

Wednesday, 27 November 2024

1  
2 (10.00 am)  
3 **LADY JUSTICE THIRLWALL:** Good morning.  
4 Yes, Mr De La Poer.  
5 **MR DE LA POER:** My Lady, our witness today is  
6 Mr Chambers. I wonder if he may come forward to the  
7 witness box.  
8 **LADY JUSTICE THIRLWALL:** Yes, come forward,  
9 Mr Chambers.  
10 MR ANTONY CHAMBERS (affirmed)  
11 Questions by MR DE LA POER  
12 **LADY JUSTICE THIRLWALL:** Do sit down, yes.  
13 **MR DE LA POER:** Please could you give us your full  
14 name?  
15 **A.** Yes, my name is Antony Nigel Chambers.  
16 **Q.** Mr Chambers, before we begin, I have been  
17 informed that there is something that you would wish to  
18 say right at the outset?  
19 **A.** Yes, thank you.  
20 So right at the outset I just want to offer my  
21 heartfelt condolences to all the Families whose babies  
22 are at the heart of this Inquiry. I can only imagine --  
23 well, I can't imagine the -- the -- the impact this has  
24 had on your lives and I am truly sorry for the pain that  
25 may have been prolonged by any decisions or actions that

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1 **A.** That is correct.  
2 **Q.** If we just identify some of the appointments  
3 in the run-up to joining the Countess of Chester. Were  
4 you the Director of Operations at an NHS Trust between  
5 2004 and 2007?  
6 **A.** Yes, that's correct.  
7 **Q.** Were you the Director of Operations, Planning  
8 and Performance at an NHS Foundation Trust between 2007  
9 and 2009?  
10 **A.** That is correct.  
11 **Q.** Were you the director of Planning, Performance  
12 and Delivery at a health board in Wales during 2012?  
13 **A.** During 2012?  
14 **Q.** During 2012.  
15 **A.** Yes, yes.  
16 **Q.** It was whilst you were in that role, I think  
17 in August of 2012, that you were appointed as Chief  
18 Executive Officer at the Countess of Chester Foundation  
19 Trust, albeit that you didn't start until December 2012?  
20 **A.** Yes, that's correct.  
21 **Q.** Was that your first role as a Chief Executive  
22 Officer?  
23 **A.** It was.  
24 **Q.** Before that, had you acted as a Deputy Chief  
25 Executive Officer?

3

1 I took in good faith. I am very grateful to have this  
2 opportunity to take part, openly and honestly, in this  
3 Inquiry and I hope that answers can be arrived at and  
4 recommendations made.  
5 Thank you.  
6 **Q.** Is it correct that you provided to the Inquiry  
7 a witness statement dated 13 August 2024?  
8 **A.** That is correct.  
9 **Q.** Is the content of that witness statement true,  
10 to the best of your knowledge and belief?  
11 **A.** I believe it is, yes.  
12 **Q.** We'll deal first with your background. Did  
13 you begin a career in the NHS sphere as a student nurse  
14 in February 1985?  
15 **A.** I did.  
16 **Q.** Did you subsequently qualify and practice as  
17 a nurse?  
18 **A.** I did.  
19 **Q.** In 1997, did you undertake a postgraduate  
20 diploma in Healthcare Services Management?  
21 **A.** That's correct.  
22 **Q.** After that, did you spend two decades in  
23 senior leadership roles, including acting as an  
24 Executive Director and as a Chief Executive Officer at  
25 various hospitals?

2

1 **A.** I think it's fair to say that the role I had  
2 in the large health board in South West Wales with -- as  
3 the Director of Planning, Performance and Delivery in  
4 effect would have been the Deputy Chief Executive,  
5 although that didn't have the specific title.  
6 **Q.** At the point that you began work as the Chief  
7 Executive of the Countess of Chester, did you consider  
8 yourself to be adequately qualified and experienced for  
9 that role?  
10 **A.** Yes, I -- I -- I do. I wouldn't have applied  
11 otherwise. It was a competitive process that I went  
12 through, there were five people that were interviewed  
13 and I equipped myself well through that interview and  
14 I believe that the Aspiring Chief Executive Development  
15 Programme that I completed, and I can't remember the  
16 exact years of that, prepared me adequately for the  
17 role.  
18 **Q.** Now, at the start of your witness statement,  
19 you can turn this up if you wish to, or I can just read  
20 it to you, it is on the first page, paragraph 3, I will  
21 just read it out so everybody knows what we are talking  
22 about, you say this:  
23 "I wholeheartedly accept that the operation of the  
24 Trust's systems failed and that there were opportunities  
25 missed to take earlier steps to identify what was

4

1 happening."

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

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

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

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

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

25 There I think is some of the failure that our

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

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

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

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

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

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

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

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

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

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

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

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

6

1 personal failure on your part?

2 **A.** No, I --

3 **Q.** Well --

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

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

11 **A.** That's correct.

12 **Q.** -- is that correct?

13 **A.** That's correct.

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

21 Should you have been told that on 24 June?

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

8

1 sure I should have been made aware.

2 The, the -- when I put myself back into late  
3 June 2016, the only time that I can absolutely say that  
4 I was made aware of these matters was on 29 June. I am  
5 not clear in my mind who made me aware. I am not clear  
6 in my mind was it on 29 June or was it, you know, a day  
7 or so sooner.

8 I don't believe I knew about these matters before  
9 29 June because as you have correctly described these  
10 are very important, very concerning matters and you can  
11 see that the actions that I took from that were very  
12 speedy and there were many, many meetings that came  
13 after 29 June so my assumption is that I didn't know and  
14 should I have known? I don't know where I was,  
15 I haven't got my diary, I don't know if I was in the  
16 hospital, but I think it's a fair assessment that  
17 I perhaps should have been told.

18 **Q.** Dr Brearey invited Mr Harvey and Ms Kelly to  
19 a meeting on 27 June of the senior paediatricians for  
20 them to explain to those two people what their concerns  
21 were. They didn't attend that meeting. Instead, later  
22 that afternoon, on the 27th, they met senior nursing  
23 managers and a plan was developed as to how to respond  
24 to the concerns. That plan included the instruction of  
25 the RCPCH to conduct a service review?

9

1 is -- well, the only thing I really remember is not  
2 knowing and then knowing.

3 **Q.** The alternative proposition is that you didn't  
4 know, in which case should you have known? It is  
5 a simple yes or no?

6 **A.** And I think -- I think the answer is that  
7 I perhaps should have known because there was key  
8 actions that were going on that would be important for  
9 me to be aware of. But I don't know whether I was in  
10 the Trust, what my diary movements -- had I been in the  
11 Trust, I am assuming I would have known, but I -- I --  
12 I don't know what my whereabouts were.

13 **Q.** Would you agree that if you were not told  
14 until 29 June, that that is indicative that the matter  
15 was not being treated seriously enough?

16 **A.** No, I don't think that's -- I don't think  
17 that's a fair assessment at all. I mean, if you look at  
18 the actions that were being proposed and discussed,  
19 these were not trivial actions, these were fairly  
20 significant important steps to help us get to a greater  
21 insight of what the concerns were and what the nature of  
22 that might be.

23 **Q.** So --

24 **A.** They were happening very, very fast so I don't  
25 think it was a lack of pace.

11

1 **A.** (Nods)

2 **Q.** Does it follow from your evidence that you  
3 were told none of that at the time it was happening?

4 **A.** And -- and that's where I think there may be  
5 lack of notes or lack of memory of when I was  
6 absolutely, when I was absolutely told.

7 I think -- I genuinely feel it's probably  
8 inconceivable that we would have got to a point to have  
9 instructed the Royal College of Paediatrics and Child  
10 Health without me being aware of it.

11 **Q.** We know that first contact with the RCPCH was  
12 on 28 June, so the day before you have told us. Does it  
13 follow that you think in fact you may have known before  
14 Mr Harvey contacted the RCPCH?

15 **A.** I -- I can't be sure. I -- I -- I only have  
16 absolute memory of the 29th. But the fact that there  
17 was actions that were already in train suggests to me  
18 that these were the right actions and it suggests to me  
19 that I may have been aware but I can't be certain.

20 **Q.** Well, there are two possibilities, either you  
21 were aware or you weren't. If you were aware, did you  
22 act too slowly to meet the paediatricians because that  
23 didn't happen until the evening of the 29th?

24 **A.** And that -- that, you know, I know I didn't  
25 act slowly so I suppose in -- in my mind what I remember

10

1 **Q.** Letby worked four days of the week of the  
2 27th?

3 **A.** Sorry, can you repeat that?

4 **Q.** Letby worked four days of the week the 27th,  
5 the 27th, the 28th, the 29th and 30th. What you are  
6 telling us is that it being the case that these two  
7 senior Consultants raised with the Director of Nursing  
8 that they thought that nurse was murdering babies or may  
9 be, that you were not told of that and she continued to  
10 go to work.

11 Are you suggesting that that nevertheless suggests  
12 that it was being taken seriously enough?

13 **A.** All I can say for certain is that I knew on  
14 the 29th and from evidence that I have heard that  
15 actions were being taken forward in terms of  
16 conversations with the Royal College. I was not aware  
17 of Letby's name at this point, I was not aware  
18 specifically of the nature of any of the concerns.

19 **Q.** It's very important that you just listen to  
20 the question that I am asking you. My question was:  
21 whether the fact that Letby continued to work and you  
22 were unaware of this, despite the allegation that had  
23 been raised against her or the suggestion of risk that  
24 she posed, that that suggests that it was not being  
25 taken seriously enough.

12

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

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

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

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

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

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

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

13

1 Some not satisfactory giving answers.

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

4 He goes on to say that, if we look down two-thirds.  
5 "Met in July 2015, three cases common theme was  
6 nurse. Discussed it at Thematic with Liverpool and in  
7 May 2016."

8 Then Dr Jayaram says:

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

14 Dr Brearey:

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

19 I suspect that's supposed to be 12 midnight.

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

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

15

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

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

6 Dr Saladi -- I don't expect we will need to bring  
7 this up -- sent an email early on the morning of the  
8 29th setting out a line of reasoning as to why he  
9 believed the police should be called, the Inquiry has  
10 already heard that Mr Harvey responded to that  
11 internally to the Executive Team, you are not on copy,  
12 but Alison Kelly was, that he thought that the police  
13 should be contacted.

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

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

18 **A.** That is correct, yes.

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

14

1 **MR DE LA POER:** Forgive me?

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

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

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

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

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

13 And then Dr Saladi adds:

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

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

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

23 **Q.** I understand that. Do --

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

16

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

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

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

11 **Q.** Was it --

12 **A.** And they were paediatricians.

13 **Q.** Was it an expert opinion?

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

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

20 **A.** Certainly, yes.

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

23 **A.** Yes.

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

17

1 **A.** No.

2 **Q.** -- about matters?

3 **A.** Absolutely not at all.

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

5 **A.** Yes.

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

7 **A.** I think that is exactly right.

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

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

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

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

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

19

1 **A.** What we had was the facts as they saw them.

2 There were -- there was -- so that, that's what we had  
3 is what was written.

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

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

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

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

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

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

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

18

1 **Q.** We are looking at this part of the meeting.

2 Do you agree or disagree that there was a rational basis  
3 for them to be suspicious that serious crimes had been  
4 committed?

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

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

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

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

20 **Q.** You know --

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

25 **Q.** You know that they had looked at equipment,

20

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

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

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

15 What did Mr Cross say, please?

16 **A.** In the outline?

17 **Q.** Yes.

18 **A.** I -- I have no -- no memory.

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

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

21

1 there must be something else.

2 Did you say that?

3 **A.** Where -- where did I say that?

4 **Q.** That is Dr Jayaram's evidence?

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

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

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

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

15 **A.** No, absolutely not.

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

20 Do you see that?

21 **A.** Yes, yes.

22 **Q.** Do you remember him saying that?

23 **A.** I -- I remember a discussion to that effect.

24 I don't remember if it was Ravi Jayaram.

25 **Q.** And 00

23

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

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

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

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

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

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

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

22

1 **LADY JUSTICE THIRLWALL:** It was Dr Brearey.

2 **MR DE LA POER:** Dr Brearey.

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

5 **Q.** Steve B.

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

8 "Nurse cannot be excluded."

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

11 **A.** That's correct. Yes.

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

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

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

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

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

24

1 and did work the next day. Should you have taken steps  
 2 to ensure that she didn't?  
 3 **A.** So can you -- can we just go back to the first  
 4 page of this note, please?  
 5 **Q.** By all means.  
 6 **A.** Can -- can we see where there was a discussion  
 7 around the association of a nurse on duty. Can you just  
 8 remind me where that was?  
 9 **Q.** I think the first page is entirely -- we have  
 10 run through almost every line of it is -- what the  
 11 doctors told you, so it will be on the second page, if  
 12 anywhere.  
 13 **A.** Okay.  
 14 **Q.** So we need to go to the second page. We have  
 15 looked at some of this already, the first half is the  
 16 doctors telling you more, there is then the discussion  
 17 about police being delayed.  
 18 Dr Brearey:  
 19 "Can we move member of staff?"  
 20 You saying you [inaudible] "Babies transferred and  
 21 then deteriorated", which suggests it is more serious  
 22 than you originally thought; do you agree?  
 23 **A.** Potentially, yes.  
 24 **Q.** So there you are.  
 25 **A.** Yes. So at the bottom of that page there you  
 25

1 how they might be wrong?  
 2 **A.** Yes, I suppose, but I am asking the question:  
 3 are we missing something?  
 4 **Q.** Yes. And so the position is: there is no  
 5 basis to think that they are wrong, you don't know  
 6 whether they are right?  
 7 **A.** That's -- that's correct.  
 8 **Q.** That their concern, their suspicion, is  
 9 rational and based upon an uncontradicted expert opinion  
 10 and we get to the end of the meeting after it's been  
 11 raised with you that there is a concern that that nurse  
 12 needs to be excluded and the management has said: she  
 13 can't be.  
 14 Is that a fair assessment of that meeting?  
 15 **A.** I don't recall why the note says the nurse  
 16 cannot be excluded. I can only assume that there had  
 17 been a discussion that isn't noted and that a rationale  
 18 for excluding her hadn't been arrived at and we needed  
 19 to establish a rationale before doing that.  
 20 **Q.** Let me help you with that. It was being  
 21 suggested that a member of staff may have murdered  
 22 babies.  
 23 **A.** But what you are --  
 24 **Q.** That -- if I may?  
 25 And that that therefore, would you agree, is  
 27

1 can say TC -- we can't:  
 2 "Issues we cannot explain, is this suspicious? Is  
 3 it criminal? Or are we missing something?"  
 4 So there was a discussion around that. There's  
 5 a causal link to one nurse. But also mentions of other  
 6 members of staff.  
 7 **Q.** Let's just pause there. Dr Harkness could not  
 8 be the explanation for the deaths --  
 9 **A.** No, no, I agree.  
 10 **Q.** -- of Child O and P so that was not a relevant  
 11 consideration, was it?  
 12 **A.** Yes, no, I agree. But I suppose what I was  
 13 hearing was that there were concerns being raised, there  
 14 was some hypothesis around what those causes of harm  
 15 might be and there was a suggestion that there was  
 16 a member of staff who was on duty more times than  
 17 another member of staff.  
 18 I -- I think it -- so that's what I was hearing.  
 19 **Q.** So the only doubt being cast upon the doctors'  
 20 rational, as you have told us, suspicion was you raising  
 21 the possibility that they might be wrong without knowing  
 22 how they might be wrong?  
 23 **A.** No, it was me raising: are we missing  
 24 something?  
 25 **Q.** Yes, that they might be wrong without knowing  
 26

1 a safeguarding concern?  
 2 **A.** It's a significant concern, safety concern.  
 3 **Q.** Yes, so --  
 4 **A.** The -- what is not being -- what is not coming  
 5 out through these minutes -- these notes, not minutes --  
 6 bearing in mind these are the notes of one individual,  
 7 so we have to accept there may be an incomplete record.  
 8 But what isn't being brought out here is discussions  
 9 that I am now aware of and perhaps was aware at the time  
 10 because it was discussed in the meeting, was the, if you  
 11 like, the -- what you are presenting is a very emphatic  
 12 description of harm. I -- and a subjective link to one  
 13 individual.  
 14 What I know had been discussed in previous  
 15 meetings, maybe the meeting on the 27th, the outpull of  
 16 that meeting may have been brought into this but not  
 17 noted is that there was very objective support and  
 18 rebuttal to the proposition that this one nurse was  
 19 deliberately causing harm.  
 20 **Q.** The rebuttal was that she was a good,  
 21 well-regarded nurse, which is I am sure you would agree  
 22 not a rebuttal to whether she is covertly deliberately  
 23 harming babies?  
 24 **A.** There was a very strong level of support for  
 25 this individual. You are right, it was, you know, it --  
 28

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

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

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

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

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

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

17 **Q.** That is.

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

24 **Q.** Why is there no discussion about that?

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

29

1 **A.** Yes.

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

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

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

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

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

17 **A.** Say again, sorry?

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

20 **A.** Thank you.

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

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

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1 **Q.** Is that because?

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

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

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

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

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

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

25 **Q.** Where do we see that there?

30

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

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

6 **A.** Right.

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

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

15 You then go on to say:

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

17 To which Dr Brearey says:

18 "Risk would be reduced."

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

21 **MR DE LA POER:** Thank you, my Lady:

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

24 Then a number of points attributed to you:

25 "Test out hypothesis with her being off."

32



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

33

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

35

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

34

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

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1 know that to be yes.

2 **A.** That is -- that is the answer.

3 **Q.** So there is potentially two explanations for  
4 that because two variables have changed. Did you ever  
5 take expert advice about from the Consultants about what  
6 the actual effect was of the redesignation and how that  
7 was relevant to the babies who had collapsed  
8 unexpectedly previously?

9 **A.** So as you -- as you reminded me, we put in  
10 process a method of daily management where we had  
11 a dashboard that gave a very clear oversight of the --  
12 the level of demand through the unit, the acuity of --  
13 of babies on the unit, the staffing levels on the unit  
14 and those -- that dashboard was shared with the -- with  
15 the clinicians.

16 **Q.** Mr Chambers, we know and we will come to it,  
17 that in March the clinicians wrote to you and set out in  
18 terms why in their expert opinion the redesignation did  
19 not explain the change in data; do you remember them  
20 doing that?

21 **A.** I -- I do remember the letter. I'm not sure  
22 that that was the entirety of the letter. I think they  
23 were, but, yes, we can go to it at some point later.

24 **Q.** We will. At all events, we will move to the  
25 staying with the subject of police, the evidence that we

37

1 meeting?

2 **A.** Can you please put the note up?

3 **Q.** Of course I can. INQ0003150.

4 **A.** So this meeting, you can see I outlined this  
5 meeting and gave an overview as to where I felt we were  
6 at that time. So we had had the Royal College review  
7 actions and recommendations, we had had the Hawdon  
8 review, we had also had the -- the review by  
9 pathologists from Alder Hey, 17 cases had been reviewed.  
10 Out of all of that there was two unascertained causes of  
11 --

12 **Q.** Mr Chambers, if I may everybody can read --

13 **A.** But it is important. This was the context for  
14 this meeting so the -- the -- the meeting at up until  
15 the -- up until the point of this meeting, that's where  
16 we as -- as a board believed we were; that there was  
17 an explanation for all but two of the causes of death.

18 Those had been --

19 **LADY JUSTICE THIRLWALL:** I'm sorry to interrupt  
20 you, Mr Chambers, but is this in this note?

21 **A.** No, but it's helpful --

22 **LADY JUSTICE THIRLWALL:** When you say "TC welcomed  
23 everyone to the meeting" that is obviously you?

24 **A.** Yes.

25 **LADY JUSTICE THIRLWALL:** Then you set out there the

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1 have heard from Ms Sian Williams supported by

2 Julie Fogarty, that having undertaken work on the rota  
3 she spoke to Executives including Alison Kelly, she  
4 doesn't suggest that she spoke to you --

5 **A.** Yes.

6 **Q.** -- saying that her conclusion was that the  
7 police should be called. Were you aware that she had  
8 said that?

9 **A.** No.

10 **Q.** Should you have been told that the Deputy  
11 Director of Nursing, who had been given a particular  
12 task directly relevant to this, had reached that  
13 conclusion? Should you have been told that?

14 **A.** Perhaps, yes.

15 **Q.** If we move forwards in time, we perhaps don't  
16 need to look at the detail but we can if you need to.

17 On 27 March there was a meeting which was attended by  
18 you and representatives of the Neonatal Network, do you  
19 remember, Julie Maddocks was there?

20 **A.** 27 March 2017?

21 **Q.** 2017. Yes, moving forward there?

22 **A.** Yes.

23 **Q.** Again, staying with the subject of the police,  
24 not all of that meeting, do you recall that Dr Brearey  
25 said "this needs to be escalated to the police" in that

38

1 context, did you set out other contexts --

2 **A.** I think the note --

3 **LADY JUSTICE THIRLWALL:** -- that you are now  
4 telling us about?

5 **A.** The meeting I think goes on to explore some of  
6 that.

7 **MR DE LA POER:** This is very important,  
8 Mr Chambers. My question was about whether Dr Brearey  
9 said that the matter needed to be escalated to the  
10 police. It's very important that we focus on that.

11 **A.** And I -- I don't disagree with that statement.

12 **Q.** So --

13 **A.** But it's important that we understand what  
14 this meeting -- what led up to this meeting and what the  
15 nature of the discussions were at this meeting because  
16 this was the first meeting where there was a decision  
17 that we would formally go to the police.

18 **Q.** Mr --

19 **A.** So the event, the matters that led up to this  
20 meeting was the sharing of the Royal College review, the  
21 Hawdon review, the -- the opinion of the Alder Hey  
22 pathologist --

23 **LADY JUSTICE THIRLWALL:** Yes, you have told us  
24 that.

25 **A.** Yes, which then was seen as -- was shared

40

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

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

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

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

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

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

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

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

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

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

13 **A.** That's correct.

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

16 On 28 March, we know that Letby was due to return  
17 to work the following day. We have a meeting.

18 INQ0014281, we can see that you attend together with  
19 Sir Duncan Nichol, Sue Hodgkinson, Ms Kelly, Mr Harvey  
20 and plainly Mr Cross, because he's making the note.

21 Again we will just confirm what is in the note.

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

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

2 **A.** Okay.

3 **Q.** We are going to look, please, at page 2.

4 Just, we can see here that Ms Maddocks was asked  
5 a direct question by you about phoning the police. Let  
6 us just note together what her answer is.

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

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

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

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

16 **A.** Yes.

17 **Q.** Do you see that?

18 **A.** Yes.

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

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

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1 police?"

2 Then a little further down it would appear that  
3 it's agreed that Mr Cross was to contact the police on  
4 Friday 31st and suggest making an appointment for  
5 3 April.

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

8 **A.** Yes, yes, yes.

9 **Q.** So do you agree it appears that the plan is  
10 going to be that the police are going to be spoken to on  
11 31 March?

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

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

16 **A.** There was never any intention to not go to the  
17 police. The decision had been made at the meeting on  
18 27 March. What we needed help and advice on is this was  
19 a serious escalation of matters and we needed to be  
20 clear around how we would manage that next step.

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

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

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

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

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

16 **A.** Correct.

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

19 **A.** Correct.

20 **Q.** Staying with the theme of the police?

21 **A.** Yes, that is okay.

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

23 **A.** Yes.

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

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

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

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

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

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

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

24 Nothing that they were saying was pointing to  
25 deliberate harm.

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

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

6 **A.** Yes, of course.

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

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

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

18 Was that fairly stating the position at its  
19 highest?

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

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

25 **A.** We had, as is discussed in the paragraphs

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1 **Q.** Well --

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

7 **Q.** 27 April?

8 **A.** 27 April.

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

12 **A.** I -- I --

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

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

20 **Q.** Yes.

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

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

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

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

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

9 **Q.** Well --

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

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

18 **A.** I think that's an unfair proposition.

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

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

25 The second paragraph:

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1 the case.

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

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

12 **Q.** Well --

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

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

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

20 **A.** So it says:

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

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

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

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

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

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

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

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

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1 just needed it to be checked."

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

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

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

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

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

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

19 **A.** Yes.

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

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

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

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

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

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

11 **A.** Yes.

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

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

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

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

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

5 **Q.** Was this said with the best of intentions?

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

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

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

17 **Q.** Was it disrespectful?

18 **A.** To who?

19 **Q.** The paediatricians?

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

24 **Q.** And was it disrespectful to the Families?

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

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

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

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

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

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

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

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

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

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

15 (11.22 am)

(A short break)

17 (11.41 am)

18 **LADY JUSTICE THIRLWALL:** Mr De La Poer.

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

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

23 **A.** That's correct, yes.

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

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1 Register; is that right?

2 **A.** That's correct.

3 **Q.** I am going to bring up the Executive Risk  
4 Register, INQ0049845.

5 If we go to page 2, please. There are just two  
6 matters to ask you about this page. The first is  
7 a reference to two particular risks, I am not entirely  
8 sure why they have been ciphered here but in fact I can  
9 tell you that it is the first risk and the penultimate  
10 risk, which is being referred to there.

11 We can see the entry at the bottom:

12 "Chairman's actions were taken on 11 July 2016 to  
13 add two risks to the Executive Risk Register from Urgent  
14 Care. There are no risks identified by the divisions  
15 for escalation to the ERR for July 2016."

16 So those are the two neonatal risks that we see  
17 there.

18 We heard from Ms Millward that she thought the  
19 reference to "chairman" was not to Sir Duncan Nichol  
20 the chairman of the Board of Directors, but to the  
21 chairman of the Corporate Directors Group which was  
22 responsible for the Executive Risk Register.

23 Now, the first question about this entry is: is  
24 that reference to chairman a reference to you?

25 **A.** I -- I believe it is, yes.

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1 a risk and then describing the risk itself, so the risk  
2 as I saw it was that we had reclassified our urgent --  
3 our neonatal unit, that there had been an increase in  
4 mortality and it was very important that in maintaining  
5 the confidence in local hospital services and in this  
6 case neonatal services, that we -- if you like, that  
7 would have been the reference around reputational risk.

8 At any day of the week, even today, there can be  
9 a woman in the obstetric unit, labouring, and whose baby  
10 may require neonatal services and it was very important  
11 that we -- was able to reassure them that the neonatal  
12 unit was safe. So that was -- it was around that issue,  
13 not any kind of reputational issue that -- that would  
14 have been a concern to the organisation around how it  
15 was viewed. It was maintaining confidence, so the way  
16 that the risk was described there and I don't know if it  
17 was redrafted at a later time, but the way it was  
18 described, described there, I think is problematic.

19 **Q.** It is problematic. You see, just help us to  
20 understand how you can be directing that a risk should  
21 be put on the Executive Risk Register without having  
22 seen what that risk is?

23 **A.** Sorry?

24 **Q.** You have told us that you didn't see it until  
25 it got on to the Risk Register as I understand it. But

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1 **Q.** Are we to understand then that on 11 July, you  
2 said you wanted two risks to be added to the Executive  
3 Risk Register from the Urgent Care Risk Register?

4 **A.** I -- I don't remember the specific instruction  
5 but it -- it's -- it's quite likely that that was  
6 an instruction.

7 **Q.** Now, the second matter to ask you about here  
8 is if we see the language of one of those two risks:

9 "Potential damage to reputation of neonatal service  
10 and wider Trust due to apparent increased mortality  
11 within the neonatal unit".

12 That was one of the two risks that it would appear  
13 you asked to come on to the Executive Risk Register and  
14 we can see that it has a risk level grading that would  
15 justify that.

16 My question, however, is whether you were struck at  
17 the time about the way in which that risk was framed, in  
18 other words by reference to reputational damage? Was  
19 that something that struck you at the time?

20 **A.** I don't remember seeing the -- the risk as it  
21 was drafted there prior to any formal Executive Risk  
22 Review Meeting. The phrasing of the risk there is in my  
23 view not necessarily capturing -- I will take my glasses  
24 off, not necessarily capturing the origin to that risk.

25 A Risk Register is about having the origin to

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1 what note appears to indicate is before it got on to the  
2 Executive Risk Register, you asked for it to be put on  
3 there which would suggest that --

4 **A.** I -- I -- I'm not sure that is necessarily the  
5 nature of the instruction. The instruction would have  
6 been we need to have risks described on the Executive  
7 Risk Register that dealt with the matters around and  
8 the -- and maintaining confidence because of the  
9 increase in neonatal mortality and I would not  
10 necessarily have seen the drafting of that prior to it  
11 going on the Risk Register.

12 **Q.** Well, Karen Townsend said the wording came  
13 from the Executives; did you know that?

14 **A.** I -- I have heard that from her evidence.  
15 I cannot imagine a scenario where that would have been  
16 the case.

17 **Q.** Well, unless the Executives were trying to  
18 control the narrative?

19 **A.** Yes, and that is what I am saying. I cannot  
20 imagine a scenario whereby we would have instructed the  
21 way a risk was described, prior to the Executive Risk  
22 Review Meeting, where then there would have been  
23 a discussion about: does this risk describe the risk?  
24 Are the actions the right actions? Are the mitigations  
25 the right mitigations? Are the scores the right scores?

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

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

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

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

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

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

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

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

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

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

10 That is attributed to you.

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

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

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

19 **A.** No, none at all.

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

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

25 I am clear that was I think number 6 in the

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

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

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

10 **A.** Yes. Yes.

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

15 **A.** Yes, that's correct.

16 **Q.** Do you recollect that?

17 **A.** Yes.

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

20 **A.** No, there was no discussion about forensic  
21 pathologist.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 **A.** No.

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

13 **A.** No.

14 **Q.** -- said was misleading?

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

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

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

25 You can see now the words that were used about

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

3 But I haven't got the specific detail.

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

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

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

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

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

25 **Q.** It's addressed to Mr Harvey.

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

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

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

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

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1 of those because she was instructed to do each.

2 **LADY JUSTICE THIRLWALL:** Are we waiting for another  
3 page?

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

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

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

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

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

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

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

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

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

17 **Q.** So --

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

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

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1 the recommendation from the Royal College review.

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

5 **A.** Yes, okay.

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

10 **A.** Yes.

11 **Q.** All right.

12 **A.** Okay.

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

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

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

25 **A.** So we can see that she did --

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

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

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

14 **Q.** Yes, the access?

15 **A.** Yes.

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

20 **A.** Yes.

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

24 **A.** Yes.

25 **Q.** Now, Dr Hawdon says this:

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

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

10 **A.** Yes.

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

14 **A.** Yes.

15 **Q.** That was never undertaken, was it?

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

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

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

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

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

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

9 **Q.** The collapse of a third was also  
10 unascertained?

11 **A.** Say, again sorry?

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

14 **A.** Okay.

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

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

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

25 **A.** Yes.

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

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

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

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

14 So that was three.

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

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

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

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1 **Q.** -- when the network reviewed it --

2 **A.** Okay.

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

5 **A.** Fine.

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

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

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

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

25 That is the quote from over the page which you

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1 remembered.

2 "I discussed your question with Ian Harvey who  
3 describes how time constraints precluded a comprehensive  
4 reading and has no recollection that he omitted to  
5 mention that further investigation of a small number of  
6 cases was recommended. It was certainly not  
7 intentional."

8 So the allegation was put that before they received  
9 the report, nobody mentioned to the Consultants about  
10 those four cases requiring broader forensic review due  
11 to being unexpected and unexplained. So that's there.

12 My question is: please tell us about the discussion  
13 you had with Mr Harvey and what it was that he was  
14 telling you about time constraints precluding  
15 a comprehensive reading?

16 **A.** I -- I -- I really don't know. To be fair,  
17 the -- in producing this document, which was a very  
18 detailed and thoughtful document in the sense that the  
19 questions that came from the paediatricians were  
20 thoughtful and there was an -- an equivalent amount of  
21 thought went into the answers and so Ian would have  
22 helped in the drafting of this response.

23 So I don't remember specifically, at all, what the  
24 time risk constraints he's referring to other than  
25 perhaps the requirement that we promised to publish the

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1 had recommended further investigation in four cases?

2 **A.** Is -- are they -- is this in respect of the  
3 feedback meeting to the clinicians, to the doctors that  
4 was taking -- that took place in January?

5 **Q.** 26 January, yes.

6 **A.** Yes. So it's in relation to that. He's  
7 right. I -- I'm not sure he was clear at that meeting  
8 that there was a requirement for a further four cases.  
9 But I know that he knew that work needed to be  
10 completed, that work was ongoing and it would have just  
11 been an oversight on his part. We also know -- I also  
12 know that following those meetings, there were several  
13 further meetings between Ian, the paediatricians, the  
14 Neonatal Network, that in your words took the number  
15 from two to four to seven to eight.

16 So it's clear that the work was ongoing and Ian was  
17 being very attentive to it. It was just an omission on  
18 his part and he apologises for that, I think, in this  
19 letter.

20 **Q.** Mr Harvey was dealing, as we understand it,  
21 with the detail of it and I understand your evidence to  
22 be to that effect?

23 **A.** Yes.

24 **Q.** I mean, was it -- were you being told that  
25 Dr Hawdon's recommendation would be entirely satisfied,

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1 findings of the College review and -- and these other  
2 matters, and that we were already struggling to hit  
3 those -- those timelines.

4 **Q.** Just -- the words included in your document  
5 "time constraints precluded a comprehensive reading"  
6 rather sounds like because he was very busy, he didn't  
7 read it properly. I mean, that's what that ordinary  
8 English language means, doesn't it?

9 **A.** Yes, you, you -- it's -- I know it's my letter  
10 but these would have been Ian's words and I think it's  
11 important that you discuss that with Ian. I wouldn't  
12 have drafted this without his support.

13 **Q.** You there appear though to be accepting to the  
14 Consultants who by now know all about Dr Hawdon's report  
15 and have had those interactions that I have described  
16 that there were in your phraseology a small number of  
17 cases were recommended for further investigation. Do  
18 you see?

19 **A.** We are still on 2.6, are we?

20 **Q.** Yes. We have read it already.

21 "... [he] has no recollection that he omitted to  
22 mention that further investigation of a small number of  
23 cases was recommended."

24 So the point really being that it would appear,  
25 Mr Chambers, that in 2018 you recognised that Dr Hawdon

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1 in terms of these broad forensic review, by  
2 Dr McPartland having a look at it?

3 **A.** I think that's probably not an unreasonable  
4 description of what I heard. Whether that was  
5 specifically what Ian was saying, Ian was not ever in  
6 the habit of being anything other than thorough.

7 **Q.** Let's have a look at the RCPCH report,  
8 INQ0009619, this is 28 November that it's received by  
9 the Trust. And we are here just going to look at the  
10 dissemination copy, so this isn't the confidential copy,  
11 this is the dissemination copy.

12 If we go to page 13, we will just consider one of  
13 the questions was: does it have clear and engaged  
14 leadership and good team working?

15 We can see that the first paragraph, if I can  
16 characterise it in this way, and ask for your agreement  
17 is overwhelmingly positive about the leadership; do you  
18 agree?

19 **A.** Yes, it describes good working relationships  
20 between doctors and nurses.

21 **Q.** Yes. Now the second paragraph raises some  
22 historical issues and identifies individual problems.  
23 But do you agree that the weight of this, what's being  
24 said about the leadership is it is very good but there  
25 are one or two problems that we have identified?

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

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1 A. Yes.  
 2 Q. Over the page. Do we see that there is  
 3 another set of recommendations, both between the network  
 4 and Commissioners about improving patient safety? They  
 5 are both highlighted for you.  
 6 A. Sorry, what was the question again?  
 7 Q. There are two recommendations to the network  
 8 and to NHS England which are aimed at improving patient  
 9 safety?  
 10 A. Correct.  
 11 Q. Let's go to page 24. We have the question  
 12 that was within the Terms of Reference: are there any  
 13 identifiable common factors or failings? And we can see  
 14 that there is a paragraph to start with, 4.6.1, which  
 15 states a number of facts, but is not in itself answering  
 16 that question; do you agree?  
 17 A. Well, I'm not sure I do, actually.  
 18 Q. So --  
 19 A. The 4.6.2.  
 20 Q. I am not asking about 4.6.2, I am asking about  
 21 4.6.1 which I suggested to you contains a number of  
 22 factual assertions which don't answer the question we  
 23 will come to 4.6.2.  
 24 A. That's correct.  
 25 Q. 4.6.2. The first bullet point indicates that

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

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

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

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

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

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

17 **A.** No.

18 **Q.** No.

19 **A.** And that is not what we read.

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

24 **A.** That's correct.

25 **Q.** That particular concern. And that by no means  
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1 his evidence is not relevant to the decisions that you  
2 are making at the time on the information available to  
3 you then.

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

10 **A.** I think that's right.

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

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

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

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

23 **Q.** Well, can I suggest, rather than us looking  
24 for that, that that is identified over lunch and we will  
25 come back to that?  
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1 accounted for the increase in mortality, did it?

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

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

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

10 **Q.** I am looking at --

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

18 His evidence was that he saw babies that were being  
19 cared for on the neonatal unit, at this time, in  
20 2015/2016 that he would have seen transferred out  
21 previous to this when he had worked there on his first  
22 placement. So these are just facts of -- and context.

23 **Q.** Mr Chambers, I have again listened courteously  
24 to you making a speech. I am asking you about what you  
25 knew at the time. Whatever the doctor has said now in  
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1 **LADY JUSTICE THIRLWALL:** We will find it over the  
2 lunch time and then you will have it.

3 **A.** Okay, thank you.

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

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

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

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

12 "Network would like a copy of the review."

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

14 **A.** Okay.

15 **Q.** And we can also see towards the bottom:

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

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

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

25 **A.** I -- I think the number that we were referring  
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1 to at this time was two, not four, and I'm pretty sure  
2 but you need to check with Mr Harvey tomorrow, that he  
3 asked the specific question of the Alder Hey pathologist  
4 how unusual is it to have unascertained causes of death  
5 and that would have been, I think, the origin to that  
6 point.

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

9 **A.** Correct.

10 **Q.** Let's see what she said about that.

11 INQ0003124. She was asked directly this question some  
12 time later. And she of course is a neonatologist,  
13 page 2.

14 **A.** Yes.

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

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

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

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1 point --

2 **Q.** I am not suggesting at this point --

3 **A.** -- because the work -- the work was already  
4 being progressed.

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

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

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

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

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

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

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

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

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

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

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1 directors should have done in November 2016?

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

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

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

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

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

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

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1 the report was handed out to the people in the room at  
 2 the start of the meeting. Does that accord with your  
 3 recollection?  
 4 A. I -- I don't know.  
 5 Q. Well, let's see what Mr Harvey says about it.  
 6 Right at the bottom we can see the sentence starts:  
 7 "The Review Team made ..."  
 8 "Over the page, please:  
 9 "... a number of recommendations although nothing  
 10 immediate."  
 11 We have just looked at the fact that were six  
 12 immediate recommendations, that was a false statement,  
 13 wasn't it?  
 14 A. Sorry, what was a false statement?  
 15 Q. That the RCPCH made a number of  
 16 recommendations, although nothing immediate?  
 17 A. I'm not sure I agree with, I think that's  
 18 a fair statement.  
 19 Q. You don't -- you don't think that the RCPCH  
 20 made any recommendations which are headed "Immediate  
 21 recommendations"?  
 22 A. One recommendation was for the in-depth review  
 23 to be commissioned which I would have seen as the  
 24 immediate recommendation.  
 25 Q. Well, the first statement is nothing

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

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1 identified an issue of leadership?

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

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

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

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

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

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

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

9 **Q.** So as you have raised it, at the meeting on  
10 26 January where the Royal College report was spoken  
11 about but had not been provided to those present, would  
12 you put that in the category of discourteous?

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

20 **Q.** So 3 February was when that report was  
21 published which meant that the Execs had had it since  
22 28 November, you have already agreed that it contains  
23 a number of patient safety recommendations to external  
24 bodies who won't know anything about those until you  
25 release the report.

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

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

8 **A.** No, no.

9 **Q.** -- what the report actually said?

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

16 **Q.** This is what we understand --

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

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

22 **A.** Yes.

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

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

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

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

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

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

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

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

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

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

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

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1 A. Say again, sorry?  
 2 Q. Isn't that what those words mean; that she is  
 3 going back on the unit?  
 4 A. And the outcome of the grievance was clear  
 5 about that, subject to the caveats that I outlined.  
 6 Q. Page 4, one-third of the way down. A comment  
 7 made by Mr Harvey, which we will need to have to give  
 8 context to what's said later. A third of the way down,  
 9 the second sentence:  
 10 "Part of this sharing is us as an organisation  
 11 drawing a line. Anyone steps over that, full  
 12 disciplinary policy may be used."  
 13 So what Letby is being told in this meeting is now  
 14 the report has been shared, a line is being drawn and if  
 15 anybody continues to talk about this, disciplinary  
 16 process.  
 17 A. No.  
 18 Q. Isn't that what that means?  
 19 A. No, not at all. The, the reference to and  
 20 there's lots of references to lines being drawn and  
 21 consequences and so on. But in truth what that related  
 22 to, the -- was the matters of the grievance and the  
 23 matters of the grievance were two-fold really: there was  
 24 the way that the Trust had handled her redeployment and  
 25 the lack of honesty and transparency around that and  
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1 that became for Kathryn de Berger.  
 2 Q. Page 6, one-third of the way down. You:  
 3 "Your resilience, Lucy, you astound me."  
 4 A. Yes.  
 5 Q. Did you --  
 6 A. I say, I say it twice.  
 7 Q. Yes. Have you ever made such a statement in  
 8 relation to the Consultants for the bravery that they  
 9 showed when trying to speak out to keep babies safe?  
 10 A. Yes, in many of the meetings that took place  
 11 in June, July 2016. If you look at the notes all of the  
 12 meeting notes at the end make a reference to thanking  
 13 everybody for their contributions, thanking everybody  
 14 for their open and candid contributions to the  
 15 discussions and a very clear statement about: These  
 16 matters are really difficult, let's take care and look  
 17 after each other.  
 18 Q. It was specifically about the courage that  
 19 they had shown?  
 20 A. Yes.  
 21 Q. Page 6, halfway down, bottom of the big  
 22 paragraph:  
 23 "Our commitment is now to meet with the Consultants  
 24 to get you back on the unit and meet with you again in  
 25 the future."  
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1 that was why I had been asked to meet with her and her  
 2 family to apologise. Normally I would never have been  
 3 in a meeting like this.  
 4 The second was in relation to areas where there had  
 5 been allegations of derogatory language and so on,  
 6 where -- you know, fell below the values of the  
 7 organisation. So the line being drawn was on the  
 8 matters of the grievance, not on the matters of the  
 9 investigations into unexplained increases in mortality.  
 10 Q. Two-thirds of the way down, you:  
 11 "We had unexpected deaths. We have received  
 12 an explanation by expert reviews."  
 13 You had not, in fact, received an explanation --  
 14 A. No.  
 15 Q. -- had you?  
 16 A. Again, as I said, when I reflected at the  
 17 start of this session this was one area if I'd have --  
 18 if I'd have -- I perhaps should have called out where  
 19 I didn't get the communications right.  
 20 And the reason for this was not in any way to  
 21 trivialise, was not in any way to, to be anything other  
 22 than trying to take the heat out of what was  
 23 increasingly a difficult relationship with her father,  
 24 particularly. And we have heard evidence from  
 25 Sue Hodgkinson yesterday about some of -- how threatening  
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1 A. Yes.  
 2 Q. You were giving her a commitment that she was  
 3 going back on the unit, weren't you?  
 4 A. I was -- I was -- as I have said, the handling  
 5 of this meeting was perhaps not as good as it could be.  
 6 But the spirit of the grievance, outcome of the  
 7 grievance was that subject to all of the things I'd  
 8 already explained being completed that you should be  
 9 returned to the unit. So it was in the spirit of that.  
 10 Q. Did you give them a commitment at the meeting?  
 11 A. Say again, sorry?  
 12 Q. Did you give them a commitment at the meeting  
 13 that she would be back on the unit?  
 14 A. I gave them a commitment, I suppose, at the  
 15 meeting that we would take forward the recommendations  
 16 from the grievance process.  
 17 Q. Well, what the words say is: your commitment  
 18 now to meet with the consultants "... get you back on  
 19 the unit." That is a commitment to get her back?  
 20 A. And, and -- and that, you know, again at that  
 21 time we hadn't completed everything. I was not able to  
 22 give that commitment. But it was necessary -- it was,  
 23 it was in the spirit of the, the letter of the grievance  
 24 that said subject to satisfactory completion of all the  
 25 reviews, and you not being called out.  
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1 So it was, it was consistent with that.  
 2 **Q.** Given what you have said, my Lady, I wonder if  
 3 I can do one very short document following this because  
 4 it's relevant to the answer which we have been given.  
 5 I note the time, but it will sit better here than at the  
 6 start of the next session, if that's possible.  
 7 **LADY JUSTICE THIRLWALL:** Yes, all right.  
 8 **MR DE LA POER:** The meeting on 30 December 2016.  
 9 INQ0004299, page 2. This is a meeting of the directors,  
 10 the Executive directors and we can see one-third of the  
 11 way down:  
 12 "Difficult meeting with Lucy and family.  
 13 Commitment to them at the meeting."  
 14 So you there appear to be talking in terms about  
 15 the fact that you were aware that you had made  
 16 a commitment and you go on to say, according to the  
 17 record:  
 18 "Exposed in the meeting somewhat."  
 19 So you appear to be recognising, do you agree, that  
 20 just a few days later, you had made her a commitment?  
 21 **A.** I think the commitment to them in the meeting  
 22 was that we would share with the board the letter of her  
 23 statement that she had shared with us at that meeting  
 24 and I think that was the relation, that was in respect  
 25 of the commitment.

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1 At that point you indicated that you had dealt with  
 2 the matter in your witness statement and would like to  
 3 refer to it. So the first question is have you had  
 4 a chance over lunch to look through your witness  
 5 statement?  
 6 **A.** I -- I have. We don't need to draw it out  
 7 now. We can bring it out in written evidence if that's  
 8 helpful or ...  
 9 **Q.** Well, is there -- in terms of the question  
 10 that I have asked you, and suggested to you that what it  
 11 came to was that the RCPCH report did not provide  
 12 an answer for the increase in neonatal mortality, having  
 13 had a chance to refresh your memory from your statement,  
 14 is that a question that you can agree with or disagree  
 15 with?  
 16 **A.** I'll read 355 of my witness statement. It is  
 17 just a short paragraph and that hopefully will resolve  
 18 the issue.  
 19 **Q.** If you just pause for one moment. 355?  
 20 **A.** 355.  
 21 **Q.** Do you have a page reference for that?  
 22 **A.** It's page 101.  
 23 **Q.** Thank you very much indeed, yes.  
 24 **A.** Is that okay?  
 25 **LADY JUSTICE THIRLWALL:** Yes, go ahead.

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1 **MR DE LA POER:** My Lady, would that now be  
 2 a convenient moment.  
 3 **LADY JUSTICE THIRLWALL:** Yes, certainly.  
 4 Mr Chambers, somebody has been working hard  
 5 downstairs to find the paragraph references for you and  
 6 we think they are between paragraphs 350 and 356 and 355  
 7 in particular. So you can look at that.  
 8 **A.** Sorry, 315?  
 9 **LADY JUSTICE THIRLWALL:** Between 3-5-0 and 356, 355  
 10 being the relevant one. I'm not going to ask you about  
 11 it now, but you will have a chance to look at it over  
 12 the break and we can come back to that at a convenient  
 13 moment this afternoon.  
 14 **A.** I'm so grateful. Thank you.  
 15 **LADY JUSTICE THIRLWALL:** So we will start again at  
 16 5 past 2.  
 17 **(1.08 pm)**  
 18 **(The luncheon adjournment)**  
 19 **(2.04 pm)**  
 20 **LADY JUSTICE THIRLWALL:** Mr De La Poer.  
 21 **MR DE LA POER:** Mr Chambers, in the morning session  
 22 just before lunch, I asked you a question. My question,  
 23 we have looked back on the transcript, was this: does it  
 24 come to this the RCPCH report did not provide an answer  
 25 to the increase -- for the increase in mortality?

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1 **A.** Oh, thank you. So:  
 2 "I was conscious that given the issues identified  
 3 within the leadership of the unit, including in relation  
 4 to not following incident reporting processes and not  
 5 having suitable processes in place to ensure timely  
 6 escalation, the report was going to be a difficult read  
 7 for Dr Brearey and Dr Jayaram. I was also mindful of  
 8 the comments in the report about the Consultants'  
 9 allegations being based on a 'gut feeling' and that the  
 10 RCPCH had not alluded to any further evidence of  
 11 wrongdoing on the part of Letby or any other [members  
 12 of] staff ..."  
 13 So:  
 14 "At the time I did not feel that the RCPCH Review  
 15 had addressed all the concerns but I did feel that we  
 16 were moving towards a position where we had a better  
 17 understanding of all the factors which may have  
 18 contributed. I felt it was positive that with the  
 19 Consultants' assistance we could start to address the  
 20 issues highlighted to us."  
 21 **Q.** Thank you. We no doubt will come back to the  
 22 RCPCH shortly. But we were dealing with the topic of  
 23 your meetings with Letby and we had dealt with your  
 24 meeting in December.  
 25 There is also a meeting on 6 February of 2017 and

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

6 **A.** Yes.

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

9 "I expect four apologies."

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

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

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

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

20 **A.** Yes.

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

23 **A.** Yes, correct.

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

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

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

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

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

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

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

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

24 **A.** Yes.

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

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1 behaviour, using the benefit of hindsight?

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

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

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

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

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

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

20 **A.** Yes, yes.

21 **Q.** Then you say this:

22 "All support your transition back."

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

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

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

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

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

14 "We will get an apology from Jim."

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

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

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

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

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1 it was that Dr McCormack had done?

2 **A.** In truth, I didn't know the specifics of what  
3 any of the Consultants had done.

4 **Q.** No, but in those circumstances, should you not  
5 have been saying: well, I will find out more about  
6 Dr McCormack and we will see whether it's appropriate  
7 for him to apologise as opposed to, however it was  
8 expressed, the sentiment is "We will get Dr McCormack to  
9 apologise to you"?

10 **A.** Yes. And I don't want to repeat, but I've  
11 already conceded that this is a point that I know  
12 I didn't get right.

13 **Q.** If we go to page 5, the bottom third of the  
14 page, we can see that there is a discussion here about  
15 Letby not wanting anything on her record. Again, just  
16 at the time, was this something that you -- that struck  
17 you as being her inappropriately trying to control the  
18 situation, or did you think that this was normal and  
19 appropriate?

20 **A.** To be honest, I -- any -- any nurse that would  
21 have been through some process like this, where they had  
22 been removed or there had been some sort of action, it  
23 would not at all be unreasonable for them to want to be  
24 clear what this would have meant in terms of their  
25 personnel record. So I didn't necessarily see anything

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1 also didn't point at any unnatural causes.

2 **Q.** Well, I am just inviting you to consider the  
3 possibility, because there is a difference between the  
4 two as you have accepted --

5 **A.** Yes, I.

6 **Q.** -- that perhaps in your mind at the time you  
7 were taking the approach that she had been vindicated --

8 **A.** No --

9 **Q.** -- when in fact that was not the case?

10 **A.** No, I mean, in my mind I was very clear what  
11 the process was, what the grievance was and what the  
12 investigations were. I was also -- as I've I think on  
13 three occasions now recognised that in handling these  
14 meetings with Letby, I was very conscious to try as much  
15 as possible to avoid further escalation from --  
16 particularly from her father. Her father wasn't at this  
17 meeting, but you got a sense of his presence.

18 **Q.** Does your wish to avoid escalation involve you  
19 being prepared to say things which weren't correct?

20 **A.** That were in -- in effect a misinterpretation  
21 of the outcome of the grievance and what Hawdon review,  
22 et cetera, had arrived at in terms of identifying  
23 unnatural causes, so only natural causes for death.

24 **Q.** Go to page 6, at the top. You said that the  
25 previous record about "we will get an apology from Jim"

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1 particularly problematic there.

2 **Q.** You see, what you say ahead of that is at the  
3 top, you are talking about the reviews with lots of  
4 learning for everyone and you say: it's only vindicated  
5 you. That's what's recorded there.

6 **A.** Well --

7 **Q.** So --

8 **A.** -- only in so much as the grievance hearings  
9 had been upheld and so far the reviews that we had had  
10 hadn't pointed to any -- any unnatural causes.

11 **Q.** Well, the RCPCH had said that they could not  
12 investigate whether Letby was responsible, didn't they?

13 **A.** The RCPCH as I said provided reassurance as to  
14 part of the question and moving us into -- into a place  
15 where we had a better understanding. But I would never  
16 argue that it had given us all the understanding.  
17 That's just Jane Hawdon and the other reviews had been  
18 undertaken.

19 **Q.** As a matter of ordinary language the RCPCH  
20 report did not vindicate Letby because it didn't  
21 investigate her?

22 **A.** No, it didn't investigate her, correct.

23 **Q.** Dr Hawdon did not vindicate Letby because it  
24 did not investigate Letby?

25 **A.** In so much -- it didn't vindicate her, but it

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1 may have been not an accurate transcription of what you  
2 said. We can see here:

3 "We will get an apology from all."

4 **A.** Yes.

5 **Q.** Do you think that is something that you said  
6 to Letby; that you would get an apology from everybody  
7 who --

8 **A.** Well, I think it -- I think earlier in the  
9 meeting I think that was already a position that had  
10 been agreed upon.

11 **Q.** Well, wasn't it a matter for the Consultants  
12 whether they wished to apologise?

13 **A.** I think the -- I don't -- I don't know how we  
14 had moved from individual apologies to an apology for  
15 all.

16 I can only assume that was something that had been  
17 done through a conversation with Ian Harvey and the  
18 Consultants themselves. It felt to be a less -- I don't  
19 know, less personal.

20 **Q.** Page 7, the fourth to last entry. Last  
21 sentence:

22 "Lucy, don't worry, we have got your back."

23 **A.** Yes. Clumsy language. The -- it is -- I have  
24 said all along the -- the intention here was to avoid  
25 any possible escalation and eight years on with what we

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

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

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

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

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

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

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

20 **A.** Yes.

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

23 Now, what is said about the neonatal services  
24 appears there on that first page and it's more what  
25 isn't there, Mr Chambers, rather than what is, that  
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1 any other -- I don't know whether that had been shared  
2 with the CQC at this time. And it -- it kind of goes to  
3 the point really that Sir Robert Francis made in -- in  
4 his evidence, you know, in respect of this very  
5 difficult balance between the duty of candour to whoever  
6 -- whether that's the family or to or external partners,  
7 regulators and so on, and the duty of care to an  
8 individual and that's a very difficult balance to tread.

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

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

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

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

23 **Q.** Should they, the CQC, have been told that  
24 Dr Hawdon had four cases that were identified as  
25 outstanding, which you were in discussion with the  
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1 I want to ask you about. So just remind yourself of  
2 what was said.

3 (Pause)

4 **A.** Okay.

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

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

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

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

24 The relationship between a single member of staff  
25 and the -- who appeared to be rota'd on shift more than  
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1 Consultants about further investigation?

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

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

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

14 **A.** Yes, I think that's right.

15 **Q.** Thank you, we can take that down.

16 My next topic is Dr Jayaram's disclosure on  
17 16 March, in fact it was 15 March, discussed at  
18 a meeting on 16 March?

19 **A.** Yes.

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

2 Q. And the reaction in the notes included  
3 Alison Kelly saying "Why now serious allegation?" And  
4 you saying "Letby can't go back on to the unit now" and  
5 Alison Kelly saying "challenge why not?"

6 So that's the disclosure and we have received  
7 evidence about that?

8 A. Yes.

9 Q. What you say in your witness statement is that  
10 you regarded that as being a very serious matter?

11 A. (Nods)

12 Q. And that you went to speak to Dr Jayaram about  
13 it?

14 A. Yes.

15 Q. So what is important for us to understand is,  
16 did you establish from Dr Jayaram, in that meeting that  
17 you had with him as a result of this, what his concerns  
18 were and why he had raised those three cases?

19 A. Yes.

20 Q. So tell us, please, about that meeting with  
21 Dr Jayaram?

22 A. Okay. It's -- it was a very short meeting.  
23 I -- we'd not if you like formally tried to diary a  
24 meeting. I had been made aware of these matters at our  
25 weekly Executive Directors Group, which on that time

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1 were being managed and resolved and where we left it,  
2 rather than getting into a very detailed conversation,  
3 because we just -- he didn't have the time and -- and is  
4 that led to the meeting on 27 March.

5 So just to be clear, the 27 March meeting, there  
6 was two, if you like, reasons as to why -- why that  
7 meeting happened, one was to get to the bottom of the --  
8 of the -- the matters of trying to explain the causes,  
9 but also to pick up with Ravi these, these concerns.

10 At that meeting on the 27th, I very deliberately  
11 asked the question: are we now saying is there  
12 criminality? Leaving a very open question for him to  
13 provide an update to what he had seen and heard in what  
14 was a safe environment because there was the network  
15 there, there was Sue there, there was Steve Brearey  
16 there.

17 He -- he didn't share that with us again. So  
18 that's the chronology of that.

19 Q. So you never asked him directly about what he  
20 had said to Sue Hodgkinson to get to the bottom --

21 A. I didn't.

22 Q. -- of what he said?

23 A. On -- on the day after we didn't have,  
24 specifically have the opportunity to do that. It -- it  
25 felt very rushed, it was a two-minute thing and I -- to

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1 fortuitously was the day after, so it was the 16th.

2 Immediately after that meeting, I said to Sue:  
3 well, let's just go and see -- let's see if -- if  
4 Dr Jayaram and/or Dr Brearey are available to have  
5 a chat. We -- I don't remember Dr Brearey being around  
6 but I do remember briefly having a conversation with  
7 Ravi in his office.

8 He seemed surprised. In his notes to the -- the  
9 notes that he did to Facere Melius he -- he makes  
10 a short reference to this meeting. The conversation  
11 that we had at the time was there was this -- there was  
12 a range of things that, that Sue Hodgkinson had said.

13 She talked about these -- this news about the  
14 conduct of -- potentially the conduct of Lucy in respect  
15 of Baby K and -- but also that he was demonstrating, you  
16 know, real high levels of anxiety and not surprising  
17 really given all that was going on.

18 So there was -- there was two bits to the  
19 conversation, really, was, you know, just -- just Ravi,  
20 tell me, is, you know, is there anything I need to know,  
21 any news of that sort? I wasn't very specific in the  
22 question I wanted it to keep it quite open but also,  
23 more importantly, how are you? How are you feeling?

24 And aware that we had exchanged letters and that  
25 he -- he'd had ongoing concerns around how these matters

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1 this day I can't remember why it was an only two-minute  
2 thing, but it was. But I knew we would have the  
3 opportunity to pick this up very soon at a -- at  
4 a meeting that was already in train to -- to get to  
5 a position of what the absolute next steps would be,  
6 which were the police.

7 Q. So you never asked him directly about the  
8 three cases that he had told Sue Hodgkinson --

9 A. I don't -- I don't recall asking him directly.  
10 I maybe asked him implicitly rather than  
11 explicitly.

12 Q. Well, he had clearly, as Sue Hodgkinson had  
13 told you, felt a great deal of reticence about talking  
14 about that because what Sue Hodgkinson talks about is the  
15 fact that he was feeling victimised and bullied and so  
16 surely if you wanted to get to the bottom of what he was  
17 saying in those circumstances, you needed to go to him  
18 in an open and collaborative way and say: I've heard  
19 about these three cases, sounds like eye witness  
20 evidence. I understand it's been difficult for you to  
21 come forward about this. It's very important you tell  
22 us about this because that will help us.

23 Wasn't that what you needed to do?

24 A. I suppose, yes, we -- we could have I could  
25 have gone about it in that way. But I also was aware

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1 that he had expressed to Sue that he felt that --  
 2 perhaps intimidated is too strong a word but he had,  
 3 he -- I didn't want to put him into a position that he  
 4 felt that he was being in any way coerced or I just  
 5 wanted to give him a safe environment to share his  
 6 concerns --  
 7 **Q.** You see --  
 8 **A.** -- in an open way.  
 9 **Q.** We don't see at any subsequent meeting that we  
 10 have been able to identify of the Executive Directors  
 11 where this topic is brought up again for you to report  
 12 back --  
 13 **A.** Yes.  
 14 **Q.** -- to the meeting, that is not recorded  
 15 anywhere, do you agree?  
 16 **A.** I -- I too have looked to see where -- the  
 17 meeting notes were reflecting that, but what I do know  
 18 is that the matter was very much going to be picked up  
 19 through the meeting scheduled for the 27 March.  
 20 **Q.** When Simon Medland was briefed, he wasn't told  
 21 about that information that had come from Dr Jayaram,  
 22 was he?  
 23 **A.** I -- yes, I -- I wasn't specifically directly  
 24 involved in the briefing of Simon Medland. I was -- the  
 25 briefing with Simon Medland seemed to be more of  
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1 again.  
 2 When he was at the CDOP meeting it wasn't raised  
 3 there. When he wrote the best points that he shared  
 4 with the police, it wasn't referenced there.  
 5 **Q.** Speaking of the police, when you were given  
 6 the opportunity to put the case at its highest, and we  
 7 have looked at this already, but we haven't dealt with  
 8 this point and you said there was no evidence, in fact  
 9 you tell us now that you had heard and considered that  
 10 the possibility of eye witness evidence but you didn't  
 11 tell the police that, why not?  
 12 **A.** What -- to be honest I don't know what we  
 13 heard. What -- what we -- what we heard was that  
 14 I think I remember -- I think this is how Sue Hodgkinson  
 15 was, you know ... suggested that the dials on a -- on  
 16 a ventilator had been moved but wasn't clear about that  
 17 and -- and there was a baby -- "desaturating" I think  
 18 was the phrase or something like that, and Letby didn't  
 19 appear to be doing anything.  
 20 So it didn't -- it didn't, you know, it -- it -- he  
 21 had given -- he had been given many opportunities, many  
 22 opportunities from that meeting on 15 April -- was it  
 23 April?  
 24 **Q.** It was March.  
 25 **A.** March, yes, from 15 March through to 17 April,  
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1 a Stephen Cross issue, although I had met Simon prior to  
 2 the board meeting.  
 3 **Q.** You had a meeting with him on 4 April?  
 4 **A.** I think so, yes.  
 5 **Q.** And you didn't raise it there to say: one of  
 6 the Consultants has raised the fact that he may have eye  
 7 witness evidence?  
 8 **A.** Yes, and that's right. We had had the meeting  
 9 on 27 March which led to Simon Medland coming in. There  
 10 had been a specific question that I had asked and it's  
 11 in the notes of 27 March, the question was along the  
 12 lines: are we now saying that this is criminal behaviour  
 13 or criminality? Leaving it very open for -- for -- for  
 14 Dr Jayaram to say, yes, I have, I've witnessed it and  
 15 that's not what he said.  
 16 He said it's -- the honest answer is we don't know,  
 17 is what he said.  
 18 **Q.** So what he told Sue Hodgkinson you didn't  
 19 believe was eye witness evidence or you thought it was  
 20 eye witness evidence that --  
 21 **A.** I -- I -- I took it on face value as to what  
 22 it was.  
 23 **Q.** So eye witness evidence?  
 24 **A.** Yes, but it was not, when it was tested with,  
 25 with Dr Jayaram, he -- he didn't -- he didn't mention it  
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1 when he had the first -- when he had the feeling with  
 2 CDOP, to have raised that. Surely if not raised with me  
 3 it would have been raised with Nigel Wenham and it  
 4 wasn't.  
 5 **Q.** My final question about this bearing in mind  
 6 that you have raised that you weren't sure what you  
 7 heard, what we can be sure about from the note, though,  
 8 was that you took it so seriously or you thought it was  
 9 so serious was that your immediate reaction was: Letby  
 10 cannot go back on the ward?  
 11 **A.** Yes.  
 12 **Q.** So plainly it was highly relevant, whatever it  
 13 was, to your thinking?  
 14 **A.** I -- I think, I think it just -- there was --  
 15 at that time, as we know, there was letters being  
 16 exchanged between -- between the Consultants and myself,  
 17 there were ongoing meetings that Ian Harvey was having  
 18 with the Consultants in respect of trying to finally get  
 19 to the position on the causes and the -- and the -- if  
 20 you like, there was -- there was one view that from  
 21 Hawdon that and McPartland that said we had arrived at  
 22 an explanation that was not -- and it was only two  
 23 unascertained.  
 24 The Consultants themselves had a different view and  
 25 were struggling to accept the opinions of the  
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1 pathologist which is fine because these things happen.

2 So we had all of that. The -- the letters  
3 exchanging and also this -- this belief that these  
4 matters hadn't been fully resolved and needed to be  
5 fully resolved and then there was these, these -- the --  
6 the observations that Sue had made based on her  
7 conversation with Ravi the day before.

8 That together to me just felt: that's it, we can't  
9 return Letby to the unit.

10 I didn't know what we were going to do with Letby  
11 at all because still it was -- it -- it -- we needed, we  
12 needed help in terms of resolving that but what was  
13 clear in my mind, as it was absolutely clear in my mind  
14 way back in June 2016, adamant that she had to be  
15 removed from the unit, so my position at that, you know  
16 to that extent had moved from the recommendations from  
17 the grievance.

18 **Q.** I am going to turn now to a board meeting that  
19 we have already looked at, but we are going to focus on  
20 a different part, INQ0003237, this is the meeting on  
21 10 January. If we go to page 2, the second paragraph,  
22 this is what is being said. You have reviewed four  
23 cases from Alder Hey and then if you just look down to  
24 three lines up from the bottom, what you are telling the  
25 board on 10 January:

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1 link to an individual and you are asserting that isn't  
2 the case.

3 **A.** And what I said to you in answer to that is  
4 consistent with that note.

5 **Q.** Well, you have said that the reports were  
6 pointing away from it as you read them but they were not  
7 saying any of them, Letby is not responsible for any of  
8 these deaths?

9 **A.** Yes, but what they were not saying as well,  
10 what they were also not saying is that there was any  
11 evidence of deliberate harm.

12 **Q.** Well, the RCPCH as we have been over already  
13 said that they weren't looking for that, they were doing  
14 a service review?

15 **A.** Correct.

16 **Q.** So that is entirely irrelevant.

17 Dr Hawdon, you appear to -- in a previous answer  
18 accepted the possibility that she didn't know that she  
19 was looking for harm and all she did was look through  
20 case notes.

21 So that was incapable of itself of disproving that  
22 Letby was causing harm, so --

23 **A.** The -- I -- I struggle, I can see there that  
24 there can be a legal set of arguments here. But the --  
25 in my mind at this time, everything that we were being

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1 "There was an unsubstantiated explanation that  
2 there was a causal link to an individual. This is not  
3 the case and the issues were around leadership and  
4 timely clinical interventions."

5 **A.** Yes.

6 **Q.** So you are telling the board, in terms, that  
7 it was not the case that Letby had caused those deaths?

8 **A.** What I was telling the board was that the  
9 investigations that we had done to that point had not --  
10 in fact were seeming to be pointing away from deliberate  
11 harm and more towards natural or explanation -- in  
12 natural causes of death and suggestions from  
13 particularly from -- and more, more explicitly from  
14 Jane Hawdon that at least in 13 of these babies there  
15 had been evidence of sub optimal care and in many,  
16 significant sub optimal care.

17 Her view was the -- that would have -- had these  
18 been different the outcomes would have been different  
19 and that is what we were being told. Not that there was  
20 a -- somebody deliberately harming.

21 **Q.** Look at what you say. "This is not the case".

22 That is you telling the board it is not the case  
23 that Letby is responsible for the increase in deaths  
24 because the run-up to that is there was  
25 an unsubstantiated explanation that there was a causal

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1 told by independent experts, independent neonatology  
2 experts, not paediatricians who have an interest in  
3 neonatology, but independent neonatology experts was  
4 that there was no evidence of deliberate harm.

5 **Q.** None of them said: there is no evidence of  
6 deliberate harm because they don't, any of them, deal  
7 with the question of whether there was deliberate harm?

8 **A.** What they said is there was no evidence of --  
9 I -- I -- we would need to go and look at the INQ just  
10 to find out exactly what the phrasing was. But my  
11 understanding of what I was hearing and being told and  
12 reading was that there was nothing pointing to unnatural  
13 causes.

14 **Q.** Mr Chambers, do you allow for the possibility  
15 that you just misunderstood what the reports were  
16 saying?

17 **A.** I don't -- I don't think that's -- I don't  
18 think that's fair. What I know on reflection would have  
19 been something that we perhaps should have done is to  
20 have got Jane Hawdon, Dr McPartland and the  
21 paediatricians together to thrash this out and we were  
22 not able to do that and to be honest, I'm not sure there  
23 was an attempt to do that.

24 The requirement to try and get these matters  
25 resolved competently and quickly meant that in the

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

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

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

16 **Q.** What is undoubtedly the case is that as at  
17 10 January, what Dr Hawdon's report did or didn't mean,  
18 what the RCPCH's report did or didn't mean, what  
19 Dr McPartland's report did or didn't mean was not the  
20 subject of consultation with the experts in the  
21 hospital, the paediatricians, was it?

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

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1 and New Year.

2 **Q.** Shall we have a look at it?

3 **A.** Yes.

4 **Q.** INQ0004299, this is the meeting on  
5 30 December, page 3. So you can perhaps help us with --  
6 so two-thirds of the way down, against your initials:  
7 "Sequence: Lucy meeting. Board meeting,  
8 10 January, formal acceptance of the review and action  
9 plan. Reserve its position on Level 1 or Level 2.  
10 Endorse transition of Lucy back to the unit."

11 Then the next bullet in the sequence:

12 "Then meeting with the paediatric Consultants."

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

17 **A.** No, not at all.

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

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

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1 in a room.

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

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

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

10 **A.** No ideally, yes.

11 **Q.** That was possible?

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

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

18 **A.** Yes.

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

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

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

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

8 You can take that down.

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

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

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

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

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

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1 either Dr Brearey or Dr Jayaram?

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

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

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

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

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

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1 on 26 January.

2 **A.** Do we not want to talk about this?

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

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

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

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

15 **LADY JUSTICE THIRLWALL:** It starts off:

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

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

20 **A.** Say again, sorry?

21 **LADY JUSTICE THIRLWALL:** It says:

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

24 **A.** Yes, thank you.

25 So one of the things you find as Chief Exec

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1 and when I read them I think, I -- I don't recognise

2 that. And this is perhaps -- perhaps one of those. And  
3 now he -- and I know it's difficult because we can't --  
4 Stephen isn't going to give evidence but he may have  
5 given some insight into that.

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

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

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

24 **A.** Mmm.

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

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1 unfortunately is that you -- you find yourself

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

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

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

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

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

5 **A.** Yes.

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

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

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

13 **A.** -- was very challenging.

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

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

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1 wanted to be sure that it was this meeting.

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

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

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

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

18 **A.** Yes, yes.

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

21 **A.** I think that's half right.

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

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

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

8 **Q.** The 26 January meeting.

9 **A.** Yes.

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

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

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

22 **A.** Yes, yes.

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

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

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

9 **A.** Okay, okay.

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

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

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

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

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

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

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

13 **A.** Yes, okay, yes.

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

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

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

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1 **Q.** You have made an assertion about it?

2 **A.** Yes.

3 **Q.** Why did you say that?

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

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

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

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

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1 the disclosures to the Inquiry did it become clear

2 perhaps why.

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

11 I didn't feel that I was raising my voice.

12 I certainly wasn't angry. I felt it -- I behaved  
13 professionally, as they did, as everybody in the meeting  
14 did and that's my recollection of that meeting.

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

18 **A.** Yes.

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

23 **A.** Yes.

24 **Q.** -- before this meeting?

25 **A.** Yes.

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

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

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

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

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

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

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

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

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

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

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

14 **A.** Yes, they were. Yes.

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

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

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1 **Q.** Then 4, they point out the transfer babies and  
2 the fact that a number of cases had been identified in  
3 relation to deteriorations which was unexplained or  
4 unusual. This -- this is a comment upon Dr Gibbs's  
5 review, I don't know if you recall but in July of  
6 2016 --

7 **A.** Yes, yes.

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

10 **A.** Correct.

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

18 Then they make this point:

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

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

9 Is that a fair summary of their position?

10 **A.** That is what they wrote.

11 **Q.** Yes. At 3 they acknowledge that:

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

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

19 **A.** Yes, yes.

20 **Q.** -- and they are saying --

21 **A.** Yes.

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

25 **A.** Yes, sure.

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

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

8 **A.** Yes.

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

11 **A.** Yes.

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

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

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

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

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

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1 requested at the top this have letter that we share this  
 2 information with the Coroner --  
 3 **Q.** Yes.  
 4 **A.** -- which we did. So we listened. We heard.  
 5 And as you know, subsequently on 27 March, the decision  
 6 was that we would go to the police.

7 **Q.** Let's remind ourselves, this is 10 February.  
 8 In terms of the points that they were making, do  
 9 you point to any of those that you thought at the time  
 10 were unreasonable or incorrect?

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

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

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

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

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1 which is why absolutely why we took the meeting on the  
 2 27th as I outlined at the start of that meeting: it was  
 3 about if we are not at the position where the board and  
 4 the organisation has answered these questions, and this  
 5 is what's inferred here, then what do we need to do to  
 6 get into the position to answer these questions?

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

10 **A.** Yes.

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

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

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

24 I thought -- genuinely believed that as of  
 25 26 January that we had had a position that said there

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1 **A.** I just --

2 **Q.** -- on point 5?

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

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

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

14 **Q.** Well --

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

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

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

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

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

12 **A.** I know, I know.

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

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

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

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

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1 you talk about what you do against your enemies?

2 **A.** I -- I -- again these are, these are Stephen's  
3 notes and quite often he, he captures things that --  
4 that just -- that -- so I -- I don't remember any  
5 discussion about plots and they certainly weren't  
6 enemies any more than we were the enemies.

7 We were just ordinary people, trying to deal with  
8 an extraordinary set of circumstances, with very little  
9 or confusing information to hand and we were trying to  
10 make the best sense of that whilst the -- the only thing  
11 that was an absolute consensus on was that we didn't  
12 really know what the absolute causes of harm were --  
13 causes of unexplained death were.

14 **MR DE LA POER:** My Lady, I am conscious of how long  
15 we have been going in terms of the shorthand writer this  
16 afternoon and I wonder if that would be a convenient  
17 moment?

18 **LADY JUSTICE THIRLWALL:** Yes, we will take  
19 15 minutes. Please come back in just before quarter to.

20 **A.** Thank you.

21 (3.28 pm)

22 (A short break)

23 (3.45 pm)

24 **LADY JUSTICE THIRLWALL:** Yes.

25 **MR DE LA POER:** Mr Chambers, your letter of reply  
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1 your position was in response "Letby is still coming  
2 back to the ward"?

3 **A.** At that time that was still -- that was still  
4 in train but no action had been taken to make it happen  
5 but in my mind it was -- at this point in time, there  
6 was still going to be plans to move her back to the  
7 unit, yes.

8 **Q.** Just considering for a moment. Do you think  
9 that you were not listening properly to what the  
10 Consultants were saying to you?

11 **A.** No, I don't think that's true. I -- we --  
12 we'd been given really strong messages from the  
13 Royal College that the unit was calmer, the unit felt  
14 safer.

15 What we were not proposing to do was to redesignate  
16 the unit back, which is I think something that the  
17 Consultants would have been keen to have explored at  
18 some point soon. What we were seeking to do was take  
19 the recommendations from the board and we were still in  
20 the process of exploring how that can be achieved and in  
21 that -- in that -- in delivering that the apology letter  
22 was an important component and for some of the  
23 Consultants also some -- some mediation.

24 **Q.** So the five points that they had made did not  
25 cause you to think we ought to think carefully about  
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1 is dated 16 February, INQ0003159. In the letter, if

2 I may summarise, you tell Dr Jayaram as the addressee of  
3 this letter that the Coroner is being informed and  
4 having the letter shared and that it's also been shared  
5 with the RCPCH and Dr Hawdon, which we see further down.

6 The point they made about the redesignation of the  
7 unit, you make an assertion as to the reasons why but  
8 you don't engage, do you, with what they said to you in  
9 their letter about whether that change in what was being  
10 observed could or could not be ascribed to the  
11 redesignation?

12 **A.** I -- I don't remember it being included in  
13 this response.

14 **Q.** We can then see that you at the bottom of the  
15 page remind them of the apology and then it's this and  
16 the sentence concludes:

17 "... and when you are doing this as action is now  
18 being taken to return her to the unit at the earliest  
19 possible time."

20 So is this right, Mr Chambers, that having had  
21 those five points made to you about what the RCPCH  
22 report does and doesn't say, what Dr Hawdon said and the  
23 fact that they are concerned that there are more such  
24 babies, the fact that they would like to see Dr Gibbs's  
25 report, the fact that the redesignation doesn't explain,  
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1 whether or not Letby should go back to the unit; is that  
2 the position?

3 **A.** The -- I don't -- I don't -- I don't think  
4 that is a fair -- a fair interpretation of this because  
5 as you know that Mr Harvey was continuing these  
6 conversations with the -- with the doctors. He was in  
7 conversation with the Royal College. He had shared  
8 their concerns with Dr Hawdon, there had been  
9 suggestions from the College around what was described  
10 as confirmatory bias.

11 I'm not suggesting that was at the front of my  
12 mind, but clearly there was -- there was more to this  
13 than just the points in the paediatricians' letter.

14 **Q.** But when all was said and done, you were still  
15 determined at this point to return Letby to the ward; is  
16 that right?

17 **A.** I -- as it says in there, that there was --  
18 the plans were still being progressed.

19 **Q.** To return her at the earliest possible time?

20 **A.** Yes.

21 **Q.** If we go over the page, just so that we  
22 consider this. You here point out to them the reviews  
23 that were done. We know, and we have already been  
24 through that the RCPCH did not consider the question of  
25 whether Letby was responsible for the deaths.  
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1 It may be a matter of fact for the Chair but it may  
2 be the fact that Dr Hawdon didn't know about the  
3 concerns and you wouldn't have criticised anybody if  
4 that was the position.

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

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

13 I can't say any more.

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

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

19 **A.** Pointing away from unnatural causes.

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

22 **A.** Sorry, repeat the question?

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

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

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

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

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

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

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

14 **A.** Yes, thank you.

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

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

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

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

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

20 **A.** Yes.

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

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

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

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

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

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

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

25 **A.** Yes, I --

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1 Q. -- mean?

2 A. I was the Chief Executive, I wasn't the font  
3 of all wisdom. I was just somebody who had  
4 a responsibility to make sure that voices were heard,  
5 questions were asked, concerns were listened to and  
6 acted upon, strategies were developed, strategies were  
7 delivered and that we had a culture where we were  
8 focused on safety.

9 I would have -- for specific expertise, I would  
10 have gone to my Director of Nursing, my Medical  
11 Director, I would have gone to -- and be guided by that  
12 be guided by my director of HR and so on.

13 Q. Were either of those subject matter experts  
14 experts in neonatology?

15 A. I don't think there were any experts in  
16 neonatology in the hospital.

17 Q. Were they experts in paediatrics?

18 A. Oh, clearly not, no.

19 Q. So were the people most likely to know in the  
20 hospital the Consultant paediatricians?

21 A. I think that's right and I think if they had  
22 real concerns that these matters hadn't been  
23 appropriately investigated, well, they were very able to  
24 make those concerns known to us, which they did.

25 We listened. We took action. The 27 March we  
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1 consensus as to what we -- what we felt were the causes  
2 to these unexplained harm. So at that point -- so there  
3 was never going to be a point that Letby would have come  
4 back had those discussions that were ongoing not been  
5 ongoing.

6 Sorry, if they -- if those had stopped, then  
7 perhaps, perhaps things would have been different.

8 But they were continuing, they were continuing in  
9 a professional way. We were listening, we were open.

10 Q. We can take that down. Were you aware at the  
11 time that on 1 March, Mr Harvey sent emails to  
12 Dr Jayaram and Dr Brearey warning them of the risk of  
13 referral to the GMC?

14 A. I'm not aware of that.

15 Q. You weren't aware of that at the time?

16 A. No, no.

17 Q. We can ask him about that, then.

18 You considered, is this right, referring the  
19 doctors to the GMC?

20 A. I don't remember that.

21 Q. Let's have a look. 16 March. INQ0003344.

22 This is the first reference to GMC I am going to ask you  
23 about. We see on page 3, right in the middle:

24 "Part of me says ring police and GMC."

25 So help us with what you were saying there, please?  
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1 brought all of that together, we went to the police.

2 Q. You listened, you tell us, but in response to  
3 them raising those very points, your response was to  
4 say: Letby's coming back on the ward and if they had  
5 stopped there, isn't that what would have happened?

6 A. No. I don't think -- I don't think that was  
7 ever going to happen really because later, as we have  
8 suggested previously, Dr Jayaram had mentioned his eye  
9 witness, if that is the right word, of -- of some kind  
10 of failure or nefarious activity or however it was  
11 described. He then failed to mention it to anybody  
12 else, again. But that was sufficient at that time for  
13 me to think: we need to stop any plan for Letby coming  
14 back to the unit and exploring what the absolute next  
15 steps were.

16 Q. My question was about this, the date of your  
17 response, that if the paediatricians had stopped here --

18 A. I just said to you she wouldn't have come  
19 back.

20 Q. -- here on 16 February, Letby would have gone  
21 back on --

22 A. No, because as I said, that's where events  
23 don't stop, do they? So the conversations were  
24 continuing, the -- the discussions were ongoing and it  
25 was becoming less and less -- there was less and less  
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1 A. Again, Stephen's notes -- he captures things  
2 that were not action points and it may have been me just  
3 speaking out loud, you know, what do we do? Do we go to  
4 the police, go to the GMC? It was not anything more  
5 than that.

6 Q. Well --

7 A. And I can't remember why ... I can't remember  
8 how that fits into the whole discussion that we were  
9 having.

10 Q. Why would you be raising the possibility of  
11 ringing the GMC if not to do so in the context of  
12 referring these two doctors or more of them?

13 A. The note at the top of the page there says: we  
14 agree on more than we disagree. The paediatric are not  
15 in a space to --

16 Q. "... to receive anything. They feel like  
17 battered wives. Execs (TC) is abuser. Paeds frustrated  
18 with IH."

19 A. Yes, yes. So it was -- it was a discussion  
20 I think around just generally how our colleagues were  
21 feeling.

22 Q. Well --

23 A. Clearly I say there Lucy cannot go back to the  
24 unit.

25 Q. Then reading on, you say:  
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1 "They want us to throw Lucy under a bus."  
2 Which might be thought to be a suggestion that they  
3 are trying to do something improper?

4 **A.** I again I -- I don't remember this  
5 conversation. I'm -- I genuinely don't remember the  
6 conversation.

7 **Q.** Well, we will come back to the GMC. We need  
8 to just pause. We have spoken about the network meeting  
9 on 27 March which Dr McGuigan attended, and he's given  
10 evidence about receiving a call from Tracy Bullock?

11 **A.** Sorry, say again?

12 **Q.** Dr McGuigan?

13 **A.** He wasn't at that meeting.

14 **LADY JUSTICE THIRLWALL:** No, he wasn't. It is  
15 a different question I think.

16 **MR DE LA POER:** Dr McGuigan has said he received  
17 a call from Tracy Bullock following that meeting,  
18 whether or not he was present, in which he was told by  
19 Tracy Bullock -- this is what she said according to  
20 Dr McGuigan, we will come to what she said about it in  
21 a moment -- that you had told Tracy Bullock that the  
22 Consultant paediatricians are refusing to accept  
23 problems with the standard of care on the neonatal unit,  
24 are instead pursuing other lines of inquiry. That she  
25 mentioned you had said there were ringleaders and things

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1 He -- I think he was the nearest that we had to  
2 an independent mindset of matters on the neonatology  
3 unit. He had no history, but he was an experienced --  
4 an experienced doctor and I think he was also  
5 a neonatologist.

6 The reason I raised this with -- with Tracy Bullock  
7 is that she was the Chief Executive at one of the local  
8 hospitals where Michael had been recruited from, so she  
9 knew him. So what I had said is we had had this  
10 meeting, lots of discussion around the issues, decision  
11 made that we would be going to the police and one of the  
12 things that I felt really compelling in -- in the  
13 meeting on the 27th was when Stephen Brearey told me  
14 about the thoughts and opinions and reflections that  
15 Michael McGuigan had had on these matters and I found  
16 that to be really quite significant.

17 I spoke to Tracy to say, you know, is -- is this  
18 guy all right? Is he -- does he know his onions? And  
19 she -- she suggested that his opinion would be worth  
20 listening to.

21 **Q.** Did you at any point in the conversation  
22 suggest that it would go badly for the ringleaders --

23 **A.** No, no, I think -- I don't know where that  
24 was. I think -- Tracy I think may have -- did she  
25 contact Michael following this meeting, this

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1 were likely to go badly for those two and she didn't  
2 want him to be affected.

3 Now, Tracy Bullock's account is considerably more  
4 temperate than that and I know that you have seen it.  
5 I want to give you the opportunity, please, to tell us;  
6 did you call Tracy Bullock and tell her that the  
7 Consultant paediatricians were refusing to accept  
8 problems with the standard of care and instead pursuing  
9 other lines of inquiry?

10 **A.** Okay, I -- it wasn't a telephone call.

11 I think we were in fact -- I remember we were on a train  
12 to Leeds. We were going to a -- one of the Chief  
13 Executive Regional Forums which was held in Leeds.  
14 I bumped into Tracy at the station and we sat together  
15 on the train and we had a conversation.

16 In the conversation, I was just discussing with her  
17 as a peer and a fellow Chief Executive and somebody  
18 whose opinion who I valued, to -- almost as a -- just to  
19 see, you know: am I missing something, is there more we  
20 can be doing? I don't remember the detail that we  
21 talked about but I would have taken her through the work  
22 that we had done, how the -- how -- how our clinical  
23 colleagues were feeling about the work we had done and  
24 the reference to Michael McGuigan was simply that  
25 Michael was a new member to the team.

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1 conversation? I think she may have had a telephone  
2 conversation with him and she was almost seeing that as  
3 a well-being check, really. You know, given that it  
4 must be difficult, arriving at the Trust at a time when  
5 all of this was going on, I think he had only been there  
6 two or three months.

7 **Q.** Mr Chambers, rather than speculating as to  
8 what was motivating Ms Bullock, the question was: did  
9 you say it? Your answer is --

10 **A.** No, I don't and I don't think she said I did  
11 either.

12 **Q.** No, but that is what Dr McGuigan --

13 **A.** And I can't comment on that.

14 **Q.** -- understood.

15 So I have put it to you, given you a fair  
16 opportunity to deal with it, you have dealt with it. Of  
17 course, things going badly for a doctor invariably means  
18 being reported to the GMC, doesn't it?

19 **A.** I don't know what -- what that refers to.

20 **Q.** Well, let's have a look at the second  
21 reference that I told you I would bring you to,  
22 INQ00015642 and we are going to go to page 48 and this  
23 is a meeting you had on 12 May, so the same day that the  
24 second meeting with the Cheshire Police took place. You  
25 have obviously heard that at that meeting you had told

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

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

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

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

14 **Q.** "Plan re management.

15 "1, GMC.

16 "2, actions from grievance.

17 "3, mitigation [from I think that says] SOS [so  
18 that will be Speak Out Safely] whistleblowing.

19 "4, action plan to manage out ... Tuesday  
20 [something] follow up call."

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

24 **A.** I am, yes.

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

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

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

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

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

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

10 So is her account of this meeting accurate?

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

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

25 But what is clear at the outcome of that meeting

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1 and aware of this.

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

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

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

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

23 **Q.** Why were you talking about referring  
24 Dr Brearey and Dr Jayaram to the GMC?

25 **A.** That is not what we were talking about. It

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1 was saying what are the potential things that we might  
2 need to do if there isn't a police investigation, 1 GMC.  
3 2, this ...

4 **Q.** What --

5 **A.** So it was -- it was nothing more, nothing more  
6 than that.

7 **Q.** Why would the GMC need to be involved at all?

8 **A.** And I -- I don't know. We were just working  
9 through scenarios. There was no detail. There was no  
10 substance and we would have had to have put  
11 a significant amount more effort into this if the police  
12 hadn't done their enquiries. Or not. We may not have  
13 needed to do that.

14 The -- it was just for me recognising that we would  
15 because of the significant escalation in these matters,  
16 for them if they then don't get resolved, if you like,  
17 by a police inquiry what -- where does that leave us in  
18 terms of patient safety?

19 **Q.** And mitigation from Speak Out Safely  
20 whistleblowing, so was that a discussion?

21 **A.** To be honest, I would not -- I wouldn't know  
22 what that meant.

23 **Q.** Well, were you discussing, as we heard  
24 yesterday, with Sue Hodgkinson effectively how you could  
25 get round the fact that they were whistleblowers?

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1 We didn't know at this point whether they were  
2 going to do a criminal investigation. They did on the  
3 basis of their second meeting with the clinicians.

4 Had they not done the police investigation I'm not  
5 sure on what basis you would do an NMC referral but  
6 I would have had to have taken guidance.

7 **Q.** Didn't you still have a safeguarding  
8 responsibility towards the babies on the unit?

9 **A.** We had -- and again I don't know whether  
10 safeguarding would have been -- would have been -- would  
11 have been appropriate at this time. Safeguarding  
12 perhaps might have been appropriate sooner than this.

13 But at this time, we'd already spoken to the police  
14 on four occasions.

15 **Q.** Let me put a potential interpretation of this  
16 note to you so that you can deal with it head on. Were  
17 you having a discussion with the HR Director about how  
18 you would get rid of Dr Jayaram and Dr Brearey by  
19 referring them to the GMC, working out a way to get  
20 round the fact that they were whistleblowers and  
21 managing them out of the organisation?

22 **A.** No. I -- I -- I don't think that was the  
23 nature of the conversation. All I was saying is I have  
24 just come from the police, if there isn't going to be  
25 a police inquiry, what are the implications of that?

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1 **A.** Sue's -- Sue's memory of this meeting is about  
2 as good as mine. She doesn't remember the -- the  
3 context to the meeting. She didn't remember that we  
4 were, were speaking to the police at this time. So  
5 I think had she been aware of that at the time of giving  
6 evidence it may have triggered something in her mind.

7 **Q.** Why were you not referring Letby to the NMC?

8 **A.** Yes, and those were things that could have  
9 been there as well.

10 **Q.** Why were you not talking about raising  
11 a safeguarding concern if the police did not take it  
12 forward?

13 **A.** Like I say the -- this was a fortuitous  
14 one-to-one meeting with myself and the director of HR.

15 Had that meeting been a one-to-one with -- with  
16 Alison Kelly, rather than Sue Hodgkinson, then, then the  
17 conversation would have probably been exactly as you  
18 described. I don't know and I can't speculate.

19 **Q.** Why can't you talk about those things as part  
20 of the plan with Sue Hodgkinson?

21 **A.** But I'm -- I'm unclear as to why -- why we  
22 would do those things if we had done all of our reviews,  
23 we'd raised those concerns with the -- with the -- with  
24 the police, the police had at that time would have  
25 spoken to the doctors on at least two occasions.

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1 I think had I not had a one-to-one scheduled with  
2 Sue, I probably wouldn't have even had this  
3 conversation. It was just one of those things where it  
4 was a coincidence that all of those things came together  
5 at that point. But as Sue said yesterday, her advice  
6 was: well, that wouldn't be sensible. But I wanted you  
7 to understand that this was not a deliberate plan, this  
8 was not something that was -- that was being engineered  
9 or concocted.

10 This was me and Sue exploring what the implications  
11 might be. Now it is -- it is -- it is -- on one level  
12 it is surprising that Sue doesn't remember that but it  
13 was -- until I had seen this meeting note I had  
14 forgotten about this meeting as well. It was eight  
15 years ago.

16 **Q.** My final topic is your departure from the  
17 Countess of Chester. We can take that down, thank you  
18 very much indeed.

19 We have heard from Lyn Simpson about the fact that  
20 there was an impending vote of no confidence --

21 **A.** Yes.

22 **Q.** -- being discussed and we know that on  
23 19 August, or perhaps the day before, Sir Duncan Nichol  
24 reached out to NHS Improvement for help and we can bring  
25 up the note that was made of the conversation Ms Simpson

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1 had with Sir Duncan, INQ0101357. This is the first  
 2 call, you are not party to this call.  
 3 I hope you have had a chance to see this in advance  
 4 but we can see the action plan as recorded in the notes  
 5 and I will tell you what Ms Simpson said, if you don't  
 6 know, about this was that the suggested way forward at  
 7 point 3 was to prevent the vote of no confidence.  
 8 I think that's supposed to be Sir Duncan to take this  
 9 forward to ensure that you don't go back to the site, to  
 10 agree that an alternative option for six months could be  
 11 found, that you would not go back to the Countess,  
 12 otherwise you would be made redundant.

13 So that appears to be the subject matter of their  
 14 conversation and Ms Simpson said she didn't intend to  
 15 use the word "prevent"; in fact it was that the vote of  
 16 no confidence was to be explored by Sir Duncan.

17 My first question for you is: did you know about  
 18 whether Sir Duncan was planning to intervene or involve  
 19 himself in any way with a vote of no confidence that was  
 20 being discussed?

21 **A.** I know that Duncan had been meeting with the--  
 22 I am going to say the paediatricians, but I -- I can't  
 23 -- I don't know specifically who and I don't know  
 24 whether it was a collective or -- or a bilateral. But  
 25 I was aware that he had, had been doing that.

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1 confidence?

2 **A.** I beg your pardon?

3 **LADY JUSTICE THIRLWALL:** Which call are we looking  
 4 at, Mr De La Poer?

5 **MR DE LA POER:** At the bottom.

6 **LADY JUSTICE THIRLWALL:** 19 September?

7 **MR DE LA POER:** 19 September --

8 **LADY JUSTICE THIRLWALL:** Yes.

9 **MR DE LA POER:** -- 2018. My question was: were you  
 10 candid with Ms Simpson about the difficulties --

11 **A.** Yes, absolutely.

12 **Q.** -- that led to the vote of no confidence?

13 **A.** Yes, yes, no, I -- there was no secret that  
 14 there had been ongoing investigations and reviews into  
 15 neonatal matters at the Trust. The -- everybody was  
 16 aware of that from 2016 onwards, 2017 and then the  
 17 police investigation and I was very candid with her  
 18 that, that the relationships between increasingly it was  
 19 the Executive and then it was myself and the -- sorry,  
 20 Ian Harvey and me, and then Ian and then it was just  
 21 me ...

22 So it felt that, you know, in the best interests of  
 23 the organisation, that I should step aside. I had been  
 24 absolutely candid with her that it was -- it was, as you  
 25 know, if you like, a breakdown of relationships as

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1 He was very keen to not take sides in any  
 2 discussions, you know, and he wanted to put the best  
 3 interests of the organisation first.

4 **Q.** So far as you understood the position, was he  
 5 trying to prevent that vote?

6 **A.** And I was going to say that there would have  
 7 been no benefit to a vote of no confidence in the  
 8 organisation. It would be a bit like a Brexit vote. It  
 9 it's never conclusive. It would have created all sorts  
 10 of other consequences and it would be better for the  
 11 organisation, better for -- for me, I suppose as well,  
 12 it's fair to say, and it was not really a surprise.

13 Because, as we know, with all of the escalating  
 14 inquiries that had gone on, then the police inquiry and  
 15 then Letby subsequently being arrested for the first  
 16 time, so I think maybe the paediatricians felt some sort  
 17 of vindication on that.

18 I felt that it was the best thing for the  
 19 organisation for me to step aside.

20 **Q.** We are going to look at the conversation you  
 21 had with Lyn Simpson and the first question which  
 22 doesn't require any detail, was that in your telephone  
 23 conversation that we see on 9 September, do you think  
 24 that you were candid with Ms Simpson about any failures  
 25 on your part which had given rise to the vote of no

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1 a resulting of escalating concerns of inquiries.

2 **Q.** I would like to ask you about page 2 of her  
 3 note which continues over the page. She ascribes this  
 4 to you at point 3, I suspect that should be "confirmed":

5 "TC confirmed he would step aside and be as  
 6 flexible towards this as he can be. However, TC advised  
 7 he would not want this to be a cost towards his career,  
 8 would want to maintain his status as a CEO."

9 Did you say that to Ms Simpson?

10 **A.** I -- I remember specifically a conversation  
 11 "what do you want from this, Tony?" What would, what  
 12 would -- you know, what -- because it felt like it was  
 13 almost a bit of a negotiation really, you know in that  
 14 you are putting the best interests of the organisation  
 15 first. I said that but I would rather that was not at  
 16 the expense of my career. So that was the gist of that  
 17 conversation.

18 **Q.** Did you say you wanted to maintain your status  
 19 as CEO?

20 **A.** Yes, I -- I would have said that, yes. But  
 21 that's not what happened.

22 **Q.** Now, what was in train here as Ms Simpson --  
 23 I understand her evidence to have accepted, was that  
 24 this was a discussion about getting you a job that you  
 25 didn't have to apply for formally, that was created for

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1 you, which you didn't have to compete for, and in  
2 relation to which there wouldn't be an overt and  
3 transparent process, so that's what's being found for  
4 you in this conversation.

5 Is that what you understood to be going on?

6 **A.** No, I think -- I think -- I think what's  
7 missing here is the facts which are I had a contract as  
8 a Chief Executive. I had done nothing that was in  
9 breach of that contract, so therefore I had  
10 a contractual right as a minimum to serve six months'  
11 notice.

12 Now, all I was wanting as a de minimis from this,  
13 if we could have got more that would have been great,  
14 but as an absolute de minimis was the opportunity to  
15 work my notice, being useful to the NHS in some other  
16 organisation rather than either take a redundancy  
17 payment, if that's what it would have been, but I wasn't  
18 being made redundant, it would have been because the  
19 post wasn't being deleted and so on, it would have  
20 been -- would have been -- in employment law, that would  
21 have been a tricky thing to have worked through.

22 So it was -- it was a very -- it was me, I believe,  
23 again putting the best interests of the patients first  
24 at the, at the expense of my -- of my own career and  
25 family.

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1 that was being referred -- that was being planned with  
2 the Medical Staff Committee and the paediatricians was  
3 an opportunity for them to, if you like, share their  
4 concerns.

5 It was never presented to me as a vote of no  
6 confidence. But clearly that's how it was likely to --  
7 that's what was likely to be the outcome.

8 **Q.** It's important I give you the opportunity to  
9 deal with an interpretation of events so that you can  
10 have your say on the point.

11 Did you leave in the circumstances you did in order  
12 to avoid scrutiny of your leadership --

13 **A.** No.

14 **Q.** -- during the period?

15 **A.** No. No, I mean, I -- there was no suggestion  
16 that -- well, I suppose maybe if I had not been  
17 supportive of these -- this plan, there could have been  
18 a vote of no confidence that would have probably meant  
19 that I had -- would be suspended. There would be -- but  
20 again that, that wasn't clear, that wasn't something  
21 that we were trying to avoid.

22 I was just, together with Sir Duncan -- Sir Duncan  
23 and I had a very close professional and personal  
24 relationship. We -- he -- he was somebody who I looked  
25 to as a Chief Exec as a -- as somebody for guidance and

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1 I wanted to be able to work my notice in an  
2 organisation so that I then had an opportunity to reset  
3 and maybe rebuild.

4 **Q.** It was described in a note to a conversation  
5 that you weren't a party to as a rehabilitation period?

6 **A.** Yes.

7 **Q.** Did you know that it was being described as  
8 that?

9 **A.** I have heard all sorts of different  
10 descriptions, not of this, but these kind of things  
11 happen to Chief Executives all the time. All the time.  
12 They call it rehabilitation, they call it going into the  
13 donkey sanctuary, but what I actually think this was  
14 about is just myself and Duncan taking a very pragmatic  
15 view on how we can, if you like, help the organisation  
16 move forward, focus on its future whilst I focus on my  
17 future. It was nothing more sinister than that.

18 **Q.** Of course it meant that the vote of no  
19 confidence was avoided. That was one part of it; is  
20 that right?

21 **A.** Yes, and again, I wasn't aware, genuinely  
22 wasn't aware that there was ever going to be a vote of  
23 no confidence. That was something that began to be  
24 talked about but I genuinely wasn't -- wasn't  
25 specifically aware of it. I thought that the meeting

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1 we always had a very open and honest discussion about  
2 when it's time, if you like.

3 **Q.** The final document that I wish to ask you  
4 about is INQ0015683. This is the settlement agreement  
5 and we are going to go to page 30 which is one of the  
6 appendices to it. Forgive me, 31, it's an internal  
7 page, I beg your pardon. This is the schedule for  
8 narrative announcement.

9 Now, was this something that was substantially  
10 drafted by your side of things?

11 **A.** That was something that Duncan and  
12 I collaborated upon.

13 **Q.** We can see in the third paragraph:  
14 "Tony's stepping down as CEO at the Countess is as  
15 a result of extraordinary circumstances. It is not  
16 a judgement on his ability as a CEO but more  
17 a reflection of his integrity as a leader."

18 Do you consider that to be an accurate statement?

19 **A.** Absolutely.

20 **Q.** If it was the case that you stepped down to  
21 avoid a vote of no confidence and you have given  
22 evidence that that isn't why, that statement would  
23 require rather more detail, wouldn't it?

24 **A.** It -- it probably would. But that was not the  
25 position and it's fair to say that in all interviews

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1 subsequent to me leaving the Countess, I was never  
 2 gifted a job. I always had to apply for a job, I was  
 3 interviewed and I was always very straight and open and  
 4 transparent about my time at the Countess. Which --  
 5 which is really easy when we are just focusing on 1% of  
 6 the business, which is the matters of the neonatal unit  
 7 that we have spent our day talking about, but the  
 8 Countess was -- was -- was much bigger than a neonatal  
 9 unit. It -- and my time at the Countess was  
 10 demonstrably successful, as outlined in this, this note  
 11 here. It's easy to characterise me by the events,  
 12 sadly, of the -- of the last 18 months of my career at  
 13 the Countess or 24 months of my career at the Countess  
 14 but there was so much more to it than that and there  
 15 were so many things that I am incredibly proud of that  
 16 are now in place at the Countess delivering benefits to  
 17 patients and staff, not least of all the new neonatal  
 18 unit which, as I understand it, is built and open.

19 One of the final things I was able to do before  
 20 I finished was to get the financial business case over  
 21 the line for the new neonatal unit.

22 **Q.** The last thing to ask you about from me is the  
 23 paragraph below:

24 "These investigations into neonatal deaths at the  
 25 Trust have escalated over the past two years and  
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1 failure in systems of care.

2 There are many examples. The Kirkup report, the  
 3 Ockenden report. Many, many examples. So it doesn't  
 4 surprise me that it inevitably put strains on  
 5 relationships because these were complicated matters.

6 **MR DE LA POER:** Mr Chambers, those are the  
 7 questions that I have for you.

8 **LADY JUSTICE THIRLWALL:** Thank you, Mr De La Poer.

9 Just before we move on, I had said that we would  
 10 come back if you felt there was something else you  
 11 wanted to say about INQ0003076, which is the meeting,  
 12 the Hummingbird meeting, that you have referred to quite  
 13 recently but I understand that that's something that  
 14 your barrister is going to deal with, is that right?  
 15 Rather than me dealing with that if that's already been  
 16 agreed I will leave that for you. Thank you.

17 Now who is going first? Is it you, Mr Skelton?

18 Questions by MR SKELTON

19 **MR SKELTON:** Mr Chambers, I ask questions on behalf  
 20 of one of the Family groups. Can I just understand your  
 21 evidence from earlier about your status in relation to  
 22 risk. I think you said you were the accountable  
 23 officer; is that correct?

24 **A.** That is correct, yes.

25 **Q.** What does that mean in practice?

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1 inevitably put relations between senior management and  
 2 paediatricians under exceptional strain."

3 I would just like you to have the opportunity,  
 4 please, to reflect on the word "inevitably".

5 Is it correct that matters would have escalated as  
 6 they did inevitably or was that as a result of the way  
 7 in which you managed the response?

8 **A.** I stand by the decisions that we made. We  
 9 were acting in good faith. I was acting in good faith.  
 10 I listened to the doctors when they raised their  
 11 concerns. I also listened to the nurses when they  
 12 raised their support.

13 I was being presented with things that at times  
 14 felt quite binary. I never took a binary view.  
 15 I listened to both.

16 Therefore Letby was removed from front line duties  
 17 and therefore we also focused on the safety of the unit  
 18 redesignating and so forth all the inquiries that went  
 19 through, all done in good faith. The -- it's easy,  
 20 really easy, when you look at these matters in the  
 21 context of what we now know following a four-year police  
 22 investigation, a 10-month trial, a retrial, but in 2016  
 23 and it's probably the case even now, in the NHS, the  
 24 biggest cause of unnatural, unexplained deaths in  
 25 maternity, in neonatal units, is not deliberate harm but  
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1 **A.** In practice it -- it's a technical thing  
 2 for -- for all Chief Executives. It's as the  
 3 accountable officer you are responsible statutorily for  
 4 the financials and delivering on the financial -- you  
 5 know the financial governance but also the internal  
 6 governance, which includes risk.

7 **Q.** Includes operational risk?

8 **A.** It includes all risk, yes.

9 **Q.** All risk. At the start of your evidence today  
 10 Mr De La Poer asked you in detail about the information  
 11 that was given to you in late June/early July about the  
 12 Consultants' concerns about Lucy Letby?

13 **A.** Yes.

14 **Q.** It was clear from that evidence and the  
 15 documents surrounding it that their concern was that she  
 16 might have been responsible for the increase in neonatal  
 17 death?

18 **A.** I think what -- what they -- what they were  
 19 saying was -- was that there had been an unexplained  
 20 increase in mortality and that there had been a member  
 21 of staff on duty more times than another member of staff  
 22 and then there was nothing really more concrete than  
 23 that.

24 **Q.** Well, there was, wasn't there, there was  
 25 stable children who deteriorated without medical

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1 explanation and unexpectedly who failed to respond as  
2 appropriately to resuscitation and they had even started  
3 to speculate, and you were aware of this, that they  
4 might have been murdered?

5 **A.** So at the time there was certainly nobody  
6 talking about criminality. There was certainly lots of  
7 examples that things had -- were happening in an  
8 unexpected and unexplained way. But there was no --  
9 there was nobody really pointing to say this was  
10 deliberate. They -- there were and I asked the question  
11 many times at many meetings: are we saying this is  
12 deliberate harm? Are we saying this is criminality? Or  
13 are we saying -- or versions of that and there was many,  
14 many thoughts and different opinions that were being  
15 raised but there was nothing that you could really put  
16 your thumb on.

17 **Q.** You were aware it was a possibility?

18 **A.** I was aware of possibility so I was listening  
19 to the doctors' concerns and I was also listening to my  
20 own gut feelings, which were I was aware from visiting  
21 the unit myself in December 2015 and other times that  
22 this was a unit that was running hot, that this was  
23 a unit that had seen an increase in demand. This was  
24 a unit that the acuity had gone up this was a unit where  
25 the birth rates had gone down so there was more than

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1 I remember the -- and maybe there was concerns raised  
2 that this member of staff needed to be removed.

3 So --

4 **Q.** Just to be clear, was it your -- is it your  
5 evidence that you were not aware of the possibility that  
6 children may have been deliberately harmed at the end of  
7 June and the beginning of July 2016?

8 **A.** I -- it was -- it was, it was much less  
9 explicit than that. If for one moment that's what  
10 I believed I had heard and that was being, that was what  
11 was being said, the board would have gone straight to  
12 the police.

13 **Q.** When did you become aware of that possibility?

14 **A.** I -- I think it as we did more investigations,  
15 as I have said previously, and we took the guidance from  
16 independent experts and the guidance that they were  
17 telling us seemed to be pointing away from deliberate  
18 harm.

19 **Q.** I am not asking you that question. I'm sorry,  
20 you are going to have to really focus on answering my  
21 question.

22 When were you aware of the possibility --

23 **A.** So I am saying to you it was something that  
24 was -- was never concretely said in the way that you  
25 have said. I mean, I think there is so much hindsight

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1 simply -- well, there was more going on than we could  
2 explain.

3 **Q.** You were aware of the possibility that the  
4 babies had been deliberately killed; yes?

5 **A.** I was aware only of the concerns that were  
6 raised and the circumstantial link with an individual  
7 member of staff.

8 **Q.** Well, the evidence you have already given and  
9 the evidence given by Ms Kelly and many others was that  
10 after the two Triplets died, the Consultants were  
11 concerned that they had been killed by Lucy Letby and  
12 they wanted her off the unit. The possibility that she  
13 had done so deliberately was a valid one, wasn't it?  
14 You were aware of that.

15 **A.** So can you show me the INQ reference of that?

16 **Q.** No, it's a vast amount of evidence that has  
17 been given over the last two --

18 **A.** But you are speaking very emphatically there  
19 and that is not what I remember.

20 **Q.** You don't remember being told by Alison Kelly  
21 that the Consultants wanted Lucy Letby off the unit?

22 **A.** Oh, I remember Alison telling me the things  
23 I had outlined, that there had been an increase in  
24 explained mortality. That there were concerns about the  
25 association with a member of staff and -- and -- and do

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1 inherent within your question. At the time that's not  
2 the information that I had or we had.

3 **Q.** Ms Kelly was clearly aware of that  
4 possibility. She talked about it in her evidence this  
5 week and she talked about safeguarding. Mr Harvey was  
6 also aware of it, he discussed it with the Royal College  
7 on the first day of their visit. Are you aware of that?

8 **A.** Yes, but what they weren't saying that this  
9 was an individual who was deliberately harming babies.  
10 This was somebody who there was a circumstantial link  
11 and gut feeling. Nothing more than that.

12 **Q.** Sorry, that's the possibility of harm was  
13 aware -- they were aware of that at that time?

14 **A.** Oh, okay. If you are -- I think it's when you  
15 use the emotive language of "murder" that it becomes,  
16 you know, not something that I heard at that time. If  
17 you are saying the possibility of harm, then, you know,  
18 there was discussions: was this a competence issue? Was  
19 this a -- you know, was there -- what was the range of  
20 scenarios and issues that we would need to explore?

21 **Q.** When were you aware of that possibility?

22 **A.** Oh, I think I -- I felt those issues almost  
23 immediately, really.

24 **Q.** All right. Well, that's taken about  
25 10 minutes to get to.

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1 Can I ask you this: what is the risk that the  
 2 Consultants were right, what was the risk?  
 3 **A.** Say again, sorry?  
 4 **Q.** What was the risk in your mind that the  
 5 Consultants were right?  
 6 **A.** Then if we didn't take action, if I didn't  
 7 remove Letby, then this deliberate harm might well  
 8 continue.  
 9 **Q.** Indeed. So risk is usually seen in two ways  
 10 or with two factors, there is a likelihood and there is  
 11 consequence. What was the likelihood that they were  
 12 right?  
 13 **A.** Based on what we knew at the time, and based  
 14 on what the conversations that we had had in various  
 15 meetings where I had said quite deliberately: are we  
 16 suggesting that this is deliberate harm? And the answer  
 17 was: we don't know ...  
 18 It's difficult to quantify that. But the fact that  
 19 we couldn't quantify it in itself didn't mitigate any of  
 20 the risk, so therefore Letby was removed, the unit was  
 21 downgraded and all the actions that followed.  
 22 **Q.** So you had an unquantifiable risk that  
 23 children might have been harmed by her and the  
 24 consequences were obvious --  
 25 **A.** Yes.

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1 **Q.** Other witnesses, I think Ms Kelly being one of  
 2 them, have accepted that there was a safeguarding risk  
 3 here which should have triggered that response. Do you  
 4 accept that or do you disagree?  
 5 **A.** I -- I would have taken advice around whether  
 6 this was a safeguarding matter from the safeguarding  
 7 lead, Alison Kelly. I would have taken advice whether  
 8 this should have been a matter for a SUDIc process from  
 9 our -- from our clinical leads.  
 10 I was minded by the fact that if there genuinely --  
 11 it was genuinely felt that this was deliberate harm by  
 12 this individual, I am absolutely confident that the  
 13 professionals, the doctors, would have alerted these  
 14 processes themselves, either directly to the police or  
 15 they would have gone through one of those mechanisms  
 16 were -- the fact that those things didn't happen in  
 17 itself created a sense that -- that risks were not --  
 18 were being managed.  
 19 **Q.** But you know that Consultants find it  
 20 extremely difficult to whistleblow on their colleagues,  
 21 they don't generally deal with these sorts of  
 22 situations, they are also extremely concerned that they  
 23 will find themselves in hot water with the GMC or  
 24 internally with their employer. There are a lot of  
 25 disincentives. Robert Francis talked about this, you

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1 **Q.** -- death and injury, they are the consequences  
 2 of not removing her; correct?  
 3 **A.** But she was removed.  
 4 **Q.** Yes, but I am asking about if she had gone  
 5 back, the consequences of --  
 6 **A.** Right, okay, yes.  
 7 **Q.** -- that risk?  
 8 **A.** By that time, so I thought we were talking  
 9 about 2016 -- in terms of 2017, you are right, there was  
 10 the -- but at that time it was genuinely felt by the  
 11 board and myself and the advice that we were getting  
 12 that it was pointing away from deliberate harm.  
 13 **Q.** Did you ever register the risk formally in any  
 14 of the management processes?  
 15 **A.** I mean, that's a really fair point. I --  
 16 I think the answer to that is no.  
 17 **Q.** From a safeguarding perspective, had this been  
 18 looked at through the lens of safeguarding, it required  
 19 an immediate response, that risk, and the reason is  
 20 requires an immediate response is because the  
 21 consequences are so grave and potentially unmanageable,  
 22 you recognise that? 24 hours local safeguarding officer  
 23 and the police, that is the appropriate response to  
 24 a risk of that sort, in an ordinary setting; correct?  
 25 **A.** Correct, yes.

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1 are well aware of this, you have been in the NHS for  
 2 years.  
 3 The fact that they don't trigger a safeguarding  
 4 process doesn't necessarily mean or exonerate one from  
 5 triggering one if you are aware of it, does it?  
 6 **A.** I am struggling to see what the risk to them  
 7 would be of triggering a safeguarding process.  
 8 **Q.** Well, the risk to it could be triggered  
 9 unnecessarily and it could cause matters to rebound on  
 10 them, obviously. That is what they talked about.  
 11 **A.** So but I -- if -- is there not a professional  
 12 responsibility to -- to do just that?  
 13 **Q.** There is and it's also on you, do you accept  
 14 it?  
 15 **A.** Yes, absolutely.  
 16 **Q.** You should have triggered the safeguarding  
 17 process just like everybody else?  
 18 **A.** I -- I -- I don't know, I am genuinely not  
 19 sure, but if the guidance that I would have been getting  
 20 from my safeguarding lead, I would be guided by that.  
 21 We -- we didn't view it as a safeguarding issue.  
 22 I don't think anybody did. I think it was viewed as  
 23 a unexplained increase in mortality with not really any  
 24 clarity as to what those causes were. You are  
 25 simplifying it to one cause. I don't think that was

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1 where -- where we viewed it.

2 **Q.** You viewed it in fact as a hypothesis and not  
3 a risk. You viewed it through the prism of  
4 a hypothesis, it is possible these babies may have been  
5 killed deliberately, but you didn't see it as a risk; is  
6 that fair?

7 **A.** I think that might be a reasonable way of  
8 describing -- describing it. I -- as I said before --  
9 at the end of my last evidence, that all evidence to  
10 date at that time pointed to unexplained deaths being  
11 more likely to be caused by a multi-factoral set of  
12 issues rather than a single act or individual. I don't  
13 think that was -- if that is a hypothesis then I accept  
14 that.

15 **Q.** You said in answer to questions from  
16 Mr De La Poer that your job as Chief Executive, or one  
17 of your jobs, is to ask the right questions?

18 **A.** Yes.

19 **Q.** Did you ever ask Ian Harvey or anyone else:  
20 have you satisfactorily excluded the possibility that  
21 Lucy Letby has deliberately harmed children?

22 **A.** We asked that question in a slightly different  
23 way in that have we been able to establish anything that  
24 is -- well, the question was framed in many different  
25 ways but one example of that, and it was a meeting on

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1 four?

2 **A.** Yes.

3 **Q.** So she did not exclude the possibility of  
4 deliberate harm and was not indeed asked to exclude it?

5 **A.** We, I believe and you -- you may wish to pick  
6 this up with -- with Mr Harvey, but the way that the  
7 work that Dr Hawdon was doing was commissioned was  
8 deliberately constructed in a way that she would keep an  
9 open mind and those things would hopefully be flushed  
10 through.

11 But in -- and the outcomes of that, her work, as  
12 I said many times, didn't point to deliberate harm. The  
13 four cases where things were unascertained, they -- when  
14 they were reviewed by pathologists didn't point to  
15 deliberate harm. I'm not sure what else to make of that  
16 other than there is no deliberate harm.

17 **Q.** That is a false inference. So you are saying  
18 they didn't positively point to deliberate harm but they  
19 quite explicitly did not exclude deliberate harm, did  
20 they, none of them? The Royal College didn't because it  
21 wasn't a Casenote Review, they never looked at the  
22 medical records of the children. Dr Hawdon looked in  
23 detail at the medical notes of the children but she  
24 explicitly said "I can't exclude unnatural causes" and  
25 she asked for forensic Casenote Review. And

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1 27 March, I asked: are we saying that this is  
2 deliberate -- that this is criminality? So we did ask  
3 that question.

4 **Q.** That is not the same question though, is it?  
5 The issue is: did you ask any of your staff if they had  
6 satisfactorily excluded the possibility, so directly  
7 confronted it and excluded it?

8 **A.** I'm not sure that we did ask what question.

9 **Q.** Because Mr De La Poer has taken you through  
10 all the various investigations so there is the  
11 Royal College investigation or review, that did not  
12 exclude that possibility, did it?

13 **A.** It's -- it gave examples of where the care  
14 could be improved or where the leadership could be  
15 improved or the staffing levels could be improved. But  
16 as I said in my own witness statement, it didn't answer  
17 the question.

18 **Q.** Nor did Dr Hawdon.

19 **A.** I -- I think Dr Hawdon's review and maybe it's  
20 a misinterpretation and I don't think it is, but  
21 Dr Hawdon's review was that there was nothing pointing  
22 to deliberate -- to unnatural causes.

23 **Q.** That's not the same as excluding it, is it?  
24 In fact, she asked from a forensic review to take place  
25 in respect of five children, although it ended up being

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1 Dr McPartland in the more limited review couldn't  
2 exclude deliberate harm either. None of them did.

3 **A.** And the guidance that we were getting that  
4 I was hearing and the inferences that we were making,  
5 that there was nothing that was suggesting unnatural  
6 causes to the causes of death to those babies. They had  
7 had postmortems previously and so on, so I -- I -- and  
8 again as I said, eight years on, when you look back, you  
9 can see that following the police inquiries and all the  
10 rest of it that the causes of death have now been called  
11 into, you know, a different explanation than the ones  
12 that we arrived at had it been -- had been agreed.

13 **Q.** But if you look at the instructions, the  
14 instructions don't say: this is the suspicion, please  
15 will you investigate it and exclude it as a possibility?

16 At no point do any of those cases that occurred --

17 **A.** Yes, and again you will need to test this but  
18 my view is that it was -- we didn't want to in any way  
19 prejudice the work that was been doing, we wanted  
20 everybody to keep an own mind as we were. I can't --  
21 I can't say any more, I'm sorry.

22 **Q.** In your response to the Consultants' concerns  
23 in 2018 you said that you believed the Trust could  
24 demonstrate that it's taken the concerns that they have  
25 very seriously and you have been open and transparent

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1 with the Coroner, with our regulators, and as far as the  
2 police investigation allows, with staff, parents and the  
3 public.

4 Can I test that, please. First of all,  
5 NHS England. You will be aware that they have provided  
6 an opening statement to this Inquiry and  
7 Sir Stephen Powis has given a statement. The opening  
8 statement by NHS England says:

9 "To the best of NHS England's knowledge the  
10 concerns about potential criminal conduct were not  
11 shared at this point [in other words, when they arose  
12 around June/July 2016] and this information was also not  
13 shared with NHS England."

14 How does that square with your assertion to the  
15 Consultants in 2018?

16 **A.** So again it's -- it's the first thing we  
17 were -- what we thought we were doing was trying to  
18 explain the causes of increased unexplained mortality.  
19 There was a suggestion that a single member of staff --  
20 that a single member of staff was on duty more times  
21 than another. So those are the two facts of it.

22 The -- in his evidence Robert Francis talked about  
23 how difficult it can be to balance the duty of candour  
24 with the duty of care and this was a balance that we  
25 were trying to manage. So hopefully from the  
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1 fully sighted on these issues, I am not absolutely  
2 certain.

3 **Q.** Do you accept that NHS England should have  
4 been told about the concerns that a single nurse was  
5 responsible for the increase in deaths when those  
6 concerns arose?

7 **A.** The -- the answer is I don't know, it's just  
8 that balance between candour and duty of candour and  
9 duty of care. I -- whether we got that balance wrong,  
10 I'm not sure at that time whether we had got the balance  
11 right.

12 **Q.** Does the same answer apply to the CQC? You  
13 will be aware that Ann Ford has given evidence in  
14 writing and orally to this Inquiry, she made clear that  
15 she would have expected your hospital --

16 **A.** Yes.

17 **Q.** -- to have told the CQC, which had visited in  
18 February, about the increased mortality as and when it  
19 arose and about concerns as and when?

20 **A.** Say that again, please?

21 **Q.** It would have expected to have been informed  
22 about increased mortality as and when it became an issue  
23 and it would have been -- can I just finish? Would have  
24 expected to have been told about the concerns in respect  
25 of a single nurse as and when that arose?  
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1 recommendations from this Inquiry there can be greater  
2 clarity around how that balance can be delivered. But  
3 candour starts with an investigation and that's what we  
4 were doing.

5 **Q.** There is clearly expectation on part of the  
6 regulatory -- of that body -- we will come on to the CQC  
7 in a moment -- that you would have told them of  
8 a concern at that level and for obvious reasons if you  
9 have a nurse that's either so incompetent that she's  
10 managed to kill a lot of children or has deliberately  
11 harmed children and you are setting in train a series of  
12 internal and external investigations to look at that  
13 concern, that is clearly a matter of interest to  
14 NHS England, isn't it?

15 **A.** And in 2016 I think the information that was  
16 shared with NHS England was around the increase in the  
17 mortality --

18 **Q.** Yes.

19 **A.** -- not the link to the nurse. The link to the  
20 nurse I think was made, the -- NHS England were made  
21 aware of that some time in 2017.

22 I know that the link person that Alison was  
23 connecting with to share all of these concerns was with  
24 Margaret Kitching, and Margaret, I think, it's fair to  
25 say, was fully sighted on these issues but when she was  
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1 **A.** Okay, so, the -- as a -- as a process arising  
2 coming out of any Serious Incident Review which I think  
3 some of the babies involved in June/July 2015 were  
4 subject to, the CQC and the CCG would have been made  
5 aware of those reviews at that time.

6 In terms of if your question is: should we have  
7 shared the Thematic Review with the CQC?, well, my  
8 understanding is that the CQC -- the Thematic Review  
9 hadn't been shared with us at that time or if it had, it  
10 had literally only just been shared with us and by "us",  
11 I mean Ian Harvey and Alison Kelly. I didn't see the  
12 Thematic Review until much later.

13 It would -- it wouldn't be usual to share something  
14 that hasn't been through our own internal governance  
15 processes and we know that the sharing the Thematic  
16 Review through our own internal governance processes had  
17 been problematic. It hadn't gone through to the QSPEC  
18 in a timely way, it hadn't gone to the  
19 Women's and Children's governance board in a timely way  
20 so it's difficult to be really clear whether that  
21 document should have been shared at that time. But it  
22 may well have been. And I think you need to test that  
23 conversation with Mr Harvey tomorrow because there isn't  
24 any clear record as to whether the CQC had got that  
25 report or -- or not.  
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1 Q. Well, the CQC through Ann Ford has given  
2 evidence that they considered the Trust not to have been  
3 transparent with them about this matter --

4 A. Yes, I -- I -- that wasn't -- we weren't  
5 a Trust that was not transparent with the CQC, we were  
6 always a Trust that if there was risk concerns, we used  
7 to be -- we were one of those Trusts that would alert  
8 the CQC rather than been waited to ask.

9 So all I can assume is that the -- the -- any delay  
10 in it being shared with the CQC was because the -- there  
11 had been a delay in the Thematic Review being shared  
12 through our own internal processes. Subsequently it was  
13 shared -- was it not shared in March?

14 Q. So their evidence is that the -- just if you  
15 give me one second, first aware of the increased  
16 mortality on 29 June when Alison Kelly rang?

17 A. Okay.

18 Q. Made a phone call?

19 A. Yes, okay.

20 Q. So many months after the Thematic Review?

21 A. (Nods)

22 Q. Do you have a comment on that?

23 A. No. If that's the point of fact, I'm --  
24 I'm -- I seem to remember and, and I can't, I can't give  
25 you the specifics, but I do seem to remember that

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1 working on your neonatal unit by this stage thought that  
2 one of their nurses had killed the children, you  
3 would --

4 A. So --

5 Q. -- need to know that in terms, wouldn't you?

6 A. So this was a board meeting in January 2017.

7 Q. Yes.

8 A. The paediatricians had been at the board  
9 meeting in I think it was 17 July 2016 with all of the  
10 board. The notes of that meeting were very frank, open  
11 and inclusive. The concerns that the paediatricians had  
12 raised would have been the board would have been sighted  
13 on them.

14 Q. But for these purposes those concerns were  
15 still in existence, they were still held, vehemently so  
16 by this point, and they had not gone away, but Mr Harvey  
17 doesn't clarify them?

18 A. Well, the report is as it's written, yes.

19 Q. Well, he should have told the board the  
20 concerns were still there --

21 A. I -- I think he -- he, he would have believed  
22 that that was something that the board did understand  
23 from previous meetings and discussions that had gone on  
24 previously.

25 Q. He mentions the Royal College review, but that

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1 bundles of documents following the review were shared  
2 with the CQC, as is common practice. They take a load  
3 of documents in advance, they do their review and then  
4 they make requests for further.

5 It was my understanding that the Thematic Review,  
6 I think, was part of one of those bundles, but I can't  
7 be absolutely certain.

8 Q. When it comes to the board, I won't take you  
9 in great detail through all the various meetings for  
10 obvious reasons. But there was a meeting on 10 January  
11 where Ian Harvey presented a report that he had done?

12 A. Yes.

13 Q. A very short report. That's at INQ0003518.  
14 It's going to come up on screen.

15 So it's a very short report, but he is basically  
16 saying: There were some concerns raised by the clinical  
17 team regarding higher than usual number of neonatal  
18 deaths from January 2015, together with inconclusive  
19 results from internal reviews.

20 He doesn't there tell the board that the actual  
21 concern was the possibility of deliberate harm, does he?

22 A. Not specifically in that paragraph, but the --

23 Q. If you were a board member, Mr Chambers, and  
24 you needed to be fully sighted to make a decision, you  
25 would want to know that the body of paediatricians

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1 had not excluded the concern, had it --

2 A. No.

3 Q. -- as you have agreed?

4 A. No.

5 Q. He also mentioned the external case review but  
6 that had not excluded that concern either, had it?

7 A. Well, it had -- there were four unascertained.

8 Q. Well, as at this stage, the concerns had not  
9 been satisfactorily excluded conclusively, had they?

10 A. Well, 13 cases had been given explanations and  
11 causes that were not deliberate harm or, or were not,  
12 were not unnatural causes. 13 had also -- it had been  
13 identified that there was strong evidence in all cases  
14 that there had been sub optimal care and in some cases  
15 significant sub optimal care. There were four cases as  
16 of out of the Jane Hawdon review that required further  
17 investigation.

18 Q. So, no?

19 A. I have outlined to you the position.

20 Q. At this stage the recommendation, it seems  
21 from you and Mr Harvey, was that the nurse who was  
22 potentially responsible should come back to the unit?

23 A. Responsible for what?

24 Q. For the harm?

25 A. The -- as I keep saying there, there was

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1 an explanation for the causes of death. There was  
2 an explanation at that time for what was previously  
3 described as an unexplained increase in mortality.  
4 There was nothing that was talking about deliberate  
5 harm.

6 **Q.** What was the explanation for Child A's death,  
7 who was the first infant --

8 **A.** It remained unascertained, as you know.

9 **Q.** So what did you mean when you just said there  
10 was an explanation? What was it?

11 **A.** I -- what I said in 13 cases there was causes  
12 and explanations given. In four cases and I think one  
13 of those four was Baby A --

14 **Q.** Yes, five cases in fact?

15 **A.** Yes. And, to be honest, you're probably  
16 better going through this report and the detail of this  
17 with Mr Harvey. But that was my understanding; that at  
18 the end of all of this, there were two cases that  
19 were -- remained unascertained, unexplained and there  
20 was a view that that in itself is not unusual.

21 **Q.** Whose view was that?

22 **A.** I -- I think Nim. Nim Subheddar maybe have --  
23 But -- but it's something that I will need to ask  
24 you to refer to, to Mr Harvey.

25 But in previous notes that we have been through  
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1 and were encouraging the Board to allow that to happen.  
2 That is the reality, isn't it?

3 **A.** There was a grievance process. Out of the  
4 grievance process there was recommendations, one of  
5 which is that subject to the completion of all of the  
6 reviews, and no suggestion of any connection with  
7 deliberate harm, then we should -- you -- Letby should  
8 be returned to the unit.

9 The position that we took to the board was the  
10 outcome of that recommendation based on all the things  
11 we knew in good faith, and we continued the  
12 conversations with the clinicians, as you know. But the  
13 other point of fact is irrespective of whether we  
14 believed at that time that Letby should have gone back  
15 to the unit, as soon as new matters became known to us,  
16 as soon as new concerns or concerns that had been known  
17 for many, many years or months were shared with us, the  
18 change for -- that Lucy Letby was, she, you know -- the  
19 status quo was maintained and the exploration of  
20 escalating to the police was explored and eventually  
21 delivered.

22 **Q.** So can I -- could you just be absolutely  
23 clear. What was the new information which tipped the  
24 balance?

25 **A.** It was, it was, it was the -- it was the  
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1 today, this was a point that Duncan made; that it was  
2 not unusual. And there will have been a source for that  
3 opinion. I'm not 100% sure what the source of that  
4 opinion was.

5 **Q.** Mr Chambers, it's an odd feature of your  
6 evidence today that you don't seem to fully recognise  
7 that the Consultants were entirely right about the risks  
8 and what had happened and you were entirely wrong. And  
9 so when I put to you that in 2017, those concerns that  
10 they had and had had indeed from 2015 had not been  
11 addressed satisfactorily and there was still a risk,  
12 that is correct, isn't it? She had in fact killed the  
13 children?

14 **A.** All -- all I -- all I can offer you is the  
15 evidence of what we knew, what we believed, what we did  
16 at the time of 2016/2017.

17 The facts that those -- the fact that that now, on  
18 the basis of the police inquiry that followed, led to  
19 indictments and convictions was not the position at that  
20 time. So it's -- both positions can be correct.

21 **Q.** Well, the position at the time was that you  
22 had a group of Consultants who didn't want Lucy Letby  
23 back on the unit because they thought she had  
24 deliberately harmed their patients and you had an  
25 Executive Team that wanted Lucy Letby back on the unit  
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1 concerns that that Dr Jayaram had, had alerted to Sue,  
2 to Sue Hodgkinson that led to me going to have  
3 a conversation with him. I did not go into that meeting  
4 in a very heavy-handed way saying, you know, "Tell me  
5 all about ..."

6 I just wanted to find a way to softly listen, that  
7 led to the meeting on 27 March, that led eventually to  
8 the police being called.

9 **Q.** Sorry, what specific information did you  
10 learn --

11 **A.** It was -- you know exactly what I am talking  
12 about. It's the --

13 **LADY JUSTICE THIRLWALL:** Just answer his question.

14 **A.** It's the -- it's the concerns that  
15 Mr Jayaram -- Dr Jayaram had raised in respect to Lucy's  
16 conduct on the unit in respect of maybe a desaturation  
17 baby that he -- that she -- that he didn't feel that she  
18 was attending to or that some dials had been adjusted.

19 Those were the nature.

20 **MR SKELTON:** Child K.

21 **A.** Yes.

22 **Q.** In short.

23 **A.** Baby K.

24 **Q.** So when they put their report in, which is the  
25 report which Simon Medland encouraged them to write,  
220

1 they wrote down a summary of their main points. That  
 2 wasn't one of their main points. They wrote down the  
 3 familiar list: deaths, an increase in deaths, sudden and  
 4 unexpected. Failure to respond to resuscitation. One  
 5 member of staff being present and investigations to date  
 6 not identifying any other potential cause for the  
 7 increased mortality.

8 That wasn't sufficient for you, was it?

9 **A.** Say again, sorry.

10 **Q.** That list wasn't sufficient for you? It  
 11 hadn't been sufficient?

12 **A.** I -- we, we'd never -- we never saw that list.

13 **Q.** So which of those bits of information? I can  
 14 take you to the document, it's INQ0003671.

15 **A.** The -- the specific bit of information was the  
 16 concerns he had raised about Baby K with Sue Hodgkinson  
 17 on 15 April.

18 **Q.** Just look at the list. I want you to tell me  
 19 what was new for you and when you learnt it.

20 If we go to the second page, please, towards the  
 21 bottom you will see a summary. If we could actually  
 22 have both the second page and the third page on the  
 23 screen so we can see the list of six points.

24 If you run through that list, was any of that news  
 25 to you in 2017 or did you know that really from then --

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1 it to characterise those factors if they were known in  
 2 2016 as unsubstantiated allegations, wouldn't it?

3 **A.** Well, the number of neonatal deaths in the  
 4 period is highly unusual. That's a fact. The number of  
 5 unprecedented, unexpected and unexplained  
 6 deaths/collapses is highly unusual I would have to take  
 7 guidance on, but, yes, I'm assuming it is, although  
 8 cause of death is uncertain.

9 So unsubstantiated? And you are making this in  
 10 reference to which point?

11 **Q.** So you said repeatedly to the board in 2017  
 12 that the Consultants' concerns were unsubstantiated?

13 **A.** Well, what they -- their concerns were not  
 14 clearly articulated. They were, they were -- they were  
 15 implicit, not explicit. It was very difficult to really  
 16 make sense of what was being said.

17 When, when Consultants were pressed they, they --  
 18 very explicitly they quite honestly said: We just don't  
 19 know. So the unsubstantiated element to this is that  
 20 quite simply all we really knew was that there had been  
 21 an unexplained increase in neonates, which is unusual,  
 22 and that there was a link to a single member of staff  
 23 being on duty at more times than others and that there  
 24 was, at best, gut feeling.

25 **Q.** You and the Executives knew all of that

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1 **A.** I -- I -- I -- this best case paper, if that's  
 2 what this was, that came out of the Simon Medland  
 3 meeting was not something that was ever shared with the  
 4 senior Management Team.

5 **Q.** Not my question.

6 Which of those bits of information were you not  
 7 aware of in 2016?

8 **A.** In 2017.

9 **Q.** Or '16, '16 I said, but '17 if you want as  
 10 well?

11 **A.** I think by 2017, and maybe even 2016, some of  
 12 this I think was shared with the Royal College by the  
 13 paediatricians.

14 **Q.** Yes.

15 **A.** Some of this I think featured implicitly in  
 16 various iterations of the Thematic Review.

17 **Q.** Yes.

18 **A.** None of it was explicitly called out.

19 The -- so I suppose, you know, you, you -- you  
 20 could argue that some, if not all, of this may well have  
 21 been known.

22 **Q.** Yes.

23 **A.** But -- but it just -- it just was -- it was  
 24 just implicit rather than explicitly called out.

25 **Q.** But it would certainly be improper, wouldn't,  
 222

1 information in 2016?

2 **A.** I -- it was never presented in that way. It  
 3 was -- it was always presented as, as a feeling rather  
 4 than really strong, I'm reluctant to use the word  
 5 "evidence", but just it was, it was -- it was just a gut  
 6 feeling.

7 **Q.** But you know now, Mr Chambers, looking at that  
 8 list, those are not feelings recorded there. They are  
 9 facts, aren't they?

10 **A.** But what was presented was feelings.

11 **Q.** No. All of those facts were presented to the  
 12 Executive in --

13 **A.** They.

14 **Q.** -- 2016.

15 **A.** They -- they were presented as: This is our  
 16 gut, this is our ...

17 And, and in hindsight, yes, I mean, maybe gut  
 18 feelings is, is, is -- is a -- is something that is  
 19 really strong, but it was never presented with the  
 20 clarity that you have presented it here.

21 **Q.** Did you ever ask them to present it?

22 **A.** Well, in so much as I've often -- I've  
 23 actually asked myself this question lots of times, you  
 24 know: why did it take Simon Medland to come along and  
 25 suggest that we write down or write down your best  
 224



1 points. But, in truth, I thought that's what the  
2 Thematic Review had done.

3 **LADY JUSTICE THIRLWALL:** We are now at half past 5,  
4 Mr Skelton. I am not stopping you, but we do have to  
5 have a break for the shorthand writer.

6 **MR SKELTON:** We do. I have got a relatively short  
7 issues, but I'm obviously in her hands.

8 **LADY JUSTICE THIRLWALL:** Yes, she's already done  
9 more time than we really should expect.

10 We will take a 10-minute break until 20 to 6.

11 (5.30 pm)

12 (A short break)

13 (5.40 pm)

14 **LADY JUSTICE THIRLWALL:** Mr Skelton, I will let you  
15 finish your point and then we will discuss where we go  
16 next.

17 **MR SKELTON:** Thank you.

18 Mr Chambers, a last and brief issue from me and  
19 it's a topic which I think Mr Baker, who also represents  
20 a group of Families, will pick up with you. But  
21 essentially it's this: it's a last opportunity from my  
22 perspective to give you the chance to speak with  
23 empathy --

24 **A.** Yes.

25 **Q.** -- and speak with insight about the events of  
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1 reason, is that they could have added in their input  
2 both factually, but also they could have said to you and  
3 the Executives: These investigations are not good  
4 enough. You need to call the police ...

5 Because that is their prerogative, isn't it? If  
6 they think their children have been murdered they have  
7 every right to say to you: The only organisation  
8 possible to investigate these activities is the police.

9 Do you understand that and accept it?

10 **A.** I -- I accept that.

11 **Q.** Lastly on the Coroner. I appreciate these are  
12 questions which I will have to put to Mr Harvey when he  
13 gives evidence, but the Coroner held an Inquest into  
14 Baby A's death on 10 October 2016.

15 At that Inquest Dr Saladi and Dr Jayaram gave  
16 evidence and neither of them indicated that they  
17 suspected Lucy Letby had murdered Child A. The hospital  
18 was represented by Louis Browne, who was just about to  
19 become a KC so he was very senior counsel. He didn't  
20 indicate that and he will explain whether or not he knew  
21 or not about the concerns that were going on at that  
22 time.

23 But it does appear that by hook or by crook the  
24 Coroner was not informed that there were suspicions  
25 about that child's death. That was unacceptable, wasn't  
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1 2016 and 2017. By July 2016, you had the position that  
2 you had a group of neonatal Consultants who suspected  
3 that their nurse, Lucy Letby, had murdered the babies on  
4 the unit and we know that from all the evidence we have  
5 received and that came to the attention, that suspicion  
6 or concern came to the attention of the Executives by  
7 2016 certainly around the summer.

8 You have at that stage an enormous asymmetry of  
9 knowledge or suspicion. The Families are grieving  
10 still, but they have no idea that the paediatricians  
11 suspect they are grieving because their children have  
12 been murdered and you have the hospital and the  
13 Executives who are thinking and looking into that issue.

14 You must understand from their perspective they  
15 needed to be told of those concerns and they needed to  
16 be told what investigations were being conducted by the  
17 hospital; do you accept that?

18 **A.** Absolutely.

19 **Q.** And that included the Royal College review,  
20 which involved many of their children, Jane Hawdon's  
21 review, which involved many of their children, and  
22 Dr McPartland. They needed to have been engaged in all  
23 of those processes, do you accept that?

24 **A.** I absolutely accept that.

25 **Q.** And one of the reasons, not simply a moral  
226

1 it?

2 **A.** It's -- it clearly, in hindsight, is  
3 absolutely unacceptable. The context that we found  
4 ourselves in at the time, these matters weren't clear.

5 I am not aware that what -- what the KC  
6 Louis Browne had been told. I am not part of any of  
7 these Coronial processes.

8 But what I am absolutely sure about is that there  
9 would have been no deliberate not sharing openly and  
10 honestly with the Coroner the concerns.

11 I don't know why Dr Saladi and Dr Jayaram didn't  
12 share those matters with, with the Coroner through that  
13 Inquiry -- through that Inquest, but I'm absolutely  
14 certain it wouldn't have been any, any sort of  
15 an instruction from the Countess, the Hospital Trust.  
16 And I think in their evidence, the doctors' evidence,  
17 they don't suggest that.

18 But it does feel to me that maybe that was  
19 something that should have been shared and I can't  
20 explain why it wasn't.

21 **Q.** You had no personal involvement in the Inquest  
22 process?

23 **A.** No, no.

24 **Q.** The Coroner, Mr Rheinberg and his then deputy,  
25 and then became Senior Coroner Mr Moore are clear that  
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1 they were never told about the suspicions in respect of  
 2 Lucy Letby during this period of time, 2016.  
 3 So far as you were aware, is that correct?  
 4 **A.** In 2016, that's possibly the case. I can't  
 5 confirm one way or another. I am sure that in 2017, the  
 6 Coroner were made aware of the concerns that the doctors  
 7 had raised. I honestly can't tell you what, what the  
 8 Coroner was told in 2016 or -- yes.  
 9 **MR SKELTON:** Thank you.  
 10 **LADY JUSTICE THIRLWALL:** Thank you, Mr Skelton.  
 11 Now, Mr Baker, well, really all counsel, it seems  
 12 to me it has been a long day already for this witness.  
 13 I imagine that you have got a little time. I think,  
 14 Mr Kennedy, probably a bit less? No time at the moment.  
 15 **MR KENNEDY:** I think having heard the evidence  
 16 I will not ask any further questions. I will just be  
 17 around and I can deal with it by way of submissions, if  
 18 that assists.  
 19 **LADY JUSTICE THIRLWALL:** Thank you. Then,  
 20 Ms Blackwell, you have got how long?  
 21 **MS BLACKWELL:** At least 20 minutes.  
 22 **LADY JUSTICE THIRLWALL:** So shall we say half  
 23 an hour. So it seems to me we might be better doing  
 24 this tomorrow morning. Everyone is nodding. I imagine  
 25 that's --

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1 Sorry, if I can just speak to you, Mr Chambers.  
 2 I had considered an early start tomorrow morning,  
 3 but I think that would not be convenient for those who  
 4 are coming some distance. So I hope that it will be  
 5 convenient for you, you haven't really got much choice  
 6 about it --  
 7 **A.** No, no, I am happy to support.  
 8 **LADY JUSTICE THIRLWALL:** -- to come at 10 o'clock  
 9 tomorrow morning.  
 10 **A.** Sorry, say again?  
 11 **LADY JUSTICE THIRLWALL:** 10 o'clock tomorrow  
 12 morning.  
 13 May I make one thing crystal clear in case it  
 14 hasn't previously been made clear, that there should be  
 15 no communication between you and your lawyers or indeed  
 16 anybody else about the evidence that you are giving to  
 17 this Inquiry.  
 18 **A.** Thank you.  
 19 **LADY JUSTICE THIRLWALL:** We will start again  
 20 tomorrow morning at 10 o'clock.  
 21 Thank you all for the long day.  
 22 **(5.49 pm)**  
 23 **(The Inquiry adjourned until 10.00 am,**  
 24 **on Thursday, 28 November 2024)**  
 25

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151/22 166/15 169/2	54/5 54/6 54/24 60/12	74/1 86/25 132/12	92/23 93/7 95/4 117/6	91/13 99/24 101/24
173/13 173/14 174/10	60/17 64/3 67/23	149/11	118/12 120/12 123/1	113/4 113/24 120/7
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190/22 190/24 190/24	82/12 83/17 86/2 86/3	10/6 22/17 22/18	147/24 149/21 160/17	144/21 147/14 148/21
191/20 191/20 196/24	87/14 87/23 90/14	22/21 22/23 31/7	162/9 164/1 164/25	148/24 148/24 152/12
198/13 207/21 213/4	91/23 92/15 93/5 94/5	35/14 39/22 43/25	167/25 168/13 173/18	153/17 155/9 156/2
221/2 221/8 221/10	94/25 96/23 98/2 98/2	70/3 71/22 72/1 73/9	178/8 179/1 183/1	166/12 167/21 169/3
227/25 228/20	100/6 100/6 100/9	73/18 76/1 76/3 82/8	183/9 185/18 185/24	174/18 185/23 191/24
<b>water [1]</b> 203/23	100/17 101/3 102/19	85/10 85/11 86/7	203/5 203/7 211/9	195/17 196/25 197/1
<b>way [63]</b> 8/25 24/7	108/17 111/9 114/9	86/21 89/25 90/8	211/10 212/20 212/24	200/9 200/10 216/21
29/1 35/14 42/15 45/5	115/10 116/11 116/16	90/13 92/13 95/5 95/5	219/13 227/20	217/7 218/22 225/19
54/8 55/22 58/17	116/18 117/5 118/6	99/20 104/12 106/16	<b>which [111]</b> 11/4	226/2 226/13 227/18
59/15 59/17 60/21	118/11 119/2 120/8	107/9 114/19 119/9	15/21 16/4 21/20	230/3
61/12 63/2 65/10	120/11 122/21 123/22	129/20 130/24 131/2	25/21 28/21 32/17	<b>whoever [1]</b> 123/5
65/20 68/1 68/7 71/3	124/10 126/3 128/12	131/3 131/5 132/1	33/8 33/16 35/17	<b>whole [4]</b> 36/18 54/3
80/16 90/20 95/21	135/5 135/9 135/12	132/1 137/1 141/10	38/17 40/25 46/9	102/9 172/8
105/6 105/8 105/24	141/20 143/3 143/5	142/1 142/12 149/25	56/25 57/10 57/21	<b>wholeheartedly [1]</b>
106/10 106/20 106/21	143/7 145/24 148/1	156/20 158/23 160/17	58/17 60/3 62/25	4/23
107/2 109/11 114/5	148/14 151/4 151/12	162/17 164/14 175/13	64/18 66/4 67/7 68/1	<b>whose [5]</b> 1/21 59/9
115/10 116/4 116/9	152/4 152/6 152/11	176/4 192/2 193/5	68/7 69/12 71/4 73/2	92/21 174/18 217/21
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149/20 171/9 183/19	172/6 172/22 173/7	209/11 210/25 211/5	90/22 93/25 94/20	29/24 30/18 37/18
185/6 185/19 194/6	176/3 176/20 180/9	211/18 211/19 211/22	94/23 96/1 96/7 97/10	44/14 45/6 52/11
197/8 199/24 205/7	181/23 182/9 184/6	211/25 213/16 214/8	99/21 100/10 102/6	53/14 55/23 57/8
205/23 207/6 207/8	184/14 186/11 191/16	217/9 218/9 220/24	105/7 109/4 112/17	65/16 87/8 87/17
208/18 212/18 212/19	196/24 198/1 198/8	221/19 223/17 223/17	113/19 119/19 121/15	90/24 96/25 102/6
220/4 220/6 224/2	200/24 201/7 204/1	227/12	123/25 125/25 128/6	106/1 124/4 125/3
229/5 229/17	204/8 205/24 212/7	<b>where [72]</b> 9/14 10/4	130/9 133/1 145/15	125/5 125/18 127/6
<b>ways [2]</b> 201/9	212/22 213/1 215/18	23/3 23/3 25/6 25/8	145/17 146/16 146/19	127/6 128/1 131/11
205/25	215/19 216/7 216/8	30/25 37/10 39/5	146/21 148/3 153/6	141/18 141/19 149/25
<b>we [706]</b>	216/10 218/21 222/10	39/15 40/16 42/22	155/3 155/12 157/4	150/2 151/3 154/14
<b>we'd [7]</b> 125/23	222/20 223/3 223/13	45/1 47/1 47/16 47/17	159/1 159/7 160/16	159/1 159/1 162/7
163/12 168/18 179/19	224/22 229/11	50/25 54/21 60/15	162/5 163/16 169/24	172/7 172/10 180/23
182/23 183/13 221/12	<b>well-being [1]</b> 158/17	60/22 71/20 85/2	173/2 173/9 173/18	181/7 182/7 182/10
<b>We'll [4]</b> 2/12 64/12	<b>well-known [1]</b> 100/6	87/20 91/13 95/7	174/13 177/7 178/3	182/19 182/21 182/21
73/22 142/7	<b>well-led [1]</b> 82/12	95/16 95/17 95/17	179/7 186/21 186/25	192/22 224/24 228/11
<b>We've [1]</b> 102/1	<b>well-managed [1]</b>	95/18 96/4 98/1 99/10	187/3 188/3 189/1	228/20
<b>Weatherley [3]</b>	151/12	104/5 104/5 104/20	189/2 189/7 192/5	<b>wider [1]</b> 58/10
103/14 103/15 116/7	<b>well-regarded [1]</b>	104/21 106/4 106/6	193/4 193/5 193/6	<b>will [101]</b> 4/20 7/7
<b>Wednesday [1]</b> 1/1	28/21	106/18 112/16 113/16	193/18 194/7 195/11	14/6 14/23 20/21
<b>week [4]</b> 12/1 12/4	<b>Wenham [3]</b> 45/15	113/16 117/21 118/15	196/6 197/20 203/3	20/22 25/11 32/9
59/8 200/5	48/4 132/3	123/11 127/1 129/11	211/17 212/2 219/5	34/14 35/25 36/5
<b>weekly [3]</b> 35/20	<b>went [14]</b> 4/11 7/11	129/16 141/12 147/5	219/23 220/24 220/25	36/20 37/16 37/24
125/25 141/11	29/9 29/18 53/23	147/9 150/5 151/10	221/13 222/6 223/10	37/24 42/13 43/21
<b>weeks [3]</b> 36/11	54/19 74/11 76/6	151/19 158/23 159/3	223/21 225/19 226/20	45/22 49/23 52/18
144/12 159/8	77/21 102/10 125/12	169/7 170/22 175/8	226/21 227/12	52/25 53/12 54/12
<b>weeks' [1]</b> 156/3	138/16 170/1 194/18	175/23 179/16 181/17	<b>whilst [5]</b> 3/16 48/24	56/12 56/13 58/23
<b>weeks's [1]</b> 33/16	<b>were [436]</b>	184/3 197/24 201/15	124/2 161/10 190/16	62/23 62/23 63/5 64/4
<b>weigh [1]</b> 81/3	<b>weren't [20]</b> 5/14 6/9	205/1 205/1 206/13	<b>whistleblow [1]</b>	64/15 64/19 66/11
<b>weight [2]</b> 36/12	6/10 10/21 44/15	206/14 207/13 214/11	203/20	67/24 68/23 73/7
80/23	49/10 52/5 95/2	225/15	<b>whistleblowers [2]</b>	73/11 73/22 74/23
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	132/6 135/13 152/14	11/12	<b>whistleblowing [2]</b>	83/23 87/24 88/1 88/2

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