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

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.

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

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.

A. -- in mortality.

Q. Forgive me for interrupting you, that isn't the question I asked. The question I asked is: does the Speak Out Safely policy regard complaints or concerns raised in good faith as protected disclosures and that the individual raising those disclosures should not be the subject of recriminations as a consequence?

A. That's what the policy says.

Q. Now, if we go back, please, to page 2 of the policy, and to the penultimate paragraph:

"All concerns raised by staff about patient care will be dealt with seriously, promptly and be subject to a thorough and impartial investigation where necessary. Managers have a particular responsibility to protect patients and to handle concerns about their care in a way that will encourage the voicing of genuine misgivings, while at the same time protecting staff against unfounded allegations. No recriminations will follow reports which are made in good faith about standards of care or possible abuses. All staff must comply with the Trust values and put the patients at the heart of everything they do."

Does that incorporate you as well, "all staff"?

A. All staff, yes.

Q. The policy requires or encourages members of

staff to raise concerns:

"If staff are uncertain about whether or not to express a concern, it is normally better for them to voice this rather than to remain silent. Often discussing an issue normally with their immediate manager will provide an opportunity to view the matter from a different perspective. From there it can go forward and be dealt with if necessary. Delay in expressing concern could lead to recurrence and/or make investigations more difficult."

The Speak Out Safely policy is pivotal to patient safety, isn't it?

A. Agreed, yes.

Q. Because members of staff are the eyes and ears of the organisation and they are the ones who are often best placed to bring to the attention of management serious safety issues?

A. That's absolutely right yes.

Q. In acting in good faith, as you agree they were, these Consultants were doing exactly what they were supposed to do, weren't they?

A. Absolutely and we, we acknowledged that at the time and all the way through these inquiries.

Q. Did you? Can we go, please, to a note, you have seen it already, it's INQ0015642 and page 48. It's

a note you know from 12 May 2017, timed at 11.45 am. I would like you to remember the time, it's important?

LADY JUSTICE THIRLWALL: 2014.

MR BAKER: 20 --

LADY JUSTICE THIRLWALL: What is the date on it? 2017?

MR BAKER: 2017, my Lady, yes. Timed at 11.45 am and it's an important note. It's a note of a conversation you had in the hospital I am assuming with Sue Hodkinson.

A. It would have been, yes.

Q. "RJ SB, Dr Jayaram and Dr Brearey plan re management, (1) GMC, (2) actions from grievance, (3) mitigation from SOS whistleblowing, (4) action plan to manage out."

Now, this is clearly a note, isn't it, of you setting out a plan to Sue Hodkinson that the Consultants would be referred to the GMC, and then managed out and that the reference to mitigation from Speak Out Safely or whistleblowing is written in because you knew that this would be contrary to the Speak Out Safely or whistleblowing policy; that is correct, isn't it?

A. I -- these are not my notes, these are from Susan Hodkinson's notebook. I would have never seen these notes and I don't remember any discussion around

mitigating Speak Out Safely or whistleblowing policies and I, to be honest, wouldn't have had the specific detail on that.

Q. Can we be clear about what you are saying.

Are you saying that Sue Hodkinson wrote this in her notebook because you didn't say it?

A. I -- the context to this meeting is really important. We discussed it yesterday. It was --

Q. No, no, we will come to context in a moment?

A. But I think it is critical --

Q. No, no, I promise you --

A. -- to understand the nature of the note.

Q. -- we will come to context in a moment. Can you answer my question, please?

Are you saying that this was written in the notebook and you didn't say it?

A. I don't remember saying it and the conversation with Ms Hodkinson was following a meeting that I had had with the police earlier that day at 9.00 am. This was a fortuitous one to one, it wasn't a planned meeting and, at that meeting with the police, I left that meeting unsure as to whether the escalation that we had taken to raise these matters to the police was going to result in a police investigation.

Q. Can I --

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

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

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

A. Sorry, what page is this?

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

LADY JUSTICE THIRLWALL: It's internal page 173.

MR BAKER: I am grateful, my Lady.

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

A. Thank you, thank you, my Lady.

MR BAKER: So at paragraph 629 you say:

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

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

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

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

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

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

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

Q. What you say at paragraph 629 is:

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

So it is clear when you wrote your witness

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

Q. These --
A. -- everything was pointing away from criminality.
Q. These are your words; do you accept that?
A. I -- that paragraph will represent the discussion that went on. I don't remember specifically the words that were used.
Q. Because you have suggested that people have a perhaps annoying habit of writing down things that you don't say, I want to be clear: you accept that these accurately record the words that you would have used in this meeting?
A. In that paragraph, this is page 6 of I'm not sure of how many notes.
Q. It begins "TC added", if we just take that paragraph in isolation.
A. I am happy to take that paragraph in isolation but the context to the paragraph is the third, fourth paragraph in the notes that -- that we have in front of us where it says:
"TC is satisfied that Cheshire Constabulary would determine whether or not there has been any criminal intent. COCH have maintained an open mind and would welcome an inquiry if necessary but this is never felt the issue."

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

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

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

MR BAKER: Thank you, my Lady.

Can I ask you then, again, something that will inevitably concern The Families: that you gave evidence that in March 2017 you were sat on the train to Leeds discussing the issues surrounding the Consultants with Tracy Bullock, another Chief Executive; do you recall giving that evidence?

A. I do, yes.

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

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

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

Q. You gave evidence about the context and

content of the conversation.

A. What I'm --

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

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

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

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

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

Q. Well --

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

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

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

A. Yes, I can see that.

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

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

Q. The --

A. I should have done better.

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

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

Q. Conscious of the time, my Lady.

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

A. That was absolutely my understanding.

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

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

"TC added through all of this ..."

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

page 4 but continues on to page 5, and the fourth item "QC", reference to Mr Medland:

"... purpose to involve was to help clinicians understand the difference between what they thought was criminal evidence and something that may not constitute as criminal evidence."

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

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

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

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

This is Simon Medland's notes. Paragraph 2:

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

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

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

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

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

the same as to what the purpose --

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

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

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

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

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

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

Questions by MS BLACKWELL

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

So we need to look with fresh eyes at some

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

LADY JUSTICE THIRLWALL: Of course, thank you.

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

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

A. For Planned Care, yes.

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

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

A. Sorry, can you repeat that?

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

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

Q. Yes.

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

Q. Yes.

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

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

"More than just an association with this nurse."

Dr Jayaram says:

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

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

A. Yes, it reflects it very well.

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

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

You go on to say:

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

What did you mean by that comment?

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

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

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

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

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

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

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

Q. Then finally, in this comment:

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

A. Yes.

Q. Those were your thoughts at this meeting?

A. Yes.

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

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

"TY to clinicians."

A. Yes, yes.

Q. What were you thanking them for?

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

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

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

A. Yes.

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

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

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

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

A. A reference to Beverley Allitt?

Q. Yes.

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

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

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

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

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

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

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

"By lunchtime tomorrow, protocol or plan."

So what were you attempting to do?

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

unit --

Q. Thank you.

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

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

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

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

A. Yes.

Q. You:

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

Then:

"Assurance in two weeks."

Then Dr Brearey, at the bottom of the page:

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

LADY JUSTICE THIRLWALL: "Re this individual".

MS BLACKWELL: I am so sorry, my Lady.

LADY JUSTICE THIRLWALL: "Concern re this individual."

MS BLACKWELL: "... concern re this individual. Not change my opinion. Spoke in May to AK and IH about his concerns."

Over the page, in the middle of the page,

Dr Jayaram:

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

Then you say:

"If the nurse is removed would deaths stop."

Dr Brearey says:

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

Do you remember that conversation?

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

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

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

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

facilitator."

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

"Equipment example. Incubator to EBMA."

Then Duncan Nichol:

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

Then your final comments:

"TY TC."

Is that you expressing thank yous?

A. Thank you, yes.

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

What was that sentiment you were expressing?

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

Q. Thank you, we can take that down, please. I would like to take you now to the notes of the meeting you had with Letby and her parents on 22 December 2016

at INQ0002913.

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

A. *(Nods)*

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

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

A. It will be, yes.

Q. Yes. You are asked by John Letby:

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

Mrs Letby says:

"Called Lucy an angel of death."

Lucy says:

"In public areas."

Sue Letby:

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

To which you said:

"It's not acceptable."

Letby said:

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

Her mother says:

"They have a personal grudge."

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

A. It was clear that it was.

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

A. It, it was something that was clearly as

a result of the outcome of the grievance process.

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

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

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

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

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

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

Dr Subhedar's response on 1 December is:

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

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

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

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

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

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

She says this:

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

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

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

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

A. I gave evidence yesterday on my reflections of this meeting and I remember the meeting being -- I needed to be clear and direct. I was very professional. I didn't raise my voice. I wasn't angry.

But it was an odd meeting because the -- the Consultants, as I think as been described here by -- by Rachel Hopwood, they didn't seem to be able to engage fully in the meeting and the reasons for that I think I explained in evidence yesterday.

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

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

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

JM, Julie Maddocks, says:

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

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

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

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

Stephen Brearey's response is:

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

Then you say:

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

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

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

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

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

Then, finally, please, at page 6:

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

Dr Jayaram says:

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

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

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

You say:

"You absolutely believe we have a criminal behaviour?"

To which Dr Jayaram says:

"We need to clarify it beyond reasonable doubt."

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

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

Your response:

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

A. Yes.

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

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

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

A. Yes.

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

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

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

A. That is correct.

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

Then a little further down:

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

Then further down still:

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

wrongdoing."

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

A. That that is my understanding.

Q. The bottom of the next page, please, page 5:

"Ian Harvey noted that the clinicians had their own separate session with the RCPCH Reviewers and in that they raised concerns about the individual. This was not in the RCPCH Terms of Reference as they considered this was an HR issue but the RCPCH did produce separate observations outside of the report in which they called out the paediatricians' concern. RCPCH stated that their allegations were based on nothing more than coincidence and ['gut feeling', I think that should be]. There was nothing definitive."

A. Correct.

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

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

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

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

Then you have been taken to the next paragraph. Following that:

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

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

Darren Martland at the bottom replied that:

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

The following page, please. Four paragraphs down:

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

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

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

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

Then the following page, please. Towards the bottom:

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

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

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

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

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

Thank you.

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

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

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

A. That's correct.

Q. Thank you.

A. I believed that.

MS BLACKWELL: Thank you very much.

My Lady, those are my questions.

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

Do you have any questions, Mr De La Poer?

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

LADY JUSTICE THIRLWALL: Yes, of course.

Further questions by MR DE LA POER

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

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

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

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

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

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

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

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

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

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

I would just like to bring that email up again. We will find that at INQ0103152. What I would like us just to focus upon is two different words, one is "unexpected", the other is "unascertained", all right? So what we can see is that Dr Subhedar is saying that:

"Unexpected collapses without a clear cause is well recognised in neonatal units and we have had a couple of cases recently. However, I cannot recall discussing any specific cases at network meetings where a baby has died suddenly and unexpectedly without a cause of death having been identified."

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

A. That is what the email says.

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

said?

A. Can you just repeat the question?

Q. Yes, of course.

A. Yes.

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

A. I think that's correct, yes.

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

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

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

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

A. Thank you, yes.

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

The passage that we were all focused on is:

"In one of the cases the cause of death is

unascertained, which is not uncommon."

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

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

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

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

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

A. I think that's fair.

Q. Do you agree that a natural reading of what

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

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

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

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

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

A. Possibly.

Q. Just as a matter of logic?

A. Possibly, yes.

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

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

Q. Well, thank you for answering my questions, there.

My Lady I have nothing more for Mr Chambers.

LADY JUSTICE THIRLWALL: Thank you.

Questions from LADY JUSTICE THIRLWALL

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

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

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

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

became a nurse in 1985.

A. A student nurse in 1985.

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

A. No, it wasn't.

LADY JUSTICE THIRLWALL: What was that in?

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

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

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

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

A. It was adult critical care.

LADY JUSTICE THIRLWALL: Adult critical care. Thank you.

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

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

A. Yes.

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

A. Yes.

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

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

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

A. Yes.

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

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

LADY JUSTICE THIRLWALL: Yes.

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

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

A. Yes.

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

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

LADY JUSTICE THIRLWALL: No.

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

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

LADY JUSTICE THIRLWALL: Yes.

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

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

A. Yes.

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

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

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

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

LADY JUSTICE THIRLWALL: Yes. No, I understand that.

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

A. I think that's correct.

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

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

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

A. Yes.

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

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

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

A. It must have been.

LADY JUSTICE THIRLWALL: Yes.

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

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

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

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

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

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

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

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

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

A. Yes, yes.

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

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

A. No, no.

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

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

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

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

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

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

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

LADY JUSTICE THIRLWALL: No, I understand that.

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

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

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

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

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

LADY JUSTICE THIRLWALL: Yes, thank you.

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

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

No, in that case. Thank you very much, Mr Chambers, you are free to go.

A. Thank you very much.

LADY JUSTICE THIRLWALL: We will rise now until 11.55.

(11.37 am)

(A short break)

(11.55 am)

LADY JUSTICE THIRLWALL: Ms Langdale?

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

MR IAN HARVEY (affirmed)

LADY JUSTICE THIRLWALL: Do sit down, Mr Harvey.

Questions by MS LANGDALE

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

A. It is.

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

A. I would, thank you.

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

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

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

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

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

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

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

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

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

A. I have.

Q. You tell us your qualifications, first of all. You attended Liverpool Medical School from 1976 and

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

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

Q. Sorry, I will move the microphone further.

A. Thank you.

Q. Is that better?

A. It is, thank you.

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

A. Predominantly, not exclusively.

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

A. That's correct.

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

A. No, I didn't.

Q. So your role was fully as the Medical

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

A. Pardon I missed had?

Q. How busy you were in the role.

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

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

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

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

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

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

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

A. That's correct.

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

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

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

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

The relationship with my other board members,

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

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

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

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

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

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

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

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

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

If we go to page, 9 we see at the top:
"The Medical Director supports the implementation of the risk management strategy and has the responsibility for all medical staff."
Two questions there, if I may: in what way did you support the implementation of the risk management strategy; and what was your responsibility for medical staff? What did that mean in practice, those two things?
A. Supporting the implementation I regard as contributing to the risk management meetings. I think we had an executive risk committee that met to review organisational risk. Also, in the lesser committee meetings, for example the quality, safety and patient experience, where we considered risk, to contribute to oversight of the risks that the divisions were reporting.
Responsibility for all medical staff, I -- I read as supporting and ensuring that medical staff were also contributing to this concept of risk management.
Q. If we go to page 14, please. We see the risk-scoring matrix. In terms of risk, Mr Harvey, the risk of babies being murdered, in terms of severity impacts, that would rank presumably as category catastrophic, would it, as number 5?

A. Yes.
Q. So how effective do you think the risk management system was at the hospital, at the time, for identifying the risk of babies being murdered?
A. I -- I think that the answer is probably not -- well, the answer is not, and I think the issue in terms of assessing risk with this sort of tool is that it relates to the common things.
I don't think -- and there are probably other extreme examples -- and they probably don't come any more extreme than the situation we are faced with, that this just isn't an efficient tool for ...
Q. As soon as the doctors raised suspicion, mere suspicion, and concern that a nurse was deliberately harming babies, there was a risk, wasn't there, of a nurse murdering and harming babies?
Now, whether that gets scored or how it gets scored, I am not going to ask you about that. We have heard some evidence about decision trees and all this process involves. But standing back, as someone with responsibility for risk, as soon as that suspicion was raised, and you knew the impact would be catastrophic were that risk to prove that it was fulfilled, did you never think to go outside of the scoring system, and rate this as a catastrophic risk that you needed to

address?
A. All I can say is that, when this was first raised, it was raised as there was an association of one member of staff. It was never raised as a -- something had been seen, something had been done. It was raised as "There is an increase in the number of deaths but we don't understand why".
Q. Murderers aren't always caught red handed, are they, Mr Harvey?
A. Pardon, sorry?
Q. Murderers aren't always caught red handed, are they? When you say there was nothing concrete, we see it later, or to substantiate concerns, we are looking at risk here, aren't we? You knew there was a risk and are you saying, because it wasn't concrete, anything that had been seen, you didn't classify it as such a risk?
A. No, I am saying that, in the way it was phrased, I -- I don't think anything of us perceived it as that sort of risk that would come to catastrophic.
Q. Let's see how it was placed on the Risk Register at INQ0004657, please. This is an entry made, 11 July 2016. To make clear for those who may not know the chronology after O and P had died, it appears, insofar as the Inquiry can see, for the first and only time on the Risk Register, and that's how it's

expressed:
"Potential damage to reputation of neonatal service and wider Trust due to apparent increased mortality within the neonatal unit."
Karen Townsend is listed as the handler, I think that means the person who puts it on there, and in her evidence she said Ms Kelly and Ms Hodkinson had scripted this for her; Ms Kelly said she had no recollection of this.
So there we are. That's the evidence we have heard so far. What do you say about that description, following the deaths of O and P, of the risk which is ranked as high?
A. I believe that is a very -- and I can't avoid using a word that I believe Mr Chambers used -- very clumsy description of the risk.
Q. Well, what's the potential damage to reputation, that's the first thing that appears: what is that?
A. I -- I think the problem here is the use of the word "reputation", and the implication that reputation is some standalone quality. And I think this is something that has been referenced on a number of occasions. In my own mind, for a hospital, reputation can never be standalone. Reputation is entirely reliant

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

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

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

Q. Do you know who wrote it?

A. I don't, no.

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

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

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

A. Yes.

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

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

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

A. Yes.

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

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

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

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

Q. Well, you know the facts --

A. Yes.

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

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

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

Q. We will go to that later then.

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

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

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

A. I would hope that was not the case.

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

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

Together establishes, in the first paragraph:

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

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

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

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

A. Not that I recall.

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

A. I regarded any patient who didn't have

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

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

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

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

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

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

A. That's --

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

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

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

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

Q. If we go now, please, to the Speak Out Safely policy, that is INQ0003012, page 1. You see at the

bottom, paragraph 2:

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

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

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

Alternatively, we see on page 6:

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

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

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

If we go to the next page, page 7:

"The person making the disclosure will be asked whether or not he/she wishes to make either a written or verbal statement. In either case, the designated

officer will write a summary of the interview which will be agreed by both parties."

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

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

We see at the bottom:

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

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

that the nurse needed to address or deal with, and then make a decision about the disciplinary policy or referral to the police. That process wasn't followed, as we have just gone through, was it?

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

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

A. Yes.

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

A. Yes.

Q. That was a serious error of thinking, wasn't

it, retrospectively? You just weren't getting the point of the Thematic Review and the Unexplained Deaths -- Sudden Unexplained -- reference to the Beverley Allitt case from Mr McCormack: you weren't seeing what was really being said, were you?

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

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

A. Yes.

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

A. Yes.

Q. -- trusted as a paediatrician?

A. I trusted him, yes.

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

A. I -- I did it was for that reason that I subsequently contacted him for further information.

Q. But it seems as though what you thought was

logical to look at what might be the reasons for an increased mortality rate, generally, drove you in your actions and reviews that you commissioned, rather than just listening to them and what they were saying?

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

Q. Are you --

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

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

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

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

Q. Well, you were surrounded by qualified nurses, weren't you, in your exec group, there was Alison Kelly

and Tony Chambers, and you are the only doctor, aren't you, in that group?

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

LADY JUSTICE THIRLWALL: Alison Kelly.

A. Sorry?

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

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

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

A. I don't think that's the case. But, as the Medical Director, then it is possible that I would have had some more weight. Having said that, I have no doubt that they are all intelligent people with a lot of experience of clinical and non-clinical matters, who would have a valid opinion, and certainly I didn't make any attempt to sway anyone's view of the situation.

Q. The last policy, if we can have a look at the Serious Incident Framework -- it is not a policy of yours, it is prepared by NHS England -- and if we look at INQ0009236, page 15. This is around how you assess whether an incident is a Serious Incident.

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

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

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

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

A. Yes.

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

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

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

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

You have said you were interested in looking at

increased mortality and you knew in 2015 there were three deaths in rapid succession of babies A, C and D -- we will come to it but the first ones that Dr Brearey draws together. You could have reported a cluster of deaths, just because they were deaths at that rate in that frequency, as a Serious Incident couldn't you, via the STEIS system, so that there were other eyes on the information?

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

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

Q. Who were commissioning care?

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

I think that we were subject to a significant level of scrutiny by the CCG and, certainly, I would have been

confident that, if there was a level of concern, then they would have raised that and -- and pushed us towards that.

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

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

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

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

Q. Well, it set him off doing a summary of cases

and a Thematic Review, didn't it? So it was unusual, you had not had that before from the neonatal unit?

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

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

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

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

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

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

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

A. I did, yes.

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

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

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

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

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

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

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

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

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

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

for Baby A, that's 31 weeks, 97.9% survival rate, Baby C, 30 weeks, 97.3% and Baby D, 99.4%.

So he's set out --

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

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

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

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

LADY JUSTICE THIRLWALL: Oh, I'm sorry.

MS LANGDALE: Confusing, sorry.

LADY JUSTICE THIRLWALL: That's my fault.

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

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

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

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

A. Yes.

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

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

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

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

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

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

Q. Have you seen it since?

A. Not that I recall.

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

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

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

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

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

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

A. Yes, I would agree with that. I would -- I would only comment that it is factually incorrect to say that it had been escalated to me, insofar as I -- I was on leave and hadn't received -- or didn't receive the email in a timely fashion and wasn't at the meeting

for the conversations.

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

LADY JUSTICE THIRLWALL: Thank you, Ms Langdale.

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

(1.06 pm)

(The luncheon adjournment)

(2.10 pm)

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

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

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

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

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

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

A. Is this the Serious Incident Review?

Q. Yes.

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

Q. But you would normally go?

A. Yes, I would.

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

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

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

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

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

"No PM, has been discussed with Coroner. Unexpected neonatal death of a Twin."

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

A. Not that I can recall.

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

A. Yes.

Q. You tell us in your statement:

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

Did you draw a link or think about the position?

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

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

A. It was, yes.

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

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

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

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

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

A. The yes.

Q. -- the Thematic Review of neonatal deaths?

A. Yes.

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

A. No.

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

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

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

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

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

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

A. Yes.

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

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

Overleaf, Sarah Harper-Lea says:

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

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

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

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

So what is your understanding of your role in terms of, first of all, the Inquest for Child A? You know it's happening you know the Coroner has been notified: who communicates with the Coroner from the hospital?

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

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

A. No, I didn't.

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

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

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

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

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

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

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

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

Q. Was it shared with the parents?

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

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

A. I don't, no.

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

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

Q. We see under "Action required":

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

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

A. I don't, no.

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

"Inquest statements need to be reviewed by

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

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

A. I -- I have no recollection of reviewing those statements.

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

A. No.

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

"Action: prepare statement bundle ..."

This is Stephen Cross' notes; do you agree?

A. They are, yes.

Q. It looks as though:

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

Would that be him doing that?

A. Pardon?

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

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

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

other doctors just to see what's happened?
A. I'm unable to answer that. I have no recollection of being sent any statements.
Q. But the principle of it, is there a problem with that from your perspective, on one view?
A. No, there is no problem with the principle, no. If Stephen Cross felt that there was a reason why Alison Kelly and I should review statements from a medical and nursing point of view, no, I would have no issue with that.
Q. If we go over the page, it looks as though, in this meeting, the meeting is going at 2016, so I have moved on in time:
"Nurse starred 2012. Why now? Occupational Health referral. What about nurse? More support."
So at this time of this meeting, it's 2016, there is discussion, isn't there, very clearly between you about Letby in this meeting?
A. Yes.
Q. So you are all discussing Letby, concerns that have been raised that she's causing deliberate harm, murdering babies and Child A's Inquest is coming up. So Stephen Cross might have every reason to want to know what the statements say and what's being said, mightn't he?

A. Yes, he might. I don't think at that time there was any statement to the effect that someone thought Letby was murdering babies.
Q. The Inquiry is investigating whether the information the Coroner has had was adequate so my broader question, by August 2016, you are all discussing a nurse and effectively reference to "Started 2012. Why now?" What does "Why now?" mean?
A. I can only imagine that it was, you know, we have had a nurse working in 2012, if there were any issues why would they be arising three or four years later.
Q. So placing first and foremost why would she be killing now, it is a question, but you know it's a question?
A. I think -- not necessarily because two lines above it does say:
"Is it competency of nurse?"
Q. We had already had meetings, hadn't we? We will go to them in the chronology I just need to deal with the Inquest point now. In June 2016, there had been meetings expressly referring to Beverley Allitt and killing, et cetera. So by the time of this meeting, it was very much a conversation point, wasn't it?
A. I'm sorry, I have lost track of the date of

this meeting.
Q. This is 2016, August 2016.
A. Right, yes.
Q. This is happening in August 2016 --
A. Yes.
Q. -- being asked about Baby A's Inquest statements required by the Coroner and, by then, you have all been talking about, in various meetings, whether Letby is killing babies?
A. Yes.
Q. You are saying there, well, why now killing babies, she started in 2012, but there is no question that you are all aware it's about whether she is killing babies and Baby A's Inquest is coming up.
So do you think the Coroner was adequately informed about the suspicions and concerns you had about Letby killing babies and whether or not Letby was looking after this baby?
A. I don't -- I don't believe that that cross-referencing happened. But potentially, well, I believe that the Coroner had had a copy of the Thematic Review, and I believe it would have been called out in that.
Q. So that can come down. Let's go to the Thematic Review, please. INQ0006817, page 1. If we go

to page 7, please. Dr Brearey is identifying on page 7 themes during discussion of all of the cases. It will come up in a moment. We see under (7) "Deteriorations", Dr Subhedar's suggestion, he is making very clear the babies suddenly and unexpectedly deteriorated and there was no clear cause for the deterioration/death identified at postmortem. So he's not describing simply deaths. He's describing suddenly and unexpectedly dying.
Did you appreciate the significance between the two: that he wasn't simply saying there are deaths, he was saying Sudden and Unexpected Deaths with no clear cause, no medical cause identified?
A. This was a feature of the meeting that we held in May. This was part of the conversation and, at that point, a number of -- well, a couple of actions came out of that meeting. I do not recall in that meeting Dr Brearey particularly stressing this one feature.
Q. Let's worry about the meeting when we get to it. Look at this document. What alarm bells does that ring for you, that description, if any, from the sound of it?
A. "Unexpectedly" is a word that would be a cause for concern.
Q. And "sudden, with no clear cause"?

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

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

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

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

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

had a degree of reassurance --

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

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

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

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

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

unusual"?

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

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

A. Yes.

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

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

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

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

A. It is.

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

A. In retrospect, yes.

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

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

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

A. Yes.

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

A. Yes.

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

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

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

A. Sorry, of concerns and when?

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

A. Um.

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

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

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

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

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

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

She says:

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

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

A. It is, yes.

Q. So you have a one-to-one with Alison Kelly:

"Neonatal review. Query results from external. Review to QSPEC."

What does the next bit say?

A. "? Issues with alignment with maternity."

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

A. That's right.

Q. "Not attending governance meetings."

What does that refer to?

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

Q. "People not attending them."

A. Yes.

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

A. And I think Alison Kelly referenced that as a concern, yes.
Q. Well, they were identifying, Dr Brearey and Ms Powell, in April 2016 that she was a common factor in the events they were concerned about; is that fair, you appreciated that?
A. Sorry, I missed the question.
Q. You appreciated that she was highlighted as a common factor in the deaths and events that they were concerned about?
A. She was associated, yes.
Q. Well, how could she be associated: what was your thinking?
A. Well, she was a factor common to a -- a number. I don't recall that she was associated with all.
Q. What are the options if she was the factor that was common?
A. Based on the conversations that we had, the most likely was simply the fact that she was more commonly on duty, on duty for longer, tended to care for the sicker babies: all the points that Eirian Powell had raised -- raised subsequently in the meeting that we had. I also am aware that there was an email from Dr Brearey referencing the fact that -- and this is

perhaps getting ahead of her -- having been taken onto days.
Q. Let's get that email up then, INQ0107818, page 2:
"There's a nurse [this is to Alison Kelly] on the unit who's been present for quite a few of the deaths and other arrests. Eirian has sensibly put her on day shifts only at the moment but can't do this indefinitely. It would be very helpful to meet before she's due to go back on night shifts."
If we go to page 1 before that:
"Hi Ian, please see Steve's comments below which alarmed me!! Since receiving this I have asked Karen Rees to liaise with Eirian regarding this particular nurse. Eirian, further review is attached for info.
"Currently reassured there are no issues so I think this is worthy of a wider review, hence our planned meeting. This has been arranged for next Wednesday to review all the issues with us."
You say:
"I see what you mean, although perhaps just meant that he was concerned for her."
What do you mean "concerned for her"?
A. Well, I -- I think if we look at Dr Brearey's email on the previous page, I -- in saying that

"sensibly moved", his major concern seemed to be with regard to the effects of that on staffing levels. He doesn't seem to be alerting to any concern about her actual practice.
Q. That can come down. You then have a meeting on 11 May, and you deal with that, if you want to refer to it in your statement, at paragraph 162 onwards. Your recollection is this meeting took place relatively late in the day. You had also been sent various documents in advance of the meeting. It may be more helpful actually to see those first, to know what you had been sent.
You'd been sent INQ0003243, page 1. This was a document prepared by Eirian Powell in a meeting with fellow nurse Karen Rees, and she produced this in anticipation of the meeting you were going to have and has set out there at the beginning:
"There is no evidence whatsoever against LL other than coincidence."
Had you read this before the meeting?
A. I don't recall when I saw this and read it. If I didn't read it before, I read it at the meeting.
Q. It records the line you have just repeated:
"She is therefore more likely to be looking after the sickest infant on the unit."
Yes?

A. Yes.
Q. Did you appreciate what band nurse she was and level of experience or did you not ask?
A. I -- I recall that, in the meeting, Eirian Powell made reference to her being qualified -- well, as she had there qualification specialty as -- as part of her -- that report, that review.
Q. So what band did you think she was: how experienced or what band?
A. I wouldn't be aware.
Q. No, so would you be surprised if she was a Band 5. There were a number of Band 6s on that unit, she was a Band 5, relatively recently qualified. Did you get that impression or ask?
A. Neither.
Q. So you took that as fact, did you, that she was looking after sicker babies and was experienced?
A. Based on who was making that statement, yes.
Q. Did you test it out in any way with Ms Powell and ask her, "Have you looked at the HR file, have you spoken to anyone else about her. She seems all of these things to you but have you had a look for anything else?"
A. Not at that point. I think that was a subsequent action.

Q. You were also sent a document, INQ0006951, page 1 called the "Additional Information Monitoring". So since 15 April 2016, Eirian Powell has been adding to her monitoring document of who's where, when, other incidents or events. Did you appreciate that it was an ongoing piece of work that Eirian Powell was doing when you had the conversation, that she was looking at events and continuing to look at events and who was there?
A. I -- I don't recall appreciating that then, no.
Q. Because it's significant, isn't it? You are having a meeting, you have been told someone's moved from nights to days and the head of the ward is effectively monitoring events and seeing who's there for them.
A. Yes, and I would also say that we looked to extend that because one of the actions that came out of that meeting was that any subsequent babies who collapsed should be reported. I'm not actually sure that happened but that was one of the actions in terms of us monitoring the continuing picture.
Q. So it was a monitor, wait and see?
A. It was monitor and alert if any concerns arise.

Q. Let's go to the notes of the meeting now then, INQ0003181, page 1. While I do, can I tell you what Dr Brearey says about this meeting. He says:
"My recollection of the meeting is that I started by talking about the Thematic Review report. I explained that we had found some clinical areas of practice we could learn from in some of the cases but they were all relatively minor and none were common to all the deaths. Generally, I was happy with the NNU being an area of good practice and the previous annual mortalities had been quite low. I felt the number of deaths in 2015 and early 2016 were exceptional. I highlighted that six of the nine deaths occurred between midnight and 4.00 am which was unusual. I highlighted that there seemed to be a disproportionately high number of sudden, unexpected collapses. We had reviewed care on multiple occasions, including with an external neonatologist, and the only common theme was the association with Letby being on duty. We needed guidance and help on how to take this forward. I also made it clear these were concerns of my colleagues and were not mine in isolation."
Do you agree with what I have just read to you, that he says that?
A. That doesn't accord with my recollection of

that meeting. I don't recall Dr Brearey being that detailed or that assertive.
Q. What's factually incorrect from what I have just read to you though? I mean, he said that he was highlighting a disproportionately high number, commonest theme was the association with Letby.
A. It wasn't -- it wasn't common to all. She was more frequently and --
Q. Six out of nine.
A. Sorry?
Q. Six out of nine, that is what he said. He didn't say it was all?
A. And that was balanced with regard to the detail that both Eirian Powell and Anne Martyn presented, in terms of presence on the unit, activity level, staffing levels, her frequency of attendance or work on the unit and I believe that there was a full discussion.
The meeting was later in the day but that did not foreshorten it in any way and, at the end of that meeting, I recall that everyone was in agreement in terms of the continuing monitoring but stepping it up and ensuring that all babies who collapsed thereafter should be reported and that they would be monitored.
I'm not sure that that actually happened.

Q. Whose responsibility is that, if it didn't? They were looking to you for leadership, guidance; did you say --

A. Well, the responsibility of that is with the clinicians who are caring for the baby who collapsed.

Q. What's your responsibility in this situation? They are actually telling you six out of nine arrests between 12.00 and 4.00 am and she was on duty or shift before 9 out of 10 of the deaths. That's actually what the Thematic Review data says?

A. Well, my responsibility was continuing to monitor and being aware in the event that any further collapses occurred. And it had obviously also, as part of this meeting been made clear that, as Stephen Brearey had alluded to in his email, Letby had been moved from nights to days, but the implication was that that was for her protection and well-being.

Neither he nor Eirian Powell nor Anne Martyn indicated that it was for any other reason than that, and I believe that was supported by the tone of Steve Brearey's email that we have just been talking about and I think the tone of the meeting that we had and my recall of it would be supported by the tone of a subsequent email that Steve Brearey sent with regard to how he perceived that meeting.

Q. Let's look at what it says there:

"Absolute no issues with nurse."

That's Eirian Powell's view, isn't it?

A. Yes.

Q. She is giving you that view, and Dr Brearey told us that both Anne Murphy and Eirian Powell countered his concerns quite forcibly and with great emotion, saying there were no issues with her?

A. I think Dr Brearey's overstating in saying "with great emotion".

Q. We have seen a number of references to Eirian Powell being emotional around these events. It wouldn't be surprising, would it: she is running a ward while she is trying to put rotas together investigating who is there on sudden collapses?

A. No, I agree but my recall is not that I -- I -- I believe that she was factual. She was obviously passionate about her unit, but I don't think that she was excessively, as is implied, passionate with regard to defence of Letby. I -- I wouldn't accept that, as I have seen described, that she and Anne Martyn were in denial. I think that has all been overstated.

Q. Why does the word "circumstantial" appear there on the notes; who was discussing circumstantial?

A. I can only surmise that that is Eirian Powell

saying that any association is purely circumstantial because of the nature of the duties.

Q. Nature of the ...?

A. Letby's duties: working more commonly, more frequently, doing additional shifts.

Q. That meeting was 11 May and there was a QSPEC meeting on 16 May, where this issue wasn't raised -- the note can go down now thank you. This issue wasn't raised and it wasn't raised at the 20 June meeting either. You said you thought it might be raised at those meetings. You were sighted on the issue, it was a patient safety issue. Did you not think it should have gone to that June meeting, as you and Alison Kelly had hypothesised back in that meeting, one to one, on 11 April?

A. I think she had made reference to not being able to get it into the May meeting, but I -- I believe that it should have gone to the June meeting, yes.

Q. So why didn't it? That is what you both agreed; was there a reason you kept it away from there?

A. I -- I can't recall why it didn't go. All I can say is we didn't have a conversation about keeping it out of that meeting.

Q. It did go to the Women and Children's Care Governance Board. If we see INQ0003212, page 5, we will

see how it was raised there. That's how it's set out, just referring to mortality rate, not sudden and unexpected deaths with a commonality of a nurse.

Dr Jayaram told the Inquiry he didn't think this was a forum where a suspicion concerning a member of staff would be raised, the Women and Governance Board; do you agree with that?

A. Never having attended that particular meeting, it would be difficult for me to -- to comment. I think there would be ways, if there was a real concern, to -- to raise that, even if it was separately with the Chair.

Q. That can go down, thank you. Now, I am going to move to June after O and P have died, and there were important meetings in June, weren't there. If we start with the emails please, INQ0003142, page 1. We see Dr Brearey, if we go over the page, page 2 first:

"I am hoping Karen has already spoken to you about our two mortalities last week. We are going to discuss them at our senior paediatricians meeting on Monday."

So Monday, 27, that is, June:

"I was wondering if it might save time if you and Ian could join us at that meeting to discuss the ongoing issues."

If we go over the page:

"Yes, Karen did discuss this with me last week.

I'm touching base. I'll discuss with Ian this AM re trying to attend your meeting."

Why didn't you attend that meeting? You didn't attend it and we know there was a different meeting instead, the Babygrow meeting where Dr Jayaram mentioned it to you, but it would have been a good idea to go to the paediatricians' meeting, wouldn't it, as the Medical Director?

A. Without access to my diary I am unable to say what other commitment I had at that time.

Q. Two babies had just died on consecutive days, you say the meeting in May was monitoring whether anything would happen. Something very serious had happened. Hard to imagine anything more serious in the hospital.

A. I was aware that we had got the Babygrow meeting and we took advantage of -- of that. As I say, I -- I can't -- I don't know what other commitment there was.

Q. Let's look at INQ0015537, page 4. It's two meetings recorded, here the left-hand side is what we'll call the Babygrow meeting, where you are discussing an appeal, and then Ravi Jayaram has a conversation with you after it, doesn't he, and brings up directly the concerns about the two deaths at the end of last week

and the concerns about one nurse, very clearly telling you. Then you have got the other side, you have recorded:

"Eirian Powell adamant no concerns."

We know, on that 27 June morning, there was a meeting by the paediatricians and it may be helpful to have this on the screen from Dr Brearey's statement, so people can follow it INQ0103104-page 44, and you will be able to see it, Mr Harvey.

It's paragraphs 248 to 250, if you could read those.

(Pause)

You see there it sets out the Consultant paediatricians meeting at 249 and, at paragraph 250, he in his statement to the Inquiry, he makes it clear he had spoken to you and said that, at their meeting, with the nurse managers, they had:

"... all agreed the appropriate action was to remove LL from clinical duties."

You responded to say that you requested an RCPCH Review. When you have finished reading that, Mr Harvey, we can go back to your second meeting on 27 June at 4.30, which reflects what you, Eirian Powell and Ms Kelly had discussed separate from the paediatricians.

Have you had time to read that?

(Pause)

Have you finished reading that?

A. Yes.

Q. So that can go down, and can we have INQ0015537, page 4. So on the right-hand side, this is the meeting, just the three of you, making all these decisions without you having even spoken to the paediatricians. You set out there various bullet points, that is the decision you take on the 27th at 4.30, with them; do you agree that note's accurate?

A. I -- I don't think that's telling the whole story, insofar as, at the end of the Babygrow meeting, there had been a discussion with Dr Jayaram and Mrs Kelly and myself. I had a conversation with Steve Brearey, subsequently, who informed me that everyone had agreed that Letby was to be taken off the unit, and I raised that issue with Mrs Kelly because that actually absolutely wasn't what had been said in the Babygrow meeting and it appeared that there had been a 180-degree change in the opinion of the senior nurses --

Q. Just pausing there --

A. -- and --

Q. -- there was no paediatrician -- Ravi Jayaram had a conversation with you, didn't he, after the meeting about that?

A. Yes, yes.

Q. But there was no paediatrician who said anything different to you in the meeting on 27 June, the Babygrow. You are saying it was a nurse that said something different?

A. Sorry, saying?

Q. Were you saying it was a nurse that said something different at the Babygrow meeting?

A. No, what -- the view was that there were no concerns with regard to Letby when we had that conversation with Dr Jayaram.

Q. It was just you and Dr Jayaram who had that conversation, wasn't it, it wasn't in the meeting. He said as you left the meeting he spoke to you about the deaths. It wasn't the subject of the Babygrow Appeal meeting?

A. Well, I believe Mrs Kelly was there as well. It wasn't the subject of the Babygrow meeting, no.

Q. No, it was a conversation he said he had with you afterwards to bring to your attention their concerns about the two deaths at the end of the week before?

A. Yes, and, in that conversation, Eirian Powell was involved and she was adamant that there were no concerns. I subsequently had a conversation with Dr Brearey, who was reporting back from the Consultants'

meeting that I believe some of the nurses also attended, that everyone was agreed that Letby should be removed from the unit.

Q. Yes.

A. Now, that hadn't been the message that Eirian Powell had delivered earlier on and, for that reason, I contacted Alison Kelly.

Q. Let's put the email on that you are referring to, that you contacted, INQ0005727, page 1. This is the email where you set out to Ms Kelly:

"Steve claiming that all in the meeting including Eirian and Anne Murphy agreed the nurse should be excluded from patient contact. 180-deg aboutface from them, if that's the case -- do you want to check?"

So it's right Dr Brearey is right. He said to you, "We have all agreed, including Eirian and Ann, she should be off". But you are having a conversation with, who, that suggests they have turned about their decision making?

A. I am saying to Alison Kelly that, based on the conversation that we had had with Eirian earlier in the day, she appeared to have changed her opinion completely. So that Letby was to be excluded when that hadn't been the message that we had had earlier on in the day and I'm suggesting that we need to check whether

that was, in fact, the case.

Q. We then see Alison Kelly sends the agreed plan of action, INQ0005745, page 1, sending it those of you who made the decision without the paediatricians. You are setting out the following actions, and the third one is:

"Ian Harvey and Alison Kelly to meet with Consultant group re their concerns."

Who's "supposed to be liaising and the team to arrange"; who's DD?

A. Yes, DD was my PA.

Q. It's here. You have identified, "Royal College lead to facilitate external NN review". So that was your idea, was it?

A. It was my suggestion, yes.

Q. Dr Brearey then sends -- there is a series of emails, starting INQ0005744, page 3. We see that in paragraph 3:

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

Then, if we go over the page to page 4:

"I understand Ian and Alison met with Eirian and Ann yesterday afternoon, and that the outcomes from that meeting don't entirely fit with what was suggested at our senior paediatricians' meeting yesterday. Hence, it would be helpful to meet sooner rather than later, with nursing and medical colleagues together."

That didn't happen, did it? You proceeded with the plan to instruct the RCPCH and, just if we can go back to page 2, we see Dr Brearey's email there:

"Just to confirm then, Ian and Alison are happy for LL to work on the NNU in the same capacity as last week despite the paediatric consultant body expressing our concerns that this may not be safe and that we prefer her not to have further patient contact?"

If we go back to page 1, it's Karen Rees who brings those emails to your attention. You then have a conversation, Mr Harvey, with Stephen Cross, if we go to INQ0003360, page 1. This is on the 29th. To be clear, those days -- 27th, 28th, 29th, 30th -- Letby is still working on the unit, while these days are passing. "Wednesday, 29 June, Harvey neonatal issue":

"Emails from Consultants -- escalating concerns. Email this PM from further Consultant. Advice: police need to be involved now."

You should know, Mr Harvey, Stephen Cross says in his written evidence:

"Based on what the Medical Director told me in relation to the neonatal unit, I noted my view in my notebook that the police should be involved now. This was not formal advice but rather a pragmatic view that, if there was a serious allegation made in the Trust, the police should be involved."

Is his note accurate?

A. I -- Stephen Cross in this note --

Q. Yes.

A. -- I think is alluding to an email that Dr Saladi had sent and he was suggesting that the police were the only organisation that could carry out the sort of investigation that he thought would be of help.

I don't recall Mr Cross giving the advice that the police needed to be involved now.

Q. It looks as though your meeting, what time does that meeting happen on 29 June?

A. Well, he's written 8.15.

Q. 8.15. So Dr Saladi's email is actually same date 8.17, a little bit later, and it's not actually Stephen Cross on that email list, but it's INQ0047571, page 2. The Inquiry has examined this email. We probably need to go to page 3 to get the end of that.

There we are.
So that's Dr Saladi's email --
A. It is, and I --
Q. -- and there is a series, isn't there, between the Consultants, and this is the one where you say, if we go to 0002 -- different INQ number, sorry Mrs Killingback. It is INQ0003112, page 2. The Consultants discuss going to the police.
You are on the email thread and you say, when there's comments it's not being treated urgently -- as I have indicated, Letby is still on the unit:
"Ravi -- this is absolutely being treated with the same degree of urgency -- it has already been discussed and action is being taken. All emails cease forthwith. We will share with you what action we are taking."
Before you comment on that, if we can just go back to 112, page 1, Dr Jayaram chimes on the 29th:
"The Trust are contacting the police soon, once some information gathering has taken place, which is why Ian asked for the chitchat to stop for now. The *(unclear)* is interesting and worrying though, given the discussions we have had."
Dr Jayaram had seen you that day, hadn't he, he had had a conversation with you --
A. Yes.

Q. -- and he said you had said that you were going to the police, which is why he said that. But I think you dispute that, do you?
A. I think, firstly, I need to go back to the meeting with Mr Cross. I think the first three lines of his notes are in reference to me taking Dr Saladi's email to him to discuss with him. He and I were in the habit of often being the first Executives in the office and I'm not sure the timing of his note is completely accurate.
I believe that I had received that email, I was on the circulation list, and I took it to Mr Cross for discussion and his advice. I think also, because of that, the advice to go to the police references Dr Saladi's comment in his email.
Q. So there Mr Cross is wrong when he says that in his written evidence then; is that what you say?
A. Well.
Q. His written evidence is that he --
A. I would say that our recollection differs. I do not recall Mr Cross, at any point at that time recommending we went to the police. I would suggest, given his, his background that had, at any point he said that, I -- we would have taken that advice.
I've stated in my, at the beginning of my evidence

that I regret that we didn't go to the police in June/July 2016. I think there is evidence that the Inquiry has that, actually, that was in my mind at that time.
Q. Shall we put that email up, Mr Harvey, INQ0004751 --
A. And I --
Q. -- page 1.
A. I believe having seen that documentary evidence that I would accept that I probably did have that conversation with Dr Jayaram. The email, with regard to "all communications should cease forthwith" is one of those emails that I had counselled many others against sending. There is a habit, a tendency when one receives -- when there is, for want of a better phrase, a hot topic for emails, because they are so easy to send, to become more and more extreme and I was attempting to -- to dampen that down. But I fully accept that I -- I got that completely wrong, that email doesn't read as it should have done.
Q. Why, when you were thinking about it as well, didn't you simply respond to Dr Saladi's email then and say yes, we should go to the police?
A. Because the nature of that was I felt that that was something that needed discussion amongst the

Executives before I sent an email that once it's out there, it's out there, and I felt that this was such a serious matter that it needed discussion amongst the executives.
Q. You had a further meeting, didn't you, with the paediatricians, Wednesday, 29 June, very briefly, INQ0003371, page 1. We see at the bottom "Dr Ravi Jayaram":
"Staff member -- almost always nurse in charge. Babies were stable then deteriorated. Why always this nurse? Babies were unwell but getting better. Babies not getting oxygen -- then crash. Babies did not respond as they should have done. Steve B. Disturbing things -- twin survived and got better in Arrowe Park."
They are repeating their direct concerns that this nurse is murdering children; do you agree?
A. They are highlighting their concerns that she's associated, that there was -- at no point did they say in their view she was murdering them.
Q. Let's look at page 2, and get off this word association. Here it's suggested more than just an association with this nurse. Dr Jayaram:
"How? Cannula air embolism."
You are medically qualified. Air embolism: what's he suggesting there?

A. He is suggesting -- he is suggesting that, if there had been an act, was that a possible mechanism.

Q. He's talking about a deliberate harm, a murder, how that could be done. Could it be that? It's not simply an association. They are describing or thinking about methods, aren't they?

A. With respect, he's talking about the possibility of accidental as well as possible deliberate and it wasn't, as it says, something going on but what?

Q. You have another meeting on 30 June, with the execs and Sir Duncan Nichol, if we can go to INQ0003361, page 2. Again, why is this meeting happening without any doctor present? Why are you just discussing it with Sir Duncan and none of the paediatricians to put their views forward?

A. I would imagine that was called simply so that the Chairman was brought up to date with the situation that we were in.

Q. Well, he's up to date with your views, he is not necessarily up to date with the paediatric views, is he? Let's see what you say when he is there on page 2:

"Can we decide what we are doing. Demands: review within two weeks. Staff member clear articulation of Consultants' concerns to Alison Kelly to formalise."

That's an action plan for you and Alison Kelly,

yes, or is that one for Sue Hodkinson to do?

A. Sorry, what was the question?

Q. Look at the clear articulation of Consultants' concerns; who's supposed to get those concerns from the Consultants?

A. It's unclear whether that is Sue Hodkinson or Alison Kelly. It would appear that the action of closure of the unit, or me to see a plan is myself and Alison Kelly.

Q. You had very clearly had their concerns by this point, hadn't you?

A. Pardon?

Q. You had had their concerns very clearly stated in a Thematic Review and the conversations you had had with Dr Jayaram after the Babygrow meeting, and with the doctors, with Dr Brearey?

A. Yes, and I believe those concerns were shared with Sir Duncan Nichol at that meeting.

Q. Let's look at the next meeting notes, INQ0015639, page 55. This is the meeting where Mr McCormack says, look at the top:

"Had thought member of staff responsible for deaths. Member of staff over the last three days, only going on what's being told by paediatricians, nights to days change."

That's reference to these deaths having happened when she's on days, you agree: o and P have died when she is on days and you have been monitoring it, there you have it, that's happened, O and P?

A. Yes.

Q. "Not sure what review will do."

You are promising a review within two weeks from somewhere from the RCPCH. He says:

"Not sure what review will do. Serious concerns, member of staff, fantastic unit but concerned Beverley Allitt/Shipman being raised."

That is loud and clear and articulated, to use the phrase that follows the documentation; do you agree, clearly articulated?

A. It is clear in that note, yes.

Q. Couldn't be clearer. From that moment on there is just no substance in saying it was about an association and if you needed further reference, look at page 58. Dr Jayaram again: "air embolism".

Explains difficulties with the resuscitations: he's been saying it constantly, hasn't he, that this is the concern?

A. Yes, I'm not sure that the notes capture the way things were discussed in the meeting. I -- I appreciate that these things were said but I'm not

sure it captures the full nature of the conversations that were had.

Q. It captures fully that there were concerns and suspicions when two babies had just died when this nurse had been moved to day shifts. You were looking to see, monitoring -- you had asked for the monitoring to continue, and you don't seem to reflect that that's what you had invited back in the meeting in May, and here you were in June with two dead babies on the unit.

Wednesday, 6 July, if we can go to the next document, please, INQ0002682, page 3. Executive Team notes again, and here we have the Royal College Review, "IH review proposal". You had made this decision, that this would happen, hadn't you?

A. This was a decision that was reached in the end in concert with others, including the paediatricians.

Q. Mm-hm.

A. I believe there were notes from a meeting that the Executives -- I think Duncan Nichol was involved, and the paediatricians, at which it was agreed, previous comments notwithstanding, that this was an appropriate route to follow.

Q. This was where you discussed CCTV, amongst other matters; is that right?

A. Discussed?
Q. Discussed CCTV --
A. Yes.
Q. -- and having CCTV and I think it was somebody who wouldn't normally, Ms Hodkinson, going off with Tim Lister to look at CCTV proposals for the neonatal unit --
A. Yes.
Q. -- for the intensive care unit. Did that strike you as odd that you had arrived at a point where you were going to get CCTV on the unit?
A. No, because I think that simply reflected the fact that we just didn't know what was going on.
I -- we know that that association was reported but, actually, because of the way the unit was set up and laid out, we actually couldn't be sure which staff were doing what and when, and I believe that's why we had a conversation about how we could best monitor the unit.
Q. You said you would get a review done within two weeks at that meeting, didn't you? The paediatricians said they wanted her off the unit and you would have to do it within a couple of weeks, is what you said?
A. We were -- I'm not sure I would have said

I would have got a college review in two weeks because that would have been optimistic. My understanding at the time was that Letby was on annual leave, which gave us some time. But I couldn't see anyway that it would be a College Review.
Q. There is another note of yours, INQ010115, page 21, 7 July:
"No safeguarding issues aware of. But share press briefing and safeguarding."
Presumably, you are speaking about the downgrade, are you, at this point, or what are you referring when you say "No safeguarding issues"?
A. To be honest, I'm not clear who all the attendees were at that meeting, and I -- I can't give any information with regard to that note, I don't recall that.
Q. It's your note but that doesn't ring a bell. It's the only reference we see to safeguarding issues. I haven't seen anything else that you have referred to in a note like that.
A. I -- I don't believe that that is something that I would have said in that meeting. What isn't clear is who has said that. But I -- I believe that reflects that someone in the meeting had made that comment.

Q. The external communication around the same time as that, INQ0103147, page 1, goes out; do you think that was a transparent and fair summary of the situation:
"Nevertheless, we have seen in some of our most poorly babies (those with high dependency needs) an increase in neonatal mortality rates for 2015 and 2016."
Was that a fair description of the babies that had died?
A. At that time, I believe that that was a reasonable description.
Q. That's what Eirian Powell had said. The doctors hadn't, had they; did you take her word for it, rather than the experienced Consultants?
A. I believe, in terms of the external communication that was the understanding at the time, that's all I could -- could say.
Q. It was Eirian Powell's belief; it was your understanding, you are saying, as a medical qualified person?
A. I was, at that time, comfortable with that communication going out.
Q. You set up subsequently, between 6 and 8 July, Silver Command, don't you? You describe that in your

statement. You say:
"It's difficult now to remember which reviews are incorporated as part of the Silver Command review or ongoing separately."
By this stage, if we go to INQ0003174, sorry 1 and 3?
LADY JUSTICE THIRLWALL: Ms Langdale just choose a moment to stop.
MS LANGDALE: After Silver Command we will stop.
Thank you. If we go to INQ0003174, page 1, there we are. So a lot of people gathered together for a morning briefing, the first page. The second page, I think there's about 36 people, and people are given different jobs and tasks, aren't they, to complete?
A. Yes.
Q. You say:
"We did not agree specific Terms of Reference. They were borne out of group discussions."
Who was in charge of who did what?
A. My recollection is that the idea for the Silver Command came from Stephen Cross. With regard to the allocation of roles, I cannot recall but could only imagine that that came from an executive conversation about who was best suited to which role.
Q. Sian Williamson told the Inquiry she was sent

off to look at rotas, which Eirian Powell had already looked at and, when she had done so, she realised and thought that you should go to the police and that she spoke about that to Alison Kelly. I can't remember if she said you as well, Mr Harvey. But do you remember knowing or being told that Sian Williamson thought you needed to go to the police, when she had done the very job that Eirian Powell had been asked to do: she and Julie Fogarty ended up doing that job?

A. I don't recall that conversation, no.

Q. This moved into the territory of the hospital investigating the hospital and actively seeking explanations for deaths, didn't it? That is what this was all about: looking at the evidence in different directions from the unit, from the rotas and trying to piece together an explanation for the deaths?

A. It -- it is trying to find any signs of changes, of actions, of activities that might, in part or in whole, explain the change in mortality, yes.

Q. It was entirely misconceived, wasn't it?

A. I think that there was important data that came out of it. I believe that we were trying to find explanations for the increase in mortality and I believe that we were doing that with the -- the best motives and in the best way that we could.

That was also something that we envisaged feeding the data into the subsequent Royal College Review. I -- as I have probably said at least twice now, accept that in reconsidering all the events of 15, 16 and 17 -- regret that I didn't stick with my original view that we should have gone to the police.

Q. Indeed, finally, the data that you were assisted to gather, if we look at INQ0002837, page 2, you found yourself drawing together with the assistance, I think, of someone in the hospital, some kind of data analysis and, for this table, for example, what was causing the spike couldn't possibly be told by this, could it, if somebody's harming babies deliberately?

A. No, that particular graph is really a reflection of the figures that we were already aware of that had actually sparked the need for the investigation.

Q. But commenting on a steady mortality rate, as though that pointed to things in the hospital being an issue, was meaningless. The rate, if it was attributed as we now know to somebody killing babies deliberately, this data didn't assist at all, did it, that you were digging out?

A. I am -- I'm sorry, all I have got is the -- the rolling mortality data here and, as I say, that was

effectively the basis for everything else that we were doing and went on to do.

Q. Another example of this slides, INQ0002837, page 3. Has the NNU been under more pressure? You take the admissions and look at the graphs. In fact, the spike, if anything, is late 2014 and, if we contrast that graph to the actual data Dr Brearey, via BadgerNet, was able to put together, INQ0103210, page 4, you see admissions had gone down in 2015, in fact.

So the concerns about acuity, activity, none of this assisted at all and it gathered a momentum, didn't it, as though it was describing a mortality rate?

A. I think in the previous graph it stated "may contribute". I don't think at any point we were saying that any one of these in isolation explained it and the figures on that table are the total admissions for a year; they are not showing the breakdown either quarterly or monthly that would actually give a reflection of intensity of work in a shorter period.

Q. In and of themselves, none of the charts you produced told you anything about the individual deaths or circumstances. They added nothing to the question you were required to investigate, which was how have these sudden and unexpected collapses happened and who is responsible, if there is a suspicion?

A. I think that that was, as is by far and away the most common situation within the NHS, an acceptance that, almost invariably, these situations are multi-factorial. There are multiple elements that contribute. At no point were we seeing -- saying that any one was the prime cause. But there was a range of issues at the same time -- whilst there had been a description of an association of one nurse with an increased number, there had been -- and a description of sudden and unexpected collapses -- there were also at that point a lot of babies who had either had postmortems which hadn't revealed anything other than natural causes or for whom it hadn't been regarded by the clinicians and/or the Coroner as sufficient that a postmortem was required. And that all served to present what was a confusing picture that we felt required clarification and this was what we were endeavouring to do.

MS LANGDALE: Thank you. I think that is a time for a break, Mr Harvey.

My Lady, may I raise that, unusually at this stage, Mr Skelton will be asking questions after the break with my Lady's permission because he's unable to be here in person tomorrow to ask them. Everybody is aware of that and content with it to be taken out of turn, if my Lady

is?

LADY JUSTICE THIRLWALL: Very well. Then you will continue tomorrow morning?

MS LANGDALE: Then I will continue Friday, Friday morning.

LADY JUSTICE THIRLWALL: Yes, okay. So we will take a break and we will come back at 4.10.

(3.53 pm)

(A short break)

(4.10 pm)

Questions by MR SKELTON

LADY JUSTICE THIRLWALL: Mr Skelton.

MR SKELTON: My Lady, thank you for allowing me to interpose this evening.

Mr Harvey, I represent some of the families in this Inquiry, including the family of Baby A, whose Inquest I am going to ask you about first, if I may, please.

I am going to just quickly resummarise the background to his Inquest because it's important that we have that settled, and you will correct me if I get any of this wrong, please.

He died, as you know, on 8 June 2015 and the Coroner was informed early on, as is standard practice for an unexpected death. A Datix was completed, the next day, Dr Sara Brigham conducted an obstetric review

but didn't find anything wrong with the obstetric care. A Perinatal Mortality Meeting took place on 24 June, which recognised that a long line had been inserted and that, some time after that, the child had been apnoeic and had a cardiac arrest from which, of course, he died, but it was uncertain if there were connections between those two events. By that stage, postmortem was awaited but a preliminary report showed no macroscopic abnormality. This is very early on and, as you know, the final report wasn't available until many months later.

Dr Brearey produced a short report on the child's death but didn't identify any clinical condition that had contributed to it and, of course, as you know, there was no reference to the unusual rash, which was the subject of later investigations. Dr Brearey's report is quite important because it's dated quite early on, it is 1 July but, in fact, it is part of the Coroner, a year later, I think as you are aware.

The same day, you may be aware that Dr Brearey spoke to Mother A, and she was distraught, not only by the child's death but by the fact that she didn't know why he died and the doctors couldn't provide an explanation for it and, as you probably also know, there was some concern that she had a medical condition

that may have contributed to his death, which, of course, proved to be wrong but it understandably upset her. He left that possibility open at the time.

She wasn't, as you know, told about the cluster of deaths that had occurred, two other children around that period of time, and she wasn't told about the rash. The postmortem then occurs many months later in -- it was conducted, in fact, sorry, in June but not reported on until December, and the cause of death was unascertained. All of that, I think, is uncontroversial and all of that, I think, is squarely within your knowledge, correct?

A. Yes.

Q. After the deaths of the two Triplets, there are a series of meetings, which I will come back to, and Ms Langdale has also asked you about them to some extent, on 29 and 30 June. There is also an action planning meeting, which I don't think you did attend but that's just within the neonatal unit and it involved HR and the nursing staff, in which Child A's Inquest was mentioned; were you aware of that quite early on?

A. I wasn't, no.

Q. You were taken by Ms Langdale to a note which recorded that by 3 August, so five weeks or so after you had met the Consultants for the meetings you have

discussed, a decision was made that you and Alison Kelly would review the statements ahead of the Inquest, correct?

A. That is what the notes stated, yes.

Q. Now, as I understand your evidence in your statement, you say:

"I would usually be informed about upcoming Inquests by Stephen Cross but would rarely have any direct involvement."

So this was an unusual form of involvement?

A. It was, yes.

Q. Can I just put two possible explanations to you, and I would like to understand if one is correct or there is another explanation. One is that you wanted to ensure that the statements that were produced for Mr Rheinberg were open and transparent about the concerns that were going on in the hospital about the child's death, which, by that stage, were squarely involving the fact that he may have been deliberately killed? (2) is you wanted the opposite of that, you wanted to stop that information from getting to the Coroner so that the Inquest proceeded on an incomplete basis. Can you identify which one of those it was or was there an alternative explanation?

A. I can't recall seeing those statements but

I could absolutely refute any allegation that we would deliberately hide any information from the Coroner or suggest to others that they should not give full and frank evidence to the Coroner.

Q. Well, what is your explanation then for reviewing the statements?

A. I can only imagine that, for some reason, Mr Cross felt that he needed us to -- to review them. I -- without recalling exactly what was in those statements, I can't say. I just cannot recall seeing those statements and, until the Inquiry made those notes available, I wasn't even aware that those statements were supposed to be made available to us.

Q. Well, without going to all the statements, just taking the two statements from Dr Saladi and Dr Jayaram, neither of them mention the suspicions that they had previously raised to you in June about Baby A's death, neither of them mention that. They are straightforward Inquest statements which factually go through their involvement with the child's care and his unfortunate demise. So the obvious concern would be that you were aware of those statements and you were aware that they were incomplete and therefore that the Coroner was going to be misled?

A. I don't recall being aware of those

statements. I certainly didn't give any advice with regard to amendment or altering of any statements that were to go to the Coroner, nor did I suggest to any party that their statement should be altered.

Q. Can I ask just to have on screen INQ0052593, please. Now, these are some emails from Josh Swash, who I think you know, is that right, from the Trust?

A. I think we were involved in meetings together, yes.

Q. He's emailing you on 27 September, so shortly before the Inquest, saying:

"Stephen Cross has asked me to forward this email to you which I have today sent to counsel regarding the above inquest and you will note that the nurse has recently been moved out of the neonatal unit was involved in the care of baby Child A. You will also note that Stephen is going to speak with counsel about disclosure to the Coroner on this matter. We will keep you informed of any developments."

Why was Mr Swash, who is from the Legal Services Department, emailing you about Lucy Letby and Child A?

A. I could only imagine that it was because he had been instructed to by Stephen Cross.

Q. Yes. Well, that's the, as it were, managerial reason why he might have done it. But, substantively,

why did he do it?

A. From what I can see, and as I read it, it's for information, in that he is telling me that Stephen is speaking with counsel about disclosure and that they would keep me informed of any developments.

There isn't anything within that that suggests that they actually wanted me to undertake any action.

Q. Why do you need to know this information though?

A. To be honest, I don't recall seeing this email and why they felt the need for me to be informed, I am not clear. I don't recall ever having a conversation with Stephen Cross about any detail with regard to the Inquest and, I'm sorry but, I -- I am unable to answer that question in detail.

Q. There is a pre-Inquest meeting with counsel and then with some of the witnesses on 8 September 2016, at which Mr Swash is present, it is INQ0108406. If we go to the third page, please. You have seen this, I think, Mr Harvey in preparation for this evidence, haven't you? So just the top section.

It appears that at the meeting -- and you can infer this from Mr Swash's correspondence that, before the substantive meeting with the doctors, the witnesses, Mr Swash had a conversation with Mr Browne, counsel,

who's giving evidence next week, about Lucy Letby, and the question posed there is:

"Was nurse involved in Child A's case?"

Also why Child A's death fits into the sequence. Then there is a question posed, "Sequence?", and it's to do with "Nurse" underneath, then "L", who I think must be Mr Browne, that is Louis Browne:

"If yes, disclose to family, plus spike in deaths, not just nurse, equals disclosure."

So it appears from that that Mr Browne, counsel, was being told about the association with the nurse, potentially in respect of Child A and had advised, if there was an association that needed to be checked, it needed to be disclosed to his family and, likewise, in respect of the spike in deaths and not just in respect of the nurse, that needed to be disclosed to the family as well. Does that make sense to you from that note?

A. From that note, yes.

Q. Is that something you would have been happy to have been disclosed to the family?

A. It is something that would have been appropriate to be disclosed to the family, yes.

Q. So your evidence today is that would you not have encouraged that to have been suppressed, this information: you would have been happy for the family to

know that there had been a potential association with a single nurse and the child's death?

A. I think that, if that was the advice that was coming, if that was from counsel, it would be difficult to disagree with that advice.

Q. If we go down to page 6, please, this is a sort of follow up note that Mr Swash makes. Sorry, page 7, I'm sorry, the next page.

There we see a large sort of arrow, and it says:

"Check through medical notes re was nurse involved in [case], Lucy Letby."

LADY JUSTICE THIRLWALL: Is it "case" or "care"?

MR SKELTON: "Care", I'm sorry, my Lady. "Care", it does say "care":

"Plus SBC to feedback re review from neonates."

Then in red, with another arrow from Lucy Letby, someone has obviously checked, it may be Mr Swash himself, "Yes, nursing notes", and there are two episodes of where she appears to be involved.

So, on the face of it, some research has been done, a check's been made, Lucy Letby has been confirmed as a nurse involved with Child A's care, and that's been noted in this record.

Now, as far as Child A's family are concerned, this information was never passed to them. That really

shouldn't have happened, should it?

A. Based on the advice of counsel and the duty of candour, no, that shouldn't have happened.

Q. Thank you. So far as your involvement is concerned, is it right that you had any contact with Mr Browne during this period of time, directly?

A. I don't recall having any contact with Mr Browne.

Q. Did you have any contact with Mr Cross about it, in respect of advising about whether to disclose to the family Lucy Letby's involvement in Baby A's care?

A. I didn't have any contact with Mr Cross with regard to a conversation about disclosure.

Q. So your evidence today is you had no involvement with the decision not to disclose this information to Child A's family?

A. I have absolutely no recollection of that sort of conversation, no.

Q. Is it your evidence that you had no involvement in the decision not to disclose those pieces of information to Mr Rheinberg?

A. I do not recall any conversation with regard to the disclosure with Mr Rheinberg either, no.

Q. Or any instruction, internally, to anyone at the Trust not to disclose that information to either the

Coroner or the family?

A. I -- I would not have given that sort of specific instruction not to disclose or to obscure evidence.

Q. Did you have any involvement in assisting the evidence or the preparation for the Consultants giving evidence to the Inquest?

A. I don't recall assisting them in the preparation, no.

Q. Did you speak to Mr Cross about the preparation for the Inquest and the concern that the two Consultants, Dr Jayaram or Dr Saladi might tell the Coroner that they were concerned Lucy Letby had murdered Child A?

A. No.

Q. You are aware that they both gave evidence and, when Dr Jayaram was asked directly by the Coroner what he thought the cause of death was, he was unable to give an explanation. He alluded cryptically to the fact that there were concerns but he did not say, in terms, that he suspected Child A had been killed; are you aware of that?

A. I am aware that was his evidence, yes.

Q. You are aware that he accepted that was wrong and he should have said that?

A. I understand that's what he said, yes.

Q. Well, do you accept that?

A. Sorry?

Q. Do you accept that it was wrong?

A. Yes.

Q. This is a catastrophic failure to be open and transparent with a judicial process, isn't it, a process which is designed to find out if people have been improperly killed or treated or murdered?

A. It's to give incomplete or false evidence under oath, yes.

Q. Well, not just that. This child had died in your hospital?

A. Yes.

Q. The Consultants who treated the child thought he had been murdered, at least that was a very real possibility in their mind, they gave in evidence a courtroom which did not explain that to the Coroner and the Inquest concluded without ascertaining the child's death?

A. That would be inappropriate.

Q. You were aware of that?

A. I was aware of?

Q. The conclusion.

A. I was, in terms of unascertained, yes.

Q. Well, if you know that the two doctors who gave evidence thought the child had been murdered and you are aware that the Coronial process proceeds to its fruition, concludes, can't be re-opened without the court's approval, and the conclusion was that the death was unascertained, then wasn't it your duty to correct the Coroner?

A. I don't -- I wasn't aware that it was their view that the baby had been murdered.

Q. It wasn't your view; you weren't aware of that?

A. No.

Q. I will come back to that.

So, as far as you were concerned, you viewed the Coronial process as having been appropriately concluded and, although you were aware that Lucy Letby was suspected of having murdered patients, including Child A, you didn't alert the Coroner to that fact?

A. I trusted my colleagues. I -- I incorrectly assumed, based on this evidence, that the appropriate evidence had been given and had been considered. I do not recall having full access or any access to the statements and reviewing them. As I have already said, I don't recall the contact from Mr Swash or the comments about reviewing the statements or indeed reviewing them.

I accept that we failed in the duty of contributing to the Inquiry.

But I did nothing to obscure or withhold any evidence.

Q. Well, you met the Coroner, didn't you, I think in 2017, so 8 February, you and Mr Cross went to see him?

A. Yes.

Q. The note that Mr Cross made says that you said to the Coroner:

"No theme has emerged from the in-depth investigations."

Do you recall saying that? You had conducted by this stage a series of investigations, I will come back to exactly what they were, but of course it's the Royal College, Dr Hawdon, Dr McPartland --

A. Yes.

Q. -- and no theme had emerged?

A. We said -- I said that but in -- I am trying to remember which -- in one of the meetings that we had with Mr Rheinberg and Mr Moore, we passed over a letter that we had had from, or Tony Chambers had had, from the paediatricians requesting that we discuss with the Coroner reopening or further investigation and, as part of the conversation around passing that letter over and

by way of explaining why the paediatricians had written that letter and why we were passing it on to the Coroner, we did inform him that one of their concerns leading to this was an association with a member of staff.

Q. Well, Mr Harvey there is no note that Mr Rheinberg has made, no note that Mr Moore has made, no note that you have made, no note that Mr Cross has made that that information was ever passed to either Mr Moore or Mr Rheinberg?

A. Well, I am confident that that was because the nature of the letter that we passed across would have been inexplicable without the covering explanation.

Q. Well, the letter says the reports -- they say the reports they have received have not reassured them that the deaths and collapses are explicable by natural causes, so you may infer from that there is still some suspicion about an unnatural cause but they certainly don't say, "We are concerned that a member of staff has killed these babies".

A. No, they don't but, because of that and by way of explanation of that concern, I recall that Mr Rheinberg and Mr Moore were informed that there was that concern about an association about a member of staff.

Q. Which meeting and who said it?

A. I am unable to -- it was the meeting where we met with them to give them the letter.

Q. Well, you met them again, I think, on 15 February and, in your statement, you describe discussing the increased mortality rates and the fact that the paediatricians had raised concerns, this is paragraph 651. But that isn't in Mr Cross' note and it isn't in Mr Rheinberg's note. I think you will understand, having prepared for this evidence today, that Mr Rheinberg denies being given that information in the most strong terms. So I am going to put to you that you never said it.

A. Well, I would suggest that I did because the letter would require that explanation to go with it. In addition, I think the timely subsequent meeting notes where I am reporting to colleagues indicates, based on my recollection at that time, that I had, and I am confident that I would have given him all that information because we were at that level of concern, with the paediatricians having presented and written that letter, that we needed to raise the basis for it.

Q. But you are also aware that the Coroner is a judicial officer and they are intricately connected to the criminal justice systems as well as their own

Coronial system?
A. Yes.
Q. If a Coroner is told that a paediatrician suspects a child has been killed or, in this case, a series of children have been killed, they must act; you are aware of that: they can't sit on that information, they have to act. They have to trigger a whole series of investigative processes. If they are investigating the child's death, they need to do so with that information in mind. If they have already investigated, they need to inform the police and, in any event, some contact with the police needed to be had because a crime is suspected; you are aware of that, aren't you?
A. I am, and I can't explain why, if that is the case, Mr Rheinberg didn't trigger it. But I am confident that I informed, along with that letter, that the paediatricians had reported an association with a member of the nursing staff? You certainly should have given him that information, shouldn't you?
A. Yes.
Q. Can I go back to June 2016, please. You had the meeting on the 29th with Alison Kelly, Tony Chambers and the Consultants, where Dr Jayaram and Dr Saladi were present, and Dr Jayaram had raised concerns about Letby

always being present, in charge, the babies being stable and deteriorating and they didn't respond to resuscitation as they should. So all information which for them were red flags about something unusual going on medically?
A. Yes.
Q. Dr Brearey said there was more than just an association with the nurse and then Dr Jayaram actually speculated, as Ms Langdale put to you earlier, how the mechanism of death may have occurred with cannulas and an air embolism; do you recall that?
A. I remember seeing the documents, yes.
Q. It's in the notes?
A. Yes.
Q. Dr Saladi talked at the same time, in that same conversation -- I can take you to the page if you want to look at the notes again -- about the Twins, Child A and Child B specifically, and mentioning one of them being mottled and then both of them having mottling, so realising more was going on; do you remember that?
A. I don't recall that but I would accept that that was said.
Q. You said before about not knowing about Child A but there's a discussion with Dr Jayaram

speculating about air embolism. There is a discussion with Dr Saladi about mottling and rashes with both of the Twins. When it came to thinking about the Inquest of Child A did you remember that information, that conversation you had just a few weeks before?
A. No.
Q. You should have done, shouldn't you, because that is information that's relevant to their deaths -- sorry Child A's death?
A. Potentially, yes. I would simply say that this was, as you would imagine, a long and intensive meeting and, if I failed to recall all the detail, then I apologise.
Q. The next day you had another meeting with some of the doctors again and this time we know Jim McCormack was there and others, and Ravi Jayaram again, and again he mentions air embolism, as you know, in that meeting on the 30th, and talks about the concern about the member of staff, in other words Lucy Letby, resuscitation problems again, happening once or twice but it was happening too many times. Then he says it causes suspicion. So it was very much in play at that meeting, wasn't it, and it's a long meeting, with lots of people wading in with their opinions but it is clear from their perspective they're talking about "suspicion"

about Lucy Letby: the word is used?
A. Yes.
Q. You gradually coalesce on a plan, and can I just put to you what the thinking was and see if you agree? If necessary, I can go to the notes because Ms Hodkinson's note is very detailed about this. Mr Chambers considered it to be a hypothesis that the children had been killed by Lucy Letby and he wanted to test that hypothesis, and the options he put were "null" or nothing, "call the police" or "undertake some form of review"; does that make sense to you?
A. Yes.
Q. I think what you opted for was the review option, which, in fact, you had already put in train by that point?
A. Yes.
Q. Because you had contacted with Sue Eardley by email and I think you had spoken to her on the telephone?
A. I had had a provisional to assess the feasibility, yes, because -- yes, because if the College had said, "Well, that isn't reasonable, it's not appropriate", then that wasn't going to be an option.
Q. Well, I think you had emailed her, hadn't you, and then she had responded and then you had a phone call

with her?
A. Yes.
Q. I don't think there are notes of that phone call, are there?
A. No.
Q. But what we understand is that -- we can infer it was the phone call at which you did mention what needed to be done, a review of the unit, but you also mentioned the concerns about the nurse; is that correct?
A. I, in one of my phone calls with Sue Eardley, mention the concerns, yes.
Q. What exactly did you say?
A. I would have said that the paediatricians had raised concerns about an association of one member of staff. But that there was no other supportive evidence to go with that; that her managers and colleagues felt that it was related to her increased level of duty and that she was qualified in specialty. I probably wouldn't have been any more specific than that.
Q. So, in your head, when you were thinking about the Consultants' suspicions were you treating it as a hypothesis that needed to be tested?
A. I was keen that we could establish what was -- what was the cause or causes of the increased mortality. That based on what are the usual, what are the common,

but not ruling out more extreme, such as gross negligence.
Q. Do you recognise that it wasn't just a hypothesis, it was a risk; did you conceptualise it as such and recognise that?
A. My understanding was that Letby was on leave and, from that perspective, that particular aspect of a potential risk had been removed.
Q. But there was, of course, the risk she would return to the unit, or somewhere else in the Trust, or seek employment elsewhere, over which you, of course, had no control; that was a risk wasn't it?
A. At that time, that might have been a risk but I think, as the notes of the meeting indicate, it was to give us time really to assess what the situation was and to decide and of course, as we know, she never did return to the unit.
Q. Just looking at the notes of that meeting, do you now see how an intervention was needed, a clear-eyed intervention was needed that, if you are in a room with some paediatricians discussing whether one of their members of staff has killed their babies, and speculating about Beverley Allitt, Harold Shipman, mechanisms of murder about which they have no professional expertise, that you need to call the

police. The only option at that point is at least to get the police involved, whether it proceeds to an investigation or not, they needed to be informed as soon as you are discussing murder: it's completely outside of your expertise?
A. I think, as I gave in evidence earlier on today, one of my regrets is that having, along with Alison Kelly, come to the view that we should contact the police in June/July, that -- that we didn't. As I also stated, I am not convinced that the police would, based on the conversations we had with them nearly a year later, have undertaken an investigation, but I fully accept that they would have had oversight and they would have been able to advise with regard to the nature of the reviews and have stepped in at the first sign of anything untoward.
Q. And protected patients because they would -- if the whole process, the cascade had been triggered, Lucy Letby wouldn't have just been on leave, she would have been suspended, without at that point blame, but while an investigation took place, the LADO would have been spoken to, and decisions would have been made about the appropriate type of investigation that was required to exclude the possibility of deliberate harm?
A. Potentially, yes.

Q. You presumably had no experience of patients being deliberately harmed by members of staff before then?
A. Before this, no.
Q. Just some obvious propositions: patients in hospital are vulnerable; they spend periods of time asleep or comatose; medical staff have access to their bodies, which, of course, doesn't occur in the ordinary community; there are cannulas inserted, injections given, drugs given, and so on; staff have access to lethal drugs. All of these circumstances make it relatively easy for healthcare staff to harm patients and relatively difficult for healthcare staff to be detected when they do so. Does that all make sense to you?
A. It does. But -- but I feel that I have to point out that, actually, we had three opportunities that were missed where there was clear evidence of harm, that we weren't fortunate enough to have been informed about.
Q. Yes, and you are talking about the insulin results, for example, in Child K with Dr Jayaram?
A. I am talking about Child F, Child K and Child L.
Q. Yes. I am sure that either Ms Langdale or

your own counsel will ask you about that but I just want it focus on those basic principles.

It's relatively easy to harm a patient given their vulnerabilities and given the access to the types of drawings that you have in hospital and it can be quite difficult to detect that because a drug overdose and injection can occur innocently, routinely?

A. I'm not sure about routinely, but yes. But I would simply say that we missed those or those opportunities were missed. We had them.

Q. Are you aware of how murders are investigated?

A. In real life, no.

Q. Do you know what a forensic pathologist does?

A. I can surmise, yes.

Q. Well, they are qualified as pathologist but they have got a specialist skill in investigating and excluding crimes, and the reason it is a specialist area is because it's difficult to identify crimes and there are particular types of investigations that are done, particular checks on the body, particular investigations which they conduct, which ordinary pathologists don't; you are aware of that?

A. Yes.

Q. Are you also aware that, in order to do those investigations, they require a history, they require

information. In other words, they are given circumstances of how the body was found, who the person was with, what might be a possible cause of the criminal activity: that makes obvious sense you to?

A. Yes.

Q. Dr McCormack actually mentioned forensic pathology in the meeting on the 30th because he was concerned that the Royal College, which you were talking about, weren't going to be able to do the kind of investigation that was required. Again, looking back, do you recognise that this required forensic pathology in order to rule out a crime?

A. In retrospect, yes, that was an opportunity missed.

Q. Just to be clear: the Royal College were instructed and they did a service review. That, in fact, not only didn't look at the medical notes but it didn't examine whether a potential crime had taken place, did it?

A. I -- in my statement, I think I have covered this, insofar as, in commissioning the review, I got the Terms of Reference or the Terms of Reference were incomplete and I -- I got that wrong.

It should have been specific with regard to a Casenote Review. I anticipated that the College would

be reviewing the individual cases. Given that they were being commissioned on the basis that we were concerned about an increased mortality, I found it difficult to imagine that they wouldn't be reviewing those cases as the basis of their review, and we had prepared all the documentation for them to do that to be told, "Well, no actually that's not part of it".

So that the review that they did, no, wasn't in a position to fulfil that brief, hence the subsequent Jane Hawdon review.

Q. Yes, so to be clear, it wasn't in a position to understand why the children had died because it wasn't incorporating a Casenote Review --

A. Yes.

Q. -- and it certainly wasn't in a position to understand if they died as a result of a crime because that is a step even further than a standard Casenote Review, that requires a forensic consideration?

A. Potentially, I would say.

Q. Not potentially, that is exactly what is required?

A. Well, I suppose it depends on the mechanism of assault or death and the obvious example would be for collapse in the case of Child F. The results were in the notes. You know, we would have known that there was

insulin, so that there was certain potential.

Q. They might have spotted something untoward that could have been a crime, it is fair to say, but the Royal College of Paediatrics and Child Health don't investigate crimes, do they?

A. No.

Q. No.

A. But on the basis that I had alerted them to a concern about one member of staff and the association with her and the review going ahead, there seemed to be an acceptance that that was a reasonable path to follow, and I would point out that the paediatricians also, I think, reviewed the Terms of Reference that we had drawn up and felt that they were reasonable and appropriate for what we were doing in that circumstance.

Q. Well, the Terms of Reference looked like they considered everything.

A. Well, that that was the intention, yes.

Q. But, in fact, it is not a Casenote Review and they didn't consider criminal activity, as you have accepted?

A. It, it -- it didn't end up as a Casenote Review, although I imagine that it was going to be because I couldn't foresee how they could fulfil their brief, based on the premise, without doing that.

Q. But just to be clear, the report that was produced as a result of that review could not be relied on to exclude the possibility that the children had been harmed?

A. No.

Q. The same really must apply to Dr Hawdon's examination and Dr McPartland's examination, because first of all, Dr Hawdon, in respect of five of the deaths -- or four, and I am sure you will be asked about why that may have changed -- couldn't find an explanation. So, by definition, she hadn't found a crime or excluded a crime. She was in the same position, really, as Child A's pathologist was: it was unascertained. So that had not excluded Lucy Letby harming them?

A. No.

Q. Dr McPartland was not a forensic pathologist, so she, by definition, couldn't investigate a crime and exclude it definitively, although, as you have said, she might have found some evidence that could incriminate?

A. Yes, and, as an example, I had a conversation -- or exchanged emails or had a conversation as well with regard to the possibility of air embolus, that having been raised, and was informed by her that she would fully expect that their postmortem

would have picked up the presence of an air embolus.

Q. Yes, but to be absolutely clear, she was not a forensic pathologist --

A. No.

Q. -- and she was not briefed to investigate criminal activity?

A. No, she was a specialist paediatric neonatal pathologist.

Q. So as all these investigations are being pursued throughout the course of 2016 and into 2017, the upshot is that none of them, in fact, exclude the possibility that had been raised on 29 and 30 June 2016 that Lucy Letby harmed the children: none of them?

A. No, which is why we ended up subsequently going to the police.

Q. Well, I will come back to that. You presented a paper to the board on 10 January 2017, INQ0003518, it'll come up; do you remember this?

A. Yes.

Q. You discussed the Royal College Review but you don't make clear that it hadn't addressed the Consultants' concerns, correct?

A. Correct.

Q. You also, without naming them, I think, mentioned Dr Hawdon and Dr McPartland because they are

the secondary reviewers, one doing a case review, the second with specialist expertise on pathology and, again, of course, you don't mention and couldn't have mentioned that they hadn't excluded a crime because they hadn't; is that correct?

A. Correct.

Q. During this meeting -- and I can take you to the notes of the substantive meeting, I think you are familiar with them but, for reference, it's INQ0003237 -- Mr Chambers repeatedly dismissed the concerns of the Consultants as being unsubstantiated. Now, the reality was that they had not, in fact, been directly investigated and excluded as possibilities. You have already accepted that?

A. They had been excluded to the extent of the reviews that we had carried out. I will accept that not to the level of a forensic, yes.

Q. Well, the reviews had not looked for a crime and they had not excluded a crime, had they?

A. The reviews hadn't been specifically commissioned to look for a crime. But I suppose we had anticipated that, in the event that there had been a malicious act, that there would have been evidence found in the course of those reviews.

Q. Well, you have a scientific background. If

you have a hypothesis that needs testing, you have to direct your research to that hypothesis. The hypothesis was: Lucy Letby has murdered or killed these children through mechanism unknown, investigate it, please.

Royal College, Dr Hawdon, Dr McPartland, or some other person, needed to actually investigate that directly, didn't they?

A. I don't think the time that these were commissioned we were in a position to say that this is suspected murder.

Q. Well, you were because that was actually mentioned explicitly -- the word "murder" is never used but the suspicion of deliberate harm is absolutely clear from the notes that you had been taken to on the 29th and the 30th?

A. And it was the anticipation that there would have been findings within the definitive note reviews to highlight.

Q. Well, they may have found something, as you say. In fact, if they had looked at the insulin results for particular children on a Casenote Review, it might have been possible, for those two children, a Casenote Review might have found that abnormal result; that is fair, isn't it?

A. Well, I would suggest that that wasn't

a might, that would have been a definite.
Q. That they would have found it --
A. Yes.
Q. -- if a Casenote Review had been undertaken?
A. Yes, because having -- as part of the preparation for this Inquiry, I have had the opportunity to -- to look at the case notes myself and those results are clearly documented actually within the written note. They are not, as sometimes happens, within the results section, where things can fall out.
Q. But the reality is that the investigations that you commissioned, as you have accepted, although they might have found evidence to support criminal activity were not designed and aimed to find it?
A. I would accept that.
Q. So when you attend the board and present your paper, you are reassuring them that proper investigations have taken place and that, as a result of those investigations, Mr Chambers is allowed to say to the board, in front of you, without correction, that the allegations against the nurse are unsubstantiated.
And you would go even further, collectively as an Executive, and advise them that Lucy Letby should be supported in her return to the unit.
That's completely unacceptable, isn't it?

A. I would only say that that was the view based on the evidence that we had at that time.
Q. It wasn't --
A. -- with -- on retrospect, yes.
And as, you know, I -- I have now repeatedly said I regret that we didn't contact the police in June/July 2016.
Q. Just focusing on that. It doesn't require retrospect. You were in a meeting, advising the most senior people in your Trust to support you putting someone back in the unit who had not been investigated for potential crimes. That is an extraordinary failure on your part, do you accept that?
A. I believe that I was making these statements in good faith, based on the evidence that I had available to me at that time.
Q. What evidence did you have that Lucy Letby had not killed those children?
A. It was the fact that nothing had been specifically raised in the course of the College review, Dr Hawdon's review, in discussing with Dr McPartland, with regard to the previous postmortems, that some of the babies had had.
Q. Well --
A. I accept, with retrospect, that that is

incomprehensive. That is with the benefit of knowing how things came out.
But this was a series of investigations, a series of reviews and a statement that was made in good faith at that time.
Q. Mr Harvey, I'm struggling to understand the logic of your answers. You have accepted, as I have taken you through them, that the Royal College Review, Dr Hawdon's review, Dr McPartland's review did not exclude a crime on the part of -- crimes committed on the part of Lucy Letby.
In this meeting it is being presented that there is no substantive evidence to that allegation and it is being recommended that she go back to the unit on that basis. That was wrong as an assertion and it was dangerous and irresponsible. The logic of that is impossible to disagree with.
A. I'm sorry. I'm sorry --
Q. Do you want me to take you through it again?
A. Well, no. I'm sorry, I apologise. I didn't hear a question.
Q. You had investigated, using the Royal College, Dr Hawdon, Dr McPartland whether or not there may have been some medical cause for these children's deaths. They had not identified a definitive theme, but none of

those investigations, as you have accepted, excluded the possibility that Lucy Letby had killed the children; you've accepted that already.
A. I accept that they didn't go to the level of a forensic investigation and, in hindsight, that was incorrect.
Q. They did not exclude a crime.
A. They certainly didn't highlight one. I can't say that they excluded.
Q. They did not exclude a crime, did they?
Any of those reviews did not exclude the possibility the children had been killed deliberately?
A. Nor did they actually bring anything out to suggest that there had been any malicious act in, in any of those.
Q. Well, in those circumstances, finally, I put to you that it was irresponsible and dangerous to return Lucy Letby to the unit because you could not be confident, as the Medical Director of the hospital responsible for patient safety at the Countess of Chester, that Lucy Letby would not harm children again?
A. I would have to accept that, with retrospect, yes, it would have been a risk -- well, more than a risk for her to have gone back on to the unit.
Q. One which should never have been countenanced?

A. Looking at this no.

MR SKELTON: Thank you. Thank you, my Lady.

LADY JUSTICE THIRLWALL: Thank you very much, Mr Skelton. Mr Harvey, we are going to adjourn now until tomorrow morning at 10 o'clock.

A. Yes, my Lady.

LADY JUSTICE THIRLWALL: So 10 o'clock tomorrow.

(5.02 pm)

(The Inquiry adjourned until 10.00 am, on Friday, 29 November 2024)

I N D E X