Wednesday, 27 November 2024

(10.00 am)

LADY JUSTICE THIRLWALL: Good morning.

Yes, Mr De La Poer.

MR DE LA POER: My Lady, our witness today is Mr Chambers. I wonder if he may come forward to the witness box.

LADY JUSTICE THIRLWALL: Yes, come forward, Mr Chambers.

MR ANTONY CHAMBERS (affirmed)

Questions by MR DE LA POER

LADY JUSTICE THIRLWALL: Do sit down, yes.

MR DE LA POER: Please could you give us your full name?

A. Yes, my name is Antony Nigel Chambers.

Q. Mr Chambers, before we begin, I have been informed that there is something that you would wish to say right at the outset?

A. Yes, thank you.

So right at the outset I just want to offer my heartfelt condolences to all the Families whose babies are at the heart of this Inquiry. I can only imagine -- well, I can't imagine the -- the -- the impact this has had on your lives and I am truly sorry for the pain that may have been prolonged by any decisions or actions that

I took in good faith. I am very grateful to have this opportunity to take part, openly and honestly, in this Inquiry and I hope that answers can be arrived at and recommendations made.

Thank you.

Q. Is it correct that you provided to the Inquiry a witness statement dated 13 August 2024?

A. That is correct.

Q. Is the content of that witness statement true, to the best of your knowledge and belief?

A. I believe it is, yes.

Q. We'll deal first with your background. Did you begin a career in the NHS sphere as a student nurse in February 1985?

A. I did.

Q. Did you subsequently qualify and practice as a nurse?

A. I did.

Q. In 1997, did you undertake a postgraduate diploma in Healthcare Services Management?

A. That's correct.

Q. After that, did you spend two decades in senior leadership roles, including acting as an Executive Director and as a Chief Executive Officer at various hospitals?

A. That is correct.

Q. If we just identify some of the appointments in the run-up to joining the Countess of Chester. Were you the Director of Operations at an NHS Trust between 2004 and 2007?

A. Yes, that's correct.

Q. Were you the Director of Operations, Planning and Performance at an NHS Foundation Trust between 2007 and 2009?

A. That is correct.

Q. Were you the director of Planning, Performance and Delivery at a health board in Wales during 2012?

A. During 2012?

Q. During 2012.

A. Yes, yes.

Q. It was whilst you were in that role, I think in August of 2012, that you were appointed as Chief Executive Officer at the Countess of Chester Foundation Trust, albeit that you didn't start until December 2012?

A. Yes, that's correct.

Q. Was that your first role as a Chief Executive Officer?

A. It was.

Q. Before that, had you acted as a Deputy Chief Executive Officer?

A. I think it's fair to say that the role I had in the large health board in South West Wales with -- as the Director of Planning, Performance and Delivery in effect would have been the Deputy Chief Executive, although that didn't have the specific title.

Q. At the point that you began work as the Chief Executive of the Countess of Chester, did you consider yourself to be adequately qualified and experienced for that role?

A. Yes, I -- I -- I do. I wouldn't have applied otherwise. It was a competitive process that I went through, there were five people that were interviewed and I equipped myself well through that interview and I believe that the Aspiring Chief Executive Development Programme that I completed, and I can't remember the exact years of that, prepared me adequately for the role.

Q. Now, at the start of your witness statement, you can turn this up if you wish to, or I can just read it to you, it is on the first page, paragraph 3, I will just read it out so everybody knows what we are talking about, you say this:

"I wholeheartedly accept that the operation of the Trust's systems failed and that there were opportunities missed to take earlier steps to identify what was

happening."

Now, I would like to give you an opportunity before we look at the detail of this, Mr Chambers, to identify for us, in light of that very broad and candid statement, what you regard as being your most significant failure?

A. I think it was not a personal failing -- failing. I have reflected long and hard as to why the board was not aware of the unexplained increase in mortality in 2015/2016 and the board was not aware of that until June 2016.

Q. If I can just stop you there. It is important that you listen to my question and I think you began by indicating that you weren't providing an answer to that question.

I'm asking you for what you regard as your most significant failure?

A. So the board wasn't aware of the raise in mortality until 2016 and there were several reasons for that. Some of that was around data, like some of it was the fact that mortality wasn't being discussed and raised through the Women's and Children's Governance Board, wasn't being raised at the divisional board and therefore wasn't being discussed at the board.

There I think is some of the failure that our

internal governance systems perhaps were not escalating soon enough, risks and concerns that may have been -- been experienced within -- within the hospital.

Q. Are you saying that that was a significant personal failure?

A. No, I -- I think as the -- the accountable officer it's my responsibility to -- for the safety and the delivery of safe care within the hospital and clearly, the -- these weren't -- the processes that we had in place weren't being used properly and I think I must take some responsibility for that.

But as the Chief Executive of a large hospital, with over 4,000 staff, you are very much reliant upon your people, the five or five different layers of governance that exist in the hospital to do their job.

Q. Mr Chambers, do you accept that there was any personal failure by you?

A. It's -- it's difficult to say otherwise. My witness statement has -- has acknowledged that.

Q. So I am giving you an opportunity publicly now to tell what, in light of your candid concession at the start, your biggest personal failing was in your view?

A. It's -- it's really, really difficult to answer that question, Mr De La Poer. There are -- as -- as a Chief Executive, as a board you are very reliant

upon the -- the processes that exist within the hospital that have been put in place that have been assured by independent people that they are robust and good and therefore I suppose, it's -- it's just that is the failure -- that, that we just didn't see it.

Q. Everything that you have just told us is to point to a system failure. I am asking you and it will be the last time that I give you this opportunity, in such broad terms, after all the reflection you have done, all the opportunity you have had to think about what went wrong and what you did wrong, if anything, last time: what was your most significant personal failure, do you think?

A. The -- the reflections I have had over what is now eight years, one of the -- one of the very enduring examples, if you like, is -- is our ability to have communicated what was a very complex set of messages, with information that was unclear and therefore I do believe that there was in -- in -- on reflection, the communications with the Families could of and should have been better.

Q. In that sentence before your final one, you used the word "our", not "my". But does it follow from that given the number of opportunities I have given you to answer the question that you are not advancing any

personal failure on your part?

A. No, I --

Q. Well --

A. Yes, thank you for -- for pulling me up on the language there. No, no I take fully and accept that as the accountable officer for the Trust, I must take some responsibility for that, take responsibility for that.

Q. We are going to move on. Your first awareness of significant problems on the neonatal unit, you tell us, was on 29 June --

A. That's correct.

Q. -- is that correct?

A. That's correct.

Q. Well, let's just see how we got there. It is uncontroversial to say that at some point on the afternoon of 24 June of 2016, so a full five days before you were told, the Director of Nursing, Alison Kelly, was told that the two most senior Consultants in the paediatric unit were concerned that a nurse may have murdered a baby the day before.

Should you have been told that on 24 June?

A. If -- if that is the facts of the matter, if that is what Alison has understood to have heard that was said to her clearly and very explicitly articulated in the way that you have just described, then, yes, I am

sure I should have been made aware.
The, the -- when I put myself back into late June 2016, the only time that I can absolutely say that I was made aware of these matters was on 29 June. I am not clear in my mind who made me aware. I am not clear in my mind was it on 29 June or was it, you know, a day or so sooner.
I don't believe I knew about these matters before 29 June because as you have correctly described these are very important, very concerning matters and you can see that the actions that I took from that were very speedy and there were many, many meetings that came after 29 June so my assumption is that I didn't know and should I have known? I don't know where I was, I haven't got my diary, I don't know if I was in the hospital, but I think it's a fair assessment that I perhaps should have been told.
Q. Dr Brearey invited Mr Harvey and Ms Kelly to a meeting on 27 June of the senior paediatricians for them to explain to those two people what their concerns were. They didn't attend that meeting. Instead, later that afternoon, on the 27th, they met senior nursing managers and a plan was developed as to how to respond to the concerns. That plan included the instruction of the RCPCH to conduct a service review?

A. (Nods)
Q. Does it follow from your evidence that you were told none of that at the time it was happening?
A. And -- and that's where I think there may be lack of notes or lack of memory of when I was absolutely, when I was absolutely told.
I think -- I genuinely feel it's probably inconceivable that we would have got to a point to have instructed the Royal College of Paediatrics and Child Health without me being aware of it.
Q. We know that first contact with the RCPCH was on 28 June, so the day before you have told us. Does it follow that you think in fact you may have known before Mr Harvey contacted the RCPCH?
A. I -- I can't be sure. I -- I -- I only have absolute memory of the 29th. But the fact that there was actions that were already in train suggests to me that these were the right actions and it suggests to me that I may have been aware but I can't be certain.
Q. Well, there are two possibilities, either you were aware or you weren't. If you were aware, did you act too slowly to meet the paediatricians because that didn't happen until the evening of the 29th?
A. And that -- that, you know, I know I didn't act slowly so I suppose in -- in my mind what I remember

is -- well, the only thing I really remember is not knowing and then knowing.
Q. The alternative proposition is that you didn't know, in which case should you have known? It is a simple yes or no?
A. And I think -- I think the answer is that I perhaps should have known because there was key actions that were going on that would be important for me to be aware of. But I don't know whether I was in the Trust, what my diary movements -- had I been in the Trust, I am assuming I would have known, but I -- I -- I don't know what my whereabouts were.
Q. Would you agree that if you were not told until 29 June, that that is indicative that the matter was not being treated seriously enough?
A. No, I don't think that's -- I don't think that's a fair assessment at all. I mean, if you look at the actions that were being proposed and discussed, these were not trivial actions, these were fairly significant important steps to help us get to a greater insight of what the concerns were and what the nature of that might be.
Q. So --
A. They were happening very, very fast so I don't think it was a lack of pace.

Q. Letby worked four days of the week of the 27th?
A. Sorry, can you repeat that?
Q. Letby worked four days of the week the 27th, the 27th, the 28th, the 29th and 30th. What you are telling us is that it being the case that these two senior Consultants raised with the Director of Nursing that they thought that nurse was murdering babies or may be, that you were not told of that and she continued to go to work.
Are you suggesting that that nevertheless suggests that it was being taken seriously enough?
A. All I can say for certain is that I knew on the 29th and from evidence that I have heard that actions were being taken forward in terms of conversations with the Royal College. I was not aware of Letby's name at this point, I was not aware specifically of the nature of any of the concerns.
Q. It's very important that you just listen to the question that I am asking you. My question was: whether the fact that Letby continued to work and you were unaware of this, despite the allegation that had been raised against her or the suggestion of risk that she posed, that that suggests that it was not being taken seriously enough.

You were Chief Executive, you know the threshold for bringing matters to you as the absolute top of the organisation. Do you agree or disagree with the suggestion that if you were not told and she continued to work that indicates that it was not being taken seriously enough?

A. I know that these matters were being taken very seriously. The fact that Letby may have been working those shifts and I -- I genuinely don't know whether that -- that was the case.

Q. You can take it from me that it is true?

A. Okay, well if that is the position, then I -- I can't answer the question particularly why I wasn't aware.

Q. Why can you not answer that question? It's a simple question in the sense that it is about how seriously you would expect as Chief Executive Officer concerns to be treated and the threshold for you being notified, particularly if it is about a member of staff posing a risk to babies?

A. And I -- I -- I can't comment on conversations and meetings that I wasn't party to. I can't really comment on how these concerns had been articulated.

I can't really comment on -- on whether these concerns were made being made very explicit around,

around Letby's conduct because they were never made explicit to me after the 29th.

Q. We are going to look at that now, I have dealt with that part of it, so let us look at the decision to call the police and how that was addressed.

Dr Saladi -- I don't expect we will need to bring this up -- sent an email early on the morning of the 29th setting out a line of reasoning as to why he believed the police should be called, the Inquiry has already heard that Mr Harvey responded to that internally to the Executive Team, you are not on copy, but Alison Kelly was, that he thought that the police should be contacted.

Ms Kelly replied she agreed. That was the resting position before lunchtime on the 29th.

You had a meeting with the Consultants on the evening of the 29 June; is that right?

A. That is correct, yes.

Q. Let's bring up the note. INQ0003371. It's timed at 5.10. We have looked at it before but we are actually going to run through. It begins -- and at the moment I am just asking you to confirm the content of this note and then I will ask you a question about it. We can see near the top that Dr Brearey is talking about postmortem reports, some, but not all, inconclusive.

Some not satisfactory giving answers.

He goes on to say they were unexplained collapses and conceding that maybe they should have been Datixed.

He goes on to say that, if we look down two-thirds.

"Met in July 2015, three cases common theme was nurse. Discussed it at Thematic with Liverpool and in May 2016."

Then Dr Jayaram says:

"Entirely subjective. Staff member almost always nurse in charge. Babies were stable and then deteriorated. Why always this nurse? Babies were unwell but getting better. Babies not getting oxygen then crash. Babies did not respond as they should."

Dr Brearey:

"Disturbing thing. Twin survived and got better in Arrowe Park. Babies coming back to Countess of Chester. Babies deteriorate, nurse 7 out of 10 between 12 noon and 4 am."

I suspect that's supposed to be 12 midnight.

Then something that is not difficult to read but which might mean something along the lines of "since change none" or something like that, we can't discern it.

LADY JUSTICE THIRLWALL: I think it is 7 out of 9, isn't it?

MR DE LA POER: Forgive me?

LADY JUSTICE THIRLWALL: I think it is 7 out of 9 or is it a 10?

MR DE LA POER: It is the text which is half cut off, my Lady.

LADY JUSTICE THIRLWALL: No, don't worry, we can follow.

MR DE LA POER: Then over the page, page 2, we have Dr Jayaram raising:

"Air embolism. Unquestionably got something at the Countess that they considered equipment, they had considered clinical matters."

And then Dr Saladi adds:

"Preterm babies. Two steps forward, one back. Don't suddenly deteriorate. These babies are relatively stable. Sudden deteriorate and collapse."

So we get to that point. Now, what you have just been given, do you agree, is the expert opinion of three senior Consultants about various aspects of the presentation of these babies who died; do you agree?

A. This was the first time I was made aware of these matters. These were very shocking things to hear.

Q. I understand that. Do --

A. And -- and but the context of this is really important. These were very, very shocking things to

hear. I listened and heard their concerns and, yes, you are right, these were shocking things to hear.

Q. No. My question was whether this was an expert opinion being given to you by three senior Consultants about the presentation of the babies who died and their expectations? Expert opinion; that's the centre of my question. Do you agree that is what you were being given?

A. We were being -- they were sharing with us their concerns, yes.

Q. Was it --

A. And they were paediatricians.

Q. Was it an expert opinion?

A. I think in the -- in sort of comparison to me, absolutely. I am a layperson in the context of this so these were concerns that were being relayed to us by the doctors in our unit.

Q. And experts compared to anybody else present at the meeting?

A. Certainly, yes.

Q. Yes. So I think we have got there. This was an expert opinion, do you agree?

A. Yes.

Q. There was no contrary expert opinion to suggest that anything that they had said was wrong?

A. What we had was the facts as they saw them. There were -- there was -- so that, that's what we had is what was written.

Q. Again focusing on my question. Was there any contrary expert opinion to suggest that anything that they were saying from their expert perspective was wrong?

A. Well, there was, there was just -- it was their opinion. There was no other contrary opinion being proposed -- proposition being proposed.

Q. So there was no rational basis for you to think that anything they were saying that was within their expertise was wrong; do you agree?

A. I thought I agree and I have always felt that the concerns that they were raising were always based on their honest belief of their concerns as they -- as they understood them to be.

Q. Well, not just honest belief. But expert knowledge, experience; do you agree?

A. This was the first meeting on the 29 June, hearing these really challenging matters. I -- I heard what they had to say. I needed to think and reflect on what else could be -- could be going on here.

Q. Do you have a difficulty accepting that they were there speaking as experts --

A. No.

Q. -- about matters?

A. Absolutely not at all.

Q. So they came to you with those concerns --

A. Yes.

Q. -- looking for leadership, do you agree?

A. I think that is exactly right.

Q. Do you agree that they set out their expert view of the problem in clear terms?

A. These notes here appear to capture I think what was said in the meeting. I can't remember all of the detail that was said but they -- as it's laid out here, they seem to be fairly clear.

Q. Do you agree that there was a rational basis based on their expert assessment of the situation for them to be suspicious that serious crimes had taken place?

A. It -- I think it's -- it's really difficult to -- to answer that question. There may be more in this meeting as we go through the meeting note that adds more context that is not being described here.

What -- what's being presented is the initial overview. What would be helpful is if you could remind us as to what the -- the ongoing discussion that happened on that meeting in the 29th.

Q. We are looking at this part of the meeting. Do you agree or disagree that there was a rational basis for them to be suspicious that serious crimes had been committed?

A. Based on what was being presented there, I had no reason to believe that there was no rational basis for what they were saying. But what I do know from many -- from my experience across the NHS is that we wouldn't jump to criminality or as a causal factor.

We would begin to -- we would want to explore, you know, a broader -- broader set of answers to those very difficult questions.

Q. The first thing is there was no suggestion that these doctors had jumped to criminality, was there? This was the product of a long period of time, thought and multiple different aspects of the situation that they were presented with; do you agree?

A. I -- I don't know how, what discussions they had had to arrive at these -- at this position.

Q. You know --

A. I suspect that this will have been something that will have developed in their mind over a period of time and this was the first time that this was being presented to me.

Q. You know that they had looked at equipment,

you know that they had looked at clinical matters, we can see that on the page, they had told you that they had conducted a number of other investigations to exclude ordinary explanations within the NHS, didn't they?

A. Well, as you can see in the note there were -- postmortems had been completed. There may have been a lack of agreement with the outcomes of those postmortems but they had been completed. So it wasn't clear.

Q. We can then see "SPC outline" and immediately after that, the entry is I think it should read why didn't we call the police as opposed to why did we because by this stage nobody has.

What did Mr Cross say, please?

A. In the outline?

Q. Yes.

A. I -- I have no -- no memory.

Q. Bearing in mind the entry afterwards refers to the police, was he giving his view, which we know he did at some point about the police and what would happen if they were contacted?

A. I -- I -- I remember Mr Cross offering his experience as an ex-police officer as to what the nature of a police investigation would look like. I do not

believe that that was at this meeting. So I don't know what the SPC outline refers to.

Q. As we are on the topic, just tell us in summary please what did Mr Cross say about what he thought would happen if the police were contacted?

A. He -- he described very -- at a very high level that it was potential that the unit could be treated as a crime scene, it could be very disruptive and that people would be interviewed and investigated. But there was nothing that he said that would have persuaded me that if the decision was to go to the police, we would have gone to the police.

So if -- if the assumption is that he was somehow trying to provide a reason not to, I don't think that's -- I don't think that's correct.

Q. Was Mr Cross's description of what would happen when the police were called in fact borne out when the police were contacted?

A. No, because it was some time later. I think perhaps Stephen's experience as a police constable were probably more grounded in a period of time when police investigations have moved on.

Q. Dr Jayaram has given evidence that when he raised concerns of deliberate harm, you said: I can see how that would be a convenient explanation for you but

there must be something else.

Did you say that?

A. Where -- where did I say that?

Q. That is Dr Jayaram's evidence?

A. Right. Ah, okay. I -- I don't remember ever saying that.

Q. Well, do you think that's something that you might have said?

A. I really don't know. It's -- but I don't remember ever saying it.

Q. Dr Brearey has given evidence that he formed the impression that you thought the concerns they were raising was to hide the doctors' failings. Was that your view?

A. No, absolutely not.

Q. We can see four lines down after you have said "Can we explore more before the police?", Dr Brearey's immediate response as recorded here was "Can we move member of staff?"

Do you see that?

A. Yes, yes.

Q. Do you remember him saying that?

A. I -- I remember a discussion to that effect. I don't remember if it was Ravi Jayaram.

Q. And 00

LADY JUSTICE THIRLWALL: It was Dr Brearey.

MR DE LA POER: Dr Brearey.

A. Right, okay, but I don't remember specifically.

Q. Steve B.

If we go over the page, we can see how that issue was resolved. One-third of the way down:

"Nurse cannot be excluded."

Now, whether something could or could not happen was a matter for the Executives, wasn't it?

A. That's correct. Yes.

Q. So that's not the doctors speaking. That is either you or one of the other Executives asserting that the nurse could not be excluded; do you agree?

A. It's just a note that says "nurse cannot be excluded". It doesn't -- I don't really know what the discussion that may have led to that note but if we were to exclude any member of staff we would look to try and find some grounds to do that.

Q. Just look at the language that's used. I am suggesting that that is something that was said by one of the Executives as opposed to one of the doctors and I think you have agreed that it --

A. I -- I suspect that's correct, yes.

Q. Yes. Letby was rostered to work the next day

and did work the next day. Should you have taken steps to ensure that she didn't?

A. So can you -- can we just go back to the first page of this note, please?

Q. By all means.

A. Can -- can we see where there was a discussion around the association of a nurse on duty. Can you just remind me where that was?

Q. I think the first page is entirely -- we have run through almost every line of it is -- what the doctors told you, so it will be on the second page, if anywhere.

A. Okay.

Q. So we need to go to the second page. We have looked at some of this already, the first half is the doctors telling you more, there is then the discussion about police being delayed.

Dr Brearey:

"Can we move member of staff?"

You saying you [inaudible] "Babies transferred and then deteriorated", which suggests it is more serious than you originally thought; do you agree?

A. Potentially, yes.

Q. So there you are.

A. Yes. So at the bottom of that page there you

can say TC -- we can't:

"Issues we cannot explain, is this suspicious? Is it criminal? Or are we missing something?"

So there was a discussion around that. There's a causal link to one nurse. But also mentions of other members of staff.

Q. Let's just pause there. Dr Harkness could not be the explanation for the deaths --

A. No, no, I agree.

Q. -- of Child O and P so that was not a relevant consideration, was it?

A. Yes, no, I agree. But I suppose what I was hearing was that there were concerns being raised, there was some hypothesis around what those causes of harm might be and there was a suggestion that there was a member of staff who was on duty more times than another member of staff.

I -- I think it -- so that's what I was hearing.

Q. So the only doubt being cast upon the doctors' rational, as you have told us, suspicion was you raising the possibility that they might be wrong without knowing how they might be wrong?

A. No, it was me raising: are we missing something?

Q. Yes, that they might be wrong without knowing

how they might be wrong?

A. Yes, I suppose, but I am asking the question: are we missing something?

Q. Yes. And so the position is: there is no basis to think that they are wrong, you don't know whether they are right?

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

Q. That their concern, their suspicion, is rational and based upon an uncontradicted expert opinion and we get to the end of the meeting after it's been raised with you that there is a concern that that nurse needs to be excluded and the management has said: she can't be.

Is that a fair assessment of that meeting?

A. I don't recall why the note says the nurse cannot be excluded. I can only assume that there had been a discussion that isn't noted and that a rationale for excluding her hadn't been arrived at and we needed to establish a rationale before doing that.

Q. Let me help you with that. It was being suggested that a member of staff may have murdered babies.

A. But what you are --

Q. That -- if I may?

And that that therefore, would you agree, is

a safeguarding concern?

A. It's a significant concern, safety concern.

Q. Yes, so --

A. The -- what is not being -- what is not coming out through these minutes -- these notes, not minutes -- bearing in mind these are the notes of one individual, so we have to accept there may be an incomplete record. But what isn't being brought out here is discussions that I am now aware of and perhaps was aware at the time because it was discussed in the meeting, was the, if you like, the -- what you are presenting is a very emphatic description of harm. I -- and a subjective link to one individual.

What I know had been discussed in previous meetings, maybe the meeting on the 27th, the outpull of that meeting may have been brought into this but not noted is that there was very objective support and rebuttal to the proposition that this one nurse was deliberately causing harm.

Q. The rebuttal was that she was a good, well-regarded nurse, which is I am sure you would agree not a rebuttal to whether she is covertly deliberately harming babies?

A. There was a very strong level of support for this individual. You are right, it was, you know, it --

that in itself could, was not any way describing around any conduct she may have been having around deliberate harm. But what we -- what was being said here was that there was just a circumstantial causal link.

So you know, we -- the nurse cannot be excluded is noted here. But let's -- let's remember -- remind ourselves of what actually happened. She was moved.

Q. Let's remind ourselves what happened, Mr Chambers. She went to work on the 30th. Do you agree?

A. I -- I don't know if that is the case.

Q. That is the case. Do you agree that as a result of the decision that she could not be excluded that patients were exposed to a risk of harm the following day?

A. If that's in effect what happened --

Q. That is.

A. That she went on to -- you can see this note -- I mean, I suppose one of the omissions here was actually trying to establish what the circumstances -- you know, what the actual work plan for this nurse was and I was not aware that she would have been working that night.

Q. Why is there no discussion about that?

A. I -- I -- I -- I don't know. I don't know.

Q. Is that because?

A. I think all I can say is that from -- from my own personal experience -- memory of this, these were very shocking things that I had -- had heard for the first time. I was trying to process matters and thoughts in my own mind and perhaps in terms of structuring my thoughts that was something that I didn't seek assurance from.

However, it wouldn't have been unreasonable to me if -- perhaps wrongly assumed that those matters would were being dealt with by others.

Q. If in doubt, patient safety comes first; is that fair?

A. Yes -- no, that's right.

Q. And that is not what happened here, is it?

A. I -- I -- this -- this was just a collection of summary notes. This wasn't a plan. The nurse cannot be excluded. I don't know why the nurse couldn't be excluded on that time. I was not aware that she was potentially being rostered on to shift and maybe I should have enquired. But what I -- what I know is that in my mind right from the get-go of all of this, the most important consideration for me was the safety of the unit.

Q. Where do we see that there?

A. Yes.

Q. Show me the note that indicates that that was the most important consideration?

A. And I -- as I said these are Stephen's notes, these were thoughts that were existing in my mind, maybe I at this time didn't articulate it, but I know the very next day when we had our further meetings, that was very clear.

Q. So you believed that the most important consideration was something that was not noted?

A. It's implicit, I suppose. But this was -- you know, the discussions that were going on about: do we call the police? Do we commission reviews? Do we shut the unit? Implicit in all of that is safety.

LADY JUSTICE THIRLWALL: The word "safety paramount" does appear; those words do appear.

A. Say again, sorry?

LADY JUSTICE THIRLWALL: The words "safety paramount" do appear above "unit closed tonight".

A. Thank you.

MR DE LA POER: "Safety paramount. Nurse cannot be excluded."

A. Safety paramount, the unit is closed tonight nurse cannot be excluded. I can't explain that statement. I -- wrongly I had assumed that the rotas

and the roster patterns would have been explored and even today I don't know whether Nurse Letby worked on the unit that night. You are telling me she did.

Q. The rota did. She exchanged messages with Dr U talking about it?

A. Right.

Q. We are going to move on to the 30th and to just look at a particular facet of the meeting INQ0003362 and we will go to page 4. There is one particular aspect and a number of things were said at this meeting but I just wish to look at one part of it.

Halfway down the page, you say and by this stage the fact that it's going to be a Level 1 unit I am sure you can agree was determined at the previous meeting.

You then go on to say:

"... nurse removed, would death stop?"

To which Dr Brearey says:

"Risk would be reduced."

LADY JUSTICE THIRLWALL: I think we agreed it's "if nurse reviewed".

MR DE LA POER: Thank you, my Lady:

"If nurse removed, would death stop? Risk would be reduced."

Then a number of points attributed to you:

"Test out hypothesis with her being off."

Then:
"Exclude or inconclusive. Police."
Then if we go over to page 5, we can see that this theme about at the meeting the hypothesis is repeated:
"Test hypothesis, yes, no, police."
So do you agree that at this meeting on the 30th, what was being said in the context of the unit being downgraded, which is what was discussed the previous day, that it would be -- the unit would be looked at without the nurse on it and an assessment would be made about whether or not harm had stopped in light of her being moved off, that is the hypothesis that you are suggesting is being tested; is that correct?
A. Potentially, or -- or was it that we -- we were aware -- excuse me -- that that the nurse was now going on two weeks's leave, which may have been the -- the opportunity to test a test hypothesis.
But in my mind -- in my mind, the nurse was going to be removed. I was adamant in my mind. But what I wanted to do and was very -- it was very important to do was to not force my position into the meeting because as Chief Executive, once you make a statement about -- it -- that then becomes a decision.
And I was very clear that that we would test all thoughts around how to manage these matters but in my

mind, Letby was going to be removed.
Q. Yes, and the simple point is this, your word being a decision, that you said: we are going to test the hypothesis of the nurse being off and see what conclusions we should draw in light of what then happens; that is what you are saying at this meeting, aren't you?
A. No, no, there was more to the hypothesis, wasn't there? The -- the hypothesis, if that's what it was, was the removal of the potential -- well, reduce the risk by removing the nurse to the point that Dr Brearey made.
But he didn't say it would remove all the risk so we also will reclassify the unit so it's no longer taking the sicker babies. The criteria for admission to the unit would be significantly different.
Q. Mr Chambers --
A. So the hypothesis was both of those things.
Q. Let's have a look at page 4. "Test out hypothesis with her being off" is what it says. The decision about Level 1 was the day before. That is what you are recorded as saying?
A. Okay, I -- this now makes sense. So "test out the hypothesis with her being off", is "her being off" the annual leave?

Q. You tell me.
A. I -- that's, that is my sense of what that refers to. Because the note underneath that wouldn't make sense because it says: then exclude or if we remain inconclusive, we go to the police.
Q. Yes.
A. So the hypothesis that we were -- that we were going to test would be: are there other potential explanations for the unexplained increase in -- that would explain the causes of the unexplained increases in deaths and collapses.
Q. The neonatal unit was monitored very closely after this meeting, during the period that she was on holiday and all the way through to when the police were contacted?
A. Correct.
Q. There was a dashboard which was monitored and reported on --
A. Correct.
Q. -- weekly.
And at -- what was revealed at meeting after meeting is that the pattern had stopped. Do you agree?
A. You were -- you are not comparing -- the unit prior to June 2016 was not --
Q. We will come to that.

A. No, I think it's important that we understand this. The unit prior to 2016 was not the same as the unit post 2016. Because -- not simply because Letby had been removed but we had changed the admission criteria to the unit, so I will -- I am going to deliberately explain what that meant, is that the gestational age of babies who would be admitted to the neonatal unit following the -- the reclassification and the downgrade, if that's the language we wish to use, would -- would have been that nobody with a gestational age of less than 32 weeks would be admitted; nobody with a low birth weight of less than 800 grams would be admitted; nobody with a complex antenatal history would be admitted.
So that was a very significant change from -- so the unit -- so to -- if you are testing the hypothesis and you are only using one criteria to test that hypothesis, then you are -- you are not presenting the whole story.
Q. No, and I am not for a moment suggesting that. If you will allow me to ask the question, there are two factors, two variables, that were changed: the unit designation and the fact that Letby wasn't there any more.
My original question was: did all of the deteriorations and sudden unexpected collapses stop? We

know that to be yes.
A. That is -- that is the answer.
Q. So there is potentially two explanations for that because two variables have changed. Did you ever take expert advice about from the Consultants about what the actual effect was of the redesignation and how that was relevant to the babies who had collapsed unexpectedly previously?
A. So as you -- as you reminded me, we put in process a method of daily management where we had a dashboard that gave a very clear oversight of the -- the level of demand through the unit, the acuity of -- of babies on the unit, the staffing levels on the unit and those -- that dashboard was shared with the -- with the clinicians.
Q. Mr Chambers, we know and we will come to it, that in March the clinicians wrote to you and set out in terms why in their expert opinion the redesignation did not explain the change in data; do you remember them doing that?
A. I --I do remember the letter. I'm not sure that that was the entirety of the letter. I think they were, but, yes, we can go to it at some point later.
Q. We will. At all events, we will move to the staying with the subject of police, the evidence that we

have heard from Ms Sian Williams supported by Julie Fogarty, that having undertaken work on the rota she spoke to Executives including Alison Kelly, she doesn't suggest that she spoke to you --
A. Yes.
Q. -- saying that her conclusion was that the police should be called. Were you aware that she had said that?
A. No.
Q. Should you have been told that the Deputy Director of Nursing, who had been given a particular task directly relevant to this, had reached that conclusion? Should you have been told that?
A. Perhaps, yes.
Q. If we move forwards in time, we perhaps don't need to look at the detail but we can if you need to. On 27 March there was a meeting which was attended by you and representatives of the Neonatal Network, do you remember, Julie Maddocks was there?
A. 27 March 2017?
Q. 2017. Yes, moving forward there?
A. Yes.
Q. Again, staying with the subject of the police, not all of that meeting, do you recall that Dr Brearey said "this needs to be escalated to the police" in that

meeting?
A. Can you please put the note up?
Q. Of course I can. INQ0003150.
A. So this meeting, you can see I outlined this meeting and gave an overview as to where I felt we were at that time. So we had had the Royal College review actions and recommendations, we had had the Hawdon review, we had also had the -- the review by pathologists from Alder Hey, 17 cases had been reviewed. Out of all of that there was two unascertained causes of --
Q. Mr Chambers, if I may everybody can read --
A. But it is important. This was the context for this meeting so the -- the -- the meeting at up until the -- up until the point of this meeting, that's where we as -- as a board believed we were; that there was an explanation for all but two of the causes of death.
Those had been --
LADY JUSTICE THIRLWALL: I'm sorry to interrupt you, Mr Chambers, but is this in this note?
A. No, but it's helpful --
LADY JUSTICE THIRLWALL: When you say "TC welcomed everyone to the meeting" that is obviously you?
A. Yes.
LADY JUSTICE THIRLWALL: Then you set out there the

context, did you set out other contexts --
A. I think the note --
LADY JUSTICE THIRLWALL: -- that you are now telling us about?
A. The meeting I think goes on to explore some of that.
MR DE LA POER: This is very important, Mr Chambers. My question was about whether Dr Brearey said that the matter needed to be escalated to the police. It's very important that we focus on that.
A. And I -- I don't disagree with that statement.
Q. So --
A. But it's important that we understand what this meeting -- what led up to this meeting and what the nature of the discussions were at this meeting because this was the first meeting where there was a decision that we would formally go to the police.
Q. Mr --
A. So the event, the matters that led up to this meeting was the sharing of the Royal College review, the Hawdon review, the -- the opinion of the Alder Hey pathologist --
LADY JUSTICE THIRLWALL: Yes, you have told us that.
A. Yes, which then was seen as -- was shared

with -- with the paediatricians and also the neonatologist. They believed that the -- that didn't explain all the causes of death so it wasn't 2, it became 4, was it 8 that needed to be, you know, looked at in more detail.

So this meeting was trying to establish what absolutely the next steps would be and as I outlined in the meeting note at the start, it's about how do we get to the point that the board and the organisation has done everything to answer questions and if it's not at that point, what do we need to do to get to that point?

So it was around exploring what the next steps would be.

Q. Mr Chambers, I have said this already and I am going to say it again, okay, there is going to be an opportunity in the course of my questions for you to give your account.

The question that I asked you was about what Dr Brearey said. It simply required you to agree that that is what he said. It is very, very important that you listen to the questions that I ask and that you answer them, all right?

The question was: did Dr Brearey say that it needed to be escalated to police?

The answer is yes. We have seen that there. We

are now going to have a look at another part of it?

A. Okay.

Q. We are going to look, please, at page 2. Just, we can see here that Ms Maddocks was asked a direct question by you about phoning the police. Let us just note together what her answer is.

"Given the information, on the balance of probabilities, illegal activity has caused the deaths."

So that is what she has said in answer to your question. Do you agree that is what she said?

A. These were very comprehensive notes so, I -- I -- I can only assume that is exactly what she said.

Q. Then if we go to page 6, we will see what you said. What you say is the only thing to do is a police investigation, two-thirds of the way down.

A. Yes.

Q. Do you see that?

A. Yes.

Q. Okay. So far so straightforward, do you agree?

A. Well, not really. Because before this you can see the note where I tried to clarify the position and get it clear in my own mind. So I ask a very emphatic question that is: so what we are saying is you absolutely believe we have criminal behaviour?

Stephen Brearey repeats the balance of probability point from that had been made earlier and Dr Jayaram says: well, the honest answer is we really don't know. It's not been sufficiently explored or reassured. There is a subtle difference.

So that led to my point that is, well, to get that distinction, we need to go to the police.

Q. Yes. And I have not asked you anything that requires you to do more than confirm that that is what you said to the meeting and so my question now is this: at the end of this meeting, your position was that the police need to be called; do you agree?

A. That's correct.

Q. Yes. We didn't need anything else. We just needed that.

On 28 March, we know that Letby was due to return to work the following day. We have a meeting. INQ0014281, we can see that you attend together with Sir Duncan Nichol, Sue Hodkinson, Ms Kelly, Mr Harvey and plainly Mr Cross, because he's making the note.

Again we will just confirm what is in the note.

"The position now, only independent robust investigation is police investigation according to the docs. No natural cause of death, use the phrase 'unnatural death'. Not when but how do we manage

police?"

Then a little further down it would appear that it's agreed that Mr Cross was to contact the police on Friday 31st and suggest making an appointment for 3 April.

Do you see that that is what is recorded at this meeting?

A. Yes, yes, yes.

Q. So do you agree it appears that the plan is going to be that the police are going to be spoken to on 31 March?

A. I think, yes, that's right.

Q. Yes. Okay. Now, we know that the police were not spoken to on 31 March. Do you know why they weren't?

A. There was never any intention to not go to the police. The decision had been made at the meeting on 27 March. What we needed help and advice on is this was a serious escalation of matters and we needed to be clear around how we would manage that next step.

What would it -- what would help the police, what would help us, so we sought independent advice? The discussion around that -- I don't remember specifically how Simon Medland came to be offering that advice, other than I was aware that Stephen and Duncan had had

a conversation, possibly following this meeting, where there was a suggestion made that getting some independent support so that we could manage the significant escalation to the police in the most effective way.

Q. My question was: do you know why the police were not contacted on the 31st? Do I understand your answer comes to this, that a decision was made instead to instruct Simon Medland?

A. That is my belief that happened, that the events that happened next.

Q. We know then that Mr Medland was instructed and that he advised that the Child Death Overview Panel was contacted, we know that led to a meeting with Detective Chief Superintendent Wenham?

A. Correct.

Q. That brings us to the meeting on 5 May, with the police?

A. Correct.

Q. Staying with the theme of the police?

A. Yes, that is okay.

Q. We will deal with other matters in due course.

A. Yes.

Q. You attended that meeting with Cheshire Constabulary, didn't you?

A. Yes, I wrote to the Chief Constable on 2 May and the meeting from that was 5 May.

Q. Now as a matter of common sense, do you agree with this: anybody who wanted a police investigation would state the case at its highest; do you agree?

A. Yes, of course.

Q. Yes. Let us see what is conveyed to the police on 5 May. INQ0102298.

We are going to go to page 3 of this, which is the second page of the notes. I am just going to take you to the very bottom. This is what is being presented by the Trust at a meeting you are present at to the police.

"As part of the review staffing was looked at. There was a notable high statistical relationship between a member of nursing staff and babies deteriorating in the unit. There is no evidence other than coincidence."

Was that fairly stating the position at its highest?

A. I -- I absolutely believe what we said there was our best understanding of the matters as we -- as we saw them.

Q. What about the Consultants' route map to that position?

A. We had, as is discussed in the paragraphs

above, that where it's headlined "Reviews", we had shared the view the reviews that had been done with the -- with the police at this meeting, so the Hawdon review, the College review. We also described the actions that we had taken around redesignating the unit. We also shared the advice that we had been -- that we had had from the criminal QC.

The ACC, the -- Darren Martland outlined the two critical issues as he saw them.

Q. Mr Chambers, we can all read that. My question was --

A. So I suppose what I am trying to say is I -- I don't think there was anything that we had shared with them did not reflect what the Consultants' concerns were.

Q. Where is the Consultants' reasoning that they gave you on 29 June and again at other times, where is that here?

A. So the concerns that the Consultants had raised with us on the 29 June had been tested through these independent expert reviews from the Royal College, from Jane Hawdon and -- and also later the reviews with the Alder Hey pathologists.

Nothing that they were saying was pointing to deliberate harm.

Q. Well --

A. So we shared that openly with -- with the police. I am also know -- I am also aware that Nigel Wenham was at this meeting and he would have heard any concerns that had been raised by the Consultants to him at the CDOP meeting, I think on 17 --

Q. 27 April?

A. 27 April.

Q. Does it come to this; that the concerns that were articulated to you by the Consultants were not set out to the police?

A. I -- I --

Q. That is a yes or no. Either they were told --

A. I -- I -- I take issue with that in the sense that it was all -- all those things were, were there within -- within the reviews that we had shared. All of those concerns had been shared with the Royal College. Can we go to the next page just to see if there is any reference?

Q. Yes.

A. We were very open with -- with the police.

Q. We are going to look at the next page. We can see here she's been moved from nights to days and redeployed off the unit whilst the review was taking place for her protection.

Let's just consider that statement for a moment, Mr Chambers. She was, as you had been told by the Consultants on a number of occasions moved from nights to days and then the pattern of collapses at nights stopped. She was moved off the unit and then the pattern of collapses stopped altogether.

You don't tell the police any of that, do you?

A. It's -- it's not clear in this, you know.

Q. Well --

A. The Datixes weren't always being completed. So -- but I don't -- I don't know the facts of this matter but you are right, it's not been articulated here.

Q. A person who wants a police investigation would state the case for an investigation at its highest. Do you agree that you did not state the case for a police investigation at its highest?

A. I think that's an unfair proposition.

We -- and we shared with the police very openly and candidly what we genuinely believed to be the position as we understood it at the time.

Q. Meeting on the 12 May. This is INQ0003076, we will see what view the Executives provided to the police there, page 6, please.

The second paragraph:

"TC stated a meeting had been held on 11 May with the Countess of Chester Executives and it was felt that the explanations of what had happened do not lie in a single place or cause and certainly not criminal. Concerns from the Consultants were also expressed to the RCPCH as it is referenced in their review."

So you were telling the police in terms that it was the collective view of the Executives that no crime had been committed?

A. I think it's fair to say that we were very much taking the independent experts' view that there was no -- no unnatural causes of death identified. There was two cases that were unascertained.

We were also aware that in the Hawdon review that there were care failures that had been identified that may well have changed the outcomes and in our mind would have been the advice that we had been given by Simon Medland.

So all of that taken together I think represents the position as it's described there.

Q. So this wasn't an investigation you were encouraging; it was an investigation that you were discouraging?

A. Absolutely not. We -- we can carry on in the note and I'll prove -- I can emphasise where that wasn't

the case.

Q. Well, you go on to say that you recognise it's a matter for Cheshire Constabulary now to determine the matter. But you have offered an opinion on the very matter that they are investigating and that opinion is to the effect that the Executives don't think there should be a police investigation because you don't think a crime has been committed?

A. No, that's not right. What we were saying is we couldn't find any evidence of criminality: you are the experts, please help us.

Q. Well --

A. So can we carry on to the notes a little bit further down, please, Mr De La Poer?

Q. Before we do, let's just remind ourselves of exactly what was said:

"... it was felt that the explanations of what has happened do not lie in a single place or cause and certainly not criminal."

A. So it says:

"TC satisfied that Cheshire Constabulary would determine whether or not there has been any criminal intent. COCH have maintained an open mind and would welcome an inquiry if necessary but this has never felt the issue. It was felt amongst the Executives that we

just needed it to be checked."

That doesn't sound to me that we were trying to not or trying to dissuade the police from doing an inquiry; it sounds to me to be the opposite.

Q. You weren't stopping them making an initial assessment of whether to investigation, of course you are not, but you are telling them before they start that initial assessment: we don't think there's anything in this, certainly not criminal?

A. What -- I suppose what we were saying is this is our belief at the time and why wouldn't we share that with them?

Q. Let's move forward, please, to the press statement of 4 February.

A. No, can we please stick with this note?

LADY JUSTICE THIRLWALL: If you just answer the questions and if we get to the end of the document and I feel it has not been fair, we will come back.

A. Yes.

LADY JUSTICE THIRLWALL: Let's just follow what Mr De La Poer -- he is not asking improper questions, let him ask.

MR DE LA POER: Mr Chambers, you need to understand this process. We have a lot to get through. As you know, your barrister representing you will have

an opportunity at the end to take you to any matter that we have left or any further thing that you want to say about it.

We are going to move through, please, to the press statement on 4 February of 2018.

I think that we have a -- I am not going to give an INQ for this because I think that there is a cleaner copy that's been provided to our presenter.

This is on 4 February 2018. We can see that you are quoted at the bottom.

A. Yes.

Q. We will go over the page to look at the particular part of the quote because we are on our topic of police. Explaining why police were brought in, he continued:

"We have had various enquiries, including the Royal College of Paediatrics Review, and there were just a few anything else that our clinician said: look, we think we have got 90% of the answers but there are still bits that we need to do and are sensibly clear that we have not missed anything."

That is not an accurate characterisation of the Consultants' position before you went to the police, is it?

A. Yes -- no, I agree with that. I -- this, as

it's presented is that this was a conversation with a journalist about neonatal matters. This was an hour's conversation with a journalist about a whole range of matters. This release came as a real surprise to me.

We -- we were having a conversation and I may well have -- well, I clearly did say these things and it's with enormous regret that -- that it was reported in this way because it doesn't feel that that was the position as -- A, as our paediatricians would have seen it and I think it's an oversimplification of the position that perhaps as we saw it.

Q. Dr Jayaram has said in evidence, and I will give you an opportunity to say whether you agree or disagree with his characterisation of this, that it was insensitive and disrespectful to paediatricians and Families, it was demeaning. Do you agree?

A. I -- I don't know, it certainly was clumsy. I wrote to the paediatricians once this press release or -- or article went out to apologise and I can see how insensitive it would be for the Families reading this, particularly where I make the reference that -- that the communication with patients -- with parents could have been better but overall the situation seems to be managed really well. I know listening to the Families' evidence at the start of this Inquiry we didn't get it

right in terms of the communications with Family and I -- so terribly and heartfeltfully sorry about that. It was done with the best intentions and this was a very clumsy article.

Q. Was this said with the best of intentions?

A. As I said, it was not even meant to be a statement I -- I -- it clearly -- it clearly wasn't within the best intentions but it was not deliberately me trying to be misleading or trying to trivialise or paint a picture that that we were getting everything right.

Q. I am just going to take you back because you don't appear to have been clear, if I may say so. Was it insensitive to say this?

A. It -- it -- as it's written here yes, clearly it was.

Q. Was it disrespectful?

A. To who?

Q. The paediatricians?

A. I -- you, you -- all I can say is if they feel that they -- if that's how they have interpreted it in the way that Dr Jayaram has done in his evidence, then why would I disagree with that?

Q. And was it disrespectful to the Families?

A. It was -- it was terrible to have seen this

eventually in print. This was never an interview around neonates. It was clumsy, it was disrespectful and I am terribly sorry.

Q. Would it have been okay for you to have said it if it was private?

A. I think it ... possibly not. Probably not because we -- I -- I now know that we hadn't got these matters right in terms of the communications with Families.

MR DE LA POER: My Lady, would that be a convenient moment?

LADY JUSTICE THIRLWALL: Yes, indeed, so we will take a 15-minute break, we will come back just before 20 to.

(11.22 am)

(A short break)

(11.41 am)

LADY JUSTICE THIRLWALL: Mr De La Poer.

MR DE LA POER: My Lady, Mr Chambers, topic two. Risk.

You were the accountable officer under the risk policy; is that correct?

A. That's correct, yes.

Q. And you were also the chair of the Corporate Directors Group which considered the Executive Risk

Register; is that right?
A. That's correct.
Q. I am going to bring up the Executive Risk Register, INQ0049845.
If we go to page 2, please. There are just two matters to ask you about this page. The first is a reference to two particular risks, I am not entirely sure why they have been ciphered here but in fact I can tell you that it is the first risk and the penultimate risk, which is being referred to there.
We can see the entry at the bottom:
"Chairman's actions were taken on 11 July 2016 to add two risks to the Executive Risk Register from Urgent Care. There are no risks identified by the divisions for escalation to the ERR for July 2016."
So those are the two neonatal risks that we see there.
We heard from Ms Millward that she thought the reference to "chairman" was not to Sir Duncan Nichol the chairman of the Board of Directors, but to the chairman of the Corporate Directors Group which was responsible for the Executive Risk Register.
Now, the first question about this entry is: is that reference to chairman a reference to you?
A. I -- I believe it is, yes.

Q. Are we to understand then that on 11 July, you said you wanted two risks to be added to the Executive Risk Register from the Urgent Care Risk Register?
A. I -- I don't remember the specific instruction but it -- it's -- it's quite likely that that was an instruction.
Q. Now, the second matter to ask you about here is if we see the language of one of those two risks:
"Potential damage to reputation of neonatal service and wider Trust due to apparent increased mortality within the neonatal unit".
That was one of the two risks that it would appear you asked to come on to the Executive Risk Register and we can see that it has a risk level grading that would justify that.
My question, however, is whether you were struck at the time about the way in which that risk was framed, in other words by reference to reputational damage? Was that something that struck you at the time?
A. I don't remember seeing the -- the risk as it was drafted there prior to any formal Executive Risk Review Meeting. The phrasing of the risk there is in my view not necessarily capturing -- I will take my glasses off, not necessarily capturing the origin to that risk.
A Risk Register is about having the origin to

a risk and then describing the risk itself, so the risk as I saw it was that we had reclassified our urgent -- our neonatal unit, that there had been an increase in mortality and it was very important that in maintaining the confidence in local hospital services and in this case neonatal services, that we -- if you like, that would have been the reference around reputational risk.
At any day of the week, even today, there can be a woman in the obstetric unit, labouring, and whose baby may require neonatal services and it was very important that we -- was able to reassure them that the neonatal unit was safe. So that was -- it was around that issue, not any kind of reputational issue that -- that would have been a concern to the organisation around how it was viewed. It was maintaining confidence, so the way that the risk was described there and I don't know if it was redrafted at a later time, but the way it was described, described there, I think is problematic.
Q. It is problematic. You see, just help us to understand how you can be directing that a risk should be put on the Executive Risk Register without having seen what that risk is?
A. Sorry?
Q. You have told us that you didn't see it until it got on to the Risk Register as I understand it. But

what note appears to indicate is before it got on to the Executive Risk Register, you asked for it to be put on there which would suggest that --
A. I -- I -- I'm not sure that is necessarily the nature of the instruction. The instruction would have been we need to have risks described on the Executive Risk Register that dealt with the matters around and the -- and maintaining confidence because of the increase in neonatal mortality and I would not necessarily have seen the drafting of that prior to it going on the Risk Register.
Q. Well, Karen Townsend said the wording came from the Executives; did you know that?
A. I -- I have heard that from her evidence. I cannot imagine a scenario where that would have been the case.
Q. Well, unless the Executives were trying to control the narrative?
A. Yes, and that is what I am saying. I cannot imagine a scenario whereby we would have instructed the way a risk was described, prior to the Executive Risk Review Meeting, where then there would have been a discussion about: does this risk describe the risk? Are the actions the right actions? Are the mitigations the right mitigations? Are the scores the right scores?

This is just an overview and I can't comment on -- on what was said by Ms Townsend but I struggle under any scenario to see how the Executive would have instructed the description of a risk.

Q. But bearing in mind the wording in your phrase is problematic, do you have any recollection of having challenged that wording and saying: look, we are not explaining what the problem is here. We need to reframe that. Do you have such a recollection?

A. I -- I -- I -- I don't -- I don't remember that discussion but I know from Ruth Millward's evidence and the way that she described the issue around this particular risk. She used very similar explanations to the one I have given, so it must have been challenged through a process.

Q. If it was challenged, we should be able to find a record of that, would you expect?

A. I think that's right, but I -- I -- I can't help you with that.

Q. If there is no such record, would you accept some personal responsibility if it transpires that there is no indication that that was changed for not having challenged it?

A. I -- I think as the -- as the chairman of this committee, I think I must take some accountability for

that. But I -- I don't think that what's been described here, if the proposition is that we were somehow putting reputation over safety, that's not right. And I sincerely hope that we can find a record that puts this straight.

Q. Next topic, we can take that down, the Royal College and Dr Hawdon.

You attended a close-out meeting on 2 September, didn't you?

A. Yes. Yes.

Q. We can bring up the notes but I only want to pick out one or two key points. The first is that you were told in that meeting about the need for a Casenote Review and an HR process?

A. Yes, that's correct.

Q. Do you recollect that?

A. Yes.

Q. There was also discussion about a forensic pathologist; do you recall that?

A. No, there was no discussion about forensic pathologist.

Q. Let's bring it up. INQ0014605. The notes start on page 33 but we will need -- we will bring up 33 first just to show that. So it starts with the feedback, which is the wash-up that you were having.

This is what we have heard from Sue Eardley and we can see the third line, three quarters of the way down: need case by case of death plus HR process for Lucy. We have covered that.

If we go over the page we will see page 34 as it appears in here and then we can see that there is a question that you asked in the middle:

"Were these unexpected? We have heard that they were not expected."

That is attributed to you.

Then if we go over the page we can see although it's attributed to you, a possibility at least is that this is a reply to your question:

"Some were unexpected, can't say if there was a link to them."

Whatever that may mean, my question was about, at the moment, forensic results pathologist Tony Beswell from Edinburgh. Any recollection of that?

A. No, none at all.

Q. Now, I mean it says "forensic results pathologist". But if you were discussing a forensic pathologist, would you have understood --

A. I -- I -- I absolutely don't, don't remember any reference to a forensic pathology at this time.

I am clear that was I think number 6 in the

recommendations from Jane Hawdon. I -- I have no memory of this being raised at this time.

Q. Well, my question was predicated on if, so if I will ask it. If forensic pathology was discussed in September of 2016, would you have understood that a forensic pathologist is a person who investigates suspicious death, would you have known that in 2016?

A. I think I -- possibly. I would have probably sought guidance as to what -- what you mean by forensic.

I wouldn't have assumed to have fully understood what the term meant.

Q. We'll move forward to the RCPCH recommendation. This is INQ0003120, the letter written on 5 September to Mr Harvey. If we look on page 2, we will see mention again of that HR investigation.

It's there saying our understanding is an allegation has been made and therefore a process of investigation needs to be put in place which sets out the nature of the allegation and the process you will follow to investigate it and their recommendation about a particular process that might be followed.

Now, we have had heard from Sue Eardley who wrote this letter and from Claire MacLaughlan who spoke about this particular recommendation. Sue Eardley's position was that this was a disciplinary investigation that was

being recommended and that is clearly indicated by the use of the word "allegation", meaning something is being investigated that has been alleged.

What Ms McLaughlan has told the Inquiry was that her expectation was that a disciplinary investigation would be started and almost immediately a safeguarding process would be triggered and the police would be contacted because effectively, as I understood her evidence, the formulation of the disciplinary allegation was such that that was the only way it could be resolved.

So that is the evidence we have received from the RCPCH about this.

Now, we know that no disciplinary process of Letby was started based upon the allegations made by the Consultants. What was your understanding of why that was?

A. I would have taken my guidance from Sue Hodkinson, who I know gave evidence yesterday, as to what would be an appropriate way of taking this matter forward. I don't remember specifically what the nature of that advice was, but there was an options paper, as I -- as I remember and I was reminded of it yesterday through her evidence, that said there was a range of scenarios or options that could be worked through to

take this matter forward and one of those options was the one that was progressed.

But I haven't got the specific detail.

Q. Which option do you believe was the one that was progressed?

A. I -- I can only remember it being option 4 but, I can't actually specifically describe in any great detail what that option was.

Q. I just invite you to take a step back from this and understand what is subsequently said and we will look at the detail of it about the RCPCH. They have given a recommendation to undertake a disciplinary process, that's what the evidence amounts to.

That disciplinary process was not instigated, we have heard evidence about advice being taken. But do you agree that in every subsequent meeting with both the board and external agencies it was presented to the outside world that the recommendations that the RCPCH had given had all been followed? That was the impression that was given, wasn't it, at all those meetings?

A. I think -- and that -- that was my best understanding of the position. I -- I -- this letter was -- remind me, was this letter to me?

Q. It's addressed to Mr Harvey.

A. Yes, I can't specifically remember this letter and maybe it's something you can pick up with Mr Harvey tomorrow. But -- but other than that, I -- I can't offer any -- any -- any particular observation.

Q. Bearing in mind you can see the text now, and you know what you were saying to people about the RCPCH had made a recommendation which we followed in terms of the Casenote Review, do you think that you misled people?

A. No.

Q. I am not suggesting intentionally. But that what you --

A. No.

Q. -- said was misleading?

A. No, I -- I don't really think it was. I mean it -- the -- it was our best understanding of -- of the position we were at -- at the time.

The -- what came out of this, as you know, was a grievance. Whether -- whether it was -- it certainly wasn't clear in my mind that there had been any recommendation from the Royal College to the effect of disciplinary.

Q. Well, again I am not suggesting this was intentional. I will be clear if I do. All right.

You can see now the words that were used about

investigating an allegation. You know the way in which you presented to everybody about whether or not what the RCPCH said should be done had been done. Now that you can see that that was a recommendation that they made that wasn't followed, do you recognise that people could have been misled by you -- and I am not suggesting you did so intentionally because of the way in which you were talking about the RCPCH's recommendations and the fact the Trust had followed them?

A. So I recognise you have asked me the same question three times and my answer I think remains the same. Notwithstanding your assurances that you are not saying anything about deliberate, all I can say at the time, I don't believe we misled anybody and what we said was our best -- best understanding of matters at the time.

Q. I am now going to look at the letter from Dr Hawdon. INQ0003358, this is the letter that accompanied her report. It's addressed to Mr Harvey again and again I would just like you to look over the page at what she says that she was and wasn't able to do.

You will recall that on that letter that we were just looking at, the RCPCH set out the areas -- the minimum areas of investigation. So she responds to each

of those because she was instructed to do each.

LADY JUSTICE THIRLWALL: Are we waiting for another page?

MR DE LA POER: I think we are waiting for page 2.

So her first response is that this is effectively a detailed chronology she was asked that she didn't have time to do it. She says for (b) that she has commented. She says that of the recommendation that she work in conjunction with a pathologist that she wasn't able to do that, that is a -- for every case.

(d) is to check out the access requirements to the unit which she says should be commissioned locally, and (e) is effectively saying she can only consider what she's been given.

So in terms of the five areas that she was asked to investigate, she's saying in terms that for some of them either she hasn't got the capacity to do it or hasn't done it. Do you see that is what she is saying?

A. Yes, she also goes on to say in (a) I do not consider would yield an investment, rather I have prepared a synopsis of key events and issues focusing particularly on events.

So her view was that -- or my interpretation of this, I have not seen this letter, but my interpretation would be that she was able to carry out the spirit of

the recommendation from the Royal College review.

Q. There is an issue about whether she knew what the RCPCH knew when they made that recommendation. That's not for us to address here.

A. Yes, okay.

Q. But you have picked on (a). But as to (c) and (d) directly, and of course the access to the unit is the very issue going to who may be harming babies, who may have access to babies, she says she's not doing it?

A. Yes.

Q. All right.

A. Okay.

Q. So she had been asked to do it, the Royal College thought she should do and she said: I am not going to do it. Did you know that Dr Hawdon had responded to say that she could not carry out all of her instructions?

A. I -- I hadn't seen this letter at the time.

Q. Now, again, you spoke externally -- and I am not suggesting deliberately, about the fact that the Trust had followed the recommendation of the Royal College and we can see that the recommendation of the Royal College was not in fact fully carried out by Dr Hawdon?

A. So we can see that she did --

Q. I haven't got to my question. My question is: do you think that people may have been misled -- I am not suggesting you did so deliberately -- by the way in which you were presenting to the outside world that the Trust had done what the Royal College had recommended?

A. Jane Hawdon produced a fairly detailed report and in that report, it dealt with some but not all of the matters as they are described here. I am not aware of the elements as they are described there in -- is it (d), around the -- and I'm not clear how we satisfied ourselves that that matter had been completely dealt with.

You'll need to explore that tomorrow. Do I feel, therefore, that we misled? Again, I -- I think that's such a strong thing to say. I -- I -- I'm not sure I do, if I'm honest.

Q. So --

A. But it's difficult for me to really give you a firm answer because I hadn't seen previously this -- I certainly hadn't seen this email at a time where we were making any kind of public statement.

Q. Do you think that people who heard you when you said there was a recommendation for a Casenote Review, and we have completed it, understood that not all of what the Royal College had recommended had been

done, do you think they understood that when you were saying it?

A. Yes, but I'm not sure I agree with your proposition, that that hadn't, that wasn't the case because the areas around the pathology matters was resolved and dealt with and Ian Harvey can take you through the detail of that.

In terms of any further requirements from pathology results from, you know -- you know, from Alder Hey was dealt with. I'm -- I'm very comfortable that we had delivered the recommendations from the Royal College review. The one that I'm less clear about is the one that's marked there as (d).

Q. Yes, the access?

A. Yes.

Q. Well, I have given you the opportunity to answer that. Let us look at the conclusion of Dr Hawdon's report. We only need to go to page 55 of this. INQ0006862. This is her summary at the end?

A. Yes.

Q. It is her amended summary because originally there were five children in section 2 and we can see that Child D has been moved up. Do you see that?

A. Yes.

Q. Now, Dr Hawdon says this:

"The death collapse is unexplained ... it is the investigation of these cases which potentially benefit from local forensic review as to the circumstances personnel accepted. Date of first collapse is noted".

So we know on, over the page -- we don't need to look at it -- she uses the phrase "broader forensic review" for her category 2 cases and you will recall that, so that is what she said. Did you read Dr Hawdon's report when it was received?

A. Yes.

Q. So you will have seen that in four cases there was a requirement for local forensic review as to circumstances, personnel, et cetera?

A. Yes.

Q. That was never undertaken, was it?

A. My understanding is that that was the instruction that was given to the pathologist from Alder Hey and when Mr Harvey sought to be clear in his mind what the word "Forensic" meant, he, as I under -- as I remember, had a communications exchange with Jane Hawdon --

Q. We will come to that. We'll come to that --

A. -- to the effect that she was fairly opaque, I suppose, as to what "forensic" meant. She kind of almost as I remember -- but I haven't seen all the email

exchanges, to the effect of: well, it can be whatever you feel it needs to be.

Q. Let's just have a look. The pathology as you have told us was part of the original Royal College recommendation for all 17 cases. In fact, as we know only four of them were looked at?

A. No, it's -- the postmortem results of the cases had been made available to Jane Hawdon.

Q. The recommendation of the Royal College, and we are not going to go back over this, was that she and a pathologist together went through it. That was the recommendation and she said in terms: I don't have the capacity, I can't contact a pathologist.

So that was three.

What happened was that four cases were sent to Dr McPartland that she had identified as her category 2. But what she's talking here now about is not about a pathology because you can see the clue is in the circumstances, personnel, et cetera.

So a pathologist is not going to be look into the circumstances and personnel, are they?

A. I -- that's correct. I -- this is something you will need to pick up with -- with Mr Harvey because there was a very specific conversation that he had with Jane Hawdon to establish, I think, what -- what would be

the appropriate resolution to -- to this -- this action.

Q. There was no local forensic review, was there, into the circumstances and personnel?

A. I -- all I know for certain is that these four cases were shared and discussed with Dr McPartland and collectively with her colleagues at Alder Hey. They arrived at a view that two of these cases, the causes of death were unascertained.

Q. The collapse of a third was also unascertained?

A. Say, again sorry?

Q. The prior collapse of a third was also unascertained?

A. Okay.

Q. But that was not an investigation into the circumstances and personnel, was it?

A. Yes -- and again, I -- I am struggling to remember how this matter was resolved. It may be that I can't -- I can't be clear.

Q. Let me help you, Mr Chambers. It was resolved because once this document was shown to the Consultants in the following year, and was shared with the network, there was a discussion about those four cases and to summarise it, four became seven --

A. Yes.

Q. -- when the network reviewed it --

A. Okay.

Q. -- and then seven became 8 when the seven Consultants on the unit?

A. Fine.

Q. So that's how it resolved. It only went up from the four, but until that point no investigation had been done.

Now, I would just like to ask you about, please, something that you said about Dr Hawdon's report. INQ0006890 and we are going to go to page 289 and just so that you understand the context of this, this is your document replying to the Consultants' list of concerns, which you sent in 2018 and we are just focusing here, and we will come back to the document in due course, upon what you say about Dr Hawdon's report.

So it's INQ0006890, page 289. And we can see at paragraph 2.6, four lines down:

"There were four cases in which Dr Hawdon felt that the cause of death was unascertained and she advised that subject to Coroner's postmortem reports, there should be broader forensic review of the cases as an independent clinical review of these cases remained unexpected and unexplained."

That is the quote from over the page which you

remembered.
"I discussed your question with Ian Harvey who describes how time constraints precluded a comprehensive reading and has no recollection that he omitted to mention that further investigation of a small number of cases was recommended. It was certainly not intentional."
So the allegation was put that before they received the report, nobody mentioned to the Consultants about those four cases requiring broader forensic review due to being unexpected and unexplained. So that's there.
My question is: please tell us about the discussion you had with Mr Harvey and what it was that he was telling you about time constraints precluding a comprehensive reading?
A. I -- I -- I really don't know. To be fair, the -- in producing this document, which was a very detailed and thoughtful document in the sense that the questions that came from the paediatricians were thoughtful and there was an -- an equivalent amount of thought went into the answers and so Ian would have helped in the drafting of this response.
So I don't remember specifically, at all, what the time risk constraints he's referring to other than perhaps the requirement that we promised to publish the

findings of the College review and -- and these other matters, and that we were already struggling to hit those -- those timelines.
Q. Just -- the words included in your document "time constraints precluded a comprehensive reading" rather sounds like because he was very busy, he didn't read it properly. I mean, that's what that ordinary English language means, doesn't it?
A. Yes, you, you -- it's -- I know it's my letter but these would have been Ian's words and I think it's important that you discuss that with Ian. I wouldn't have drafted this without his support.
Q. You there appear though to be accepting to the Consultants who by now know all about Dr Hawdon's report and have had those interactions that I have described that there were in your phraseology a small number of cases were recommended for further investigation. Do you see?
A. We are still on 2.6, are we?
Q. Yes. We have read it already.
"... [he] has no recollection that he omitted to mention that further investigation of a small number of cases was recommended."
So the point really being that it would appear, Mr Chambers, that in 2018 you recognised that Dr Hawdon

had recommended further investigation in four cases?
A. Is -- are they -- is this in respect of the feedback meeting to the clinicians, to the doctors that was taking -- that took place in January?
Q. 26 January, yes.
A. Yes. So it's in relation to that. He's right. I -- I'm not sure he was clear at that meeting that there was a requirement for a further four cases. But I know that he knew that work needed to be completed, that work was ongoing and it would have just been an oversight on his part. We also know -- I also know that following those meetings, there were several further meetings between Ian, the paediatricians, the Neonatal Network, that in your words took the number from two to four to seven to eight.
So it's clear that the work was ongoing and Ian was being very attentive to it. It was just an omission on his part and he apologises for that, I think, in this letter.
Q. Mr Harvey was dealing, as we understand it, with the detail of it and I understand your evidence to be to that effect?
A. Yes.
Q. I mean, was it -- were you being told that Dr Hawdon's recommendation would be entirely satisfied,

in terms of these broad forensic review, by Dr McPartland having a look at it?
A. I think that's probably not an unreasonable description of what I heard. Whether that was specifically what Ian was saying, Ian was not ever in the habit of being anything other than thorough.
Q. Let's have a look at the RCPCH report, INQ0009619, this is 28 November that it's received by the Trust. And we are here just going to look at the dissemination copy, so this isn't the confidential copy, this is the dissemination copy.
If we go to page 13, we will just consider one of the questions was: does it have clear and engaged leadership and good team working?
We can see that the first paragraph, if I can characterise it in this way, and ask for your agreement is overwhelmingly positive about the leadership; do you agree?
A. Yes, it describes good working relationships between doctors and nurses.
Q. Yes. Now the second paragraph raises some historical issues and identifies individual problems. But do you agree that the weight of this, what's being said about the leadership is it is very good but there are one or two problems that we have identified?

A. No.
Q. Is that a fair summary of what it's saying?
A. No, I don't -- I don't think you can weigh paragraph 1 or paragraph 4.3.1 as a dominant paragraph over 4.3.2. Quite often you find with any kind of review that is done, whether it's a CQC review, or -- they will often start with very warm comfortable descriptions and then will get into the, if you like, the -- the meat of the issues that need to be resolved and I think this report is a bit like that.
So but my -- you know, my thoughts -- what were my thoughts about the -- the -- the neonatal unit?
We had some truly brilliant doctors working there who worked really hard. We also had some wonderful nurses there who too worked hard. The relationships between the two could change by a shift. What -- what -- what we did know, and what I knew from my own observations from doing walkabouts on the unit, is that this was a unit that was under significant pressure. This was a unit that had gaps in some of the medical rotas. This was a unit that had gaps in the nursing rotas and these were things that we were seeking to resolve.
So --
Q. Mr Chambers, I have listened courteously to

you making a speech. I am asking you about this document and what it says about the leadership. We have looked at the first paragraph.
In relation to some of the problems that are identified it is observed for example, do you agree, this is not uncommon on an LNU and there is a training issue that needs to be identified. But I am suggesting to you that when you take those two paragraphs collectively the thrust of what the RCPCH are saying is that this is a well led unit; do you agree?
A. I -- I think that's not an unreasonable --
Q. So well-led unit is what the RCPCH is saying.
Let's have a look at what else is said. Page 20. We can see that there is a recommendation, do you agree, to the Child Death Overview Panel about how they could improve their processes to improve patient safety; do you see that?
A. Yes.
Q. Page 22, we can see that there is a recommendation towards the bottom, both to NHS England and the network about how they can improve matters in order to promote patient safety; do you agree?
A. Yes, that was in relation to the transport services.
Q. Yes.

A. Yes.
Q. Over the page. Do we see that there is another set of recommendations, both between the network and Commissioners about improving patient safety? They are both highlighted for you.
A. Sorry, what was the question again?
Q. There are two recommendations to the network and to NHS England which are aimed at improving patient safety?
A. Correct.
Q. Let's go to page 24. We have the question that was within the Terms of Reference: are there any identifiable common factors or failings? And we can see that there is a paragraph to start with, 4.6.1, which states a number of facts, but is not in itself answering that question; do you agree?
A. Well, I'm not sure I do, actually.
Q. So --
A. The 4.6.2.
Q. I am not asking about 4.6.2, I am asking about 4.6.1 which I suggested to you contains a number of factual assertions which don't answer the question we will come to 4.6.2.
A. That's correct.
Q. 4.6.2. The first bullet point indicates that

staffing levels were inadequate. There is no analysis about whether or not those staffing levels were different before this issue arose, is there? It's a bare statement of the fact that the standards are not being met?
A. I think that's right, yes.
Q. To determine whether or not staffing factors were the cause of the increase in mortality, you would need, wouldn't you, to conduct an analysis about whether there had been a change because if the staffing factors were constant, that would tend to suggest that the staffing factors are not responsible for the increase; do you agree?
A. What we knew from the work that we had done before -- between the 29 June 2016 and the recommendation to the board on the -- was it 14 July, that we would downgrade the unit, we would move -- we would conduct a Royal College review. In those intervening periods we did some fairly high level work that looked at demand, acuity, birth rates, weights, staffing levels and the -- what we knew at that time is that the unit had seen a significant increase in activity, we knew at that time that the acuity had gone up.
These were not cause or explanatory but they were

just context. So I think, you know, if we -- if we know that and then we have a unit where the staffing levels are inadequate, that's a concern.

Q. I am not suggesting you shouldn't be concerned. We are looking for an answer to the question of what might explain the increase and there is no analysis here provided by the Royal College beyond the bare statement that that standard is not being met to identify how it might be that staffing levels at one point in time when there wasn't an increase were materially different to staffing levels at the time when there was an increase?

A. And I was saying that in that same time there had been a change in demand, acuity and complexity.

Q. Are the Royal College telling you that staffing levels are the explanation?

A. No.

Q. No.

A. And that is not what we read.

Q. Next potential explanation. There are concerns about transport not being timely enough. Now, that could only apply to babies who were transported off the unit, couldn't it?

A. That's correct.

Q. That particular concern. And that by no means

accounted for the increase in mortality, did it?

A. Well, I -- I don't know. But it's a factor.

Q. Well, did you conduct any analysis to work out of those babies who died, how many of them were transport babies and therefore how many would be explained by this concern?

A. So Jane Hawdon, when she did her review, she identified that there had been significant delays in -- in sepsis treatments and also in transport and transfer.

Q. I am looking at --

A. We also -- we also know, Mr De La Poer, that in the evidence given by one of the Registrars, and I can't point you to the INQ, but maybe somebody can, the evidence there was that this was one of our doctors that had worked in the unit as a trainee before 2015, worked in the unit 2015/2016 and then worked in the unit post, so 2018.

His evidence was that he saw babies that were being cared for on the neonatal unit, at this time, in 2015/2016 that he would have seen transferred out previous to this when he had worked there on his first placement. So these are just facts of -- and context.

Q. Mr Chambers, I have again listened courteously to you making a speech. I am asking you about what you knew at the time. Whatever the doctor has said now in

his evidence is not relevant to the decisions that you are making at the time on the information available to you then.

If we have a look at the third point, that is a recommendation, do you agree, about improving detection; it is not about what may have caused the increase, it is about improving detection, in other words explaining why an increase might occur; do you agree?

A. I think that's right.

Q. Similarly the fourth point is about improving detection, not explaining or pointing to anything that might be a cause; do you agree?

A. I think that's probably right as well.

Q. So does it come to this, and we have been through it in substantial detail: the Royal College did not provide you with an answer for why the mortality rate had increased?

A. Okay, can we refer back to my witness statement where I deal with this very point? I am struggling to find the actual paragraph number, if somebody can help me.

Q. Well, can I suggest, rather than us looking for that, that that is identified over lunch and we will come back to that?

LADY JUSTICE THIRLWALL: We will find it over the lunch time and then you will have it.

A. Okay, thank you.

MR DE LA POER: And you will have an opportunity to answer that. We will move forward in our timing.

We know, don't we, that the network contacted the hospital to say that they would like a copy of this report, that's correct?

A. I -- yes, I am assuming so yes.

Q. We can have a look, INQ0004299, and we can see page 2. We can see near the top:

"Network would like a copy of the review."

That's what's being said four lines down.

A. Okay.

Q. And we can also see towards the bottom:

"Duncan Nichol [his initials]: finish review (some unexplained but not unusual)"

So it seems to be an acknowledgement that there are four cases presumably from what Dr Hawdon has said which are unexplained, the ones that she recommended for further forensic review.

What was the expertise that was present in the room there to assert that some unexplained neonatal deaths were not unusual?

A. I -- I think the number that we were referring

to at this time was two, not four, and I'm pretty sure but you need to check with Mr Harvey tomorrow, that he asked the specific question of the Alder Hey pathologist how unusual is it to have unascertained causes of death and that would have been, I think, the origin to that point.

Q. Dr Hawdon had identified four unexplained and unascertained deaths?

A. Correct.

Q. Let's see what she said about that. INQ0003124. She was asked directly this question some time later. And she of course is a neonatologist, page 2.

A. Yes.

Q. So here she is talking about the broader review along the lines of the RCPCH, who was on duty, who was perhaps unattended with the babies, those sort of things. So she is giving some helpful pointers about what she meant.

"Many deaths were explained but some of these may have been prevented with different management. Completely unexplained on a neonatal unit is rare so by definition more than one unexplained death does arouse suspicion."

So when she's asked in April, that's what she says.

Should the Execs have gone back to her, bearing in mind she was the one saying that they were unexplained and unascertained to understand the potential significance of that?

A. I am -- I'm not sure there was a need to do that because at this time, this was April, middle of April 20 --

Q. When Dr Hawdon at the end of October told you that there were four unexplained and unascertained deaths we know what she would have said if she was asked because she was asked five months later and she said it was suspicious. My question to you is: should you have gone back to Dr Hawdon when she gave her report to ask: well, what is the potential significance of this?

A. It's difficult -- it's difficult to really answer that because at this -- at April 2017, Mr Harvey, the paediatricians, Nim Subhedar had already arrived at a position that said, whether the number was two, four, it became seven, eight ... that -- at that point it was clear we needed to work out what the best way to answer these questions that seemed to be left unanswered, that led to the meeting on 27 March which then led to the police being involved.

So I'm not sure why you feel that it would have been necessary to go back to Jane Hawdon at this

point --

Q. I am not suggesting at this point --

A. -- because the work -- the work was already being progressed.

Q. I am certainly it will have been my question. My suggestion was that in November, just after you had received her report, should you have gone back to ask her what the significance of her findings might be?

A. I -- I don't know that that discussion didn't happen. And if it did happen, it would have been with Ian and themselves. I am curious as to how the four babies that we have, that you are referring to here are the same who were -- where the conversations were taken and the investigation was taken to the pathologist at Alder Hey.

So I am -- I am not really clear what -- what -- what you are trying to -- what your proposition is.

Q. I have asked the question twice, I'll try once more.

I am suggesting that bearing in mind that Dr Hawdon said that four babies were unexplained and unascertained, the Executive Directors should have gone back to her, at that stage, and said to her: well, what is the suggested or potential significance of this; do you agree or disagree that that's what the Executive

directors should have done in November 2016?

A. Actually the work to try and understand the -- the unascertained causes of death in these four babies was progressing and being taken forward by the Alder Hey pathologist. Perhaps the conversation that has been played out in this email could have -- could have been played out sooner. I'm not sure it would have changed anything.

Q. If you had been told by a Consultant neonatologist that more than one unexplained death is suspicious, that wouldn't have immediately caused you to say: I think we have reached a threshold to go to the police, that is what you are saying when you are saying it wouldn't make a difference?

A. It's well, I -- I -- I hadn't seen these things so it's really difficult for me to make any -- any, any particular comment in -- in -- in the light of -- I can only comment on the matters that I was aware of at the time.

I was -- I was clear, we -- we knew that there was four babies whose deaths had been unascertained and that was what we were exploring with the Alder Hey pathologist. The -- whether that was, whether Ian had specifically asked the question around how unusual that was, I can't comment.

Q. We are going to --
A. But nothing -- nothing at all that was coming from the -- from Jane Hawdon's review and the pathology review was pointing to anything suspicious.
Q. Well, the amount of significance that can be ascribed to that is a matter of factual dispute because it depends on whether she knew about the concerns about Letby. But we are going to move on to the board meeting?
A. So can I respond to that, please?
Q. I --
A. It -- it's -- that is a fair challenge on -- in one respect but to be -- in the spirit of trying to keep an open mind it was not unreasonable to ask Dr Hawdon to do -- to do the review with just the case notes that she had rather than in -- in a sense leading her to a particular point.
We were hoping that these concerns would be -- would be -- would come out through the course of the review.
Q. We are now going to turn to the board meeting on 10 January. We are staying with the RCPCH so we are focusing on what's said there. INQ0003237 and we are going to the bottom of page 1, please.
Now, this is a meeting which, as we understand it,

the report was handed out to the people in the room at the start of the meeting. Does that accord with your recollection?
A. I -- I don't know.
Q. Well, let's see what Mr Harvey says about it. Right at the bottom we can see the sentence starts:
"The Review Team made ..."
"Over the page, please:
"... a number of recommendations although nothing immediate."
We have just looked at the fact that were six immediate recommendations, that was a false statement, wasn't it?
A. Sorry, what was a false statement?
Q. That the RCPCH made a number of recommendations, although nothing immediate?
A. I'm not sure I agree with, I think that's a fair statement.
Q. You don't -- you don't think that the RCPCH made any recommendations which are headed "Immediate recommendations"?
A. One recommendation was for the in-depth review to be commissioned which I would have seen as the immediate recommendation.
Q. Well, the first statement is nothing

immediate, but there were six immediate recommendations weren't there? Didn't you know this?
A. There were six recommendations. The -- whether they were it's -- it's -- it's important to understand when -- when you have reviews, like you have with the CQC, an immediate recommendation is one that you take action on that day, where there's an immediate patient safety risk. There was nothing in the Royal College review that I felt fell into that kind of category.
Q. So although there was a heading "Recommendations immediate" you didn't think that they were immediate recommendations?
A. It's -- it's -- it's -- I suppose it is a bit semantics. An immediate recommendation is one that requires immediate action where there is an immediate patient safety risk, it's almost one where -- where there are examples where the CQC come in, and they review -- they see something and they almost, you know, press the stop button.
I didn't read those recommendations in that way. But that isn't to suggest that they were not recommendations that needed to be dealt with promptly.
Q. In line 5:
"In one of the cases the cause of death is

unascertained which is not uncommon."
In fact, at this stage, Dr Hawdon had identified four unexplained and unascertained cases, hadn't she?
A. Sorry, where are we now?
Q. Five lines down, end of the line:
"In one of the cases the cause of death is unascertained which is not uncommon."
A. Okay.
Q. Dr Hawdon had identified four cases, hadn't she?
A. And the four, as I understand it here, were the ones that Ian is making reference to; that they were -- sorry, I will put my glasses back on:
"Alder Hey will undertake a review into these causes of death."
Q. And page 2, bottom of the first paragraph:
"The case reviews very much reinforce what is in the review. It comes down to issues of leadership, escalation, timely intervention and does not highlight any single individual."
Now, you have already agreed with me that the review does not suggest that there is a leadership problem. You said it was well led. That's what the take-away from the review is.
Why are the board being told that the review has

identified an issue of leadership?

A. The -- the review pointed to sometimes difficult relationships between the doctors and the nurses on the unit. It made references to delays in and fear around being able to seek support from Consultants out of hours; that was what was -- as I understand was a comment from some of the juniors.

So there were some -- there were some leadership challenges there. The -- but you didn't allow me to go back to my witness statement, which would have --

LADY JUSTICE THIRLWALL: No, you are going to be allowed to do that. It was just we didn't have time to find the page.

A. Yes, but it dealt, it sort of -- but it just sort of -- it captures this and that is that I don't believe that the Royal College answered all the questions that we had said and that is what is said in my witness statement.

But what it goes on to say is that -- but it was helpful and gradually moving us into a -- into the right direction.

MR DE LA POER: We don't need to look at every reference, unless you require it, but on three separate occasions the board are told that what it comes down to is, among other things, leadership in circumstances

where, as you have agreed with me what the report was saying was it was a well -- overall it was a well-led unit.

That's what -- the message that's being given to the board a number of times was that the Executives seeking to discredit the Consultants by misrepresenting --

A. No, no.

Q. -- what the report actually said?

A. No, I don't -- I don't believe it was. I mean it was just drawing out a range of -- of comments that had come from the Royal College review. Just at the start of this -- this -- this theme here you said that the -- the report was tabled at the start of this meeting.

Q. This is what we understand --

A. Is it this report or the Royal College report because my understanding is the Royal College report had been shared with the board in advance of this meeting?

Q. So your understanding -- that is what I was seeking to elicit your evidence --

A. Yes.

Q. -- that we have received evidence that it was tabled at this meeting. But it's your recollection that it was provided in advance?

A. Yes, I -- I -- yes. It was never our practice to -- it's very discourteous to do that sort of thing to the board. And it may be that we wouldn't have -- they may only have had it one or two days before and it's -- it's quite possible that this paper was tabled on the day. But again it wasn't our practice because it's, it's -- it's discourteous. People need time to read and reflect.

Q. So as you have raised it, at the meeting on 26 January where the Royal College report was spoken about but had not been provided to those present, would you put that in the category of discourteous?

A. I -- on reflection, I think it was wrong that we hadn't shared it before. We were very keen that we wanted to have a meeting to discuss the Royal College review, but also we were conscious that that we wanted to share the document, the Royal College review, with all internal and external partners, stakeholders, you know, at the same time, including the Families.

Q. So 3 February was when that report was published which meant that the Execs had had it since 28 November, you have already agreed that it contains a number of patient safety recommendations to external bodies who won't know anything about those until you release the report.

Do you agree that by delaying the publication of that report until the beginning of February, that patients were put at risk?

A. I don't think they were. The -- the -- the recommendations -- about things like the transport was well-known and well understood within the Neonatal Network and I don't think there was anything in the report that wouldn't have been familiar.

Q. Well, what about the fact that the doctors on the unit were not following the SUDiC process, which was one of the recommendations that was made? Didn't they all, all of them, need to know as soon as possible in case there was a Sudden and Unexpected Death and they failed to follow the right protocol?

A. I think that's fair. I and that perhaps was an oversight.

Q. Well, I am not going to go through it forensically. But the overall effect of not providing that report for the length of time that it was held by the Execs, do you agree, it put patients at risk, at unnecessary risk?

A. I don't think it put them under unnecessary risk. We had daily management arrangements in place. We knew what was going on in the unit and so we had good oversight. Patient safety was absolutely the focus.

Q. Part 5: your meetings with Letby.
You met with Letby on 22 December of 2016, a meeting attended by her parents as well, is that correct?
A. That is correct, yes.
Q. We are going to look at some of the things that you said.
A. Okay.
Q. INQ0003463. At the centre of the page in the middle of the large paragraph, this is you:
"The second point is the explanation that the only reasonable cause was mischievous behaviour, but we never accepted this ..."
Is that something that you said?
A. Possibly, and we never accepted it as the only reasonable explanation.
Q. Further down, at the end of that paragraph:
"Unsubstantiated claims were made that the only common link was that Lucy was on duty."
Do you agree that that is not an accurate characterisation of what the Consultants had told you?
A. What the Consultants told us at the time was circumstance and gut feeling and a circumstantial link with a member of staff, who seemed to be on duty more times than others. I think it broadly is the same.

Q. We've been through all of this. You have accepted that they gave their expert opinion to you about various aspects of what was happening on the unit and that that was the context for saying that: having tried to identify every other cause, we are left only with this, which is why we think it is a real possibility.
That was what they were saying?
A. Yes. And you're characterising the whole of the conversations that went on in June and July, including the board meeting that was had, that was a very open discussion, you're boiling that down to the very first meeting on 29 June. There were many, many meetings that happened after that that would have explored these concerns, these issues.
What, what -- the only thing we knew for certain, the only thing that we all agreed on at the time is that none of us really knew what was going on.
Q. Well --
A. None of us really knew what the causes of death were.
Q. We are not going to go over all of that again.
Let's look at page 2 in the centre. You say:
"We are within our rights to phone the police but we didn't believe it."

Did you say that?
A. I don't know if I said that, but I perhaps would have said something to that effect, that, we -- you know, clearly we were -- we could have phoned the police but on balance we wanted to try and understand what the other causes might be for the unexplained increase in mortality.
Q. The large paragraph, second part of it:
"We now want to work with you to make sure you transition safely and successfully back to the unit."
So you were telling Letby she was going back to the unit?
A. There was the grievance hearing as you know, there was the letter from Ann Weatherley that you know, and we can go to the letter from Ann Weatherley if you like, but in the recommendations from the grievance one of those recommendations was that subject to the completion of all the enquiries and subject to you not being, if you like, called out in -- from these enquiries the Trust should begin to explore your return to the unit and, and this was in effect a shorthand for that.
Q. You were telling her in that meeting she was going back, weren't you?
A. No. No.

Q. Isn't that what it means?
A. No, I don't -- I -- I -- I was saying that ...
This meeting is -- it's worth reminding ourselves what this meeting was about. This was a meeting following the grievance where there had been -- where the grievance had been upheld and the -- Letby's family it's fair to say were very upset and very angry about how they felt she had been treated unfairly by the Trust.
I'm prepared to accept that we had not been as open and honest with her at the time.
As you can see when you read the notes from this meeting Letby's father was very angry. He was making threats. He was making threats that would have just made an already difficult situation even worse by threatening GMC referrals for the doctors, he was threatening guns to my head and all sorts of things.
So what I was trying to do here, perhaps very clumsily -- and I suppose right at the start of this session, not this session, the first session, where you asked were there any reflections of where you maybe hadn't got things right, I think the handling of this meeting was probably one of those.
Q. My question was: isn't that what those words mean?

A. Say again, sorry?
Q. Isn't that what those words mean; that she is going back on the unit?
A. And the outcome of the grievance was clear about that, subject to the caveats that I outlined.
Q. Page 4, one-third of the way down. A comment made by Mr Harvey, which we will need to have to give context to what's said later. A third of the way down, the second sentence:
"Part of this sharing is us as an organisation drawing a line. Anyone steps over that, full disciplinary policy may be used."
So what Letby is being told in this meeting is now the report has been shared, a line is being drawn and if anybody continues to talk about this, disciplinary process.
A. No.
Q. Isn't that what that means?
A. No, not at all. The, the reference to and there's lots of references to lines being drawn and consequences and so on. But in truth what that related to, the -- was the matters of the grievance and the matters of the grievance were two-fold really: there was the way that the Trust had handled her redeployment and the lack of honesty and transparency around that and

that was why I had been asked to meet with her and her family to apologise. Normally I would never have been in a meeting like this.
The second was in relation to areas where there had been allegations of derogatory language and so on, where -- you know, fell below the values of the organisation. So the line being drawn was on the matters of the grievance, not on the matters of the investigations into unexplained increases in mortality.
Q. Two-thirds of the way down, you:
"We had unexpected deaths. We have received an explanation by expert reviews."
You had not, in fact, received an explanation --
A. No.
Q. -- had you?
A. Again, as I said, when I reflected at the start of this session this was one area if I'd have -- if I'd have -- I perhaps should have called out where I didn't get the communications right.
And the reason for this was not in any way to trivialise, was not in any way to, to be anything other than trying to take the heat out of what was increasingly a difficult relationship with her father, particularly. And we have heard evidence from Sue Hodkinson yesterday about some of -- how threatening

that became for Kathryn de Berger.
Q. Page 6, one-third of the way down. You:
"Your resilience, Lucy, you astound me."
A. Yes.
Q. Did you --
A. I say, I say it twice.
Q. Yes. Have you ever made such a statement in relation to the Consultants for the bravery that they showed when trying to speak out to keep babies safe?
A. Yes, in many of the meetings that took place in June, July 2016. If you look at the notes all of the meeting notes at the end make a reference to thanking everybody for their contributions, thanking everybody for their open and candid contributions to the discussions and a very clear statement about: These matters are really difficult, let's take care and look after each other.
Q. It was specifically about the courage that they had shown?
A. Yes.
Q. Page 6, halfway down, bottom of the big paragraph:
"Our commitment is now to meet with the Consultants to get you back on the unit and meet with you again in the future."

A. Yes.
Q. You were giving her a commitment that she was going back on the unit, weren't you?
A. I was -- I was -- as I have said, the handling of this meeting was perhaps not as good as it could be. But the spirit of the grievance, outcome of the grievance was that subject to all of the things I'd already explained being completed that you should be returned to the unit. So it was in the spirit of that.
Q. Did you give them a commitment at the meeting?
A. Say again, sorry?
Q. Did you give them a commitment at the meeting that she would be back on the unit?
A. I gave them a commitment, I suppose, at the meeting that we would take forward the recommendations from the grievance process.
Q. Well, what the words say is: your commitment now to meet with the consultants "... get you back on the unit." That is a commitment to get her back?
A. And, and -- and that, you know, again at that time we hadn't completed everything. I was not able to give that commitment. But it was necessary -- it was, it was in the spirit of the, the letter of the grievance that said subject to satisfactory completion of all the reviews, and you not being called out.

So it was, it was consistent with that.

Q. Given what you have said, my Lady, I wonder if I can do one very short document following this because it's relevant to the answer which we have been given. I note the time, but it will sit better here than at the start of the next session, if that's possible.

LADY JUSTICE THIRLWALL: Yes, all right.

MR DE LA POER: The meeting on 30 December 2016. INQ0004299, page 2. This is a meeting of the directors, the Executive directors and we can see one-third of the way down:

"Difficult meeting with Lucy and family. Commitment to them at the meeting."

So you there appear to be talking in terms about the fact that you were aware that you had made a commitment and you go on to say, according to the record:

"Exposed in the meeting somewhat."

So you appear to be recognising, do you agree, that just a few days later, you had made her a commitment?

A. I think the commitment to them in the meeting was that we would share with the board the letter of her statement that she had shared with us at that meeting and I think that was the relation, that was in respect of the commitment.

At that point you indicated that you had dealt with the matter in your witness statement and would like to refer to it. So the first question is have you had a chance over lunch to look through your witness statement?

A. I -- I have. We don't need to draw it out now. We can bring it out in written evidence if that's helpful or ...

Q. Well, is there -- in terms of the question that I have asked you, and suggested to you that what it came to was that the RCPCH report did not provide an answer for the increase in neonatal mortality, having had a chance to refresh your memory from your statement, is that a question that you can agree with or disagree with?

A. I'll read 355 of my witness statement. It is just a short paragraph and that hopefully will resolve the issue.

Q. If you just pause for one moment. 355?

A. 355.

Q. Do you have a page reference for that?

A. It's page 101.

Q. Thank you very much indeed, yes.

A. Is that okay?

LADY JUSTICE THIRLWALL: Yes, go ahead.

MR DE LA POER: My Lady, would that now be a convenient moment.

LADY JUSTICE THIRLWALL: Yes, certainly.

Mr Chambers, somebody has been working hard downstairs to find the paragraph references for you and we think they are between paragraphs 350 and 356 and 355 in particular. So you can look at that.

A. Sorry, 315?

LADY JUSTICE THIRLWALL: Between 3-5-0 and 356, 355 being the relevant one. I'm not going to ask you about it now, but you will have a chance to look at it over the break and we can come back to that at a convenient moment this afternoon.

A. I'm so grateful. Thank you.

LADY JUSTICE THIRLWALL: So we will start again at 5 past 2.

(1.08 pm)

(The luncheon adjournment)

(2.04 pm)

LADY JUSTICE THIRLWALL: Mr De La Poer.

MR DE LA POER: Mr Chambers, in the morning session just before lunch, I asked you a question. My question, we have looked back on the transcript, was this: does it come to this the RCPCH report did not provide an answer to the increase -- for the increase in mortality?

A. Oh, thank you. So:

"I was conscious that given the issues identified within the leadership of the unit, including in relation to not following incident reporting processes and not having suitable processes in place to ensure timely escalation, the report was going to be a difficult read for Dr Brearey and Dr Jayaram. I was also mindful of the comments in the report about the Consultants' allegations being based on a 'gut feeling' and that the RCPCH had not alluded to any further evidence of wrongdoing on the part of Letby or any other [members of] staff ..."

So:

"At the time I did not feel that the RCPCH Review had addressed all the concerns but I did feel that we were moving towards a position where we had a better understanding of all the factors which may have contributed. I felt it was positive that with the Consultants' assistance we could start to address the issues highlighted to us."

Q. Thank you. We no doubt will come back to the RCPCH shortly. But we were dealing with the topic of your meetings with Letby and we had dealt with your meeting in December.

There is also a meeting on 6 February of 2017 and

the INQ for that is INQ0014279. We are just going to pick out some of the things that Letby was saying in the first instance. Do you see towards the bottom that a conversation begins about who the apology is going to be from?

A. Yes.

Q. If we go over the page, we will see what Letby then says:

"I expect four apologies."

Now, did you feel in this meeting that Letby was trying to take control of what was going on?

A. I think that was an attempt on her -- on her behalf, yes, I think she was. There's no doubt she felt incredibly aggrieved and perhaps this was her moment to have the -- her matters of grievance properly aired.

So I think there was an element where -- where that may have been the case.

Q. Of course if we now bring hindsight into it, which you didn't have at the time --

A. Yes.

Q. -- she is sitting there knowing the crimes that she had committed?

A. Yes, correct.

Q. Would you agree, as someone who was present at the meeting, that that was deeply manipulative

behaviour, using the benefit of hindsight?

A. Yes, I -- I have to say I didn't feel like I was being manipulated at the time. In the benefit of hindsight, it's fair to say I have never really reflected on it in that way.

I -- I -- I really don't know. It was her father that seemed to be pulling the strings as opposed to Letby herself.

Q. Well, we will come back to what Letby is saying about apologies in a moment just to work through it in order. If we just go to page 3, just to deal with something that you say.

In the large paragraph towards the top, what you are recorded as saying is:

"We have made it clear we support the nursing medical team."

Now, just so that we are clear about that, are you talking about both the nursing team and the team of doctors when you say that?

A. Yes, yes.

Q. Then you say this:

"All support your transition back."

Now was it true that the medical team supported her transition back?

A. It's true that we had had a conversation with

them at the meeting earlier in January. It was true that we had shared with them the -- the outcomes of the board meeting that there had been earlier that month and it was true, as far as I was aware at that point, that they -- after those, after the meeting with the Consultants they were, I was I wouldn't say comfortable, is -- is -- is the right word but they recognised that an apology letter was something that would be helpful.

They had been guided by Dr Tighe, I think, in terms of -- in terms of -- well, if that takes the way of any perceived threat of a GMC, let's just do it.

So I think -- and in terms of the transition back to the unit, we -- we -- we hadn't got into any specific planning about that.

Q. If we just have a look -- my question was: was it true to the doctors supported her transition back?

A. Yes, I -- I think in -- in truth that's definitely an overstatement of the position.

Q. Now, let's return to Letby's behaviour in this.

We can see after Mr Harvey makes an assertion in the middle in relation to Dr Brearey and Dr Jayaram, Letby raises Dr V and Dr McCormack?

A. Yes.

Q. Now, Dr McCormack hadn't participated in the

grievance process. Again, did you think that looking back on it that this is her seeking to manipulate and control the situation?

A. I again didn't view it that way. I hadn't seen all of the detail of the grievance. It was not appropriate that I should. All I had had was the grievance outcome letter from Ann Weatherley, so I had no reason at this time to doubt that Dr McCormack had been involved in some way in the grievance and I -- had I have known, I would have challenged that statement.

Q. Well, you see, what you do in fact say, five lines up from the bottom, the last sentence is, you tell Letby:

"We will get an apology from Jim."

That's Dr Jim McCormack. So what you are telling Letby, after she said "well, I want an apology from Dr McCormack" is that you will get one for her?

A. Well, that's how it's written here. I -- in truth there would have been a conversation with Jim about how he felt about offering an apology.

I don't think the note as it's written there it, it would have been quite so blunt. And I do know that Ian did speak to Mr McCormack and he did write a fairly neutral apology note.

Q. Bearing in mind that you didn't even know what

it was that Dr McCormack had done?
A. In truth, I didn't know the specifics of what any of the Consultants had done.
Q. No, but in those circumstances, should you not have been saying: well, I will find out more about Dr McCormack and we will see whether it's appropriate for him to apologise as opposed to, however it was expressed, the sentiment is "We will get Dr McCormack to apologise to you"?
A. Yes. And I don't want to repeat, but I've already conceded that this is a point that I know I didn't get right.
Q. If we go to page 5, the bottom third of the page, we can see that there is a discussion here about Letby not wanting anything on her record. Again, just at the time, was this something that you -- that struck you as being her inappropriately trying to control the situation, or did you think that this was normal and appropriate?
A. To be honest, I -- any -- any nurse that would have been through some process like this, where they had been removed or there had been some sort of action, it would not at all be unreasonable for them to want to be clear what this would have meant in terms of their personnel record. So I didn't necessarily see anything

particularly problematic there.
Q. You see, what you say ahead of that is at the top, you are talking about the reviews with lots of learning for everyone and you say: it's only vindicated you. That's what's recorded there.
A. Well --
Q. So --
A. -- only in so much as the grievance hearings had been upheld and so far the reviews that we had had hadn't pointed to any -- any unnatural causes.
Q. Well, the RCPCH had said that they could not investigate whether Letby was responsible, didn't they?
A. The RCPCH as I said provided reassurance as to part of the question and moving us into -- into a place where we had a better understanding. But I would never argue that it had given us all the understanding. That's just Jane Hawdon and the other reviews had been undertaken.
Q. As a matter of ordinary language the RCPCH report did not vindicate Letby because it didn't investigate her?
A. No, it didn't investigate her, correct.
Q. Dr Hawdon did not vindicate Letby because it did not investigate Letby?
A. In so much -- it didn't vindicate her, but it

also didn't point at any unnatural causes.
Q. Well, I am just inviting you to consider the possibility, because there is a difference between the two as you have accepted --
A. Yes, I.
Q. -- that perhaps in your mind at the time you were taking the approach that she had been vindicated --
A. No --
Q. -- when in fact that was not the case?
A. No, I mean, in my mind I was very clear what the process was, what the grievance was and what the investigations were. I was also -- as I've I think on three occasions now recognised that in handling these meetings with Letby, I was very conscious to try as much as possible to avoid further escalation from -- particularly from her father. Her father wasn't at this meeting, but you got a sense of his presence.
Q. Does your wish to avoid escalation involve you being prepared to say things which weren't correct?
A. That were in -- in effect a misinterpretation of the outcome of the grievance and what Hawdon review, et cetera, had arrived at in terms of identifying unnatural causes, so only natural causes for death.
Q. Go to page 6, at the top. You said that the previous record about "we will get an apology from Jim"

may have been not an accurate transcription of what you said. We can see here:
"We will get an apology from all."
A. Yes.
Q. Do you think that is something that you said to Letby; that you would get an apology from everybody who --
A. Well, I think it -- I think earlier in the meeting I think that was already a position that had been agreed upon.
Q. Well, wasn't it a matter for the Consultants whether they wished to apologise?
A. I think the -- I don't -- I don't know how we had moved from individual apologies to an apology for all.
I can only assume that was something that had been done through a conversation with Ian Harvey and the Consultants themselves. It felt to be a less -- I don't know, less personal.
Q. Page 7, the fourth to last entry. Last sentence:
"Lucy, don't worry, we have got your back."
A. Yes. Clumsy language. The -- it is -- I have said all along the -- the intention here was to avoid any possible escalation and eight years on with what we

know and we look at this, these are the kind of things that you know you didn't get right.

Q. If it was an attempt by Letby to take control and get what she wanted, to go on the offensive, she succeeded in recruiting you to that; do you agree?

A. No, I don't think so at all. I think she'd -- my -- my take on all of this is the only thing that Letby wanted was something that acknowledged that she had been treated unfairly and she sought no other redress that I was aware of, other than at some point, subject to all of the plans and processes, to get back to her job that she really loved.

Q. My next topic is the CQC. It will be a brief one.

There was a meeting on 17 February 2017 which you attended with the CQC, do you know the one that I am speaking about?

A. I think so, yes.

Q. Again we can put it up on screen --

A. Yes.

Q. -- if we need to. In fact, if you would like me to do that, we will. INQ0014405.

Now, what is said about the neonatal services appears there on that first page and it's more what isn't there, Mr Chambers, rather than what is, that

I want to ask you about. So just remind yourself of what was said.

(Pause)

A. Okay.

Q. The context -- we will look at the detail of this letter -- was that on 10 February the Consultants had written to you and in that letter they had made some observations to you about Dr Hawdon's report, for example, and the fact that she thought there were four cases that required review and they had made it very clear in this a letter, as we will come to, that they were worried about patient safety.

Now, that isn't what they had identified in Dr Hawdon's report as being an outstanding enquiry and the fact that they were just a few days earlier to this meeting saying that they were still very concerned, notwithstanding the outcome of the reports. Neither of those things appear to have been reported to the CQC.

My question is: firstly, were they reported to the CQC?

A. Well, the concerns raised by the Consultants around increased mortality, unexpected collapses, the CQC, were -- were absolutely aware of at this time.

The relationship between a single member of staff and the -- who appeared to be rota'd on shift more than

any other -- I don't know whether that had been shared with the CQC at this time. And it -- it kind of goes to the point really that Sir Robert Francis made in -- in his evidence, you know, in respect of this very difficult balance between the duty of candour to whoever -- whether that's the family or to or external partners, regulators and so on, and the duty of care to an individual and that's a very difficult balance to tread.

So this note I think was -- was an attempt to tread that balance.

In terms of the updates as to where we were in terms of the completion of trying to -- the investigations into the causes of the increased mortality, we were very -- we were very early in those conversations with -- with -- with -- with the -- with the doctors.

I am aware of the letter that you are referring to. I am also aware of the conversations that Mr Harvey had with them and the network colleagues following those meetings.

So it isn't reflected in this note, but I don't feel that well it's not reflected in the note.

Q. Should they, the CQC, have been told that Dr Hawdon had four cases that were identified as outstanding, which you were in discussion with the

Consultants about further investigation?

A. I'm pretty sure -- whilst I don't remember the specifics of the, of the meeting, I can see no reason at all why we wouldn't have shared with the CQC the outcome of Jane Hawdon's review. I -- and that there were four cases that that we were unascertained, unexplained and that we were seeking, and had sought, help from the Alder Hey pathologist.

I can see nothing problematic about sharing that with the CQC and -- and we may well have done.

Q. So this is right then, based on what you have told us no good reason not to say that, no record of it being said?

A. Yes, I think that's right.

Q. Thank you, we can take that down.

My next topic is Dr Jayaram's disclosure on 16 March, in fact it was 15 March, discussed at a meeting on 16 March?

A. Yes.

Q. And in summary -- we can look at the detail of the note, but in fact I am going to ask more general questions than that. In summary you were told by Sue Hodkinson that Dr Jayaram in a meeting with her the day before had disclosed three particular cases and the note of that meeting refers to one involving a valve?

A. Yes.
Q. And the reaction in the notes included Alison Kelly saying "Why now serious allegation?" And you saying "Letby can't go back on to the unit now" and Alison Kelly saying "challenge why not?"
So that's the disclosure and we have received evidence about that?
A. Yes.
Q. What you say in your witness statement is that you regarded that as being a very serious matter?
A. (Nods)
Q. And that you went to speak to Dr Jayaram about it?
A. Yes.
Q. So what is important for us to understand is, did you establish from Dr Jayaram, in that meeting that you had with him as a result of this, what his concerns were and why he had raised those three cases?
A. Yes.
Q. So tell us, please, about that meeting with Dr Jayaram?
A. Okay. It's -- it was a very short meeting. I -- we'd not if you like formally tried to diary a meeting. I had been made aware of these matters at our weekly Executive Directors Group, which on that time

fortuitously was the day after, so it was the 16th.
Immediately after that meeting, I said to Sue: well, let's just go and see -- let's see if -- if Dr Jayaram and/or Dr Brearey are available to have a chat. We -- I don't remember Dr Brearey being around but I do remember briefly having a conversation with Ravi in his office.
He seemed surprised. In his notes to the -- the notes that he did to Facere Melius he -- he makes a short reference to this meeting. The conversation that we had at the time was there was this -- there was a range of things that, that Sue Hodkinson had said.
She talked about these -- this news about the conduct of -- potentially the conduct of Lucy in respect of Baby K and -- but also that he was demonstrating, you know, real high levels of anxiety and not surprising really given all that was going on.
So there was -- there was two bits to the conversation, really, was, you know, just -- just Ravi, tell me, is, you know, is there anything I need to know, any news of that sort? I wasn't very specific in the question I wanted it to keep it quite open but also, more importantly, how are you? How are you feeling?
And aware that we had exchanged letters and that he -- he'd had ongoing concerns around how these matters

were being managed and resolved and where we left it, rather than getting into a very detailed conversation, because we just -- he didn't have the time and -- and is that led to the meeting on 27 March.
So just to be clear, the 27 March meeting, there was two, if you like, reasons as to why -- why that meeting happened, one was to get to the bottom of the -- of the -- the matters of trying to explain the causes, but also to pick up with Ravi these, these concerns.
At that meeting on the 27th, I very deliberately asked the question: are we now saying is there criminality? Leaving a very open question for him to provide an update to what he had seen and heard in what was a safe environment because there was the network there, there was Sue there, there was Steve Brearey there.
He -- he didn't share that with us again. So that's the chronology of that.
Q. So you never asked him directly about what he had said to Sue Hodkinson to get to the bottom --
A. I didn't.
Q. -- of what he said?
A. On -- on the day after we didn't have, specifically have the opportunity to do that. It -- it felt very rushed, it was a two-minute thing and I -- to

this day I can't remember why it was an only two-minute thing, but it was. But I knew we would have the opportunity to pick this up very soon at a -- at a meeting that was already in train to -- to get to a position of what the absolute next steps would be, which were the police.
Q. So you never asked him directly about the three cases that he had told Sue Hodkinson --
A. I don't -- I don't recall asking him directly.
I maybe asked him implicitly rather than explicitly.
Q. Well, he had clearly, as Sue Hodkinson had told you, felt a great deal of reticence about talking about that because what Sue Hodkinson talks about is the fact that he was feeling victimised and bullied and so surely if you wanted to get to the bottom of what he was saying in those circumstances, you needed to go to him in an open and collaborative way and say: I've heard about these three cases, sounds like eye witness evidence. I understand it's been difficult for you to come forward about this. It's very important you tell us about this because that will help us.
Wasn't that what you needed to do?
A. I suppose, yes, we -- we could have I could have gone about it in that way. But I also was aware

that he had expressed to Sue that he felt that -- perhaps intimidated is too strong a word but he had, he -- I didn't want to put him into a position that he felt that he was being in any way coerced or I just wanted to give him a safe environment to share his concerns --

Q. You see --

A. -- in an open way.

Q. We don't see at any subsequent meeting that we have been able to identify of the Executive Directors where this topic is brought up again for you to report back --

A. Yes.

Q. -- to the meeting, that is not recorded anywhere, do you agree?

A. I -- I too have looked to see where -- the meeting notes were reflecting that, but what I do know is that the matter was very much going to be picked up through the meeting scheduled for the 27 March.

Q. When Simon Medland was briefed, he wasn't told about that information that had come from Dr Jayaram, was he?

A. I -- yes, I -- I wasn't specifically directly involved in the briefing of Simon Medland. I was -- the briefing with Simon Medland seemed to be more of

a Stephen Cross issue, although I had met Simon prior to the board meeting.

Q. You had a meeting with him on 4 April?

A. I think so, yes.

Q. And you didn't raise it there to say: one of the Consultants has raised the fact that he may have eye witness evidence?

A. Yes, and that's right. We had had the meeting on 27 March which led to Simon Medland coming in. There had been a specific question that I had asked and it's in the notes of 27 March, the question was along the lines: are we now saying that this is criminal behaviour or criminality? Leaving it very open for -- for -- for Dr Jayaram to say, yes, I have, I've witnessed it and that's not what he said.

He said it's -- the honest answer is we don't know, is what he said.

Q. So what he told Sue Hodkinson you didn't believe was eye witness evidence or you thought it was eye witness evidence that --

A. I -- I -- I took it on face value as to what it was.

Q. So eye witness evidence?

A. Yes, but it was not, when it was tested with, with Dr Jayaram, he -- he didn't -- he didn't mention it

again.

When he was at the CDOP meeting it wasn't raised there. When he wrote the best points that he shared with the police, it wasn't referenced there.

Q. Speaking of the police, when you were given the opportunity to put the case at its highest, and we have looked at this already, but we haven't dealt with this point and you said there was no evidence, in fact you tell us now that you had heard and considered that the possibility of eye witness evidence but you didn't tell the police that, why not?

A. What -- to be honest I don't know what we heard. What -- what we -- what we heard was that I think I remember -- I think this is how Sue Hodkinson was, you know ... suggested that the dials on a -- on a ventilator had been moved but wasn't clear about that and -- and there was a baby -- "desaturating" I think was the phrase or something like that, and Letby didn't appear to be doing anything.

So it didn't -- it didn't, you know, it -- it -- he had given -- he had been given many opportunities, many opportunities from that meeting on 15 April -- was it April?

Q. It was March.

A. March, yes, from 15 March through to 17 April,

when he had the first -- when he had the feeling with CDOP, to have raised that. Surely if not raised with me it would have been raised with Nigel Wenham and it wasn't.

Q. My final question about this bearing in mind that you have raised that you weren't sure what you heard, what we can be sure about from the note, though, was that you took it so seriously or you thought it was so serious was that your immediate reaction was: Letby cannot go back on the ward?

A. Yes.

Q. So plainly it was highly relevant, whatever it was, to your thinking?

A. I -- I think, I think it just -- there was -- at that time, as we know, there was letters being exchanged between -- between the Consultants and myself, there were ongoing meetings that Ian Harvey was having with the Consultants in respect of trying to finally get to the position on the causes and the -- and the -- if you like, there was -- there was one view that from Hawdon that and McPartland that said we had arrived at an explanation that was not -- and it was only two unascertained.

The Consultants themselves had a different view and were struggling to accept the opinions of the

pathologist which is fine because these things happen.
So we had all of that. The -- the letters exchanging and also this -- this belief that these matters hadn't been fully resolved and needed to be fully resolved and then there was these, these -- the -- the observations that Sue had made based on her conversation with Ravi the day before.
That together to me just felt: that's it, we can't return Letby to the unit.
I didn't know what we were going to do with Letby at all because still it was -- it -- it -- we needed, we needed help in terms of resolving that but what was clear in my mind, as it was absolutely clear in my mind way back in June 2016, adamant that she had to be removed from the unit, so my position at that, you know to that extent had moved from the recommendations from the grievance.
Q. I am going to turn now to a board meeting that we have already looked at, but we are going to focus on a different part, INQ0003237, this is the meeting on 10 January. If we go to page 2, the second paragraph, this is what is being said. You have reviewed four cases from Alder Hey and then if you just look down to three lines up from the bottom, what you are telling the board on 10 January:

"There was an unsubstantiated explanation that there was a causal link to an individual. This is not the case and the issues were around leadership and timely clinical interventions."
A. Yes.
Q. So you are telling the board, in terms, that it was not the case that Letby had caused those deaths?
A. What I was telling the board was that the investigations that we had done to that point had not -- in fact were seeming to be pointing away from deliberate harm and more towards natural or explanation -- in natural causes of death and suggestions from particularly from -- and more, more explicitly from Jane Hawdon that at least in 13 of these babies there had been evidence of sub optimal care and in many, significant sub optimal care.
Her view was the -- that would have -- had these been different the outcomes would have been different and that is what we were being told. Not that there was a -- somebody deliberately harming.
Q. Look at what you say. "This is not the case".
That is you telling the board it is not the case that Letby is responsible for the increase in deaths because the run-up to that is there was an unsubstantiated explanation that there was a causal

link to an individual and you are asserting that isn't the case.
A. And what I said to you in answer to that is consistent with that note.
Q. Well, you have said that the reports were pointing away from it as you read them but they were not saying any of them, Letby is not responsible for any of these deaths?
A. Yes, but what they were not saying as well, what they were also not saying is that there was any evidence of deliberate harm.
Q. Well, the RCPCH as we have been over already said that they weren't looking for that, they were doing a service review?
A. Correct.
Q. So that is entirely irrelevant.
Dr Hawdon, you appear to -- in a previous answer accepted the possibility that she didn't know that she was looking for harm and all she did was look through case notes.
So that was incapable of itself of disproving that Letby was causing harm, so --
A. The -- I -- I struggle, I can see there that there can be a legal set of arguments here. But the -- in my mind at this time, everything that we were being

told by independent experts, independent neonatology experts, not paediatricians who have an interest in neonatology, but independent neonatology experts was that there was no evidence of deliberate harm.
Q. None of them said: there is no evidence of deliberate harm because they don't, any of them, deal with the question of whether there was deliberate harm?
A. What they said is there was no evidence of -- I -- I -- we would need to go and look at the INQ just to find out exactly what the phrasing was. But my understanding of what I was hearing and being told and reading was that there was nothing pointing to unnatural causes.
Q. Mr Chambers, do you allow for the possibility that you just misunderstood what the reports were saying?
A. I don't -- I don't think that's -- I don't think that's fair. What I know on reflection would have been something that we perhaps should have done is to have got Jane Hawdon, Dr McPartland and the paediatricians together to thrash this out and we were not able to do that and to be honest, I'm not sure there was an attempt to do that.
The requirement to try and get these matters resolved competently and quickly meant that in the

pre-Covid world, when we didn't have Teams meetings and all of those kind of things, getting such a meeting together face to face, would have been very, very tricky. That would have been the best way that we could have managed in terms of thrashing this -- these matters out.

But that isn't to suggest there was not an attempt to try and get to the bottom of the lack of consensus, if you were, around what Hawdon was saying and what the McPartland was saying and what our Consultants were thinking and then what they were saying to Ian Harvey, with Nim in the period of time from June -- sorry, from January 2017 onwards.

This is something that you might want to check with Ian. I -- I haven't got the absolute detail.

Q. What is undoubtedly the case is that as at 10 January, what Dr Hawdon's report did or didn't mean, what the RCPCH's report did or didn't mean, what Dr McPartland's report did or didn't mean was not the subject of consultation with the experts in the hospital, the paediatricians, was it?

A. We -- we had been listening to the independent experts. We were not -- not listening to our own paediatricians in the hospital. In hindsight, it would have been far better to have got those people together

in a room.

Q. Before the board received it, so that the board could have the balanced --

A. I -- again it would have -- it would have ideally, yes. But in -- in reality that was not possible.

Q. It was not possible to provide the Hawdon report and the RCPCH report to the Consultant paediatricians before 10 January?

A. No ideally, yes.

Q. That was possible?

A. Yes, of course, apologies, I had misunderstood your question.

Q. Of course, the board having been told that this is not the case, that there is a causal link, they then went on to approve what was proposed to them, that Letby would go back on the unit?

A. Yes.

Q. Now, had the Consultants come together -- sorry, the Executives come together before this to sequence how it was all going to work, what the board were going to say, what was going to be said to the Consultant paediatricians, all of that sort of thing?

A. Not really. There was a meeting early in the New Year, or in fact it may have been between Christmas

and New Year.

Q. Shall we have a look at it?

A. Yes.

Q. INQ0004299, this is the meeting on 30 December, page 3. So you can perhaps help us with -- so two-thirds of the way down, against your initials:

"Sequence: Lucy meeting. Board meeting, 10 January, formal acceptance of the review and action plan. Reserve its position on Level 1 or Level 2. Endorse transition of Lucy back to the unit."

Then the next bullet in the sequence:

"Then meeting with the paediatric Consultants."

Were the board told what you said to them about "There was an unsubstantiated explanation, there was no causal link to an individual, this is not the case" in order to procure their agreement to your plan?

A. No, not at all.

I think what we presented to the board was -- was our best understanding of the position we found ourselves in at the time. The -- we would never mislead the board, ever mislead the board.

And Duncan Nichol was at this meeting, he was fully aware of the discussions that were ongoing. I would have taken guidance by him and, you know, the arrows there down on the right-hand side of the page, you know,

all that represents is a sequence of meetings that would need to be arranged and established and also an outline of what the purpose of those meetings would be. These aren't decisions.

Q. We are going to move to the question of the management of the Consultants over the timeline, draw your attention to some events within it.

You can take that down.

The start of this is on 20 July, a meeting, INQ0004330. So just have a look here. There's a discussion about the dashboard and then about six lines down:

"TC reluctant to change leadership at present with review in August."

So was there a discussion in July of 2016 about changing the leadership of either the paediatric department or the neonatal unit?

A. It looks like there must have been. I don't remember a discussion about it and as you can see I wouldn't have supported any changes at this point. So I -- I can say no more than that.

Q. It may be that your lack of recollection means you can't answer this question, but what justification was there in July 2016 or potential justification that would lead to a conversation about it about replacing

either Dr Brearey or Dr Jayaram?

A. I -- again -- I -- I am struggling to identify any specific issue that would have -- would have required that kind of a conversation. There were, there were -- as we know there had been lack of compliance to Datix reporting, but that had improved.

I think it's fair to say at this time the clinicians were -- were not really happy with the downgrading of the unit. They took that quite personally and they saw it as a criticism and when we were doing the weekly monitoring and the dashboard, there had been times where I was made aware that people were pushing really hard against the criteria that had been agreed to try and admit babies that were not compliant with that criteria.

So those are the things that may have been going through people's minds. But I didn't believe that any of that was any particular reason why we would need to change reason -- leadership, and why would we?

Q. Well, it would appear that at least somebody in that meeting thought it appropriate to discuss that?

A. I -- I -- I genuinely don't know. I mean, these are Stephen Cross's notes, aren't they, and quite often with Stephen Cross's notes there are things that seem to pop in them that seem to come from left field

and when I read them I think, I -- I don't recognise that. And this is perhaps -- perhaps one of those. And now he -- and I know it's difficult because we can't -- Stephen isn't going to give evidence but he may have given some insight into that.

Q. 20 September 2016, an email that Dr Jayaram sent, INQ0003133. We'll look on page 2, please. So it's a very long email, but just to gather the sense of what he is saying here, three lines down at the top:

"We do genuinely feel that many decisions regarding our service are being made with no input from us and when communicated and presented to us as a fait accompli ... Hospital at Home, Babygrow ... the 9th post ... feedback from the RCPCH Review ... and the effect of all this I have a group of colleagues who do not feel that they are listened to or valued by the Trust and consequently fear that our relationship with the senior management is breaking down. Morale amongst us is exponentially decreasing."

So Dr Jayaram is raising with you his concern about the relationship between senior management and the Consultants in this email and in particular things being presented as a fait accompli?

A. Mmm.

Q. Now, we are going to come now to the meeting

on 26 January.

A. Do we not want to talk about this?

Q. Well, I am going to ask you about the meeting of 26 January, is there something --

A. Well, there is context to this letter that's probably important.

Q. Well, if you think so, then tell us.

A. Okay. So in the letter and in the note there it makes reference to additional Consultant recruitment. It also makes reference to the -- the Babygrow, Hospital at Home and it's worth just -- just recognising this. I met with the Consultants after this letter or maybe this letter came from the meeting I had with them, I can't --

LADY JUSTICE THIRLWALL: It starts off:

"Thank you for finding the time to come to meet with us yesterday."

So that sounds as though they had met you the previous day, doesn't it?

A. Say again, sorry?

LADY JUSTICE THIRLWALL: It says:

"Thank you for finding the time to come to meet with us yesterday."

A. Yes, thank you.

So one of the things you find as Chief Exec

unfortunately is that you -- you find yourself apologising for all sorts of things that other people had done that you knew nothing about and this was one of those examples. So in terms of in terms of -- the -- the Hospital at Home service, this was a change that the CCG were implementing that was making -- that was not popular with the Consultants but it wasn't -- but again I had to respond to it and supported them in making representations to the CCG that these plans were perhaps not sensible.

In terms of the Babygrow appeal this was an appeal that I launched within the first few weeks of joining the Trust as the Chief Executive. It was very obvious that our neonatal unit needed to be replaced. It was old, it was small, it was dark. The Babygrow appeal was a charity that had been set up and by this time had been running for a number of years. We were hoping to achieve a 3 million target to be able to rebuild the -- the neonatal unit.

I walked into this meeting to be -- to be greeted with a group of Consultants who were really quite angry because they had met with I think our Director of Estates the day or two before saying that he had been requested to work out what the possibility of a new neonatal unit would be rather than a build, it would be

a refurb because the Babygrow appeal wasn't achieving the financial targets.

LADY JUSTICE THIRLWALL: Is his name Kevin Eccles? was that Kevin Eccles?

A. Yes.

LADY JUSTICE THIRLWALL: Because we have got a paragraph about it in the letter, yes.

A. So and then -- the Consultant paediatrician appointment, the financial context that we were in at the time --

MR DE LA POER: Can I just stop you there Mr Chambers.

A. -- was very challenging.

Q. There was a simple point to be made about this email which is that what Dr Jayaram has said to you is that as at 20 September, for a number of reasons, all of which I read out on there, there was a breakdown in the relationship or there was a breaking down relationship between the senior management and the Consultants and there was a concern that things were being presented as a fait accompli?

A. And I think what I was trying to explain is quite often these things were presented to me as a fait accompli as well, so I can understand their grumpiness. In that meeting I tried to reassure them

that the Babygrow appeal would continue as it did and that we would rebuild a new neonatal unit, that we would in due course commence with the recruitment of the eighth and ninth Consultant paediatrician.

This -- and I followed this letter with the letter of my own and then there was some exchanges and things felt better as a result of that.

Q. The 26 January meeting.

A. Yes.

Q. Maintaining the themes that were raised by Dr Jayaram here about relationship breaking down, things being presented as a fait accompli. Is it right that you approached that meeting to present the Consultants with a fait accompli?

A. Can we -- can you put up the meeting so I can be absolutely clear which one we are referring to?

Q. Yes, of course we are going to look at the detail of it, INQ0003523. And I was just asking you a general question which I would hope you would be able to recall one way or the other once you can remind yourself of which meetings we are talking about --

A. Yes, yes.

Q. -- about whether or not you approached it intending to present to the Consultants a fait accompli?

A. What -- I remember the meeting now I just

wanted to be sure that it was this meeting.

What we were presenting to the Consultants was the -- the view of the board from earlier that month.

Q. But that -- that board view, just so that we are all clear about it, the one where they had endorsed what you recommended having been told that there was no causal link between the individual; that's the meeting we are talking about?

A. That -- that -- that's the one where I presented, we presented to the board what we believed was our best understanding of the outcomes of the reviews and that there was not any anything pointing towards deliberate harm.

Q. The paediatricians, who I think you agree as experts in the subject matter should have by now seen both of those reports, you have already told us you think that would have been the better way of doing it?

A. Yes, yes.

Q. They came into this meeting without having seen either of those reports; is that right?

A. I think that's half right.

The -- some of the Consultants as I understand it had seen drafts of the Royal College report. I do not know for certain whether they had had the Hawdon report at this time.

Q. Well, the evidence is, as the Inquiry currently understands, of the Consultant body Dr Jayaram and Dr Brearey had seen a draft version which according to them they had been given a time limit to look through it of about an hour and that as far as the Hawdon report is concerned, as at this meeting, the evidence the Inquiry has gathered so far indicates that not a single one of the Consultants had seen it?

A. Okay, okay.

Q. You have candidly accepted they all should have seen it going into the meeting?

A. It would have -- it would have been really helpful, yes.

Q. Well, it would have meant that it was a discussion rather than you telling them what was in the report?

A. It -- this was, this is an interesting meeting because there -- it -- what I was expecting was that, was a discussion. But I am aware that there had been conversations prior to this meeting between some of the paediatricians, I think Sean Tighe, Dr Tighe, who was the -- the -- in a sense the BMA person and also I think David Semple, one of the -- one of the divisional directors who was an obstetrician who had suggested to them that -- that we as an Executive were looking to

blame and that they should just sit on their hands and not say anything. I didn't know any of that, unfortunately.

In the meeting, it just felt odd that there was no dialogue and no conversation.

Q. The meeting was in part to tell them what the Royal College and Dr Hawdon had said, if it's right that only two of them had had some time previously an hour to look at the draft report, hadn't seen the final report, none of them had seen the Hawdon report, it couldn't be a discussion about those topics, could it, whatever the plan beforehand?

A. Yes, okay, yes.

Q. Now, as you know, you rehearsed them in your statement, different people have different recollections of your behaviour in that -- I am not going to put to you one side or another, I am going to give you an opportunity to answer the allegation that some people have made, that you behaved in an oppressive or overbearing or bullying way in that meeting.

I want to give you the opportunity to say whether you recognise that description of yourself?

A. I -- I remember this meeting. I remember it being a very tense meeting and I don't and I didn't really understand why. Only, you know, when I had seen

the disclosures to the Inquiry did it become clear perhaps why.

I felt the need to be fairly clear and direct in terms of the outcome, particularly of the grievance, where as we have discussed previously there was allegations that there had been derogatory language used, inappropriate language used and -- and I wanted to be clear that, you know, that didn't meet the values of our organisation and that we needed to not see any -- any further examples of that.

I didn't feel that I was raising my voice. I certainly wasn't angry. I felt it -- I behaved professionally, as they did, as everybody in the meeting did and that's my recollection of that meeting.

Q. Now, something you said on page 2 was about the Speak Out Safely and the fact that that had been professionally managed.

A. Yes.

Q. Now, the Inquiry has received some evidence from Alison Kelly about it but in terms of the formalities, in fact the Consultants' concerns were not discussed at any Speak Out Safely meeting --

A. Yes.

Q. -- before this meeting?

A. Yes.

Q. You have made an assertion about it?

A. Yes.

Q. Why did you say that?

A. I think -- well, the Speak Out Safely arrangements within the organisation were -- it's fair to say were fairly nascent, they were fairly new, they were something that had been brought in, I think, in late December 2015 so they were still very much embedding.

My feeling that -- or, if you like, my -- where I would have taken the evidence that I felt it had been well-managed professionally managed was Consultant concerns had been raised, they had been heard, action had been taken. Letby had been removed because that was seen as one of the potential risk factors and then towards -- to be able to explain any further risk factors or causes we had undertaken independent professional reviews from the College and then Hawdon and you can see -- so that's where I took the -- the -- the -- you know, the reassurance that they had spoken out, we had listened and action had been taken, but I am aware that it wasn't necessarily within the policy.

Q. Do you think you should have checked before you made an assertion like that?

A. I think, with regret, I should have done. But

actually the -- the actions that we took were probably consistent with what the policy would have guided us to anyway.

Q. Well, the policy required an allegation of criminality to be referred to the LADO?

A. It may well have done but not every Speak Out Safely is about criminality. It can be about any number of issues of safety. It can be about staffing levels, it can be about equipment, it can be about psychological safety and so on.

Q. Well, we have already been through that policy with the person who was a designated officer. In this meeting the Consultants were told that Letby was coming back on the unit, weren't they?

A. They were told that the -- that was the outcome from the board meeting, yes.

Q. Yes. And there was no discussion in this meeting about Dr Hawdon's four cases, was there?

A. This is the point that you drove me -- you pointed me to before lunch in respect of the -- the letters exchanges between myself and the paediatricians in April and the oversight from Ian or the omission from Ian and ...

Q. Following this meeting, 10 February, the Consultants wrote you a letter and you mentioned it many

times, I said we were going to come back to it, INQ0003117.

By this time, they had seen both Dr Hawdon's report and all of them the RCPCH report. What they say here about the RCPCH report is that the report identified some areas of clinical care but which we know to be no worse than any other local neonatal unit in the region and correctly identified that over a number of years the neonatal unit has outcomes as good or better than the other local neonatal units based on most national audit standards.

So they were making a point about the interpretation of the RCPCH report, do you agree?

A. Yes, they were. Yes.

Q. At point 2, they say they agree with the conclusion of Dr Hawdon's Casenote Review that four babies who died require a broader forensic review and they go on to say that they are concerned about more than just those identified by Dr Hawdon and express their wish, in the last sentence there, to be keen to learn and improve the care for all.

We can go over the page. And offer an opinion that the episodes of care that Dr Hawdon considered sub optimal could explain the rise in neonatal mortality and sudden collapses in the period.

So that's them offering their expert view about what Dr Hawdon has said, agreeing with her about four cases, saying that there are more cases than she was worried about and pointing out that their expert interpretation of her report is that the failings in care doesn't explain the overall increase. So again that's -- for the moment let's just note that that's what they are saying.

Is that a fair summary of their position?

A. That is what they wrote.

Q. Yes. At 3 they acknowledge that:

"... postmortem diagnoses have been made in a number of cases but there is considerable doubt about why certain babies collapsed unexpectedly and subsequently did not respond to appropriate resuscitation measures."

So what they are doing is they are going beyond what may be apparent on the Casenote Review --

A. Yes, yes.

Q. -- and they are saying --

A. Yes.

Q. -- this was our experience and of course that's something they had raised before about babies not responding appropriately to resuscitation?

A. Yes, sure.

Q. Then 4, they point out the transfer babies and the fact that a number of cases had been identified in relation to deteriorations which was unexplained or unusual. This -- this is a comment upon Dr Gibbs's review, I don't know if you recall but in July of 2016 --

A. Yes, yes.

Q. -- he did a review, so effectively a proxy of babies who survived collapses --

A. Correct.

Q. -- to look at that and they are wondering here what happened to Dr Gibbs's review which we have heard from Dr Gibbs, we have seen the notes. He said that there were about six babies that he was concerned about from the cohort he reviewed and it doesn't appear that those findings were formally shared at any point, they are asking about them.

Then they make this point:

"There have been no deaths or unexpected collapses on the neonatal unit since July 2016. Unwell babies have been cared for, received intensive care and in some cases transferred to other hospitals but their clinical courses have been far more predictable and responsive to treatment than previous cases. This cannot be solely attributed to the redesignation of the neonatal unit or

any other changes in practice that have occurred since then. Some of the babies who collapsed in 2015 and 2016 were born at greater than 32 weeks' gestation and many were not receiving intensive care at the time of their collapses."

So there they are drawing your attention, aren't they, to the fact there have been no similar cases --

A. Yes.

Q. -- since the redesignation and Letby being moved off?

A. Yes.

Q. They are making what is an expert point about the fact that the redesignation doesn't explain this; do you agree?

A. That's what they have written there, yes.

Q. Yes. They conclude by saying that they are only asking these questions because patient safety is absolute priority.

So let's just ask for your impression of this letter when you received it. Did you regard that as a reasonable letter for them to have written?

A. I did. And I -- I -- I think it was copied into Mr Harvey, I can see that it was and that he was already having these types of conversations, listening to these kind of concerns with them. They also

requested at the top this have letter that we share this information with the Coroner --

Q. Yes.

A. -- which we did. So we listened. We heard. And as you know, subsequently on 27 March, the decision was that we would go to the police.

Q. Let's remind ourselves, this is 10 February.

In terms of the points that they were making, do you point to any of those that you thought at the time were unreasonable or incorrect?

A. I think all of them had points of fact, all of them, all of the points I think -- well, particularly the one around the redesignation of the unit not being the only explanation for the reduction in -- in baby deaths.

All I know is that if we had had the criteria for admission at the neonatal unit post, if we had that the revised criteria in the neonatal unit, if we had had that prior to 2016, a lot of the babies that Hawdon had reviewed would in effect not have been on that unit.

So it's -- it's fair it say that the -- it's not quite as simple as is described here. But these are fair points.

Q. They are fair points but you would say it is factually inaccurate or needs further information --

A. I just --

Q. -- on point 5?

A. It's -- it's an opinion that is -- is -- is understandable because of the amount of criticism that the clinicians would have felt at that time and I didn't think it was, you know, surprising that they would want to push back and we were wanting to listen and learn.

Q. Mr Chambers, you appear, if I may say so, in that last answer to suggest they are saying this as push-back to criticism as opposed to the fact that that is their --

A. No. I think -- I think it's both of those things.

Q. Well --

A. It's -- it's clearly -- there's never been a doubt in my mind ever that these doctors had the safety and well-being of babies at their -- at the front of their mind.

There's never been a doubt in my mind that we as an Executive Team and a board had the safety in babies at the front of our mind, but as is -- is often the case, and I think Simon Medland talked about it in his evidence when he talked about where you get a misalignment in -- in duties of care, and this -- this is I think just a kind of real world example of that,

which is why absolutely why we took the meeting on the 27th as I outlined at the start of that meeting: it was about if we are not at the position where the board and the organisation has answered these questions, and this is what's inferred here, then what do we need to do to get into the position to answer these questions?

Q. The 27th, you are referring to 27 March which is five or six weeks after they sent this message; is that the meeting that you are referring to?

A. Yes.

Q. Let's see what the meeting immediately afterwards says about this letter. INQ0003379, this is the 14th, it begins by saying the letter was hand-delivered by Dr Brearey. You say "seemed to have gone backwards" and Ian Harvey "wondered what they were plotting".

Now, is the reality, Mr Chambers, that at this stage, having received what you have characterised today as being a reasonable letter making reasonable points, that the reaction was to become defensive?

A. No, not at all. I seem to have gone backwards is -- is a fair representation of on reading that letter.

I thought -- genuinely believed that as of 26 January that we had had a position that said there

were two unascertained and that all the evidence that we were getting from independent specialist advice was pointing away from deliberate harm or unnatural causes.

I was aware that the Royal College review had said that the unit seemed to be running better, calmer, safer since the redesignation. And then there's the letter that we have just gone through and I kind of think, well, has the position gone backwards? It felt perhaps it was. Let's go and find out what the position is.

Q. As at 26 January, as you pointed out, none of the paediatricians had seen any of the --

A. I know, I know.

Q. -- reports or at least had an opportunity to consider them properly.

You haven't addressed the "wondered what they were plotting" which was part of my -- part that I drew your attention to when asking whether this had become defensive?

A. Apologies, it hadn't been bolded out so I had -- I wondered what they were plotting. That looks like it's attributed to a comment that Mr Harvey had made. You are going to have to ask Ian Harvey.

Q. Well, you were present at the meeting. It doesn't seem to have been the subject of challenge. And the word "plotting", would you agree is generally what

you talk about what you do against your enemies?
A. I -- I -- again these are, these are Stephen's notes and quite often he, he captures things that -- that just -- that -- so I -- I don't remember any discussion about plots and they certainly weren't enemies any more than we were the enemies.
We were just ordinary people, trying to deal with an extraordinary set of circumstances, with very little or confusing information to hand and we were trying to make the best sense of that whilst the -- the only thing that was an absolute consensus on was that we didn't really know what the absolute causes of harm were -- causes of unexplained death were.
MR DE LA POER: My Lady, I am conscious of how long we have been going in terms of the shorthand writer this afternoon and I wonder if that would be a convenient moment?
LADY JUSTICE THIRLWALL: Yes, we will take 15 minutes. Please come back in just before quarter to.
A. Thank you.
(3.28 pm)
(A short break)
(3.45 pm)
LADY JUSTICE THIRLWALL: Yes.
MR DE LA POER: Mr Chambers, your letter of reply

is dated 16 February, INQ0003159. In the letter, if I may summarise, you tell Dr Jayaram as the addressee of this letter that the Coroner is being informed and having the letter shared and that it's also been shared with the RCPCH and Dr Hawdon, which we see further down.
The point they made about the redesignation of the unit, you make an assertion as to the reasons why but you don't engage, do you, with what they said to you in their letter about whether that change in what was being observed could or could not be ascribed to the redesignation?
A. I -- I don't remember it being included in this response.
Q. We can then see that you at the bottom of the page remind them of the apology and then it's this and the sentence concludes:
"... and when you are doing this as action is now being taken to return her to the unit at the earliest possible time."
So is this right, Mr Chambers, that having had those five points made to you about what the RCPCH report does and doesn't say, what Dr Hawdon said and the fact that they are concerned that there are more such babies, the fact that they would like to see Dr Gibbs's report, the fact that the redesignation doesn't explain,

your position was in response "Letby is still coming back to the ward"?
A. At that time that was still -- that was still in train but no action had been taken to make it happen but in my mind it was -- at this point in time, there was still going to be plans to move her back to the unit, yes.
Q. Just considering for a moment. Do you think that you were not listening properly to what the Consultants were saying to you?
A. No, I don't think that's true. I -- we -- we'd been given really strong messages from the Royal College that the unit was calmer, the unit felt safer.
What we were not proposing to do was to redesignate the unit back, which is I think something that the Consultants would have been keen to have explored at some point soon. What we were seeking to do was take the recommendations from the board and we were still in the process of exploring how that can be achieved and in that -- in that -- in delivering that the apology letter was an important component and for some of the Consultants also some -- some mediation.
Q. So the five points that they had made did not cause you to think we ought to think carefully about

whether or not Letby should go back to the unit; is that the position?
A. The -- I don't -- I don't -- I don't think that is a fair -- a fair interpretation of this because as you know that Mr Harvey was continuing these conversations with the -- with the doctors. He was in conversation with the Royal College. He had shared their concerns with Dr Hawdon, there had been suggestions from the College around what was described as confirmatory bias.
I'm not suggesting that was at the front of my mind, but clearly there was -- there was more to this than just the points in the paediatricians' letter.
Q. But when all was said and done, you were still determined at this point to return Letby to the ward; is that right?
A. I -- as it says in there, that there was -- the plans were still being progressed.
Q. To return her at the earliest possible time?
A. Yes.
Q. If we go over the page, just so that we consider this. You here point out to them the reviews that were done. We know, and we have already been through that the RCPCH did not consider the question of whether Letby was responsible for the deaths.

It may be a matter of fact for the Chair but it may be the fact that Dr Hawdon didn't know about the concerns and you wouldn't have criticised anybody if that was the position.

And similarly Dr McPartland. So none of them had expressly dealt with the question: has Letby done this, had they?

A. But all of the advice that they were giving us were pointing away from deliberate harm and they had arrived at those opinions without having to be guided to those opinions. We took those opinions in good faith as they were presented in good faith.

I can't say any more.

Q. Let's just deal with this point of pointing away from deliberate harm; it is a phrase you have used several times. That's your interpretation of them.

In fact, none of the reports you receive even uses that phrase, does it?

A. Pointing away from unnatural causes.

Q. Offering some explanation, potentially, for some of the deaths?

A. Sorry, repeat the question?

Q. Offering some explanation potentially for some of the deaths; at its highest, that is what they were saying?

A. I think they were saying something stronger. I think they were saying that there was nothing that was pointing towards unnatural causes. They had been given in -- in all but three of the cases there had been causes of deaths attributed either supporting the position that the postmortems had arrived at at the time of death or supporting the -- the reviews of the postmortems that had been undertaken by Alder Hey people.

So, I -- I fail to see how being presented with an independent, from an independent neonatologist and an independent pathologist, who hadn't, had arrived at natural causes, therefore excluding unnatural causes, if there is such a phrase, how that is inconsistent with me saying: everything wasn't -- was pointing away from deliberate harm.

Q. There are two categories of babies, the first in Dr Hawdon's case was unexplained and unascertained, four of them?

A. Yes.

Q. That's a significant number of children. If we are talking about murder; one is significant, isn't it?

In Dr McPartland's case she said two of those four was unexplained, she didn't consider any of the others

and she said in the case of a third that the prior collapse was unexplained.

So that's the one category, do you agree that is a fair summary of that category?

A. I'm not sure. I would have to see the notes.

Q. Well, we have been over a number of times and looked at the notes. If you don't accept that proposition I am not going to press you on the point.

A. Okay, I -- I am not trying to be awkward or, or difficult or avoiding a question. I just don't want to make a statement that I don't feel comfortable that I've got the information to make.

Q. And it is important that you don't do that.

A. Yes, thank you.

Q. The other category. Now, we know for example that Dr Jayaram raised the possibility of air embolus explaining, we see that in a note in a meeting. Were you satisfied in your own mind that the possibility that an individual had deliberately administered an air embolism had been carefully looked at by both of the people who had scrutinised this and that they had satisfied themselves that there was no possibility that that was the case?

A. Again, I'm not a pathologist. I cannot offer an opinion around whether air embolus is something what

can be determined from a postmortem or not or you -- I can't answer that question.

Q. Well, this is what we have forensic pathologists for, among other things, to help with as I think you have told us that you believe you may have had an understanding at the time, although you would have checked that forensic pathologists are there to investigate suspicious deaths. It is an additional specialty requires you to be registered with the Home Office.

The point really is this, Mr Chambers: how could you take any real comfort from Dr Hawdon and Dr McPartland if you didn't know whether or not they had specifically investigated the possibility of some nefarious means of bringing about the death?

A. All -- all I can say is we took or I personally took on good faith the advice and the guidance that I had been or we'd been given I -- I had been given as well. In terms of the specifics of that question, I -- I would respectfully suggest you might want to pick that up with one of our medical colleagues, Mr Ian Harvey, perhaps tomorrow.

Q. Were you deferring to Mr Harvey for your understanding of what these reports did or did not --

A. Yes, I --

Q. -- mean?
A. I was the Chief Executive, I wasn't the font of all wisdom. I was just somebody who had a responsibility to make sure that voices were heard, questions were asked, concerns were listened to and acted upon, strategies were developed, strategies were delivered and that we had a culture where we were focused on safety.
I would have -- for specific expertise, I would have gone to my Director of Nursing, my Medical Director, I would have gone to -- and be guided by that be guided by my director of HR and so on.
Q. Were either of those subject matter experts experts in neonatology?
A. I don't think there were any experts in neonatology in the hospital.
Q. Were they experts in paediatrics?
A. Oh, clearly not, no.
Q. So were the people most likely to know in the hospital the Consultant paediatricians?
A. I think that's right and I think if they had real concerns that these matters hadn't been appropriately investigated, well, they were very able to make those concerns known to us, which they did.
We listened. We took action. The 27 March we

brought all of that together, we went to the police.
Q. You listened, you tell us, but in response to them raising those very points, your response was to say: Letby's coming back on the ward and if they had stopped there, isn't that what would have happened?
A. No. I don't think -- I don't think that was ever going to happen really because later, as we have suggested previously, Dr Jayaram had mentioned his eye witness, if that is the right word, of -- of some kind of failure or nefarious activity or however it was described. He then failed to mention it to anybody else, again. But that was sufficient at that time for me to think: we need to stop any plan for Letby coming back to the unit and exploring what the absolute next steps were.
Q. My question was about this, the date of your response, that if the paediatricians had stopped here --
A. I just said to you she wouldn't have come back.
Q. -- here on 16 February, Letby would have gone back on --
A. No, because as I said, that's where events don't stop, do they? So the conversations were continuing, the -- the discussions were ongoing and it was becoming less and less -- there was less and less

consensus as to what we -- what we felt were the causes to these unexplained harm. So at that point -- so there was never going to be a point that Letby would have come back had those discussions that were ongoing not been ongoing.
Sorry, if they -- if those had stopped, then perhaps, perhaps things would have been different.
But they were continuing, they were continuing in a professional way. We were listening, we were open.
Q. We can take that down. Were you aware at the time that on 1 March, Mr Harvey sent emails to Dr Jayaram and Dr Brearey warning them of the risk of referral to the GMC?
A. I'm not aware of that.
Q. You weren't aware of that at the time?
A. No, no.
Q. We can ask him about that, then.
You considered, is this right, referring the doctors to the GMC?
A. I don't remember that.
Q. Let's have a look. 16 March. INQ0003344. This is the first reference to GMC I am going to ask you about. We see on page 3, right in the middle:
"Part of me says ring police and GMC."
So help us with what you were saying there, please?

A. Again, Stephen's notes -- he captures things that were not action points and it may have been me just speaking out loud, you know, what do we do? Do we go to the police, go to the GMC? It was not anything more than that.
Q. Well --
A. And I can't remember why ... I can't remember how that fits into the whole discussion that we were having.
Q. Why would you be raising the possibility of ringing the GMC if not to do so in the context of referring these two doctors or more of them?
A. The note at the top of the page there says: we agree on more than we disagree. The paediatric are not in a space to --
Q. "... to receive anything. They feel like battered wives. Execs (TC) is abuser. Paeds frustrated with IH."
A. Yes, yes. So it was -- it was a discussion I think around just generally how our colleagues were feeling.
Q. Well --
A. Clearly I say there Lucy cannot go back to the unit.
Q. Then reading on, you say:

"They want us to throw Lucy under a bus."
Which might be thought to be a suggestion that they are trying to do something improper?
A. I again I -- I don't remember this conversation. I'm -- I genuinely don't remember the conversation.
Q. Well, we will come back to the GMC. We need to just pause. We have spoken about the network meeting on 27 March which Dr McGuigan attended, and he's given evidence about receiving a call from Tracy Bullock?
A. Sorry, say again?
Q. Dr McGuigan?
A. He wasn't at that meeting.
LADY JUSTICE THIRLWALL: No, he wasn't. It is a different question I think.
MR DE LA POER: Dr McGuigan has said he received a call from Tracy Bullock following that meeting, whether or not he was present, in which he was told by Tracy Bullock -- this is what she said according to Dr McGuigan, we will come to what she said about it in a moment -- that you had told Tracy Bullock that the Consultant paediatricians are refusing to accept problems with the standard of care on the neonatal unit, are instead pursuing other lines of inquiry. That she mentioned you had said there were ringleaders and things

were likely to go badly for those two and she didn't want him to be affected.
Now, Tracy Bullock's account is considerably more temperate than that and I know that you have seen it. I want to give you the opportunity, please, to tell us; did you call Tracy Bullock and tell her that the Consultant paediatricians were refusing to accept problems with the standard of care and instead pursuing other lines of inquiry?
A. Okay, I -- it wasn't a telephone call. I think we were in fact -- I remember we were on a train to Leeds. We were going to a -- one of the Chief Executive Regional Forums which was held in Leeds. I bumped into Tracy at the station and we sat together on the train and we had a conversation.
In the conversation, I was just discussing with her as a peer and a fellow Chief Executive and somebody whose opinion who I valued, to -- almost as a -- just to see, you know: am I missing something, is there more we can be doing? I don't remember the detail that we talked about but I would have taken her through the work that we had done, how the -- how -- how our clinical colleagues were feeling about the work we had done and the reference to Michael McGuigan was simply that Michael was a new member to the team.

He -- I think he was the nearest that we had to an independent mindset of matters on the neonatology unit. He had no history, but he was an experienced -- an experienced doctor and I think he was also a neonatologist.
The reason I raised this with -- with Tracy Bullock is that she was the Chief Executive at one of the local hospitals where Michael had been recruited from, so she knew him. So what I had said is we had had this meeting, lots of discussion around the issues, decision made that we would be going to the police and one of the things that I felt really compelling in -- in the meeting on the 27th was when Stephen Brearey told me about the thoughts and opinions and reflections that Michael McGuigan had had on these matters and I found that to be really quite significant.
I spoke to Tracy to say, you know, is -- is this guy all right? Is he -- does he know his onions? And she -- she suggested that his opinion would be worth listening to.
Q. Did you at any point in the conversation suggest that it would go badly for the ringleaders --
A. No, no, I think -- I don't know where that was. I think -- Tracy I think may have -- did she contact Michael following this meeting, this

conversation? I think she may have had a telephone conversation with him and she was almost seeing that as a well-being check, really. You know, given that it must be difficult, arriving at the Trust at a time when all of this was going on, I think he had only been there two or three months.
Q. Mr Chambers, rather than speculating as to what was motivating Ms Bullock, the question was: did you say it? Your answer is --
A. No, I don't and I don't think she said I did either.
Q. No, but that is what Dr McGuigan --
A. And I can't comment on that.
Q. -- understood.
So I have put it to you, given you a fair opportunity to deal with it, you have dealt with it. Of course, things going badly for a doctor invariably means being reported to the GMC, doesn't it?
A. I don't know what -- what that refers to.
Q. Well, let's have a look at the second reference that I told you I would bring you to, INQ00015642 and we are going to go to page 48 and this is a meeting you had on 12 May, so the same day that the second meeting with the Cheshire Police took place. You have obviously heard that at that meeting you had told

the Cheshire Police there was no evidence, that's what the Trust thought but that you welcomed the Cheshire Police investigating.

So page 48, please. The first thing we are going to do, because this is the potentially important meeting, is we are just going to identify the parts of this note which was made by Sue Hodkinson in what she tells us was a one-to-one with you.

So TC, your initials there, we have got the date, the time at 11.45 am. RJ and SB, that will be a reference to Dr Jayaram and Dr Brearey; is that correct?

A. I -- yes, it will be, yes.

Q. "Plan re management.

"1, GMC.

"2, actions from grievance.

"3, mitigation ['from' I think that says] SOS [so that will be Speak Out Safely] whistleblowing.

"4, action plan to manage out ... Tuesday [something] follow up call."

Now, Ms Hodkinson has given us some evidence about this yesterday. Are you aware of her evidence on the point?

A. I am, yes.

Q. Let me just summarise it. She told us that

she was surprised and disappointed by what you were saying, that she had understood that you were frustrated, that was a discussion which was never implemented about how to manage Dr Brearey and Dr Jayaram out of the Trust; that that included a referral to the GMC and that she challenged you about it in the meeting, although she did also go on to say you will have to ask Mr Chambers whether I challenged him.

So is her account of this meeting accurate?

A. To be honest, I am not being difficult, I don't actually remember the meeting. But I do remember the context around the meeting. I have nothing to suggest that this meeting didn't take place, but normally Sue's notes are very comprehensive and these are just some jottings.

I'd written to the Chief Constable on 2 May 2017. We met with the police for the first time on 5 May. We had a follow-on meeting on 12 May at 9 o'clock in the morning. At that meeting, you present one version that I think is a misrepresentation of what we said to the police. We were not trying to play down the concerns and we will go through the meeting notes of that meeting later with my barrister.

But what is clear at the outcome of that meeting

was that the police were themselves not sure whether this met the threshold of a criminal investigation and this was despite having had meetings with the paediatricians at the CDOP. I was very clear that before any decision could be made that suggested that there wouldn't be an investigation that they should meet with the doctors again, which they did, I believe, on -- I'm not sure but it was within a few days.

Q. It was 16 May although I may be mistaken about that?

A. 16th, yes, and then that led to the commencement of Operation Hummingbird. So this meeting here, this note here was I think I remember driving back from the police headquarters and it was about a 40-minute drive to the Trust. I remember reflecting on where we were and also thinking to myself: what would be the implications if they don't do a police investigation?

We'd had now a -- what felt to be a breakdown in the relationship between the doctors and the nurses. We were aware that the nurses struggled and had felt with -- felt that Letby had been treated badly. They felt that perhaps that she had been -- all the things you have heard from, you know, from Eirian Powell and others' evidence and I was kind of sympathetic to this

and aware of this.

For me, what this meeting was all about was patient safety and insomuch as if we have a scenario that there is a breakdown in relationship between the leaders of our services and the nurses in those services, then that's never going to be good for patient safety. So I kind of was thinking if there isn't a police investigation, what are we going to do? So this was just almost a -- a -- well, we can do this, we can do that. "Sue, guide me."

But as you know, it didn't lead to anything because Operation Hummingbird was commenced I think soon afterwards, the 17th or something like that.

But what is absolutely clear in that meeting note at the police headquarters on 12 May at 9 am, the -- there was a clear, clear message from me that the police before making any decision around not doing a criminal investigation or these concerns don't meet the threshold of a criminal investigation ... they needed to speak to the doctors first.

So I left really not being sure what the outcome would be and that is the context to this meeting.

Q. Why were you talking about referring Dr Brearey and Dr Jayaram to the GMC?

A. That is not what we were talking about. It

was saying what are the potential things that we might need to do if there isn't a police investigation, 1 GMC. 2, this ...

Q. What --

A. So it was -- it was nothing more, nothing more than that.

Q. Why would the GMC need to be involved at all?

A. And I -- I don't know. We were just working through scenarios. There was no detail. There was no substance and we would have had to have put a significant amount more effort into this if the police hadn't done their enquiries. Or not. We may not have needed to do that.

The -- it was just for me recognising that we would because of the significant escalation in these matters, for them if they then don't get resolved, if you like, by a police inquiry what -- where does that leave us in terms of patient safety?

Q. And mitigation from Speak Out Safely whistleblowing, so was that a discussion?

A. To be honest, I would not -- I wouldn't know what that meant.

Q. Well, were you discussing, as we heard yesterday, with Sue Hodkinson effectively how you could get round the fact that they were whistleblowers?

A. Sue's -- Sue's memory of this meeting is about as good as mine. She doesn't remember the -- the context to the meeting. She didn't remember that we were, were speaking to the police at this time. So I think had she been aware of that at the time of giving evidence it may have triggered something in her mind.

Q. Why were you not referring Letby to the NMC?

A. Yes, and those were things that could have been there as well.

Q. Why were you not talking about raising a safeguarding concern if the police did not take it forward?

A. Like I say the -- this was a fortuitous one-to-one meeting with myself and the director of HR.

Had that meeting been a one-to-one with -- with Alison Kelly, rather than Sue Hodkinson, then, then the conversation would have probably been exactly as you described. I don't know and I can't speculate.

Q. Why can't you talk about those things as part of the plan with Sue Hodkinson?

A. But I'm -- I'm unclear as to why -- why we would do those things if we had done all of our reviews, we'd raised those concerns with the -- with the -- with the police, the police had at that time would have spoken to the doctors on at least two occasions.

We didn't know at this point whether they were going to do a criminal investigation. They did on the basis of their second meeting with the clinicians.

Had they not done the police investigation I'm not sure on what basis you would do an NMC referral but I would have had to have taken guidance.

Q. Didn't you still have a safeguarding responsibility towards the babies on the unit?

A. We had -- and again I don't know whether safeguarding would have been -- would have been -- would have been appropriate at this time. Safeguarding perhaps might have been appropriate sooner than this.

But at this time, we'd already spoken to the police on four occasions.

Q. Let me put a potential interpretation of this note to you so that you can deal with it head on. Were you having a discussion with the HR Director about how you would get rid of Dr Jayaram and Dr Brearey by referring them to the GMC, working out a way to get round the fact that they were whistleblowers and managing them out of the organisation?

A. No. I -- I -- I don't think that was the nature of the conversation. All I was saying is I have just come from the police, if there isn't going to be a police inquiry, what are the implications of that?

I think had I not had a one-to-one scheduled with Sue, I probably wouldn't have even had this conversation. It was just one of those things where it was a coincidence that all of those things came together at that point. But as Sue said yesterday, her advice was: well, that wouldn't be sensible. But I wanted you to understand that this was not a deliberate plan, this was not something that was -- that was being engineered or concocted.

This was me and Sue exploring what the implications might be. Now it is -- it is -- it is -- on one level it is surprising that Sue doesn't remember that but it was -- until I had seen this meeting note I had forgotten about this meeting as well. It was eight years ago.

Q. My final topic is your departure from the Countess of Chester. We can take that down, thank you very much indeed.

We have heard from Lyn Simpson about the fact that there was an impending vote of no confidence --

A. Yes.

Q. -- being discussed and we know that on 19 August, or perhaps the day before, Sir Duncan Nichol reached out to NHS Improvement for help and we can bring up the note that was made of the conversation Ms Simpson

had with Sir Duncan, INQ0101357. This is the first call, you are not party to this call.

I hope you have had a chance to see this in advance but we can see the action plan as recorded in the notes and I will tell you what Ms Simpson said, if you don't know, about this was that the suggested way forward at point 3 was to prevent the vote of no confidence. I think that's supposed to be Sir Duncan to take this forward to ensure that you don't go back to the site, to agree that an alternative option for six months could be found, that you would not go back to the Countess, otherwise you would be made redundant.

So that appears to be the subject matter of their conversation and Ms Simpson said she didn't intend to use the word "prevent"; in fact it was that the vote of no confidence was to be explored by Sir Duncan.

My first question for you is: did you know about whether Sir Duncan was planning to intervene or involve himself in any way with a vote of no confidence that was being discussed?

A. I know that Duncan had been meeting with the-- I am going to say the paediatricians, but I -- I can't -- I don't know specifically who and I don't know whether it was a collective or -- or a bilateral. But I was aware that he had, had been doing that.

He was very keen to not take sides in any discussions, you know, and he wanted to put the best interests of the organisation first.

Q. So far as you understood the position, was he trying to prevent that vote?

A. And I was going to say that there would have been no benefit to a vote of no confidence in the organisation. It would be a bit like a Brexit vote. It it's never conclusive. It would have created all sorts of other consequences and it would be better for the organisation, better for -- for me, I suppose as well, it's fair to say, and it was not really a surprise.

Because, as we know, with all of the escalating inquiries that had gone on, then the police inquiry and then Letby subsequently being arrested for the first time, so I think maybe the paediatricians felt some sort of vindication on that.

I felt that it was the best thing for the organisation for me to step aside.

Q. We are going to look at the conversation you had with Lyn Simpson and the first question which doesn't require any detail, was that in your telephone conversation that we see on 9 September, do you think that you were candid with Ms Simpson about any failures on your part which had given rise to the vote of no

confidence?

A. I beg your pardon?

LADY JUSTICE THIRLWALL: Which call are we looking at, Mr De La Poer?

MR DE LA POER: At the bottom.

LADY JUSTICE THIRLWALL: 19 September?

MR DE LA POER: 19 September --

LADY JUSTICE THIRLWALL: Yes.

MR DE LA POER: -- 2018. My question was: were you candid with Ms Simpson about the difficulties --

A. Yes, absolutely.

Q. -- that led to the vote of no confidence?

A. Yes, yes, no, I -- there was no secret that there had been ongoing investigations and reviews into neonatal matters at the Trust. The -- everybody was aware of that from 2016 onwards, 2017 and then the police investigation and I was very candid with her that, that the relationships between increasingly it was the Executive and then it was myself and the -- sorry, Ian Harvey and me, and then Ian and then it was just me ...

So it felt that, you know, in the best interests of the organisation, that I should step aside. I had been absolutely candid with her that it was -- it was, as you know, if you like, a breakdown of relationships as

a resulting of escalating concerns of inquiries.

Q. I would like to ask you about page 2 of her note which continues over the page. She ascribes this to you at point 3, I suspect that should be "confirmed":

"TC confirmed he would step aside and be as flexible towards this as he can be. However, TC advised he would not want this to be a cost towards his career, would want to maintain his status as a CEO."

Did you say that to Ms Simpson?

A. I -- I remember specifically a conversation "what do you want from this, Tony?" What would, what would -- you know, what -- because it felt like it was almost a bit of a negotiation really, you know in that you are putting the best interests of the organisation first. I said that but I would rather that was not at the expense of my career. So that was the gist of that conversation.

Q. Did you say you wanted to maintain your status as CEO?

A. Yes, I -- I would have said that, yes. But that's not what happened.

Q. Now, what was in train here as Ms Simpson -- I understand her evidence to have accepted, was that this was a discussion about getting you a job that you didn't have to apply for formally, that was created for

you, which you didn't have to compete for, and in relation to which there wouldn't be an overt and transparent process, so that's what's being found for you in this conversation.

Is that what you understood to be going on?

A. No, I think -- I think -- I think what's missing here is the facts which are I had a contract as a Chief Executive. I had done nothing that was in breach of that contract, so therefore I had a contractual right as a minimum to serve six months' notice.

Now, all I was wanting as a de minimis from this, if we could have got more that would have been great, but as an absolute de minimis was the opportunity to work my notice, being useful to the NHS in some other organisation rather than either take a redundancy payment, if that's what it would have been, but I wasn't being made redundant, it would have been because the post wasn't being deleted and so on, it would have been -- would have been -- in employment law, that would have been a tricky thing to have worked through.

So it was -- it was a very -- it was me, I believe, again putting the best interests of the patients first at the, at the expense of my -- of my own career and family.

I wanted to be able to work my notice in an organisation so that I then had an opportunity to reset and maybe rebuild.

Q. It was described in a note to a conversation that you weren't a party to as a rehabilitation period?

A. Yes.

Q. Did you know that it was being described as that?

A. I have heard all sorts of different descriptions, not of this, but these kind of things happen to Chief Executives all the time. All the time. They call it rehabilitation, they call it going into the donkey sanctuary, but what I actually think this was about is just myself and Duncan taking a very pragmatic view on how we can, if you like, help the organisation move forward, focus on its future whilst I focus on my future. It was nothing more sinister than that.

Q. Of course it meant that the vote of no confidence was avoided. That was one part of it; is that right?

A. Yes, and again, I wasn't aware, genuinely wasn't aware that there was ever going to be a vote of no confidence. That was something that began to be talked about but I genuinely wasn't -- wasn't specifically aware of it. I thought that the meeting

that was being referred -- that was being planned with the Medical Staff Committee and the paediatricians was an opportunity for them to, if you like, share their concerns.

It was never presented to me as a vote of no confidence. But clearly that's how it was likely to -- that's what was likely to be the outcome.

Q. It's important I give you the opportunity to deal with an interpretation of events so that you can have your say on the point.

Did you leave in the circumstances you did in order to avoid scrutiny of your leadership --

A. No.

Q. -- during the period?

A. No. No, I mean, I -- there was no suggestion that -- well, I suppose maybe if I had not been supportive of these -- this plan, there could have been a vote of no confidence that would have probably meant that I had -- would be suspended. There would be -- but again that, that wasn't clear, that wasn't something that we were trying to avoid.

I was just, together with Sir Duncan -- Sir Duncan and I had a very close professional and personal relationship. We -- he -- he was somebody who I looked to as a Chief Exec as a -- as somebody for guidance and

we always had a very open and honest discussion about when it's time, if you like.

Q. The final document that I wish to ask you about is INQ0015683. This is the settlement agreement and we are going to go to page 30 which is one of the appendices to it. Forgive me, 31, it's an internal page, I beg your pardon. This is the schedule for narrative announcement.

Now, was this something that was substantially drafted by your side of things?

A. That was something that Duncan and I collaborated upon.

Q. We can see in the third paragraph:

"Tony's stepping down as CEO at the Countess is as a result of extraordinary circumstances. It is not a judgement on his ability as a CEO but more a reflection of his integrity as a leader."

Do you consider that to be an accurate statement?

A. Absolutely.

Q. If it was the case that you stepped down to avoid a vote of no confidence and you have given evidence that that isn't why, that statement would require rather more detail, wouldn't it?

A. It -- it probably would. But that was not the position and it's fair to say that in all interviews

subsequent to me leaving the Countess, I was never gifted a job. I always had to apply for a job, I was interviewed and I was always very straight and open and transparent about my time at the Countess. Which -- which is really easy when we are just focusing on 1% of the business, which is the matters of the neonatal unit that we have spent our day talking about, but the Countess was -- was -- was much bigger than a neonatal unit. It -- and my time at the Countess was demonstrably successful, as outlined in this, this note here. It's easy to characterise me by the events, sadly, of the -- of the last 18 months of my career at the Countess or 24 months of my career at the Countess but there was so much more to it than that and there were so many things that I am incredibly proud of that are now in place at the Countess delivering benefits to patients and staff, not least of all the new neonatal unit which, as I understand it, is built and open.

One of the final things I was able to do before I finished was to get the financial business case over the line for the new neonatal unit.

Q. The last thing to ask you about from me is the paragraph below:

"These investigations into neonatal deaths at the Trust have escalated over the past two years and

inevitably put relations between senior management and paediatricians under exceptional strain."

I would just like you to have the opportunity, please, to reflect on the word "inevitably".

Is it correct that matters would have escalated as they did inevitably or was that as a result of the way in which you managed the response?

A. I stand by the decisions that we made. We were acting in good faith. I was acting in good faith. I listened to the doctors when they raised their concerns. I also listened to the nurses when they raised their support.

I was being presented with things that at times felt quite binary. I never took a binary view. I listened to both.

Therefore Letby was removed from front line duties and therefore we also focused on the safety of the unit redesignating and so forth all the inquiries that went through, all done in good faith. The -- it's easy, really easy, when you look at these matters in the context of what we now know following a four-year police investigation, a 10-month trial, a retrial, but in 2016 and it's probably the case even now, in the NHS, the biggest cause of unnatural, unexplained deaths in maternity, in neonatal units, is not deliberate harm but

failure in systems of care.

There are many examples. The Kirkup report, the Ockenden report. Many, many examples. So it doesn't surprise me that it inevitably put strains on relationships because these were complicated matters.

MR DE LA POER: Mr Chambers, those are the questions that I have for you.

LADY JUSTICE THIRLWALL: Thank you, Mr De La Poer.

Just before we move on, I had said that we would come back if you felt there was something else you wanted to say about INQ0003076, which is the meeting, the Hummingbird meeting, that you have referred to quite recently but I understand that that's something that your barrister is going to deal with, is that right? Rather than me dealing with that if that's already been agreed I will leave that for you. Thank you.

Now who is going first? Is it you, Mr Skelton?

Questions by MR SKELTON

MR SKELTON: Mr Chambers, I ask questions on behalf of one of the Family groups. Can I just understand your evidence from earlier about your status in relation to risk. I think you said you were the accountable officer; is that correct?

A. That is correct, yes.

Q. What does that mean in practice?

A. In practice it -- it's a technical thing for -- for all Chief Executives. It's as the accountable officer you are responsible statutorily for the financials and delivering on the financial -- you know the financial governance but also the internal governance, which includes risk.

Q. Includes operational risk?

A. It includes all risk, yes.

Q. All risk. At the start of your evidence today Mr De La Poer asked you in detail about the information that was given to you in late June/early July about the Consultants' concerns about Lucy Letby?

A. Yes.

Q. It was clear from that evidence and the documents surrounding it that their concern was that she might have been responsible for the increase in neonatal death?

A. I think what -- what they -- what they were saying was -- was that there had been an unexplained increase in mortality and that there had been a member of staff on duty more times than another member of staff and then there was nothing really more concrete than that.

Q. Well, there was, wasn't there, there was stable children who deteriorated without medical

explanation and unexpectedly who failed to respond as appropriately to resuscitation and they had even started to speculate, and you were aware of this, that they might have been murdered?

A. So at the time there was certainly nobody talking about criminality. There was certainly lots of examples that things had -- were happening in an unexpected and unexplained way. But there was no -- there was nobody really pointing to say this was deliberate. They -- there were and I asked the question many times at many meetings: are we saying this is deliberate harm? Are we saying this is criminality? Or are we saying -- or versions of that and there was many, many thoughts and different opinions that were being raised but there was nothing that you could really put your thumb on.

Q. You were aware it was a possibility?

A. I was aware of possibility so I was listening to the doctors' concerns and I was also listening to my own gut feelings, which were I was aware from visiting the unit myself in December 2015 and other times that this was a unit that was running hot, that this was a unit that had seen an increase in demand. This was a unit that the acuity had gone up this was a unit where the birth rates had gone down so there was more than

simply -- well, there was more going on than we could explain.

Q. You were aware of the possibility that the babies had been deliberately killed; yes?

A. I was aware only of the concerns that were raised and the circumstantial link with an individual member of staff.

Q. Well, the evidence you have already given and the evidence given by Ms Kelly and many others was that after the two Triplets died, the Consultants were concerned that they had been killed by Lucy Letby and they wanted her off the unit. The possibility that she had done so deliberately was a valid one, wasn't it? You were aware of that.

A. So can you show me the INQ reference of that?

Q. No, it's a vast amount of evidence that has been given over the last two --

A. But you are speaking very emphatically there and that is not what I remember.

Q. You don't remember being told by Alison Kelly that the Consultants wanted Lucy Letby off the unit?

A. Oh, I remember Alison telling me the things I had outlined, that there had been an increase in explained mortality. That there were concerns about the association with a member of staff and -- and -- and do

I remember the -- and maybe there was concerns raised that this member of staff needed to be removed.

So --

Q. Just to be clear, was it your -- is it your evidence that you were not aware of the possibility that children may have been deliberately harmed at the end of June and the beginning of July 2016?

A. I -- it was -- it was, it was much less explicit than that. If for one moment that's what I believed I had heard and that was being, that was what was being said, the board would have gone straight to the police.

Q. When did you become aware of that possibility?

A. I -- I think it as we did more investigations, as I have said previously, and we took the guidance from independent experts and the guidance that they were telling us seemed to be pointing away from deliberate harm.

Q. I am not asking you that question. I'm sorry, you are going to have to really focus on answering my question.

When were you aware of the possibility --

A. So I am saying to you it was something that was -- was never concretely said in the way that you have said. I mean, I think there is so much hindsight

inherent within your question. At the time that's not the information that I had or we had.

Q. Ms Kelly was clearly aware of that possibility. She talked about it in her evidence this week and she talked about safeguarding. Mr Harvey was also aware of it, he discussed it with the Royal College on the first day of their visit. Are you aware of that?

A. Yes, but what they weren't saying that this was an individual who was deliberately harming babies. This was somebody who there was a circumstantial link and gut feeling. Nothing more than that.

Q. Sorry, that's the possibility of harm was aware -- they were aware of that at that time?

A. Oh, okay. If you are -- I think it's when you use the emotive language of "murder" that it becomes, you know, not something that I heard at that time. If you are saying the possibility of harm, then, you know, there was discussions: was this a competence issue? Was this a -- you know, was there -- what was the range of scenarios and issues that we would need to explore?

Q. When were you aware of that possibility?

A. Oh, I think I -- I felt those issues almost immediately, really.

Q. All right. Well, that's taken about 10 minutes to get to.

Can I ask you this: what is the risk that the Consultants were right, what was the risk?

A. Say again, sorry?

Q. What was the risk in your mind that the Consultants were right?

A. Then if we didn't take action, if I didn't remove Letby, then this deliberate harm might well continue.

Q. Indeed. So risk is usually seen in two ways or with two factors, there is a likelihood and there is consequence. What was the likelihood that they were right?

A. Based on what we knew at the time, and based on what the conversations that we had had in various meetings where I had said quite deliberately: are we suggesting that this is deliberate harm? And the answer was: we don't know ...

It's difficult to quantify that. But the fact that we couldn't quantify it in itself didn't mitigate any of the risk, so therefore Letby was removed, the unit was downgraded and all the actions that followed.

Q. So you had an unquantifiable risk that children might have been harmed by her and the consequences were obvious --

A. Yes.

Q. -- death and injury, they are the consequences of not removing her; correct?

A. But she was removed.

Q. Yes, but I am asking about if she had gone back, the consequences of --

A. Right, okay, yes.

Q. -- that risk?

A. By that time, so I thought we were talking about 2016 -- in terms of 2017, you are right, there was the -- but at that time it was genuinely felt by the board and myself and the advice that we were getting that it was pointing away from deliberate harm.

Q. Did you ever register the risk formally in any of the management processes?

A. I mean, that's a really fair point. I -- I think the answer to that is no.

Q. From a safeguarding perspective, had this been looked at through the lens of safeguarding, it required an immediate response, that risk, and the reason is requires an immediate response is because the consequences are so grave and potentially unmanageable, you recognise that? 24 hours local safeguarding officer and the police, that is the appropriate response to a risk of that sort, in an ordinary setting; correct?

A. Correct, yes.

Q. Other witnesses, I think Ms Kelly being one of them, have accepted that there was a safeguarding risk here which should have triggered that response. Do you accept that or do you disagree?

A. I -- I would have taken advice around whether this was a safeguarding matter from the safeguarding lead, Alison Kelly. I would have taken advice whether this should have been a matter for a SUDiC process from our -- from our clinical leads.

I was minded by the fact that if there genuinely -- it was genuinely felt that this was deliberate harm by this individual, I am absolutely confident that the professionals, the doctors, would have alerted these processes themselves, either directly to the police or they would have gone through one of those mechanisms were -- the fact that those things didn't happen in itself created a sense that -- that risks were not -- were being managed.

Q. But you know that Consultants find it extremely difficult to whistleblow on their colleagues, they don't generally deal with these sorts of situations, they are also extremely concerned that they will find themselves in hot water with the GMC or internally with their employer. There are a lot of disincentives. Robert Francis talked about this, you

are well aware of this, you have been in the NHS for years.

The fact that they don't trigger a safeguarding process doesn't necessarily mean or exonerate one from triggering one if you are aware of it, does it?

A. I am struggling to see what the risk to them would be of triggering a safeguarding process.

Q. Well, the risk to it could be triggered unnecessarily and it could cause matters to rebound on them, obviously. That is what they talked about.

A. So but I -- if -- is there not a professional responsibility to -- to do just that?

Q. There is and it's also on you, do you accept it?

A. Yes, absolutely.

Q. You should have triggered the safeguarding process just like everybody else?

A. I -- I -- I don't know, I am genuinely not sure, but if the guidance that I would have been getting from my safeguarding lead, I would be guided by that.

We -- we didn't view it as a safeguarding issue. I don't think anybody did. I think it was viewed as a unexplained increase in mortality with not really any clarity as to what those causes were. You are simplifying it to one cause. I don't think that was

where -- where we viewed it.
Q. You viewed it in fact as a hypothesis and not a risk. You viewed it through the prism of a hypothesis, it is possible these babies may have been killed deliberately, but you didn't see it as a risk; is that fair?
A. I think that might be a reasonable way of describing -- describing it. I -- as I said before -- at the end of my last evidence, that all evidence to date at that time pointed to unexplained deaths being more likely to be caused by a multi-factoral set of issues rather than a single act or individual. I don't think that was -- if that is a hypothesis then I accept that.
Q. You said in answer to questions from Mr De La Poer that your job as Chief Executive, or one of your jobs, is to ask the right questions?
A. Yes.
Q. Did you ever ask Ian Harvey or anyone else: have you satisfactorily excluded the possibility that Lucy Letby has deliberately harmed children?
A. We asked that question in a slightly different way in that have we been able to establish anything that is -- well, the question was framed in many different ways but one example of that, and it was a meeting on

27 March, I asked: are we saying that this is deliberate -- that this is criminality? So we did ask that question.
Q. That is not the same question though, is it? The issue is: did you ask any of your staff if they had satisfactorily excluded the possibility, so directly confronted it and excluded it?
A. I'm not sure that we did ask what question.
Q. Because Mr De La Poer has taken you through all the various investigations so there is the Royal College investigation or review, that did not exclude that possibility, did it?
A. It's -- it gave examples of where the care could be improved or where the leadership could be improved or the staffing levels could be improved. But as I said in my own witness statement, it didn't answer the question.
Q. Nor did Dr Hawdon.
A. I -- I think Dr Hawdon's review and maybe it's a misinterpretation and I don't think it is, but Dr Hawdon's review was that there was nothing pointing to deliberate -- to unnatural causes.
Q. That's not the same as excluding it, is it? In fact, she asked from a forensic review to take place in respect of five children, although it ended up being

four?
A. Yes.
Q. So she did not exclude the possibility of deliberate harm and was not indeed asked to exclude it?
A. We, I believe and you -- you may wish to pick this up with -- with Mr Harvey, but the way that the work that Dr Hawdon was doing was commissioned was deliberately constructed in a way that she would keep an open mind and those things would hopefully be flushed through.
But in -- and the outcomes of that, her work, as I said many times, didn't point to deliberate harm. The four cases where things were unascertained, they -- when they were reviewed by pathologists didn't point to deliberate harm. I'm not sure what else to make of that other than there is no deliberate harm.
Q. That is a false inference. So you are saying they didn't positively point to deliberate harm but they quite explicitly did not exclude deliberate harm, did they, none of them? The Royal College didn't because it wasn't a Casenote Review, they never looked at the medical records of the children. Dr Hawdon looked in detail at the medical notes of the children but she explicitly said "I can't exclude unnatural causes" and she asked for forensic Casenote Review. And

Dr McPartland in the more limited review couldn't exclude deliberate harm either. None of them did.
A. And the guidance that we were getting that I was hearing and the inferences that we were making, that there was nothing that was suggesting unnatural causes to the causes of death to those babies. They had had postmortems previously and so on, so I -- I -- and again as I said, eight years on, when you look back, you can see that following the police inquiries and all the rest of it that the causes of death have now been called into, you know, a different explanation than the ones that we arrived at had it been -- had been agreed.
Q. But if you look at the instructions, the instructions don't say: this is the suspicion, please will you investigate it and exclude it as a possibility?
At no point do any of those cases that occurred --
A. Yes, and again you will need to test this but my view is that it was -- we didn't want to in any way prejudice the work that was been doing, we wanted everybody to keep an own mind as we were. I can't -- I can't say any more, I'm sorry.
Q. In your response to the Consultants' concerns in 2018 you said that you believed the Trust could demonstrate that it's taken the concerns that they have very seriously and you have been open and transparent

with the Coroner, with our regulators, and as far as the police investigation allows, with staff, parents and the public.

Can I test that, please. First of all, NHS England. You will be aware that they have provided an opening statement to this Inquiry and Sir Stephen Powis has given a statement. The opening statement by NHS England says:

"To the best of NHS England's knowledge the concerns about potential criminal conduct were not shared at this point [in other words, when they arose around June/July 2016] and this information was also not shared with NHS England."

How does that square with your assertion to the Consultants in 2018?

A. So again it's -- it's the first thing we were -- what we thought we were doing was trying to explain the causes of increased unexplained mortality. There was a suggestion that a single member of staff -- that a single member of staff was on duty more times than another. So those are the two facts of it.

The -- in his evidence Robert Francis talked about how difficult it can be to balance the duty of candour with the duty of care and this was a balance that we were trying to manage. So hopefully from the

recommendations from this Inquiry there can be greater clarity around how that balance can be delivered. But candour starts with an investigation and that's what we were doing.

Q. There is clearly expectation on part of the regulatory -- of that body -- we will come on to the CQC in a moment -- that you would have told them of a concern at that level and for obvious reasons if you have a nurse that's either so incompetent that she's managed to kill a lot of children or has deliberately harmed children and you are setting in train a series of internal and external investigations to look at that concern, that is clearly a matter of interest to NHS England, isn't it?

A. And in 2016 I think the information that was shared with NHS England was around the increase in the mortality --

Q. Yes.

A. -- not the link to the nurse. The link to the nurse I think was made, the -- NHS England were made aware of that some time in 2017.

I know that the link person that Alison was connecting with to share all of these concerns was with Margaret Kitching, and Margaret, I think, it's fair to say, was fully sighted on these issues but when she was

fully sighted on these issues, I am not absolutely certain.

Q. Do you accept that NHS England should have been told about the concerns that a single nurse was responsible for the increase in deaths when those concerns arose?

A. The -- the answer is I don't know, it's just that balance between candour and duty of candour and duty of care. I -- whether we got that balance wrong, I'm not sure at that time whether we had got the balance right.

Q. Does the same answer apply to the CQC? You will be aware that Ann Ford has given evidence in writing and orally to this Inquiry, she made clear that she would have expected your hospital --

A. Yes.

Q. -- to have told the CQC, which had visited in February, about the increased mortality as and when it arose and about concerns as and when?

A. Say that again, please?

Q. It would have expected to have been informed about increased mortality as and when it became an issue and it would have been -- can I just finish? Would have expected to have been told about the concerns in respect of a single nurse as and when that arose?

A. Okay, so, the -- as a -- as a process arising coming out of any Serious Incident Review which I think some of the babies involved in June/July 2015 were subject to, the CQC and the CCG would have been made aware of those reviews at that time.

In terms of if your question is: should we have shared the Thematic Review with the CQC?, well, my understanding is that the CQC -- the Thematic Review hadn't been shared with us at that time or if it had, it had literally only just been shared with us and by "us", I mean Ian Harvey and Alison Kelly. I didn't see the Thematic Review until much later.

It would -- it wouldn't be usual to share something that hasn't been through our own internal governance processes and we know that the sharing the Thematic Review through our own internal governance processes had been problematic. It hadn't gone through to the QSPEC in a timely way, it hadn't gone to the Women's and Children's governance board in a timely way so it's difficult to be really clear whether that document should have been shared at that time. But it may well have been. And I think you need to test that conversation with Mr Harvey tomorrow because there isn't any clear record as to whether the CQC had got that report or -- or not.

Q. Well, the CQC through Ann Ford has given evidence that they considered the Trust not to have been transparent with them about this matter --

A. Yes, I -- I -- that wasn't -- we weren't a Trust that was not transparent with the CQC, we were always a Trust that if there was risk concerns, we used to be -- we were one of those Trusts that would alert the CQC rather than been waited to ask.

So all I can assume is that the -- the -- any delay in it being shared with the CQC was because the -- there had been a delay in the Thematic Review being shared through our own internal processes. Subsequently it was shared -- was it not shared in March?

Q. So their evidence is that the -- just if you give me one second, first aware of the increased mortality on 29 June when Alison Kelly rang?

A. Okay.

Q. Made a phone call?

A. Yes, okay.

Q. So many months after the Thematic Review?

A. (Nods)

Q. Do you have a comment on that?

A. No. If that's the point of fact, I'm -- I'm -- I seem to remember and, and I can't, I can't give you the specifics, but I do seem to remember that

bundles of documents following the review were shared with the CQC, as is common practice. They take a load of documents in advance, they do their review and then they make requests for further.

It was my understanding that the Thematic Review, I think, was part of one of those bundles, but I can't be absolutely certain.

Q. When it comes to the board, I won't take you in great detail through all the various meetings for obvious reasons. But there was a meeting on 10 January where Ian Harvey presented a report that he had done?

A. Yes.

Q. A very short report. That's at INQ0003518. It's going to come up on screen.

So it's a very short report, but he is basically saying: There were some concerns raised by the clinical team regarding higher than usual number of neonatal deaths from January 2015, together with inconclusive results from internal reviews.

He doesn't there tell the board that the actual concern was the possibility of deliberate harm, does he?

A. Not specifically in that paragraph, but the --

Q. If you were a board member, Mr Chambers, and you needed to be fully sighted to make a decision, you would want to know that the body of paediatricians

working on your neonatal unit by this stage thought that one of their nurses had killed the children, you would --

A. So --

Q. -- need to know that in terms, wouldn't you?

A. So this was a board meeting in January 2017.

Q. Yes.

A. The paediatricians had been at the board meeting in I think it was 17 July 2016 with all of the board. The notes of that meeting were very frank, open and inclusive. The concerns that the paediatricians had raised would have been the board would have been sighted on them.

Q. But for these purposes those concerns were still in existence, they were still held, vehemently so by this point, and they had not gone away, but Mr Harvey doesn't clarify them?

A. Well, the report is as it's written, yes.

Q. Well, he should have told the board the concerns were still there --

A. I -- I think he -- he, he would have believed that that was something that the board did understand from previous meetings and discussions that had gone on previously.

Q. He mentions the Royal College review, but that

had not excluded the concern, had it --

A. No.

Q. -- as you have agreed?

A. No.

Q. He also mentioned the external case review but that had not excluded that concern either, had it?

A. Well, it had -- there were four unascertained.

Q. Well, as at this stage, the concerns had not been satisfactorily excluded conclusively, had they?

A. Well, 13 cases had been given explanations and causes that were not deliberate harm or, or were not, were not unnatural causes. 13 had also -- it had been identified that there was strong evidence in all cases that there had been sub optimal care and in some cases significant sub optimal care. There were four cases as of out of the Jane Hawdon review that required further investigation.

Q. So, no?

A. I have outlined to you the position.

Q. At this stage the recommendation, it seems from you and Mr Harvey, was that the nurse who was potentially responsible should come back to the unit?

A. Responsible for what?

Q. For the harm?

A. The -- as I keep saying there, there was

an explanation for the causes of death. There was an explanation at that time for what was previously described as an unexplained increase in mortality. There was nothing that was talking about deliberate harm.

Q. What was the explanation for Child A's death, who was the first infant --

A. It remained unascertained, as you know.

Q. So what did you mean when you just said there was an explanation? What was it?

A. I -- what I said in 13 cases there was causes and explanations given. In four cases and I think one of those four was Baby A --

Q. Yes, five cases in fact?

A. Yes. And, to be honest, you're probably better going through this report and the detail of this with Mr Harvey. But that was my understanding; that at the end of all of this, there were two cases that were -- remained unascertained, unexplained and there was a view that that in itself is not unusual.

Q. Whose view was that?

A. I -- I think Nim. Nim Subhedar maybe have --

But -- but it's something that I will need to ask you to refer to, to Mr Harvey.

But in previous notes that we have been through

today, this was a point that Duncan made; that it was not unusual. And there will have been a source for that opinion. I'm not 100% sure what the source of that opinion was.

Q. Mr Chambers, it's an odd feature of your evidence today that you don't seem to fully recognise that the Consultants were entirely right about the risks and what had happened and you were entirely wrong. And so when I put to you that in 2017, those concerns that they had and had had indeed from 2015 had not been addressed satisfactorily and there was still a risk, that is correct, isn't it? She had in fact killed the children?

A. All -- all I -- all I can offer you is the evidence of what we knew, what we believed, what we did at the time of 2016/2017.

The facts that those -- the fact that that now, on the basis of the police inquiry that followed, led to indictments and convictions was not the position at that time. So it's -- both positions can be correct.

Q. Well, the position at the time was that you had a group of Consultants who didn't want Lucy Letby back on the unit because they thought she had deliberately harmed their patients and you had an Executive Team that wanted Lucy Letby back on the unit

and were encouraging the Board to allow that to happen. That is the reality, isn't it?

A. There was a grievance process. Out of the grievance process there was recommendations, one of which is that subject to the completion of all of the reviews, and no suggestion of any connection with deliberate harm, then we should -- you -- Letby should be returned to the unit.

The position that we took to the board was the outcome of that recommendation based on all the things we knew in good faith, and we continued the conversations with the clinicians, as you know. But the other point of fact is irrespective of whether we believed at that time that Letby should have gone back to the unit, as soon as new matters became known to us, as soon as new concerns or concerns that had been known for many, many years or months were shared with us, the change for -- that Lucy Letby was, she, you know -- the status quo was maintained and the exploration of escalating to the police was explored and eventually delivered.

Q. So can I -- could you just be absolutely clear. What was the new information which tipped the balance?

A. It was, it was, it was the -- it was the

concerns that that Dr Jayaram had, had alerted to Sue, to Sue Hodkinson that led to me going to have a conversation with him. I did not go into that meeting in a very heavy-handed way saying, you know, "Tell me all about ..."

I just wanted to find a way to softly listen, that led to the meeting on 27 March, that led eventually to the police being called.

Q. Sorry, what specific information did you learn --

A. It was -- you know exactly what I am talking about. It's the --

LADY JUSTICE THIRLWALL: Just answer his question.

A. It's the -- it's the concerns that Mr Jayaram -- Dr Jayaram had raised in respect to Lucy's conduct on the unit in respect of maybe a desaturation baby that he -- that she -- that he didn't feel that she was attending to or that some dials had been adjusted.

Those were the nature.

MR SKELTON: Child K.

A. Yes.

Q. In short.

A. Baby K.

Q. So when they put their report in, which is the report which Simon Medland encouraged them to write,

they wrote down a summary of their main points. That wasn't one of their main points. They wrote down the familiar list: deaths, an increase in deaths, sudden and unexpected. Failure to respond to resuscitation. One member of staff being present and investigations to date not identifying any other potential cause for the increased mortality.

That wasn't sufficient for you, was it?

A. Say again, sorry.

Q. That list wasn't sufficient for you? It hadn't been sufficient?

A. I -- we, we'd never -- we never saw that list.

Q. So which of those bits of information? I can take you to the document, it's INQ0003671.

A. The -- the specific bit of information was the concerns he had raised about Baby K with Sue Hodkinson on 15 April.

Q. Just look at the list. I want you to tell me what was new for you and when you learnt it.

If we go to the second page, please, towards the bottom you will see a summary. If we could actually have both the second page and the third page on the screen so we can see the list of six points.

If you run through that list, was any of that news to you in 2017 or did you know that really from then --

A. I -- I -- I -- this best case paper, if that's what this was, that came out of the Simon Medland meeting was not something that was ever shared with the senior Management Team.

Q. Not my question.

Which of those bits of information were you not aware of in 2016?

A. In 2017.

Q. Or '16, '16 I said, but '17 if you want as well?

A. I think by 2017, and maybe even 2016, some of this I think was shared with the Royal College by the paediatricians.

Q. Yes.

A. Some of this I think featured implicitly in various iterations of the Thematic Review.

Q. Yes.

A. None of it was explicitly called out.

The -- so I suppose, you know, you, you -- you could argue that some, if not all, of this may well have been known.

Q. Yes.

A. But -- but it just -- it just was -- it was just implicit rather than explicitly called out.

Q. But it would certainly be improper, wouldn't,

it to characterise those factors if they were known in 2016 as unsubstantiated allegations, wouldn't it?

A. Well, the number of neonatal deaths in the period is highly unusual. That's a fact. The number of unprecedented, unexpected and unexplained deaths/collapses is highly unusual I would have to take guidance on, but, yes, I'm assuming it is, although cause of death is uncertain.

So unsubstantiated? And you are making this in reference to which point?

Q. So you said repeatedly to the board in 2017 that the Consultants' concerns were unsubstantiated?

A. Well, what they -- their concerns were not clearly articulated. They were, they were -- they were implicit, not explicit. It was very difficult to really make sense of what was being said.

When, when Consultants were pressed they, they -- very explicitly they quite honestly said: We just don't know. So the unsubstantiated element to this is that quite simply all we really knew was that there had been an unexplained increase in neonates, which is unusual, and that there was a link to a single member of staff being on duty at more times than others and that there was, at best, gut feeling.

Q. You and the Executives knew all of that

information in 2016?

A. I -- it was never presented in that way. It was -- it was always presented as, as a feeling rather than really strong, I'm reluctant to use the word "evidence", but just it was, it was -- it was just a gut feeling.

Q. But you know now, Mr Chambers, looking at that list, those are not feelings recorded there. They are facts, aren't they?

A. But what was presented was feelings.

Q. No. All of those facts were presented to the Executive in --

A. They.

Q. -- 2016.

A. They -- they were presented as: This is our gut, this is our ...

And, and in hindsight, yes, I mean, maybe gut feelings is, is, is -- is a -- is something that is really strong, but it was never presented with the clarity that you have presented it here.

Q. Did you ever ask them to present it?

A. Well, in so much as I've often -- I've actually asked myself this question lots of times, you know: why did it take Simon Medland to come along and suggest that we write down or write down your best

points. But, in truth, I thought that's what the Thematic Review had done.

LADY JUSTICE THIRLWALL: We are now at half past 5, Mr Skelton. I am not stopping you, but we do have to have a break for the shorthand writer.

MR SKELTON: We do. I have got a relatively short issues, but I'm obviously in her hands.

LADY JUSTICE THIRLWALL: Yes, she's already done more time than we really should expect.

We will take a 10-minute break until 20 to 6.

(5.30 pm)

(A short break)

(5.40 pm)

LADY JUSTICE THIRLWALL: Mr Skelton, I will let you finish your point and then we will discuss where we go next.

MR SKELTON: Thank you.

Mr Chambers, a last and brief issue from me and it's a topic which I think Mr Baker, who also represents a group of Families, will pick up with you. But essentially it's this: it's a last opportunity from my perspective to give you the chance to speak with empathy --

A. Yes.

Q. -- and speak with insight about the events of

2016 and 2017. By July 2016, you had the position that you had a group of neonatal Consultants who suspected that their nurse, Lucy Letby, had murdered the babies on the unit and we know that from all the evidence we have received and that came to the attention, that suspicion or concern came to the attention of the Executives by 2016 certainly around the summer.

You have at that stage an enormous asymmetry of knowledge or suspicion. The Families are grieving still, but they have no idea that the paediatricians suspect they are grieving because their children have been murdered and you have the hospital and the Executives who are thinking and looking into that issue.

You must understand from their perspective they needed to be told of those concerns and they needed to be told what investigations were being conducted by the hospital; do you accept that?

A. Absolutely.

Q. And that included the Royal College review, which involved many of their children, Jane Hawdon's review, which involved many of their children, and Dr McPartland. They needed to have been engaged in all of those processes, do you accept that?

A. I absolutely accept that.

Q. And one of the reasons, not simply a moral

reason, is that they could have added in their input both factually, but also they could have said to you and the Executives: These investigations are not good enough. You need to call the police ...

Because that is their prerogative, isn't it? If they think their children have been murdered they have every right to say to you: The only organisation possible to investigate these activities is the police.

Do you understand that and accept it?

A. I -- I accept that.

Q. Lastly on the Coroner. I appreciate these are questions which I will have to put to Mr Harvey when he gives evidence, but the Coroner held an Inquest into Baby A's death on 10 October 2016.

At that Inquest Dr Saladi and Dr Jayaram gave evidence and neither of them indicated that they suspected Lucy Letby had murdered Child A. The hospital was represented by Louis Browne, who was just about to become a KC so he was very senior counsel. He didn't indicate that and he will explain whether or not he knew or not about the concerns that were going on at that time.

But it does appear that by hook or by crook the Coroner was not informed that there were suspicions about that child's death. That was unacceptable, wasn't

it?

A. It's -- it clearly, in hindsight, is absolutely unacceptable. The context that we found ourselves in at the time, these matters weren't clear.

I am not aware that what -- what the KC Louis Browne had been told. I am not part of any of these Coronial processes.

But what I am absolutely sure about is that there would have been no deliberate not sharing openly and honestly with the Coroner the concerns.

I don't know why Dr Saladi and Dr Jayaram didn't share those matters with, with the Coroner through that Inquiry -- through that Inquest, but I'm absolutely certain it wouldn't have been any, any sort of an instruction from the Countess, the Hospital Trust. And I think in their evidence, the doctors' evidence, they don't suggest that.

But it does feel to me that maybe that was something that should have been shared and I can't explain why it wasn't.

Q. You had no personal involvement in the Inquest process?

A. No, no.

Q. The Coroner, Mr Rheinberg and his then deputy, and then became Senior Coroner Mr Moore are clear that

they were never told about the suspicions in respect of Lucy Letby during this period of time, 2016.

So far as you were aware, is that correct?

A. In 2016, that's possibly the case. I can't confirm one way or another. I am sure that in 2017, the Coroner were made aware of the concerns that the doctors had raised. I honestly can't tell you what, what the Coroner was told in 2016 or -- yes.

MR SKELTON: Thank you.

LADY JUSTICE THIRLWALL: Thank you, Mr Skelton.

Now, Mr Baker, well, really all counsel, it seems to me it has been a long day already for this witness. I imagine that you have got a little time. I think, Mr Kennedy, probably a bit less? No time at the moment.

MR KENNEDY: I think having heard the evidence I will not ask any further questions. I will just be around and I can deal with it by way of submissions, if that assists.

LADY JUSTICE THIRLWALL: Thank you. Then, Ms Blackwell, you have got how long?

MS BLACKWELL: At least 20 minutes.

LADY JUSTICE THIRLWALL: So shall we say half an hour. So it seems to me we might be better doing this tomorrow morning. Everyone is nodding. I imagine that's --

Sorry, if I can just speak to you, Mr Chambers.

I had considered an early start tomorrow morning, but I think that would not be convenient for those who are coming some distance. So I hope that it will be convenient for you, you haven't really got much choice about it --

A. No, no, I am happy to support.

LADY JUSTICE THIRLWALL: -- to come at 10 o'clock tomorrow morning.

A. Sorry, say again?

LADY JUSTICE THIRLWALL: 10 o'clock tomorrow morning.

May I make one thing crystal clear in case it hasn't previously been made clear, that there should be no communication between you and your lawyers or indeed anybody else about the evidence that you are giving to this Inquiry.

A. Thank you.

LADY JUSTICE THIRLWALL: We will start again tomorrow morning at 10 o'clock.

Thank you all for the long day.

(5.49 pm)

(The Inquiry adjourned until 10.00 am, on Thursday, 28 November 2024)

I N D E X