

Thursday, 28 November 2024

(10.00 am)

MR ANTONY CHAMBERS (continued)

Questions by MR BAKER

LADY JUSTICE THIRLWALL: Mr Baker.

MR BAKER: Mr Chambers, I ask questions on behalf of 12 Families or The Families of 12 children.

Can I take you back to something you said yesterday morning. You said:

"I thought -- I agree and I have always felt that the concerns that they, the Consultants, were raising were always based upon their honest belief and their concerns as they understood them to be."

In the afternoon, you said:

"Clearly, there's never been a doubt in my mind, ever, that those doctors had the safety and well-being of babies at the front of their minds."

Does that represent your belief in 2016, that these were issues being raised by the Consultants in good faith?

A. Absolutely. Yes.

Q. Can you see the significance of that now, even with reflection?

A. I think in my evidence yesterday, I -- I recognised that what I was hearing the Consultants say

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Q. You see, what you should have understood from history, from the case of Beverley Allitt, from Shipman, from all of the other cases of healthcare homicide, that often the signs at the start are subtle and need investigation and that safeguarding is crucial; do you accept that?

A. We did or I did -- was aware of the -- less aware of the Shipman stuff but certainly, more recently with the Beverley Allitt, and I think the difference between the two, and it's not even a subtle difference, but one of the differences between the two is in the Beverley Allitt there was actual evidence of deliberate harm.

What we had was --

Q. There was evidence here.

A. What we had, sir, was gut feelings and nothing was presented in a very explicit way that would make you feel that this was the only explanation for the matters that we were facing.

Q. It doesn't need to be the only explanation. It just needs to be a possibility that requires investigation; do you agree?

A. And that's what we did.

Q. We will come on to that in a moment. But the good faith element is crucial for this reason, and let

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was delivered in absolute good faith, but I also said that, from my own experience and the experience across the NHS more widely, is that the causes of unexplained increases in mortality from experience have always been multi-factorial.

So I clearly was reflecting on what I was hearing from the doctors, but I was also considering what I knew to be facts from previous experience across the NHS.

So it was never binary. It wasn't -- it was never -- it was -- it was, I suppose, a binary position.

Q. You accepted, on multiple occasions put to you by Mr Skelton, put to you by Mr De La Poer, that the paediatricians were the experts in the room when it came to these issues, these issues of neonatology and paediatric care?

A. They were our experts, they were our doctors and they were the ones that were closest to these issues. But, equally, what they were presenting was I think it may have been clear in their mind that they were making themselves understood but, in truth, it was never quite as explicit as that. It was quite implicit.

So it was felt that we needed to try and establish the causes because we understood from history that it was always not a simple single thing; it was always multi-factorial.

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me take you to a document, INQ0003014.

Now, this is the Speak Out Safely policy. If you look at, first of all, page 10, there's a reference here to malicious allegations:

"Where a deliberate, false or malicious allegation is made the person concerned may be liable to action against them under the Trust's disciplinary procedure. The decision on whether to invoke that procedure will be taken by the Chief Executive after due consideration of the designated officer's investigation and report."

So, first of all, it is correct, isn't it, that the Speak Out Safely policy identifies that action should only be taken in respect of malicious allegations, ie those that are not made in good faith?

A. That's what it says here, yes.

Q. An allegation or concern that is raised in good faith should be regarded as a protected disclosure and protection should be given to the whistleblower in those circumstances.

Do you agree?

A. I think it -- at the time in, at the very start of these discussions or concerns being raised, it was being raised very much around trying to establish and understand the causes of an unexplained increase --

Q. That isn't the question I asked you.

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1 A. -- in mortality.
 2 Q. Forgive me for interrupting you, that isn't
 3 the question I asked. The question I asked is: does the
 4 Speak Out Safely policy regard complaints or concerns
 5 raised in good faith as protected disclosures and that
 6 the individual raising those disclosures should not be
 7 the subject of recriminations as a consequence?
 8 A. That's what the policy says.
 9 Q. Now, if we go back, please, to page 2 of the
 10 policy, and to the penultimate paragraph:
 11 "All concerns raised by staff about patient care
 12 will be dealt with seriously, promptly and be subject to
 13 a thorough and impartial investigation where necessary.
 14 Managers have a particular responsibility to protect
 15 patients and to handle concerns about their care in
 16 a way that will encourage the voicing of genuine
 17 misgivings, while at the same time protecting staff
 18 against unfounded allegations. No recriminations will
 19 follow reports which are made in good faith about
 20 standards of care or possible abuses. All staff must
 21 comply with the Trust values and put the patients at the
 22 heart of everything they do."
 23 Does that incorporate you as well, "all staff"?
 24 A. All staff, yes.
 25 Q. The policy requires or encourages members of

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1 a note you know from 12 May 2017, timed at 11.45 am.
 2 I would like you to remember the time, it's important?
 3 LADY JUSTICE THIRLWALL: 2014.
 4 MR BAKER: 20 --
 5 LADY JUSTICE THIRLWALL: What is the date on it?
 6 2017?
 7 MR BAKER: 2017, my Lady, yes. Timed at 11.45 am
 8 and it's an important note. It's a note of
 9 a conversation you had in the hospital I am assuming
 10 with Sue Hodkinson.
 11 A. It would have been, yes.
 12 Q. "RJ SB, Dr Jayaram and Dr Brearey plan re
 13 management, (1) GMC, (2) actions from grievance, (3)
 14 mitigation from SOS whistleblowing, (4) action plan to
 15 manage out."
 16 Now, this is clearly a note, isn't it, of you
 17 setting out a plan to Sue Hodkinson that the Consultants
 18 would be referred to the GMC, and then managed out and
 19 that the reference to mitigation from Speak Out Safely
 20 or whistleblowing is written in because you knew that
 21 this would be contrary to the Speak Out Safely or
 22 whistleblowing policy; that is correct, isn't it?
 23 A. I -- these are not my notes, these are from
 24 Susan Hodkinson's notebook. I would have never seen
 25 these notes and I don't remember any discussion around

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1 staff to raise concerns:
 2 "If staff are uncertain about whether or not to
 3 express a concern, it is normally better for them to
 4 voice this rather than to remain silent. Often
 5 discussing an issue normally with their immediate
 6 manager will provide an opportunity to view the matter
 7 from a different perspective. From there it can go
 8 forward and be dealt with if necessary. Delay in
 9 expressing concern could lead to recurrence and/or make
 10 investigations more difficult."
 11 The Speak Out Safely policy is pivotal to patient
 12 safety, isn't it?
 13 A. Agreed, yes.
 14 Q. Because members of staff are the eyes and ears
 15 of the organisation and they are the ones who are often
 16 best placed to bring to the attention of management
 17 serious safety issues?
 18 A. That's absolutely right yes.
 19 Q. In acting in good faith, as you agree they
 20 were, these Consultants were doing exactly what they
 21 were supposed to do, weren't they?
 22 A. Absolutely and we, we acknowledged that at the
 23 time and all the way through these inquiries.
 24 Q. Did you? Can we go, please, to a note, you
 25 have seen it already, it's INQ0015642 and page 48. It's

6

1 mitigating Speak Out Safely or whistleblowing policies
 2 and I, to be honest, wouldn't have had the specific
 3 detail on that.
 4 Q. Can we be clear about what you are saying.
 5 Are you saying that Sue Hodkinson wrote this in her
 6 notebook because you didn't say it?
 7 A. I -- the context to this meeting is really
 8 important. We discussed it yesterday. It was --
 9 Q. No, no, we will come to context in a moment?
 10 A. But I think it is critical --
 11 Q. No, no, I promise you --
 12 A. -- to understand the nature of the note.
 13 Q. -- we will come to context in a moment. Can
 14 you answer my question, please?
 15 Are you saying that this was written in the
 16 notebook and you didn't say it?
 17 A. I don't remember saying it and the
 18 conversation with Ms Hodkinson was following a meeting
 19 that I had had with the police earlier that day at
 20 9.00 am. This was a fortuitous one to one, it wasn't
 21 a planned meeting and, at that meeting with the police,
 22 I left that meeting unsure as to whether the escalation
 23 that we had taken to raise these matters to the police
 24 was going to result in a police investigation.
 25 Q. Can I --

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1 A. My feeling was that we then -- if the police
2 did not continue into a police investigation, which they
3 did -- they ultimately did, then there may well be
4 a patient safety risk, where there's been a breakdown in
5 relationships between doctors and nurses, and I was just
6 flagging with Sue what are the options if we find
7 ourselves faced with that risk. It was not a plan.

8 Q. Can I remind you what said in your witness
9 statement, please, at paragraph 629 about your beliefs
10 regarding the progress of the police investigation.

11 At paragraph 629 of your witness statement -- and
12 here you are dealing with the 12 May 2017, this note --

13 A. Sorry, what page is this?

14 Q. I don't know the page, I'm afraid. I have
15 just got the -- it is --

16 LADY JUSTICE THIRLWALL: It's internal page 173.

17 MR BAKER: I am grateful, my Lady.

18 LADY JUSTICE THIRLWALL: It is page 173 of your
19 statement.

20 A. Thank you, thank you, my Lady.

21 MR BAKER: So at paragraph 629 you say:

22 "On 12 May 2017 at 11.45 am [and you refer the page
23 number and reference], I had a meeting with Sue
24 Hodkinson about Dr Jayaram and Dr Brearey and the
25 potential options for managing the two Consultants

9

1 statement that your memory of events was that, as of
2 12 May, you didn't believe the police were going to
3 proceed with a criminal investigation?

4 A. It wasn't clear on leaving that meeting, on
5 12 May, that there was going to be a police
6 investigation.

7 Q. You say here it was unlikely, don't you, that
8 there would be?

9 A. Well, I -- I -- it wasn't clear in my mind
10 whether it was likely or unlikely. It, it was not
11 something that -- that formal decision hadn't been made.

12 I had requested that the police have another
13 conversation with the -- with the clinicians and,
14 following that conversation, then they could -- as the
15 experts around whether there would be a requirement,
16 whether this met the requirement for a criminal inquiry,
17 they could then arrive at their view.

18 Q. What you had told the police at that meeting
19 was that there was no evidence to warrant a police led
20 investigation?

21 A. And what I further went on to ask is, "But we
22 need your help, you're the experts in this".

23 Q. Let's look at the note of the meeting then,
24 it's INQ0003076, and page 6, please. So we can see
25 here, towards the bottom of the page, the paragraph that

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1 should Cheshire Constabulary decide not to commence
2 a formal investigation."

3 It's rather surprising, isn't it, that in this
4 statement you don't say that "I have no recollection at
5 all of this meeting occurring"?

6 A. It's, it is absolutely the case that I have no
7 recollection of this conversation. This matter was only
8 really brought to my attention when we looked at the
9 disclosures that had been shared as part of my R9
10 request to the Inquiry.

11 It -- it took a lot of reflection on my part to
12 actually remember the conversation.

13 Q. Well, you just told us you couldn't remember
14 the conversation.

15 A. I don't remember having it. I only had my
16 memory jogged when I had been drawn to the attention of
17 the notes in -- in, in Ms Hodkinson's notebook.

18 Q. What you say at paragraph 629 is:

19 "At the time, the police did not seem to feel that
20 a criminal investigation was likely and therefore
21 I needed to have it clear in my mind what would happen
22 if this stance was not accepted by the Consultants and
23 there was resistance to try to move forward and focus on
24 the safety of the NNU."

25 So it is clear when you wrote your witness

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1 begins "TC stated", and TC is you in the context of
2 this, this note. Can you see that?

3 A. Yes.

4 Q. "TC stated it would become a wider GMC issue
5 as there becomes a point where a group of clinicians who
6 are not prepared it take the recommendations of RCPCH
7 are blocking the ability to move forward, which creates
8 a more difficult and dangerous environment for sick
9 babies. TC added that the Consultants have made their
10 points and they have been seen and not judged as
11 sufficient to warrant a police-led investigation."

12 First of all, that's entirely misleading, isn't it,
13 about the status of the evidence at this stage?

14 A. What -- remember, these are the notes of a --
15 of a meeting that, from memory, I think by this time,
16 was at least the second, if not the third time that we
17 had met with the police to discuss these matters. At
18 those previous meetings, we had shared very openly and
19 a detailed description of the concerns, as they had been
20 described to us by the Consultants and also the outcome
21 of the evidence from the various inquiries that we had
22 done, and also we shared with them the opinion that we
23 had sought from Mr Simon Medland around -- in
24 preparation for any police investigation so, at that
25 time --

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1 Q. These --
 2 A. -- everything was pointing away from
 3 criminality.
 4 Q. These are your words; do you accept that?
 5 A. I -- that paragraph will represent the
 6 discussion that went on. I don't remember specifically
 7 the words that were used.
 8 Q. Because you have suggested that people have
 9 a perhaps annoying habit of writing down things that you
 10 don't say, I want to be clear: you accept that these
 11 accurately record the words that you would have used in
 12 this meeting?
 13 A. In that paragraph, this is page 6 of I'm not
 14 sure of how many notes.
 15 Q. It begins "TC added", if we just take that
 16 paragraph in isolation.
 17 A. I am happy to take that paragraph in isolation
 18 but the context to the paragraph is the third, fourth
 19 paragraph in the notes that -- that we have in front of
 20 us where it says:
 21 "TC is 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 is never felt
 25 the issue."

13

1 these did not meet necessarily meet the threshold of
 2 a criminal investigation.
 3 Q. You --
 4 A. I think that's what the paragraph is saying.
 5 Q. You are making clear at 9.00 in the morning,
 6 the same day the note is written by Sue Hodgkinson at
 7 11.45, you are making clear that if the Consultants do
 8 not accept your decision to move on, you are going to
 9 refer them to the GMC and potentially ruin their
 10 careers?
 11 A. No, that is not what that note represents.
 12 That note represents a discussion that if the police
 13 inquiry does not go ahead then we may have a problem, as
 14 it was described, I think, further in -- in the note
 15 above.
 16 Q. Why is that a matter for the GMC? Why is it
 17 a matter of professional misconduct?
 18 A. And, and I -- I -- we had had this
 19 conversation with the police it was unclear whether
 20 there was going to be a police investigation. I had had
 21 a fortuitous one to one scheduled with, with
 22 Ms Hodgkinson and I reflected with her that, if we can't
 23 help our Consultants to move forward, then we would have
 24 a problem and we -- and I -- we were almost just
 25 exploring how we might how, how that might need to be

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1 Q. You could --
 2 A. "It was felt amongst the Executives that we
 3 just needed it to be checked."
 4 And that was the --
 5 Q. You could hardly stand before Cheshire
 6 Constabulary and suggest that you had greater
 7 jurisdiction to investigate a potential crime?
 8 A. And that is absolutely why we sought the
 9 higher authority and we sought their input.
 10 Q. But what you were saying in the penultimate
 11 paragraph is very clear, isn't it, you are making the
 12 point that you do not believe that there is any evidence
 13 to warrant a police-led investigation and you are
 14 misleading by the Cheshire Constabulary by suggesting to
 15 them that this matter has been fully investigated and
 16 there is no evidence to warrant a police investigation?
 17 A. I think I am representing what, what our
 18 thoughts were at the time --
 19 Q. You are?
 20 A. -- which is that, that the evidence or the
 21 outcome of the enquiries to date were pointing away from
 22 deliberate harm. We had had we had had guidance from
 23 Simon Medland that suggested that the -- from his
 24 discussions with the -- with the paediatricians, as
 25 an independent ear, listening to their concerns, that

14

1 resolved. It was never a plan.
 2 Q. You see, I suggest to you this shows a very
 3 clear insight into your character: that you were putting
 4 pressure on whistleblowers, contrary to the hospital's
 5 own patient safety policy, and you were planning to have
 6 them disciplined and moved on if they didn't accept it?
 7 A. No, I think it's -- that is not the
 8 interpretation of this or my character.
 9 My character is such that we always had a focus on
 10 patient safety and the well-being of our -- of our
 11 staff.
 12 Q. Can I ask --
 13 A. We had -- we had taken independent expert
 14 guidance from the Royal College. They had identified
 15 a series of recommendations --
 16 **LADY JUSTICE THIRLWALL:** I don't want to cut across
 17 you, Mr Chambers, but you have given that evidence
 18 already this morning, and indeed yesterday, and we are
 19 quite -- as you know we are over running --
 20 A. Apologies.
 21 **LADY JUSTICE THIRLWALL:** -- and I want you to be
 22 able to give such further information as you want us to
 23 have but it's probably best not to repeat what you said
 24 already.
 25 A. Apologies.

16

1 **MR BAKER:** Thank you, my Lady.
 2 Can I ask you then, again, something that will
 3 inevitably concern The Families: that you gave evidence
 4 that in March 2017 you were sat on the train to Leeds
 5 discussing the issues surrounding the Consultants with
 6 Tracy Bullock, another Chief Executive; do you recall
 7 giving that evidence?

8 **A.** I do, yes.

9 **Q.** Now, at that time, in March 2017,
 10 The Families -- because the Trust in its opening
 11 conceded that there was a total failure to fulfil its
 12 duty of candour, The Families had no knowledge at all
 13 about these issues.

14 Is it right that the only prospect that they would
 15 have of finding out about those issues was
 16 coincidentally sitting behind you on a train to Leeds?

17 **A.** I think that's really unfair. The
 18 conversation that I was having with, with a peer, I was
 19 desperately trying to establish in my own mind whether
 20 I was missing something, I was seeking guidance. I had
 21 explained to Ms Bullock that -- all the work that we
 22 have -- that we'd done and I also explained that we had
 23 had a meeting with the paediatricians earlier, and that
 24 we were --

25 **Q.** You gave evidence about the context and

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1 weren't clear to people who were already grieving. So
 2 it was, it was a regret that I got the balance wrong but
 3 it was not around trying to keep anything hidden.

4 **Q.** First of all, choosing what families would or
 5 would not want to hear is patronising and paternalistic,
 6 isn't it?

7 **A.** Yes, I can see that.

8 **Q.** The Countess of Chester Hospital, in their
 9 opening to the Inquiry, conceded that there was a total
 10 failure by the Trust to fulfil the duty of candour. Do
 11 you take responsibility for that failing?

12 **A.** I think it is something that, in my
 13 reflections yesterday, I absolutely acknowledged that we
 14 hadn't got that right: we could have done better, we
 15 should have done better.

16 **Q.** The --

17 **A.** I should have done better.

18 **Q.** Contacting the police. The inevitable
 19 consequence of that would be that this would all have
 20 become very public, wouldn't it, and we see in evidence
 21 from Dr Brearey and from Mr Medland this dichotomy that
 22 you appear to have been behind: that it's a choice
 23 between calling the police and leading to everything
 24 becoming public, the toothpaste coming out of the tube,
 25 or protecting patient safety?

19

1 content of the conversation.

2 **A.** What I'm --

3 **Q.** What I am asking you about is: why did you
 4 think this was an appropriate conversation to have on
 5 a public train?

6 **A.** It was a conversation with a colleague. We
 7 were not discussing patient details; I was just
 8 discussing my own thoughts and feelings.

9 **Q.** You see the lack of candour in this case is
 10 staggering for one reason: that it keeps the Families in
 11 the dark. But I would suggest to you also it goes hand
 12 in hand with your general approach to this: that you
 13 took every step possible to keep the Consultants'
 14 concerns from becoming public?

15 **A.** I -- I think as I explained yesterday, the
 16 duty of candour is -- it's a difficult balance between
 17 being -- between a duty of candour and a duty of care.

18 This was a balance that we were or I was trying to
 19 get the balance right and, clearly, that was not
 20 something that I -- I got right. I am absolutely clear
 21 in my own mind that we could have and should have done
 22 better in terms of the communications with the Families.

23 **Q.** Well --

24 **A.** It was also clear in my mind that I did not
 25 want to further add distress to families when matters

18

1 **A.** Again, that isn't correct. The -- we took
 2 action. We -- one of the -- Letby was identified as
 3 being on duty more times than another member of staff.
 4 She was redeployed whilst we sought to try and establish
 5 what the causes might be. And the detail of those
 6 outcomes from those investigations have been discussed
 7 thoroughly in this Inquiry already.

8 **Q.** Conscious of the time, my Lady.

9 I am going to deal with one issue and then put
 10 a final point to you. But you said in your evidence
 11 before the Inquiry yesterday, and indeed you repeated
 12 today, that the purpose of instructing Simon Medland QC
 13 was to facilitate a referral to the police?

14 **A.** That was absolutely my understanding.

15 **Q.** Well, first of all, can I take you to
 16 INQ0003076, please, which again is the note of a meeting
 17 of Operation Hummingbird, and to page 4.

18 Again, this is a meeting 9.00 am on 12 May. You
 19 immediately, following this meeting, went back to the
 20 hospital and had a conversation with Sue Hodgkinson about
 21 steps to be taken in respect to the Consultants. But,
 22 at the bottom of the page:

23 "TC added through all of this ..."

24 Can you see, it is a section which is describing
 25 what you were saying? The list begins at the bottom of

20

1 page 4 but continues on to page 5, and the fourth item
2 "QC", reference to Mr Medland:
3 "... purpose to involve was to help clinicians
4 understand the difference between what they thought was
5 criminal evidence and something that may not constitute
6 as criminal evidence."

7 Now, that's what you were telling the police on
8 12 May the purpose of Simon Medland was?

9 **A.** Yes, no, in my misunderstanding, the purpose
10 of Simon Medland was to assist the Trust in preparing
11 an approach to the police, understanding what
12 information they would require and to prepare the
13 bundles for them.

14 The note there, I think, represents my
15 understanding of the outcome of the meeting that he had
16 with the -- with the paediatricians, and this was his
17 description of what he felt the task had been. I did
18 not instruct Simon Medland. That was an instruction
19 that came from -- from, I think, both Duncan Nichol and
20 also Stephen Cross.

21 **Q.** Well, let me help refresh your memory.
22 I mean, you have given clear evidence just now about
23 what you instructed Simon Medland to do and how we
24 should interpret your words on 12 May. Can we go to
25 INQ0015670, please.

21

1 the same as to what the purpose --

2 **A.** Absolutely. I think when we were at the
3 police I was very cognisant of the notes from Simon
4 Medland and was just reiterating those.

5 **Q.** You sought at every stage to stall and
6 obstruct the police being called or this being made
7 public and, ultimately, sought to ruin the careers of
8 the Consultants who brought this to your attention?

9 Now, that is utterly reprehensible behaviour and
10 unfitting of a CEO in the NHS, isn't it?

11 **A.** Had that been what I had done, then it would
12 be. But I think it's an outrageous statement and
13 I fully -- and I do not believe that represents my
14 actions.

15 **MR BAKER:** Thank you, my Lady I have no more
16 questions.

17 **LADY JUSTICE THIRLWALL:** Thank you, Mr Baker.
18 Ms Blackwell?

19 Questions by MS BLACKWELL

20 **MS BLACKWELL:** Mr Chambers, I have some questions
21 finally, based around your state of knowledge, questions
22 that you were asked yesterday and also this morning
23 about what you were told at various points in time and
24 about your behaviour and that of others.

25 So we need to look with fresh eyes at some

23

1 This is Simon Medland's notes. Paragraph 2:

2 "Simon Medland began by stating who he was and why
3 he was here. Been instructed by the hospital to bring
4 an independent objective view to present situation and
5 see if formal report to police was presently merited, in
6 other words whether there is presently information
7 giving rise to reasonable grounds for suspecting that
8 a criminal offence has been committed in respect of any
9 one of the neonatal deaths in question."

10 What you said just now to the Inquiry was utterly
11 misleading, wasn't it?

12 **A.** Not at all. All I am explaining to you is my
13 understanding of what I thought Mr Medland was -- was
14 there to do.

15 The discussions around the specifics of the
16 instructions, and I have no doubt at all that Mr Medland
17 was, was seeking to do what he described here, but that
18 was not what I believed what we had -- what we'd asked
19 him to do. I wonder whether the instructions just
20 developed through conversations between Stephen Cross,
21 who was the person who had the direct relationship --
22 instruction relationship with Mr Medland.

23 **Q.** You see, I suggest to you that these words
24 here, set out by Mr Medland, describing his instructions
25 and your words used to the police on 12 May are exactly

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1 documents which have already been electronically
2 presented, and I will take those matters, my Lady as
3 efficiently as I can.

4 **LADY JUSTICE THIRLWALL:** Of course, thank you.

5 **MS BLACKWELL:** First of all, please may we put up
6 the notes of the meeting of 29 June 2016, which are at
7 INQ0003371.

8 Thank you. Now, if we look at the top right-hand
9 portion of the page, we can see the initials and names
10 of those present: you, Alison Kelly, Ian Harvey, Dave
11 Semple, who was the Divisional Medical Director; is that
12 right?

13 **A.** For Planned Care, yes.

14 **Q.** Yes, Dr Brearey, Dr Jayaram, Dr Saladi,
15 Lorraine Burnett and Stephen Cross.

16 Now, you have been taken to these notes before.
17 The first question I want to establish with you,
18 Mr Chambers, is what was the atmosphere like during the
19 course of this meeting?

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

21 **Q.** Yes, what was the atmosphere like during the
22 course of this meeting?

23 **A.** Oh, right. Well, this was the first time that
24 these matters had been formally discussed with me.

25 **Q.** Yes.

24

1 A. So my personal feelings were that I was
2 shocked. I wanted to listen and understand. I wanted
3 to be able to reflect, so that we could establish
4 a plan.

5 Q. Yes.

6 A. The atmosphere in the meeting was very open,
7 was very friendly, and people were very candid. Despite
8 it being a very difficult meeting, it felt that this was
9 a team of people coming together, trying to resolve some
10 very difficult issues.

11 Q. Let's look at the top of page 2, please. We
12 can see that Dr Brearey says:

13 "More than just an association with this nurse."

14 Dr Jayaram says:

15 "How? Cannula, air embolism, crystal ball,
16 unquestionably got something going on at the Countess
17 but what?"

18 Does that reflect what you remember as being the
19 type of suggestions that were being made during the
20 course of the meeting?

21 A. Yes, it reflects it very well.

22 Q. Right. A little further down -- you have
23 already been taken to this -- you say:

24 "Why did we [and that should be 'not call the
25 police']?"

25

1 setting itself up to care for Level 2 types of babies
2 can satisfy itself that two Consultant ward rounds
3 a week would meet the requirements of a Level 2
4 facility.

5 Q. Then finally, in this comment:

6 "Can we explore more before we go to the police?"

7 A. Yes.

8 Q. Those were your thoughts at this meeting?

9 A. Yes.

10 Q. Could we go to page 3, please, finally, and
11 just look at your comment in conclusion.

12 Does that read "[Thank you] to clinicians", at the
13 very bottom:

14 "TY to clinicians."

15 A. Yes, yes.

16 Q. What were you thanking them for?

17 A. I am thanking them for their -- bringing these
18 matters to my attention, I am thanking them for what
19 they do every day to keep our patients safe and well
20 cared for, I am thanking them for being so open and
21 candid and I am thanking them in advance of any actions
22 that we would need from them to help us resolve these
23 matters. I was, if you like, sort of thanking them in
24 advance of that.

25 Q. Thank you. We can take that down, please, and

27

1 You go on to say:

2 "If Twins and Triplets, why did the Trust take them
3 on?"

4 What did you mean by that comment?

5 A. We were -- well, I was just surprised that we
6 had this level of complexity and acuity being cared for
7 on our neonatal unit. Normally, this kind of history,
8 the plan would normally have been that they would be in
9 a higher acuity, probably a Level 3 unit.

10 Normally, I would have expected these kind of cases
11 to have been cared for at Arrowe Park.

12 Q. Right. So were you questioning whether or not
13 the Countess was the right place for those types of
14 babies?

15 A. I was aware that the Countess, from my own
16 eyesight when I had been walking around -- that this was
17 a unit under -- under pressure, that staff had explained
18 to me that they felt that at times the unit felt
19 chaotic. I was concerned when I heard this was part of
20 those issues being generated, by looking at caring for
21 babies that perhaps we shouldn't have been caring for.

22 Q. Did you know at that time that there were no
23 more than two Consultant ward rounds a week?

24 A. It wasn't clear to me at that time, and had
25 it've been then it's difficult to see how a unit that is

26

1 may we replace it with the notes for the meeting of the
2 following day, INQ0003362. These are the notes of the
3 meeting of 30 June, prepared by Stephen Cross. We have
4 already looked -- not you and I, Mr Chambers -- but the
5 Inquiry has already looked at notes of the same meeting
6 prepared by Sue Hodkinson?

7 A. Yes.

8 Q. But these aren't Mr Cross' notes and I want to
9 take you to page 2, please, and to the comment in the
10 middle of the page attributed to Jim McCormack, where we
11 can see:

12 "Suspicious in last 18 months, members of staff --
13 astounding".

14 Now, we know from Sue Hodkinson's notes that she
15 has also made a record of him referring to Beverley
16 Allitt and Shipman at this point in the meeting.
17 Mr Cross hasn't made a note of that.

18 Is that something that you remember Mr McCormack
19 saying during the course of that meeting?

20 A. A reference to Beverley Allitt?

21 Q. Yes.

22 A. I -- I have no memory of that.

23 Q. Right. It's been suggested to you that that
24 should have resonated in your ears and that that should
25 have been something which you repeated to others.

28

1 You've said this morning that you were aware of
2 both cases. How much in the forefront of your mind were
3 each of those cases, during the course of this meeting
4 and going forwards?

5 **A.** It's fair to say it wasn't right at the front
6 of my mind. I was, what was right at the focus and the
7 front of my mind was trying to ensure that our unit was
8 safe, that we were keeping an open mind about any
9 potential causes and I don't remember any specific
10 reflections that I may have had at this time, in respect
11 of Beverley Allitt.

12 **Q.** Well, if we look further down the page, we can
13 see that, towards the bottom, you are making these
14 comments:

15 "Recognise not easy. Set of protocols needed
16 backbone. Numbers. Network. Inevitable consequences
17 of where we are."

18 Then, over the page, please, your comments five
19 lines down:

20 "By lunchtime tomorrow, protocol or plan."

21 So what were you attempting to do?

22 **A.** Yes. So it's worth remembering this was the
23 second meeting that I had had in respect of these
24 matters, and we were already trying to establish a plan
25 and protocol for the redesignation of our neonatal

29

1 Dr Jayaram:

2 "Concern potentially member of staff causing harm.
3 Recurring theme. These babies should never have died."

4 Then you say:

5 "If the nurse is removed would deaths stop."

6 Dr Brearey says:

7 "The risk would be reduced", not removed but
8 reduced.

9 Do you remember that conversation?

10 **A.** I -- I do. And I think it reflects the
11 evidence that I've given all the way through this
12 Inquiry, is that there wasn't an absolute clarity of
13 what the causes of the unexplained increases in harm
14 were. There was definitely concerns being raised around
15 the conduct of one individual but there was also serious
16 concerns being raised around the demand, the acuity and
17 the care on the unit.

18 That led, inevitably, to the actions that followed,
19 which was the removal of Letby and then the commencement
20 of various enquiries.

21 **Q.** Thank you. Page 5, please. Towards the
22 bottom, Dr Brearey again:

23 "I made my views clear. Nagging after last night.
24 We will take on observations. Felt observations made
25 before meeting. Datix. Problems with governance

31

1 unit --

2 **Q.** Thank you.

3 **A.** -- and the purpose for that was safety.

4 **Q.** If we look towards the bottom of the page, we
5 can see David Semple say:

6 "Assurance re what's happening after two weeks."

7 That is a reference to Letby going off on leave for
8 two weeks?

9 **A.** Yes.

10 **Q.** You:

11 "Open mind. Police exclusion. Stephen Cross
12 challenge re practice of clinicians."

13 Then:

14 "Assurance in two weeks."

15 Then Dr Brearey, at the bottom of the page:

16 "Care is not perfect. Common theme of this nurse.
17 Doesn't take away concern [for] this individual."

18 **LADY JUSTICE THIRLWALL:** "Re this individual".

19 **MS BLACKWELL:** I am so sorry, my Lady.

20 **LADY JUSTICE THIRLWALL:** "Concern re this
21 individual."

22 **MS BLACKWELL:** "... concern re this individual.

23 Not change my opinion. Spoke in May to AK and IH about
24 his concerns."

25 Over the page, in the middle of the page,

30

1 facilitator."

2 Then over the page, we can see there is a reference
3 by Dr Jayaram to:

4 "Equipment example. Incubator to EBMA."

5 Then Duncan Nichol:

6 "Review has to take its course. May be
7 inconclusive. May say the unthinkable. States agreed
8 as discussed safety paramount. Will need help across
9 the network. Must stick together."

10 Then your final comments:

11 "TY TC."

12 Is that you expressing thank yous?

13 **A.** Thank you, yes.

14 **Q.** "Regroup tomorrow, plan and comms. View when
15 can this happen. Tough call. Personal, look after each
16 other, one team."

17 What was that sentiment you were expressing?

18 **A.** That was just, just recognising that these
19 were very difficult matters that we, we were trying to
20 understand. It's easy, it, it -- I think personal was
21 more around just look after yourselves, work as one
22 team, and keeping an open mind.

23 **Q.** Thank you, we can take that down, please.

24 I would like to take you now to the notes of the meeting
25 you had with Letby and her parents on 22 December 2016

32

1 at INQ0002913.

2 You were explaining in your evidence yesterday that
3 the grievance brought by Letby was split into two parts,
4 that she complained by the way in which the Trust had
5 treated her and that that was with a lack of
6 transparency, which you accepted had some force in it?

7 **A.** (Nods)

8 **Q.** She had also complained about what had been
9 a series of comments made about her by the Consultants.
10 It was being suggested to you yesterday by Mr De La Poer
11 that you may have been manipulated by Letby, who was
12 demanding apologies from the Consultants during the
13 course of this meeting.

14 Can we go to page 5, please, and just look in the
15 middle of the page at what has been recorded as having
16 been said by Letby and SL, who I think is Sue Letby;
17 that's her mother, isn't it?

18 **A.** It will be, yes.

19 **Q.** Yes. You are asked by John Letby:

20 "Have you read the interviews. I can't believe the
21 comments."

22 Mrs Letby says:

23 "Called Lucy an angel of death."

24 Lucy says:

25 "In public areas."

33

1 a result of the outcome of the grievance process.

2 **Q.** Thank you. That can come down, please. Now,
3 on 10 January 2017, there was a board meeting, which you
4 were taken to yesterday, by Mr De La Poer, in which you
5 said:

6 "In one of the cases, the cause of death is
7 unascertained which is not uncommon."

8 Mr De La Poer asked you where you had got
9 information to be able to speak in those terms. You
10 made reference yesterday to Dr Nim Subhedhar having
11 provided that information.

12 I would like to take you now to INQ0103152, which
13 is an email from Dr Subhedhar to Ian Harvey. If we look,
14 first of all, please, at the bottom of the page, and to
15 the email from Dr Harvey that precipitated the response
16 at the top of the page. So on 25 November 2016, Ian
17 Harvey is saying:

18 "Dear Nim, I'm sorry that we couldn't meet
19 yesterday I was hoping to ask you about one aspect of
20 our review. One feature of some of collapses was that
21 the neonatologist said that they were either unexpected
22 and/or didn't respond to resuscitation in the expected
23 fashion. The College reviewers have noted that similar
24 cases have been discussed at the network review group
25 from other units, although Stephen Brearey tells me that

35

1 Sue Letby:

2 "Mr McCormack said the Trust is harbouring
3 a murderer, you are harbouring a murderer. Dr V said
4 she is cold and calculated. Eirian Powell said 'What if
5 Letby goes home and kills herself', and Steve Brearey
6 said 'I don't care', and Ravi Jayaram said 'You
7 knowingly deliberate action by Lucy Letby', heard in
8 outpatients by a nurse, someone is deliberately killing
9 babies, in statements, and people named said it."

10 To which you said:

11 "It's not acceptable."

12 Letby said:

13 "It's personal, it's not acceptable."

14 Her mother says:

15 "They have a personal grudge."

16 Was it against that background that Letby, in that
17 meeting, was requiring there to be apologies from the
18 Consultants?

19 **A.** It was clear that it was.

20 **Q.** Right. Was this something that the Executive
21 pushed in circumstances where there was an option not to
22 ask the Consultants to apologise, or was this something
23 that came out of the recommendations from the grievance
24 procedure?

25 **A.** It, it was something that was clearly as

34

1 he has no recollection of this. Please could you tell
2 me, are there a group of babies in whom this is
3 a feature and, therefore, have there been similar cases
4 reported at other units. I am happy it discuss by phone
5 if you feel that would be easier or more useful."

6 Dr Subhedhar's response on 1 December is:

7 "Dear Ian, thank you for your email. In answer to
8 your question, unexpected collapse without a clear cause
9 is well recognised in neonatal units and we have had
10 a couple of cases at Liverpool Women's Hospital
11 recently. However, I cannot recall discussing any
12 specific cases at network meetings where a baby has died
13 suddenly and unexpectedly without a cause of death
14 having been identified. However, as a network, we have
15 only started collating reviewing deaths in a systematic
16 way trivial recently and the process is still not yet
17 completely robust."

18 Now, that email was not sent to you but did you
19 become aware of its contents?

20 **A.** I -- I don't remember being specifically drawn
21 to the content of it but I would have been made aware of
22 Nim's comments from Ian Harvey. I can't recall when but
23 I would have, through discussions, been made aware.

24 **Q.** Thank you. That can come down, please. The
25 next date in the chronology is 26 January 2017, which

36

1 was a meeting with the Consultants. We don't need to go
2 to the notes but it has been suggested to you that the
3 tone of the meeting was both intimidating and bullying
4 and that that tone was set by you.

5 Would you like to look, please, Mr Chambers, at
6 paragraph 467 of your witness statement. In this part
7 of your witness statement, you say that you have seen
8 the account of Rachel Hopwood, who was the non-executive
9 director and chair of the Audit Committee -- she's due
10 to give evidence to the Inquiry shortly -- and she gave
11 information in her witness statement, which is at
12 INQ0012969 -- again, we don't need to put it up -- about
13 her opinion of the meeting of 26 January:

14 She says this:

15 "I thought it was reasonably professional,
16 I thought the Consultants seemed under a lot of stress,
17 two Consultants seemed extremely stressed and their
18 whole body language seemed very defensive. I have had
19 much worse meetings in my professional life much, much
20 harsher."

21 Now, you reflect upon that, I think, in your
22 witness statement and also, it's right to say, that
23 Stephen Cross was asked in his witness statement about
24 the meeting and the tone of it, that's at INQ0013007 --
25 again, we don't need to put it up -- in which he says:

37

1 JM, Julie Maddocks, says:

2 "Given the information, on the balance of
3 probability, illegal activity has caused the deaths."

4 So that's her view. If we then go, please, to
5 page 4, in the middle of the page again, this is you,
6 Mr Chambers:

7 "I thought we had agreed we need to do more now but
8 if we are saying this needs to be done in a different
9 way."

10 Now, that is your reaction it seems from
11 Dr Jayaram's information provided above, that, in his
12 view, what needs to be done is to speak to members of
13 the unit individually, amongst other things.

14 Stephen Brearey's response is:

15 "Don't think we are but the joint review has not
16 offered anything else."

17 Then you say:

18 "As a board we have been guided by everybody that
19 we have a safe unit. You guys, the nursing team,
20 I can't risk babies being nursed in that environment.
21 If there is a forensic dive needed we can do that, get
22 in a higher authority, require authority, we can get on
23 with that."

24 So what were the options during the course of that
25 meeting?

39

1 "I wouldn't call it anger. I would call it, you
2 know, a strong line."

3 That phrase of a "strong line", is that something
4 you recognise from your recollection/your memory of how
5 that meeting panned out?

6 **A.** I gave evidence yesterday on my reflections of
7 this meeting and I remember the meeting being --
8 I needed to be clear and direct. I was very
9 professional. I didn't raise my voice. I wasn't angry.
10 But it was an odd meeting because the -- the
11 Consultants, as I think as been described here by -- by
12 Rachel Hopwood, they didn't seem to be able to engage
13 fully in the meeting and the reasons for that I think
14 I explained in evidence yesterday.

15 **Q.** Thank you. Could we go, please, to
16 INQ0003150, which are the notes of the meeting of
17 27 March 2017. Now, this meeting was followed by
18 a discussion that you had with Dr Jayaram and Sue
19 Hodkinson, following his disclosure about the
20 circumstances of his eye witness evidence in relation to
21 Baby K.

22 Could we go, please, to page 2 of the notes and the
23 middle of page 2, we can see you saying:

24 "I need to know if we do an individual Casenote
25 Review or phone the police."

38

1 **A.** If felt to me that we had probably explored,
2 I think, all of the options around seeking independent
3 expert advice, with the exception of the independent --
4 independent expert advice of the police.

5 **Q.** Thank you. Can we go to the following page,
6 please, page 5. The middle of the page, your comments:

7 "This is really helpful. Of the 13 deaths we have
8 8 where we do not sufficiently have a clear answer on.
9 Royal College reviews indicate that there was no single
10 causal factor and we have had the internal review.
11 I can go to the police, that's the position. If we are
12 going to the police, this is what we have done and we
13 have got to the point where we cannot answer all of the
14 questions. Also we need to exclude any other causal
15 factors. It's a significant step as implications are
16 massive from this."

17 Then, finally, please, at page 6:

18 "You say we have shared everything with various
19 stakeholders. We need to do the same with the police."

20 Dr Jayaram says:

21 "I agree with NM. The focus needs to be on the
22 babies who have died. We have discussed a lot of
23 implications to the unit, the Trust and parents and
24 colleagues but this is for the greater good, the future.
25 It's a big issue it's huge."

40

1 Then Mr Harvey references a meeting with Mother C
2 and Dr Brearey says:

3 "That's a consensus. Morally speaking, we cannot
4 live with ourselves. Keeping from them is difficult for
5 any of the clinicians."

6 You say:

7 "You absolutely believe we have a criminal
8 behaviour?"

9 To which Dr Jayaram says:

10 "We need to clarify it beyond reasonable doubt."

11 Dr Brearey talks about the balance of probabilities
12 and Dr Jayaram says:

13 "The honest answer is that we don't know. It's not
14 been sufficiently explored or reassured there is
15 a subtle distinction."

16 Your response:

17 "To get the distinction, the only thing to do is
18 a police investigation."

19 Now, despite the other concerns that were
20 addressed, was that the firm decision in your mind by
21 the end of that meeting?

22 **A.** It, it was -- it was a firm decision in my
23 mind at the end of the meeting but I think the decision
24 was crystallised in my mind during the course of the
25 meeting.

41

1 far, Mr Chambers, has been that it was as a result of
2 how you felt following this meeting as to whether or not
3 the escalation that you had made to the police was going
4 to result in a police investigation that caused you to
5 have the conversation that you had with Sue Hodgkinson,
6 in the terms in which we have seen in her handwritten
7 note later the same day?

8 **A.** Yes.

9 **Q.** So I would like to give you the opportunity,
10 please, to -- for us to look at some of the other
11 comments that were being made during the course of this
12 meeting and to seek your comments on them. Can we go to
13 page 2, please. Third paragraph down, "DM", that is
14 Darren Martland the Assistant Chief Constable?

15 **A.** Yes.

16 **Q.** "... had concerns after reading the reviews.
17 Several reviews have been conducted and there is nothing
18 in the reviews, as a non-clinical expert, as to a direct
19 allegation or suggestion of a significant negligence or
20 act that could potentially constitute as a criminal act.
21 If the police were to get involved, they would look at
22 securing and preserving evidence in relation to
23 a criminal investigation. There have been a number of
24 issues raised that have requested service reviews. If
25 the police get involved, it is a criminal investigation

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1 **Q.** Thank you. Just two more meetings now,
2 please. The first -- and we don't need to go to these
3 notes because you weren't at the meeting -- was 27 April
4 2017 which was the CDOP meeting about which the Inquiry
5 has heard. I would just like to ask you about evidence
6 that has been given to the Inquiry by Nigel Wenham.
7 I think it was during the course of him being asked
8 questions about this meeting.

9 But he told the Inquiry that, in his opinion, the
10 Executives were trying to shut down concerns and they
11 were trying to shut the doors on a police investigation.

12 What are your comments about Nigel Wenham's
13 evidence on that point?

14 **A.** Well, my immediate comment is that I think his
15 interpretation of our feelings is wrong. I am unclear
16 as to how he may have arrived at that view. Ian Harvey
17 had been at this meeting and had been very clear and
18 very candid about all of the concerns, all of the
19 investigations.

20 I can only -- I can only comment on that.

21 **Q.** Thank you. Finally then, the meeting notes
22 from 12 May 2017, which were at INQ0003076.

23 You were taken to these yesterday by Mr De La Poer.
24 You have also been taken to a couple of paragraphs from
25 these notes by Mr Baker this morning. Your evidence so

42

1 and Cheshire Constabulary would be bound to speak to the
2 families of the babies concerned. This is
3 uncomfortable, as there is no specific allegation at
4 this point to suggest a criminal act. We do not have
5 any reasonable grounds to suspect or believe that this
6 may have been the case."

7 So is that what was being said towards the
8 beginning of the meeting?

9 **A.** Yes.

10 **Q.** Thank you. If we go to page 4, please. Three
11 paragraphs down, Ian Harvey added that:

12 "The content and tone of Dr Jayaram's email, with
13 the assertion that they have not been listened to, hints
14 at a lack of Trust with the Countess Executive Team.
15 The two leads for both paediatrics and neonatologists
16 are aware met with Cheshire Constabulary and that there
17 is going to be potential for an investigation. At no
18 point has the Countess uncovered anything that would
19 indicate a significant chance that there was
20 an underlying criminal act but the clinicians still feel
21 it is unexplained."

22 Just pausing there, that is reference to the fact
23 the clinicians had already spoken to the police prior to
24 this meeting?

25 **A.** That is correct.

44

1 Q. "Darren Martland replied that Cheshire
2 Constabulary have similar concerns. If an objective
3 third party view is taken, we have clinicians who are
4 experts in their field and other reviews conducted and
5 at this stage there is no direct allegation of any
6 wrongdoing on the part of an individual or significant
7 negligence, which could potentially constitute to
8 a criminal offence. There is nothing to suggest that
9 this is the case. Darren Martland will be guided by the
10 Countess on where we go next. The Constabulary can do
11 nothing if the Countess are satisfied with everything
12 that has been done so far."

13 Then a little further down:

14 "Ian Harvey agreed with Darren Martland regarding
15 the Families, most of which have come to terms with what
16 has happened to their babies."

17 Then further down still:

18 "Darren Martland questioned if there is any scope
19 for an external review, if there is a body that would
20 sit independently and would take all of the reviews to
21 look at from a third party perspective with the
22 requisite clinical expertise. Dependent on these
23 findings, it would dictate whether it is an issue for
24 the hospital in terms of management, potential issues
25 for learning points or potential evidence of a criminal

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1 through reviews and reports they have not
2 investigated... If there is no direct allegation or
3 suggestion from the Countess of any potential criminal
4 wrongdoing then Darren Martland would be comfortable to
5 put it into writing based on meetings and documentation
6 so far in response to Tony Chambers' letter that
7 Cheshire Constabulary will not conduct a criminal
8 investigation at this stage, with the caveat 'if further
9 information comes to light'", and he asks you what your
10 intentions are.

11 "[The Countess] have not spoken to Dr Jayaram yet.
12 It would be dependent upon the outcome of this meeting.
13 It cannot be left as they have made the same allegation
14 again but with more focus than previous. A conversation
15 would be required around the discussions the Countess
16 and Cheshire Constabulary have had in light of their
17 email. There is a need to discuss what the Countess can
18 do to reach an end point which they are comfortable
19 with."

20 Then you have been taken to the next paragraph.

21 Following that:

22 "Tony Chambers added that the Consultants have made
23 their points and they have been seen and not judged as
24 sufficient to warrant a police-led investigation,
25 looking at how close it constitutes as a criminal act.

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1 wrongdoing."

2 So was the Assistant Chief Constable at that point
3 suggesting that there may still be other organisations
4 that might have a further look at matters at the
5 Countess prior to the police investigating?

6 A. That that is my understanding.

7 Q. The bottom of the next page, please, page 5:
8 "Ian Harvey noted that the clinicians had their own
9 separate session with the RCPCH Reviewers and in that
10 they raised concerns about the individual. This was not
11 in the RCPCH Terms of Reference as they considered this
12 was an HR issue but the RCPCH did produce separate
13 observations outside of the report in which they called
14 out the paediatricians' concern. RCPCH stated that
15 their allegations were based on nothing more than
16 coincidence and ['gut feeling', I think that should be].
17 There was nothing definitive."

18 A. Correct.

19 Q. The top of the next page, please. Now, you
20 have been taken to the second paragraph down, where you
21 state that it was certainly not criminal, and I would
22 like to ask you, please, to go a little further down the
23 page:

24 "DM [Darren Martland] was clear to Tony Chambers
25 that all Cheshire Constabulary have done to date is look

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1 There was a need to explore to ensure the Countess had
2 not missed anything but there is also a need to move
3 on."

4 Darren Martland at the bottom replied that:

5 "If the Countess' position is that they are
6 satisfied of where they are and there was nothing,
7 anything that would cause to believe potentially
8 criminal offences had been committed, which would
9 warrant a police investigation, then that needs to be
10 placed in writing."

11 The following page, please. Four paragraphs down:

12 "Tony Chambers stated the Countess will have
13 a conversation with the clinicians following this
14 meeting to agree these points and state that, based on
15 what has been provided as a clinical team and what is
16 known from the reviews, it doesn't appear that there are
17 grounds for a criminal investigation."

18 But then, at the bottom the page, you say this:

19 "Tony Chambers clarified whether it's possible to
20 have a conversation with the clinicians without
21 involving the Families as the clinicians would value the
22 conversation with a police officer. Darren Martland
23 wished to make clear that Cheshire Constabulary are not
24 opening up an investigation. This is about dissecting
25 an email submitted by Dr Jayaram and confirming that

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1 there is nothing else that ought to be aware of that is
2 not in the email."

3 Then the following page, please. Towards the
4 bottom:

5 "Tony Chambers agreed that, as Dr Jayaram had
6 bypassed the Countess of Chester Executive Team, it is
7 appropriate that he has the opportunity to speak and
8 when the decision is made to either proceed or not to
9 a full inquiry, it will be based on the whole picture
10 and it will be a stronger position for the Countess."

11 At this point, you say you would feel more
12 comfortable that the clinicians should be able to move
13 on.

14 Now, if we turn, finally, to the summary of the
15 meeting, which appears at page 10, Darren Martland
16 summarised the position that there had been a number of
17 reviews, et cetera. Then the paragraph below.

18 "As it stands, the reports don't indicate anything
19 that would necessitate or warrant a criminal
20 investigation. However, Cheshire Constabulary have
21 received a report from the Consultant, Dr Jayaram, and
22 it has been agreed it is appropriate he is met by
23 a police officer, which will be facilitated on 15 May.
24 Depending on the outcome of the meeting, if nothing new
25 is raised and everything he states is contained within

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1 **MR DE LA POER:** My Lady, there are two short
2 matters, if I may, just to pick up on.

3 **LADY JUSTICE THIRLWALL:** Yes, of course.

4 **Further questions by MR DE LA POER**

5 **MR DE LA POER:** Perhaps we can keep that document
6 up, as we were just being asked about it. It relates to
7 a passage your attention was drawn to and the word
8 "bypass", Mr Chambers. INQ0003076.

9 If we go to page 7, the part we have just looked at
10 was on page 8. We can see five paragraphs up from the
11 bottom, beginning "NW", that is Mr Wenham, Detective
12 Chief Superintendent Wenham, as he was:

13 "... added an observation that Dr Jayaram had sent
14 the email directly to the police and bypassed the
15 Countess of Chester Executive Team. Cheshire
16 Constabulary are duty bound to respond to Dr Jayaram on
17 behalf of the clinical team. It might be appropriate to
18 have a conversation with Dr Jayaram around the content
19 of the letter and gain a feeling of anything else that
20 he may wish to disclose, which would add some value to
21 the content.

22 So the word "bypassed" appears earlier in the
23 meeting and appears to have been Detective Chief
24 Superintendent saying that there was an obligation on
25 the police to go back to Dr Jayaram?

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1 the document he sent, then a decision will be made at
2 the conclusion of that meeting whether an investigation
3 should take place or, whether comfortable, that nothing
4 significant has been raised outside of the letter that
5 could potentially give cause for concern that a criminal
6 offence had been committed."

7 Thank you.

8 Now, Mr Chambers, when you left that meeting, did
9 you believe, firstly, that Dr Jayaram would be spoken to
10 by the police and given an opportunity once more to air
11 his concerns?

12 **A.** Yes, I believed that was going to happen and,
13 in effect, did happen.

14 **Q.** Did you believe that, depending on what came
15 out of that meeting, there would then be a decision by
16 Cheshire Constabulary as to whether or not to
17 investigate the matter?

18 **A.** That's correct.

19 **Q.** Thank you.

20 **A.** I believed that.

21 **MS BLACKWELL:** Thank you very much.

22 My Lady, those are my questions.

23 **LADY JUSTICE THIRLWALL:** Thank you very much
24 indeed, Ms Blackwell.

25 Do you have any questions, Mr De La Poer?

50

1 **A.** I think this is a very helpful comment from
2 Mr Wenham. I remember at the meeting this comment being
3 made and it helped to give clarity to the discussions
4 that had been going on between myself and Mr Martland.

5 **Q.** So when we see on page 8 you effectively
6 reflecting the Detective Chief Superintendent's
7 language, the passage that we looked at just a moment
8 ago, that you are agreeing with him -- in other words
9 you are acknowledging that he said there is a duty to go
10 back, you are saying, "Yes, go back and talk to
11 Dr Jayaram"?

12 **A.** I think I was agreeing with that proposition
13 and I -- as I said before, I found it very helpful
14 because the -- my feeling was, was that we were being
15 asked to offer an opinion on an email that had been sent
16 directly to the police that we had only glanced at, at
17 this meeting.

18 It felt that it would not be appropriate for us to
19 offer that opinion, and so Mr Wenham's intervention was
20 incredibly helpful.

21 **Q.** Thank you very much indeed. We can take that
22 document down.

23 The second matter is just an email you were taken
24 to just a few moments ago, that Dr Subhedar sent. That
25 email was put alongside the meeting notes.

52

1 I would just like to bring that email up again. We
 2 will find that at INQ0103152. What I would like us just
 3 to focus upon is two different words, one is
 4 "unexpected", the other is "unascertained", all right?
 5 So what we can see is that Dr Subhedar is saying that:
 6 "Unexpected collapses without a clear cause is well
 7 recognised in neonatal units and we have had a couple of
 8 cases recently. However, I cannot recall discussing any
 9 specific cases at network meetings where a baby has died
 10 suddenly and unexpectedly without a cause of death
 11 having been identified."

12 So that's "unascertained", without a cause of death
 13 unidentified. So what he's saying is he has experience
 14 of babies collapsing unexpectedly but what he doesn't
 15 have experience of, although he caveats it that their
 16 data is not well collated, but he is saying "I have not
 17 had experience of a sudden and unexpected collapse where
 18 the cause of death is unascertained"; that is what he is
 19 saying, do you agree?

20 **A.** That is what the email says.

21 **Q.** That is what the email says. Of course, we
 22 know that one of the themes of the Thematic Review was
 23 that the babies had suddenly and unexpectedly collapsed,
 24 so that was part of the cohort that there was concern
 25 about; do you agree? That's what the Thematic Review

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1 unascertained, which is not uncommon."

2 So in one of the cases of this cohort that has
 3 unexpected collapses, the cause of death is
 4 unascertained, which is not uncommon.

5 Now, I would just like to your help on this,
 6 Mr Chambers. What Dr Subhedar had been saying is he had
 7 not come across a case where, in an unexpected collapse,
 8 there was unascertained cause of death; that is what he
 9 was saying. So, in other words, it is sufficiently
 10 uncommon that for a Consultant neonatologist in
 11 a Level 3 centre, he didn't have any experience of it,
 12 so he, by implication, is saying it's extremely
 13 uncommon; do you agree that is what Dr Subhedar was
 14 saying?

15 **A.** I -- well, the communications with Dr Subhedar
 16 were between Ian Harvey and Dr Subhedar. The note here
 17 is a reference to the presentation from Ian Harvey.

18 My -- it's difficult for me to mistake a specific
 19 comment on this and I -- I think the best person that
 20 can help the Inquiry would be Mr Harvey.

21 **Q.** I am sure that's right but you had been
 22 invited and had made a comment earlier upon it, so
 23 I just use this opportunity, if I may.

24 **A.** I think that's fair.

25 **Q.** Do you agree that a natural reading of what

55

1 said?

2 **A.** Can you just repeat the question?

3 **Q.** Yes, of course.

4 **A.** Yes.

5 **Q.** We know that the cohort of babies that the
 6 doctors were worried about had within them a group of
 7 babies who had suddenly and unexpectedly collapsed.

8 **A.** I think that's correct, yes.

9 **Q.** So we keep the distinction in our mind there
 10 is the unexpected collapse, there is the unascertained
 11 cause of death. So if we can go back to that meeting,
 12 please, INQ0003237, and we look at page 2.

13 So here we have Mr Harvey's presentation, and this
 14 was the passage --

15 **A.** Apologies, can you just remind me what meeting
 16 this is?

17 **Q.** If we go back up, it's the presentation to the
 18 board, on the 10th.

19 **A.** Thank you, yes.

20 **Q.** Quite right to ask me. So the email came in
 21 on 1 December to Mr Harvey, this is Mr Harvey responding
 22 but you have been taken to both of these, and I just
 23 want to lay it on the side.

24 The passage that we were all focused on is:

25 "In one of the cases the cause of death is

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1 Dr Subhedar had said in that email was that
 2 an unexpected collapse in circumstances where the cause
 3 of death was unascertained was extremely unusual because
 4 he hadn't come across it; do you agree that that's what
 5 he was saying?

6 **A.** I -- I am not clear. I don't know of the
 7 nature of the conversation that went on and feel --
 8 I feel inadequately aware of the detail to be answer to
 9 be able to answer that question.

10 The point that we -- you are referring to was
 11 a conversation that you and I had yesterday, was around
 12 the use of the word "uncommon", and where we had got
 13 that -- if you like, where we had got the assurance for
 14 that. I said that I think it had come to from Nim
 15 Subhedar, and I had assumed that it would have been
 16 Ian's interpretation of that, and I suggest you take
 17 that up with him.

18 **Q.** Today, you were taken to that email and
 19 appeared comfortable commenting upon it. I am just
 20 trying to just -- if it is right that the natural and
 21 ordinary meaning of what Dr Subhedar was saying is that
 22 he had never come across a case where there was
 23 an unexpected collapse and the cause of death was
 24 unascertained, if that's right -- and I accept from you
 25 at face value that you don't feel qualified to interpret

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1 his email in that way -- but if that is what he's
2 saying, then the assertion that is being made here that
3 in one of the cases the cause of death is unascertained,
4 which is not uncommon, that assertion would be the very
5 opposite of what Dr Subhedar had said, wouldn't it?

6 **A.** Possibly.

7 **Q.** Just as a matter of logic?

8 **A.** Possibly, yes.

9 **Q.** There wouldn't be a possibly about it; it
10 would be inconsistent?

11 **A.** I -- I can't give you a definitive answer, I'm
12 sorry.

13 **Q.** Well, thank you for answering my questions,
14 there.

15 My Lady I have nothing more for Mr Chambers.

16 **LADY JUSTICE THIRLWALL:** Thank you.

17 **Questions from LADY JUSTICE THIRLWALL**

18 **LADY JUSTICE THIRLWALL:** I have got one or two
19 questions for you, Mr Chambers. We can either take
20 a break and do them after that or we can continue.

21 **A.** I am happy to continue, if that's okay.

22 **LADY JUSTICE THIRLWALL:** I thought you would
23 perhaps prefer that. Thank you.

24 Going back to the beginning of your evidence, we
25 went through your CV and you tell us that you, I think,

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1 us for the first time this morning. You said that you
2 had been in the unit yourself --

3 **A.** Yes.

4 **LADY JUSTICE THIRLWALL:** -- which I think you told
5 us yesterday --

6 **A.** Yes.

7 **LADY JUSTICE THIRLWALL:** -- and my memory of it,
8 and it may be wrong, is that you had been there in sort
9 of December 2015?

10 **A.** It, it would have been -- it was definitely
11 December 2015. I can't be clear what time in December.

12 **LADY JUSTICE THIRLWALL:** No, I am not asking you
13 that. I just wanted to make sure that I had remembered
14 that correctly. Then what you said today, which I don't
15 think you said yesterday, I think you said it felt very
16 busy yesterday.

17 **A.** Yes.

18 **LADY JUSTICE THIRLWALL:** But today you said that
19 you felt the unit was chaotic when you visited it; is
20 that right?

21 **A.** I -- I think that, that wasn't necessarily my
22 interpretation of it but I remember that there had been
23 an email sent to me by Dr ZA that led, that led to my
24 visit.

25 **LADY JUSTICE THIRLWALL:** Yes.

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1 became a nurse in 1985.

2 **A.** A student nurse in 1985.

3 **LADY JUSTICE THIRLWALL:** A student nurse, and then
4 at some point you took a degree, was that -- but that
5 wasn't a nursing degree?

6 **A.** No, it wasn't.

7 **LADY JUSTICE THIRLWALL:** What was that in?

8 **A.** It was essentially an English degree. It was
9 a media and communications degree.

10 **LADY JUSTICE THIRLWALL:** Media and communications,
11 thank you. Then for how long did you work as a nurse?

12 **A.** So I commenced training in '85, qualified in
13 1988 and went into full time education in 1991. So
14 I would have been -- worked as a Registered Nurse for
15 about three years.

16 **LADY JUSTICE THIRLWALL:** What areas did you work
17 in, just briefly?

18 **A.** It was adult critical care.

19 **LADY JUSTICE THIRLWALL:** Adult critical care.
20 Thank you.

21 Now, a few minutes ago, it may have been more than
22 a few minutes, but anyway this morning, you were being
23 taken to notes of an interview of a meeting on 29 June,
24 and we have been through it several times and I just
25 wanted to ask you about something which I think you told

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1 **A.** I think she had used the word "chaotic".

2 **LADY JUSTICE THIRLWALL:** I see. Well, that's
3 a different matter because I was going to ask you did
4 you take that up with someone, but she raised it with
5 you?

6 **A.** Yes.

7 **LADY JUSTICE THIRLWALL:** What did you do? Firstly,
8 did you find it chaotic when you got there or did you
9 just find it busy?

10 **A.** It, it's -- it didn't strike me as being
11 chaotic.

12 **LADY JUSTICE THIRLWALL:** No.

13 **A.** But the units or any ward and department can
14 be very busy at different times of day or different days
15 of week, just -- just by the natural variation that
16 there can be.

17 So I have no doubt in my mind that Dr ZA at the
18 time was reaching out to say, "Look, this is busy, it's
19 chaotic, staff are feeling very stressed". I went to
20 visit. We walked, we talked, we listened, we probably
21 had a cup of tea. The fact that we had a cup of tea
22 suggests that it perhaps wasn't chaotic. But the
23 outcome of that meeting, that walkabout, was I think two
24 things really: (1) I pushed again on the Consultant
25 recruitment and just to see where that was up to --

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1 **LADY JUSTICE THIRLWALL:** Yes.

2 **A.** -- and also pushed Alison Kelly on getting
3 to -- getting to look at the nurse staffing ratios and
4 to see if we had the skill mixes right and can we
5 improve the nursing skill mixes. So there was different
6 definitive actions taken.

7 **LADY JUSTICE THIRLWALL:** Yes, thank you. Then
8 going back to your evidence at the beginning of your
9 evidence yesterday, you were telling us about the
10 meeting of 29 June, and I think you said this was the
11 first you had heard about the increase --

12 **A.** Yes.

13 **LADY JUSTICE THIRLWALL:** -- in mortality but
14 I think, having heard your evidence, and then again
15 something you said this morning, you say this was the
16 first time it had formally been brought to your
17 attention?

18 **A.** And the -- the fact that we had a meeting on
19 29 June at 5.00, with all of the people who were in
20 attendance, inevitably meant that I had been brought --
21 this had been brought to my attention during the course
22 of that day.

23 So it, you know, there, there had been
24 an unexplained increase and the association with
25 a member of staff more, but -- so it was the first time

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1 that. But you also said that you had very strong views
2 that had been expressed by nursing colleagues.

3 Now, I just would like to know, please, at what
4 point you had been given all that information. It was
5 obviously before this meeting, it must have been?

6 **A.** It must have been.

7 **LADY JUSTICE THIRLWALL:** Yes.

8 **A.** But it was probably that day. I'm --

9 **LADY JUSTICE THIRLWALL:** So who do you think -- you
10 may be able to remember who you spoke to?

11 **A.** It can only be from Alison Kelly is my -- is
12 my view. It certainly wouldn't have been from, if you
13 like, further down the nursing ranks. I would probably
14 just be -- Alison would have been making me aware, or
15 Ian because he had also been at the meeting where Eirian
16 Powell had offered her.

17 So it could have been from either Ian Harvey or
18 Alison, and they would have described to me, on the one
19 hand, nurse association on duty, more times than
20 another, but also well regarded, trained in specialty
21 and all the points that Eirian Powell had previously
22 made. So I think I must have been aware of that.

23 **LADY JUSTICE THIRLWALL:** Would it be fair to assume
24 that that would have affected the way you heard what the
25 Consultants were saying.

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1 that I had the opportunity to hear all of the concerns.

2 **LADY JUSTICE THIRLWALL:** Yes. No, I understand
3 that.

4 A phrase that you have used several times when
5 giving your evidence yesterday and I think also today is
6 "what I was hearing", and you say that of other people
7 because sometimes the way of describing what someone
8 says is to say "what they said was", but you are always
9 very careful to say "what I was hearing". I assume that
10 means, but does it -- I mean, you have got the degree in
11 media and communications -- is that acknowledging that
12 when you are listening to someone, you are applying
13 various filters, consciously or unconsciously --

14 **A.** I think that's correct.

15 **LADY JUSTICE THIRLWALL:** -- is that what you mean?

16 **A.** There will always be those unconscious biases,
17 there will be -- and that is true for everybody.

18 **LADY JUSTICE THIRLWALL:** No, I understand that
19 I just wanted to be clear that that is what you meant by
20 it.

21 **A.** Yes.

22 **LADY JUSTICE THIRLWALL:** You also told us, when you
23 were being asked questions, I think, by Mr De La Poer,
24 that you were getting all this detailed information from
25 the doctors, and I am not asking you to go back through

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1 **A.** Yes, I -- it would have -- again, it would
2 have been context, it would have been -- I suppose what
3 you hear is through the filters, yes. So, yes, I think
4 that's fair. And it -- and I think for me the -- the
5 actions that we took --

6 **LADY JUSTICE THIRLWALL:** Don't worry about that, at
7 the moment, I just really wanted to know how you
8 received that information.

9 **A.** So therefore I think inevitably, so, yes.

10 **LADY JUSTICE THIRLWALL:** I am not sort of cutting
11 you off but you have told us what the actions were --

12 **A.** Yes, yes.

13 **LADY JUSTICE THIRLWALL:** -- and I can see now, from
14 what you have just said as to perhaps some of the
15 thinking that would have occurred.

16 Yes. Thank you. One of the things that I have
17 raised before, we heard evidence from Karen Rees about
18 her response when she heard that Dr Jayaram had
19 expressed concerns about a nurse deliberately harming
20 babies and she went to speak to Dr Brearey, and the fact
21 that there was a very clear request from Brearey to take
22 Lucy Letby off the ward. Did you know about that?

23 **A.** No, no.

24 **LADY JUSTICE THIRLWALL:** When did you first learn
25 about that?

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1 A. That discussion?
 2 **LADY JUSTICE THIRLWALL:** Just roughly.
 3 A. Yes, I'm not sure I ever did hear about that.
 4 It may be that I only really became absolutely aware of
 5 it was through the trial, the criminal trial, where
 6 I think that discussion had been played out.
 7 **LADY JUSTICE THIRLWALL:** So Alison Kelly didn't
 8 tell you about it?
 9 A. I don't have a specific collection of it.
 10 **LADY JUSTICE THIRLWALL:** You weren't aware of it at
 11 the meeting on 29 June?
 12 A. No.
 13 **LADY JUSTICE THIRLWALL:** All right. On a separate
 14 topic, and again we have touched on it today, you have
 15 been asked questions about the way you approach people,
 16 and you know your demeanour, and I think you describe
 17 yourself as direct, and you don't say this, but plain
 18 speaking. Do you acknowledge that some people might
 19 experience your style as being somewhat intimidating?
 20 A. I -- I described my approach to one meeting as
 21 being direct. My style, more generally, is much more
 22 collaborative than that, much more open with that. I --
 23 from my own experience as a Chief Exec, it's better to
 24 not offer your opinion because that quite often closes
 25 down discussion. So when I described my -- my approach,

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1 Executives. I mean, we have heard from Ms Kelly that
 2 she was so busy in back-to-back meetings and that she
 3 didn't have time to look at all her emails, for example?
 4 A. I --
 5 **LADY JUSTICE THIRLWALL:** What was it like for you?
 6 A. Yes. No, it was -- it was similar. If we
 7 think about -- this was the pre-Covid world --
 8 **LADY JUSTICE THIRLWALL:** Yes.
 9 A. -- where everything was pretty much face to
 10 face, so quite often things were very time inefficient
 11 and there was huge amounts of time being wasted in
 12 face-to-face meetings that could now be delivered on
 13 Teams, much more effectively and efficiently.
 14 Lots of time would be used by travelling to these
 15 meetings.
 16 **LADY JUSTICE THIRLWALL:** So what sort of --
 17 A. So people were very busy.
 18 **LADY JUSTICE THIRLWALL:** So from your
 19 perspective --
 20 A. Yes.
 21 **LADY JUSTICE THIRLWALL:** -- did you feel that you
 22 were so busy you couldn't get everything done?
 23 A. I -- on -- I think one of my reflections in my
 24 witness statement is that -- and it's one of those
 25 things that is so blindingly obvious in, in -- you know,

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1 it was to that meeting.
 2 **LADY JUSTICE THIRLWALL:** So, generally, you weren't
 3 direct?
 4 A. No, I was much more collaborative than that,
 5 much more of a collective leadership style, seeking to
 6 listen, seeking to try to understand and always
 7 recognising people's contributions.
 8 **LADY JUSTICE THIRLWALL:** Yes. So I mean, this is
 9 really just so I understand: do you think there are ever
 10 circumstances when somebody in a meeting with you may
 11 find you intimidating?
 12 A. It's no doubt, and from what I what we have
 13 heard in evidence around the meeting at the end of June,
 14 on the 29th, that my very probably uncharacteristically
 15 direct style probably was more impactful because it was
 16 very different to what people would have been used to.
 17 **LADY JUSTICE THIRLWALL:** So are you agreeing me
 18 that that might have felt intimidating, or not?
 19 A. Possibly, possibly.
 20 I -- it can be intimidating inevitably because it's
 21 the Chief Executive who -- who's having that
 22 conversation.
 23 **LADY JUSTICE THIRLWALL:** Yes, yes understood.
 24 Can I just ask about how busy everybody was, not
 25 the clinicians or the wards but you and the other

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1 after the events, that you know we, we were probably
 2 trying to do a whole range of things that meant that,
 3 for the Executives, there was very much a culture of
 4 very long hours, I think there was a culture of reading
 5 emails early in the morning or late at night and the --
 6 the operational reality of a hospital continues and the
 7 Countess of Chester was a very busy district general
 8 hospital, whose emergency workload was significant.
 9 So, yes, everybody was stretched.
 10 **LADY JUSTICE THIRLWALL:** Everybody was stretched,
 11 understood.
 12 Just one last topic, if I may, and it's about the
 13 grievance process. I don't want to go back over it. We
 14 can all see what's written down.
 15 But there are a couple of points in Sir Duncan
 16 Nichol's statement, one point in Sir Duncan Nichol's
 17 statement, where he indicates that you had said to him
 18 that you weren't comfortable with -- something about the
 19 grievance wasn't quite right, or something like that?
 20 A. Yes, I -- I remember this conversation with
 21 Sir Duncan and I don't remember the specific detail of
 22 it but it is kind of both of our reflections.
 23 **LADY JUSTICE THIRLWALL:** Yes.
 24 A. And the two of them really were that there
 25 could not have been anything more unhelpful at that time

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1 than a grievance investigation in the way that it was
2 played out. It, it, it, it made a -- relationships that
3 were -- already had the potential to be challenging
4 becoming more so.

5 The inquiry -- sorry, the grievance was not
6 something -- I was aware that it was happening but not
7 all the detail of it. Perhaps I should have been. But
8 it wasn't for a Chief Executive to -- to stick their
9 nose into these things.

10 **LADY JUSTICE THIRLWALL:** No, I understand that.

11 **A.** And what was more frustrating about the
12 outcome of the grievance process was the -- the approach
13 to mediation, and things of that sort. And I think Sue
14 Hodgkinson in her evidence suggests that -- that, on
15 reflection, that should have been paused.

16 So my reflections in the conversation with
17 Sir Duncan was around that. I couldn't really offer any
18 observation around the process itself.

19 **LADY JUSTICE THIRLWALL:** No, I am not asking you
20 to, I just wondered what you thought wasn't right.

21 **A.** It was just -- I mean, as you can imagine, it
22 just made a difficult situation even more difficult and
23 it's a regret that, that it ever really was undertaken
24 but I understand because of the -- it's an independent
25 process that's available to members of staff,

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1 **Q.** Before I begin asking you questions,
2 Mr Harvey, I understand you would like to say something?

3 **A.** I would, thank you.

4 I am sorry for the hurt that has been caused to the
5 parents and the Families of the babies. I extend that
6 to the parents and the Families of the babies that were
7 the subject of the reviews but didn't feature in the
8 trial, and aren't part of this Inquiry.

9 It was only ever my desire to have a safe hospital
10 and to be able to tell the parents what had happened on
11 the neonatal unit and, if I failed in those aims, I'm
12 truly sorry.

13 I am grateful for the opportunity to come to this
14 Inquiry to explain my part in the Executive decision
15 making and to assist in the recommendations going
16 forwards. Thank you.

17 **Q.** Mr Harvey, you say "if I failed in those
18 aims". Reflecting now, do you think you did fail in
19 those aims to secure patient safety or baby safety?

20 **A.** I think the simple fact that there was
21 an increase in mortality is an indication that we got
22 things wrong. I think I've made clear in my statement
23 that I failed in my communication to the Families, in
24 the nature and the quality of the information that they
25 were given.

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1 I understand why it happened. It was just an absolute
2 regret that it did.

3 **LADY JUSTICE THIRLWALL:** Yes, thank you.

4 I'm sorry, my computer has just chosen this moment
5 to switch off.

6 Thank you, those are all the questions I have.
7 Does anybody want to ask anything arising out of that?

8 No, in that case. Thank you very much,

9 Mr Chambers, you are free to go.

10 **A.** Thank you very much.

11 **LADY JUSTICE THIRLWALL:** We will rise now until
12 11.55.

13 (11.37 am)

(A short break)

15 (11.55 am)

16 **LADY JUSTICE THIRLWALL:** Ms Langdale?

17 **MS LANGDALE:** My Lady, may I call Mr Harvey.

18 **MR IAN HARVEY (affirmed)**

19 **LADY JUSTICE THIRLWALL:** Do sit down, Mr Harvey.

20 **Questions by MS LANGDALE**

21 **MS LANGDALE:** Mr Harvey, you have provided
22 a statement to the Inquiry, dated 11 August 2024. Can
23 you confirm the contents are true and accurate as far as
24 you are concerned?

25 **A.** It is.

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1 **Q.** Did you fail to have Letby investigated
2 earlier by the police and to be removed from the
3 neonatal unit?

4 **A.** I am aware, from all the documentation, that
5 in June/July 2016 I had expressed an opinion that we
6 should approach the police and I sincerely regret that
7 we didn't at that time.

8 I -- I think looking at the processes that we went
9 through, I can understand why we did what we did. But
10 certainly, on reflection, I'm not comfortable seeing
11 that and thinking that we didn't. I'm not convinced,
12 based on the communications and the conversations we had
13 with the police nearly a year later, that they would
14 have necessarily acted at that point but I have to
15 accept that there would have been the potential for
16 oversight or advice with regard to the processes and the
17 reviews we undertook, and the possibility that they
18 could have stepped in sooner should something have been
19 found.

20 **Q.** All right. Let's go to your statement. If we
21 look at the beginning of your statement, Mr Harvey. You
22 have got it with you, haven't you, as well?

23 **A.** I have.

24 **Q.** You tell us your qualifications, first of all.

25 You attended Liverpool Medical School from 1976 and

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1 obtained a Bachelor of Medicine and Bachelor of Surgery
2 degree in 1981. In 1994 you began your employment at
3 the Countess of Chester Hospital as a Consultant
4 orthopaedic and trauma surgeon, with a specialist
5 interest in upper limb and hand surgery? You were
6 always --

7 **A.** I'm sorry, could I just apologise. I am
8 struggling to hear you.

9 **Q.** Sorry, I will move the microphone further.

10 **A.** Thank you.

11 **Q.** Is that better?

12 **A.** It is, thank you.

13 **Q.** You were always dealing with adult patients,
14 I think?

15 **A.** Predominantly, not exclusively.

16 **Q.** You were appointed as Medical Director at the
17 Countess in July 2012, initially undertaking the role
18 part time and keeping some clinical sessions, and taking
19 on the role as Medical Director full time in October
20 2013?

21 **A.** That's correct.

22 **Q.** So from October 2013 did you have no clinical
23 duties?

24 **A.** No, I didn't.

25 **Q.** So your role was fully as the Medical

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1 professional activity since you retired and you applied
2 for voluntary erasure from the medical register in June
3 2020. At that time, your application was refused by the
4 GMC:

5 "... on the basis that there was an ongoing
6 investigation into a complaint which had been made about
7 me by four paediatricians of the Countess of Chester
8 Hospital and it was considered [you were told] to be in
9 the public interest to conclude that investigation."

10 In May 2022, you were informed by the GMC that
11 their investigation had concluded and no further action
12 would be taken, and you reapplied for voluntary erasure
13 on the same grounds, and that was granted in June 2022?

14 **A.** That's correct.

15 **Q.** You say, about governance and leadership at
16 the hospital:

17 "The board was at the head of the Trust governance
18 structure and comprised of senior members of staff
19 including Chief Executive, Director of Nursing and
20 myself."

21 Can you tell us, first of all, about your
22 relationship with your fellow Executives and then with
23 also Sir Duncan Nichol, as chair of the board?

24 **A.** In well, I -- difficult to describe.

25 The relationship with my other board members,

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1 Director, and you tell us it encompassed a wide range of
2 responsibilities. Would you like to summarise those for
3 us, and how busy you were in the role?

4 **A.** Pardon I missed had?

5 **Q.** How busy you were in the role.

6 **A.** My main role as Medical Director was
7 essentially to act as an adviser on medical matters to
8 the board, to act as a conduit between the board and
9 medical staff, to advise and support the implementation
10 of clinical strategy. I was also overseer of medical
11 recruitment and discipline.

12 I had the additional role, as I believe most
13 medical directors do, of responsible officer, which is
14 a GMC role, responsible for overseeing appraisal and
15 revalidation of Consultants and permanent medical staff.
16 In addition, I was also the -- the Caldicott Guardian,
17 so overseeing information governance, and the director
18 of infection prevention and control.

19 I was probably no more busy, no less busy than any
20 of my colleagues and I was certainly, I would say, no
21 busier than the vast majority of the clinicians in the
22 hospital.

23 **Q.** You say you gave notice of your retirement
24 around February 2018, six months before your intended
25 retirement date. You haven't undertaken any

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1 I believe was -- was good. I think there was a very
2 coherent and collaborative approach from the Executives.
3 I think that we communicated well and on a regular basis
4 and in general well, if not almost exclusively decisions
5 were made collaboratively. I can't remember ever there
6 having to be a vote on making a decision.

7 I met with Sir Duncan Nichol on a fairly regular
8 basis. I believe we had a good relationship. I was
9 comfortable to -- to share everything with him. He had
10 a high level of -- of gravitas and, obviously, given his
11 background huge experience, which I found invaluable,
12 and I would have to say that I had never experienced
13 a better chair of a meeting.

14 **Q.** Did you know that Sir Duncan Nichol had a role
15 in the NHS at the time of the Beverley Allitt case and
16 he was responsible for circulating from the Clothier
17 report various recommendations arising out of the
18 Inquiry into Beverley Allitt; did you ever discuss with
19 him the Beverley Allitt case or any of his experience at
20 that time in the NHS?

21 **A.** No, I didn't and, to be honest, I wasn't aware
22 of that.

23 **Q.** Is that because you never mentioned the case
24 of Beverley Allitt to him, as he will have been aware of
25 that?

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1 A. I don't think I ever specifically mentioned
2 that -- that case to him.
3 Q. Okay.
4 A. I am aware that there are notes of some
5 meetings in which the name "Allitt" appears.
6 Q. We will go to the meetings but is that the
7 first time you had heard the name Allitt in those
8 meetings?
9 A. No, I -- I was aware of Beverley Allitt.
10 Q. You say at paragraph 22 of your statement that
11 you:
12 "... described the culture and atmosphere at the
13 Trust as generally positive. Senior medical posts in
14 most specialties were highly sought after. There was
15 a feeling that for a medium-sized Trust it punched well
16 above its weight and, despite what were at times severe
17 pressures, there was a can-do attitude."
18 Is that how you experienced it, generally?
19 A. I would stand by that statement, yes.
20 Q. You say:
21 "From 2016 there was a change in the atmosphere
22 between the Executives and the paediatric medical staff
23 due to the issues on the NNU unit. These relationships
24 became strained, although I do not believe that it
25 carried over into the rest of the Trust or affected the

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1 with the clinical staff, and that could be medical or
2 nursing to -- to the Inquest to support them.
3 Q. Why wouldn't it often be Stephen Cross?
4 A. I would imagine that would be because of his,
5 his role.
6 Q. So he was a senior person, he would only come
7 to the serious ones or the ones the hospital was
8 concerned about, given his seniority?
9 A. I'm really not in a position to comment,
10 I haven't got the experience and the knowledge of that.
11 Q. Did you get involved at any time in discussing
12 Inquests or statements for Inquests -- we are going to
13 come to references to that but, from memory now, were
14 you involved in discussions about many Inquests in the
15 hospital?
16 A. No, I can only think of one or two that I was
17 involved in and the one that I -- I attended at the
18 Coroner's Inquest was -- was to do with an adult.
19 Q. To do with?
20 A. An adult.
21 Q. An adult. If somebody spoke to you about
22 an Inquest in relation to a child or a baby, would that
23 be typical or unusual?
24 A. That would be unusual.
25 Q. Why?

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1 management or governance of the hospital."
2 Do you say that is the position?
3 A. Yes.
4 Q. So, as far as you were aware, before the
5 issues raised on the neonatal unit, you didn't think
6 there was any issue between doctors and nurses generally
7 as groups within the hospital and not on the neonatal
8 unit, before the issues around Letby arose?
9 A. There was nothing that had come to me, no.
10 Q. You say that Stephen Cross and you had a close
11 working relationship and you valued his opinion. In
12 what way did you value his opinion, about what matters?
13 A. I -- I think it was primarily involved with --
14 with legal matters. He was a huge support in helping
15 with doctors who were going through legal cases, those
16 who were subject to a negligence claim, for example. My
17 experience has been that he and his team were very
18 supportive of teams that were involved in Inquests.
19 Q. In what way did you support teams or doctors
20 who were involved in Inquests?
21 A. I believe that he and/or his team would meet
22 with doctors beforehand, they would review what was
23 going to be involved in the Inquest, and they would
24 support the attendees at an Inquest, probably not often,
25 it would be Stephen Cross but one of his team would go

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1 A. I suppose partly because of their -- just the
2 numbers in relation -- in comparison to the numbers of
3 adult deaths that we would have in the Countess of
4 Chester Hospital. And also because it was unusual for
5 there to be circumstances around an Inquest that would
6 require me to be informed.
7 Q. As a Medical Director?
8 A. Yes.
9 Q. Can we look then at some of the policies. You
10 refer to them in your statement, Mr Harvey but we have
11 them on the screen, other people can see them as well.
12 So we are going to look, first, please, at the
13 "Risk Management Strategy and Operational Policy" that
14 applied, which is INQ0014962. It begins at page 1 but
15 if we can look at page 2.
16 So this is the "Risk Management Strategy and
17 Operational Policy", Mr Harvey. You will have seen it
18 before I am sure. If we go to page 2, we see the
19 introduction and the commitment to delivering high
20 levels of safe and effective patient care. Underneath
21 "Aims", the last bullet point:
22 "The Trust maintains a coordinated approach in
23 managing risks through a systematic process of
24 identification, assessment, control and management of
25 risk."

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1 If we go to page, 9 we see at the top:

2 "The Medical Director supports the implementation
3 of the risk management strategy and has the
4 responsibility for all medical staff."

5 Two questions there, if I may: in what way did you
6 support the implementation of the risk management
7 strategy; and what was your responsibility for medical
8 staff? What did that mean in practice, those two
9 things?

10 **A.** Supporting the implementation I regard as
11 contributing to the risk management meetings. I think
12 we had an executive risk committee that met to review
13 organisational risk. Also, in the lesser committee
14 meetings, for example the quality, safety and patient
15 experience, where we considered risk, to contribute to
16 oversight of the risks that the divisions were
17 reporting.

18 Responsibility for all medical staff, I -- I read
19 as supporting and ensuring that medical staff were also
20 contributing to this concept of risk management.

21 **Q.** If we go to page 14, please. We see the
22 risk-scoring matrix. In terms of risk, Mr Harvey, the
23 risk of babies being murdered, in terms of severity
24 impacts, that would rank presumably as category
25 catastrophic, would it, as number 5?

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1 address?

2 **A.** All I can say is that, when this was first
3 raised, it was raised as there was an association of one
4 member of staff. It was never raised as a -- something
5 had been seen, something had been done. It was raised
6 as "There is an increase in the number of deaths but we
7 don't understand why".

8 **Q.** Murderers aren't always caught red handed, are
9 they, Mr Harvey?

10 **A.** Pardon, sorry?

11 **Q.** Murderers aren't always caught red handed, are
12 they? When you say there was nothing concrete, we see
13 it later, or to substantiate concerns, we are looking at
14 risk here, aren't we? You knew there was a risk and are
15 you saying, because it wasn't concrete, anything that
16 had been seen, you didn't classify it as such a risk?

17 **A.** No, I am saying that, in the way it was
18 phrased, I -- I don't think anything of us perceived it
19 as that sort of risk that would come to catastrophic.

20 **Q.** Let's see how it was placed on the Risk
21 Register at INQ0004657, please. This is an entry made,
22 11 July 2016. To make clear for those who may not know
23 the chronology after O and P had died, it appears,
24 insofar as the Inquiry can see, for the first and only
25 time on the Risk Register, and that's how it's

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1 **A.** Yes.

2 **Q.** So how effective do you think the risk
3 management system was at the hospital, at the time, for
4 identifying the risk of babies being murdered?

5 **A.** I -- I think that the answer is probably
6 not -- well, the answer is not, and I think the issue in
7 terms of assessing risk with this sort of tool is that
8 it relates to the common things.

9 I don't think -- and there are probably other
10 extreme examples -- and they probably don't come any
11 more extreme than the situation we are faced with, that
12 this just isn't an efficient tool for ...

13 **Q.** As soon as the doctors raised suspicion, mere
14 suspicion, and concern that a nurse was deliberately
15 harming babies, there was a risk, wasn't there, of
16 a nurse murdering and harming babies?

17 Now, whether that gets scored or how it gets
18 scored, I am not going to ask you about that. We have
19 heard some evidence about decision trees and all this
20 process involves. But standing back, as someone with
21 responsibility for risk, as soon as that suspicion was
22 raised, and you knew the impact would be catastrophic
23 were that risk to prove that it was fulfilled, did you
24 never think to go outside of the scoring system, and
25 rate this as a catastrophic risk that you needed to

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1 expressed:

2 "Potential damage to reputation of neonatal service
3 and wider Trust due to apparent increased mortality
4 within the neonatal unit."

5 Karen Townsend is listed as the handler, I think
6 that means the person who puts it on there, and in her
7 evidence she said Ms Kelly and Ms Hodgkinson had scripted
8 this for her; Ms Kelly said she had no recollection of
9 this.

10 So there we are. That's the evidence we have heard
11 so far. What do you say about that description,
12 following the deaths of O and P, of the risk which is
13 ranked as high?

14 **A.** I believe that is a very -- and I can't avoid
15 using a word that I believe Mr Chambers used -- very
16 clumsy description of the risk.

17 **Q.** Well, what's the potential damage to
18 reputation, that's the first thing that appears: what is
19 that?

20 **A.** I -- I think the problem here is the use of
21 the word "reputation", and the implication that
22 reputation is some standalone quality. And I think this
23 is something that has been referenced on a number of
24 occasions. In my own mind, for a hospital, reputation
25 can never be standalone. Reputation is entirely reliant

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1 on safety and the quality of care and, in my own mind,
2 if I see reference to reputation, I always think of
3 those as underpinning it.

4 **Q.** Did you see this Risk Register entry at the
5 time?

6 **A.** I don't recall seeing it, no.

7 **Q.** Do you know who wrote it?

8 **A.** I don't, no.

9 **Q.** Why does it use the word "apparent" increased
10 mortality; there was no question over the fact that
11 there had been increased mortality, was there?

12 **A.** I think "apparent" is used because, whilst
13 there was an increased number of deaths, the "apparent",
14 I think, is a way of capturing the fact that it might
15 not be statistically significant but, by the same token,
16 that wasn't a basis for deciding on whether to -- to
17 review or not because the increase that we had was
18 noticeable and entirely unacceptable, and it wasn't
19 subject to a statistical assessment to see whether it
20 sort of passed a level where we should be concerned, the
21 number itself was sufficient.

22 **Q.** Let's not worry about statistics, Mr Harvey.
23 The numbers were very small, weren't they, if you are
24 talking about statistics?

25 **A.** Yes.

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1 and you have looked at all of the documents in
2 preparation for your statement, so you know the facts.
3 So do you agree there was an increase, not simply in
4 mortality but in Sudden and Unexpected Deaths, within
5 the neonatal unit at the time this was entered on
6 11 July 2016?

7 **A.** I would say that I was aware of an increased
8 number of deaths, I'm not sure that I could say for sure
9 that the sudden and unexpected.

10 **Q.** We will go to that later then.

11 But nowhere here is the risk identified as a risk
12 to babies on the unit. That's the real risk, isn't it:
13 the safety of babies on the neonatal unit?

14 **A.** It is. But, as I have already said, my own
15 regard, with regards to the use of "reputation" is that
16 it is underpinned by safety and the quality of care.

17 **Q.** Or is it that it's of more concern to those
18 entering the information on the register than the safety
19 of the babies: reputation comes first?

20 **A.** I would hope that was not the case.

21 **Q.** That can come down, please, and if we can have
22 INQ0014165, page 3. This is the safeguarding policy,
23 Mr Harvey, that was in place.

24 We see at the beginning an introduction from your
25 colleague, Ms Kelly, reminding everybody what Working

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1 **Q.** So let's talk about the situation on the
2 ground, which was Sudden and Unexpected Deaths of
3 infants in the neonatal unit. The number of Sudden and
4 Unexpected Deaths had definitely increased and you knew
5 that as a hospital and the person entering this or
6 drafting that, if it was anyone connected at all to the
7 neonatal unit and what was going on, would have known
8 that too; do you agree?

9 **A.** I'm sorry, I am struggling to hear still.

10 **Q.** You would expect the person writing this, if
11 they knew anything about the neonatal unit, to know that
12 the Sudden and Unexpected Deaths had increased -- not
13 "apparently", but they had increased?

14 **A.** Yes.

15 **Q.** So there is no justification for the word
16 "apparent", is there?

17 **A.** Again, it's a -- I think it is -- it's a word
18 that has been used and perhaps shouldn't have been.

19 **Q.** So you agree, no justification, a simple yes
20 will do: you agree?

21 **A.** I would need to understand in detail why
22 "apparent" had been put in, yes.

23 **Q.** Well, you know the facts --

24 **A.** Yes.

25 **Q.** -- you knew them at the time you were there

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1 Together establishes, in the first paragraph:

2 "Every adult has a responsibility to protect
3 children and, as employees of the Trust, we are duty
4 bound always to act in the best interests of a child
5 about whom we may have concerns."

6 Were you well versed in the safeguarding policy and
7 the safeguarding culture within the hospital, or not?

8 **A.** I was aware of the policy, I had read the
9 policy. I, as part of the mandatory training that we
10 were all required to complete, had completed the
11 safeguarding element. I would have to admit that I'm
12 not sure that I could -- could say that I was well
13 versed and I -- as I think we all did with our
14 individual roles -- deferred to a degree to Mrs Kelly as
15 the lead.

16 **Q.** Did Mrs Kelly ever have a conversation with
17 you about the safeguarding process or policies, or what
18 needed to be done when concerns were raised about
19 a member of staff?

20 **A.** Not that I recall.

21 **Q.** In your own working at the Trust, and
22 certainly through the period we are examining, did you
23 regard neonates as more vulnerable than other patients
24 in any way?

25 **A.** I regarded any patient who didn't have

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1 capacity as more vulnerable.
 2 **Q.** So you would treat adult patients who were
 3 vulnerable in the same vein as you would neonates who
 4 are vulnerable?
 5 **A.** I would hope so, yes.
 6 **Q.** Do you think that where there are child
 7 protection requirements within the hospital, that it was
 8 important to remind yourself that you were dealing with
 9 children who are afforded greater protection with
 10 safeguarding policies, aren't they?
 11 **A.** Yes.
 12 **Q.** Yet at no time do you or Mrs Kelly appear to
 13 have stood back and say, "These are tiny infants and we
 14 need to protect them first and foremost"?
 15 **A.** No. But, by the same token, nor did any of
 16 the other staff who had particular roles with regard to
 17 safeguarding approach us with their concerns or approach
 18 me with their concerns.
 19 **Q.** Would you have known who to go and speak with;
 20 did you know Dr Mittal?
 21 **A.** I did, yes.
 22 **Q.** Did you ever think to touch base with him and
 23 talk about it?
 24 **A.** I didn't.
 25 **Q.** Do you know if he was even aware of the

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1 **Q.** So you found it all difficult to follow, and
 2 we'll come to that later, what was happening. But you
 3 never doubted that the Consultants were worried and
 4 concerned?
 5 **A.** I always accepted that Dr Brearey had a level
 6 of concern about that association.
 7 **Q.** The Inquiry has heard from a number of doctors
 8 and people who were Registrars at the time, who also had
 9 concerns and anxieties about coming to work. Have you
 10 listened to much of the evidence?
 11 **A.** I have, yes.
 12 **Q.** Did you hear Dr Lambie's evidence?
 13 **A.** I didn't but I have been made aware of it.
 14 **Q.** Right. So it wasn't simply Dr Brearey who was
 15 concerned. At the time, did you speak to any other
 16 doctors, apart from the paediatricians we are going to
 17 go to, who were in meetings and the like, did you ever
 18 take a walk onto the neonatal unit or talk to younger
 19 doctors, to see what's going on?
 20 **A.** I did do visits to the unit but I -- I don't
 21 recall specifically going to -- to talk to the junior
 22 doctors.
 23 **Q.** So what did you visit it for?
 24 **A.** I was going to say, sorry, I'm -- I am aware
 25 from the evidence that they had raised and expressed

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1 concerns that babies were at risk, as far as the
 2 Consultants were concerned, from a member of staff?
 3 **A.** I'm sorry: could you repeat that?
 4 **Q.** Were you even aware whether Dr Mittal knew
 5 that the Consultants were saying babies were at risk
 6 from a member of staff?
 7 **A.** No, I wasn't.
 8 **Q.** Can we go to page 30, please, of the policy.
 9 In the bottom paragraph:
 10 "All concerns raised by staff about patient care
 11 will be dealt with seriously, promptly and be subject to
 12 a thorough and impartial investigation where necessary.
 13 Managers have a particular responsibility to protect
 14 patients and to handle concerns about their care in
 15 a way that will encourage the voicing of genuine
 16 misgivings, while at the same time protecting staff
 17 against unfounded allegations."
 18 First of all, in all of the time you dealt with the
 19 events we are concerned with, did you ever doubt that
 20 the Consultants had genuine misgivings about the nurse?
 21 **A.** I never doubted that Dr Brearey, in
 22 particular, had concerns. Those concerns were, at the
 23 outset, not fully voiced and were difficult to follow on
 24 occasion. But at no point did I doubt that the concern
 25 was real as, as he perceived it.

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1 concerns with their seniors. Those concerns that the
 2 trainees had were never passed on to me.
 3 **Q.** How did you, as a manager, encourage the
 4 voicing of genuine misgivings; just standing back, what
 5 was your style? If you thought somebody was worried
 6 about something or concerned, did you think about how
 7 can you encourage them to speak fully?
 8 **A.** I -- I tried to make myself approachable.
 9 Whilst I was busy, I didn't have, from the evidence of
 10 Mr Chambers and Mrs Kelly, the same back-to-back
 11 meetings that they had.
 12 I had maintained a separate office away from the
 13 other executives and I had made it clear that I had
 14 an open-door policy, so that if my door was open and
 15 there wasn't a meeting going on, then anyone was free
 16 as, as many did, be it with a professional or a personal
 17 issue, to come and speak with me.
 18 **Q.** The second part of this policy refers to
 19 managers having a responsibility to protect staff
 20 against unfounded allegations -- unfounded allegations.
 21 **A.** Yes.
 22 **Q.** Were you ever concerned that there were
 23 unfounded allegations being made about a nurse?
 24 **A.** I was very mindful at this time of Stepping
 25 Hill. But it was the alternative story from Stepping

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1 Hill which was the nurse who had been incarcerated
2 inappropriately and incorrectly for six weeks and the
3 effect that it had had on her life and career, and that
4 was in -- in my mind.

5 **Q.** You are aware that, whilst she was on remand,
6 she was not charged, was she, and somebody else was
7 charged and convicted for the very serious crimes that
8 occurred there.

9 **A.** That's --

10 **Q.** Tampering with saline bags: very difficult
11 forensic investigations required, isn't it, to find
12 who's done that and, indeed, the person was convicted,
13 a different nurse?

14 **A.** It, it is but it's easier to know that someone
15 has done it, if one has the evidence, for example, in
16 the insulin -- knowing it was insulin.

17 **Q.** Is that why it's important that investigations
18 are conducted with those with the resources and training
19 to do it, like the police, who can, in the case you have
20 described, drill into in fact who was responsible?

21 **A.** It's why it's important that an appropriate --
22 a review appropriate to the circumstances at the time is
23 carried out, yes.

24 **Q.** If we go now, please, to the Speak Out Safely
25 policy, that is INQ0003012, page 1. You see at the
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1 officer will write a summary of the interview which will
2 be agreed by both parties."

3 If we go over the page, to page 8. We see fifth
4 paragraph down:

5 "In certain cases, such as allegations of ill
6 treatment of patients, exclusion from work on full pay
7 may have to be considered immediately. Protection of
8 patients is paramount in all cases."

9 We see at the bottom:

10 "If as a result of the investigation the Chief
11 Executive decides there is a case to be answered by the
12 person against who the disclosure has been made, the
13 Trust disciplinary procedure will be invoked and, if
14 there appears to be evidence of a criminal act [appears
15 to be evidence], the Chief Executive will consult the
16 police before invoking the disciplinary procedure."

17 Mrs Appleton-Cairns told the Inquiry that the Speak
18 Out Safely process was not followed in this case because
19 Ms Hodkinson and you decided not to follow it. Clearly,
20 the Consultants were raising concerns but this policy
21 was not employed, namely one of you sitting down,
22 writing what the concerns were, although they had
23 already been set out arguably in the Thematic Review,
24 but writing them down, then looking at them and seeing
25 if there was a case to answer, if there was something
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1 bottom, paragraph 2:

2 "The policy supports staff by ensuring their
3 concerns are fully investigated and that there is
4 someone independent outside of their team to speak to."

5 If we go over the page, to page 3, underneath
6 "Process to be followed":

7 "When staff wish to express their concern about
8 patient care, they should normally do so to their line
9 manager."

10 Alternatively, we see on page 6:

11 "There are designated officers, any of whom can be
12 used as the initial point of contact for disclosures
13 made under this policy."

14 We see you, Ms Hodkinson and Ms Kelly as designated
15 officers. We see the roles and responsibilities below:

16 "On being informed of the issue of concern, the
17 designated officer will arrange an initial interview
18 with the person making the disclosure to establish
19 details. The person making the disclosure was reassured
20 about their right to protection from possible reprisals
21 or victimisation."

22 If we go to the next page, page 7:

23 "The person making the disclosure will be asked
24 whether or not he/she wishes to make either a written or
25 verbal statement. In either case, the designated
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1 that the nurse needed to address or deal with, and then
2 make a decision about the disciplinary policy or
3 referral to the police. That process wasn't followed,
4 as we have just gone through, was it?

5 **A.** It wasn't. When the increased mortality was
6 first raised, I viewed it as a clinical issue. The
7 nature of the conversations were more to explain that
8 increased mortality. I don't recall a conversation with
9 Mrs Hodkinson about whether it would constitute Speak
10 Out Safely or not. But I would accept that we were
11 late -- I know that, subsequently, I am documented as
12 saying that it should fall under Speak Out Safely but
13 that was late on in the process.

14 **Q.** Throughout the process, you seem set on what
15 you have just said: trying to explain the increased
16 mortality, weren't you; that was your focus throughout
17 the process?

18 **A.** Yes.

19 **Q.** We will come to all the information but,
20 whatever information was coming in at various stages
21 from the paediatricians or anywhere else, you remained
22 on that focus: trying to explain increased mortality
23 with the various reviews you commissioned and the like?

24 **A.** Yes.

25 **Q.** That was a serious error of thinking, wasn't
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1 it, retrospectively? You just weren't getting the point
2 of the Thematic Review and the Unexplained Deaths --
3 Sudden Unexplained -- reference to the Beverley Allitt
4 case from Mr McCormack: you weren't seeing what was
5 really being said, were you?

6 **A.** I felt at the time that we were following what
7 was a logical progression of investigation, based on the
8 situation that we had been presented with and, based on
9 the information that we, we were being provided by both
10 the reviewers and other experts and, at the time, it
11 felt like the right and logical process to -- to follow.

12 **Q.** When you say what you were being told, the
13 thinking and the picture was developing, wasn't it --

14 **A.** Yes.

15 **Q.** -- as, as matters went on: the thinking for
16 Dr Brearey, who you respected --

17 **A.** Yes.

18 **Q.** -- trusted as a paediatrician?

19 **A.** I trusted him, yes.

20 **Q.** Dr Subhedar, the Inquiry has heard from him,
21 from Liverpool Women's Hospital, he was involved in that
22 Thematic Review, as an external party: respected him?

23 **A.** I -- I did it was for that reason that

24 I subsequently contacted him for further information.

25 **Q.** But it seems as though what you thought was
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1 and Tony Chambers, and you are the only doctor, aren't
2 you, in that group?

3 **A.** I am the only one from a doctor background,
4 yes. I mean, I'm not sure, given the length of their
5 managerial careers, I would describe Tony Chambers and
6 Lorraine Burnett as nurses.

7 **LADY JUSTICE THIRLWALL:** Alison Kelly.

8 **A.** Sorry?

9 **LADY JUSTICE THIRLWALL:** I think it was Alison
10 Kelly you were asked about.

11 **A.** I think Alison Kelly, in her evidence,
12 demonstrated that she kept close links and undertook
13 clinical work and I would happily describe Alison Kelly
14 as a nurse as well as the Director of Nursing.

15 **MS LANGDALE:** Do you think they may have relied on
16 you, believing you to have a greater medical
17 understanding of matters on the neonatal unit, than they
18 did?

19 **A.** I don't think that's the case. But, as the
20 Medical Director, then it is possible that I would have
21 had some more weight. Having said that, I have no doubt
22 that they are all intelligent people with a lot of
23 experience of clinical and non-clinical matters, who
24 would have a valid opinion, and certainly I didn't make
25 any attempt to sway anyone's view of the situation.
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1 logical to look at what might be the reasons for
2 an increased mortality rate, generally, drove you in
3 your actions and reviews that you commissioned, rather
4 than just listening to them and what they were saying?

5 **A.** I believe that I -- I was listening. I accept
6 what they were saying and their level of expertise and
7 knowledge but, by the same token, they were not able to
8 describe anything that took -- took it over a bar where
9 I -- I -- I had that extra level of concern.

10 **Q.** Are you --

11 **A.** And, I mean, as I said right at the outset,
12 having reflected at length, yes, I -- I regret that
13 I didn't speak with the police in June/July 2016.

14 **Q.** Are you quite a rigid thinker, Mr Harvey: once
15 you made a choice and you are on a track, you stay on
16 it?

17 **A.** I don't think that I am. I -- I don't think
18 that is the sort of thinking that would work, coming
19 from a clinical background, and I certainly try to tried
20 to hear what everyone was saying.

21 Certainly, in those early meetings, I was cognisant
22 of the -- the conversations that we were also having
23 with the nursing staff and, and their views.

24 **Q.** Well, you were surrounded by qualified nurses,
25 weren't you, in your exec group, there was Alison Kelly
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1 **Q.** The last policy, if we can have a look at the
2 Serious Incident Framework -- it is not a policy of
3 yours, it is prepared by NHS England -- and if we look
4 at INQ0009236, page 15. This is around how you assess
5 whether an incident is a Serious Incident.

6 You will understand: what is the significance --
7 perhaps you can explain: when you report a Serious
8 Incident, who reviews it, where does it go? What was
9 your understanding at the time, if something was logged
10 as a Serious Incident or reported, who would get to see
11 the information?

12 **A.** Initially, it would come in through the Risk
13 Team. They, they would identify it. Typically it would
14 have been an incident that is reported through the Datix
15 incident reporting system. That would be assessed and
16 escalated to the Serious Incident committee that Alison
17 Kelly and I both sat on, and we would regularly meet
18 with the Risk Team and a representative of Stephen
19 Cross's team to discuss the Serious Untoward Incidents.

20 **Q.** How did they get escalated out of the hospital
21 to NHS England or elsewhere for review?

22 **A.** My understanding is that it would go through
23 the STEIS reporting system? So if you reported
24 something through STEIS, it was scrutinised outside of
25 the hospital, as well as within?
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1 A. Yes.

2 Q. When we look at whether an incident is
3 a Serious Incident, we see at 1.1, three paragraphs
4 there, I don't need to take you through them all, but we
5 see at the bottom, it's suggested:

6 "Where it is not clear whether or not an incident
7 fulfils the definition of a Serious Incident, providers
8 and Commissioners must engage in open and honest
9 discussions to agree the appropriate and proportionate
10 response. It may be unclear initially whether any
11 weaknesses in a system or process including acts or
12 omissions in care, caused or contributed towards
13 a serious outcome but the simplest and most defensible
14 position is to discuss openly to investigate
15 proportionately and to let the investigation decide."

16 It makes the point the incident can always be
17 downgraded. If we go to page 33, reporting a Serious
18 Incident, it sets out, as you have said, that it can be
19 reported on the NHS Serious Incident Management System
20 and, if we see the bullet points:

21 "You can report incidents which will give rise to
22 significant media interest or be of suggests to other
23 agencies, such as the police or other external
24 agencies."

25 You have said you were interested in looking at
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1 confident that, if there was a level of concern, then
2 they would have raised that and -- and pushed us towards
3 that.

4 I -- I think it was also confused somewhat, despite
5 what it says here, by the fact that I understand that
6 the reporting rules changed in 2015 and, having formally
7 been a requirement to routinely report any neonatal
8 death on STEIS, that requirement was removed by
9 a decision at a national level. I can't speak to that.

10 Q. Ruth Millward told the Inquiry it was a missed
11 opportunity that that cluster of deaths wasn't reported
12 to STEIS; do you agree with that?

13 A. I -- I think, potentially, it was a missed
14 opportunity. I think the problem is the interpretation
15 of a cluster and is the number itself *per se* sufficient
16 to trigger?

17 I think part of the problem was the level of
18 assurance that was given by the reviews that Dr Brearey
19 had carried out that actually didn't raise any specific
20 clinical or associated concerns at that time. And, yes,
21 potentially in doing that, each was considered
22 individually, and it wasn't viewed as a -- a cluster
23 that would -- would set off an alert that there was
24 something linking them together.

25 Q. Well, it set him off doing a summary of cases
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1 increased mortality and you knew in 2015 there were
2 three deaths in rapid succession of babies A, C and D --
3 we will come to it but the first ones that Dr Brearey
4 draws together. You could have reported a cluster of
5 deaths, just because they were deaths at that rate in
6 that frequency, as a Serious Incident couldn't you, via
7 the STEIS system, so that there were other eyes on the
8 information?

9 A. I -- I can only say that when -- at that
10 meeting, I wasn't present at that meeting when those
11 three babies were discussed. So it's difficult to
12 comment about what my thoughts would have been at the
13 time.

14 There is reference in the policy to working with
15 the Commissioners, and Mrs Kelly and I met regularly
16 with the -- I am unsure of their title now, but the --
17 the risk and governance lead for the Clinical
18 Commissioning Group, the CCG, to whom we were not
19 beholden but who had --

20 Q. Who were commissioning care?

21 A. -- were our Commissioners, yes. And we would
22 meet regularly to discuss what had been through our
23 serious incident panel.

24 I think that we were subject to a significant level
25 of scrutiny by the CCG and, certainly, I would have been
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1 and a Thematic Review, didn't it? So it was unusual,
2 you had not had that before from the neonatal unit?

3 A. I'm not sure it was those three but those
4 three were part of a much larger number that did, yes.

5 Q. We will go to that then, I think it might help
6 you more to see the detail.

7 That can go down. Before we go to the detail of
8 what you learnt when, you mentioned the Clinical
9 Commissioning Group and you mentioned the CQC. As you
10 sit there, what's your impression of how much
11 information you were sharing, first of all with the CQC,
12 through 2016 about the paediatricians' concerns that
13 there was a Beverley Allitt situation?

14 A. Firstly, I don't think that we were aware that
15 we had a Beverley Allitt situation.

16 Q. Just to give you context there, Mr Harvey, we
17 see that, and there's been some evidence about it with
18 your former Exec colleague, Mr Chambers. In a meeting
19 on 30 June there was Mr McCormack at that meeting
20 saying:

21 "What's being raised is a Beverley Allitt/Shipman
22 situation."

23 So Mr McCormack, did you know him well in the
24 hospital?

25 A. I did, yes.
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1 Q. Is he a plain-speaking man?
 2 A. Yes.
 3 Q. And he seems to have put it right out there
 4 centre at that meeting, doesn't he, this is the
 5 situation that's being raised?
 6 A. I don't believe that he said that it is. He
 7 might have said: is it?
 8 In terms of your question with regard to the CQC,
 9 I am confident that I shared and we -- we're sort of
 10 moving on -- the Thematic Review of Dr Brearey with the
 11 CQC ahead of them -- their visit in February 2016.
 12 Q. In terms of the Commissioners, it doesn't have
 13 to be early February 2016, if you can remember moving
 14 through the year, how much information were you sharing
 15 with them, for example after O and P had died? So
 16 let's --
 17 A. Sorry, I missed the last --
 18 Q. After O and P had died, so late-June 2016
 19 onwards, how much were you sharing with the
 20 Commissioners?
 21 A. I -- I can't recall how much I shared with the
 22 CCG. I was slow and limited in my communications with
 23 Specialised Commissioning, who had oversight of neonatal
 24 services.
 25 Q. That's right, it is the Specialised

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1 You deal with this in your statement, Mr Harvey, at
 2 paragraph 61 and say that you were focusing on adult
 3 deaths?
 4 A. That's correct.
 5 Q. So tell us, what was the process for adult
 6 deaths? What were you doing, the Medical Director
 7 reviewing them, and why were you reviewing them?
 8 A. On a national level, the index of mortality
 9 had been introduced and effectively league tables were
 10 being published of individual hospitals' performance
 11 with regard to mortality and I had instituted a process
 12 by where we had teams of doctors and nurses reviewing
 13 deaths, I was overseeing that, and to allow publication
 14 of regular reports to the board with regard to concerns
 15 about levels and types of care.
 16 Q. You tell us:
 17 "I was confident that there was a process in place
 18 for the review of child deaths under the paediatric and
 19 neonatal units but the same could not be said for
 20 adults."
 21 So what did you think that process was for
 22 reviewing child deaths?
 23 A. My understanding of the process that we had
 24 from -- for child deaths was, was two-fold. On
 25 a national level it was the publication of MBRRACE data,

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1 Commissioners, yes.
 2 A. Sorry?
 3 Q. It is the Specialised Commissioners, not the
 4 CCG. Carry on.
 5 A. Yes. And I -- my concern was always that we
 6 should be able to tell the parents and The Families what
 7 had happened.
 8 I was also mindful of the risks of the effects of
 9 press leaks and unfortunately subsequently that came to
 10 pass. That probably resulted in an inappropriate degree
 11 of keeping hold of the information, although I would
 12 also say that there wasn't a great deal of pushback from
 13 Specialised Commissioning with regard to what they were
 14 being told at any particular time.
 15 Q. Let's move now to some of the documents,
 16 Mr Harvey. If we can have on screen, please,
 17 INQ0014813, page 4. This is a Board of Directors
 18 meeting, 1 September 2015 and you're present.
 19 And can you tell us, please, page 10, there's an
 20 entry there to receive the Trust's mortality report:
 21 "Mr Harvey presented the mortality report to the
 22 board and outlined the new process for review of
 23 mortality at the Trust. He now personally reviews every
 24 death in the Trust and then refers cases for further
 25 review where appropriate."

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1 which allowed comparison to other hospitals and Trusts.
 2 Within the hospital, I believe that we had
 3 a neonatal Mortality Review group who were responsible
 4 for reviewing individual cases.
 5 Q. That can go down and can we have instead,
 6 please, INQ0003144, page 5. This is an email sent to
 7 you, Mr Harvey, and others, from Ruth Millward:
 8 "We have three neonates under review. Plan is to
 9 arrange a speciality-specific SI Panel ..."
 10 Just a bit further down, thank you,
 11 Mrs Killingback:
 12 "... for next Friday to go through all three cases.
 13 Child death is no longer included in a Serious Incident
 14 by definition in the SI framework or on STEIS. However,
 15 it may be reported as a Serious Incident under any other
 16 category."
 17 So Ms Millward setting the situation out for you.
 18 Then we see a further email on page 4 from you:
 19 "Can you keep me informed in relation to the three
 20 neonatal deaths as I manage both legal and on the
 21 bereavement team and there will need to be confirmation
 22 of processes going forwards."
 23 Sorry, that's from Sarah, Sarah Harper-Lea.
 24 So you are alerted to those deaths, aren't you, by
 25 Ruth Millward in 2015?

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1 **A.** I would only say that I didn't attend that
2 meeting. I don't have my calendar, but I understand
3 that I was on annual leave and I am not able to recall
4 seeing that email at that time.

5 **Q.** So when you came back -- you tell us you were
6 on leave 22 June until 6 July. So when you came back,
7 do you have a habit of going back through your emails
8 when you have been away or do you start again when you
9 come back? What's the position?

10 **A.** I would generally try to review the emails
11 that I had missed while I had been away.

12 **Q.** We know that a summary document was prepared
13 for that meeting by Dr Brearey. We can have that on
14 screen, please, INQ0003191, page 1.

15 You tell us in your statement you have seen this
16 document before, but you can't recall who provided it to
17 you. But we see here, if we go over the page to page 2,
18 then page 3, we see in that summary document early on
19 Dr Brearey thought it necessary to include the number of
20 deaths for the whole of 2014, three, and of course you
21 are reporting or he is reporting on three in less than
22 three weeks.

23 And if we go to page 5, he has set out the
24 survival, the percentage survival rate and of course he
25 has given in the report the gestations and it sets out

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1 **A.** I -- I can't say for sure when I first saw
2 this particular document. I would have looked at the
3 figures but I would also have been influenced by the
4 text and the description.

5 **Q.** These are small numbers; it is the people and
6 the babies that matter, isn't it, in the end?

7 **A.** Yes.

8 **Q.** But you look at this stuff, so tell us?

9 **A.** Sorry, I don't understand the question.

10 **Q.** Tell us: what would you take from that, those
11 statistics?

12 **A.** I'm not sure I would have taken anything from
13 those numbers *per se*.

14 **Q.** That can come down and, if we can have
15 INQ0003530, page 1. This is the Serious Incident Review
16 and you are not there. It's a very short note of that
17 meeting at the top, but we know that Alison Kelly did
18 suggest reporting Child D through the STEIS system.
19 Would you have seen the report through the STEIS system
20 that came back in relation to Baby D?

21 **A.** Not as a matter of routine, I don't think, no.

22 **Q.** Have you seen it since?

23 **A.** Not that I recall.

24 **Q.** But at the time, it would be something that
25 your colleagues would no doubt tell you about: you are

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1 for Baby A, that's 31 weeks, 97.9% survival rate,

2 Baby C, 30 weeks, 97.3% and Baby D, 99.4%.

3 So he's set out --

4 **LADY JUSTICE THIRLWALL:** I don't think we have got
5 right document on the screen.

6 **MS LANGDALE:** Sorry. No, that is right one, with
7 the gestation at the left and the survival percentage on
8 the right.

9 **LADY JUSTICE THIRLWALL:** So can we just have the
10 number again, I think it's gone.

11 **MS LANGDALE:** That is page 5. I am giving you the
12 gestation dates from an earlier part in the report.

13 **LADY JUSTICE THIRLWALL:** Oh, I'm sorry.

14 **MS LANGDALE:** Confusing, sorry.

15 **LADY JUSTICE THIRLWALL:** That's my fault.

16 **MS LANGDALE:** But we know Baby A is 31 weeks, so if
17 we look at 31 weeks it's 97.9; Baby C is 30 weeks, 97.3;
18 Baby D 37 weeks, we need to go further down to see that.

19 So he has chosen to set out in that summary the
20 number of deaths, compared with the year previously, and
21 the survival rates for babies of that gestation
22 generally. Would you have looked at those figures -- it
23 sounds like you are quite interested in numbers: would
24 you have looked at those numbers with any interest when
25 it was sent to you?

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1 not reporting many babies through the STEIS system, are
2 you, at this time?

3 **A.** Possibly. But I -- I honestly can't recall it
4 being raised with me.

5 **Q.** Well, we see, if we go to INQ0014204, page 2,
6 this is the STEIS report or the "Level 2 Root Cause
7 Analysis Report" for Baby D. It sets out, in that
8 fourth paragraph under "Detection of incident":

9 "The incident was escalated to the Medical Director
10 and Director of Nursing and Quality, subsequently
11 discussed in Extraordinary Executive Serious Incident
12 Panel, there had been three neonatal deaths in a short
13 period of time and the circumstances were discussed to
14 identify if there was any commonality which linked the
15 deaths."

16 From your perspective, was it important to do that
17 when you had three in succession, just to look to see if
18 there were any environmental factors, whatever they
19 were, that linked the deaths, given that there were
20 three in that short period of time?

21 **A.** Yes, I would agree with that. I would --

22 I would only comment that it is factually incorrect to

23 say that it had been escalated to me, insofar as I --

24 I was on leave and hadn't received -- or didn't receive

25 the email in a timely fashion and wasn't at the meeting

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1 for the conversations.

2 **MS LANGDALE:** That may be a convenient time to stop
3 for the lunch break, Mr Harvey.

4 **LADY JUSTICE THIRLWALL:** Thank you, Ms Langdale.

5 So we will take a break now and we will come back
6 in at 2.10.

7 (1.06 pm)

8 (The luncheon adjournment)

9 (2.10 pm)

10 **MS LANGDALE:** Mr Harvey, before the break, I had
11 referred you to the emails that alerted you to three
12 deaths and you said you were on leave then and the STEIS
13 report for Baby D, which you said you don't remember
14 being escalated to you.

15 We do know that you attended a Serious Incident
16 Panel in relation to Child E on 13 August 2015, so if we
17 could go please to INQ0002659, page 4.

18 While that's being found, Mr Harvey, it's right
19 that you were invited to Serious Incident reviews of
20 deaths of babies and neonates, weren't you: you weren't
21 able to attend them all, we see, but you were invited to
22 them?

23 **A.** I'm sorry, which meetings were those?

24 **Q.** The meetings for the babies that died: you
25 were invited to reviews for those babies but I think

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1 Did anyone in the meeting make reference to the
2 fact that A, C and D had happened just over a month
3 before?

4 **A.** Not that I can recall.

5 **Q.** We know Letby was the incident reporter but
6 you wouldn't have known her name then, but it's clear
7 that this unexpected death had been brought to your
8 attention and you sat in the meeting discussing it; is
9 that correct?

10 **A.** Yes.

11 **Q.** You tell us in your statement:

12 "I don't recall any discussion regarding
13 an increase in neonatal mortality at this meeting and
14 I don't think anyone sought to draw a link."

15 Did you draw a link or think about the position?

16 **A.** No, I don't think I did. I think that was
17 because this case was considered on its own -- sorry,
18 "merits" isn't the right word, but was considered on
19 its -- in isolation and the fact that there was to be no
20 postmortem, that it had been discussed with the Coroner,
21 I felt indicated that both the medical staff reporting
22 and the Coroner did not have any concerns, so that, even
23 though it was titled an "unexpected neonatal death",
24 there wasn't any concern with regard to that either
25 amongst the medical team or the Coroner.

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1 you, in fact, only were able to attend Baby E; is that
2 right?

3 **A.** Is this the Serious Incident Review?

4 **Q.** Yes.

5 **A.** Yes, I wasn't able to -- well, I was on leave
6 for the earlier meeting, yes.

7 **Q.** But you would normally go?

8 **A.** Yes, I would.

9 **Q.** So what is the purpose of you going to these
10 reviews?

11 **A.** The purpose of me attending was, as with
12 Mrs Kelly, that there was senior medical and nursing
13 oversight of incidents that were coming through.

14 **Q.** This is coming through because it's reported
15 as an unexpected death, isn't it? If we look at the
16 top, on the left-hand side, a diagnosis of "GI bleed"
17 was made "Query Cause". Reference at 2300 hours to
18 a further GI bleed.

19 "Baby had a sudden deterioration at 23.40 hours
20 with bradycardia down to 80-90 bpm. There was a noted
21 colour change over the abdomen, purple discoloured
22 patches", and so it continues.

23 We see on the next page, page 5, it's recorded:

24 "No PM, has been discussed with Coroner.

25 Unexpected neonatal death of a Twin."

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1 **Q.** We know now, of course, that Mother E had very
2 really evidence to give about her child's deterioration
3 and what she was told by Letby at the time.

4 **A.** Yes.

5 **Q.** As part of this process, was there no contact
6 with the mother at all to discuss with her how she had
7 experienced what happened that night?

8 **A.** Not in those terms. Although the form clearly
9 indicates that there is a duty of candour assessment
10 and, on the back of that, one would anticipate that
11 there would have been contact with the parents to fulfil
12 that requirement.

13 **Q.** Is that something you would ask about in the
14 meeting yourself, to say, "Look, who's speaking with the
15 parents or discussing this"?

16 **A.** I think if it was -- it was part of the form
17 that we considered and I think if there was nothing
18 under the duty of candour assessment to indicate that
19 that had been fulfilled and there had been
20 a conversation, then, yes, I think either Mrs Kelly or
21 I would have queried what the plans were for a meeting
22 or a conversation with the family.

23 **Q.** That can come down, please, and if we can have
24 INQ0003200, page 1. Wednesday, 9 September, at
25 an Executive Directors Group meeting, we see at page 3,

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1 under the standing item, Sian Williamson reports that
2 a baby death had been reported to STEIS and
3 an investigation was taking place I took you to that
4 report earlier, but this is where it's highlighted to
5 you where the report is happening at that time.

6 So you've been in the Serious Incident Review for
7 Baby E and this is being reported to you at this
8 meeting. What does "standing agenda item" mean, does
9 that keep recurring and coming back?

10 **A.** It means that quality matters was one item
11 that would feature on the agenda every meeting, yes.

12 **Q.** That can come down and if we go please to
13 INQ0003575, page 1. In fact, if we can go to page 2
14 first. We see an email from you to Dr Joanne Davies:

15 "With the CQC due in less than one month, is there
16 anything that I need a heads up relating to the most
17 audit report? Are there any significant concerns
18 outliers or actions?"

19 If we go back to page 1. Dr Joanne Davies replies
20 to you. The Inquiry has heard evidence about this
21 largely obstetric report that was done, although it was
22 entitled "Stillbirth and neonatal deaths", in fact
23 Mr McCormack and Dr Fogarty accepted it was largely
24 an obstetric report, wasn't it?

25 **A.** It was, yes.

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1 weren't they, the obstetric and the neonatal deaths?

2 **A.** They were different bundle but one would say
3 that they were contiguous, in terms of it being
4 stillbirth and neonates, and my feeling was that there
5 was potential for joint learning, a joining up of the
6 combination of antenatal and postnatal and neonatal care
7 and, I -- I believe the response I got from Dr Brearey
8 was that that was an appropriate action.

9 **Q.** That can go down, please, and can we have
10 INQ0008927, page 7. While we are finding that,
11 Mr Harvey, which board did you think, as far as the
12 Thematic Review and the neonatal deaths review was
13 concerned, which committee should be hearing about that?
14 QSPEC or the Women and Children's Board, which one?

15 **A.** In the first instance, I would have imagined
16 it should have gone through the Women and Children's
17 Care Governance Board. The line of escalation normally
18 would be then through the divisional board and,
19 ultimately, in terms of the board committee, is the
20 Quality Safety and Patient Experience Committee.

21 **Q.** Because it clearly was a matter for that
22 patient safety experience committee, wasn't it --

23 **A.** The yes.

24 **Q.** -- the Thematic Review of neonatal deaths?

25 **A.** Yes.

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1 **Q.** So no mistake about it, no one thought that
2 had done anything in terms of investigating neonatal
3 deaths, it was looking at antenatal care, improvements
4 around care, but not the deaths themselves or causation
5 of deaths?

6 **A.** No.

7 **Q.** So you have asked for that, you get that
8 response. We see as well, if we go to INQ0038984,
9 page 2, you asked Dr Brearey the same. It looks like
10 you are asking for the external review that you
11 commissioned. We know what you are referring to there
12 is Dr Subhedar contributes to the Thematic Review,
13 doesn't he, from your --

14 **A.** Yes, I believe this refers to the Thematic
15 Review, yes.

16 **Q.** If we go back to page 1, we see Dr Brearey's
17 response, at the bottom:

18 "It wasn't an external review but we did have
19 a review of all the cases from 2015 to identify any
20 themes or common learning and I did invite an external
21 neonatologist to join us, which was very useful."

22 You then communicate with Alison Kelly about
23 whether the review should get joined up at the Women and
24 Children's Governance Board. That, in fact, never
25 happened because they were very different reviews,

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1 **Q.** So when it got there, it is obviously a matter
2 of interest when other people could have had an input
3 into it?

4 **A.** Yes.

5 **Q.** Looking at this email, please, from Sarah
6 Harper-Lea, and you are copied into this, at this time,
7 February 2016, there's reference to Child A's Inquest,
8 various bits of information being attached. Reference
9 at the bottom to:

10 "The Coroner also believed the Trust should
11 consider completing a SUI report due to the
12 complications in long line and catheter insertion.

13 Overleaf, Sarah Harper-Lea says:

14 "We were informed Child A's parents had a number of
15 concerns in relation to his treatment and were seeking
16 legal representation. In terms of the Inquest
17 investigation, it is noted Dr Brearey is completing
18 a neonatal review referred to within the QSR report
19 attached. If the neonatal review has been completed do
20 you consider that a SUI investigation, as suggested by
21 the Coroner needs to be undertaken or do you consider
22 this review will cover the matter sufficiently?"

23 Then if we go back to page 7, the previous page, we
24 see your reply:

25 "Thanks Sarah. Yes, I agree. I think that the

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1 timescale is unrealistic. I believe Steve's review is
2 equivalent of a SUI but we can make a final decision
3 when we see the report. I believe that an external
4 neonatologist was involved."

5 So what is your understanding of your role in terms
6 of, first of all, the Inquest for Child A? You know
7 it's happening you know the Coroner has been notified:

8 who communicates with the Coroner from the hospital?

9 **A.** My understanding was that communication with
10 the Coroner was through Stephen Cross' office.

11 **Q.** So you yourself didn't have a direct
12 conversation?

13 **A.** No, I didn't.

14 **Q.** The Inquiry has heard evidence from Dr Brearey
15 that, around this time, he asked for a meeting with you,
16 Mr Harvey; what do you say about that?

17 **A.** I would say that that doesn't match either my
18 recollection or the documentation. We've already seen
19 the email that I sent Dr Brearey asking for confirmation
20 that there had been an external review, to which he
21 confirmed there was and sent me a copy. This was in
22 advance of the CQC visit.

23 He did not, in that email, request a meeting,
24 urgent or otherwise. He did not send any further emails
25 requesting urgent meetings, nor did he take advantage of

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1 **Q.** Was it shared with the parents?

2 **A.** I -- I can't answer that.

3 **Q.** Well, it wasn't, was it? I don't think that
4 was shared with the parents at that time. Do you know,
5 if not, why not?

6 **A.** I don't, no.

7 **Q.** Who would make that kind of decision, whether
8 it would be shared with the parents?

9 **A.** I suppose it depends on whether it was going
10 to be the whole Thematic Review or the portion of the
11 Thematic Review with regard to just their baby.

12 **Q.** We see under "Action required":

13 "In order to prepare for the Inquest we need to
14 consider duty of candour which Steve Brearey has advised
15 Dr Saladi would be best placed to do", having been
16 involved in the treatment of the baby presumably.

17 Do you know what the hospital did or secured in
18 terms of assistance or support in relation to Baby A's
19 Inquest?

20 **A.** I don't, no.

21 **Q.** If we go, please, to INQ0007197, page 138,
22 this is an executive meeting. If you look in the
23 handwriting, I think this is Stephen Cross' handwriting,
24 isn't it? See to the right:

25 "Inquest statements need to be reviewed by

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1 my open-door policy to bring any concerns to me, nor did
2 he approach my PA to arrange an appointment to meet me
3 to speak.

4 **Q.** It does look as though you were sent on
5 7 March, INQ0008927, page 5, the report attached to this
6 email. So the draft minutes of the Thematic Review
7 meeting had been sent before and now you get the report
8 sent, but you also get this email from Sarah Harper-Lea.
9 So it's paragraph 2 that attaches for you the Thematic
10 Neonatal Review, and reference to paragraph 1 for
11 Baby A's Inquest:

12 "The Inquest for the above had been set by the
13 Coroner to be held on 23 March. This date has now been
14 withdrawn and will be set at a later date. This is due
15 to the fact that the Coroner requested an additional
16 eight reports be obtained from the junior doctors that
17 were involved in Child A's care and that a Thematic
18 Neonatal Unit Mortality Review needed to be completed
19 reviewed and shared as appropriate."

20 Do you know if that Thematic Neonatal Unit Review
21 was shared with the Coroner?

22 **A.** I don't know for certain, although I seem to
23 recall in the documents that have been made available to
24 me by the Inquiry that there is reference to the Coroner
25 having had a copy of the Thematic Review.

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1 Ian Harvey and Alison Kelly. Coroner pushing for
2 statements."

3 Does that ring a bell about how statements were
4 looked at?

5 **A.** I -- I have no recollection of reviewing those
6 statements.

7 **Q.** Have you ever been sent statements that are
8 going either to a court case or an Inquest that doctors
9 have written?

10 **A.** No.

11 **Q.** It does seem to record that, doesn't it, at
12 that meeting:

13 "Action: prepare statement bundle ..."

14 This is Stephen Cross' notes; do you agree?

15 **A.** They are, yes.

16 **Q.** It looks as though:

17 "Action: prepare statement bundle for Alison Kelly
18 and Ian Harvey."

19 Would that be him doing that?

20 **A.** Pardon?

21 **Q.** Would that be him preparing that statement
22 bundle for you, that note?

23 **A.** It would be he or his team, yes.

24 **Q.** So might you have asked for the statement
25 bundle, given the Coroner has asked for statements from

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1 other doctors just to see what's happened?

2 **A.** I'm unable to answer that. I have no
3 recollection of being sent any statements.

4 **Q.** But the principle of it, is there a problem
5 with that from your perspective, on one view?

6 **A.** No, there is no problem with the principle,
7 no. If Stephen Cross felt that there was a reason why
8 Alison Kelly and I should review statements from
9 a medical and nursing point of view, no, I would have no
10 issue with that.

11 **Q.** If we go over the page, it looks as though, in
12 this meeting, the meeting is going at 2016, so I have
13 moved on in time:

14 "Nurse started 2012. Why now? Occupational Health
15 referral. What about nurse? More support."

16 So at this time of this meeting, it's 2016, there
17 is discussion, isn't there, very clearly between you
18 about Letby in this meeting?

19 **A.** Yes.

20 **Q.** So you are all discussing Letby, concerns that
21 have been raised that she's causing deliberate harm,
22 murdering babies and Child A's Inquest is coming up. So
23 Stephen Cross might have every reason to want to know
24 what the statements say and what's being said, mightn't
25 he?

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1 this meeting.

2 **Q.** This is 2016, August 2016.

3 **A.** Right, yes.

4 **Q.** This is happening in August 2016 --

5 **A.** Yes.

6 **Q.** -- being asked about Baby A's Inquest
7 statements required by the Coroner and, by then, you
8 have all been talking about, in various meetings,
9 whether Letby is killing babies?

10 **A.** Yes.

11 **Q.** You are saying there, well, why now killing
12 babies, she started in 2012, but there is no question
13 that you are all aware it's about whether she is killing
14 babies and Baby A's Inquest is coming up.

15 So do you think the Coroner was adequately informed
16 about the suspicions and concerns you had about Letby
17 killing babies and whether or not Letby was looking
18 after this baby?

19 **A.** I don't -- I don't believe that that
20 cross-referencing happened. But potentially, well,
21 I believe that the Coroner had had a copy of the
22 Thematic Review, and I believe it would have been called
23 out in that.

24 **Q.** So that can come down. Let's go to the
25 Thematic Review, please. INQ0006817, page 1. If we go

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1 **A.** Yes, he might. I don't think at that time
2 there was any statement to the effect that someone
3 thought Letby was murdering babies.

4 **Q.** The Inquiry is investigating whether the
5 information the Coroner has had was adequate so my
6 broader question, by August 2016, you are all discussing
7 a nurse and effectively reference to "Started 2012. Why
8 now?" What does "Why now?" mean?

9 **A.** I can only imagine that it was, you know, we
10 have had a nurse working in 2012, if there were any
11 issues why would they be arising three or four years
12 later.

13 **Q.** So placing first and foremost why would she be
14 killing now, it is a question, but you know it's
15 a question?

16 **A.** I think -- not necessarily because two lines
17 above it does say:

18 "Is it competency of nurse?"

19 **Q.** We had already had meetings, hadn't we? We
20 will go to them in the chronology I just need to deal
21 with the Inquest point now. In June 2016, there had
22 been meetings expressly referring to Beverley Allitt and
23 killing, et cetera. So by the time of this meeting, it
24 was very much a conversation point, wasn't it?

25 **A.** I'm sorry, I have lost track of the date of

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1 to page 7, please. Dr Brearey is identifying on page 7
2 themes during discussion of all of the cases. It will
3 come up in a moment. We see under (7) "Deteriorations",
4 Dr Subhedar's suggestion, he is making very clear the
5 babies suddenly and unexpectedly deteriorated and there
6 was no clear cause for the deterioration/death
7 identified at postmortem. So he's not describing simply
8 deaths. He's describing suddenly and unexpectedly
9 dying.

10 Did you appreciate the significance between the
11 two: that he wasn't simply saying there are deaths, he
12 was saying Sudden and Unexpected Deaths with no clear
13 cause, no medical cause identified?

14 **A.** This was a feature of the meeting that we held
15 in May. This was part of the conversation and, at that
16 point, a number of -- well, a couple of actions came out
17 of that meeting. I do not recall in that meeting
18 Dr Brearey particularly stressing this one feature.

19 **Q.** Let's worry about the meeting when we get to
20 it. Look at this document. What alarm bells does that
21 ring for you, that description, if any, from the sound
22 of it?

23 **A.** "Unexpectedly" is a word that would be a cause
24 for concern.

25 **Q.** And "sudden, with no clear cause"?

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1 A. Um, "sudden" less so; "no clear cause",
2 possibly. And I -- I can't remember at what point that
3 I exchanged emails with Dr Subhedar with regard to this
4 particular issue. I think that was further down the
5 line. But at the time that this report was presented,
6 it wasn't presented with any urgency or any request for
7 an urgent meeting and that evening reading paragraph 1
8 would alter how one perceived.

9 Q. You are the Medical Director, you get an email
10 where it identifies there's a review to follow. When
11 you get a review, it's about a number of deaths of
12 babies, Sudden and Unexpected Deaths. Never mind
13 anything else that was or wasn't said in this page: were
14 you worried when you read that as to what that might
15 represent?

16 A. I probably wasn't as worried as I should have
17 been, with retrospect.

18 Q. What have you learnt, medically or otherwise,
19 that makes you realise that in retrospect, that "sudden
20 and unexpected" was significant in what was being said
21 here?

22 A. I think that came out eventually from
23 a specific request that I made of Dr Jane Hawdon. It
24 hadn't been something that had been explicit elsewhere.
25 It certainly hadn't been explicit in her report. I had

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1 unusual"?

2 A. Not insofar as the action underneath indicated
3 that they were going to be carrying out a further
4 review, focusing on the nursing observations. So it
5 appeared from that that there was further investigation
6 and action ongoing with regard to that point.

7 Q. Attached to this, there was a table, wasn't
8 there, identifying names of staff allocated and on duty.

9 A. Yes.

10 Q. What did you think when you saw -- we know it
11 was Eirian Powell -- somebody had been required to go
12 through shifts and identify who was present at Sudden
13 and Unexpected Deaths, just the mere fact of putting
14 that together?

15 A. I -- I viewed it as being comprehensive.
16 I viewed it as an investigation into an association,
17 potentially in terms of competence. I viewed it also
18 with regard to a look at the actual staffing levels and
19 the associations of numbers of staff at any given time.

20 Q. Eirian Powell agreed in oral evidence that she
21 did feel sometimes, and when she looks back, the fact
22 that she was having to do this with rotas, it wasn't
23 really her role and she accepted it's something that the
24 police might be doing. If you are pulling this stuff
25 together and looking who's where, when, in the

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1 had a degree of reassurance --

2 Q. Let's worry about that letter, sorry, we'll
3 get to Dr Hawdon but --

4 A. Sorry, I was just going to say I had had
5 a degree of reassurance also from Dr Subhedar, which was
6 one reason perhaps why I hadn't chased or requested
7 further information from Dr Hawdon sooner.

8 Q. Timing of arrest. Dr Brearey has identified
9 arrests between midnight and 4.00 am. So he's found
10 a pattern there, and he's bothered to put that down.
11 What did you make of that?

12 A. In isolation, I didn't make a great deal of
13 it. This coincided also with a report coming out from
14 Imperial College, with regard to concerns specifically
15 at weekends. But it is recognised that there is
16 a greater risk of incidents, of care failures at
17 weekends and during the night and, without any further
18 information there, that was how I interpreted that.

19 Q. In the Dr Shipman case, a GP noticed patients
20 were dying in the afternoon at home, Dr Shipman's
21 patients when he went to visit them. She didn't know
22 any more than that but the pattern of dying on their own
23 at home in the afternoons was unusual, that alerted her
24 to something that was unusual. Do you think Dr Brearey
25 identifying this should have made you think, "This is

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1 circumstances that Dr Brearey has outlined it's an
2 investigative role, isn't it, it is something different
3 from --

4 A. It is.

5 Q. -- drawing up rotas. It is, isn't it, it
6 clearly is, when you see it?

7 A. In retrospect, yes.

8 Q. She was being asked to do that as the deputy
9 ward manager who very much supported her staff,
10 including Letby at that time?

11 A. I -- I don't recall her being asked to do
12 that. I think she undertook that as part of the review
13 that they were doing.

14 Q. Yes, the review with Dr Brearey and Ms Powell
15 were doing it together --

16 A. Yes.

17 Q. -- and that was her task which she duly
18 fulfilled?

19 A. Yes.

20 Q. When you saw that, again as the Medical
21 Director, did you look and think, "Who's doing this why
22 are we doing this"?

23 A. No, I -- I viewed it as a comprehensive review
24 of that unit. It didn't, at that time, set off the
25 alarm bells that perhaps it should.

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1 Q. You did say a moment ago, if the Coroner had
2 been sent this review, that was adequate information and
3 the Coroner would be aware of your concerns or the
4 hospital's concerns. You were sent the review. Were
5 you aware of the concerns then?

6 A. Sorry, of concerns and when?

7 Q. Well, when I asked you a moment ago about the
8 Coroner being sent the Thematic Review and whether the
9 Coroner got adequate information, you said he would have
10 been aware of our concerns, he's got the Thematic
11 Review: this review.

12 A. Um.

13 Q. So what concerns should the Coroner have taken
14 from this review?

15 A. I'm not sure that he would have concerns,
16 other than the fact of the numbers. I don't think at
17 the time that we considered this report, in the meeting
18 of May, that there was the high level of concern that
19 you are suggesting and alluding to.

20 Certainly, it wasn't something that Dr Brearey
21 pushed in that meeting. Dr Brearey, at the end of that
22 meeting, seemed comfortable with the conversations that
23 we had had, and with the action that was proposed and,
24 obviously, with looking at this through -- through
25 hindsight, everything looks very different. But that

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1 Q. So you have a one-to-one with Alison Kelly:
2 "Neonatal review. Query results from external.
3 Review to QSPEC."

4 What does the next bit say?

5 A. "? Issues with alignment with maternity."

6 Q. That was your earlier thought about whether it
7 should be aligned with that Fogarty review?

8 A. That's right.

9 Q. "Not attending governance meetings."

10 What does that refer to?

11 A. I'm -- I -- I could guess but it would be no
12 more than a guess, so it's probably not appropriate to
13 make any comment.

14 Q. "People not attending them."

15 A. Yes.

16 Q. We have seen that on the apologies, there are
17 a lot of apologies. That brings me to another question:
18 there are a lot of meetings as well and, as far as this
19 issue is concerned, that don't seem to be addressing
20 this one, the neonatal deaths. We will come to it when
21 it finally reaches the Women and Governance Board, but
22 when there are so many meetings and we see a critical
23 issue like this not raised in any of the meetings for
24 some time, were they effective, the meetings, the big
25 meetings for QSPEC and the Women's and Governance, or

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1 misrepresents the conversation and the meeting that we
2 had around this document in the May that this was
3 brought to that meeting.

4 Q. Okay, we will go to that in a moment. Can we,
5 first of all, please, have a look at INQ0003089, page 2.
6 It's an email from Ms Powell to Ms Kelly and it's
7 forwarded to you:

8 "Hi Alison. I was hoping we could arrange
9 a meeting with you to discuss how to move forward with
10 regards to our findings. High mortality. Eight as
11 opposed to our normal two to three per year
12 a commonality was that a particular nurse was on duty,
13 either leading up to or during. This particular nurse
14 commenced working on the unit in January 2012 without
15 incident. A doctor was also identified as a common
16 theme, however not as many as the nurse."

17 She says:

18 "Thanks for the update. Could you please send Ian
19 and I the report. Once we have reviewed, I think it
20 would be good for me, you Ian, Steve and Ravi to meet to
21 discuss."

22 We see if we look at INQ0101115, page 12
23 a handwritten note, which I think might be one of yours,
24 Mr Harvey; is that your handwriting?

25 A. It is, yes.

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1 were people not attending and they weren't working
2 particularly well?

3 A. I -- I think that the -- the alarm bells that
4 should have been leading to more rapid escalation
5 weren't ringing. I know that it references needing
6 a one to one with Dr Jayaram. I cannot recall whether
7 that took place and, if so, how expeditiously after that
8 meeting it was.

9 Q. But you thought that, did you, that you needed
10 to have a one to one with him?

11 A. Yes.

12 Q. So if it didn't happen, whose responsibility
13 is that?

14 A. It would be -- well, he would only know about
15 it by me approaching him.

16 Q. So if he hasn't had one with you, you
17 recognised the need and didn't follow through on it?

18 A. I might have done but I don't have any record
19 of that.

20 Q. What did you mean, "Query results from
21 external"?

22 A. I -- I'm, I'm questioning the results
23 presumably from the Thematic Review. My notes are
24 obviously very short and I can't be any more specific.

25 Q. You both appear to be saying it should go to

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1 QSPEC, the neonatal review, yes?
 2 **A.** Yes, and I think that's reflected in
 3 a communication from Alison Kelly to Ruth Millward,
 4 subsequently.
 5 **Q.** Can we go next please to INQ0003121, page 1.
 6 This follows Alison Kelly receiving that rota with
 7 Letby's name in red. She sends an email to you:
 8 "Hi Ian, I have realised that the NNU doc review
 9 that was sent to us was indeed the review with the
 10 Consultant from Liverpool Women's. Eirian has also sent
 11 through a separate doc with the clinical detail and the
 12 teams involved. The above is not going to QSPEC today
 13 but thought it will need to go to May's meeting. Before
 14 then, I suggest we meet with Steve and Eirian in early
 15 May to check on actions as a few are due to be completed
 16 in April."
 17 Did she accompany that email, it looks like she
 18 did, with the reviewed table, which had got Letby's name
 19 in red?
 20 **A.** *(No audible response)*
 21 **Q.** Can you remember?
 22 **A.** I can't remember, sorry.
 23 **Q.** It may be her name had stood out before but
 24 when her name was in red done by Eirian Powell, it
 25 really stood out, didn't it, how often she was there?

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1 perhaps getting ahead of her -- having been taken onto
 2 days.

3 **Q.** Let's get that email up then, INQ0107818,
 4 page 2:

5 "There's a nurse [this is to Alison Kelly] on the
 6 unit who's been present for quite a few of the deaths
 7 and other arrests. Eirian has sensibly put her on day
 8 shifts only at the moment but can't do this
 9 indefinitely. It would be very helpful to meet before
 10 she's due to go back on night shifts."

11 If we go to page 1 before that:

12 "Hi Ian, please see Steve's comments below which
 13 alarmed me!! Since receiving this I have asked Karen
 14 Rees to liaise with Eirian regarding this particular
 15 nurse. Eirian, further review is attached for info.

16 "Currently reassured there are no issues so I think
 17 this is worthy of a wider review, hence our planned
 18 meeting. This has been arranged for next Wednesday to
 19 review all the issues with us."

20 You say:

21 "I see what you mean, although perhaps just meant
 22 that he was concerned for her."

23 What do you mean "concerned for her"?

24 **A.** Well, I -- I think if we look at Dr Brearey's
 25 email on the previous page, I -- in saying that

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1 **A.** And I think Alison Kelly referenced that as
 2 a concern, yes.

3 **Q.** Well, they were identifying, Dr Brearey and
 4 Ms Powell, in April 2016 that she was a common factor in
 5 the events they were concerned about; is that fair, you
 6 appreciated that?

7 **A.** Sorry, I missed the question.

8 **Q.** You appreciated that she was highlighted as
 9 a common factor in the deaths and events that they were
 10 concerned about?

11 **A.** She was associated, yes.

12 **Q.** Well, how could she be associated: what was
 13 your thinking?

14 **A.** Well, she was a factor common to a --
 15 a number. I don't recall that she was associated with
 16 all.

17 **Q.** What are the options if she was the factor
 18 that was common?

19 **A.** Based on the conversations that we had, the
 20 most likely was simply the fact that she was more
 21 commonly on duty, on duty for longer, tended to care for
 22 the sicker babies: all the points that Eirian Powell had
 23 raised -- raised subsequently in the meeting that we
 24 had. I also am aware that there was an email from
 25 Dr Brearey referencing the fact that -- and this is

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1 "sensibly moved", his major concern seemed to be with
 2 regard to the effects of that on staffing levels. He
 3 doesn't seem to be alerting to any concern about her
 4 actual practice.

5 **Q.** That can come down. You then have a meeting
 6 on 11 May, and you deal with that, if you want to refer
 7 to it in your statement, at paragraph 162 onwards. Your
 8 recollection is this meeting took place relatively late
 9 in the day. You had also been sent various documents in
 10 advance of the meeting. It may be more helpful actually
 11 to see those first, to know what you had been sent.

12 You'd been sent INQ0003243, page 1. This was
 13 a document prepared by Eirian Powell in a meeting with
 14 fellow nurse Karen Rees, and she produced this in
 15 anticipation of the meeting you were going to have and
 16 has set out there at the beginning:

17 "There is no evidence whatsoever against LL other
 18 than coincidence."

19 Had you read this before the meeting?

20 **A.** I don't recall when I saw this and read it.

21 If I didn't read it before, I read it at the meeting.

22 **Q.** It records the line you have just repeated:

23 "She is therefore more likely to be looking after
 24 the sickest infant on the unit."

25 Yes?

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1 **A.** Yes.

2 **Q.** Did you appreciate what band nurse she was and
3 level of experience or did you not ask?

4 **A.** I -- I recall that, in the meeting, Eirian
5 Powell made reference to her being qualified -- well, as
6 she had there qualification specialty as -- as part of
7 her -- that report, that review.

8 **Q.** So what band did you think she was: how
9 experienced or what band?

10 **A.** I wouldn't be aware.

11 **Q.** No, so would you be surprised if she was
12 a Band 5. There were a number of Band 6s on that unit,
13 she was a Band 5, relatively recently qualified. Did
14 you get that impression or ask?

15 **A.** Neither.

16 **Q.** So you took that as fact, did you, that she
17 was looking after sicker babies and was experienced?

18 **A.** Based on who was making that statement, yes.

19 **Q.** Did you test it out in any way with Ms Powell
20 and ask her, "Have you looked at the HR file, have you
21 spoken to anyone else about her. She seems all of these
22 things to you but have you had a look for anything
23 else?"

24 **A.** Not at that point. I think that was
25 a subsequent action.

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1 **Q.** Let's go to the notes of the meeting now then,
2 INQ0003181, page 1. While I do, can I tell you what
3 Dr Brearey says about this meeting. He says:
4 "My recollection of the meeting is that I started
5 by talking about the Thematic Review report.
6 I explained that we had found some clinical areas of
7 practice we could learn from in some of the cases but
8 they were all relatively minor and none were common to
9 all the deaths. Generally, I was happy with the NNU
10 being an area of good practice and the previous annual
11 mortalities had been quite low. I felt the number of
12 deaths in 2015 and early 2016 were exceptional.
13 I highlighted that six of the nine deaths occurred
14 between midnight and 4.00 am which was unusual.
15 I highlighted that there seemed to be
16 a disproportionately high number of sudden, unexpected
17 collapses. We had reviewed care on multiple occasions,
18 including with an external neonatologist, and the only
19 common theme was the association with Letby being on
20 duty. We needed guidance and help on how to take this
21 forward. I also made it clear these were concerns of my
22 colleagues and were not mine in isolation."
23 Do you agree with what I have just read to you,
24 that he says that?

25 **A.** That doesn't accord with my recollection of

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1 **Q.** You were also sent a document, INQ0006951,
2 page 1 called the "Additional Information Monitoring".
3 So since 15 April 2016, Eirian Powell has been adding to
4 her monitoring document of who's where, when, other
5 incidents or events. Did you appreciate that it was
6 an ongoing piece of work that Eirian Powell was doing
7 when you had the conversation, that she was looking at
8 events and continuing to look at events and who was
9 there?

10 **A.** I -- I don't recall appreciating that then,
11 no.

12 **Q.** Because it's significant, isn't it? You are
13 having a meeting, you have been told someone's moved
14 from nights to days and the head of the ward is
15 effectively monitoring events and seeing who's there for
16 them.

17 **A.** Yes, and I would also say that we looked to
18 extend that because one of the actions that came out of
19 that meeting was that any subsequent babies who
20 collapsed should be reported. I'm not actually sure
21 that happened but that was one of the actions in terms
22 of us monitoring the continuing picture.

23 **Q.** So it was a monitor, wait and see?

24 **A.** It was monitor and alert if any concerns
25 arise.

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1 that meeting. I don't recall Dr Brearey being that
2 detailed or that assertive.

3 **Q.** What's factually incorrect from what I have
4 just read to you though? I mean, he said that he was
5 highlighting a disproportionately high number, commonest
6 theme was the association with Letby.

7 **A.** It wasn't -- it wasn't common to all. She was
8 more frequently and --

9 **Q.** Six out of nine.

10 **A.** Sorry?

11 **Q.** Six out of nine, that is what he said. He
12 didn't say it was all?

13 **A.** And that was balanced with regard to the
14 detail that both Eirian Powell and Anne Martyn
15 presented, in terms of presence on the unit, activity
16 level, staffing levels, her frequency of attendance or
17 work on the unit and I believe that there was a full
18 discussion.

19 The meeting was later in the day but that did not
20 foreshorten it in any way and, at the end of that
21 meeting, I recall that everyone was in agreement in
22 terms of the continuing monitoring but stepping it up
23 and ensuring that all babies who collapsed thereafter
24 should be reported and that they would be monitored.
25 I'm not sure that that actually happened.

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1 Q. Whose responsibility is that, if it didn't?
2 They were looking to you for leadership, guidance; did
3 you say --

4 A. Well, the responsibility of that is with the
5 clinicians who are caring for the baby who collapsed.

6 Q. What's your responsibility in this situation?
7 They are actually telling you six out of nine arrests
8 between 12.00 and 4.00 am and she was on duty or shift
9 before 9 out of 10 of the deaths. That's actually what
10 the Thematic Review data says?

11 A. Well, my responsibility was continuing to
12 monitor and being aware in the event that any further
13 collapses occurred. And it had obviously also, as part
14 of this meeting been made clear that, as Stephen Brearey
15 had alluded to in his email, Letby had been moved from
16 nights to days, but the implication was that that was
17 for her protection and well-being.

18 Neither he nor Eirian Powell nor Anne Martyn
19 indicated that it was for any other reason than that,
20 and I believe that was supported by the tone of Steve
21 Brearey's email that we have just been talking about and
22 I think the tone of the meeting that we had and my
23 recall of it would be supported by the tone of
24 a subsequent email that Steve Brearey sent with regard
25 to how he perceived that meeting.

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1 saying that any association is purely circumstantial
2 because of the nature of the duties.

3 Q. Nature of the ...?

4 A. Letby's duties: working more commonly, more
5 frequently, doing additional shifts.

6 Q. That meeting was 11 May and there was a QSPEC
7 meeting on 16 May, where this issue wasn't raised -- the
8 note can go down now thank you. This issue wasn't
9 raised and it wasn't raised at the 20 June meeting
10 either. You said you thought it might be raised at
11 those meetings. You were sighted on the issue, it was
12 a patient safety issue. Did you not think it should
13 have gone to that June meeting, as you and Alison Kelly
14 had hypothesised back in that meeting, one to one, on
15 11 April?

16 A. I think she had made reference to not being
17 able to get it into the May meeting, but I -- I believe
18 that it should have gone to the June meeting, yes.

19 Q. So why didn't it? That is what you both
20 agreed; was there a reason you kept it away from there?

21 A. I -- I can't recall why it didn't go. All
22 I can say is we didn't have a conversation about keeping
23 it out of that meeting.

24 Q. It did go to the Women and Children's Care
25 Governance Board. If we see INQ0003212, page 5, we will

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1 Q. Let's look at what it says there:

2 "Absolute no issues with nurse."

3 That's Eirian Powell's view, isn't it?

4 A. Yes.

5 Q. She is giving you that view, and Dr Brearey
6 told us that both Anne Murphy and Eirian Powell
7 countered his concerns quite forcibly and with great
8 emotion, saying there were no issues with her?

9 A. I think Dr Brearey's overstating in saying
10 "with great emotion".

11 Q. We have seen a number of references to Eirian
12 Powell being emotional around these events. It wouldn't
13 be surprising, would it: she is running a ward while she
14 is trying to put rotas together investigating who is
15 there on sudden collapses?

16 A. No, I agree but my recall is not that I --
17 I -- I believe that she was factual. She was obviously
18 passionate about her unit, but I don't think that she
19 was excessively, as is implied, passionate with regard
20 to defence of Letby. I -- I wouldn't accept that, as
21 I have seen described, that she and Anne Martyn were in
22 denial. I think that has all been overstated.

23 Q. Why does the word "circumstantial" appear
24 there on the notes; who was discussing circumstantial?

25 A. I can only surmise that that is Eirian Powell

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1 see how it was raised there. That's how it's set out,
2 just referring to mortality rate, not sudden and
3 unexpected deaths with a commonality of a nurse.

4 Dr Jayaram told the Inquiry he didn't think this
5 was a forum where a suspicion concerning a member of
6 staff would be raised, the Women and Governance Board;
7 do you agree with that?

8 A. Never having attended that particular meeting,
9 it would be difficult for me to -- to comment. I think
10 there would be ways, if there was a real concern, to --
11 to raise that, even if it was separately with the Chair.

12 Q. That can go down, thank you. Now, I am going
13 to move to June after O and P have died, and there were
14 important meetings in June, weren't there. If we start
15 with the emails please, INQ0003142, page 1. We see
16 Dr Brearey, if we go over the page, page 2 first:

17 "I am hoping Karen has already spoken to you about
18 our two mortalities last week. We are going to discuss
19 them at our senior paediatricians meeting on Monday."

20 So Monday, 27, that is, June:

21 "I was wondering if it might save time if you and
22 Ian could join us at that meeting to discuss the ongoing
23 issues."

24 If we go over the page:

25 "Yes, Karen did discuss this with me last week.

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1 I'm touching base. I'll discuss with Ian this AM re
 2 trying to attend your meeting."
 3 Why didn't you attend that meeting? You didn't
 4 attend it and we know there was a different meeting
 5 instead, the Babygrow meeting where Dr Jayaram mentioned
 6 it to you, but it would have been a good idea to go to
 7 the paediatricians' meeting, wouldn't it, as the Medical
 8 Director?
 9 **A.** Without access to my diary I am unable to say
 10 what other commitment I had at that time.
 11 **Q.** Two babies had just died on consecutive days,
 12 you say the meeting in May was monitoring whether
 13 anything would happen. Something very serious had
 14 happened. Hard to imagine anything more serious in the
 15 hospital.
 16 **A.** I was aware that we had got the Babygrow
 17 meeting and we took advantage of -- of that. As I say,
 18 I -- I can't -- I don't know what other commitment there
 19 was.
 20 **Q.** Let's look at INQ0015537, page 4. It's two
 21 meetings recorded, here the left-hand side is what we'll
 22 call the Babygrow meeting, where you are discussing
 23 an appeal, and then Ravi Jayaram has a conversation with
 24 you after it, doesn't he, and brings up directly the
 25 concerns about the two deaths at the end of last week

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1 *(Pause)*
 2 Have you finished reading that?
 3 **A.** Yes.
 4 **Q.** So that can go down, and can we have
 5 INQ0015537, page 4. So on the right-hand side, this is
 6 the meeting, just the three of you, making all these
 7 decisions without you having even spoken to the
 8 paediatricians. You set out there various bullet
 9 points, that is the decision you take on the 27th at
 10 4.30, with them; do you agree that note's accurate?
 11 **A.** I -- I don't think that's telling the whole
 12 story, insofar as, at the end of the Babygrow meeting,
 13 there had been a discussion with Dr Jayaram and
 14 Mrs Kelly and myself. I had a conversation with Steve
 15 Brearey, subsequently, who informed me that everyone had
 16 agreed that Letby was to be taken off the unit, and
 17 I raised that issue with Mrs Kelly because that actually
 18 absolutely wasn't what had been said in the Babygrow
 19 meeting and it appeared that there had been a 180-degree
 20 change in the opinion of the senior nurses --
 21 **Q.** Just pausing there --
 22 **A.** -- and --
 23 **Q.** -- there was no paediatrician -- Ravi Jayaram
 24 had a conversation with you, didn't he, after the
 25 meeting about that?

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1 and the concerns about one nurse, very clearly telling
 2 you. Then you have got the other side, you have
 3 recorded:
 4 "Eirian Powell adamant no concerns."
 5 We know, on that 27 June morning, there was
 6 a meeting by the paediatricians and it may be helpful to
 7 have this on the screen from Dr Brearey's statement, so
 8 people can follow it INQ0103104-page 44, and you will be
 9 able to see it, Mr Harvey.
 10 It's paragraphs 248 to 250, if you could read
 11 those.
 12 *(Pause)*
 13 You see there it sets out the Consultant
 14 paediatricians meeting at 249 and, at paragraph 250, he
 15 in his statement to the Inquiry, he makes it clear he
 16 had spoken to you and said that, at their meeting, with
 17 the nurse managers, they had:
 18 "... all agreed the appropriate action was to remove
 19 LL from clinical duties."
 20 You responded to say that you requested an RCPCH
 21 Review. When you have finished reading that, Mr Harvey,
 22 we can go back to your second meeting on 27 June at
 23 4.30, which reflects what you, Eirian Powell and
 24 Ms Kelly had discussed separate from the paediatricians.
 25 Have you had time to read that?

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1 **A.** Yes, yes.
 2 **Q.** But there was no paediatrician who said
 3 anything different to you in the meeting on 27 June, the
 4 Babygrow. You are saying it was a nurse that said
 5 something different?
 6 **A.** Sorry, saying?
 7 **Q.** Were you saying it was a nurse that said
 8 something different at the Babygrow meeting?
 9 **A.** No, what -- the view was that there were no
 10 concerns with regard to Letby when we had that
 11 conversation with Dr Jayaram.
 12 **Q.** It was just you and Dr Jayaram who had that
 13 conversation, wasn't it, it wasn't in the meeting. He
 14 said as you left the meeting he spoke to you about the
 15 deaths. It wasn't the subject of the Babygrow Appeal
 16 meeting?
 17 **A.** Well, I believe Mrs Kelly was there as well.
 18 It wasn't the subject of the Babygrow meeting, no.
 19 **Q.** No, it was a conversation he said he had with
 20 you afterwards to bring to your attention their concerns
 21 about the two deaths at the end of the week before?
 22 **A.** Yes, and, in that conversation, Eirian Powell
 23 was involved and she was adamant that there were no
 24 concerns. I subsequently had a conversation with
 25 Dr Brearey, who was reporting back from the Consultants'

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1 meeting that I believe some of the nurses also attended,
2 that everyone was agreed that Letby should be removed
3 from the unit.

4 **Q.** Yes.

5 **A.** Now, that hadn't been the message that Eirian
6 Powell had delivered earlier on and, for that reason,
7 I contacted Alison Kelly.

8 **Q.** Let's put the email on that you are referring
9 to, that you contacted, INQ0005727, page 1. This is the
10 email where you set out to Ms Kelly:

11 "Steve claiming that all in the meeting including
12 Eirian and Anne Murphy agreed the nurse should be
13 excluded from patient contact. 180-deg aboutface from
14 them, if that's the case -- do you want to check?"

15 So it's right Dr Brearey is right. He said to you,
16 "We have all agreed, including Eirian and Ann, she
17 should be off". But you are having a conversation with,
18 who, that suggests they have turned about their decision
19 making?

20 **A.** I am saying to Alison Kelly that, based on the
21 conversation that we had had with Eirian earlier in the
22 day, she appeared to have changed her opinion
23 completely. So that Letby was to be excluded when that
24 hadn't been the message that we had had earlier on in
25 the day and I'm suggesting that we need to check whether

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1 Then, if we go over the page to page 4:

2 "I understand Ian and Alison met with Eirian and
3 Ann yesterday afternoon, and that the outcomes from that
4 meeting don't entirely fit with what was suggested at
5 our senior paediatricians' meeting yesterday. Hence, it
6 would be helpful to meet sooner rather than later, with
7 nursing and medical colleagues together."

8 That didn't happen, did it? You proceeded with the
9 plan to instruct the RCPCH and, just if we can go back
10 to page 2, we see Dr Brearey's email there:

11 "Just to confirm then, Ian and Alison are happy for
12 LL to work on the NNU in the same capacity as last week
13 despite the paediatric consultant body expressing our
14 concerns that this may not be safe and that we prefer
15 her not to have further patient contact?"

16 If we go back to page 1, it's Karen Rees who brings
17 those emails to your attention. You then have
18 a conversation, Mr Harvey, with Stephen Cross, if we go
19 to INQ0003360, page 1. This is on the 29th. To be
20 clear, those days -- 27th, 28th, 29th, 30th -- Letby is
21 still working on the unit, while these days are passing.
22 "Wednesday, 29 June, Harvey neonatal issue":

23 "Emails from Consultants -- escalating concerns.
24 Email this PM from further Consultant. Advice: police
25 need to be involved now."

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1 that was, in fact, the case.

2 **Q.** We then see Alison Kelly sends the agreed plan
3 of action, INQ0005745, page 1, sending it those of you
4 who made the decision without the paediatricians. You
5 are setting out the following actions, and the third one
6 is:

7 "Ian Harvey and Alison Kelly to meet with
8 Consultant group re their concerns."

9 Who's "supposed to be liaising and the team to
10 arrange"; who's DD?

11 **A.** Yes, DD was my PA.

12 **Q.** It's here. You have identified,
13 "Royal College lead to facilitate external NN review".
14 So that was your idea, was it?

15 **A.** It was my suggestion, yes.

16 **Q.** Dr Brearey then sends -- there is a series of
17 emails, starting INQ0005744, page 3. We see that in
18 paragraph 3:

19 "There has been a watchful waiting approach since
20 our last meeting with Ian and Alison in March. However,
21 since the episodes and deaths last week there was
22 a consensus at the senior paediatricians meeting that we
23 felt that on the basis of ensuring patient safety on
24 NNU this member of staff should not have any further
25 patient contact on NNU."

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1 You should know, Mr Harvey, Stephen Cross says in
2 his written evidence:

3 "Based on what the Medical Director told me in
4 relation to the neonatal unit, I noted my view in my
5 notebook that the police should be involved now. This
6 was not formal advice but rather a pragmatic view that,
7 if there was a serious allegation made in the Trust, the
8 police should be involved."

9 Is his note accurate?

10 **A.** I -- Stephen Cross in this note --

11 **Q.** Yes.

12 **A.** -- I think is alluding to an email that
13 Dr Saladi had sent and he was suggesting that the police
14 were the only organisation that could carry out the sort
15 of investigation that he thought would be of help.

16 I don't recall Mr Cross giving the advice that the
17 police needed to be involved now.

18 **Q.** It looks as though your meeting, what time
19 does that meeting happen on 29 June?

20 **A.** Well, he's written 8.15.

21 **Q.** 8.15. So Dr Saladi's email is actually same
22 date 8.17, a little bit later, and it's not actually
23 Stephen Cross on that email list, but it's INQ0047571,
24 page 2. The Inquiry has examined this email. We
25 probably need to go to page 3 to get the end of that.

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1 There we are.

2 So that's Dr Saladi's email --

3 **A.** It is, and I --

4 **Q.** -- and there is a series, isn't there, between
5 the Consultants, and this is the one where you say, if
6 we go to 0002 -- different INQ number, sorry
7 Mrs Killingback. It is INQ0003112, page 2. The
8 Consultants discuss going to the police.

9 You are on the email thread and you say, when
10 there's comments it's not being treated urgently -- as
11 I have indicated, Letby is still on the unit:

12 "Ravi -- this is absolutely being treated with the
13 same degree of urgency -- it has already been discussed
14 and action is being taken. All emails cease forthwith.
15 We will share with you what action we are taking."

16 Before you comment on that, if we can just go back
17 to 112, page 1, Dr Jayaram chimes on the 29th:

18 "The Trust are contacting the police soon, once
19 some information gathering has taken place, which is why
20 Ian asked for the chitchat to stop for now. The
21 (*unclear*) is interesting and worrying though, given the
22 discussions we have had."

23 Dr Jayaram had seen you that day, hadn't he, he had
24 had a conversation with you --

25 **A.** Yes.

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1 that I regret that we didn't go to the police in
2 June/July 2016. I think there is evidence that the
3 Inquiry has that, actually, that was in my mind at that
4 time.

5 **Q.** Shall we put that email up, Mr Harvey,
6 INQ0004751 --

7 **A.** And I --

8 **Q.** -- page 1.

9 **A.** I believe having seen that documentary
10 evidence that I would accept that I probably did have
11 that conversation with Dr Jayaram. The email, with
12 regard to "all communications should cease forthwith" is
13 one of those emails that I had counselled many others
14 against sending. There is a habit, a tendency when one
15 receives -- when there is, for want of a better phrase,
16 a hot topic for emails, because they are so easy to
17 send, to become more and more extreme and I was
18 attempting to -- to dampen that down. But I fully
19 accept that I -- I got that completely wrong, that email
20 doesn't read as it should have done.

21 **Q.** Why, when you were thinking about it as well,
22 didn't you simply respond to Dr Saladi's email then and
23 say yes, we should go to the police?

24 **A.** Because the nature of that was I felt that
25 that was something that needed discussion amongst the

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1 **Q.** -- and he said you had said that you were
2 going to the police, which is why he said that. But
3 I think you dispute that, do you?

4 **A.** I think, firstly, I need to go back to the
5 meeting with Mr Cross. I think the first three lines of
6 his notes are in reference to me taking Dr Saladi's
7 email to him to discuss with him. He and I were in the
8 habit of often being the first Executives in the office
9 and I'm not sure the timing of his note is completely
10 accurate.

11 I believe that I had received that email, I was on
12 the circulation list, and I took it to Mr Cross for
13 discussion and his advice. I think also, because of
14 that, the advice to go to the police references
15 Dr Saladi's comment in his email.

16 **Q.** So there Mr Cross is wrong when he says that
17 in his written evidence then; is that what you say?

18 **A.** Well.

19 **Q.** His written evidence is that he --

20 **A.** I would say that our recollection differs.

21 I do not recall Mr Cross, at any point at that time
22 recommending we went to the police. I would suggest,
23 given his, his background that had, at any point he said
24 that, I -- we would have taken that advice.

25 I've stated in my, at the beginning of my evidence

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1 Executives before I sent an email that once it's out
2 there, it's out there, and I felt that this was such
3 a serious matter that it needed discussion amongst the
4 executives.

5 **Q.** You had a further meeting, didn't you, with
6 the paediatricians, Wednesday, 29 June, very briefly,
7 INQ0003371, page 1. We see at the bottom "Dr Ravi
8 Jayaram":

9 "Staff member -- almost always nurse in charge.
10 Babies were stable then deteriorated. Why always this
11 nurse? Babies were unwell but getting better. Babies
12 not getting oxygen -- then crash. Babies did not
13 respond as they should have done. Steve B. Disturbing
14 things -- twin survived and got better in Arrowe Park."

15 They are repeating their direct concerns that this
16 nurse is murdering children; do you agree?

17 **A.** They are highlighting their concerns that
18 she's associated, that there was -- at no point did they
19 say in their view she was murdering them.

20 **Q.** Let's look at page 2, and get off this word
21 association. Here it's suggested more than just
22 an association with this nurse. Dr Jayaram:

23 "How? Cannula air embolism."

24 You are medically qualified. Air embolism: what's
25 he suggesting there?

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1 A. He is suggesting -- he is suggesting that, if
2 there had been an act, was that a possible mechanism.

3 Q. He's talking about a deliberate harm,
4 a murder, how that could be done. Could it be that?
5 It's not simply an association. They are describing or
6 thinking about methods, aren't they?

7 A. With respect, he's talking about the
8 possibility of accidental as well as possible deliberate
9 and it wasn't, as it says, something going on but what?

10 Q. You have another meeting on 30 June, with the
11 execs and Sir Duncan Nichol, if we can go to INQ0003361,
12 page 2. Again, why is this meeting happening without
13 any doctor present? Why are you just discussing it with
14 Sir Duncan and none of the paediatricians to put their
15 views forward?

16 A. I would imagine that was called simply so that
17 the Chairman was brought up to date with the situation
18 that we were in.

19 Q. Well, he's up to date with your views, he is
20 not necessarily up to date with the paediatric views, is
21 he? Let's see what you say when he is there on page 2:

22 "Can we decide what we are doing. Demands: review
23 within two weeks. Staff member clear articulation of
24 Consultants' concerns to Alison Kelly to formalise."

25 That's an action plan for you and Alison Kelly,

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1 That's reference to these deaths having happened
2 when she's on days, you agree: O and P have died when
3 she is on days and you have been monitoring it, there
4 you have it, that's happened, O and P?

5 A. Yes.

6 Q. "Not sure what review will do."

7 You are promising a review within two weeks from
8 somewhere from the RCPCH. He says:

9 "Not sure what review will do. Serious concerns,
10 member of staff, fantastic unit but concerned Beverly
11 Allitt/Shipman being raised."

12 That is loud and clear and articulated, to use the
13 phrase that follows the documentation; do you agree,
14 clearly articulated?

15 A. It is clear in that note, yes.

16 Q. Couldn't be clearer. From that moment on
17 there is just no substance in saying it was about an
18 association and if you needed further reference, look at
19 page 58. Dr Jayaram again: "air embolism".

20 Explains difficulties with the resuscitations: he's
21 been saying it constantly, hasn't he, that this is the
22 concern?

23 A. Yes, I'm not sure that the notes capture the
24 way things were discussed in the meeting. I --

25 I appreciate that these things were said but I'm not

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1 yes, or is that one for Sue Hodgkinson to do?

2 A. Sorry, what was the question?

3 Q. Look at the clear articulation of Consultants'
4 concerns; who's supposed to get those concerns from the
5 Consultants?

6 A. It's unclear whether that is Sue Hodgkinson or
7 Alison Kelly. It would appear that the action of
8 closure of the unit, or me to see a plan is myself and
9 Alison Kelly.

10 Q. You had very clearly had their concerns by
11 this point, hadn't you?

12 A. Pardon?

13 Q. You had had their concerns very clearly stated
14 in a Thematic Review and the conversations you had had
15 with Dr Jayaram after the Babygrow meeting, and with the
16 doctors, with Dr Brearey?

17 A. Yes, and I believe those concerns were shared
18 with Sir Duncan Nichol at that meeting.

19 Q. Let's look at the next meeting notes,
20 INQ0015639, page 55. This is the meeting where
21 Mr McCormack says, look at the top:

22 "Had thought member of staff responsible for
23 deaths. Member of staff over the last three days, only
24 going on what's being told by paediatricians, nights to
25 days change."

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1 sure it captures the full nature of the conversations
2 that were had.

3 Q. It captures fully that there were concerns and
4 suspicions when two babies had just died when this nurse
5 had been moved to day shifts. You were looking to see,
6 monitoring -- you had asked for the monitoring to
7 continue, and you don't seem to reflect that that's what
8 you had invited back in the meeting in May, and here you
9 were in June with two dead babies on the unit.

10 Wednesday, 6 July, if we can go to the next
11 document, please, INQ0002682, page 3. Executive Team
12 notes again, and here we have the Royal College Review,
13 "IH review proposal". You had made this decision, that
14 this would happen, hadn't you?

15 A. This was a decision that was reached in the
16 end in concert with others, including the
17 paediatricians.

18 Q. Mm-hm.

19 A. I believe there were notes from a meeting that
20 the Executives -- I think Duncan Nichol was involved,
21 and the paediatricians, at which it was agreed, previous
22 comments notwithstanding, that this was an appropriate
23 route to follow.

24 Q. This was where you discussed CCTV, amongst
25 other matters; is that right?

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1 A. Discussed?

2 Q. Discussed CCTV --

3 A. Yes.

4 Q. -- and having CCTV and I think it was somebody

5 who wouldn't normally, Ms Hodgkinson, going off with Tim

6 Lister to look at CCTV proposals for the neonatal

7 unit --

8 A. Yes.

9 Q. -- for the intensive care unit. Did that

10 strike you as odd that you had arrived at a point where

11 you were going to get CCTV on the unit?

12 A. No, because I think that simply reflected the

13 fact that we just didn't know what was going on.

14 I -- we know that that association was reported

15 but, actually, because of the way the unit was set up

16 and laid out, we actually couldn't be sure which staff

17 were doing what and when, and I believe that's why we

18 had a conversation about how we could best monitor the

19 unit.

20 Q. You said you would get a review done within

21 two weeks at that meeting, didn't you? The

22 paediatricians said they wanted her off the unit and you

23 would have to do it within a couple of weeks, is what

24 you said?

25 A. We were -- I'm not sure I would have said

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1 Q. The external communication around the same

2 time as that, INQ0103147, page 1, goes out; do you think

3 that was a transparent and fair summary of the

4 situation:

5 "Nevertheless, we have seen in some of our most

6 poorly babies (those with high dependency needs)

7 an increase in neonatal mortality rates for 2015 and

8 2016."

9 Was that a fair description of the babies that had

10 died?

11 A. At that time, I believe that that was

12 a reasonable description.

13 Q. That's what Eirian Powell had said. The

14 doctors hadn't, had they; did you take her word for it,

15 rather than the experienced Consultants?

16 A. I believe, in terms of the external

17 communication that was the understanding at the time,

18 that's all I could -- could say.

19 Q. It was Eirian Powell's belief; it was your

20 understanding, you are saying, as a medical qualified

21 person?

22 A. I was, at that time, comfortable with that

23 communication going out.

24 Q. You set up subsequently, between 6 and 8 July,

25 Silver Command, don't you? You describe that in your

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1 I would have got a college review in two weeks because

2 that would have been optimistic. My understanding at

3 the time was that Letby was on annual leave, which gave

4 us some time. But I couldn't see anyway that it would

5 be a College Review.

6 Q. There is another note of yours, INQ010115,

7 page 21, 7 July:

8 "No safeguarding issues aware of. But share press

9 briefing and safeguarding."

10 Presumably, you are speaking about the downgrade,

11 are you, at this point, or what are you referring when

12 you say "No safeguarding issues"?

13 A. To be honest, I'm not clear who all the

14 attendees were at that meeting, and I -- I can't give

15 any information with regard to that note, I don't recall

16 that.

17 Q. It's your note but that doesn't ring a bell.

18 It's the only reference we see to safeguarding issues.

19 I haven't seen anything else that you have referred to

20 in a note like that.

21 A. I -- I don't believe that that is something

22 that I would have said in that meeting. What isn't

23 clear is who has said that. But I -- I believe that

24 reflects that someone in the meeting had made that

25 comment.

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1 statement. You say:

2 "It's difficult now to remember which reviews are

3 incorporated as part of the Silver Command review or

4 ongoing separately."

5 By this stage, if we go to INQ0003174, sorry 1 and

6 3?

7 **LADY JUSTICE THIRLWALL:** Ms Langdale just choose

8 a moment to stop.

9 **MS LANGDALE:** After Silver Command we will stop.

10 Thank you. If we go to INQ0003174, page 1, there

11 we are. So a lot of people gathered together for

12 a morning briefing, the first page. The second page,

13 I think there's about 36 people, and people are given

14 different jobs and tasks, aren't they, to complete?

15 A. Yes.

16 Q. You say:

17 "We did not agree specific Terms of Reference.

18 They were borne out of group discussions."

19 Who was in charge of who did what?

20 A. My recollection is that the idea for the

21 Silver Command came from Stephen Cross. With regard to

22 the allocation of roles, I cannot recall but could only

23 imagine that that came from an executive conversation

24 about who was best suited to which role.

25 Q. Sian Williamson told the Inquiry she was sent

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1 off to look at rotas, which Eirian Powell had already
2 looked at and, when she had done so, she realised and
3 thought that you should go to the police and that she
4 spoke about that to Alison Kelly. I can't remember if
5 she said you as well, Mr Harvey. But do you remember
6 knowing or being told that Sian Williamson thought you
7 needed to go to the police, when she had done the very
8 job that Eirian Powell had been asked to do: she and
9 Julie Fogarty ended up doing that job?

10 **A.** I don't recall that conversation, no.

11 **Q.** This moved into the territory of the hospital
12 investigating the hospital and actively seeking
13 explanations for deaths, didn't it? That is what this
14 was all about: looking at the evidence in different
15 directions from the unit, from the rotas and trying to
16 piece together an explanation for the deaths?

17 **A.** It -- it is trying to find any signs of
18 changes, of actions, of activities that might, in part
19 or in whole, explain the change in mortality, yes.

20 **Q.** It was entirely misconceived, wasn't it?

21 **A.** I think that there was important data that
22 came out of it. I believe that we were trying to find
23 explanations for the increase in mortality and I believe
24 that we were doing that with the -- the best motives and
25 in the best way that we could.

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1 effectively the basis for everything else that we were
2 doing and went on to do.

3 **Q.** Another example of this slides, INQ0002837,
4 page 3. Has the NNU been under more pressure? You take
5 the admissions and look at the graphs. In fact, the
6 spike, if anything, is late 2014 and, if we contrast
7 that graph to the actual data Dr Brearey, via BadgerNet,
8 was able to put together, INQ0103210, page 4, you see
9 admissions had gone down in 2015, in fact.

10 So the concerns about acuity, activity, none of
11 this assisted at all and it gathered a momentum, didn't
12 it, as though it was describing a mortality rate?

13 **A.** I think in the previous graph it stated "may
14 contribute". I don't think at any point we were saying
15 that any one of these in isolation explained it and the
16 figures on that table are the total admissions for
17 a year; they are not showing the breakdown either
18 quarterly or monthly that would actually give
19 a reflection of intensity of work in a shorter period.

20 **Q.** In and of themselves, none of the charts you
21 produced told you anything about the individual deaths
22 or circumstances. They added nothing to the question
23 you were required to investigate, which was how have
24 these sudden and unexpected collapses happened and who
25 is responsible, if there is a suspicion?

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1 That was also something that we envisaged feeding
2 the data into the subsequent Royal College Review. I --
3 as I have probably said at least twice now, accept that
4 in reconsidering all the events of 15, 16 and 17 --
5 regret that I didn't stick with my original view that we
6 should have gone to the police.

7 **Q.** Indeed, finally, the data that you were
8 assisted to gather, if we look at INQ0002837, page 2,
9 you found yourself drawing together with the assistance,
10 I think, of someone in the hospital, some kind of data
11 analysis and, for this table, for example, what was
12 causing the spike couldn't possibly be told by this,
13 could it, if somebody's harming babies deliberately?

14 **A.** No, that particular graph is really
15 a reflection of the figures that we were already aware
16 of that had actually sparked the need for the
17 investigation.

18 **Q.** But commenting on a steady mortality rate, as
19 though that pointed to things in the hospital being
20 an issue, was meaningless. The rate, if it was
21 attributed as we now know to somebody killing babies
22 deliberately, this data didn't assist at all, did it,
23 that you were digging out?

24 **A.** I am -- I'm sorry, all I have got is the --
25 the rolling mortality data here and, as I say, that was

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1 **A.** I think that that was, as is by far and away
2 the most common situation within the NHS, an acceptance
3 that, almost invariably, these situations are
4 multi-factorial. There are multiple elements that
5 contribute. At no point were we seeing -- saying that
6 any one was the prime cause. But there was a range of
7 issues at the same time -- whilst there had been
8 a description of an association of one nurse with
9 an increased number, there had been -- and a description
10 of sudden and unexpected collapses -- there were also at
11 that point a lot of babies who had either had
12 postmortems which hadn't revealed anything other than
13 natural causes or for whom it hadn't been regarded by
14 the clinicians and/or the Coroner as sufficient that
15 a postmortem was required. And that all served to
16 present what was a confusing picture that we felt
17 required clarification and this was what we were
18 endeavouring to do.

19 **MS LANGDALE:** Thank you. I think that is a time
20 for a break, Mr Harvey.

21 My Lady, may I raise that, unusually at this stage,
22 Mr Skelton will be asking questions after the break with
23 my Lady's permission because he's unable to be here in
24 person tomorrow to ask them. Everybody is aware of that
25 and content with it to be taken out of turn, if my Lady

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1 is?
2 **LADY JUSTICE THIRLWALL:** Very well. Then you will
3 continue tomorrow morning?

4 **MS LANGDALE:** Then I will continue Friday, Friday
5 morning.

6 **LADY JUSTICE THIRLWALL:** Yes, okay. So we will
7 take a break and we will come back at 4.10.

8 (3.53 pm)

9 (A short break)

10 (4.10 pm)

11 Questions by MR SKELTON

12 **LADY JUSTICE THIRLWALL:** Mr Skelton.

13 **MR SKELTON:** My Lady, thank you for allowing me to
14 interpose this evening.

15 Mr Harvey, I represent some of the families in this
16 Inquiry, including the family of Baby A, whose Inquest
17 I am going to ask you about first, if I may, please.

18 I am going to just quickly resummarise the
19 background to his Inquest because it's important that we
20 have that settled, and you will correct me if I get any
21 of this wrong, please.

22 He died, as you know, on 8 June 2015 and the
23 Coroner was informed early on, as is standard practice
24 for an unexpected death. A Datix was completed, the
25 next day, Dr Sara Brigham conducted an obstetric review

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1 that may have contributed to his death, which, of
2 course, proved to be wrong but it understandably upset
3 her. He left that possibility open at the time.

4 She wasn't, as you know, told about the cluster of
5 deaths that had occurred, two other children around that
6 period of time, and she wasn't told about the rash. The
7 postmortem then occurs many months later in -- it was
8 conducted, in fact, sorry, in June but not reported on
9 until December, and the cause of death was
10 unascertained. All of that, I think, is uncontroversial
11 and all of that, I think, is squarely within your
12 knowledge, correct?

13 **A.** Yes.

14 **Q.** After the deaths of the two Triplets, there
15 are a series of meetings, which I will come back to, and
16 Ms Langdale has also asked you about them to some
17 extent, on 29 and 30 June. There is also an action
18 planning meeting, which I don't think you did attend but
19 that's just within the neonatal unit and it involved HR
20 and the nursing staff, in which Child A's Inquest was
21 mentioned; were you aware of that quite early on?

22 **A.** I wasn't, no.

23 **Q.** You were taken by Ms Langdale to a note which
24 recorded that by 3 August, so five weeks or so after you
25 had met the Consultants for the meetings you have

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1 but didn't find anything wrong with the obstetric care.
2 A Perinatal Mortality Meeting took place on 24 June,
3 which recognised that a long line had been inserted and
4 that, some time after that, the child had been apnoeic
5 and had a cardiac arrest from which, of course, he died,
6 but it was uncertain if there were connections between
7 those two events. By that stage, postmortem was awaited
8 but a preliminary report showed no macroscopic
9 abnormality. This is very early on and, as you know,
10 the final report wasn't available until many months
11 later.

12 Dr Brearey produced a short report on the child's
13 death but didn't identify any clinical condition that
14 had contributed to it and, of course, as you know, there
15 was no reference to the unusual rash, which was the
16 subject of later investigations. Dr Brearey's report is
17 quite important because it's dated quite early on, it is
18 1 July but, in fact, it is part of the Coroner, a year
19 later, I think as you are aware.

20 The same day, you may be aware that Dr Brearey
21 spoke to Mother A, and she was distraught, not only by
22 the child's death but by the fact that she didn't know
23 why he died and the doctors couldn't provide
24 an explanation for it and, as you probably also know,
25 there was some concern that she had a medical condition

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1 discussed, a decision was made that you and Alison Kelly
2 would review the statements ahead of the Inquest,
3 correct?

4 **A.** That is what the notes stated, yes.

5 **Q.** Now, as I understand your evidence in your
6 statement, you say:

7 "I would usually be informed about upcoming
8 Inquests by Stephen Cross but would rarely have any
9 direct involvement."

10 So this was an unusual form of involvement?

11 **A.** It was, yes.

12 **Q.** Can I just put two possible explanations to
13 you, and I would like to understand if one is correct or
14 there is another explanation. One is that you wanted to
15 ensure that the statements that were produced for
16 Mr Rheinberg were open and transparent about the
17 concerns that were going on in the hospital about the
18 child's death, which, by that stage, were squarely
19 involving the fact that he may have been deliberately
20 killed? (2) is you wanted the opposite of that, you
21 wanted to stop that information from getting to the
22 Coroner so that the Inquest proceeded on an incomplete
23 basis. Can you identify which one of those it was or
24 was there an alternative explanation?

25 **A.** I can't recall seeing those statements but

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1 I could absolutely refute any allegation that we would
2 deliberately hide any information from the Coroner or
3 suggest to others that they should not give full and
4 frank evidence to the Coroner.

5 **Q.** Well, what is your explanation then for
6 reviewing the statements?

7 **A.** I can only imagine that, for some reason,
8 Mr Cross felt that he needed us to -- to review them.
9 I -- without recalling exactly what was in those
10 statements, I can't say. I just cannot recall seeing
11 those statements and, until the Inquiry made those notes
12 available, I wasn't even aware that those statements
13 were supposed to be made available to us.

14 **Q.** Well, without going to all the statements,
15 just taking the two statements from Dr Saladi and
16 Dr Jayaram, neither of them mention the suspicions that
17 they had previously raised to you in June about Baby A's
18 death, neither of them mention that. They are
19 straightforward Inquest statements which factually go
20 through their involvement with the child's care and his
21 unfortunate demise. So the obvious concern would be
22 that you were aware of those statements and you were
23 aware that they were incomplete and therefore that the
24 Coroner was going to be misled?

25 **A.** I don't recall being aware of those

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1 why did he do it?

2 **A.** From what I can see, and as I read it, it's
3 for information, in that he is telling me that Stephen
4 is speaking with counsel about disclosure and that they
5 would keep me informed of any developments.

6 There isn't anything within that that suggests that
7 they actually wanted me to undertake any action.

8 **Q.** Why do you need to know this information
9 though?

10 **A.** To be honest, I don't recall seeing this email
11 and why they felt the need for me to be informed, I am
12 not clear. I don't recall ever having a conversation
13 with Stephen Cross about any detail with regard to the
14 Inquest and, I'm sorry but, I -- I am unable to answer
15 that question in detail.

16 **Q.** There is a pre-Inquest meeting with counsel
17 and then with some of the witnesses on 8 September 2016,
18 at which Mr Swash is present, it is INQ0108406. If we
19 go to the third page, please. You have seen this,
20 I think, Mr Harvey in preparation for this evidence,
21 haven't you? So just the top section.

22 It appears that at the meeting -- and you can infer
23 this from Mr Swash's correspondence that, before the
24 substantive meeting with the doctors, the witnesses,
25 Mr Swash had a conversation with Mr Browne, counsel,

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1 statements. I certainly didn't give any advice with
2 regard to amendment or altering of any statements that
3 were to go to the Coroner, nor did I suggest to any
4 party that their statement should be altered.

5 **Q.** Can I ask just to have on screen INQ0052593,
6 please. Now, these are some emails from Josh Swash, who
7 I think you know, is that right, from the Trust?

8 **A.** I think we were involved in meetings together,
9 yes.

10 **Q.** He's emailing you on 27 September, so shortly
11 before the Inquest, saying:

12 "Stephen Cross has asked me to forward this email
13 to you which I have today sent to counsel regarding the
14 above inquest and you will note that the nurse has
15 recently been moved out of the neonatal unit was
16 involved in the care of baby Child A. You will also
17 note that Stephen is going to speak with counsel about
18 disclosure to the Coroner on this matter. We will keep
19 you informed of any developments."

20 Why was Mr Swash, who is from the Legal Services
21 Department, emailing you about Lucy Letby and Child A?

22 **A.** I could only imagine that it was because he
23 had been instructed to by Stephen Cross.

24 **Q.** Yes. Well, that's the, as it were, managerial
25 reason why he might have done it. But, substantively,

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1 who's giving evidence next week, about Lucy Letby, and
2 the question posed there is:

3 "Was nurse involved in Child A's case?"

4 Also why Child A's death fits into the sequence.

5 Then there is a question posed, "Sequence?", and it's to
6 do with "Nurse" underneath, then "L", who I think must
7 be Mr Browne, that is Louis Browne:

8 "If yes, disclose to family, plus spike in deaths,
9 not just nurse, equals disclosure."

10 So it appears from that that Mr Browne, counsel,
11 was being told about the association with the nurse,
12 potentially in respect of Child A and had advised, if
13 there was an association that needed to be checked, it
14 needed to be disclosed to his family and, likewise, in
15 respect of the spike in deaths and not just in respect
16 of the nurse, that needed to be disclosed to the family
17 as well. Does that make sense to you from that note?

18 **A.** From that note, yes.

19 **Q.** Is that something you would have been happy to
20 have been disclosed to the family?

21 **A.** It is something that would have been
22 appropriate to be disclosed to the family, yes.

23 **Q.** So your evidence today is that would you not
24 have encouraged that to have been suppressed, this
25 information: you would have been happy for the family to

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1 know that there had been a potential association with
2 a single nurse and the child's death?

3 **A.** I think that, if that was the advice that was
4 coming, if that was from counsel, it would be difficult
5 to disagree with that advice.

6 **Q.** If we go down to page 6, please, this is
7 a sort of follow up note that Mr Swash makes. Sorry,
8 page 7, I'm sorry, the next page.

9 There we see a large sort of arrow, and it says:
10 "Check through medical notes re was nurse involved
11 in [case], Lucy Letby."

12 **LADY JUSTICE THIRLWALL:** Is it "case" or "care"?

13 **MR SKELTON:** "Care", I'm sorry, my Lady. "Care",
14 it does say "care":

15 "Plus SBC to feedback re review from neonates."

16 Then in red, with another arrow from Lucy Letby,
17 someone has obviously checked, it may be Mr Swash
18 himself, "Yes, nursing notes", and there are two
19 episodes of where she appears to be involved.

20 So, on the face of it, some research has been done,
21 a check's been made, Lucy Letby has been confirmed as
22 a nurse involved with Child A's care, and that's been
23 noted in this record.

24 Now, as far as Child A's family are concerned, this
25 information was never passed to them. That really

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1 Coroner or the family?

2 **A.** I -- I would not have given that sort of
3 specific instruction not to disclose or to obscure
4 evidence.

5 **Q.** Did you have any involvement in assisting the
6 evidence or the preparation for the Consultants giving
7 evidence to the Inquest?

8 **A.** I don't recall assisting them in the
9 preparation, no.

10 **Q.** Did you speak to Mr Cross about the
11 preparation for the Inquest and the concern that the two
12 Consultants, Dr Jayaram or Dr Saladi might tell the
13 Coroner that they were concerned Lucy Letby had murdered
14 Child A?

15 **A.** No.

16 **Q.** You are aware that they both gave evidence
17 and, when Dr Jayaram was asked directly by the Coroner
18 what he thought the cause of death was, he was unable to
19 give an explanation. He alluded cryptically to the fact
20 that there were concerns but he did not say, in terms,
21 that he suspected Child A had been killed; are you aware
22 of that?

23 **A.** I am aware that was his evidence, yes.

24 **Q.** You are aware that he accepted that was wrong
25 and he should have said that?

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1 shouldn't have happened, should it?

2 **A.** Based on the advice of counsel and the duty of
3 candour, no, that shouldn't have happened.

4 **Q.** Thank you. So far as your involvement is
5 concerned, is it right that you had any contact with
6 Mr Browne during this period of time, directly?

7 **A.** I don't recall having any contact with
8 Mr Browne.

9 **Q.** Did you have any contact with Mr Cross about
10 it, in respect of advising about whether to disclose to
11 the family Lucy Letby's involvement in Baby A's care?

12 **A.** I didn't have any contact with Mr Cross with
13 regard to a conversation about disclosure.

14 **Q.** So your evidence today is you had no
15 involvement with the decision not to disclose this
16 information to Child A's family?

17 **A.** I have absolutely no recollection of that sort
18 of conversation, no.

19 **Q.** Is it your evidence that you had no
20 involvement in the decision not to disclose those pieces
21 of information to Mr Rheinberg?

22 **A.** I do not recall any conversation with regard
23 to the disclosure with Mr Rheinberg either, no.

24 **Q.** Or any instruction, internally, to anyone at
25 the Trust not to disclose that information to either the

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1 **A.** I understand that's what he said, yes.

2 **Q.** Well, do you accept that?

3 **A.** Sorry?

4 **Q.** Do you accept that it was wrong?

5 **A.** Yes.

6 **Q.** This is a catastrophic failure to be open and
7 transparent with a judicial process, isn't it, a process
8 which is designed to find out if people have been
9 improperly killed or treated or murdered?

10 **A.** It's to give incomplete or false evidence
11 under oath, yes.

12 **Q.** Well, not just that. This child had died in
13 your hospital?

14 **A.** Yes.

15 **Q.** The Consultants who treated the child thought
16 he had been murdered, at least that was a very real
17 possibility in their mind, they gave in evidence
18 a courtroom which did not explain that to the Coroner
19 and the Inquest concluded without ascertaining the
20 child's death?

21 **A.** That would be inappropriate.

22 **Q.** You were aware of that?

23 **A.** I was aware of?

24 **Q.** The conclusion.

25 **A.** I was, in terms of unascertained, yes.

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1 Q. Well, if you know that the two doctors who
2 gave evidence thought the child had been murdered and
3 you are aware that the Coronial process proceeds to its
4 fruition, concludes, can't be re-opened without the
5 court's approval, and the conclusion was that the death
6 was unascertained, then wasn't it your duty to correct
7 the Coroner?

8 A. I don't -- I wasn't aware that it was their
9 view that the baby had been murdered.

10 Q. It wasn't your view; you weren't aware of
11 that?

12 A. No.

13 Q. I will come back to that.

14 So, as far as you were concerned, you viewed the
15 Coronial process as having been appropriately concluded
16 and, although you were aware that Lucy Letby was
17 suspected of having murdered patients, including
18 Child A, you didn't alert the Coroner to that fact?

19 A. I trusted my colleagues. I -- I incorrectly
20 assumed, based on this evidence, that the appropriate
21 evidence had been given and had been considered. I do
22 not recall having full access or any access to the
23 statements and reviewing them. As I have already said,
24 I don't recall the contact from Mr Swash or the comments
25 about reviewing the statements or indeed reviewing them.

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1 by way of explaining why the paediatricians had written
2 that letter and why we were passing it on to the
3 Coroner, we did inform him that one of their concerns
4 leading to this was an association with a member of
5 staff.

6 Q. Well, Mr Harvey there is no note that
7 Mr Rheinberg has made, no note that Mr Moore has made,
8 no note that you have made, no note that Mr Cross has
9 made that that information was ever passed to either
10 Mr Moore or Mr Rheinberg?

11 A. Well, I am confident that that was because the
12 nature of the letter that we passed across would have
13 been inexplicable without the covering explanation.

14 Q. Well, the letter says the reports -- they say
15 the reports they have received have not reassured them
16 that the deaths and collapses are explicable by natural
17 causes, so you may infer from that there is still some
18 suspicion about an unnatural cause but they certainly
19 don't say, "We are concerned that a member of staff has
20 killed these babies".

21 A. No, they don't but, because of that and by way
22 of explanation of that concern, I recall that
23 Mr Rheinberg and Mr Moore were informed that there was
24 that concern about an association about a member of
25 staff.

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1 I accept that we failed in the duty of contributing
2 to the Inquiry.

3 But I did nothing to obscure or withhold any
4 evidence.

5 Q. Well, you met the Coroner, didn't you, I think
6 in 2017, so 8 February, you and Mr Cross went to see
7 him?

8 A. Yes.

9 Q. The note that Mr Cross made says that you said
10 to the Coroner:

11 "No theme has emerged from the in-depth
12 investigations."

13 Do you recall saying that? You had conducted by
14 this stage a series of investigations, I will come back
15 to exactly what they were, but of course it's the Royal
16 College, Dr Hawdon, Dr McPartland --

17 A. Yes.

18 Q. -- and no theme had emerged?

19 A. We said -- I said that but in -- I am trying
20 to remember which -- in one of the meetings that we had
21 with Mr Rheinberg and Mr Moore, we passed over a letter
22 that we had had from, or Tony Chambers had had, from the
23 paediatricians requesting that we discuss with the
24 Coroner reopening or further investigation and, as part
25 of the conversation around passing that letter over and

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1 Q. Which meeting and who said it?

2 A. I am unable to -- it was the meeting where we
3 met with them to give them the letter.

4 Q. Well, you met them again, I think, on
5 15 February and, in your statement, you describe
6 discussing the increased mortality rates and the fact
7 that the paediatricians had raised concerns, this is
8 paragraph 651. But that isn't in Mr Cross' note and it
9 isn't in Mr Rheinberg's note. I think you will
10 understand, having prepared for this evidence today,
11 that Mr Rheinberg denies being given that information in
12 the most strong terms. So I am going to put to you that
13 you never said it.

14 A. Well, I would suggest that I did because the
15 letter would require that explanation to go with it. In
16 addition, I think the timely subsequent meeting notes
17 where I am reporting to colleagues indicates, based on
18 my recollection at that time, that I had, and I am
19 confident that I would have given him all that
20 information because we were at that level of concern,
21 with the paediatricians having presented and written
22 that letter, that we needed to raise the basis for it.

23 Q. But you are also aware that the Coroner is
24 a judicial officer and they are intricately connected to
25 the criminal justice systems as well as their own

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1 Coronial system?

2 **A.** Yes.

3 **Q.** If a Coroner is told that a paediatrician
4 suspects a child has been killed or, in this case,
5 a series of children have been killed, they must act;
6 you are aware of that: they can't sit on that
7 information, they have to act. They have to trigger
8 a whole series of investigative processes. If they are
9 investigating the child's death, they need to do so with
10 that information in mind. If they have already
11 investigated, they need to inform the police and, in any
12 event, some contact with the police needed to be had
13 because a crime is suspected; you are aware of that,
14 aren't you?

15 **A.** I am, and I can't explain why, if that is the
16 case, Mr Rheinberg didn't trigger it. But I am
17 confident that I informed, along with that letter, that
18 the paediatricians had reported an association with
19 a member of the nursing staff? You certainly should
20 have given him that information, shouldn't you?

21 **A.** Yes.

22 **Q.** Can I go back to June 2016, please. You had
23 the meeting on the 29th with Alison Kelly, Tony Chambers
24 and the Consultants, where Dr Jayaram and Dr Saladi were
25 present, and Dr Jayaram had raised concerns about Letby

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1 speculating about air embolism. There is a discussion
2 with Dr Saladi about mottling and rashes with both of
3 the Twins. When it came to thinking about the Inquest
4 of Child A did you remember that information, that
5 conversation you had just a few weeks before?

6 **A.** No.

7 **Q.** You should have done, shouldn't you, because
8 that is information that's relevant to their deaths --
9 sorry Child A's death?

10 **A.** Potentially, yes. I would simply say that
11 this was, as you would imagine, a long and intensive
12 meeting and, if I failed to recall all the detail, then
13 I apologise.

14 **Q.** The next day you had another meeting with some
15 of the doctors again and this time we know Jim McCormack
16 was there and others, and Ravi Jayaram again, and again
17 he mentions air embolism, as you know, in that meeting
18 on the 30th, and talks about the concern about the
19 member of staff, in other words Lucy Letby,
20 resuscitation problems again, happening once or twice
21 but it was happening too many times. Then he says it
22 causes suspicion. So it was very much in play at that
23 meeting, wasn't it, and it's a long meeting, with lots
24 of people wading in with their opinions but it is clear
25 from their perspective they're talking about "suspicion"

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1 always being present, in charge, the babies being stable
2 and deteriorating and they didn't respond to
3 resuscitation as they should. So all information which
4 for them were red flags about something unusual going on
5 medically?

6 **A.** Yes.

7 **Q.** Dr Brearey said there was more than just
8 an association with the nurse and then Dr Jayaram
9 actually speculated, as Ms Langdale put to you earlier,
10 how the mechanism of death may have occurred with
11 cannulas and an air embolism; do you recall that?

12 **A.** I remember seeing the documents, yes.

13 **Q.** It's in the notes?

14 **A.** Yes.

15 **Q.** Dr Saladi talked at the same time, in that
16 same conversation -- I can take you to the page if you
17 want to look at the notes again -- about the Twins,
18 Child A and Child B specifically, and mentioning one of
19 them being mottled and then both of them having
20 mottling, so realising more was going on; do you
21 remember that?

22 **A.** I don't recall that but I would accept that
23 that was said.

24 **Q.** You said before about not knowing about
25 Child A but there's a discussion with Dr Jayaram

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1 about Lucy Letby: the word is used?

2 **A.** Yes.

3 **Q.** You gradually coalesce on a plan, and can
4 I just put to you what the thinking was and see if you
5 agree? If necessary, I can go to the notes because
6 Ms Hodgkinson's note is very detailed about this.
7 Mr Chambers considered it to be a hypothesis that the
8 children had been killed by Lucy Letby and he wanted to
9 test that hypothesis, and the options he put were "null"
10 or nothing, "call the police" or "undertake some form of
11 review"; does that make sense to you?

12 **A.** Yes.

13 **Q.** I think what you opted for was the review
14 option, which, in fact, you had already put in train by
15 that point?

16 **A.** Yes.

17 **Q.** Because you had contacted with Sue Eardley by
18 email and I think you had spoken to her on the
19 telephone?

20 **A.** I had had a provisional to assess the
21 feasibility, yes, because -- yes, because if the College
22 had said, "Well, that isn't reasonable, it's not
23 appropriate", then that wasn't going to be an option.

24 **Q.** Well, I think you had emailed her, hadn't you,
25 and then she had responded and then you had a phone call

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1 with her?

2 **A.** Yes.

3 **Q.** I don't think there are notes of that phone
4 call, are there?

5 **A.** No.

6 **Q.** But what we understand is that -- we can infer
7 it was the phone call at which you did mention what
8 needed to be done, a review of the unit, but you also
9 mentioned the concerns about the nurse; is that correct?

10 **A.** I, in one of my phone calls with Sue Eardley,
11 mention the concerns, yes.

12 **Q.** What exactly did you say?

13 **A.** I would have said that the paediatricians had
14 raised concerns about an association of one member of
15 staff. But that there was no other supportive evidence
16 to go with that; that her managers and colleagues felt
17 that it was related to her increased level of duty and
18 that she was qualified in speciality. I probably
19 wouldn't have been any more specific than that.

20 **Q.** So, in your head, when you were thinking about
21 the Consultants' suspicions were you treating it as
22 a hypothesis that needed to be tested?

23 **A.** I was keen that we could establish what was --
24 what was the cause or causes of the increased mortality.
25 That based on what are the usual, what are the common,

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1 police. The only option at that point is at least to
2 get the police involved, whether it proceeds to
3 an investigation or not, they needed to be informed as
4 soon as you are discussing murder: it's completely
5 outside of your expertise?

6 **A.** I think, as I gave in evidence earlier on
7 today, one of my regrets is that having, along with
8 Alison Kelly, come to the view that we should contact
9 the police in June/July, that -- that we didn't. As
10 I also stated, I am not convinced that the police would,
11 based on the conversations we had with them nearly
12 a year later, have undertaken an investigation, but
13 I fully accept that they would have had oversight and
14 they would have been able to advise with regard to the
15 nature of the reviews and have stepped in at the first
16 sign of anything untoward.

17 **Q.** And protected patients because they would --
18 if the whole process, the cascade had been triggered,
19 Lucy Letby wouldn't have just been on leave, she would
20 have been suspended, without at that point blame, but
21 while an investigation took place, the LADO would have
22 been spoken to, and decisions would have been made about
23 the appropriate type of investigation that was required
24 to exclude the possibility of deliberate harm?

25 **A.** Potentially, yes.

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1 but not ruling out more extreme, such as gross
2 negligence.

3 **Q.** Do you recognise that it wasn't just
4 a hypothesis, it was a risk; did you conceptualise it as
5 such and recognise that?

6 **A.** My understanding was that Letby was on leave
7 and, from that perspective, that particular aspect of
8 a potential risk had been removed.

9 **Q.** But there was, of course, the risk she would
10 return to the unit, or somewhere else in the Trust, or
11 seek employment elsewhere, over which you, of course,
12 had no control; that was a risk wasn't it?

13 **A.** At that time, that might have been a risk but
14 I think, as the notes of the meeting indicate, it was to
15 give us time really to assess what the situation was and
16 to decide and of course, as we know, she never did
17 return to the unit.

18 **Q.** Just looking at the notes of that meeting, do
19 you now see how an intervention was needed, a clear-eyed
20 intervention was needed that, if you are in a room with
21 some paediatricians discussing whether one of their
22 members of staff has killed their babies, and
23 speculating about Beverley Allitt, Harold Shipman,
24 mechanisms of murder about which they have no
25 professional expertise, that you need to call the

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1 **Q.** You presumably had no experience of patients
2 being deliberately harmed by members of staff before
3 then?

4 **A.** Before this, no.

5 **Q.** Just some obvious propositions: patients in
6 hospital are vulnerable; they spend periods of time
7 asleep or comatose; medical staff have access to their
8 bodies, which, of course, doesn't occur in the ordinary
9 community; there are cannulas inserted, injections
10 given, drugs given, and so on; staff have access to
11 lethal drugs. All of these circumstances make it
12 relatively easy for healthcare staff to harm patients
13 and relatively difficult for healthcare staff to be
14 detected when they do so. Does that all make sense to
15 you?

16 **A.** It does. But -- but I feel that I have to
17 point out that, actually, we had three opportunities
18 that were missed where there was clear evidence of harm,
19 that we weren't fortunate enough to have been informed
20 about.

21 **Q.** Yes, and you are talking about the insulin
22 results, for example, in Child K with Dr Jayaram?

23 **A.** I am talking about Child F, Child K and
24 Child L.

25 **Q.** Yes. I am sure that either Ms Langdale or

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1 your own counsel will ask you about that but I just want
2 it focus on those basic principles.

3 It's relatively easy to harm a patient given their
4 vulnerabilities and given the access to the types of
5 drawings that you have in hospital and it can be quite
6 difficult to detect that because a drug overdose and
7 injection can occur innocently, routinely?

8 **A.** I'm not sure about routinely, but yes. But
9 I would simply say that we missed those or those
10 opportunities were missed. We had them.

11 **Q.** Are you aware of how murders are investigated?

12 **A.** In real life, no.

13 **Q.** Do you know what a forensic pathologist does?

14 **A.** I can surmise, yes.

15 **Q.** Well, they are qualified as pathologist but
16 they have got a specialist skill in investigating and
17 excluding crimes, and the reason it is a specialist area
18 is because it's difficult to identify crimes and there
19 are particular types of investigations that are done,
20 particular checks on the body, particular investigations
21 which they conduct, which ordinary pathologists don't;
22 you are aware of that?

23 **A.** Yes.

24 **Q.** Are you also aware that, in order to do those
25 investigations, they require a history, they require

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1 be reviewing the individual cases. Given that they were
2 being commissioned on the basis that we were concerned
3 about an increased mortality, I found it difficult to
4 imagine that they wouldn't be reviewing those cases as
5 the basis of their review, and we had prepared all the
6 documentation for them to do that to be told, "Well, no
7 actually that's not part of it".

8 So that the review that they did, no, wasn't in
9 a position to fulfil that brief, hence the subsequent
10 Jane Hawdon review.

11 **Q.** Yes, so to be clear, it wasn't in a position
12 to understand why the children had died because it
13 wasn't incorporating a Casenote Review --

14 **A.** Yes.

15 **Q.** -- and it certainly wasn't in a position to
16 understand if they died as a result of a crime because
17 that is a step even further than a standard Casenote
18 Review, that requires a forensic consideration?

19 **A.** Potentially, I would say.

20 **Q.** Not potentially, that is exactly what is
21 required?

22 **A.** Well, I suppose it depends on the mechanism of
23 assault or death and the obvious example would be for
24 collapse in the case of Child F. The results were in
25 the notes. You know, we would have known that there was

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1 information. In other words, they are given
2 circumstances of how the body was found, who the person
3 was with, what might be a possible cause of the criminal
4 activity: that makes obvious sense you to?

5 **A.** Yes.

6 **Q.** Dr McCormack actually mentioned forensic
7 pathology in the meeting on the 30th because he was
8 concerned that the Royal College, which you were talking
9 about, weren't going to be able to do the kind of
10 investigation that was required. Again, looking back,
11 do you recognise that this required forensic pathology
12 in order to rule out a crime?

13 **A.** In retrospect, yes, that was an opportunity
14 missed.

15 **Q.** Just to be clear: the Royal College were
16 instructed and they did a service review. That, in
17 fact, not only didn't look at the medical notes but it
18 didn't examine whether a potential crime had taken
19 place, did it?

20 **A.** I -- in my statement, I think I have covered
21 this, insofar as, in commissioning the review, I got the
22 Terms of Reference or the Terms of Reference were
23 incomplete and I -- I got that wrong.

24 It should have been specific with regard to
25 a Casenote Review. I anticipated that the College would

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1 insulin, so that there was certain potential.

2 **Q.** They might have spotted something untoward
3 that could have been a crime, it is fair to say, but the
4 Royal College of Paediatrics and Child Health don't
5 investigate crimes, do they?

6 **A.** No.

7 **Q.** No.

8 **A.** But on the basis that I had alerted them to
9 a concern about one member of staff and the association
10 with her and the review going ahead, there seemed to be
11 an acceptance that that was a reasonable path to follow,
12 and I would point out that the paediatricians also,
13 I think, reviewed the Terms of Reference that we had
14 drawn up and felt that they were reasonable and
15 appropriate for what we were doing in that circumstance.

16 **Q.** Well, the Terms of Reference looked like they
17 considered everything.

18 **A.** Well, that that was the intention, yes.

19 **Q.** But, in fact, it is not a Casenote Review and
20 they didn't consider criminal activity, as you have
21 accepted?

22 **A.** It, it -- it didn't end up as a Casenote
23 Review, although I imagine that it was going to be
24 because I couldn't foresee how they could fulfil their
25 brief, based on the premise, without doing that.

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1 Q. But just to be clear, the report that was
2 produced as a result of that review could not be relied
3 on to exclude the possibility that the children had been
4 harmed?

5 A. No.

6 Q. The same really must apply to Dr Hawdon's
7 examination and Dr McPartland's examination, because
8 first of all, Dr Hawdon, in respect of five of the
9 deaths -- or four, and I am sure you will be asked about
10 why that may have changed -- couldn't find
11 an explanation. So, by definition, she hadn't found
12 a crime or excluded a crime. She was in the same
13 position, really, as Child A's pathologist was: it was
14 unascertained. So that had not excluded Lucy Letby
15 harming them?

16 A. No.

17 Q. Dr McPartland was not a forensic pathologist,
18 so she, by definition, couldn't investigate a crime and
19 exclude it definitively, although, as you have said, she
20 might have found some evidence that could incriminate?

21 A. Yes, and, as an example, I had
22 a conversation -- or exchanged emails or had
23 a conversation as well with regard to the possibility of
24 air embolus, that having been raised, and was informed
25 by her that she would fully expect that their postmortem

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1 the secondary reviewers, one doing a case review, the
2 second with specialist expertise on pathology and,
3 again, of course, you don't mention and couldn't have
4 mentioned that they hadn't excluded a crime because they
5 hadn't; is that correct?

6 A. Correct.

7 Q. During this meeting -- and I can take you to
8 the notes of the substantive meeting, I think you are
9 familiar with them but, for reference, it's
10 INQ0003237 -- Mr Chambers repeatedly dismissed the
11 concerns of the Consultants as being unsubstantiated.
12 Now, the reality was that they had not, in fact, been
13 directly investigated and excluded as possibilities.
14 You have already accepted that?

15 A. They had been excluded to the extent of the
16 reviews that we had carried out. I will accept that not
17 to the level of a forensic, yes.

18 Q. Well, the reviews had not looked for a crime
19 and they had not excluded a crime, had they?

20 A. The reviews hadn't been specifically
21 commissioned to look for a crime. But I suppose we had
22 anticipated that, in the event that there had been
23 a malicious act, that there would have been evidence
24 found in the course of those reviews.

25 Q. Well, you have a scientific background. If

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1 would have picked up the presence of an air embolus.

2 Q. Yes, but to be absolutely clear, she was not
3 a forensic pathologist --

4 A. No.

5 Q. -- and she was not briefed to investigate
6 criminal activity?

7 A. No, she was a specialist paediatric neonatal
8 pathologist.

9 Q. So as all these investigations are being
10 pursued throughout the course of 2016 and into 2017, the
11 upshot is that none of them, in fact, exclude the
12 possibility that had been raised on 29 and 30 June 2016
13 that Lucy Letby harmed the children: none of them?

14 A. No, which is why we ended up subsequently
15 going to the police.

16 Q. Well, I will come back to that. You presented
17 a paper to the board on 10 January 2017, INQ0003518,
18 it'll come up; do you remember this?

19 A. Yes.

20 Q. You discussed the Royal College Review but you
21 don't make clear that it hadn't addressed the
22 Consultants' concerns, correct?

23 A. Correct.

24 Q. You also, without naming them, I think,
25 mentioned Dr Hawdon and Dr McPartland because they are

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1 you have a hypothesis that needs testing, you have to
2 direct your research to that hypothesis. The hypothesis
3 was: Lucy Letby has murdered or killed these children
4 through mechanism unknown, investigate it, please.

5 Royal College, Dr Hawdon, Dr McPartland, or some
6 other person, needed to actually investigate that
7 directly, didn't they?

8 A. I don't think the time that these were
9 commissioned we were in a position to say that this is
10 suspected murder.

11 Q. Well, you were because that was actually
12 mentioned explicitly -- the word "murder" is never used
13 but the suspicion of deliberate harm is absolutely clear
14 from the notes that you had been taken to on the 29th
15 and the 30th?

16 A. And it was the anticipation that there would
17 have been findings within the definitive note reviews to
18 highlight.

19 Q. Well, they may have found something, as you
20 say. In fact, if they had looked at the insulin results
21 for particular children on a Casenote Review, it might
22 have been possible, for those two children, a Casenote
23 Review might have found that abnormal result; that is
24 fair, isn't it?

25 A. Well, I would suggest that that wasn't

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1 a might, that would have been a definite.
 2 **Q.** That they would have found it --
 3 **A.** Yes.
 4 **Q.** -- if a Casenote Review had been undertaken?
 5 **A.** Yes, because having -- as part of the
 6 preparation for this Inquiry, I have had the opportunity
 7 to -- to look at the case notes myself and those results
 8 are clearly documented actually within the written note.
 9 They are not, as sometimes happens, within the results
 10 section, where things can fall out.
 11 **Q.** But the reality is that the investigations
 12 that you commissioned, as you have accepted, although
 13 they might have found evidence to support criminal
 14 activity were not designed and aimed to find it?
 15 **A.** I would accept that.
 16 **Q.** So when you attend the board and present your
 17 paper, you are reassuring them that proper
 18 investigations have taken place and that, as a result of
 19 those investigations, Mr Chambers is allowed to say to
 20 the board, in front of you, without correction, that the
 21 allegations against the nurse are unsubstantiated.
 22 And you would go even further, collectively as an
 23 Executive, and advise them that Lucy Letby should be
 24 supported in her return to the unit.
 25 That's completely unacceptable, isn't it?
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1 incomprehensive. That is with the benefit of knowing
 2 how things came out.
 3 But this was a series of investigations, a series
 4 of reviews and a statement that was made in good faith
 5 at that time.
 6 **Q.** Mr Harvey, I'm struggling to understand the
 7 logic of your answers. You have accepted, as I have
 8 taken you through them, that the Royal College Review,
 9 Dr Hawdon's review, Dr McPartland's review did not
 10 exclude a crime on the part of -- crimes committed on
 11 the part of Lucy Letby.
 12 In this meeting it is being presented that there is
 13 no substantive evidence to that allegation and it is
 14 being recommended that she go back to the unit on that
 15 basis. That was wrong as an assertion and it was
 16 dangerous and irresponsible. The logic of that is
 17 impossible to disagree with.
 18 **A.** I'm sorry. I'm sorry --
 19 **Q.** Do you want me to take you through it again?
 20 **A.** Well, no. I'm sorry, I apologise. I didn't
 21 hear a question.
 22 **Q.** You had investigated, using the Royal College,
 23 Dr Hawdon, Dr McPartland whether or not there may have
 24 been some medical cause for these children's deaths.
 25 They had not identified a definitive theme, but none of
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1 **A.** I would only say that that was the view based
 2 on the evidence that we had at that time.
 3 **Q.** It wasn't --
 4 **A.** -- with -- on retrospect, yes.
 5 And as, you know, I -- I have now repeatedly said
 6 I regret that we didn't contact the police
 7 in June/July 2016.
 8 **Q.** Just focusing on that. It doesn't require
 9 retrospect. You were in a meeting, advising the most
 10 senior people in your Trust to support you putting
 11 someone back in the unit who had not been investigated
 12 for potential crimes. That is an extraordinary failure
 13 on your part, do you accept that?
 14 **A.** I believe that I was making these statements
 15 in good faith, based on the evidence that I had
 16 available to me at that time.
 17 **Q.** What evidence did you have that Lucy Letby had
 18 not killed those children?
 19 **A.** It was the fact that nothing had been
 20 specifically raised in the course of the College review,
 21 Dr Hawdon's review, in discussing with Dr McPartland,
 22 with regard to the previous postmortems, that some of
 23 the babies had had.
 24 **Q.** Well --
 25 **A.** I accept, with retrospect, that that is
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1 those investigations, as you have accepted, excluded the
 2 possibility that Lucy Letby had killed the children;
 3 you've accepted that already.
 4 **A.** I accept that they didn't go to the level of
 5 a forensic investigation and, in hindsight, that was
 6 incorrect.
 7 **Q.** They did not exclude a crime.
 8 **A.** They certainly didn't highlight one. I can't
 9 say that they excluded.
 10 **Q.** They did not exclude a crime, did they?
 11 Any of those reviews did not exclude the
 12 possibility the children had been killed deliberately?
 13 **A.** Nor did they actually bring anything out to
 14 suggest that there had been any malicious act in, in any
 15 of those.
 16 **Q.** Well, in those circumstances, finally, I put
 17 to you that it was irresponsible and dangerous to return
 18 Lucy Letby to the unit because you could not be
 19 confident, as the Medical Director of the hospital
 20 responsible for patient safety at the Countess of
 21 Chester, that Lucy Letby would not harm children again?
 22 **A.** I would have to accept that, with retrospect,
 23 yes, it would have been a risk -- well, more than a risk
 24 for her to have gone back on to the unit.
 25 **Q.** One which should never have been countenanced?
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1 A. Looking at this no.
 2 **MR SKELTON:** Thank you. Thank you, my Lady.
 3 **LADY JUSTICE THIRLWALL:** Thank you very much,
 4 Mr Skelton. Mr Harvey, we are going to adjourn now
 5 until tomorrow morning at 10 o'clock.
 6 A. Yes, my Lady.
 7 **LADY JUSTICE THIRLWALL:** So 10 o'clock tomorrow.
 8 (5.02 pm)
 9 (The Inquiry adjourned until 10.00 am,
 10 on Friday, 29 November 2024)

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