDOP, but, how was that assured? What was your
7 process for making sure that families had received
8 bereavement support?
9 A. Yes, I think you have got to detach the two
10 things here. I think if you put CDOP over to, over this
11 side --
12 Q. Yes.
13 A. -- as like a -- it's a stage that kicks in
14 here in notifications. But the actual activity sort of
15 takes place some time down the line.
16 Q. Right.
17 A. Well, the bereavement issues with families
18 need to be dealt with here.
19 Q. Of course they do.
20 A. Not down there. So --
21 Q. May I be clear. I'm not saying you could make
22 sure that that happened at the time.
23 A. So in terms of the bereavement issues, if
24 they --
25 Q. How did you check it's happened --

1 A. From my experience when a child has died,
2 normally as I say you'll end up in an A&E situation or
3 a home environment. The bereavement issues would always
4 be picked up by the health professionals within the
5 hospital setting and I am not aware of any issues really
6 where it fails because it's a natural process for them
7 health professionals to follow up on.
8 But the Rapid Response Meeting is a process to
9 check that that's been done and is it being managed?
10 Q. Yes. But isn't the best way to check as to
11 whether it's happened to ask The Families?
12 A. For -- for those individuals who are working
13 with that family, the families at that time, yes.
14 Q. And if CDOP have a role to assure whether or
15 not that is happening, shouldn't they be making that
16 enquiry of the families?
17 A. Yes. But I mean I would certainly go back to
18 the point where this is a CDOP sort of a process further
19 down the line, sort of at the end, whereas the questions
20 need to be asked earlier on in the process.
21 Q. Okay, I've asked the question.
22 A. Okay.
23 Q. That's your perspective. May we just go back
24 in this guidance, please, to page 5 where the objectives
25 for CDOP are set out. I am so sorry, I think it's the

1 internal page 5, so page 6 in the pdf.
2 No, that is -- can we try one more page, please.
3 So at page 7, there we are. "Objectives". Sorry
4 for the reference.
5 There are a series of objectives under the bullet
6 point. If we just go over the page, please, to pdf
7 page 8, towards the bottom of the list, one of the -- in
8 fact the final bullet, "Objectives of CDOP: "
9 "Where patterns and trends are identified CDOP will
10 ensure that LSCBs respond with appropriate campaigns and
11 activities."
12 So from the context of public health presumably,
13 but where patterns and trends are identified CDOP's
14 objective is to report that back so something can be
15 done about it.
16 One of the things you told us in your witness
17 statement, for your reference, I am not saying we need
18 to put it up but it's in paragraph 33, which is
19 something we have looked at already, you were reflecting
20 on the shortcomings of CDOP, delay you have told us
21 about, geographic boundaries was another problem. But
22 the other sentence that you have put in there is that
23 CDOP tended to look at cases individually rather than
24 comparing a number of similar cases.
25 My question to you is: if CDOP is going to look at

1 cases individually, isn't it inevitable that patterns
2 are going to be very hard to detect?
3 **A.** When the cases are scheduled and listed then
4 all the professionals involved in the CDOP go away and
5 research their systems and provide the relevant agency
6 information into the system. So, for example, if the
7 Constabulary were provided with, which they will be
8 provided with, the agenda for the next CDOP and it's got
9 15 cases on it we would research all those cases.
10 Now, from that research we may identify that that
11 family's already been open to service. Occasionally you
12 might identify that there's been a previous death within
13 the family or at that address or an issue and that would
14 be part of the report that we would prepare to take to
15 the CDOP. Other professionals would do the same.
16 So if we are talking about patterns in terms of
17 geography you may, you may identify through addresses or
18 locations. If we are talking about patterns in terms of
19 like modifiable factors, then that's part of the group
20 to identify for example issues around smoking being
21 a relevant factor or cots.
22 **Q.** Well, may I give you a factor that comes
23 really directly from these facts. We know that we have
24 got -- the witness before you had had all of these
25 deaths reported to him on the relevant forms across the

1 12 months that we are concerned with, but at CDOP level
2 no system, no process that could join those together and
3 to allow you as the member to be aware that there was
4 this continuing increase and pattern of fatalities.
5 Wasn't that a shortcoming? Shouldn't there be
6 a process that doesn't rely on the individual members to
7 highlight commonalities amongst cases?
8 **A.** I -- I wouldn't disagree with you and
9 certainly when we look at the neonatal deaths and the
10 numbers involved and the fact that CDOP wasn't sighted
11 on the majority of those then there's definitely gaps in
12 the system.
13 I mean it's six years, seven years since I've been
14 involved.
15 **Q.** I know.
16 **A.** So systems will have changed since then
17 anyway. But certainly looking back then yes, there was
18 gaps in the system in terms of CDOP's ability to
19 identify repeats.
20 **Q.** Thank you. That document can come down, thank
21 you very much.
22 I wanted to move on just briefly to deal with the
23 journey, as you have called it, from the notification,
24 your first notification in March of '17 to the decision
25 of the Constabulary as to whether or not there would be

1 a police investigation.
2 Just in relation to that March meeting, as you told
3 Ms Langdale King's Counsel effectively all of the
4 information, all of the documents that was presented to
5 you and your colleagues at that meeting was the
6 Royal College review, and the redacted version of that
7 at that, and a short tracker of actions in relation to
8 it. Those were the only documents.
9 But from your perspective that material was
10 obviously significant and enough that it engaged your
11 police officer's instincts that more was required here,
12 is that right?
13 **A.** It caused me concern, yes.
14 **Q.** Yes. And so anybody who's listening to your
15 evidence, anybody who is following this Inquiry should
16 understand that that is the sort of information that
17 should be reported to the police if it is available?
18 **A.** Yes.
19 **Q.** Thank you. You have dealt with the chronology
20 as it goes along, but there was just one more document
21 that I wanted to look at, please.
22 So just to orientate ourselves there is the meeting
23 on 24 March when the Executives come to CDOP, there is
24 then a meeting a month or so later on 27 April, where
25 you go to the Countess of Chester with Hayley Frame and

1 talk to the Executives and the doctors and then on that
2 day, you deal with it in your statement -- I don't
3 suggest that we turn it up -- you go back to the police
4 station, you speak to your ACC and you send an email to
5 the Executives and effectively what you are asking for
6 in that email is an official letter that they send to
7 you to invite you to consider the problem; okay?
8 **A.** (Nods)
9 **Q.** And it's just that letter that I would like to
10 look at. It is INQ0102319. So if we could go to the
11 second page, please, we will find it.
12 So this is a letter we can see that's dated
13 2 May 17, it's from Tony Chambers the Chief Executive of
14 the Countess of Chester, it's to your
15 Chief Constable Byrne and it comes out of the email that
16 you have sent in the chronology and it is an invitation
17 to the police to commence what's called in the final
18 paragraph a forensic investigation into the
19 circumstances.
20 But can I just invite your attention to that final
21 paragraph and what I am going to ask you a question
22 about are the words that come after. What you are
23 being -- in fact I am going to read it out loud:
24 "I am writing formally requesting that
25 Cheshire Police conduct a forensic investigation into

1 the circumstances surrounding the deaths ..."
2 And then these words:
3 "... with a view to excluding any unnatural
4 causes."
5 What I would like your reflection on, please, as
6 a police officer, with all of that experience that you
7 have told us about, when you begin an investigation, do
8 you know where you are going to end up?
9 **A.** No, absolutely not. I wouldn't use that
10 language.
11 **Q.** No, not at all. Those final words have no
12 place in this letter, do they?
13 **A.** They do not, no.
14 **Q.** You told us that your impression or your
15 reflections of the conduct of the Executives in these
16 meetings in this chronology was of attempting to shut
17 doors of the investigation as it was being considered.
18 Is this an example of that?
19 **A.** It looks that way. I would interpret it that
20 way. It's trying to maybe direct a mindset.
21 **Q.** Yes. Finally, officer -- thank you that can
22 come down -- I just wanted to touch upon something you
23 have told us already, which was when the decision was
24 made to launch this investigation on 15 May 17, one of
25 the initial priorities, one of the key priorities was

1 family liaison, talking to the families involved and you
2 have told us about that first 36 hours.
3 Can I just deal with this. We have heard from
4 another witness, a clinician, that he had concerns about
5 telling families the true picture or his concerns about
6 what was happening in the hospital for fear of
7 prejudicing a criminal investigation or a potential
8 police investigation.
9 Can I suggest to you that if a clinician has those
10 sorts of concerns what needs to happen is that they
11 telephone the police and the police will be able to
12 advise them about what can be said and what can't?
13 **A.** Sorry, can you just clarify and repeat that
14 again? Sorry to ask you.
15 **Q.** Well, in this case we end up with a position
16 where we have got doctors that are having conversations
17 with patients where their patients want to know how
18 their children have died and the doctor has a suspicion
19 that the answer as to how their children have died may
20 be the presence and activities of a nurse, but in his
21 mind he feels he cannot say that, he cannot be candid
22 because he's concerned about prejudicing a police
23 investigation. I hope I have summarised that fairly.
24 **A.** Okay. I think I understand now.
25 I'm not -- at the beginning in the early stages of

1 the investigation there was an agreement or some
2 communication between the Constabulary and the Countess
3 at an Executive level as to how they would manage and
4 communicate with their staff --
5 **Q.** Yes.
6 **A.** -- and how they should respond to any requests
7 or media or any other type of activity.
8 So there was an expectation that that would be
9 managed if I remember at those early stages. How it
10 progressed in the investigation, I'm not -- I couldn't
11 comment on.
12 **Q.** But really the point I am asking you to
13 comment on is the way that that clinician works that
14 out, the way that he gets guidance is to speak to the
15 police because they will be best placed to say what can
16 safely be said and what can't?
17 **A.** Yes. Well, that, that would be the answer.
18 Yes, speak to the police and I would imagine that at
19 that point through the Inquiry team there would have
20 been a liaison into the Countess.
21 **MR JAMIESON:** Yes, thank you very much. Those are
22 all of my questions, my Lady.
23 Questions by LADY JUSTICE THIRLWALL
24 **LADY JUSTICE THIRLWALL:** Thank you, Mr Jamieson.
25 Mr Wenham, just before you go, would you mind going

1 back to 27 April. I know you probably feel we've spent
2 rather a lot of time on that and the reference is
3 INQ102292. It's the note of Stephen Cross.
4 Thank you, and could we look at page 7, please.
5 It is just really for me to look at something which
6 I hadn't picked up before. At the top:
7 "IH to protect nurse."
8 And then:
9 "Hayley, what is nurse doing now?"
10 And then a little bit later.
11 "IH: grievance, HR process. Recommendation of
12 mediation. Behavioural issues."
13 Which Ms Langdale took you to.
14 "No previous [perhaps concern] nurse skills or
15 abilities, then criticised for what we did to be
16 reintroduced."
17 So that sounded as though -- it looks as though the
18 nurse is to be reintroduced and Hayley says:
19 "Not wise for her to return."
20 Can you remember anything about that?
21 **A.** I -- we mentioned this before. There was some
22 discussion around the nurse clearly in that meeting.
23 **LADY JUSTICE THIRLWALL:** Yes.
24 **A.** I can't remember that specific point.
25 **LADY JUSTICE THIRLWALL:** It was not attributed to

1 you, it is just I noticed it afterwards and I want to
2 ask you about it.
3 **A.** I can't remember the specific point but,
4 I mean, if there would have been a timeline on that or
5 a date suggested for that nurse to be returned that
6 would have caused me some concerns clearly. But I can't
7 comment any further.
8 **LADY JUSTICE THIRLWALL:** No. All right. Thank,
9 you that was my only question.
10 **A.** Thank you.
11 **LADY JUSTICE THIRLWALL:** Thank you very much indeed
12 for coming this afternoon. You are now free to go.
13 **A.** Thank you.
14 **MS LANGDALE:** 10 o'clock.
15 **LADY JUSTICE THIRLWALL:** 4.15 feels like an early
16 finish, doesn't it? Enjoy your extra 15 minutes. See
17 you in the morning at 10 o'clock.
18 **(4.16 pm)**
19 **(The Inquiry adjourned until 10.00 am,**
20 **on Thursday, 21 November 2024)**
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