

Friday, 29 November 2024

(10.00 am)

**MR IAN HARVEY (continued)**

**Questions by MS LANGDALE (continued)**

**LADY JUSTICE THIRLWALL:** Ms Langdale.

**MS LANGDALE:** Mr Harvey, do you have your statement with you as well today?

**A.** I do, thank you.

**Q.** Yesterday, in answer to Mr Skelton, you accepted that the RCPCH Review didn't exclude the possibility that Letby had harmed babies; you remember that?

**A.** I do.

**Q.** That was made clear to you at the time, wasn't it: that it wasn't going to deal with that question about Letby. Shall I take you to the interview you had with the reviewers at INQ0014604, page 1.

We see here the note of your interview with the reviewers and one of the reviewers said at the beginning:

"We may not be able to explore the detail of the deaths, the correlation of one nurse."

If we go to page 6 -- I don't think that's the right page. It's the one that says "not sure if the review will give you the answers you are's looking for".

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what was actually said. At no --

**Q.** What about -- sorry.

**A.** At no point did any member of the College team come to either I or -- in the course of the meeting I had with Mrs Kelly and the Review Team, nor at the mopping up meeting at the end of the review with the two members of the team, I believe, and Tony Chambers and Alison Kelly, at no point did they indicate that they had considered aborting the review.

**Q.** Well, let's look at the first comment then, INQ0014604, page 1, do you dispute this was said:

"We may not be able to explore the detail of the deaths, correlation of one nurse, paediatricians see as elephant in the room."

Do you dispute that they said "we may not be able to explore the detail, we may not be able to examine the deaths and explore that level of detail"? It may not have been expressed as clearly as you would have liked it but, if you were listening, that's what they said; do you agree?

**A.** I understand that they told us that they may not be able to do a detailed case report, as I believe I said in evidence yesterday. That was unexpected. I appreciate that the Casenote Review wasn't explicit in the Terms of Reference, but I wrongly, as it turns out,

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Can we try please INQ0014605, page 6.

It's got a different number, Mr Harvey, and "IC" refers to you at the top. Do you see there the reviewer is saying:

"Not sure if the review will give you the answers you are looking for. Considered aborting and starting again but Terms of Reference to be important to get the background."

When they said "not sure it will give you the answers you are looking for", they were clearly, in the context of what I've referred you to earlier, saying, "We can't look at the correlation of a nurse and the deaths, that's not what we do, we are doing a broader review". Do you agree that's what they were flagging up for you at an early stage?

**A.** I don't read that sentence as that actually being said to us because I am clear that, at no point, did the Review Team tell us that they had considered aborting the review and starting again. At no time did they explicitly or implicitly suggest that they considered aborting the review.

**Q.** That is what the note says, are you saying someone's written that when it's not the case, or written it later, or what's your thinking about that?

**A.** I'm not sure that that is a verbatim report of

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assumed that, in commissioning them to review on the back of concerns about increased mortality, it was inherent in that review that they would actually be reviewing the cases that were the cause of the need for the review.

**Q.** Sue Eardley gave evidence to say that she wrote notes pretty verbatim, and this isn't talking about case notes, it says in terms, "not be able to explore the detail of the deaths". The paediatricians had raised suspicions about the causes of the deaths. You will have appreciated straightaway that they were not going to tell you what the causes of the deaths were or the detail of the individual deaths; that's what that says?

**A.** They were indicating that they -- and actually the statement says "may not be able", it wasn't definitive. But, on the basis of the conversations that we had with the College, the feeling was that it was still going to be a worthwhile exercise. It was an opportunity for them to have conversations with all the members of staff including the paediatricians.

**Q.** The Review Team might have thought it was a worthwhile exercise to have a broader canvas but you are spending money and taking time on a review that isn't going to answer the question that you have got in

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1 front of you, that the paediatricians have raised?

2 **A.** I believe that potentially, at that time,  
3 being faced with an increased mortality of unknown  
4 origin, it was perfectly reasonable to explore with  
5 neonatal experts, both medical and nursing, the full  
6 range of potential causes, and I think that was  
7 reflected in the Terms of Reference.

8 **Q.** You referred then in your answer to the  
9 increase in mortality. Can we please have INQ0010256,  
10 page 1. It's the Terms of Reference for this review  
11 and, again, we see at bullet point 4 "apparent increase"  
12 in mortality being described. It was an increase in  
13 mortality; why did you say "apparent increase" in the  
14 Terms of Reference?

15 **A.** "Apparent", as I think I gave in evidence  
16 yesterday, was used in terms of, whilst I accepted that  
17 the increase -- there was an absolute increase in the  
18 number, that we had not subjected it to statistical  
19 analysis and, whilst appreciating the significance of  
20 each individual death, I described it as "apparent"  
21 because it was not proven to be statistically  
22 significant. There was no other significance to the use  
23 of that word.

24 **Q.** You were steering a wide-ranging review,  
25 weren't you, in the knowledge that it was never going to

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1 **A.** It was.

2 **Q.** During that time, there was no proper  
3 investigation taking place into Letby and her role in  
4 respect of the deaths, was there?

5 **A.** We were following the process that had been  
6 initiated with the College. We were following the  
7 process that they had recommended in terms of a further  
8 Casenote Review, and I would have to say that the basis  
9 of the College report, after they had consulted with the  
10 paediatricians, did nothing to raise the level of  
11 concern because of the terms that they used in their  
12 report.

13 **Q.** Let's look at how you managed the receipt of  
14 the report. Doctors Brearey and Jayaram were given one  
15 hour to read the draft report in November 2016, weren't  
16 they?

17 **A.** I don't believe that that time limit was  
18 imposed. I gave Dr -- and this was on the College's  
19 advice, that it should be shared with some of the senior  
20 members but that was purely for a fact checking and  
21 confirmation, so --

22 **Q.** They could only check facts if they saw the  
23 whole report and there were parts of it that they  
24 weren't shown, weren't there?

25 **A.** On -- the implication from the advice from the

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1 be able to exclude the possibility that Letby had harmed  
2 babies?

3 **A.** I was commissioning this review on the basis  
4 that we had an unexplained increase in mortality.  
5 I believed it would be an opportunity for the  
6 paediatricians to discuss. I, at the outset,  
7 anticipated and we had prepared all the documentation  
8 for the team to review the individual cases but, having  
9 initiated the process, I felt that it was still  
10 appropriate and valid to fully explore the full range of  
11 potential contributory factors.

12 **Q.** It wasn't the full range because they couldn't  
13 explore the one that the paediatricians had raised:  
14 whether a nurse was responsible for causing the deaths.  
15 That was the very option they could not review?

16 **A.** I was not under that impression at the time  
17 that this was commissioned and at the time we prepared  
18 for the report.

19 **Q.** Was that because you didn't listen to what was  
20 being said to you?

21 **A.** I don't believe so, no.

22 **Q.** You instructed them on 7 July 2016, you  
23 received a draft report 18 October 2016 and a final  
24 report 28 November 2016. This was a long period of  
25 time, this review?

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1 College was that the "green text", as they described it,  
2 was confidential and not for wider sharing.

3 **Q.** Well, let's put the green text, so people know  
4 what you are saying here. INQ0005273, pages 8 and 9.  
5 I take the point in your statement, Mr Harvey, you don't  
6 like the use of the word "redacted". What you are  
7 saying there is the green text was something they had  
8 highlighted as different and you took that out, that's  
9 why you took it out before people saw the report?

10 **A.** On the College advice, yes.

11 **Q.** You had commissioned the report though, you  
12 could share it with who you wanted to, they couldn't  
13 tell you what to do about that, could they: you are the  
14 person paying for it, you are the person who knows who  
15 needs to see what within your organisation?

16 **A.** That -- that is true but, having commissioned  
17 that report from a Royal College, having had a team that  
18 was a team of experts and that team included a lay  
19 member, who was, albeit inactive, but a barrister.

20 **Q.** So what did you draw from the fact that she  
21 was described as a barrister, albeit a non-practising  
22 barrister?

23 **A.** From that and her -- the description of her  
24 activities with the NMC and NCAS, I took it that what  
25 was being presented was reasonable and appropriate

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1 advice and, in being advised that the green text was not  
2 for wider sharing, that there was a basis for that that  
3 I should listen to.

4 **Q.** So you took it as legal advice, effectively?

5 **A.** No, I don't -- I didn't take it as legal  
6 advice but I took it as senior and knowledgeable advice.

7 **Q.** Did you go to people within your own  
8 organisation who were knowledgeable, some of your own  
9 in-house lawyers, or Mr Cross, and say, "Look, I think  
10 everyone needs to see this"?

11 **A.** I didn't put it in those terms, no. It was  
12 shared with Mr Cross.

13 **Q.** If we can see, on 3.12 -- that's the paragraph  
14 in green text -- while we are on this page and so  
15 everybody is clear, we know there was a confidential  
16 version that contained everything that we see, there was  
17 a disseminated version that removed the green text that  
18 we are going to see as we go through and then there was  
19 a published version. I think the published version was  
20 the one that went to the Families, too; is that right?

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

22 **Q.** The published version had some other things  
23 taken out, such as at the top of this page:

24 "However, in June 2016, the deaths of two of the  
25 three Triplets provoked further concerns and triggered

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1 have a read of that:

2 "Please find attached the draft report for your  
3 review. It does provide some fairly strong  
4 recommendations so I would be grateful if you and  
5 (*unclear*) could have a first read through yourself and  
6 let me know anything that might be sensitive. Once you  
7 are happy, perhaps you can share it with a few selected  
8 people, including I would guess Ravi, Stephen and  
9 Eirian, to check for any obvious inaccuracies."

10 Where does that say you can't share parts of the  
11 report with the Consultants?

12 **A.** It doesn't reference it in that email but I --  
13 I recall that there was another email that made that  
14 sort of reference.

15 **Q.** So you think somewhere in all of the documents  
16 we will find an email saying that?

17 **A.** I -- I believe so.

18 **Q.** Is it what you didn't want to do: share the  
19 concerns about the nurse that they had flagged up  
20 because they flagged up an HR process was necessary  
21 immediately, didn't they?

22 **A.** No, it wasn't my deliberate intention to -- to  
23 withhold that from them.

24 **Q.** That can come down. The final report was  
25 provided on 28 November 2016. Why did it take until

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1 this review."

2 That was taken out, wasn't it, and so was the  
3 Appendix 4, which I don't need to go to, the chronology,  
4 before it was more widely published?

5 **A.** I would have to accept what you say. I --  
6 I cannot remember.

7 **Q.** If we go to the next page, page 10, we see the  
8 other parts that are in green. So you would agree with  
9 me, that when Drs Brearey and Jayaram saw the report,  
10 those bits had been taken out?

11 **A.** Yes.

12 **Q.** Did you see any reason at all to take those  
13 bits out from Dr Jayaram and Dr Brearey's reading: they  
14 knew all about the nurse and what was going on; it was  
15 their concerns?

16 **A.** Over and above the advice from the -- the  
17 College, no, I didn't. And I can fully appreciate how  
18 that would influence how Dr Jayaram and Dr Brearey would  
19 subsequently review the report because it obviously  
20 didn't truly reflect the conversations that they had had  
21 with the College team.

22 **Q.** Can we have a look, please, at INQ0003403,  
23 page 1, and it's the email from Ms Eardley sending the  
24 draft report. I just want to see where you say she said  
25 "Don't share the green text with the Consultants", so

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1 February 2017 and a leak to The Sunday Times for it to  
2 finally be published?

3 **A.** To be perfectly honest, I am unable to answer  
4 that question.

5 **Q.** Sorry, "to be perfectly honest" ...?

6 **A.** I am unable to answer that question.

7 **Q.** Well, you had this report; you were keen to  
8 get it; it needed to be shared, didn't it?

9 **A.** It did.

10 **Q.** So why didn't you?

11 **A.** Sorry, without reviewing the documentation,  
12 I -- I -- I can't answer that.

13 **Q.** Well, there's no documents --

14 **A.** I can't recall.

15 **Q.** -- that answer it, it is just the chronology  
16 of facts. We know that it was leaked to The Sunday  
17 Times, you were asked about that --

18 **A.** Yes.

19 **Q.** -- the comments on that, and then -- we will  
20 come to it later -- there were letters and phone calls  
21 made to parents and there was a very much on the back  
22 foot response to what you should be doing with the  
23 report: why was that; why did you sit on it?

24 **A.** I can only imagine it was because we were  
25 drawing up a plan of action with regard to how and to

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1 whom we should be sharing it and in what order. What  
2 I can't explain is why that took so long.

3 **Q.** Well, what was your thinking about in what  
4 order: what order should it have been?

5 **A.** Well, the order should have been that it  
6 should have been shared with the parents.

7 **Q.** So what was troubling you, as soon as you got  
8 it in November 2016, about sharing it with the parents?

9 **A.** I -- I don't recall that there was anything  
10 that was troubling me with regard to sharing it with the  
11 parents.

12 **Q.** Well, it was troubling you that you couldn't  
13 share the bits in green with Drs Jayaram and Brearey, so  
14 were you troubled about having to share that with the  
15 parents?

16 **A.** Until we had completed the full Casenote  
17 Review -- and because of that I don't think that we felt  
18 that we had actually fulfilled the requirement of the  
19 report -- I was uncomfortable with sharing until we were  
20 able to give a much fuller picture.

21 **Q.** The report had said, we had it on the screen  
22 a moment ago:

23 "In the light of information shared with the Review  
24 Team, the RCPCH advised the Trust to follow corporate  
25 processes in responding to allegations of misconduct by

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1 **A.** That would not accord with the subsequent  
2 emails in which Sue Eardley recommended independent  
3 neonatal experts to do the Casenote Review.

4 **Q.** I am asking about the first part, about the  
5 investigation into Letby, opening an investigation "in  
6 responding to allegations of misconduct". The first  
7 part, the bit that the Consultants were concerned about,  
8 not the case review and further requirements around  
9 that.

10 **A.** And I don't think that I or any of my  
11 colleagues interpreted that as responding to allegations  
12 of misconduct by Letby.

13 **Q.** Can you try and explain that because I'm not  
14 sure I understand it at all.

15 **A.** In retrospect, I should have sought  
16 clarification on that.

17 **Q.** What needed clarifying?

18 **A.** What needed clarifying was regard to the  
19 specific allegations of misconduct.

20 **Q.** The allegations of misconduct was that they  
21 suspected her of deliberately harming babies. Go back  
22 to your 30 June meeting: "Beverley Allitt situation",  
23 "Shipman situation", that she was killing babies.  
24 Allegations of misconduct, there isn't a worse one, is  
25 there, than being suspected of killing babies?

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1 opening an investigation. It was also recommended  
2 a full and independent Casenote Review was required on  
3 the deaths, prioritising those that were unexpected."

4 So that report flagged up very clearly a need to  
5 respond to allegations of misconduct. That didn't  
6 happen, did it; you did not, pursuant to that  
7 recommendation, open an investigation into Letby?

8 **A.** It wasn't explicit in that with regard to the  
9 misconduct, although --

10 **Q.** Because they hadn't described the precise  
11 misconduct: is that what you are saying?

12 **A.** Well, yes, and, by the same token, I would  
13 accept that I didn't seek clarification.

14 **Q.** Well, let's have it back on the screen,  
15 INQ0005273, page 10:

16 "In the light of information ..."

17 Do you see that paragraph below the green text?

18 **A.** Yes.

19 **Q.** "... advise the Trust to follow corporate  
20 processes in responding to allegations of misconduct by  
21 opening an investigation."

22 It wasn't an investigation you could conduct, they  
23 couldn't conduct it but the police could conduct it.

24 That was another moment when it should have been obvious  
25 that you contacted the police; do you agree?

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1 **A.** But then if you follow with the recommendation  
2 directly underneath, that in the black text it is advice  
3 but the recommendation underneath does not actually  
4 tally with that, because it doesn't mention any further  
5 details about allegations of misconduct. It simply goes  
6 on as the recommendation, following on from that  
7 paragraph, that there should be a thorough external  
8 independent review of --

9 **Q.** Of every death because --

10 **A.** Yes.

11 **Q.** -- as they told you at the beginning, they  
12 couldn't look at the deaths, they weren't able to do  
13 that --

14 **A.** Yes.

15 **Q.** -- they didn't have pathologists, they didn't  
16 have the variety of expertise within it and it's not  
17 what they do in a service review. So doesn't the next  
18 paragraph just say, "Have a thorough external  
19 independent review of each death, try and understand  
20 what happened"?

21 **A.** Yes, and that was -- those were the  
22 recommendations following on from the paragraph above.  
23 It didn't, in any way, in terms of the recommendation of  
24 what we should do, be any more specific than we should  
25 be doing an external, independent review of each death.

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1 **Q.** Let's take that down, please, and can we go to  
2 INQ0004341, page 1. This is a Quality Safety and  
3 Patient Experience Committee on Monday, 19 September,  
4 where you provide a report back on the RCPC at page 2.  
5 Perhaps we can all take time to read what you say at the  
6 top of page 2 about the NNU.

7 If we can make it larger, thank you.

8 You are giving a verbal update and you say:

9 "The external Review Team had not raised any  
10 immediate concerns and the Trust was awaiting the final  
11 report. The team had been very complimentary about the  
12 staff they had met. The College had recommended that  
13 Trust commissions a forensic review of the cases that  
14 sparked the external in the first place, carried out by  
15 two independent paediatricians."

16 So you refer to the need for a forensic review but  
17 you say they hadn't raised any immediate concerns. They  
18 had, hadn't they? They had said:

19 "It is important that the Trust takes immediate  
20 steps to formalise the actions you are taking with the  
21 nurse."

22 **A.** I would draw a distinction in terms of the use  
23 of immediate concerns. For most Trusts/hospitals, if  
24 an external organisation comes in, for example the CQC,  
25 an immediate concern is one where they say there and

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1 explicit.

2 I -- in terms of further investigation, I believe  
3 that we associated that with the Casenote Review because  
4 that was, as we viewed it, part of the investigation  
5 into how the babies had died, whether there were any  
6 factors that might be associated.

7 **Q.** You weren't prepared to conduct or authorise  
8 any investigation, until you had satisfied yourself as  
9 Medical Director that you had concrete proof; is that  
10 the position?

11 **A.** I wouldn't go so far as saying "concrete  
12 proof".

13 **Q.** What would you say then?

14 **A.** But we were faced with a situation where there  
15 was an increase in mortality, which was unexplained. We  
16 were faced with a report that had highlighted concerns  
17 about some areas. We had had the Silver Control review  
18 which had highlighted some areas of concern, and we were  
19 in a position where there was a series of postmortems  
20 that had not highlighted any evidence of anything but  
21 natural causes.

22 **Q.** The postmortems, as you well know by now, were  
23 conducted without anyone knowing there was a suspicion  
24 or concern about somebody being present at the deaths,  
25 and that they were sudden and unexpected. That's really

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1 then, "You have to do this right now before we leave the  
2 building. You have to stop this service. You have to  
3 do this". And in describing immediate concerns there,  
4 that was what I was capturing.

5 **Q.** Can we look, please, at INQ0003120. If we go  
6 over the page, "Action required", at the top. If we can  
7 highlight, "It is important the Trust takes immediate  
8 steps to formalise the actions you are taking with the  
9 nurse":

10 "Our understanding is an allegation has been made  
11 and a process of investigation needs to be put in place  
12 which sets out nature of the allegation and the process  
13 you will follow."

14 It should have said or might have said "Go to the  
15 police", but you are the decision maker here and you  
16 have the bigger picture and you had had all of the  
17 meetings and emails from Drs Brearey, Jayaram and the  
18 other Consultants.

19 This was a request or a recommendation to take  
20 immediate action and, here you are, telling the QSPEC,  
21 that they had not raised any immediate concerns. They  
22 were concerned that you weren't dealing with one of the  
23 most serious allegations that could be made; do you  
24 agree?

25 **A.** I'm -- I am not convinced that that is

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1 important when assessing what's happened to a baby,  
2 isn't it: you need clinicians and pathologists to be  
3 speaking about the concerns of the clinicians and for  
4 the pathology team to know what those concerns are, when  
5 they are looking forensically at what may have occurred;  
6 you know that is the case?

7 **A.** I -- I do.

8 **Q.** Why didn't you know that then?

9 **A.** I would also say that, in the documentation  
10 that would be requesting the postmortem and the document  
11 that was going to the Coroner who might request  
12 a postmortem, there was nothing that those submitting  
13 those applications were putting in that led to a more  
14 detailed postmortem.

15 **Q.** That can --

16 **A.** And that would influence how we would view the  
17 situation.

18 **Q.** So what was the point of asking for their  
19 advice at all because they had told you they couldn't  
20 really answer your question. When they had given you  
21 this advice, you ignored it anyway because you know  
22 better?

23 **A.** No, I didn't know better. But we acted on  
24 their advice in progressing with the Casenote Review.

25 **Q.** Let's go to that, if that can come down.

20

1 Dr Hawdon gave evidence to the Inquiry, Mr Harvey, and  
2 she was asked if she was aware there was a particular  
3 member of staff that they suspected was harming babies.  
4 She said:

5 "I now feel misled. I can't say who misled me but  
6 I feel misled and, as I have said before, if those  
7 details had been made available to me, the process which  
8 would have followed would have been very different."

9 Dr Hawdon feels misled. She didn't know that the  
10 Consultants were suspicious about a member of staff and  
11 that would have influenced her in both how she conducted  
12 her work and what she said subsequently.

13 Do you take responsibility for Dr Hawdon being  
14 misled about both what was required and the information  
15 that she was given?

16 **A.** I was responsible for instructing Dr Hawdon.  
17 I recall that in the process of a conversation with her  
18 I made reference to there having been a member of staff  
19 who was associated more commonly.

20 **Q.** "Associated"? We have been through this  
21 yesterday. "Associated" doesn't communicate suspected  
22 of killing babies?

23 **A.** Well, I put it in terms of association and  
24 I was influenced by the Royal College report and their  
25 reference to "gut feeling". The College report having

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1 process we were going through was a reasonable and  
2 appropriate route of escalation?

3 **Q.** Well, we will come on to the paediatricians  
4 and their conversations with you. But let's deal with  
5 INQ0003123, page 1. This is where Dr Hawdon raises  
6 issues of consent with you. You say.

7 "Re parental consent: we had informed parents ahead  
8 of the review that it was occurring. I had not got  
9 a particular template. Whilst I have done a lot of  
10 adult Mortality Reviewing, I have no experience in  
11 neonates."

12 So tell us what you say you had done in terms of  
13 getting informed parental consent ahead of the Hawdon  
14 Review?

15 **A.** I was seeking Dr Hawdon's advice with regard  
16 to the most appropriate communication to -- to do that.

17 **Q.** Well, you have asked her for a template but  
18 you actually assert: we had informed parents ahead of  
19 the review. So, from her point of view, you have got  
20 the consents.

21 **A.** No, I -- all I am implying is that I -- that  
22 there was information that a review was going to occur.  
23 In asking for a template, I believe I'm indicating that  
24 we hadn't, at that point, had informed consent.

25 **Q.** So you agree you hadn't informed any parent

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1 not put it any stronger than that, I believe that would  
2 influence how I would, in turn, speak to Dr Hawdon and  
3 commission Dr Hawdon.

4 **Q.** So you took the impression of the reviewers,  
5 who had met people over a shorter period of time than  
6 you, and you say you rely on gut feeling, as described  
7 by them, rather than your own impression of Dr Brearey,  
8 who you had spoken to many times about this?

9 **A.** Given the expertise of the College Reviewers,  
10 yes.

11 **Q.** What expertise, can you expand on that?

12 **A.** My understanding that these were very  
13 experienced specialist neonatologists with great  
14 experience and knowledge.

15 **Q.** Because by using the word "association" of one  
16 member of staff, and sometimes you add, "and there were  
17 others there but less frequently", you were minimising,  
18 weren't you, the allegations that had been made when you  
19 spoke to Dr Hawdon?

20 **A.** I'm not clear that, at that point, the  
21 allegations were any greater. We had -- in the series  
22 of meetings with the paediatricians -- had a number of  
23 detailed conversations and, in going through this  
24 process, I think there is documentary evidence to  
25 confirm that the paediatricians had felt that the

22

1 about this at all, at the time of writing that email?

2 **A.** I am indicating that we had informed them that  
3 the review was occurring.

4 **Q.** Yes. Just answer this question: had you  
5 contacted any parent of the babies that Dr Hawdon  
6 reviewed to ask them if their medical notes, their  
7 babies' medical notes, could go to Dr Hawdon and the  
8 purposes of the review; had you asked any parent at the  
9 time of writing the email?

10 **A.** I cannot recall, based on that email.

11 **Q.** Don't worry about the email.

12 **A.** Yes.

13 **Q.** You know now. Had you done that?

14 **A.** I don't know, I'm sorry.

15 **Q.** I'm sorry?

16 **A.** I said, "I don't know, I'm sorry".

17 **Q.** You didn't, did you? You do know you didn't  
18 do that. You are here to tell truth: you didn't do  
19 that?

20 **A.** I am fully aware of the oath that I took and  
21 I cannot remember.

22 **Q.** You would remember writing to parents about  
23 this review, if you had done so, wouldn't you? How  
24 would you have got the information. Just think about  
25 how you would have got the information, who would have

24

1 got it for you -- these babies, where their parents  
2 were -- who would have got that information at this time  
3 in September 2016 for you?

4 **A.** I would almost certainly have delegated this  
5 task. But I have no recollection of following that  
6 through. If I didn't, then that is a significant error  
7 on my part and I'm -- I'm very sorry for that.

8 **Q.** I'm not sure what an apology means when you  
9 caveat with "if I didn't". We know, and you have seen  
10 the documents, after The Sunday Times publish or refer  
11 to publishing the report, in that February 2017, there  
12 are efforts to contact parents. We don't see any  
13 evidence of efforts to contact parents before then. The  
14 Inquiry has seen no such evidence.

15 So, if you did do this, we don't have any documents  
16 and only you would remember. But it looks like you  
17 didn't, so why not own the fact you didn't do that?

18 **A.** If there is no evidence to that effect, I can  
19 only surmise that it didn't, in which case I'm truly  
20 sorry that I didn't.

21 **Q.** That feels much harder than it should be,  
22 Mr Harvey, to get that acceptance.

23 **A.** Absolutely not. It is based on the fact that  
24 I, many years after the fact, cannot remember.

25 **Q.** Well, you apologised at the beginning  
25

1 nurse records are entered on to Meditech, so presumably  
2 will need to be printed off one at a time. All entries  
3 are under patient care notes. In addition, the  
4 reviewers will need to access BadgerNet. Some of the  
5 X-rays are also quite important in some of the cases but  
6 I am sure you have thought of this already."

7 You hadn't thought about those things already, had  
8 you?

9 **A.** I had, insofar as I had requested that we pull  
10 together all the -- all the documentation that we had  
11 for each baby to be sent.

12 **Q.** The Royal College had suggested that:  
13 "When these further forensic Casenote Reviews were  
14 conducted with expertise in neonatology and pathology,  
15 it should ideally have case notes, and electronic  
16 records should ideally be paginated to facilitate  
17 reference and triangulation."

18 What's the important of to facilitate reference and  
19 triangulation in a forensic review; what are people  
20 trying to triangulate when they conduct a forensic  
21 review?

22 **A.** Presumably to be able to cross-reference the  
23 timing of events.

24 **Q.** So it's really important and Dr Brearey is  
25 making it clear to make sure they have all the

27

1 yesterday for getting communications with families  
2 wrong, and you have had a long time to think about it.  
3 Did you listen to the parents' evidence in this Inquiry?

4 **A.** I did.

5 **Q.** So you know what they all have said about  
6 that?

7 **A.** Yes.

8 **Q.** So you have had a chance to think about it.  
9 So are you genuinely saying, "I got that wrong, I didn't  
10 contact people and I shouldn't have said that to  
11 Dr Hawdon"? Or are you saying, "I don't recollect and,  
12 if I didn't, I'm sorry"?

13 **A.** I am saying that where I am found to have  
14 failed in either the type, the quantity, the quality of  
15 any communications, I'm truly sorry.

16 **Q.** Let's go to INQ0103171, page 1. Dr Brearey,  
17 despite the fact you don't seem to look to him for his  
18 views on a number of occasions when you are not meeting  
19 with the paediatricians, tries to assist you,  
20 20 September, in this email:

21 "Dear Ian, I have been thinking about the upcoming  
22 Casenote Review. As I have gone through these cases  
23 a number of times, I just needed to point out that  
24 providing just the case notes to the reviewers will not  
25 be enough for them to review the care fully. All the

26

1 information, X-rays, X-ray reports, case notes, medical  
2 notes, and ideally you should be having conversations  
3 with the clinicians who were there, in case the notes  
4 don't record everything. That's a forensic review,  
5 isn't it?

6 **A.** Yes?

7 **Q.** Proper consultation between clinicians and  
8 pathologists?

9 **A.** Yes.

10 **Q.** Dr Hawdon described getting a box with  
11 different case notes in different places, no doubt  
12 because people had gone through them many times from  
13 what you have said. But no thought given to the queries  
14 Dr Brearey raises.

15 Indeed, when we look at who put them together --  
16 give me one moment -- I think it came from Annemarie  
17 Lawrence -- we will check that -- but from a different  
18 team, a Risk Team putting the bundles together. You  
19 didn't get assistance, did you, from a doctor or  
20 somebody who had already (*unclear*) the notes about how  
21 you needed to put that material together?

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

23 **Q.** You didn't. The other important issue was  
24 which babies were you going to even invite the review  
25 upon. You didn't get their assistance with that either,

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1 the paediatricians, did you?

2 **A.** No.

3 **Q.** We know Baby A had died and was a Twin and his  
4 sister had also deteriorated and collapsed, and we know  
5 Baby E had died, and he also had a twin, Baby F, and you  
6 know that O and P were part of triplets. So, at the  
7 time you were asking Dr Hawdon to look at this review  
8 the concept must have become clearer that multiple  
9 births were being affected two pairs of twins and  
10 triplets as well.

11 Whilst Dr Hawdon was asked to look at Baby A and E,  
12 she was not asked to look at babies B and F was she?

13 **A.** No.

14 **Q.** Had she been invited and someone given thought  
15 to the fact, well, let's have the twins, in both cases,  
16 it may have been much more value. Even at that stage,  
17 with just a Casenote Review, looking at E and F would  
18 have been much greater value, wouldn't it?

19 **A.** Yes, it would.

20 **Q.** You said yesterday you had gone through the  
21 notes and seen the insulin report and where it was. As  
22 night follows day, Dr Hawdon would have done, wouldn't  
23 she?

24 **A.** She would.

25 **Q.** You had also in your Silver Command got

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1 that had been identified in the course of Ruth  
2 Millward's earlier review of incident reports and absent  
3 incident reports.

4 **Q.** Can we go now, please, to INQ0058920, page 1.  
5 This is moving forward in time, February 2017, and you  
6 write to Dr Subhedar and say:

7 "As you are probably aware, the RCPCH Review has  
8 leaked to The Sunday Times. I believe that we have  
9 forwarded embargoed copies to Commissioners, regulators  
10 and the network."

11 Embargoed copies: do you mean the ones without the  
12 green text?

13 **A.** I would imagine so, yes.

14 **Q.** Yes, so your Commissioners are not aware of  
15 that or your regulators either; might they have been  
16 interested to know that?

17 **A.** Yes.

18 **Q.** That there was a misconduct allegation that  
19 needed investigation, somebody who's commissioning  
20 services from the hospital might want to know that, on  
21 behalf of the mothers that are going into that hospital  
22 and having babies; do you agree?

23 **A.** Yes.

24 **Q.** So why did they get the embargoes or not that  
25 information: what were you hiding there Mr Harvey?

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1 different people looking at case notes and reviews and  
2 yet somehow Baby F wasn't looked at, in your Silver  
3 Command exercise.

4 So when you say yesterday it was a collective  
5 failure or the paediatricians didn't spot it, neither  
6 did your Silver Command exercise, did it?

7 **A.** No, and the Silver Command exercise,  
8 I believe, the identification of the notes for review  
9 was carried out by Dr John Gibbs and by -- I believe Ann  
10 Fisher, the nurse who assisted him in reviewing.

11 **Q.** If they looked at Baby F, you don't know that  
12 either. It doesn't seem to be very clear. They were  
13 looking at babies that were transported out, I think is  
14 their explanation?

15 **A.** Yes.

16 **Q.** It's not clear what the focus was on any  
17 review or why various babies were chosen. That's  
18 something that required the police, didn't it, who look  
19 at all the babies forensically, carefully and get  
20 independent expert evidence to do so. That is what this  
21 cried out for?

22 **A.** At the time, this was primarily about  
23 reviewing the babies who died, so they were part of the  
24 Jane Hawdon review. I believe that the baby -- the four  
25 babies that she reviewed who had collapsed were those

30

1 **A.** I don't believe that we were hiding anything  
2 at that time. I think that we were going through the  
3 process of trying to get a complete picture of the  
4 position. I think that, as I have already alluded to,  
5 we were influenced by the nature of the Royal College  
6 report and the reference to gut feeling, which  
7 underplayed the situation and didn't do anything other  
8 than, I think, push us in the direction of trying to get  
9 more information.

10 **Q.** That was your view. Others were entitled to  
11 make their own professional assessments on a proper,  
12 full, transparent basis of the information that you had,  
13 weren't they? You deprived them of that, the  
14 Commissioners, the regulators?

15 **A.** And I -- I think as I said yesterday, yes,  
16 I should have had a conversation with Specialised  
17 Commissioning at an earlier time.

18 **Q.** When we look, please, at INQ0103192, page 1,  
19 we see Dr Subhedar's response to you, in respect of the  
20 RCPCH Report and Jane Hawdon's review, and you say you  
21 respected Dr Subhedar, the Inquiry has heard from  
22 Dr Subhedar. He points out at paragraph 2:

23 "My own interpretation of the 13 deaths included in  
24 her review suggests there were four cases in which there  
25 is no clearly identified cause of collapse death, and

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1 a further three cases where the cause of the initial  
2 collapse leading ultimately to the baby's death remain  
3 unexplained."

4 He then says:

5 "I am broadly in agreement with her  
6 recommendations, however it should be noted that many of  
7 these recommendations are relevant to all NNUs not just  
8 Countess of Chester. Additionally I see no specific  
9 justification for recommendation 5, on the basis of her  
10 review."

11 That was a recommendation where she said:

12 "Although no death in the series was known, subject  
13 to outstanding postmortem reports, to be secondary to  
14 undiagnosed pneumothorax or duct-dependent congenital  
15 heart disease, consideration should be given to training  
16 and checklists in the event of unexpected collapse to  
17 consider these."

18 So he was making the point that the one point where  
19 she commented on deaths wasn't relevant to the cohort,  
20 so you had got absolutely nothing from that report in  
21 respect of the deaths that you were concerned about, or  
22 the Consultants had raised concerns about.

23 **A.** I'm sorry, I'm not sure I understand the  
24 question.

25 **Q.** You didn't get any evidence at all from

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1 So you didn't do what Dr Hawdon said, did you; you  
2 just went to Dr McPartland who you knew already?

3 **A.** In the first instance, I discussed it with  
4 Dr McPartland. She didn't challenge and I made her  
5 aware of Dr Hawdon's recommendations.

6 **Q.** You didn't make her aware that you were  
7 concerned there were allegations that a nurse had been  
8 harming or killing babies, an Allitt or Shipman  
9 situation, you did not say that to Dr McPartland at all?

10 **A.** I believe in conversation with Dr McPartland,  
11 I did make reference to the fact that our paediatricians  
12 had suggested an increased association with one member  
13 of staff. I also asked her about air embolus, which is  
14 something that Dr Jayaram had raised as a potential  
15 cause of harm and --

16 **Q.** You didn't ask her to posit whether that was  
17 a cause of harm or death in a case. You sent an email  
18 asking about venous froth on a lung, or something, and  
19 whether that could be representative of air embolism and  
20 as a response.

21 **A.** No, I did ask her specifically whether she  
22 would be confident that she would identify air embolus  
23 as a cause of death and --

24 **Q.** Did you say "In relation to this baby or this  
25 baby", or give her the notes, or did you just throw

35

1 Dr Hawdon that undermined the Consultants' allegations  
2 or concerns that Letby had been harming and killing  
3 babies?

4 **A.** Nor did we get anything that actually  
5 supported those allegations.

6 **Q.** Did Dr Subhedra's letter reassure you when he  
7 said that there was nothing or much of what had been  
8 said that wasn't relevant to all NNUs, not just the  
9 Countess of Chester; so your broader canvas was as much  
10 relevant to the Countess of Chester as other hospitals?

11 **A.** I'm not sure that I would describe it as  
12 "assurance".

13 **Q.** Did it take you away?

14 **A.** The degree -- the degree of variability within  
15 medicine is such that, whilst there can be a lot of  
16 commonality, it doesn't take a great deal of difference  
17 to produce vastly different results and, at this time,  
18 we were obviously proceeding with the -- as Dr Hawdon  
19 had suggested, a further review of the pathology with  
20 regard to some of the babies.

21 **Q.** You didn't pursue what Dr Hawdon suggested at  
22 all. You went to Dr McPartland to ask her to just go  
23 back over the postmortems that had been conducted when  
24 they didn't know there was any suspicions or concerns  
25 and they required a forensic postmortem.

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1 something out generically?

2 **A.** No, that was -- it was a general question.

3 **Q.** What's the point of that? What's the point of  
4 a general question? You are a doctor, you need to know  
5 the specifics. You can't just say "When does this  
6 happen or when does the other happen".

7 **A.** Well, it was posed by Dr Jayaram as  
8 a potential, again, it wasn't put in terms of specifics  
9 and, at that time, there wasn't a specific. It had been  
10 raised as a possible cause of death --

11 **Q.** He had raised it as a possible mode of attack  
12 for some of the babies in the meetings when you were all  
13 discussing concerns. He had said "cannula air  
14 embolism"?

15 **A.** That can be either deliberate or accidental  
16 and I was asking Dr McPartland whether she was confident  
17 that, whichever mechanism, air embolus would be  
18 identified at a postmortem, and I had the answer from  
19 her that they would.

20 **Q.** She said she had spoken to somebody who  
21 conducted the postmortem in the case you were concerned  
22 about. There was nothing transparent in your question  
23 or open about "In relation to this baby, in these  
24 circumstances, looking at this", was there? You did  
25 a one line email, she does a one line back and you said

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1 that satisfied you that that was medically sound in  
2 response to inform your thinking about this?

3 **A.** In terms of a general request, with regard to  
4 the likelihood of identifying air embolism as a cause of  
5 death, yes.

6 **Q.** So with no notice to her at all what you were  
7 thinking about, you relied on her in relation to that;  
8 is that what you are saying?

9 **A.** No, I am saying that there was -- I would  
10 accept there was limited notice.

11 **Q.** So let's just see, so we are all clear, the  
12 emails. Yours is INQ0102010. You say:

13 "Just one query. The report states a very small  
14 air embolism might not be detectable at autopsy. Does  
15 that mean that a significant embolism would be evident?"

16 So "very small embolism" might not be, first of  
17 all. So did you think, well, neonates are small, it  
18 wouldn't take much of a significant embolism. Why are  
19 you asking the question? You are not ...

20 **A.** "Very small" would imply that it was not  
21 clinically significant. That's why I was asking about  
22 a significant -- "significant embolism" would imply one  
23 that would be sufficient to cause harm.

24 **Q.** What do you mean the size of the embolism  
25 or --

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1 embolism. That's really what you were seeking to ask,  
2 and you didn't give her the full picture, did you: you  
3 just did a one liner and now rely on it?

4 **A.** No, but that -- I took from that exchange  
5 that, had there been a significant air embolism in one  
6 of those babies, that they would have actually seen the  
7 evidence at the postmortem.

8 **Q.** So you are turning into the investigator, you  
9 are trying to understand the medicine that's not your  
10 area of expertise. You then rely on it and protect  
11 Letby from a police investigation. Have you become the  
12 judge and jury deciding whether this is made out,  
13 whether this allegation is proven, putting the bits  
14 together as best you can?

15 **A.** No, I'm simply trying to understand the  
16 evidence that is being presented to us.

17 **Q.** That can come down, please. Well, that wasn't  
18 being presented: you were asking for it, you were  
19 positively going out through Silver Command directions  
20 and then through approaching McPartland and Hawdon, you  
21 are going out looking for evidence?

22 **A.** I'm seeking clarification with regard to the  
23 facts that were being presented to us.

24 **Q.** What's the difference between that and looking  
25 for evidence? You are looking for evidence of the

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1 **A.** Yes.

2 **Q.** -- the impact, the clinical impact?

3 **A.** Well, both size and --

4 **Q.** Presumably, the amount of air embolism  
5 required in a tiny neonate is different, isn't it, than  
6 adults, the patients you were used to working with. It  
7 would take a very small amount, wouldn't it?

8 **A.** This is a question of proportionality and  
9 "very small", when talking about a neonate would be very  
10 different from "very small" with regard to an adult. So  
11 that this is purely the proportionality, and hence  
12 significant -- a "significant embolism" in a neonate  
13 would be completely different from a "significant  
14 embolism" in an adult.

15 **Q.** Let's see the response, INQ0102011. We have  
16 to enlarge that if we can:

17 "A significant air embolism should be accompanied  
18 by froth in the vessels or lungs."

19 Dr McPartland gave evidence that her approach would  
20 have been very different to that generic question, had  
21 you been specific or set out what you were interested in  
22 and why. That was an email exchange where you didn't  
23 give the other person any of the information they needed  
24 to answer the question you say you were seeking to ask:  
25 whether these postmortems would have detected air

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1 deaths around the deaths?

2 **A.** I am -- I am not looking, I am querying  
3 whether there would have been evidence or not.

4 **Q.** INQ0060264, page 1. This is Dr Hawdon's  
5 report. We don't need to go through it but the metadata  
6 indicates, I think, by 1 March, there's been about eight  
7 versions where you are adding, aren't you, Mr Harvey,  
8 and I just want to be clear that's what's going on.

9 So if we go to page 7, first of all. We see the  
10 green and the types, the additions, track changes,  
11 I don't need you to comment on these in relation to  
12 Child O or generally. But what's happening, you are  
13 adding to this document, at various times, information  
14 that is coming in, is that right?

15 **A.** I'm using Dr Hawdon's report as a -- the basis  
16 of pulling together all the information that we had had  
17 from the various reviews.

18 **Q.** And you are putting it in one place. So if we  
19 go to page 9, you add from Dr McPartland's review,  
20 Child O, you have put this section in. It continues  
21 throughout, where you are adding various things from  
22 notes, it can't simply be from Dr Hawdon herself, it is  
23 from other material, isn't it: you are combining bits of  
24 information that you get?

25 **A.** I am and, in doing that, I -- I haven't made  
40

1 clear the nature of that report. I shouldn't have left  
2 Dr Hawdon's name on the top of that because I was  
3 simply, I was using her report as the basis for  
4 collating all the information together as we were trying  
5 to understand the whole picture for each baby.

6 **Q.** Page 26, you have added various details:  
7 "Letby: Registrar Harkness called and in  
8 attendance."

9 You are adding stuff from the rota review that's  
10 been done as well, presumably? Dr Hawdon said she  
11 didn't have the material or details to go through that.

12 So you know you had had people in the hospital  
13 doing that, so you are adding various bits, aren't you,  
14 as you go along. Then we go to page 59, and you have  
15 moved Child D up -- I think you did that in your version  
16 2 -- following the postmortem review. So you have moved  
17 that top to the top.

18 Very intricate document and then there is something  
19 else you prepare separately, it would appear,  
20 INQ0062339, page 1. Then you start to move the material  
21 around, after the version 8, it seems like you have done  
22 this for each baby, pulling things together in this way;  
23 is that right?

24 **A.** Yes.

25 **Q.** So why are you doing this? That can go down  
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1 **A.** I was looking to try and establish the causes  
2 of death. I -- as a doctor, as a clinician, would  
3 commonly be faced with those -- those scenarios in terms  
4 of obviously, most commonly, natural causes of death and  
5 this was, to a large degree, a clinical review. It was  
6 the fact that, despite all that, we couldn't come to  
7 an answer and these documents were prepared really to  
8 try and understand the whole detail that we had regard,  
9 with regard to every baby to discuss with the  
10 paediatricians, to discuss with Dr Subhedar and, on the  
11 back of those conversations, it was apparent that we had  
12 to speak to the police.

13 **Q.** When you say "to discuss with the  
14 paediatricians", did you put yourself on a par with the  
15 paediatricians and Dr Subhedar when it came to  
16 neonates --

17 **A.** No.

18 **Q.** -- because Dr Subhedar sent you a very clear  
19 letter which indicated, I suggest, that you should go to  
20 the police, as did your own paediatricians' concerns  
21 earlier. But you think you need to follow what they are  
22 saying, understand if it's right, have discussions with  
23 them: why? What's your status in all of this?

24 **A.** I am -- I'm not sure that that is supported by  
25 the documentation. There are multiple meetings that  
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1 now, thank you.

2 **A.** I believe this came on the back of the ongoing  
3 concerns that were being expressed. It was an attempt  
4 to draw all the information together to be able to  
5 understand, ultimately, where we were going to go next.

6 This was the prelude after the conversation with  
7 the paediatricians, after the conversation with the  
8 Coroner and the subsequent meeting with Dr Subhedar and  
9 the paediatricians having pulled all this information  
10 together, that -- that realisation that we were going to  
11 have to go to the police.

12 **Q.** This is something that the police would have  
13 been doing. You are trying to draw all this material  
14 together. You are getting members of your hospital  
15 staff to do similar things. We have heard from Sian  
16 Williams, she's doing rotas, and she says go to the  
17 police and you, yourself, are behaving like a detective,  
18 pulling it together. Because you are all suspicious and  
19 you need to understand what's happened and you are the  
20 wrong people to be doing it. This should never have  
21 been happening.

22 **A.** I wouldn't say that I was acting like  
23 a policeman. I wasn't investigating in that way. It  
24 is --

25 **Q.** What, you weren't looking for a crime?  
42

1 indicate that, at various times, the paediatricians were  
2 accepting and agreeing that the line that we were taking  
3 was appropriate, and I think we have Dr Jayaram agreeing  
4 that a College Review was appropriate.

5 **Q.** I am going to come to why they may or may not  
6 have agreed with you, Mr Harvey, so can we just confine  
7 ourselves at the moment to how you end up doing these  
8 investigations yourself. You have given your answer:  
9 you didn't think you were behaving like the police?

10 **A.** I don't think that this was an investigation.  
11 This was collating all the information that we had.

12 **Q.** Can we have on screen, please, INQ0003135,  
13 page 1, and this is an email to you from Dr McPartland,  
14 and it indicates how little time she was under the  
15 impression she needed to give to this review that was  
16 happening about the postmortems and she says clearly:  
17 "It's not a full and formal medico-legal review.  
18 That would involve a second report and take about four  
19 hours of work per case."

20 A forensic review would take many, many more hours  
21 than that. It shows she had nothing like that in her  
22 mind, would you agree?

23 **A.** Yes.

24 **Q.** Had no idea what you were really interested  
25 in:  
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1 "If you require an analysis of this depth, it is  
2 probably best performed independently by someone from  
3 another centre."

4 Why did she say that; what's the importance of it  
5 being independent?

6 **A.** I suppose so it can be seen to be someone who  
7 wasn't involved in the original postmortem.

8 **Q.** She could see that. Why couldn't you see  
9 that?

10 **A.** That wasn't a suggestion that we needed to  
11 undertake that. It was a view, "require".

12 **Q.** In the end, Mr Harvey, both Drs Hawdon and  
13 McPartland felt they didn't have the full facts and  
14 misled -- Dr Hawdon said very clearly "misled" and  
15 Dr McPartland said, had she had the full facts about  
16 suspicions and concerns, she would have dealt with the  
17 situation differently.

18 You are responsible for them being misled, aren't  
19 you?

20 **A.** I do not believe that they were misled.

21 **Q.** So they are wrong: when Dr Hawdon says she was  
22 misled, she is wrong about that, is she?

23 **A.** Dr Hawdon has her opinion, based on how we  
24 know that this ended. I do not believe that I mislead  
25 either Dr Hawdon or Dr McPartland. I believe that

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1 **Q.** Do you accept that you and your Executive  
2 colleagues, particularly Mr Chambers and Ms Kelly,  
3 created an atmosphere of fear --

4 **A.** I --

5 **Q.** -- fear of speaking up and saying what people  
6 thought?

7 **A.** I cannot -- I wouldn't speak on behalf of  
8 Mr Chambers or Mrs Kelly. I did not seek to create  
9 an atmosphere of fear. That would be completely  
10 contrary to how my practice had been up until that time.  
11 I have accepted that there were one or two emails that  
12 I completely inappropriately worded and that that might  
13 affect how they may see -- they might be received.  
14 Having said that, I did have a number of individual  
15 meetings with Dr Jayaram and Dr Brearey, where I tried  
16 to explore the concerns.

17 But, ultimately, I accept that it is always going  
18 to be the perception of the person on the receiving end  
19 and, if they felt that they were intimidated, then that  
20 certainly wasn't the intent or the purpose but I would  
21 apologise to them for that.

22 **Q.** Dr Isaac gave evidence to the Inquiry that she  
23 was going to sign a letter or write a letter with  
24 concerns but didn't because of a culture of fear. It  
25 was more than simply not stating things: people were

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1 I commissioned them in good faith, based on the  
2 understanding of the situation at that time and, having  
3 been influenced by the various things that had been  
4 along the way. And I would refer again, in terms of  
5 Dr Hawdon, the strength or otherwise of my commissioning  
6 was significantly influenced by the way that the Royal  
7 College had phrased their recommendations and their  
8 findings.

9 **Q.** We are going to move on now to the grievance,  
10 the doctors and your interaction with them. Before  
11 I take you to various documents, Mr Harvey, do you have  
12 any reflection or regrets about how the paediatric  
13 Consultants were treated by the Executive Team after  
14 they had raised concerns and suspicions about Letby?

15 **A.** I think I included in my reflections that one  
16 of the greatest regrets of my career is the breakdown in  
17 the communication between the paediatricians and the  
18 Executives and with me in particular.

19 I recognise how intense and difficult a situation  
20 that was. I recognise the strength of feeling they had  
21 and the suffering that they had associated with the  
22 grievance process, and I can fully understand their  
23 anger in terms of the perception of the Royal College  
24 report because it didn't reflect what they felt and  
25 recalled that they had reported to the College.

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1 worried for their careers if they did. They were  
2 worried that their jobs were at stake if they stood up  
3 and said what they thought, and it was a genuine  
4 concern, wasn't it?

5 **A.** If that was how they felt then, yes, but I can  
6 think of nothing that was done or said that would have,  
7 certainly from my perspective, threatened their career  
8 or their standing.

9 **Q.** It wasn't just Drs Brearey and Jayaram that  
10 referred to that. I have said Dr Isaac gave that  
11 evidence, and Dr ZA gave evidence that, when she was  
12 contributing to the signed letters and the concerns  
13 around Letby, she had a conversation with her husband  
14 about how were they going to pay the mortgage, what  
15 would happen if she lost her job. Under your period of  
16 tenure as Medical Director, doctors, who had no doubt  
17 trained and worked hard to become doctors and enjoyed  
18 their work with patients, were worried about losing  
19 their jobs for raising patient safety concerns; do you  
20 accept that?

21 **A.** I accept that I failed in the duty of pastoral  
22 care that I should have offered and, until that time,  
23 I feel I had offered to medical colleagues.

24 **Q.** How had you done that? How had you offered  
25 support to any of your medical colleagues?

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1 A. Are we talking about prior or are we talking  
2 about the paediatricians involved?

3 Q. Through the period, I'm talking about any of  
4 the ones I've mentioned: the paediatricians, Dr Isaac,  
5 any of them. What did you do to go and seek somebody  
6 out and say "This is difficult, am I making it worse,  
7 how could I help?" Anything like that?

8 A. In terms of the paediatricians, I have  
9 accepted that I -- I failed in that regard at that  
10 particular time.

11 Q. Over a long period of time: this went on for  
12 a long period of time. It was a year.

13 A. I did have meetings with Dr Brearey and  
14 Dr Jayaram. They tapered off. I remember conversations  
15 with Dr Jayaram in my office where he was expressing his  
16 anger at the situation and how he perceived things.  
17 I tried to be supportive. I was trying to be supportive  
18 in protecting them from the threat of the GMC.

19 Q. Well, we will come to the threats from the  
20 GMC. But what did you understand they were before we go  
21 to documents?

22 A. Sorry?

23 Q. What do you understand, who was threatened  
24 with the GMC, by whom?

25 A. Dr Brearey and Dr Jayaram were threatened with  
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1 retorted jokingly that he had not wanted to spoil his  
2 clean sheet."

3 Do you remember saying that to Susan Gilby?

4 A. I did not say that.

5 Q. If we go to some of the other documents of  
6 meetings, INQ0006265, page 1, to put this in context,  
7 this is a meeting between the Execs, and it's a meeting  
8 when there is a "Susan Hodgkinson Options Document". For  
9 everybody's assistance perhaps we will go to that on the  
10 screen as well now, INQ0051682, page 1.

11 This is an options paper presented at the Executive  
12 Team meeting on 8 September and we see at the bottom of  
13 the page, in the box on left, Option 4 was:

14 "Reintegrate back within the NNU without ITU/HDU  
15 duties whilst competencies reviewed."

16 I am sure we will have that back in a moment.  
17 There we are. So this is looking at the options  
18 managing Letby. We see that is the Option number 4. If  
19 we go back to the paper, the notes of the meeting on  
20 Thursday, the 8th, INQ006265, page 1, we see there that  
21 Mrs Hodgkinson recommends Option 4, so that's getting her  
22 back, and then this note here:

23 "Potential deal with Steve."

24 What did that refer to? Here he is the lead  
25 neonatologist, her going back on the ward. That was  
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1 the GMC by Letby's father. At no point did I threaten  
2 any of the paediatricians that I would consider or was  
3 going to report them to the GMC, nor did I have  
4 a conversation with the liaison adviser of the GMC who  
5 I met on a regular basis that I was even considering  
6 that, although I might have highlighted that there was  
7 a risk that they could be reported by someone else.

8 Q. So you did, as the responsible officer, speak  
9 to the GMC about the possibility of the paediatricians  
10 being referred to them, did you?

11 A. I -- I cannot recall but in the regular  
12 meetings I would highlight potential issues that might  
13 be coming to the GMC and, if the meeting with him had  
14 coincided with knowledge of this, then I believe that  
15 I would have highlighted that there was a risk that they  
16 might be contacted by someone, and it wouldn't be me,  
17 with regard to a complaint.

18 Q. The Inquiry has a statement from Susan Gilby,  
19 who of course took over as Chief Executive, didn't she?  
20 She says that, when she did, she had a conversation with  
21 you and you did say to her, she says this:

22 "I do clearly recall that almost his parting words,  
23 I had put away my notes and was standing to leave, were,  
24 "You need to refer those paediatricians to the GMC".  
25 I replied by asking why he had not done so and he  
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1 going to cause problems, wasn't it? So what does  
2 "potential deal with Steve" refer to?

3 A. I -- I don't know. I have no recollection of  
4 that conversation.

5 Q. You are obviously at the meeting, it's "How do  
6 we manage Letby". Your head of HR is saying, "Let's get  
7 her back into the NNU", and you have got the lead  
8 neonatologist who's told you very clearly he suspects  
9 she is harming/killing babies. So you have got  
10 a problem there, haven't you, Mr Harvey: so what was  
11 being discussed about "potential deal with Steve"?

12 A. I, as I have already said, cannot remember the  
13 conversation around that item. I can only surmise that  
14 this is related to the grievance.

15 Q. Options, you are talking about Letby there.  
16 So what's the deal with Steve in relation to the  
17 grievance?

18 A. I can't tell you. I would imagine only  
19 Mrs Hodgkinson would be able to tell you about that.

20 Q. Were you discussing how you might manage to  
21 get Steve out or think about getting a deal to get him  
22 to move on or anything like that?

23 A. At no point was I party to a conversation  
24 about how we would manage out any of the paediatricians  
25 from the unit.  
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1 Q. Did you know whether other members of the  
2 Executive Team had had those conversations?  
3 A. I wasn't aware of any conversations with  
4 regard to that, no.  
5 Q. Well, let's have a look at INQ0015642,  
6 page 48. It's a bit later in time. This is by May  
7 2017. It's a note of a meeting, Mr Chambers,  
8 Mrs Hodkinson. We see there:  
9 "Plan re management: GMC; actions from grievance;  
10 action plan to manage out; follow up call."  
11 Dr Brearey, as lead neonatologist, was becoming  
12 a problem, wasn't he, when you all wanted to get Letby  
13 back on the unit?  
14 A. I didn't see him as a problem.  
15 Q. Did you know that Mr Chambers and  
16 Mrs Hodkinson were discussing that?  
17 A. No.  
18 Q. Really?  
19 A. Really, I did not.  
20 **MS LANGDALE:** I think that might be a convenient  
21 moment for a break, my Lady.  
22 **LADY JUSTICE THIRLWALL:** Very well. We will come  
23 back in 11.45.  
24 (11.26 am)  
25 (A short break)  
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1 those kinds of letters, what she was told?  
2 A. Yes.  
3 Q. Did you at any time think that the grievance  
4 was about what the doctors had done or said and how they  
5 had behaved?  
6 A. That wasn't how I perceived the grievance, no.  
7 Q. Who were you relying on for information about  
8 the grievance before it started, around the time it  
9 started?  
10 A. Ultimately, because it involved Letby, the  
11 information I was getting was from HR, so Sue Hodkinson,  
12 and from nursing, so Alison Kelly.  
13 Q. So at no time did you think, from talking to  
14 them, that the grievance was about how the doctors had  
15 behaved or what they had done or said?  
16 A. That wasn't my perception at the time, no.  
17 Q. We see your interview for the grievance,  
18 INQ0003156, page 1, and, if we can go to page 2, we see  
19 halfway down, Dr Green asks you:  
20 "In the analysis table, the column showing 'Doctors  
21 removed', were you aware?"  
22 So everyone understands, there was a table, wasn't  
23 there, that Eirian Powell had attached to the Thematic  
24 Review, highlighting the nurses present on duty or on  
25 the shift before, and then another column had been added  
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1 (11.44)  
2 **MS LANGDALE:** Mr Harvey, we were examining or  
3 moving on to the treatment of the Consultants. The  
4 grievance process: what did you understand the grievance  
5 was about at the time?  
6 A. My understanding was that the grievance was  
7 about the way Letby had been managed with regard to  
8 being taken off the unit.  
9 Q. Was it about what she was told about why she  
10 was moved off the unit or what she had allegedly done:  
11 what was it, as far as you were concerned?  
12 A. As far as I was -- as far as I understood, it  
13 was with regard to how the -- the Trust had managed her  
14 off the unit, with the information that she was given  
15 with regard to why she had been moved.  
16 Q. Had the Trust been open with her or  
17 transparent about why she had been moved, as far as you  
18 were aware?  
19 A. As I understood it, the basis of the grievance  
20 was that she -- she hadn't been.  
21 Q. Did you know at the time how the letters had  
22 gone out to her about how she was being moved off the  
23 unit?  
24 A. I wasn't aware of those, no.  
25 Q. But you understood the grievance was about  
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1 to that: which doctors were --  
2 A. Yes.  
3 Q. -- around at the time?  
4 So when you were asked, "The column showing  
5 'Doctors removed', were you aware", you say, "I wasn't  
6 aware of that", because, as far as you were concerned,  
7 you had seen both, had you, whether doctors and nurses  
8 were there or what?  
9 A. At this -- at -- currently today, I'm unsure  
10 but I -- given that this was a timely comment, I can  
11 only stand by the comment I made there.  
12 Q. Yes. So were you aware the doctors were  
13 removed, and you say, "I wasn't aware of that". So  
14 whatever he was referring to wasn't something -- did you  
15 understand the question?  
16 A. Well, only insofar as he was asking if I had  
17 known that a column with the doctors had been removed.  
18 Q. You then say:  
19 "There's been a number of behaviours on the ward  
20 that do not reflect too well. I had to go and speak to  
21 RJ that some of the trainees had been making reference  
22 to 'angel of death' but no specific person was named.  
23 There was behaviour in clinic, it's being heard talking  
24 about killing babies on the unit. Had to speak to Ravi  
25 about comments and killing babies. This was not denied  
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1 and RJ did accept that it was inappropriate."

2 So you raise it. Why did you raise that in this  
3 context, is my first question, and the second is: what  
4 were you telling him?

5 **A.** I think this was an answer, probably not just  
6 in relation to that one question, but following on from  
7 the two above, as well, in explaining the situation with  
8 regard to Letby on the unit.

9 **Q.** What behaviours were you describing, what did  
10 you go and speak to Ravi Jayaram about?

11 **A.** I had spoken to Dr Jayaram about a comment  
12 that had been fed to me by a member of the nursing staff  
13 about the trainees describing the angel of death.

14 **Q.** Who told you that?

15 **A.** I cannot remember who that was. All I know is  
16 it was one of the senior nurses.

17 **Q.** So Karen Rees, Eirian Powell, Alison Kelly,  
18 they are your options?

19 **A.** Quite possibly, yes.

20 **Q.** Well, which one?

21 **A.** I don't know. I can't remember.

22 **Q.** When did she say to you a trainee had spoken  
23 about "angel of death"?

24 **A.** I am unable to remember precisely when that  
25 was said either.

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1 there isn't anything to find."

2 Not killing babies, Nurse T, sorry. That's the  
3 evidence we have heard. Did you bother to find out if  
4 anybody had heard that directly or you just went to say  
5 to Dr Jayaram, "Is that your evidence? Have you said  
6 this?", and he said, "Sorry about that, it's  
7 inappropriate"?

8 **A.** I -- my course of action was to approach  
9 Dr Jayaram to see whether what had been reported was --  
10 was correct.

11 **Q.** You see, you don't say here it was Dr Jayaram.  
12 You say:

13 "There was behaviour in clinic, it being heard  
14 talking about killing babies on the unit."

15 You don't say it was Dr Jayaram who was heard to  
16 say that. You simply say, "I had to speak to him about  
17 comments that it was appropriate", but you are saying  
18 you knew straight at the time it was supposed to be  
19 being said about him?

20 **A.** That was how it had been reported to me and  
21 that was the reason that I -- I spoke to him. I can't  
22 speak for how those notes record what I actually said in  
23 that interview.

24 **Q.** But in terms of your reasoning, so one of the  
25 senior nurses tell you that's what he said, or been

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1 **Q.** So no specific person named?

2 **A.** No, because that was who said that or who  
3 reported that to me, sorry.

4 **Q.** So did you have any name to provide about  
5 those comments "killing babies" or "angel of death"?

6 **A.** With regard to the second, that was with  
7 regard to me being told that Dr Jayaram had been heard  
8 to make that statement in clinic.

9 **Q.** You accepted that to be true, presumably,  
10 because you are repeating it here; is that right?

11 **A.** I was accepting that to be true on the basis  
12 that I went to have a conversation with Dr Jayaram about  
13 it and he confirmed that that comment had been made by  
14 him and had accepted, as I put in that note, that it was  
15 inappropriate.

16 **Q.** You say that Dr Jayaram said he had said  
17 "She's killing babies"?

18 **A.** No, I didn't say that there was a reference to  
19 a specific person. The comment was that the -- there  
20 was someone killing babies on the unit.

21 **Q.** We have heard directly from the person that  
22 was attributed to by Eirian Powell, who says that, in  
23 fact, what she had heard was words to the effect of  
24 Dr Jayaram saying about the review:

25 "Just because it didn't find anything, doesn't mean

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1 heard to say by some other nurse, and you go and say to  
2 him, "Don't say that"?

3 **A.** No. The approach was, in the first instance,  
4 to ask if that was what had been said, was that correct  
5 as it had been reported? Not to go and directly  
6 admonish him for something that had been reported  
7 because I am very well aware that things can be  
8 misunderstood things can be misheard.

9 So my approach would have been to speak to him to  
10 say that I had heard about this but was that -- my first  
11 approach would be, "Is this correct?"

12 **Q.** Ravi Jayaram did have suspicions that someone  
13 was killing babies, didn't he?

14 **A.** Ravi Jayaram had concerns about the increase  
15 in mortality.

16 **Q.** Had suspicions and concerns -- we have been  
17 through this -- suspicions and concerns, talking about  
18 methods of attack, that babies were being deliberately  
19 harmed and, after O and P, that was loud and clear in  
20 the meeting in June. So he had those suspicions and, in  
21 effect, you have a conversation that it's inappropriate  
22 to be talking about the very safeguarding concern they  
23 are all worried about.

24 **A.** I believe that the conversation was with  
25 regard to it being inappropriate to be saying it in

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1 a public place.

2 **Q.** Was it ever suggested to you it was in  
3 a public place, talking to another member of staff in  
4 a clinic?

5 **A.** Well --

6 **Q.** It doesn't mean it is overheard, does it,  
7 suggested?

8 **A.** If it's in a clinic, it has potential to be  
9 overheard.

10 **Q.** Yes, but it has not been stated that it has,  
11 but speaking to go a colleague about safeguarding  
12 concerns is a totally valid thing to do, isn't it?

13 **A.** In those circumstances yes. But --

14 **Q.** Well, that was the circumstance.

15 **A.** But, well, that wasn't as described to me when  
16 I spoke to Dr Jayaram.

17 **Q.** You, at the top of this page, make a comment,  
18 Mr Harvey:

19 "There are issues with nursing with regards to  
20 investigations compared to medical staffing. We have  
21 measures specifically supported by the GMC and NCAS, if  
22 there are doubts speak to them. RC then would manage  
23 resistance from the Consultants. If I were a doctor,  
24 then there would be a period of supervised practice and  
25 development but there was a block on that as the

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1 **A.** I --

2 **Q.** -- in the way the Consultants think about  
3 nurses?

4 **A.** I don't believe that that's what I was doing  
5 and, in fact, directly after that, it all, I also say  
6 that the Executives had considered should we go to the  
7 police.

8 **Q.** You have told us a moment ago what you thought  
9 this grievance was about. Why is it that you are  
10 talking at all about the Consultants and how they  
11 thought there was a difference, you say, between how  
12 doctors and nurses were treated and not recognising it;  
13 why is that even a feature in this interview?

14 **A.** Simply because that was my interpretation of  
15 the answers that were going with the questions that were  
16 put to me.

17 **Q.** So the questions that were put to you were  
18 getting you to criticise the doctors, and that's what  
19 you comfortably, it would appear, do, don't you? Look  
20 at your answers.

21 **A.** I wasn't specifically aiming to criticise the  
22 doctors in the course of this.

23 **Q.** Did you appreciate your comments were relied  
24 upon to do that very fact at the end of it?

25 **A.** I would accept that they -- they could be

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1 Consultants were not prepared to have the nurse on the  
2 unit and, if we do, they said the police would be  
3 called."

4 You are trying to make that their concerns about  
5 her coming back on the unit an issue between doctors and  
6 nurses, that they are treated differently; do you see  
7 the top paragraph?

8 **A.** I do.

9 **Q.** Why are you saying that?

10 **A.** I am saying that because that was my  
11 perception at the time. I would accept that I have put  
12 in a factual inaccuracy in saying there was a block by  
13 the Consultants. I did not at the time understand that,  
14 in fact, there couldn't be supervised practice because  
15 the nursing staff didn't have the numbers to be able to  
16 support that as an option.

17 **Q.** If you go to the page before, you are telling  
18 him as well:

19 "There was a threat to go to the police from the  
20 Consultants. Execs considered do we go to the police?"

21 You are describing these Consultants as, in some  
22 way, high-handed doctors, Consultants, who think they  
23 are different from nurses in processes and procedures.  
24 You are creating an impression, aren't you, that there  
25 is a chasm between the Consultants and the nurses --

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1 interpreted in that way.

2 **Q.** You accept that you criticised the Consultants  
3 and that was used against them; is that what you accept?

4 **A.** I accept that there was comments with regard  
5 to behaviour. I, again, would simply say that the  
6 sentence that's highlighted with regard to the threat to  
7 go to the police is also associated with the fact that  
8 we also, as Executives, had considered should we go to  
9 the police.

10 **Q.** Look at the next question on page 2 from  
11 Dr Green:

12 "Did you hear about Jim McCormack telling Eirian  
13 Powell she was harbouring a murderer.

14 "No, I hadn't heard that."

15 What did you think you were being asked that for?  
16 What's the relevance of that to the issue about how  
17 Letby had been managed?

18 **A.** I -- the only interpretation of that is that  
19 it's extending into the medical staff.

20 **Q.** The grave irony, of course, about that  
21 comment, upon the focus, of which was being used here  
22 against the Consultants, is that it was true: she was in  
23 the hospital and you were harbouring a murderer. She  
24 wasn't being investigated by the police. But this  
25 comment is being used in a different context, isn't it,

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1 to seek to invite criticism of the Consultants,  
 2 including Mr McCormack now; do you agree?  
 3 **A.** It could be interpreted that way, yes.  
 4 **Q.** It's the only way, isn't it, Mr Harvey?  
 5 I gave you a chance, and you took it fully, to explain  
 6 what you thought this grievance was about and here you  
 7 are, on page 2, criticising the attitudes of Consultants  
 8 towards the nurses and being asked about comments and  
 9 whether they are inappropriate when, in fact -- in  
 10 fact -- whether they are inappropriate or not, they have  
 11 turned out to be true: she was killing babies and the  
 12 hospital was harbouring a murderer?

13 **A.** We have the advantage of hindsight there,  
 14 obviously. But --

15 **Q.** At the time you knew the suspicion.

16 **A.** -- the context of my answer to that question  
 17 was with regard to the earlier ones about the issue of  
 18 Letby being taken off the unit.

19 **Q.** Have you heard of the concept, Mr Harvey, of  
 20 bullying up? Rather than Consultants being seen to  
 21 bully nurses, bullying up; that different groups in the  
 22 hierarchy can come together and bully up? So the  
 23 Consultants, one is always ready to believe, are  
 24 arrogant, aloof, very aware of their own education;  
 25 that's a popular conception. And nurses are unseen or

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1 You go straight into that, not that they didn't  
 2 want her there with supervised practice and you didn't  
 3 add "We have got CCTV as well", did you, "We are  
 4 thinking about CCTV"; you didn't give him the full  
 5 picture of that?

6 **A.** No, I didn't and I've already accepted that  
 7 I was factually incorrect in making the statement about  
 8 them blocking because I am now aware that, in fact, the  
 9 reason there wasn't supervised practice was insufficient  
 10 staff numbers to be able to support that as an action.

11 **Q.** It was because they thought she might do more  
 12 harm to babies. That's why they kept coming back to  
 13 you, "We think she's causing harm to babies". O and P  
 14 had died; they should never have died after that 11 May  
 15 meeting, Mr Harvey, in 2016, when she could have been  
 16 off the ward and referred to the police then.

17 **A.** Sorry, when?

18 **Q.** 11 May 2016, when you had that meeting  
 19 together?

20 **A.** I would not accept that, as a result of the  
 21 11 May meeting and the conversations that we had and the  
 22 approach that Dr Brearey and the nursing staff had, that  
 23 there was anything that would have supported any action.  
 24 Dr Brearey was entirely supportive of the action that  
 25 came out of that meeting and I would highlight that one

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1 domestic staff. We have heard from Mrs Hodgkinson, she  
 2 would go along the hospital in roles where she might be  
 3 unseen. They are very traditional characterisations of  
 4 hierarchies, aren't they, and they are not always true,  
 5 in fact.

6 Sometimes it can be the other way round, bullying  
 7 up: people have more power in different places in the  
 8 hierarchy. Did you ever stop and think that the group  
 9 of senior nurses advising you had their own issues,  
 10 potentially, about the relationships between Consultants  
 11 and nurses and, in fact, on the neonatal unit, until the  
 12 issue of Letby arose, it was harmonious, in that  
 13 respect? You hadn't heard anything about the issues  
 14 between doctors and nurses, you said, before this issue.  
 15 So why are you raising that now?

16 **A.** Because it seemed pertinent to the questions  
 17 that were being asked and pertinent to the issues around  
 18 Letby's removal.

19 **Q.** They say:

20 "We felt redeployment was the best course of  
 21 action. How did you agree the course of action?"

22 Then you are effectively saying:

23 "The Consultants wanted to block it because they  
 24 might be able to have supervised practice, they didn't  
 25 want a nurse to have that. It wasn't fair."

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1 of the actions was the reporting of any further  
 2 collapses or incidents, and I believe that that applied  
 3 to Baby N, but that wasn't escalated or reported.

4 **Q.** Let's go to page 3 of the grievance. You do  
 5 refer, at the end of page 2, to:

6 "Got security to review. Lack of security re  
 7 getting in and out of the unit became apparent."

8 Then, at the top of page 3, calling the police, you  
 9 say:

10 "They would have left a bomb site if they had come  
 11 in. More and more sure it was right not to call the  
 12 police as things have progressed."

13 This is you in November:

14 "Have you had any previous cases like this?"

15 "Not personally. Paediatrics was happy to quote  
 16 Beverley Allitt but equally there was the nurse in  
 17 Stockport who was ultimately not responsible for  
 18 anything."

19 "Paediatrics was happy to quote Beverley Allitt",  
 20 are you belittling the way they expressed their concerns  
 21 or minimising them in this interview?

22 **A.** No.

23 **Q.** "Happy to quote", I say that because of "happy  
 24 to quote". Not that they were very worried, they are  
 25 concerned, they think someone is killing babies but

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1 "happy to quote", as though in some way it's a bland  
2 overview, cheap comparison?

3 **A.** No, I don't -- I don't think there's any  
4 interpretation into that.

5 **Q.** Did you do anything or say anything in this  
6 grievance interview to Dr Green, who you knew was  
7 investigating it, to stop the questioning around the  
8 behaviour of the Consultants or the attitude of the  
9 Consultants, and say to him -- you are the Medical  
10 Director, there to support medical staff -- say to him:

11 "I didn't understand this was part of this  
12 process."

13 Or did you just answer the questions?

14 **A.** I, with regret, just answered the questions.

15 **Q.** That can come down, please. INQ0002884,  
16 page 1. This is an email to you included on it, from  
17 Hayley Cooper, Letby's representative:

18 "I am emailing yet again."

19 Did she often directly email you?

20 **A.** No.

21 **Q.** How many did you get directly from Letby or  
22 her representative, roughly?

23 **A.** Very few.

24 **Q.** Was it common in other areas of the hospital,  
25 where there were grievances being raised or concerns, to

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1 had with a nurse was to the effect that a ninth  
2 Consultant being appointed was necessary if the  
3 redesignation was to be reversed. That is what  
4 Dr Brearey says he spoke about.

5 You receive this on 23 November and call Dr Brearey  
6 in for a meeting on 24 November: why?

7 **A.** It was to have a conversation with him with  
8 regard to what was alleged in this email. I believe  
9 that this relates to the Royal College review that he,  
10 Dr Jayaram and, I believe, Ann Fisher had reviewed and  
11 I think it was on College advice that that was, in the  
12 first instance, a confidential review and I think I had  
13 advised them that, at that point, it wasn't to be  
14 shared.

15 **Q.** Can I just go back to that, Mr Harvey and make  
16 it very clear. You commissioned that review?

17 **A.** Yes.

18 **Q.** You were not required to be secretive or cover  
19 it up. You could share it with who you chose having  
20 commissioned it, provided you and your lawyers were  
21 satisfied that you had fulfilled your obligations around  
22 how certain aspects of personal data were shared; do you  
23 understand that: it was your choice?

24 **A.** I -- I understand that now. But at the time,  
25 it was my interpretation that the Royal College knew

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1 get emails directly from the member of staff affected or  
2 their representative?

3 **A.** No.

4 **Q.** So this was the only time you got direct  
5 emails from an RCN rep or, as we will move on to, the  
6 person who was complaining?

7 **A.** This is the only time that I can recall.

8 **Q.** So you get an email.

9 "Yesterday, some of her colleagues informed her  
10 that a Consultant, SB, is going around the NNU and  
11 informing staff that he has seen the external reports,  
12 and I quote 'appears to be bragging about it stating the  
13 report has cleared all the medical team as expected and  
14 he also informed the staff that he had been given the  
15 funding for a new Consultant post because of it'. On  
16 behalf of my member, we would like to know why this is  
17 happening, as we were given assurances not two weeks ago  
18 that a confidential meeting would take place with the  
19 medical director and key people regarding the draft  
20 report, and it would be kept confidential until the  
21 report was finalised and nothing would be discussed  
22 yet."

23 So this is the RCPCH Report and Dr Brearey has  
24 given evidence that he spoke to Ruth Millward, the Head  
25 of Risk and Patient Safety, and the only conversation he

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1 what they were doing and what they were talking about  
2 and that they would follow their instructions.

3 **Q.** So stop saying that you were prevented from  
4 circulating that report. You could have done what you  
5 wanted with it, with the members of staff and the  
6 Consultants. Nothing stopped you doing that. But it  
7 suited you to be secretive about it because the green  
8 bits that we have gone to flagged up the Consultants'  
9 suspicions and suggested that Letby needed to be  
10 investigated as a matter of urgency?

11 **A.** That is absolutely not the case.

12 **Q.** Well, we have gone to the documents.

13 **A.** As I have stated I was reliant on the

14 expertise of the advice of the Royal College.

15 I accepted what they said on face value because it  
16 appeared to be backed up by appropriate expertise and  
17 knowledge and I took that as what was normal practice.

18 **Q.** When you had Dr Brearey in your office on the  
19 24th, what did he tell you about the conversations he  
20 had had and did you accept what he said were the  
21 conversations he had had?

22 **A.** I -- I believe I met him together with  
23 Mrs Hodkinson. I can't remember from memory what the  
24 conversation was.

25 **Q.** Why did you have Mrs Hodkinson there?

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1 A. Because I believe that, actually, it was  
 2 Mrs Hodkinson who had advised that we needed to meet  
 3 with him.  
 4 Q. So if we go to INQ0003094, we see your letter  
 5 in response, subsequent to that meeting. Mrs Hodkinson  
 6 gave evidence that you were heavy handed in your  
 7 approach or this letter was heavy handed; do you agree?  
 8 Particularly if we highlight paragraph 3, and the last  
 9 two sentences of the one above?  
 10 A. I -- I accept that that could be read as heavy  
 11 handed, yes.  
 12 Q. "The final report, will be shared with the  
 13 clinical teams as well as others but this will be done  
 14 in a controlled way, by which I mean as an order of  
 15 priority and sharing the information whilst ensuring  
 16 appropriate support for those with whom it is being  
 17 shared."  
 18 Your order of priority was Executives first, to  
 19 look at the documents, the RCPCH Report; two Consultants  
 20 for a limited period of time thereafter; and the full  
 21 report to Consultants, many months after. That was your  
 22 controlled way, wasn't it?  
 23 A. That wasn't what I was implying at that point,  
 24 no. It was simply making sure that we had  
 25 an appropriate order of priority. It was important that

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1 your presence on the NNU and the collapsed deaths of  
 2 babies. I acknowledge that these concerns were raised  
 3 through the appropriate channels, in line with both the  
 4 Trust's Speak Out Safely policy and the guidance  
 5 proffered by the GMC."

6 Was that accurate?

7 A. I'm not sure about the reference to guidance  
 8 proffered by the GMC because I did not have any  
 9 conversation with the GMC.

10 Q. This, of course, the comments about in line  
 11 with Trust Speak Out Safely policy, relied on comments  
 12 you had made, wasn't it? Did you think that the Trust's  
 13 Speak Out Safely policy had been followed; is that what  
 14 you were trying to suggest?

15 A. I -- I don't think it had been followed in  
 16 a timely fashion.

17 Q. But do you think it was followed at all?

18 A. I think eventually it was, yes.

19 Q. So do you think that was a justified  
 20 conclusion:

21 "I acknowledge these concerns were raised through  
 22 the appropriate channels in line with the Trust's Speak  
 23 Out Safely policy."

24 A. In terms of the early time, no, it's not.

25 Q. So that's not an accurate conclusion either?

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1 those staff who were vested in this had the opportunity  
 2 to see it at the same time. But also mindful that it  
 3 was a matter of importance that it was shared with the  
 4 families.

5 Q. So the staff who were vested in it first, when  
 6 should they have all seen it?

7 A. They should have seen it once we had corrected  
 8 factual -- corrected any factual inaccuracies and  
 9 received the final version from the College.

10 Q. That can come down. Can we have, please, the  
 11 grievance finding, INQ0003611, page 2. If we look at  
 12 the top, paragraph 4, a finding:

13 "Whilst I recognise the board found themselves in  
 14 a difficult position, I conclude the Trust has not been  
 15 as open and honest with you [that is Letby] as they  
 16 could be in relation to the circumstances."

17 So criticism for how the Executives and HR managed  
 18 communications with her, yes?

19 A. Yes.

20 Q. Justified?

21 A. Yes.

22 Q. Then we see at paragraph 7:

23 "No party refutes that concerns were raised by the

24 Consultants, in particular Stephen Brearey, to the  
 25 Executive Team around a perceived commonality between

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1 A. I don't believe it is.

2 Q. What about:

3 "I do not find the Consultants' concerns when  
 4 reiterated to the Executive Team were clear, honest and  
 5 objective."

6 Was that justified?

7 A. I would dispute the use of the word "honest".

8 Q. Did you see this at the time?

9 A. No.

10 Q. When you first saw it, did you think, "How  
 11 come they are commenting on the Consultants' interaction  
 12 with the Executives"?

13 A. To be honest, I'm unable to remember when or,  
 14 in fact, if I ever saw the final mediation report.

15 Q. Do you agree, leaving the grievance now, you  
 16 contributed to criticisms unjustifiably of the  
 17 Consultants in the context of the grievance process?

18 That's where your contributions ended up: adding to the  
 19 criticisms of them, that they had made various remarks,  
 20 including Jim McCormack, that they shouldn't have made,  
 21 and somehow, at the end of that grievance process,  
 22 Consultants were being asked to apologise to Letby?

23 A. I wasn't the one who made any reference to Jim  
 24 McCormack, I was asked about that and said that I didn't  
 25 know about it. That must have come from somewhere else.

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1 I accept that I made reference with regard to some of  
2 the reasons why Letby had been removed, with regard to  
3 the behaviour. But it wasn't my specific desire or aim  
4 to aim anything at the paediatricians, be they trainees  
5 or the Consultants?

6 **Q.** Your comments about Dr Jayaram directly led to  
7 him being asked to make an apology to Lucy Letby, didn't  
8 they?

9 **A.** I can't say whether it was my comments alone  
10 that solely led to that.

11 **Q.** You are the Medical Director, you have gone  
12 and said, "I have been to speak to him, he's  
13 acknowledged it's inappropriate", as though he had  
14 acknowledged something about himself was inappropriate.  
15 That was used against Dr Jayaram and you must have known  
16 it was going to be?

17 **A.** I would not have known that it was going to be  
18 used against him.

19 **Q.** Were you unconcerned then whether it would be  
20 used against him because you chose to say it in the  
21 context of a grievance process?

22 **A.** It seemed timely with regard to the questions  
23 that were being asked to feed that in. I have no  
24 knowledge with regard to what other contributors to the  
25 mediation or to the grievance might have said that might

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1 **Q.** Well, it's important when you are a leader,  
2 isn't it, to understand perspective, where people might  
3 be coming from. To understand -- we have heard Eirian  
4 Powell was emotional, forceful, describing her support  
5 for Letby. But we know she managed a ward where Letby  
6 worked. So it's not surprising, perhaps, that she had  
7 her own relationship that was in her mind, her own  
8 professional relationship at the time that may have  
9 influenced her thinking; do you agree?

10 **A.** Yes.

11 **Q.** You, meanwhile, as the Medical Director,  
12 hadn't worked with Letby; did you spend any time with  
13 Letby, generally?

14 **A.** No.

15 **Q.** So you were distant from that and, as  
16 a leader, can see the perspectives people might bring to  
17 a situation, can't you?

18 **A.** I accept that.

19 **Q.** So did you realise that your senior nurses  
20 Karen Rees, Eirian Powell, certainly, had been meeting  
21 with Letby a lot, or had worked, in Eirian Powell's  
22 case, with Letby a lot and that might make this very  
23 difficult for them, for a number of reasons; did you  
24 think about that?

25 **A.** Well, no, because I wasn't aware of it.

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1 have reinforced that. So I -- I can't say that it was  
2 mine -- my evidence alone.

3 I accept, as Medical Director, that might carry  
4 a degree of weight, but that was never my intention.

5 **Q.** Can we go, please, to INQ0003463, page 1.  
6 This is a meeting with Mr and Mrs Letby, Letby, Hayley  
7 Cooper, the representative, Karen Rees; were you aware  
8 they were meeting weekly?

9 **A.** I'm sorry?

10 **Q.** Were you aware there were weekly meetings  
11 taking place between Karen Rees, as a senior nurse,  
12 Letby, not always her parents, but there were weekly  
13 meetings with Letby?

14 **A.** I wasn't.

15 **Q.** Were you aware how close Karen Rees and Hayley  
16 Griffiths had become to Letby's position --

17 **A.** I wasn't.

18 **Q.** -- and as friends, if they believed that at  
19 the time?

20 **A.** No.

21 **Q.** Should you have been alert to that; should you  
22 have thought "Who's getting involved with who here"?

23 **A.** To be honest, I'm not sure that is a question  
24 I can answer. I don't know whether I -- I should have  
25 known or not.

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1 **Q.** You were aware Eirian Powell managed her and  
2 was going to have worked with her, weren't you?

3 **A.** Yes.

4 **Q.** Let's have a look at INQ0003463, page 3. This  
5 is where you're meeting on 22 December with Letby's  
6 parents and you say:

7 "Concerns were raised [this is about the  
8 Consultants]. We undertook a couple of reviews,  
9 subsequently came together in May, after two further  
10 baby deaths. We support any member of staff in raising  
11 a concern. We accept the behaviours were not  
12 appropriate. We set actions to undertake an external  
13 review and close to a conclusion. There was a panel of  
14 four of them [this is the RCPCH] who spent three days  
15 here. They compiled their report quicker than normal.  
16 They then came out for a secondary review, taken to  
17 a further level. A small component needs to be  
18 completed early in the New Year, that's why we have not  
19 shared the completed review."

20 Over the page, at page 5, you are asked by  
21 Mr Letby:

22 "Have you spoken to Ravi?"

23 You say:

24 "It's not appropriate behaviour. Not had it

25 reported to me subsequently. SH [Mrs Hodkinson] and

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1 I met with Dr Brearey. Will be followed up with  
2 documentation to all of them."

3 That's what you choose to say to him. You are not  
4 happy with their behaviours. They have raised concerns  
5 and suspicions. You know you are not being, or your  
6 hospital isn't being, honest and open with them about  
7 the level of suspicion and then here you are saying  
8 "It's not appropriate behaviour", and criticising the  
9 Consultants to Letby: why?

10 **A.** I would simply say that this was a difficult  
11 meeting. I was, I suppose, simply reporting the  
12 comments that had been referenced in the grievance.  
13 I can only say that I was influenced by being in  
14 a meeting that I hadn't anticipated with Letby and her  
15 parents.

16 **Q.** Who asked you to be in that meeting?

17 **A.** I'm not sure whether it was Tony Chambers or  
18 Sue Hodgkinson.

19 **Q.** Can we go to INQ00 --

20 **LADY JUSTICE THIRLWALL:** Sorry, Ms Langdale, just  
21 before we move, could we have a look at page 5, which  
22 was the page number, I think, that you were looking at,  
23 wasn't it, whereas we have got page 4 on there.

24 Thank you. We could follow it perfectly but it  
25 just wasn't in front of us.

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1 traced. I am interested to know who tabled this and who  
2 was present as they are potentially professionals that  
3 I will be working with in the future and feel it is only  
4 fair for me to know. I believe the meeting took place  
5 shortly after the deaths of the two Triplets and  
6 involved senior and junior doctors. I would appreciate  
7 any help you can offer."

8 You wouldn't necessarily have known this,  
9 Mr Harvey, but we know, of course, that Letby was  
10 texting and messaging Dr U for information about babies  
11 on the unit. You, as the Medical Director, are now  
12 being emailed and asked for information of people  
13 discussing concerns about her. What do you make of  
14 that: has that happened before?

15 **A.** It's not happened before and I regarded it --  
16 and regard it -- as a completely inappropriate email.

17 **Q.** What did you do with it?

18 **A.** I cannot remember. I don't even remember. It  
19 was only when this was made available as part of the  
20 Inquiry that I -- I saw it. I have not had any response  
21 made available to me. I could only imagine, having  
22 received this, that I would have discussed it either  
23 with Alison Kelly or with Sue Hodgkinson.

24 **Q.** We haven't seen a reply anywhere, Mr Harvey,  
25 as it sounds like you have. You have just seen the

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1 **MS LANGDALE:** Sorry.

2 **LADY JUSTICE THIRLWALL:** No, that's --

3 **MS LANGDALE:** So "Have you spoken to Ravi", and  
4 there is the answer:

5 "Not appropriate behaviour, nor had it been  
6 reported to me subsequently and you met with the other  
7 doctors."

8 So you are telling them your processes and what you  
9 were doing.

10 **A.** Yes.

11 **Q.** If we go now to INQ0057499, page 1.

12 "Dear Ian ..."

13 So we now have Ms Letby emailing the Medical  
14 Director:

15 "Dear Ian ..."

16 Read the content of the email before I ask

17 a question. She says:

18 "There is something that has been playing on my  
19 mind since receipt of my grievance statements that I am  
20 wondering if you could help me with. Karen Rees was  
21 informed that a junior doctor openly tabled a meeting,  
22 when discussing the increased mortality rates and my  
23 possible connection/involvement with this. When Karen  
24 asked, the details of the doctor in the meeting were not  
25 provided. Is there an agenda or minutes which could be

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1 email for a second time. This email is a standalone, as  
2 far as we can ascertain?

3 **A.** I mean, I can honestly say that I would not  
4 have forwarded that information to her. It would not  
5 have been appropriate.

6 **Q.** Somebody has told her about this meeting,  
7 though. There is somebody in her group within the  
8 hospital who have informed her, on the face of it, that  
9 there's been some kind of discussion involving a junior  
10 doctor. That appears to be information she has of sorts  
11 there?

12 **A.** Yes.

13 **Q.** When you got that, did you question why  
14 somebody who was suspected of a crime, was having access  
15 to that information and, furthermore, feeling confident  
16 enough to ask you, as the Medical Director, for further  
17 information?

18 **A.** I -- because I can't remember this email,  
19 I can't remember what action I would have taken on  
20 result -- on receipt of this email.

21 **Q.** What made you think it was inappropriate?

22 **A.** The tone of the email. The approach to me  
23 asking for that information.

24 **Q.** What is it about the tone?

25 **A.** It's being made as a very sort of personal

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1 approach. It is -- the tone of the writing within it  
2 and, also, it is the nature of the request that is being  
3 put in there.

4 **Q.** You had obviously met her at the meeting on  
5 22 December because we have been to those notes. Had  
6 you met her on other occasions before receiving this?

7 **A.** The only time I ever met Letby was in meetings  
8 with others in Tony Chambers' office.

9 **Q.** That can come down. Can we have please  
10 INQ0005795. This appears to be you requesting  
11 information or Ms Hodkinson providing it for you in  
12 preparation for meeting with the Consultants, can you  
13 see? You are being provided with information from the  
14 grievance hearing, which you can add to the briefing  
15 paper for the meeting.

16 Can we see there you are asking for or receiving --  
17 perhaps you can tell us what you are asking for --  
18 comments about the behaviours of the Consultants. Do  
19 you know why you were asking for that information?

20 **A.** I'm -- I can't see anything in that email to  
21 indicate that this was being sent to me in response to  
22 a request. It would appear that it was sent by  
23 Mrs Hodkinson in preparation for a meeting that I was to  
24 be involved in.

25 **Q.** So you received that. What did you make of  
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1 you anything they have done is inappropriate, I suggest  
2 you were bullying and intimidating them?

3 **A.** I wasn't intentionally doing that.

4 **Q.** Can we have a look please at INQ0003119,  
5 page 1. This is a letter from Dr Jayaram on 2 March to  
6 you:

7 "I am still very uncomfortable with all of this."

8 He sets out why he thinks it's inappropriate that  
9 they are being invited to mediation process. It says:

10 "During the course of the fact finding process for  
11 the grievance someone reported that I and two other  
12 Consultants had been heard to say potentially slanderous  
13 things about LL. You yourself have not seen in writing  
14 what is alleged to have been said, due to the documents  
15 being confidential, have no knowledge of who reported  
16 this, nor of who subsequently fed this back to LL. It  
17 is unclear as to whether these were remarks made in  
18 formal minuted meetings or remarks made in private that  
19 were overheard and reported back, or both. It's also  
20 unclear, as you have not seen the grievance report, how  
21 accurate these reports may be and how much may have been  
22 lost or exaggerated in translation.

23 "As Steve and I are the only paediatricians named  
24 in the grievance, we alone have been asked to engage in  
25 mediation process. However, if the mediation process is  
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1 all of that coming your way?

2 **A.** I understood that this was advice from  
3 Sue Hodkinson with regard to actions to be taken as  
4 a result of the grievance.

5 **Q.** It looks as though it's information being  
6 provided to you before the meeting on 6 February 2017,  
7 if we go to that. INQ0014279, page 1. This is another  
8 meeting you are at with Mr Chambers, as well, with  
9 Letby's parents, and we see at page 3, you say, halfway  
10 down the page:

11 "I met with SB and RJ at lunchtime. We talked  
12 about how we needed to support you and the mediation  
13 process. All members of the team will need a level of  
14 mediation/remediation process. They accept they have  
15 not acted professionally."

16 That is what you say to them: why?

17 **A.** I would only say that in response to the  
18 conversations that I had with Dr Brearey and Dr Jayaram.  
19 I -- on reflection, and particularly with regard to one  
20 of your earlier comments and questions with regard to  
21 how they might feel -- accept that they might feel  
22 forced into making that concession when that actually  
23 wasn't appropriate.

24 **Q.** Were you bullying and intimidating them,  
25 Mr Harvey? If they are accepting in conversation with  
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1 to facilitate the reintegration of Letby and to be  
2 an enabler for safety in working, we suggested all seven  
3 Consultants should be part of the process, as all of us  
4 have expressed the same sentiments explicitly. You  
5 explained the recommendation for only two of us to be  
6 involved came from the external person who had been  
7 asked to review the whole grievance."

8 He concludes:

9 "After our meeting, it's become clear there are  
10 still no clear explanations for at least eight of the  
11 unexplained collapses and deaths and possibly more cases  
12 that have not yet been removed", and that they had  
13 raised the concern eight months ago.

14 When you read that, did you think, "This is  
15 nonsense, they shouldn't be mediating"?

16 **A.** I firstly wasn't aware that the mediation was  
17 a voluntary process. When I read this, I was  
18 uncomfortable. I cannot say for sure when but I had  
19 conversations both with Tony Chambers and Sir Duncan  
20 Nichol expressing concern about how the grievance  
21 process had run and the effect that it had had.

22 **Q.** Dr Jayaram says he spoke to you in  
23 an unscheduled face-to-face discussion, at some point  
24 between his initial meeting with the mediator and the  
25 planned meeting, and he again expressed concerns about  
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1 the mediation process and Letby returning to work.  
 2 That's right, he did have a follow-up discussion, didn't  
 3 he --

4 **A.** Yes.

5 **Q.** -- as well as that? He says:

6 "During this discussion, I said to him that, if, as  
 7 was suggested, the behaviour of some Consultants fell  
 8 short of GMC standards, it should be his duty as Medical  
 9 Director to report those Consultants to the GMC, and he  
 10 queried how he could allow me and other colleagues to  
 11 continue to care for babies if we behaved  
 12 unprofessionally."

13 Do you remember that?

14 **A.** I don't.

15 **Q.** The GMC is floating around there, isn't it, we  
 16 have seen it in conversations, in discussions, there is  
 17 references to you referring to the GMC.

18 **A.** The only references that I made with regard to  
 19 the GMC were reporting the threat from Letby's father  
 20 that he would report them and in trying to support  
 21 Dr Jayaram and Dr Brearey in avoiding that process, I am  
 22 and was only too aware of the impact, even on doctors  
 23 who have committed no wrong, of undergoing a GMC  
 24 process, and I was doing everything that I could to try  
 25 and prevent them having to go through that. At no point

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1 the GMC would be duty bound to contact the doctor and  
 2 initiate some form of investigation.

3 I'm fully aware of the impact of even receiving  
 4 that first letter from the GMC on doctors. I had had  
 5 a number of phone calls from doctors in the evening or  
 6 at the weekend because they just received a letter and  
 7 the impact on them. And safeguarding or not, there  
 8 would have been an initial response from the GMC if, for  
 9 example, Mr Letby had written making a complaint.

10 **Q.** In the informal conversation you had with  
 11 Dr Jayaram encouraging him or telling him to have  
 12 mediation, he says that you said to him he didn't need  
 13 to worry, if Letby came back to work on the neonatal  
 14 unit, it would be unlikely she would stay at the  
 15 Countess very long and she would probably apply for  
 16 a job elsewhere, as soon as possible. Can you remember  
 17 saying that?

18 **A.** I don't recall saying that, no.

19 **Q.** Well, you wanted her back on the unit, didn't  
 20 you, and you knew that the relationships were not  
 21 harmonious on the unit?

22 **A.** I -- at that point, I don't think we had  
 23 completed all our investigations and, as Medical  
 24 Director, I wouldn't have been comfortable with her  
 25 going back on the unit until we had completed those.

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1 did I ever threaten any of them with reporting them to  
 2 the GMC.

3 **Q.** Let's look at page 2 of the document on  
 4 screen. This is where you follow up and say:

5 "Thanks for coming in."

6 You say:

7 "Please can I counsel you to make effort to attend  
 8 the preliminary meeting with the facilitator. I think  
 9 this gesture would go a long way to protect you from  
 10 a possible referral to the GMC from other parties,  
 11 which, having supported many doctors have done no wrong,  
 12 even then isn't a comfortable process."

13 You were the responsible officer, weren't you,  
 14 around GMC referral?

15 **A.** Yes.

16 **Q.** You should have been saying, "You have raised  
 17 safeguarding concerns, don't worry about a GMC referral,  
 18 Dr Jayaram. Don't even think about it?"

19 **A.** Um.

20 **Q.** Here you are passing on, you say it was  
 21 Mr Letby's view, rather than yours, but passing on "You  
 22 may have a referral"?

23 **A.** I don't think that that would have captured  
 24 what would have happened, even had it been safeguarding,  
 25 if a party from outside had made a referral to the GMC,

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1 **Q.** Option 4 was -- the meeting we went to earlier  
 2 was approved by the Execs. The plan was she could be  
 3 back on the unit reviewing competence and the like, and  
 4 that is what you expected in due course?

5 **A.** I -- I can't remember the option paper and  
 6 certainly I wouldn't have been comfortable with that and  
 7 we had -- until we had completed all our investigations.

8 **Q.** But if she got to the point that she was back  
 9 on the ward, and you were comfortable with it, would it  
 10 be logical in your view that she may not be and would  
 11 have left anyway and gone elsewhere?

12 **A.** Sorry I didn't catch the last --

13 **Q.** The suggestion that you said, that she, if she  
 14 came back on to the unit, might look for a job  
 15 elsewhere, if she was back on the unit and you were  
 16 satisfied that she could be back on the unit, do you see  
 17 that she may still have wished to leave because the  
 18 relationships were so fractured by then between her and  
 19 the doctors?

20 **A.** If that was the case, yes. But I don't  
 21 believe that would have been the case, given the  
 22 subsequent events.

23 **Q.** No. But the comment Dr Jayaram has made  
 24 resonates with you thinking, if she was okay to go back  
 25 on the ward, she might still choose to leave because the

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1 atmosphere is not very good. That is the kind of remark  
2 you may well said him: go to the mediation, if she comes  
3 back she will probably leave anyway?

4 **A.** I don't recall making that comment.

5 **Q.** There's an Executive meeting on 14 February.  
6 Can we go, please, to INQ0003379, page 1. See at the  
7 top, it's recorded there "What are they plotting":

8 "Wondered what they are plotting."

9 Do you know what you were meaning by suggesting  
10 "plotting", what were they plotting: what were you  
11 thinking?

12 **A.** I was expressing frustration at trying to  
13 understand the basis of -- I believe, this relates to  
14 a letter. "Plotting", I don't think, was used as any  
15 sort of implication of underhand. It was simply a way  
16 of trying to ask what was the underlying motive for the  
17 letter?

18 **Q.** It was an us and them situation, wasn't it:  
19 the Execs versus the Consultants?

20 **A.** It is one of my great regrets that, at this  
21 stage, it was reaching that position, yes.

22 **Q.** There was secrecy: secrecy from your side in  
23 terms of information that you were sharing with them;  
24 and from their side, having emails deciding what to do  
25 about that?

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1 "I repeat my comments of yesterday at the top.  
2 I gather an apology letter was forwarded to Lucy  
3 yesterday and I would like to thank your part for that.  
4 I repeat my comments that we must separate the concerns  
5 raised and the reviews from the grievance procedure."

6 What did you mean by that?

7 **A.** I would say it's -- it's apparent in that  
8 sentence that as -- that the grievance procedure was  
9 running in parallel to the other reviews, the College  
10 review, the Hawdon Review, McPartland, and I think, as  
11 others have said, retrospect, that wasn't an appropriate  
12 position. The grievance procedure should have been  
13 halted.

14 My level of knowledge of grievance procedure at  
15 that time wasn't such that I challenged it. I --  
16 I should have done. I think that is an inappropriate  
17 line but that was my understanding at the time.

18 **Q.** You were aware, as a consequence of the  
19 grievance procedure, Letby had sent a letter of  
20 communication to colleagues, saying she had been fully  
21 exonerated, exonerated of any concerns or complaints  
22 about her?

23 **A.** I was subsequently aware of that letter.

24 **Q.** So very difficult to separate that from the  
25 grievance procedure, where it was being deployed as

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1 **A.** It reflected the fact that neither was feeling  
2 entirely comfortable with the other and that was  
3 a dreadful situation to have had at that time.

4 **Q.** If we see, halfway down, it said:

5 "Steve Brearey said to IH, 'may need  
6 representation'."

7 You tell us in your statement at paragraph 609:

8 "I vaguely recall Steve Brearey suggesting that he  
9 felt he was being challenged and may need  
10 representation."

11 Can you remember what he needed representation  
12 about, or thought he did need representation about?

13 **A.** I could only imagine that it was with regard  
14 to the grievance.

15 **Q.** They felt their jobs were on the line, they  
16 were on the line, didn't they?

17 **A.** According to their subsequent evidence, yes.  
18 That wasn't apparent at the time.

19 **Q.** Do you think the combination of you,  
20 Mr Chambers and Ms Kelly could be an intimidating group  
21 of Execs?

22 **A.** I wouldn't see us as intimidating, no.

23 **Q.** Can we go to INQ0006890, page 236. We have  
24 been to this but just look at the top paragraph. You  
25 suggest there:

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1 an answer to the concerns raised --

2 **A.** Yes.

3 **Q.** -- namely that the Consultants had behaved  
4 unprofessionally, were discredited. That was the effect  
5 of the grievance process, wasn't it, to discredit the  
6 Consultants: you did it in your grievance interview,  
7 others did it to follow?

8 **A.** I don't believe that I did discredit them.

9 **Q.** You discredited them in the meeting with  
10 Mr Letby, didn't you, you discredited them to him?

11 **A.** I -- I would accept that it wasn't the right  
12 thing to do, to run the grievance procedure in parallel  
13 with the continuing reviews.

14 **Q.** Well, it allowed you to express your  
15 frustration and hostility to the Consultants' position,  
16 didn't it, and their behaviour. You were frustrated by  
17 their continued requests around Letby not being  
18 permitted back on to the ward, weren't you?

19 **A.** I had a degree of frustration but that wasn't  
20 with regard to supporting her back onto the ward. My  
21 frustration was with regard to trying to pull everything  
22 together to get to a consensus.

23 **Q.** INQ0003073, page 1. Dr Brearey didn't go to  
24 the mediation, we know that, and he sends a letter to  
25 you on 6 March expressing dissatisfaction with the way

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1 the Trust has handled it. I will give everyone time to  
2 read that page and then if we can scroll over to the  
3 concluding paragraph on the second page. *(Pause)*

4 It's page 3, I think. There's the end of the  
5 letter, reminding you of Dr Subhedar stating that he too  
6 was concerned about the cause of death and/or  
7 deterioration, remaining unexplained.

8 So you were having a clear pointer from Dr Brearey  
9 there, weren't you, that you hadn't, in any sense,  
10 examined the cause and concerns and the suspicion around  
11 Letby, and it was time to refer to the police.

12 He doesn't say "refer to the police", I am saying  
13 you reading it, you are being told very clearly there,  
14 despite the pressure being put on them, and Dr Jayaram  
15 said he felt under duress, having spoken to  
16 Mrs Hodgkinson to do the mediation, they remind you,  
17 again, what they are really concerned about: babies on  
18 the unit, if she's going to come back.

19 **A.** They do, and it was apparent from this letter  
20 that the chances of a consensus were not there. I'm  
21 unsure of the timing of this letter, with regard to the  
22 letter requesting that we go to the Coroner. I believe  
23 there is a fairly close temporal relationship -- and it  
24 was that combination and the subsequent meeting that  
25 I had with Dr Subhedar and with the paediatricians that

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1 What's "the case"?

2 **A.** I think it, it refers to the fact that one  
3 explanation or one factor in the increase in the  
4 mortality would have been the increase in intensity.

5 **Q.** That had nothing to do with the deaths, the  
6 sudden and unexplained deaths that needed baby-by-baby  
7 investigation and explanation, did it, and you knew that  
8 by this point?

9 It was irrelevant. It was irrelevant to the issue  
10 that needed investigating and irrelevant to each baby  
11 that had died suddenly and unexpectedly?

12 **A.** It was one -- one feature of a whole range of  
13 multi-factorial elements. There is obviously a great  
14 deal of limited detail within this board report in terms  
15 of not that it didn't report what was said but a limited  
16 amount was -- was said.

17 Certainly at this time, we were still faced with  
18 a situation where we had an increased level of  
19 mortality, that we were still trying to come to  
20 understand the cause, that we hadn't yet had --  
21 completed the investigations. We were waiting for final  
22 reports.

23 And irrespective of the final recommendations,  
24 I would not have been comfortable with considering as  
25 I have already said the return of Letby until those

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1 caused me to advise the Executives that we were in  
2 a position where there was no alternative, in my opinion  
3 but to go to the police.

4 **Q.** Can we move on now to preparation for an  
5 extraordinary Board of Directors meeting, 10 January  
6 2017. If we go to INQ0003518, page 1. Turn to page 2  
7 when we get there.

8 That's what you were inviting the Board to do:

9 "Support the Executive in assisting the staff  
10 member's return to work on the neonatal unit, the  
11 reviews having found no evidence of a single person's  
12 culpability and in implementing the recommendations of  
13 the grievance investigation."

14 So January 2017, no investigation into the  
15 allegations that Letby's deliberately harming children  
16 and you make that recommendation to the board.

17 And if we go to the meeting notes INQ0003237,  
18 page 3, one comment, if you can expand on it, please.  
19 Paragraph 5:

20 "Mr Harvey said that when thinking back to activity  
21 one alarm bell was how many cots the unit had over their  
22 allocation, the number of low birth weight and gestation  
23 babies and this strengthened the case that it was due to  
24 the intensity of the number of babies coming to the  
25 unit."

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1 reviews and investigations had been completed.

2 **Q.** You did not say at this meeting or  
3 subsequently, loud and clear, that the paediatricians  
4 were concerned that there was a nurse killing babies and  
5 the RCPCH Review had said it needs to be investigated or  
6 had said, some time previously, that it needed to be  
7 investigated?

8 **A.** I wasn't explicit in this meeting. But this  
9 had been discussed with the board previously.

10 I didn't feel that we had anything else coming out  
11 from the reviews to that point that would have supported  
12 that assertion. That was my, my honest view at the time  
13 I made this report.

14 **Q.** We will be hearing from the board next week,  
15 Mr Harvey. You have seen and referred in your statement  
16 to Sir Duncan Nichol saying he felt misled. There are  
17 a number of people that have told the Inquiry they felt  
18 misled by you.

19 Can you understand why Dr Hawdon, Dr McPartland and  
20 Sir Duncan Nichol would all be saying they had been  
21 misled by you?

22 **A.** I struggle to understand why they would say  
23 they had been misled other than the fact that it is  
24 extremely easy to make those comments. It is extremely  
25 easy to view one's views at the time on the basis of

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1 hindsight and knowing how this ends and I don't think  
2 that is a true reflection of the situation that was  
3 presented at the time.

4 **Q.** Let's look at a board meeting on 14 July 2016,  
5 INQ0004216. This is where it's being discussed whether  
6 the police should be contacted.

7 Look at what Mr Wilkie says on page 5. The whole  
8 board meeting will be uploaded in due course but look at  
9 number 5:

10 "Mr Wilkie stated he wanted to better understand  
11 what are the critical issues that mean it's not  
12 appropriate to engage the police as he could see  
13 disquiet. Mr Brearey replied that this has been  
14 discussed after the last meeting with Mr Harvey. There  
15 is a considerable amount of discomfort regarding the  
16 member of staff. It was felt that this was dragging on  
17 and this would not solve the problem. There is  
18 a fantastic team and he morale is very low. They will  
19 see a member of staff being closely supervised for no  
20 apparent reason. People do have anxiety about that and  
21 there is definitely discomfort."

22 Over the page:

23 "Mrs Hopwood asked how practical it was for the  
24 staff member to work under supervision."

25 If we go to page 7, we see Mr Wilkie said that:

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1 agrees."

2 Dr Jayaram replied:

3 "The only alternative is to go straight to the  
4 police and that they would want hard evidence."

5 Who was the person propelling the notion that you  
6 needed hard evidence or substantiation and proof, is  
7 that something you were saying, that you needed  
8 something clear?

9 **A.** Well, that was a statement made by Dr Jayaram.

10 **Q.** Yes, and it's something we know you have been  
11 saying. You keep saying, "There wasn't evidence. There  
12 wasn't evidence, that's why we had to go and get  
13 evidence and go and get these reviews". That was  
14 something you believed, didn't you: you needed evidence  
15 rather than suspicion of a concern?

16 **A.** I believe that that was -- that was the belief  
17 of most or all of us. I would highlight on the page  
18 before that Dr Jayaram, there is reference to Dr Jayaram  
19 agreeing with the actions that they were appropriate and  
20 proportionate from that meeting and, at the risk of  
21 repeating myself, I have already agreed that I regret  
22 that we didn't speak with the police in June/July 2016.

23 **Q.** Do you regret that you weren't more open with  
24 people around you so that they could make their own  
25 decision about whether that was necessary or not?

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1 "As a layperson who did not know how effective the  
2 measures will be and asked how confident the Trust were  
3 that we are removing all risk. Mr Chambers replied  
4 there will be weekly monitoring on neonatal services at  
5 the Executive Directors Group."

6 Did you tell the board that at this time you had  
7 been storing samples, two of the samples, the TPN bags  
8 that Dr Green came to collect and were stored at the  
9 hospital in case they were used, needed to be used  
10 further? Did you ever mention that?

11 **A.** To the board, no.

12 **Q.** Why not? What does that tell you, that you  
13 are keeping samples?

14 **A.** That was simply a reflection of the concerns  
15 that had been raised and Dr Green had informed us they  
16 had been kept. Dr Brearey subsequently informed us that  
17 the pathologist had no need of those, those samples.

18 **Q.** Then we see at page 7 at the bottom:

19 "Sir Duncan stated there is a major future exercise  
20 to look at everything and noted the Trust is committed  
21 [when it comes] to do this. In the meantime the  
22 previously expressed concerns about the individual,  
23 actions are being taken. It's agreed that these are  
24 reasonable as we cannot see a single hypothesis. We  
25 have to move forward in this way if the majority

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1 **A.** I believe that I was open in the conversations  
2 that I had with individuals, within the limit of the  
3 extent of the information that we had.

4 **MS LANGDALE:** My Lady, this might be a good moment.  
5 May I suggest a shorter lunch break, if that suits  
6 people.

7 **LADY JUSTICE THIRLWALL:** Yes, certainly,  
8 45 minutes?

9 Very well, so we will take the lunch break now and  
10 we will come back at 1.50.

11 (1.06 pm)

(The luncheon adjournment)

13 (1.48 pm)

14 **LADY JUSTICE THIRLWALL:** Yes.

15 **MS LANGDALE:** Mr Harvey, can we move, please, to  
16 the topic of what the parents were told, and can we have  
17 on screen, please, INQ0003100, page 1. This is  
18 an internal communications document, Mr Harvey, copied  
19 in to the Executives and it's clear that the hospital  
20 were sent an email that the newspaper was going to  
21 publish a reference to the Royal College reports and  
22 invited comment. We see here a draft comment in  
23 paragraph 3:

24 "Medical Director at the Countess of Chester, Ian  
25 Harvey, said, 'We have done all we can to keep parents

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1 informed and our clinical teams will be contacting them  
 2 again ahead of the review being published to make sure  
 3 a copy is available for them. 13 detailed independent  
 4 case note and pathology reviews will also be shared with  
 5 the families on an individual basis. Our work on this  
 6 has only completed within the last two weeks and now we  
 7 have the full and accurate information to share with  
 8 parents. We are sorry for any distress or upset this  
 9 review may have caused. Those families affected have  
 10 been through so much already."

11 First of all, did you approve that comment in  
 12 response to the publication?

13 **A.** I -- I will have done.

14 **Q.** Was it true?

15 **A.** It was true to the best of my knowledge.

16 **Q.** "We have done all we can to keep parents  
 17 informed": that simply wasn't true.

18 **A.** At that time, that was how we felt about the  
 19 situation. In retrospect, I think we all -- I, as well,  
 20 as an individual, but also as the Executive Team --  
 21 acknowledged that, actually, there was more that we  
 22 could have done.

23 **Q.** You didn't keep the parents informed at all,  
 24 so that wasn't true but what you say is because that's  
 25 what you thought was the best thing to do? Is that your

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1 **Q.** Were you planning to share it all, the  
 2 comments about the nurse. You had had it since  
 3 28 November and in draft since 18 October. Were you  
 4 planning to share with all the parents of the babies the  
 5 doctors were concerned about, the suspicion of the  
 6 nurse?

7 **A.** I think the intention was that we were going  
 8 to be sharing the version that was described for  
 9 dissemination, so that wouldn't have included the green  
 10 text.

11 We had a plan for that sharing and, yes, our hand  
 12 was forced, insofar as we had to be precipitate in how  
 13 we got the report out and shared to parents because of  
 14 the impending publication.

15 **Q.** We will look at another letter INQ0012619,  
 16 page 3. So it is a different INQ, INQ0012619, page 3.  
 17 The template:

18 "Following on from your conversation with our  
 19 Deputy Director of Nursing, Sian Williams, please find  
 20 enclosed a copy of our report. During this telephone  
 21 conversation, it was explained to you that we asked for  
 22 this external assessment from the Royal College of  
 23 Paediatrics and Child Health and the Royal College of  
 24 Nursing. This step was taken because we wanted to  
 25 better understand why there had been a greater number of

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1 answer, because the parents hadn't been kept informed at  
 2 all, had they?

3 **A.** We had contacted, to the best of our ability,  
 4 to inform that, because of the concerns, a review was  
 5 ongoing. We obviously made it clear that we would be  
 6 contacting again to ensure that copies of the review  
 7 were going to be available for them to review.

8 **Q.** Let's look at the letter. INQ0014411, page 3,  
 9 the template letter, dated 8 February, page 3. That's  
 10 a letter, isn't it, from you, which follows the fact  
 11 that you know it's going to be published in The Times,  
 12 letting the parents know about the RCPCH Review and on  
 13 Friday last week, again pursuant to knowledge that it  
 14 was going to be published, parents are attempted to be  
 15 contacted; is that right?

16 **A.** Yes.

17 **Q.** So your hand was forced, wasn't it, Mr Harvey,  
 18 by the press publishing the RCPCH or the fact of the  
 19 RCPCH report and something of its contents and, at that  
 20 point Sian Williams, was tasked with trying to contact  
 21 the parents because it was going to come into the public  
 22 domain; is that right?

23 **A.** We had planned that we were going to be  
 24 sharing the review with the parents. I obviously  
 25 haven't got that plan with the timescale.

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1 deaths than we would normally expect on our neonatal  
 2 unit. In the report, it describes no single causal  
 3 factor to explain the increase we have seen in our  
 4 mortality numbers. It makes a total of 24  
 5 recommendations across a range of areas, including  
 6 compliance with standard staffing, competencies,  
 7 leadership, team working and culture ... We are  
 8 desperately sorry for any distress or upset this review  
 9 has caused."

10 This letter covered up the concerns that were  
 11 raised by the paediatricians and the concerns that the  
 12 RCPCH fed back to you about allegations of misconduct  
 13 not being investigated, didn't it?

14 **A.** I would dispute that it covered up any  
 15 allegations that the Royal College made. I would refer,  
 16 again, to their reference to gut -- "gut feeling". I do  
 17 not feel that the Royal College report was explicit in  
 18 any way. I believe that that had a significant role in  
 19 directing us. I believe that this letter summarises the  
 20 situation as it was on 8 February when it was dated.

21 **Q.** What is your explanation for only sending it  
 22 on 8 February, when you had had the report for months  
 23 and when there was publication of the report through the  
 24 press?

25 **A.** I -- I have no true recollection of why there

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1 was that delay. I can only surmise that that was to  
2 allow time for the Casenote Review, as well, in that the  
3 Royal College Review alone would obviously leave a lot  
4 of questions.

5 **Q.** Parents gave evidence, which you will have  
6 heard, varying from: first of all, there hadn't been  
7 attempts to really contact them because the hospital  
8 should have known where they were and weren't contacting  
9 them; secondly, that they had a letter delivered by  
10 black cab just hours before the report was published; in  
11 another case, where someone was a patient at the  
12 hospital in a subsequent pregnancy, nobody tracking her  
13 down and telling her about this, while no doubt comms  
14 and everyone else is thinking what to say. What do you  
15 say about how this was communicated and when?

16 **A.** As I think we, I -- I have already said, I am  
17 fully aware that the standard and the nature of our  
18 communications was way below the standard that was --  
19 was expected of us and that we should have maintained.

20 I don't think that it was appropriate, I don't  
21 think that it was of a high enough standard and I don't  
22 think that it actually truly recognised the distress  
23 that these parents and families would be suffering.

24 **Q.** Was it deceptive, in that it did not  
25 communicate the suspicion and concern that their babies

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1 **Q.** Duty of care to who?

2 **A.** Well, duty of care to staff.

3 **Q.** So you were balancing candour to parents of  
4 babies with the duty of care to Letby?

5 **A.** And I would say that that -- yes, at that  
6 point, that was a factor. It is very easy, with  
7 hindsight, knowing what we know now, to say, well, as  
8 has been regularly said, that that was obviously  
9 completely wrong. But that wasn't the situation that we  
10 were faced with at the time and, until such time as  
11 there was clarity, I believe that there was that  
12 conflict for us. And it wasn't just for me: I think it  
13 was for all of us and I think that, and I hope that,  
14 something that will come out of this Inquiry is some  
15 clarity for those who follow us with regard to how to  
16 get that balance right.

17 **Q.** When they did see reports, because, you say,  
18 of the duty you had to staff, that's why you removed the  
19 green text, wherever it went: to the parents, to the  
20 CQC, in due course, and to external regulators, because  
21 duvet you had to Letby; is that the position?

22 **A.** No. I'm not sure. I wasn't in direct  
23 contact, I -- with the CQC, I wasn't their point of  
24 contact, so I'm unsure at what point we shared the full  
25 report with them. I think I have already conceded that

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1 had been deliberately harmed?

2 **A.** I do not believe that it was deceptive.

3 I believe that it was stating the position as we  
4 understood it at that time.

5 **Q.** You have said you hadn't communicated before  
6 this time but, having opened the channels of  
7 communication, you needed to be transparent and candid  
8 about what you were really dealing with at the Trust,  
9 didn't you?

10 **A.** I would refer to comments made by both  
11 Sir Robert Francis and Mr Medland, that we were faced  
12 with intersecting and clashing duties and that  
13 influenced the nature of communication. I -- I'm not  
14 sure that we got the balance right.

15 **Q.** What's the balance, what's the competing duty,  
16 when it comes to being open and honest with parents  
17 about their babies and their babies' injuries and  
18 deaths; what are you balancing with that?

19 **A.** Well, this, I think, was what Mr Medland  
20 referred to as the -- the differing duties.

21 **Q.** No, you tell me, not Mr Medland, what was the  
22 other duty for you?

23 **A.** For me, it was duty of candour but also a duty  
24 of care, and it was that intersection that I think  
25 proved difficult for us.

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1 I was slow in sharing the complete report with  
2 specialised commissioning.

3 **Q.** Mother C, she's represented with other  
4 families in this Inquiry, so I will ask you this  
5 briefly, she wrote to you directly, didn't she --

6 **A.** She did.

7 **Q.** -- as a bereaved parent and following the  
8 publication of the review, and you had a meeting with  
9 her; do you remember that?

10 **A.** I do.

11 **Q.** You do: you do remember that?

12 **A.** Yes.

13 **Q.** What did you say to her at that meeting about  
14 what was happening?

15 **A.** I -- I don't have any notes of that meeting  
16 and I cannot recall the detail of the conversation.

17 **Q.** Were you very clear after the meeting that she  
18 would want to know what the hospital knew about her  
19 baby, in other words she would want candour and want to  
20 know, moving forwards, what had happened and what was  
21 being done?

22 **A.** Yes.

23 **Q.** Did you fulfil that obligation of candour with  
24 Mother C, and indeed all of the other parents, moving  
25 forwards from that time, in terms of telling them about

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1 the risk that had been identified in their babies' cases  
2 from a particular nurse?

3 **A.** At the time that that was ongoing, given that  
4 we were faced with an increase in mortality, that at  
5 that point there remained no definitive evidence, no, we  
6 did not raise that as a specific issue.

7 **Q.** Did it ever occur to you that the parents may  
8 have relevant evidence to give or to assist in the  
9 investigation that was necessary?

10 **A.** To my regret, no, it didn't.

11 **Q.** You know that Dr Hawdon's report was sent as  
12 a simple page with an attachment of medical notes,  
13 a page or so, that related to their child, don't you?  
14 That is all they got, a little explanation of the  
15 report, to help navigate why it was done, what its  
16 purpose was. They simply got a couple of pages that  
17 related to their child; that was inadequate  
18 communication about that review, wasn't it?

19 **A.** It was sent with a letter recognising that  
20 they might not be able to interpret the details of the  
21 report and that we were happy to arrange meetings to go  
22 through that with them in detail and explain the  
23 meanings of those.

24 **Q.** You never did, did you?

25 **A.** I fully accept that that communication was

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1 have contributed.

2 **Q.** As a Medical Director, a medically qualified  
3 person, why didn't you choose to speak or meet with  
4 a number of them, as soon as this had happened and the  
5 communication channel had been opened? Were you worried  
6 because you had that duty, as far as you were concerned,  
7 to the member of staff and you were not going to tell  
8 them about the suspicions or concerns about her, because  
9 that's the decision you had made?

10 **A.** No, absolutely not.

11 **Q.** Well, you had made that decision, hadn't you,  
12 not to share the suspicion and concern about Letby?  
13 That was a conscious decision, Mr Harvey, and one you  
14 stuck to.

15 **A.** Well, we are, we're discussing arranging to  
16 meet the Families and, to be perfectly honest, it --  
17 whilst planning to meet with individuals, I hadn't  
18 considered that we should actually meet them more -- in  
19 a more timely fashion as -- rather than reporting what  
20 was found as a fact finding, and that's a significant  
21 omission.

22 **Q.** Did you give thought to when that more timely  
23 occasion might be, as the months passed after February?

24 **A.** I'm sorry, I don't understand the question.

25 **Q.** When did you think that would be? If it

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1 both crass and inappropriate. We went through -- we  
2 went along that in completely the wrong way. I --  
3 sorry, I have lost my line -- train of thought now.

4 It was done in completely the wrong way. It was  
5 unthinking and insensitive. I would only say that we  
6 were keen to share the information as soon as possible.  
7 We were aware that there had been inordinate delays but  
8 I accept that that doesn't excuse the way in which this  
9 was done.

10 **Q.** It's not simply the way in which it was done,  
11 it was the information and the evidence they could have  
12 brought to the problem you were facing: they had  
13 relevant evidence to give, didn't they?

14 **A.** It is now apparent, yes.

15 **Q.** The mother of Baby D, who had pushed for the  
16 Inquest, was always of the firm view the Sudden and  
17 Unexpected Death could not be explained and something  
18 must have happened. Had she seen the green text, she  
19 would have picked up the phone to the police herself,  
20 most likely, wouldn't she? You deprived the parents of  
21 an opportunity to have an input on the issue the  
22 hospital was addressing?

23 **A.** I -- I don't feel that I can speak to what  
24 might have happened but I accept that the Families  
25 potentially had significant information that they could

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1 wasn't going to be in February, early February, when  
2 were you going to meet them?

3 **A.** I -- I believe it would be when we had -- we  
4 were in a position to pass on all the information, so  
5 that we weren't leaving any details hanging or  
6 unanswered.

7 **Q.** That can come down now, thank you. I am sure  
8 you will be asked more questions about that topic.

9 I am going to ask you now about finally going to  
10 the police. Can we have on screen, please, INQ0003159,  
11 page 1. This is a letter from Mr Chambers to  
12 Dr Jayaram, setting out that:

13 "The Trust first advised the Coroner of Cheshire on  
14 Friday, 8 July and subsequently kept him informed.  
15 I can confirm that a copy of the report was shared with  
16 the Coroner on 20 January, following which a meeting  
17 with Mr Rheinberg, the Trust Medical Director and  
18 Director of Corporate and Legal Services, was held on  
19 8 February."

20 If we go over the page, Mr Chambers states:

21 "There has been a thorough internal and external  
22 review. Explains the RCPCH review, independent external  
23 review, of the 13 deaths ... thorough review of activity  
24 and acuity levels and staffing profiles."

25 You attended the meeting on 15 February 2017 with

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1 the Coroner, yes?

2 **A.** Yes.

3 **Q.** Can we have that on screen, please,  
4 INQ0002048\_0102. You will no doubt have seen this  
5 attendance note. Can you just cast your eye over that  
6 and tell us if you agree that's an accurate note of  
7 that? *(Pause)*

8 **A.** I believe so.

9 **Q.** That is an accurate note? We will be hearing  
10 from Mr Rheinberg next week and, whilst it may be the  
11 case the green text went through to the Coroner's  
12 office, he has no recollection of reading that before  
13 the meeting and was reliant on what was said in the  
14 meeting. There is nothing that's said verbally that  
15 puts centre front, does it, that there are suspicions  
16 and concerns of a nurse deliberately harming a baby?

17 **A.** I recall that either Mr Cross or I, in passing  
18 the paediatricians' letter across to Mr Rheinberg  
19 explained the background to that letter and the  
20 paediatricians' concerns. I'm also aware that there is  
21 documentation within the Inquiry that confirms that part  
22 of the bundle that Mr Rheinberg received was actually  
23 the full RCPCH Report, which included reference to the  
24 paediatricians' concerns.

25 **Q.** Thank you that can go down now.

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1 **A.** I can't say, sorry.

2 **Q.** "... or other experts conduct further review,  
3 eg Janet Rennie, if anything to be gained.

4 "Dr Jayaram: What would be the level of depth?"

5 Then page 5, you say at the bottom:

6 "Stephen Cross and I have expressed and advised the  
7 teams concerned. We met the Coroner. This is the  
8 second occasion we have met with Mr Rheinberg and Alan  
9 Moore. We have shared the review and a copy of your  
10 letter and specifically called out the team's concerns.

11 "NR advised we should leave it with him as he was  
12 reviewing his jurisdiction. It's been one definite  
13 Inquest and two potential. No indication of reopening  
14 any of the cases.

15 "Mr Chambers: he phoned police or acted within  
16 normal Inquest process. He has had everything we and  
17 you have had."

18 Over the page, you saying:

19 "Absolutely, why we met with him. At some point we  
20 need to meet with the parents."

21 At that stage, what were you thinking you needed to  
22 meet with the parents to say?

23 **A.** At that point, I was recognising that we had  
24 not had the opportunity to meet with the parents to  
25 discuss that -- the reviews that we had had to date.

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1 If we move then to a meeting on 27 March 2017,  
2 INQ0003150, page 1, and, to put it in context when it  
3 comes up, this is when the paediatricians describe  
4 feeling desperate with their jobs under threat.  
5 Dr Brearey says he's looking for another position in  
6 another hospital, and Letby had come on to the ward to  
7 have tea and reorientation updates. That's where we are  
8 at in the timeline.

9 We see on page 1, Dr Jayaram:

10 "There have been deaths ..."

11 Then the next page:

12 "JM [Julie Maddocks]: given the information on the  
13 balance of probability, illegal activity has caused the  
14 deaths."

15 You say:

16 "Or reasonable doubt."

17 Then over the page, page 3, you say:

18 "You have had access to everything, including the  
19 reference to the HR processes that were redacted."

20 You are referring there, they have seen the green  
21 print of the RCPCH:

22 "Refer [over the next page, at page 4] with three  
23 options: contact the police; internal with NS support  
24 ..."

25 What does "NS" mean?

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1 I believe the background of this meeting is that it  
2 followed the meeting that I had had with Dr Subhedhar and  
3 some or all of the paediatricians having met the  
4 Coroner, which they expressed their continuing concerns,  
5 at which they presented those babies for whom they still  
6 had major concerns and, on the back of which meeting,  
7 I felt that there was nothing further for us to do,  
8 short of speaking to the police. And I believe it was  
9 on the back of me describing that situation to my  
10 Executive colleagues and to Tony Chambers that this  
11 meeting, with some of the paediatricians and with the  
12 network, was scheduled.

13 **Q.** The conference with Mr Medland was scheduled,  
14 wasn't it, for the paediatricians to meet him and, if we  
15 go to INQ0014378, page 1, we see your background summary  
16 document that was sent to Mr Medland, as part of his  
17 instructions. We see on page 2, at the top:

18 "Two Triplets born, died on 23rd and 24th.

19 Exacerbated the concerns there being no obvious cause  
20 for the babies' collapse and it was alleged that the  
21 nurse referred to above was involved in the care of  
22 these babies."

23 Why do you say "alleged"?

24 **A.** Because I didn't know for sure what level of  
25 care, whilst -- had -- had been associated with her at

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1 that time.

2 **Q.** The 30 June meeting made it very clear to you  
3 that she was looking after Babies O and P and, indeed,  
4 she had entered the Datix, which was the incident  
5 reported for P. You knew that she was the nurse who was  
6 present with O and P., so why do you say "alleged" and  
7 that you didn't know about the association: were you  
8 minimising it, playing it down?

9 **A.** No, absolutely not.

10 **Q.** So you had forgotten when you wrote that, is  
11 that the explanation: you had forgotten?

12 **A.** Sorry.

13 **Q.** You had forgotten that she was the nurse  
14 caring for O and P when you wrote it?

15 **A.** I was aware that she was on the unit. I --  
16 I wasn't and hadn't checked to what extent she was  
17 responsible for their care but was making clear that  
18 she -- she was there.

19 **Q.** On page 4, at the end the summary:

20 "In summary, we can demonstrate we have taken the  
21 concerns raised seriously. We have open and transparent  
22 with the Coroner, our regulators, parents and the  
23 public."

24 Pausing there, I think you accept you weren't open  
25 and transparent with the regulators or the parents and,

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1 to be reported to the police with a view to excluding  
2 any unnatural causes. Rather than reporting concerns,  
3 you just wanted to exclude unnatural causes, something  
4 like that?

5 **A.** No. I wasn't -- I wasn't aware of this  
6 rationale document. I hadn't seen it until this  
7 Inquiry. I think my view was summarised in the last  
8 paragraph of the document that has just been taken down,  
9 my summary, and that was that we required the assistance  
10 of the police.

11 **Q.** 13 April 2017 is a board meeting. If we can  
12 have, please, INQ0003236, page 1, Mr Medland attends.  
13 Page 3, Mr Wilkie is concerned, look at the top:

14 "... if we can truthfully argue there has not been  
15 a delay and it has not been possible to do sooner."

16 You say:

17 "Due process. We have done everything in  
18 a reasonable and explicable order but are beholden to  
19 other delay."

20 Sir Duncan said:

21 "The board need to decide if we feel the work took  
22 too long. Did it answer Dr Hawdon's report?"

23 Mr Harvey said:

24 "That's why I met with the Consultants with the  
25 review, to come to one view. Their view doubles the

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1 therefore, the public; is that right? You now accept  
2 that you were not open and transparent with the  
3 regulators, parents and the public; you say you were  
4 with the Coroner?

5 **A.** I -- I -- I -- I accept that we -- we weren't  
6 as open as we should have been. I believe that we were  
7 open and transparent with the Coroner. I believe that  
8 we did pass on all the information to him.

9 **Q.** You covered up from the parents and the  
10 regulators the suspicions and concerns about Letby?

11 **A.** I wouldn't describe that as covering up.  
12 I believe that was based on the -- the conflicting cares  
13 that we were associated with at a time when we still  
14 weren't completely sure what the situation was.

15 **Q.** That was what you describe as motivating the  
16 cover up but you agree you withheld that information and  
17 concealed it because of the reasons, you say, that you  
18 had a duty of care to a member of staff?

19 **A.** I wouldn't describe that as a cover up.

20 **Q.** Mr Cross' document, INQ0006123, page 1, he  
21 summarises it thus for Mr Medland, on 3 April:

22 "No evidence to justify criminal investigation.  
23 However, in the spirit of openness and transparency the  
24 matter is being reported to the police."

25 Was it your view at this time that it simply needed

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1 number of cases where there are concerns and they could  
2 not define what they felt was a forensic view."

3 So you are saying there you know that Dr Hawdon's  
4 report -- the Consultants are still concerned and they  
5 have more cases where there are concerns, just as  
6 Dr Subhedar said. Then you say they could not define  
7 what they felt was a forensic review. Who are you  
8 suggesting didn't know how to define what was a forensic  
9 review?

10 **A.** I suspect that that is probably a typo and  
11 probably reflects Dr Hawdon's response that  
12 Mr Medland -- excuse me -- had picked up on. Dr Hawdon  
13 had made reference to a forensic review and Mr Medland  
14 had advised that we ask what was meant by a forensic  
15 review, in her opinion, and the response from Dr Hawdon  
16 was, "Well, it can, effectively be whatever you want it  
17 to mean".

18 **Q.** If you look at page 5:

19 "Mr Harvey stated he met with one of the sets of  
20 parents and their concern was that we will turn their  
21 world on its head and they would start grieving all over  
22 again."

23 To be clear, that wasn't any of the parents of the  
24 babies named on indictment, but you are saying that you  
25 spoke to some parent, did you? You don't give us

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1 a name; tell us what you mean there, who have you spoken  
2 to?

3 **A.** I'm sorry, how do you mean?

4 **Q.** You are telling the meeting you had spoken  
5 with a set of parents who was concerned that their world  
6 would be turned over and they would start grieving all  
7 over again.

8 **A.** Yes. It was a concern that had been expressed  
9 on the back of fresh revelations that had come out in  
10 the press. The story in The Times had reopened their  
11 wounds, their grieving process, and I was simply  
12 highlighting the impact that all of this was having and  
13 would continue to have on the parents, and that we  
14 needed to be aware of that.

15 **Q.** It would be inevitable that that would turn  
16 their world on its head but no one had suggested to you  
17 they wouldn't want to know the truth, would they?

18 **A.** And I wasn't suggesting there that we should  
19 hide it to protect them.

20 **Q.** So why were you suggesting it at all in this  
21 context?

22 **A.** I wasn't. I was highlighting that this was  
23 an issue that we needed to be aware of in approaching  
24 the parents, that it was going to be a very difficult  
25 and a very stressful time. This wasn't an implication

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1 Mr Harvey, on 19 April 2017 and Financial Officer, Simon  
2 Holden. This is his note, Chief of Finance. We see  
3 halfway down Executive Directors:

4 "A broader forensic review of four cases  
5 recommended, similar to CDOP [Child Death Overview  
6 review] to investigate."

7 Were you discussing the Child Death Overview Panel  
8 investigating those cases, was that a plan at that  
9 point?

10 **A.** I think that is a reflection of one of  
11 Mr Medland's recommendations, that a way to approach the  
12 police would be through CDOP, on which Mr Wenham sat.

13 **Q.** Why does it mention four cases recommended  
14 then. It looks as though there is a discussion of  
15 investigating cases or not?

16 **A.** I think that relates to Dr Hawdon's review.

17 **Q.** Next document INQ0003076, page 5. Meeting,  
18 Friday, 12 May with the police. If we look halfway down  
19 the page:

20 "Ian Harvey has repeatedly challenged the  
21 clinicians, asking if there has been any acts which  
22 Countess of Chester needed to be aware of which would  
23 effectively give a case but repeatedly they have said  
24 no."

25 Why did you contribute that to the meeting?

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1 that we should be paternalistic and protect them.

2 **Q.** It's clear over the page, page 6, to complete  
3 it:

4 "Sir Duncan added we are still searching for  
5 explanations. Not saying she's still in the frame but  
6 it is a legitimate point that the forensic review be  
7 conducted."

8 So there is still the need for investigation, that  
9 is what the Chair of the board says?

10 **A.** Yes, and my understanding from before  
11 Mr Medland was instructed, through to this, was this was  
12 all a prelude to contacting the police.

13 **Q.** So your view is that, on 13 April, the plan  
14 was to go to the police; is that what you thought was  
15 going to happen?

16 **A.** My view was that, prior to the instruction of  
17 Mr Medland, we were going to the police and I think that  
18 is borne out by the final paragraph of the summary  
19 document I prepared for Mr Medland.

20 **Q.** Then after this meeting, did you still think  
21 that was the case, after this board meeting?

22 **A.** As far as I was concerned, that was our only  
23 option.

24 **Q.** Can we go please to INQ0101091, page 739.  
25 This is a meeting between Executive Directors,

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1 **A.** In meeting with the police, I felt it was  
2 important that we presented a comprehensive picture.

3 **Q.** Is that comprehensive?

4 **A.** Well, I think the whole document ends up  
5 comprehensive. I mean, a single sentence in isolation  
6 is never going to be comprehensive but I feel that in  
7 subsequent paragraphs there is further detail.

8 This is simply calling out that they had their  
9 concerns about the repeated presence of Letby in  
10 relation to deaths and collapses but, to that point,  
11 they had not, at any point seen, nor did they report,  
12 any other evidence that was definitive or even  
13 indicative of a malicious act.

14 **Q.** Next page, Mr Harvey. Page 6, third paragraph  
15 down:

16 "Ian Harvey added Countess of Chester are mindful  
17 they do not want to use Cheshire Constabulary as a HR  
18 process for staff. If you place yourself in the mindset  
19 of paediatricians to see what the motivation is, there  
20 is a strong sense of personal accountability that  
21 a clinician feels and when there is no clinical  
22 explanation they feel uncomfortable. It is unusual that  
23 they have a collective mindset. This is a problem which  
24 the Countess of Chester need to manage as it is not  
25 a criminal issue."

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1 Why did you say that?

2 **A.** I suspect that the last sentence is a typo, in  
3 saying that it would be a problem we would have to  
4 manage if -- if it was not a criminal issue.

5 I am initially paraphrasing the Coroner in  
6 saying -- he told us that he wasn't a QA process for the  
7 hospital. I was recognising that we weren't relying on  
8 the police to help us with staff but I was also calling  
9 out that the paediatricians felt that strong sense of  
10 personal accountability when they were faced with  
11 a situation which they can't directly explain and with  
12 which they are extremely uncomfortable. In this  
13 particular situation, the high mortality.

14 **Q.** Page 8, please. You wish to raise two issues  
15 at the top.

16 "When the issues were first raised by Stephen  
17 Brearey, it was held under the Speak Out Safely policy  
18 that he had protection as a whistleblower."

19 Not true, would you agree?

20 **A.** I accept that that was only actually enacted  
21 later on in the process, yes.

22 **Q.** Why was it even relevant to raise that?

23 **A.** I -- I think it was just part of  
24 a comprehensive conversation and it was to indicate  
25 that, certainly, albeit later than should have been the  
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1 "My own feeling is that, unless there is something  
2 that the paediatricians haven't disclosed previously  
3 that evidences criminal activity, there will not be  
4 an investigation and the police will assist us in  
5 a message that will allow us to close down the  
6 speculation here and deal with the issues of culture."

7 That sums up the contribution you made to the  
8 meeting and what you thought would be the effect of the  
9 meeting, doesn't it?

10 **A.** No, it doesn't. That sums up the feeling that  
11 I and, I believe he reported yesterday, Tony Chambers  
12 had from the conversations that we had had with the  
13 police with their what seemed to be reluctance to  
14 initiate an investigation, their asking if there was any  
15 other organisation that we could take this to and, at  
16 the close of that meeting, as Tony Chambers had alluded  
17 to, that uncertainty that led to him saying that, before  
18 you make a final decision, it is imperative that you  
19 speak with the paediatricians.

20 **Q.** Fortunately, of course, Dr Jayaram had  
21 communicated directly and, pursuant to a meeting with  
22 the paediatricians, the investigation was launched and  
23 the paediatricians' concerns were as they had been  
24 relayed to the Executives. What do you think was  
25 different: why did they understand the need for forensic  
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1 process, Stephen Brearey had that protection.

2 **Q.** Mr Wenham gave evidence to say that, at the  
3 meeting on 12 May, it appeared that the Executives were  
4 trying to shut the doors on the investigation; do you  
5 accept that?

6 **A.** No, absolutely not.

7 **Q.** When you read the contributions you made now,  
8 do you understand why that may be the impression given?

9 **A.** No, I don't because, if you read the notes as  
10 a totality, I believe it is clear that Mr Chambers was  
11 pushing the police to proceed.

12 **Q.** Your contributions, I am asking you about. As  
13 a Medical Director, when you read all of your  
14 contributions?

15 **A.** I was simply providing factual background, and  
16 I was not trying to influence them one way or the other.  
17 I was giving them the basis of coming, and I wouldn't  
18 accept that I was actually trying to dissuade them.

19 **Q.** If we go to, please, INQ0014678, page 1, you  
20 update Margaret Kitching, NHS England on 12 May:

21 "Just wanted to update you ... they are minded not  
22 to hold an investigation. Firstly, they don't feel  
23 there is evidence of criminal activity and, secondly,  
24 they are mindful of the effects on families."

25 In the second paragraph, you say:

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1 investigation and you did not?

2 **A.** I believe that they were in a position both  
3 to -- I believe they received further information.  
4 I hadn't, at this time, been aware of the reports with  
5 regard to Baby K, although I believe others did. I am  
6 also aware that, when we went to the police, we were in  
7 a position to say, "Well, whilst it falls short of  
8 a police inquiry, we have taken every reasonable step  
9 that a hospital could do and we cannot explain the  
10 increased mortality to the satisfaction of, at this  
11 point, the most important people", that being the  
12 paediatricians.

13 **Q.** INQ0107034, page 35. It is a statement of  
14 Michael Gregory, Medical Director for Specialised  
15 Commissioning. You have accepted, Mr Harvey, that you  
16 were not frank with the Commissioners of Specialised  
17 Services. Can we just read, please, the reflections  
18 from 136 to 141 of this statement. *(Pause)*

19 He says that he wasn't informed, you weren't open.  
20 He said, at paragraph 138:

21 "Specialised Commissioning was not informed that  
22 the Consultant paediatrician concerns related to one  
23 individual. If I knew this in hindsight I could have  
24 pressed the hospital further. However, it's difficult  
25 to press on something that I was not informed about and  
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1 I had limited authority in my role when dealing with the  
2 hospital Medical Director. When I raised the  
3 possibility of an individual having disproportionate  
4 involvement, this was dismissed by Ian Harvey who  
5 informed me that they had undertaken multiple reviews  
6 and discounted this as a possibility."

7 Paragraph 140:

8 "Throughout the relevant period, Specialised  
9 Commissioning was willing to offer the hospital support,  
10 however what support we did offer was not being taken.  
11 By April 2017, I was growing increasingly frustrated.  
12 The Royal College report had a section missing and did  
13 not contain the individual case reviews that I thought  
14 Ian Harvey had agreed to provide. I felt there was  
15 a lack of transparency from the hospital, avoidance of  
16 answers and wanting to defer the issues we raised. We  
17 were still in email contact with the hospital in April  
18 2017 but, when we asked questions, we did not receive  
19 straight answers. My sense was that the hospital was  
20 intent in conducting its own process through their board  
21 and were evasive in response to our questions. The  
22 message that kept coming from the hospital was that we  
23 had to wait until they had done things internally.  
24 However, what that involved was not relayed to us."

25 Do you accept, from his perspective, that was the  
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1 a very difficult situation and was asking for more time  
2 so that he could handle matters within the hospital.  
3 When I pressed him as to what this difficult situation  
4 was he indicated that the hospital were having issues  
5 with the paediatricians."

6 In paragraph 105:

7 "Ian Harvey also seemed to suggest that one  
8 clinician had some sort of agenda."

9 Is that accurate?

10 **A.** I don't believe it is accurate, no.

11 **Q.** Why would he suggest that? You did have  
12 an issue with the paediatricians and you did have  
13 a particular concern about how your lead neonatologist  
14 on a ward was going to be able to work with somebody he  
15 wouldn't mediate with and didn't think should be there.  
16 We have gone through the documents, I don't need to  
17 repeat them?

18 **A.** I was -- I was looking at both paragraphs and  
19 I would dispute the extent to which I was pushed.  
20 I believe that, given that a more senior Medical  
21 Director working with Specialised Commissioning was  
22 involved, he was in a position to actually enforce if he  
23 felt it was appropriate and I -- I wouldn't have, in  
24 those circumstances, withheld anything.

25 **Q.** Can we go back to 97 and 98, finally, on this  
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1 impact of the failure to be open with them?

2 **A.** In the first instance, I would dispute his  
3 assertion that he had raised the possibility of  
4 an individual with disproportionate involvement.  
5 I believe that, in the meeting with him, I had described  
6 that. I have accepted that we were slow in sharing  
7 information with Specialised Commissioning but I would  
8 also dispute the degree to which they pressured to  
9 obtain information.

10 It was not a desire to hide anything from them. It  
11 was perhaps an inappropriate degree of concern about  
12 documents leaking into the public domain before we had  
13 had the opportunity to share them with the people who  
14 needed to see them, for example the parents.

15 **Q.** We see at paragraph 104 and 105, if that  
16 assists you, when he says:

17 "When I pushed Ian Harvey [paragraph 104] on the  
18 involvement of an individual staff member, he stated he  
19 did not want to go into any more detail until the  
20 hospital had made a significant announcement about the  
21 decision they had taken to speak to an appropriate body  
22 on the following Monday. He did not indicate what that  
23 announcement was, nor what the appropriate body was he  
24 was referring to. I don't believe an announcement was  
25 made on the Monday. Ian Harvey told me he was handling  
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1 statement. Paragraphs 97 and 98, which is page 25. It  
2 says:

3 "On 10 January, extraordinary board meeting. I did  
4 not know about the meeting. My understanding the board  
5 papers were not made public or shared with NHS England.  
6 I do not believe the board papers for the meeting were  
7 public at that stage. I was not aware that  
8 an individual was involved or that a nurse had ever been  
9 taken out of the unit [this is 10 January]. Had  
10 Specialised Commissioning North been told that an  
11 individual had been moved off the neonatal unit due to  
12 concerns from clinicians, we would also have expected to  
13 have been informed of the decision to reinstate her on  
14 the unit.

15 "We were never informed there were concerns with  
16 regard to an individual nurse. In my role, I had  
17 experiences with other Medical Directors in hospitals  
18 who have rung me up to inform me about concerns with  
19 particular individuals. Informing of these concerns and  
20 decisions is part of having an open and transparent  
21 culture of patient safety, which I came to believe was  
22 lacking at the hospital."

23 He says there he has had experiences of other  
24 Medical Directors. Did you ever share concerns with  
25 Specialist Commissioners about members of staff, if you  
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1 had them?

2 **A.** In other circumstances, no.

3 **Q.** No. This can go down, thank you.

4 In the end, Mr Harvey, whatever the systems are in  
5 place, it's important, isn't it, in the NHS that the  
6 culture is such that people can speak out without fear  
7 or concern when they are worried about patients, and do  
8 you accept now that you weren't listening to concerns  
9 raised and you weren't acting on them, as you should  
10 have done in your time as Medical Director?

11 **A.** I believe that I was listening.

12 I accept that I didn't act in, in the way that  
13 others wanted me to and I accept that there were actions  
14 that I should have taken in a much more timely fashion  
15 than I did.

16 **MS LANGDALE:** Those are my questions, thank you.

17 **LADY JUSTICE THIRLWALL:** Thank you very much,  
18 Ms Langdale.

19 Mr Baker?

20 **Questions by MR BAKER**

21 **MR BAKER:** Mr Harvey, I ask questions on behalf of  
22 the Families of a number of harmed and murdered babies,  
23 including, for these purposes, Family C and Family D.

24 Can I begin by taking you back to something that  
25 you said to Ms Langdale, not too long ago. You

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1 never going to work.

2 It is always going to be underpinned by how safe  
3 you are and how good your care is.

4 **Q.** You see, I suggest you reached the point by  
5 small increments, but by April 2017 a situation had  
6 developed whereby the Executives were desperate that the  
7 Consultants' concerns do not become public. That is  
8 what had happened, isn't it?

9 **A.** I don't think this was a desire to obscure  
10 their concerns or hide their concerns. Our concern was  
11 always how we would be able to come to a consensus with  
12 regard to what had caused, if anything, the deaths of  
13 all the babies that we were reviewing. And I would say  
14 at that point, in April 2017, certainly from my  
15 perspective, the decision was that we had to go to the  
16 police.

17 **Q.** You see, you have been questioned about  
18 whether that was actually what the Trust Executives were  
19 wanting to do in April 2017, and I won't repeat  
20 questions that have been just put to you by Ms Langdale  
21 on that point, but I would say the Families do not  
22 accept that, that even in April 2017 you were still  
23 trying to cover things up, weren't you?

24 **A.** No, absolutely not.

25 **Q.** In that case, can I take you to a letter that

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1 described competing duties between the duty of candour  
2 and the duty to staff and that isn't quite what  
3 Mr Medland said, when he talked about not always well  
4 aligned or not always aligned duties of care.

5 He spoke about a dichotomy, apparently, between  
6 patient safety and reputational management.

7 Now, is that not a perfectly credible  
8 interpretation of what he saw in the Trust by April  
9 2017: a tension between candour and safety on one hand  
10 and reputational harm on the other hand?

11 **A.** I don't recall that Mr Medland actually  
12 described reputation in the way that you are perhaps  
13 implying.

14 **Q.** He said it wasn't in evidence, he wasn't  
15 describing it in a superficial way, just pure bad  
16 publicity but reputation was part of what he observed.

17 **A.** And I refer to one of my earlier answers,  
18 that, certainly as far as I am concerned, the reputation  
19 of a hospital or a hospital Trust is not some standalone  
20 character that one can protect. It is inherently  
21 reliant on the safety and the quality of the care that  
22 that organisation provides and at no point did I and  
23 I am sure any of my Executive colleagues have a level of  
24 concern purely about the reputation of the Trust because  
25 that's just a house built on shifting sand. That is

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1 you wrote to Mother C on 28 April 2017. Now, Mother C,  
2 you will recall, you had already had interactions with  
3 previously in February and throughout the early part of  
4 2017 because you had been -- you had reached a point  
5 where you were having to communicate with her about the  
6 RCPCH Report and Hawdon investigations, firstly because  
7 she had contacted you or the Trust in July 2016 and then  
8 because of The Times *exposé* regarding the Hawdon Report,  
9 the RCPCH Report.

10 You wrote to her on 28 April 2017 and this is at  
11 INQ0008973. Now, if what you say is correct, that in  
12 April 2017 you had reached the point where you knew that  
13 the police were going to be called, and you wanted that  
14 to happen, then can you explain to the Inquiry why none  
15 of that appears at all within your letter to Mother C?

16 **A.** That is because, at that point, that was my  
17 own personal view. As is apparent, despite that a being  
18 my own personal view, Mr Medland had been commissioned  
19 for a report and --

20 **Q.** This is 28 April, Mr Medland had been and  
21 gone.

22 **A.** Yes, and at this point, it was my view that we  
23 were. I was waiting, and I can only surmise I was  
24 waiting, until we had had the confirmation that we had  
25 met and were going to meet with the police.

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1 **Q.** Those words are weak, aren't they, because it  
 2 would have been open to you to write to Mother C on  
 3 28 April if it were the view of you and all the  
 4 Executives -- because Tony Chambers told the Inquiry  
 5 yesterday, and the day before, it was also his view as  
 6 well in April 2017 that the police were going to be  
 7 called -- it would have been open to write to her and to  
 8 say, "I cannot update you at the moment because there  
 9 are further matters which need to be confirmed and  
 10 I will write to you soon". Instead, you wrote to her  
 11 providing her with extracts from the Hawdon Report,  
 12 which you describe as "An independent external review  
 13 regarding the care of your baby".

14 Mother C could have come away from reading that  
 15 letter with a sense that the Countess of Chester had  
 16 entirely fulfilled its duties, investigated the death of  
 17 her baby carefully and that nobody had any concerns  
 18 beyond those recorded within the pages that follow.  
 19 That would have been utterly misleading -- I go further,  
 20 a lie -- wouldn't it?

21 **A.** I would say that I was fully anticipating,  
 22 firstly, that there would be a follow-up meeting because  
 23 there would be a need, given the nature of the contents  
 24 of that report, to discuss the contents in detail and  
 25 I would also -- I think also in the background of my

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1 never wanted to seek legal advice over all of this  
 2 because, as I said in my original letter, we want to  
 3 move forward. However, this really is prolonging our  
 4 suffering.

5 "I would be grateful if you could send me a copy of  
 6 the report from the Royal College of Paediatrics' review  
 7 and a copy of the subsequent investigations regarding  
 8 [Child C]. This really is the least that we deserve at  
 9 this stage."

10 Mother C was begging you for answers by this point,  
 11 having been fobbed off on previous occasions. Now, your  
 12 response to her was dishonest, if you believed at that  
 13 point the only solution was to call the police; do you  
 14 agree?

15 **A.** I don't. This letter is heart-rending.

16 **Q.** Is what, sorry?

17 **A.** Heart-rending.

18 **Q.** Yes.

19 **A.** It captures an emotion that many will not  
 20 know, fortunately, and, in reading this, in fact it  
 21 served to reinforce the effects of delays, and I believe  
 22 that that would influence how I might write, taking this  
 23 into account to suggest that there were going to be  
 24 further delays again.

25 I -- I -- I wouldn't accept that the letter I wrote

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1 mind was that I had previously sent one, two letters  
 2 that had again simply passed on a message of it being  
 3 a holding message.

4 **Q.** Can I give you some words from Mother C that  
 5 preceded your letter. I'm about to give you some  
 6 insight into her level of desperation at this time.  
 7 It's INQ0008971. If we go on to the next page, please:

8 "Dear Mr Harvey ..."

9 This is 19 April, some nine days earlier:

10 "Thank you for your letter dated 3 March. I am  
 11 sure you are aware that being informed that there were  
 12 areas of further investigation required regarding our  
 13 son's case was a surprise to us, given the information  
 14 we had been given by yourself and Sian Williams up to  
 15 this point."

16 I pause there to say that the information that had  
 17 been given to her by Sian Williams and yourself to this  
 18 point was that there were no real concerns and nothing  
 19 required investigating:

20 "Whilst I am aware that things don't happen  
 21 instantly and reports and results take time, I really  
 22 would like to point out how awful this is for us. We  
 23 are still waiting. Our son would have been two in June.  
 24 It has been six and a half weeks since your last letter.  
 25 I really cannot tolerate any further delays. I have

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1 was dishonest.

2 **Q.** But how awful, you would have known, it would  
 3 be to receive that letter from you, which suggests  
 4 nothing but minor issues relating to care and to find  
 5 out a few weeks later that the Trust were contacting the  
 6 police because they believed crimes had been committed.  
 7 You must have known that when you wrote the letter?

8 **A.** I didn't know at that point that -- what the  
 9 result of a police conversation was going to be and  
 10 I was mindful of -- and, again, it's that clash with  
 11 regard to the extent of the duty of candour -- I was  
 12 mindful of introducing additional distress that might  
 13 not actually have a basis.

14 **Q.** You were hedging your bets that she would  
 15 never find out about the police?

16 **A.** Absolutely not.

17 **Q.** What about Mother D? The Hawdon Report for  
 18 Mother D describes issues relating to the care that was  
 19 provided to Child D. An Inquest was due to be happening  
 20 fairly soon. The Trust had been advised by Hill  
 21 Dickinson in the run-up to the Inquest to admit  
 22 liability, you had Jane Hawdon's report identifying  
 23 areas of care. The Trust didn't even fulfil the basic  
 24 level of candour in coming forward and saying, "We are  
 25 concerned that breaches of duty, let alone murder, have

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1 contributed to harm to your child". Was there  
2 an institutional lack of candour in the Countess of  
3 Chester at this time?

4 **A.** I don't believe that there was, no.

5 **Q.** Can I go back then to the start of the  
6 chronology, insofar as you were concerned. The opening  
7 statement on behalf of the Executives states that the  
8 first time that concerns about Letby were raised with  
9 senior managers, including yourself, was at the end of  
10 June 2016, after the sad deaths of Child O and P.  
11 That's not correct, insofar as you, is it? You knew  
12 before the death of O and P that concerns had been  
13 raised regarding Letby?

14 **A.** I was aware that an association had been  
15 reported. I -- at that point, before June/July, didn't  
16 view it as any more than that and I believe that that's  
17 supported by the tone and the content of the meeting of  
18 the 11 May 2016, and the actions that came out of that,  
19 and the subsequent email from Dr Brearey in terms of  
20 summary of the meeting.

21 **Q.** Let's go through those. We can go to them in  
22 a moment but can we begin, first of all, with your  
23 knowledge about the Thematic Review.

24 If we go please to INQ0003140. Now, an issue in  
25 Dr Brearey's evidence is that he says that he had asked  
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1 **Q.** Yes. Okay. Well, if we go up to Dr Brearey's  
2 response to you on the next page:

3 "Hi, Ian. It wasn't an external review but we did  
4 have a review of all the cases from 2015."

5 He attaches the draft minutes and actions from the  
6 meeting and says that he's only circulated it on to  
7 attendees.

8 Then at the top of this page, you email Alison  
9 Kelly, and you say:

10 "FYI, in the light of Sarah's earlier graph [it is  
11 actually the second paragraph that's the important one],  
12 I queried with Steve the sharing of joint work with obs  
13 and their previous review, and he said they will get  
14 joined up at the Women and Children's Governance Board."

15 Now, nowhere in your email to Stephen Brearey or  
16 his response does that information appear about querying  
17 with Steve the shared work and his response "They will  
18 get joined up to Women and Children's Governance Board",  
19 so it must follow that, either there were additional  
20 emails that we haven't seen, which is what Dr Brearey  
21 says, or you had a conversation with Dr Brearey about  
22 this?

23 **A.** I -- I believe that there is reference in  
24 another email to Dr Brearey talking about that sharing  
25 your joint work.  
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1 you for a meeting in February 2016. Now, you emailed  
2 Stephen Brearey on 15 February at 10.22 in the morning.  
3 The letter begins at the bottom of this page "Dear  
4 Steve", but if we go on to the next page:

5 "Am I correct in thinking that you commissioned  
6 an external review of recent neonatal deaths? If so, is  
7 there any early feedback ahead of this week's visit."

8 That is the CQC visit. How did you find out about  
9 the Thematic Review?

10 **A.** I believe through Alison Kelly.

11 **Q.** So as of 15 February 2015, Alison Kelly knew  
12 that a Thematic Review was under way because she told  
13 you about it?

14 **A.** I -- I believe that she was aware of a review,  
15 whether it was termed a Thematic Review, I wouldn't  
16 know.

17 **Q.** Yes, I mean her evidence was somewhat  
18 different to that, but your recollection is that she  
19 informed you of a Thematic Review. I mean, somebody  
20 had: you clearly had prior knowledge when you emailed  
21 Stephen Brearey?

22 **A.** Well, I -- I wasn't told by Dr Brearey.

23 **Q.** No.

24 **A.** It would have to have come either through  
25 Eirian Powell and thereby Alison Kelly.  
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1 **Q.** So what Dr Brearey says in his evidence is  
2 that he communicated with you that he hasn't been able  
3 to find the email confirming this but that you told him  
4 that you would be -- he would be to merge the obstetric  
5 and neonatal reviews but, at the same time, he asked you  
6 for a meeting: a meeting with you and Alison Kelly. So:

7 "My recollection is that I also asked for a meeting  
8 with him and Alison Kelly at this time. He replied to  
9 say that the report and the obstetric report completed  
10 in November 2015 should be amalgamated but did not  
11 indicate when we would meet to discuss."

12 So your email to Alison Kelly relaying information  
13 from Stephen Brearey, which isn't in his email to you,  
14 does sort of suggest, doesn't it that that exchange had  
15 taken place?

16 **A.** I would also point out that there are some  
17 factual inaccuracies in Dr Brearey's recollection of the  
18 initiation of this email trail.

19 **Q.** Well --

20 **A.** In his statement Dr Brearey says that --

21 **Q.** Could you answer the question, please?

22 **A.** Well, I -- yes, I am doing, sir.

23 **Q.** The question I asked is: does your comment not  
24 imply, as Dr Brearey says, that there were further  
25 discussions between you and him of the sort that he  
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1 described?

2 **A.** I do not believe so because I think his memory  
3 is faulty on certain issues with regard to these email  
4 trails.

5 **Q.** So you deny that he asked you for a meeting in  
6 February 2016?

7 **A.** I have no recollection and, certainly, based  
8 on the order of events in Dr Brearey's statement, I have  
9 no reason to believe that he did.

10 **Q.** No, but your answer is you have no collection.  
11 Thank you.

12 We then have emails to between Eirian Powell and  
13 Alison Kelly in March 2016. I can take you to them if  
14 necessary but it provides a request to Alison Kelly for  
15 a meeting and provides a copy of the Thematic Review  
16 subsequently, but refers to high mortality and  
17 a commonality with a particular nurse.

18 Were you aware of those emails and the sending on  
19 of the Thematic Review in March 2016?

20 **A.** Without seeing whether I am on the circulation  
21 list, I -- I can't answer that.

22 **Q.** You are not on the circulation list of this  
23 email chain but what I am asking you is did Alison Kelly  
24 make you aware that there were further emails regarding  
25 the Thematic Review?

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1 **A.** My interpretation was alarmed that there was  
2 a nurse who had been moved on to day shifts.

3 **Q.** Because you thought that might be inconvenient  
4 for her or ...?

5 **A.** Well, given the tone of Dr Brearey's email,  
6 and his description of Eirian "sensibly" putting her on  
7 to day shifts and more a concern with regard to staffing  
8 numbers, I didn't read that as a particular concern  
9 other than for the well-being of the nurse. I didn't  
10 read that as an indication he was concerned about that  
11 nurse's performance in some way.

12 **Q.** Really?

13 **A.** And I -- and I believe that was reflected in  
14 my response to Alison Kelly's email that, as I read it,  
15 it may well just be that he was concerned regarding her  
16 welfare or words to that effect.

17 **Q.** So you thought that Alison Kelly was alarmed  
18 in the context of high number of deaths and other  
19 arrests and a nurse who was present for those who's been  
20 moved on to day shifts, only for the moment -- you  
21 thought her alarm related to concern for the nurse's  
22 well-being, not that correlation?

23 **A.** I believe that is reflected in my email  
24 response to Alison Kelly's, yes.

25 **Q.** Did you not realise, I suggest to you you must

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1 **A.** Not at that time. If she -- if she did it  
2 would have been by forwarding them to me.

3 **Q.** So if we come on to May 2016. If we go,  
4 please, to INQ0003138, and this is an email from Alison  
5 Kelly, 3 May 2016, which includes you and Stephen  
6 Brearey. This is at the very bottom, onto the next  
7 page. We see here there's an original appointment at  
8 the bottom there which has your name on it as well, "To  
9 Ian Harvey", and it is being cancelled and they are  
10 looking for an alternative date for the meeting. What  
11 did you understand the purpose of that email meeting to  
12 be: to discuss the Thematic Review and concerns that had  
13 been raised?

14 **A.** My, my understanding was, yes, it was to  
15 discuss the Thematic Review.

16 **Q.** INQ0003087, please. Again, we have an email  
17 from Stephen Brearey, which is referring to, as you have  
18 been asked already:

19 "Quite a few of the deaths and arrests. Eirian has  
20 sensibly put her on day shifts at the moment but can't  
21 do this indefinitely."

22 You are being emailed by Alison Kelly there saying:

23 "Please see Steve's comments below which alarmed  
24 me!"

25 What did you understand her to be alarmed by?

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1 have done, that Stephen Brearey's concerns related to  
2 the correlation, by this time, between sudden unexpected  
3 collapses, a nurse being present on the ward at the  
4 point when these happened, and concern about what was  
5 causing these collapses, how they might be connected?

6 **A.** As it was expressed in his email of 4 May, no.

7 **Q.** Not how it was expressed in his email on 4 May  
8 but based on everything that you had heard up until that  
9 point?

10 **A.** Based on everything that I had heard ...?

11 **Q.** Up until that point?

12 **A.** No, I hadn't picked it up. It hadn't been

13 expressed in that sort of way in any of the  
14 communications that I -- I had seen, nor do I believe  
15 that it was explicitly referred to in the meeting that  
16 we subsequently had.

17 **Q.** So your evidence is that, at this point in May  
18 2016, you had no clue at all about any concerns  
19 regarding the connection between Lucy Letby and sudden,  
20 unexpected and unexplained collapses on the ward and  
21 deaths?

22 **A.** At this time, with the Thematic Review, I was  
23 aware that there were concerns with regard to  
24 an increased number of deaths, that they were being  
25 investigated, that whilst one member of staff had been

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1 on duty more frequently, the individual case reviews,  
2 whilst highlighting some themes, had not caused any  
3 major concerns to be raised.

4 **Q.** If we go then to the meeting that occurred on  
5 11 May 2016 and we look at the handwritten note of that,  
6 which is INQ0003181. So there is a little more  
7 information here. Again, the Thematic Review is  
8 discussed, and it says about deteriorations:

9 "Deteriorated 9.00 pm - 6 times, midnight to 4."  
10 Did you not see anything significant about the fact  
11 that all of these deteriorations were occurring at night  
12 shifts?

13 **A.** As I believe I gave in evidence yesterday,  
14 there is evidence that standards of care are lower at  
15 weekends and at night and, in seeing that, that would  
16 have been my initial concern.

17 **Q.** Well, we can go to that issue because it's  
18 down the bottom of the page. Can you see where it says  
19 "sub optimal care". It describes one case, where there  
20 were concerns about the care that had been provided and  
21 the pharmacist's poor decision-making. So can you take  
22 from that that, in all of the cases being described, in  
23 only one was Stephen Brearey able to identify evidence  
24 of sub optimal care; that's what's being recorded here,  
25 isn't it?

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1 **A.** I think that some of the language that Stephen  
2 Brearey has used in describing how Eirian Powell and  
3 Anne Martyn behaved in that meeting is at the very least  
4 inappropriate.

5 **Q.** Well --

6 **A.** I -- I would accept that Eirian Powell put  
7 a number of points that would indicate why Lucy Letby  
8 might be more commonly either associated with these  
9 babies or --

10 **Q.** We can see what she said because there are  
11 some sentences or words here that have the hallmarks of  
12 what she said in evidence and elsewhere:

13 "Absolutely no issues with nurse."

14 Yes, can you see that; it is about halfway down the  
15 page?

16 **A.** Yes.

17 **Q.** "Circumstantial. One doctor also named across  
18 number of cases. Six babies Nurse Lucy Letby, sudden  
19 deterioration."

20 Then at the bottom:

21 "Trained at Chester."

22 These were all words that Eirian Powell has used  
23 elsewhere and she is coming out here, isn't she, and  
24 saying there is absolutely no issues with Lucy Letby.

25 It's all circumstantial, there is also a doctor

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1 **A.** That's what's been reported there, yes.

2 **Q.** So questions about care being poorer at night  
3 may be generic but, in this case, that issue has already  
4 been looked at, hasn't it?

5 **A.** I am not sure that there was sufficient detail  
6 in the Thematic Review to be able to say for sure. I am  
7 aware that one of the actions coming out of the Thematic  
8 Review was that there was to be a further review by  
9 Stephen Brearey and Eirian Powell into observations in  
10 the time leading up to the collapses.

11 **Q.** You see, Stephen Brearey's description of this  
12 meeting is that he was trying to get across concerns  
13 about this connection between the strange timing of the  
14 collapses and deaths which had changed since the nurse  
15 had switched shifts, the fact that she was always on  
16 duty when it happened, the fact these were sudden,  
17 unexpected, unexplained collapses, for which no cause  
18 could be found on the Thematic Review and other reviews  
19 and he says that, in effect, Eirian Powell argued the  
20 case for Lucy Letby and that shifted or diverted the  
21 decision making within the meeting away from looking at  
22 those questions of sudden, unexpected, unexplained  
23 collapses.

24 It's a fair description of what happened, isn't it,  
25 that Eirian Powell came out fighting for Lucy Letby?

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1 involved.

2 Now, Dr Harkness who I think is the other doctor  
3 who appears regularly, doesn't appear for all the cases  
4 and he had left by this point. But here she is, Eirian  
5 Powell, arguing the corner for Lucy Letby?

6 **A.** I think that she was simply countering some of  
7 the points that had been made and Stephen Brearey  
8 highlighted the time frame of some of the collapses. He  
9 called out the fact that Lucy Letby was on duty more  
10 often than others but, certainly, my recollection is  
11 that he is overstating the degree to which he presented  
12 this data and how he presented it.

13 Certainly at the end of the meeting, he gave the  
14 impression of being comfortable with the conversation  
15 that we had had, with the opportunity that he had had to  
16 be listened to and that he agreed with what was decided,  
17 was which -- which was that we would implement a much  
18 closer monitoring of babies who collapsed thereafter.

19 **Q.** But not a much closer monitoring of Lucy  
20 Letby, was there?

21 **A.** Well, based on the conversation that we  
22 would -- we had had, at that point, there did not appear  
23 to be a basis for that.

24 **Q.** Well, there was a reference to suggest there  
25 was more than enough in sudden, unexpected and

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1 unexplained deaths, with a nurse present at all of them  
2 and concerns being raised by a paediatrician, to warrant  
3 some sort of safeguarding exercise?

4 **A.** I -- I'm not sure that the sudden and  
5 unexpected actually associated Letby present at all of  
6 those.

7 **Q.** Well, it was. By this time, a table had been  
8 drawn up with Lucy Letby's name highlighted in red  
9 across it?

10 **A.** In terms of those babies, we had both  
11 indictment and non-indictment babies and, obviously, if  
12 one simply takes out the indictment babies one's  
13 presented with a very different picture.

14 **Q.** Well, she was present for all of the collapses  
15 and unexplained and sudden collapses that were  
16 highlighted within the Thematic Review, and there was  
17 a concern being raised about her potential connection to  
18 this, not necessarily in terms of homicide but certainly  
19 in terms of competence. The effect here is really just  
20 to kick the can down the road, isn't it?

21 **A.** I'm sorry?

22 **Q.** The effect is to kick the can down the road.  
23 No safeguarding is put in place in respect of her  
24 practice in any way, following this meeting?

25 **A.** No, I accept that safeguarding wasn't put in  
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1 the case.

2 **Q.** It was there to be found though, wasn't it?

3 **A.** Pardon?

4 **Q.** It was there to be found, the evidence, with  
5 investigation. You have already said the insulin  
6 results for F were there to be found?

7 **A.** Well, the insulin result was there dependent  
8 on a doctor doing the right thing with that result.

9 **Q.** That, that had happened already. What I am  
10 talking about is steps that you could have taken,  
11 further investigations, further scrutiny between  
12 February and May 2016 could have highlighted the insulin  
13 results could, indeed have brought in the stories of the  
14 parents who had witnessed --

15 **A.** I would say that that is by no means likely.  
16 It was only after the police inquiry was instituted  
17 that, in fact, Dr ZA remembered that there might have  
18 been this result. I would suggest that the biggest  
19 missed opportunity there was actually in August 2015  
20 when, having considered that insulin result, Dr ZA  
21 excluded accidental administration, actually considered  
22 deliberate administration.

23 **Q.** We understand the point, Mr Harvey. It's been  
24 made --

25 **A.** Absolutely, but I think this needs to be clear  
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1 place.

2 **Q.** And --

3 **A.** I don't believe that it was just kicking the  
4 can down the road. We felt that we needed that  
5 monitoring of any further unexpected events. I believe  
6 that there was one and that wasn't actually reported,  
7 despite the action plan and the guidance that was coming  
8 from this meeting.

9 **Q.** If we --

10 **A.** I would also comment with regard to the email  
11 that Stephen Brearey subsequently sent with regard to  
12 how he viewed the meeting.

13 **Q.** Sorry, could you repeat the last bit, sorry,  
14 I didn't quite catch you -- oh, how he viewed the  
15 meeting, thank you.

16 Can we come on to what happens after O and P  
17 collapse, please. I think on behalf of the parents of O  
18 and P, they would regard the meeting in May 2016 as  
19 an opportunity and a missed opportunity to avoid the  
20 deaths of their sons. Would you accept that action  
21 could have been taken between February and May 2016 to  
22 prevent Lucy Letby causing harm to Babies O and P and  
23 all those who fell after February 2016?

24 **A.** No, I -- I cannot accept that there was  
25 sufficient in between February and May for that to be  
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1 because --

2 **Q.** Can I come on to things, though, that you can  
3 give direct evidence about. Please, we do understand  
4 the point about the insulin and Dr ZA.

5 Your reaction after being informed of the concerns  
6 surrounding the death of Child O and Child P was that  
7 the police should be called. That was your first  
8 reaction upon seeing Dr Saladi's email, was that the  
9 police should be called?

10 **A.** It was.

11 **Q.** If we go to INQ0047571, and down on to page 2,  
12 please, we can see Dr Saladi's email here to you and to  
13 Alison Kelly. Now, you must have read this in light of  
14 the meeting in May 2016 and the information you had had  
15 up until that point?

16 **A.** Yes.

17 **Q.** If we go up a page, we can see Alison Kelly's  
18 email to you beginning "Hi Ian":

19 "I am not at Execs this AM but have briefed Sian  
20 fully. I have discussed reactions we are taking and  
21 I know we are commissioning an extra clinical review but  
22 Sian and I did also discuss the police. I know this is  
23 a big step but it's something we need to consider in  
24 light of heightened concerns."

25 So Alison Kelly saying to you that she thought  
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1 a discussion regarding the police needed to take place.

2 Then Ian Harvey:

3 "I have already emailed Stephen to meet ahead of  
4 the Execs. I will keep you updated. My own feeling,  
5 the police having been raised, I think we will have to."

6 In other words, "We will have to call the police"?

7 **A.** Yes.

8 **Q.** If we then go on to the same day, you had  
9 a meeting with Stephen Cross and, if we go to  
10 INQ0003360, this is Stephen Cross' note but it is a note  
11 of a meeting with you, 29 June. Now, at the bottom, it  
12 says:

13 "Deaths of Triplets has raised concern. Nurse was  
14 on duty at deaths. Sufficient level of concern that  
15 illegal activity in neonates."

16 In the first paragraph at the bottom, it said.

17 "Advice: police need to be involved now."

18 At the end of the first paragraph.

19 Who is giving the advice that the police need to be  
20 involved now; is that you or Stephen Cross?

21 **A.** I believe that the timing of that entry is  
22 incorrect. I think this reflects me going to Stephen  
23 Cross, having seen the copy of Dr Saladi's email, which  
24 I think was timed on the email system a couple of  
25 minutes after the time Stephen Cross has --

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1 then, where it says:

2 "Nurse was on duty at deaths. Sufficient level of  
3 concern that illegal activity in neonatal."

4 I mean, who is saying that; is that you or Stephen  
5 Cross saying that?

6 **A.** I am unsure where that's come from.

7 **Q.** Well, given that you had emailed Alison Kelly  
8 shortly before saying that you thought the police did  
9 need to be called, your evidence to the Inquiry is you  
10 thought then the police needed to be called, either this  
11 is you advising Stephen Cross the police need to be  
12 called or it is Stephen Cross agreeing with you that the  
13 police need to be called?

14 **A.** I -- I'm unable to remember which way. All  
15 I can say is that the earlier emails indicate that my  
16 initial response was that we needed to speak to the  
17 police.

18 **Q.** Yes, I mean there is no record of any  
19 disagreement from Stephen Cross regarding this, so does  
20 it follow that he agreed with you the police need to be  
21 called, or are you saying that there was a dispute as to  
22 whether the police needed to be called?

23 **A.** I -- I can't speak for Stephen Cross and  
24 I can't recall the full detail of that conversation.

25 **Q.** Was it not a fairly uncommon conversation to  
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1 **Q.** Oh, yes, yes. So, I mean, it -- Dr Saladi's  
2 email is 8.17 --

3 **A.** Yes.

4 **Q.** -- and this note is at 8.15 --

5 **A.** Yes.

6 **Q.** -- and your email to Alison Kelly was at 8.31.  
7 So let's put aside the precise time of maybe 8.19 that's  
8 written on the note --

9 **A.** Yes.

10 **Q.** -- but it clearly is a note written fairly  
11 soon after you have received Dr Saladi's email and you  
12 have been to see Stephen Cross?

13 **A.** Yes, and my reading of that is that that is  
14 from Dr Saladi's email.

15 **Q.** Sorry, could you explain that, please? So you  
16 are saying that, where Stephen Cross has written,  
17 "Ian Harvey neonatal issue. Emails from Consultants  
18 escalating concerns. Email this AM from further  
19 Consultant. Advice: police need to be involved now";  
20 are you saying that's just a recital of what Dr Saladi  
21 said in his email?

22 **A.** I -- I believe that is either that or that is  
23 a reflection of what I had said and had indicated in the  
24 email that I had sent to Alison Kelly.

25 **Q.** Well, what about the bit right at the end  
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1 be having with a legal director?

2 **A.** Absolutely.

3 **Q.** Are you saying you don't recall anything about  
4 this conversation?

5 **A.** I am saying that because these are events that  
6 occurred eight years ago.

7 **LADY JUSTICE THIRLWALL:** Mr Baker, just before you  
8 continue, we will need to take a break.

9 **MR BAKER:** Yes, of course.

10 **LADY JUSTICE THIRLWALL:** How much longer do you  
11 think you have got? I am not going to suggest you do it  
12 now, I just want to know.

13 **MR BAKER:** No. Let me come on to -- actually that  
14 probably is a convenient moment. I am about to come on  
15 to the next meeting.

16 **LADY JUSTICE THIRLWALL:** Very good. We will come  
17 back at 3.50.

18 (3.34 pm)

(A short break)

20 (3.50 pm)

21 **LADY JUSTICE THIRLWALL:** Mr Baker.

22 **MR BAKER:** Thank you, my Lady.

23 We had just dealt with discussions whereby it  
24 appeared to have reached a point where you wanted to  
25 call the police, Alison Kelly wanted to call the police,  
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1 and Stephen Cross, at least, appeared to agree to that  
2 or acquiesced to it.

3 The next meeting on 29 June involves the  
4 Consultants and now Tony Chambers, and it's INQ0003371.  
5 You can see Tony Chambers, Alison Kelly, Ian Harvey and  
6 then we have Stephen Brearey, Ravi Saladi and others.

7 Stephen Brearey's evidence is that when we went to  
8 the meeting with the Executives, the Executives were  
9 looking for reasons to either not go to the police or to  
10 defer the decision. Now, insofar as you were concerned  
11 and insofar as Stephen Cross was concerned and insofar  
12 as Alison Kelly was concerned, prior to this meeting you  
13 had all seemingly come to the view that the police were  
14 going to be called; what caused your change in mind?

15 **A.** I have read through these documents in detail,  
16 I have tried to recall the conversations that went on  
17 and I am unable to explain the change in approach.

18 **Q.** Can I help you with it. If we begin with some  
19 of the background. We have Stephen Brearey here:

20 "Steve B, some PM reports but not all.  
21 Inconclusive. Some not satisfactorily giving answers.  
22 Inconsistent Datix reports."

23 A little further down the page:

24 "Unexpected collapses. Perhaps should have  
25 a Datix. A lot of complexity around reporting."

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1 forwards.

2 Do you agree that that's closer from that note that  
3 this isn't just people saying she's always there when  
4 people collapse?

5 **A.** Yes.

6 **Q.** It's paediatricians saying, "There's something  
7 more to this, there's something more unusual about  
8 this"?

9 **A.** That is certainly something that comes out of  
10 those notes.

11 **Q.** Then we have the first statement from the  
12 Executives. "TC", Tony Chambers:

13 "Why did we call the police? If Twins/Triplets why  
14 did the Trust take them on. Can we explore more before  
15 police?"

16 It's Tony Chambers calming down the idea of going  
17 to the police, isn't it? That's clear from the note?

18 **A.** I'm not sure that that reads as him calming  
19 down. I think --

20 **Q.** I am not suggesting he was calm but I mean  
21 that's him raising the issue of why don't we defer  
22 calling the police?

23 **A.** No, I think he is simply putting in  
24 a challenge with regard to is there something that we  
25 need to explore before the police? He was asking those

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1 Further down the page:

2 "Pseudomonas grown from taps but not evident in  
3 incidents."

4 Then Ravi Jayaram:

5 "Entirely subjective staff member almost always  
6 nurse in charge. Babies were stable then deteriorated.  
7 Why always this nurse? Babies were unwell but getting  
8 better. Babies not getting oxygen then crash. Babies  
9 did not respond as they should."

10 Stephen Brearey:

11 "Disturbing thing twin survived and got better at  
12 Arrowe Park. Babies coming back to Countess of Chester,  
13 babies deteriorate. Nurse 7 out of 9 between 12 noon  
14 and 4 am, and since then none."

15 On the following page:

16 "More than just an association with this nurse.

17 "Ravi: how? Cannula? Air embolism? Crystal ball?  
18 Unquestionably got something going on in the Countess of  
19 Chester but what?"

20 Then Saladi:

21 "Preterm babies. Two steps forward and one step  
22 back. Don't suddenly deteriorate."

23 So here we have this sort of very clear expression  
24 of something, more than just an association, quite  
25 significant concerns by paediatricians being put

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1 in the room whether the police was the next step, where  
2 they -- did they have a degree of concern that it was  
3 the police.

4 I don't read that, knowing how Tony Chambers ran  
5 his meetings and was keen to hear from everyone in the  
6 meeting and give everyone the opportunity, I believe  
7 that this was just a request to explore the full range  
8 of the options. I don't believe that he was actually  
9 specifically leaning towards --

10 **Q.** He's the new person in the room. You had  
11 talked about calling the police, Alison Kelly had talked  
12 about calling the police, Dr Saladi had talked about  
13 calling the police, and here we have Ravi Jayaram and  
14 Stephen Brearey raising their concerns very clearly  
15 about criminality. Tony Chambers is the new person in  
16 the room here, and that's what changes the dynamic,  
17 isn't it, that is why the police aren't called?

18 **A.** I -- I would simply say that he was exploring  
19 all the options and, as the Chief Executive, that's what  
20 I would expect him to do.

21 **Q.** Yes, and if we look at the reasons why the  
22 police aren't called, or one of the reasons, on to  
23 page 3:

24 "Police consequences. Balance needed."

25 Is it the concern about the consequences of calling

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1 the police, reputational harm, that is acting as the  
2 deterrent to doing it?

3 **A.** I don't believe that reputation was one of the  
4 consequences that was discussed and I believe that the  
5 consequences were with regard to the effect on the unit.

6 **Q.** Well, let's balance that. The effect on the  
7 unit, if Lucy Letby is still working there, and she was  
8 at this point, is she murders more babies; isn't that  
9 more serious?

10 **A.** Again, using hindsight, yes.

11 **Q.** Before I conclude, I mean, I would suggest on  
12 behalf of the families that this sets the tone, this  
13 marks the sea change between you wanting to call the  
14 police and the police not being called, and you becoming  
15 party to, a supporter of or at least acquiescent to that  
16 decision. But that decision at that point not to call  
17 the police you accept was wrong. The consequence is  
18 that it defers justice for the Families for another  
19 year; do you accept that?

20 **A.** I -- I accept, on the basis that I have  
21 already said that I believe we should have been in touch  
22 with the police earlier, that had the potential to delay  
23 things, yes.

24 **Q.** Finally, just to clarify a point. It was  
25 implied in questions to Alison Kelly that Alison Kelly

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1 Alison Kelly, who kept very good notes but that may have  
2 been a feature of the circumstance of the meeting. To  
3 my regret, I was a very poor note keeper, and I think  
4 that's probably evident to the Inquiry, in comparison  
5 with some of my colleagues.

6 **Q.** Thank you. My Lady, it occurs to me I just  
7 need to go back, very briefly, to Mrs Hodkinson's note  
8 and then that is my final question.

9 If we go back, please, to INQ0015639, and to  
10 page 58, please, again, a point was made to Tony  
11 Chambers about this meeting on 30 June -- you were  
12 present, this is Sue Hodkinson's note of it -- that Tony  
13 Chambers asked Stephen Brearey the question:

14 "If we remove Letby from the ward, will unit be  
15 safe?"

16 He responded that the risk would be reduced. It  
17 was suggested to Tony Chambers that that meant that  
18 Stephen Brearey didn't really believe that Lucy Letby  
19 was behind the incidents. If you could look over,  
20 please, to the right-hand side, right-hand column here,  
21 I don't know if you recall the conversation but it  
22 begins, "TC: direct LL removed. Unit safe?", and  
23 Stephen Brearey is noted to answer, "Risk removed". Do  
24 you recall that exchange?

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

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1 and Sian Williams might not have met with Mother C in  
2 July 2016. Can I take you please to INQ0008969, and to  
3 the next page, please.

4 This is a letter to you from Mother C in February  
5 2017, raising her concerns. If we go on to the next  
6 page, in the second paragraph she describes having read  
7 about the article in the Chester Chronicle in July 2016  
8 and then mentions that she met with Sian Williams and  
9 Alison Kelly "when I turned up at the Bereavement  
10 Office". So you agree that Mother C wrote to you in the  
11 early part of 2017, recalling having met Sian Williams  
12 and Alison Kelly in the Bereavement Office?

13 **A.** I -- I do on seeing this document, yes.

14 **Q.** Yes. You know that there are no notes of the  
15 meeting between Sian Williams, Alison Kelly and  
16 Mother C, and it was suggested that that was unusual.  
17 You agree that you met Mother C in 2017, don't you?

18 **A.** Yes.

19 **Q.** There are no notes of that meeting either, are  
20 there?

21 **A.** There aren't, no.

22 **Q.** No. Is there any reason why notes weren't  
23 being taken of meetings between Sian Williams, Alison  
24 Kelly, you and parents?

25 **A.** No. I would say that it would be unusual for

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1 **Q.** No, so you can't say whether it was risk  
2 reduced, according to Stephen Cross's notes, or risk  
3 removed?

4 **A.** I'm sorry, I can't clarify that, no.

5 **MR BAKER:** Thank you.

6 Thank you, my Lady, I have no more questions.

7 **LADY JUSTICE THIRLWALL:** Thank you very much,  
8 Mr Baker.

9 Mr Kennedy?

10 **Questions by MR KENNEDY**

11 **MR KENNEDY:** Mr Harvey, I have some questions on  
12 behalf of the Countess of Chester Trust. Can I just  
13 pick matters up, on 29 June, where Mr Baker just left  
14 them. At that stage, as you have just agreed with him,  
15 your state of mind is, "We need to call the police".  
16 You agree that the paediatricians in the meeting are  
17 saying that there is something more than simple  
18 commonality, and they are talking about criminal  
19 activity as one explanation, agreed?

20 **A.** I -- I would need to see the notes in front of  
21 me to remind me, I'm sorry.

22 **Q.** We can look at the notes again. It's  
23 INQ0003371, but it's the note about air embolus; do you  
24 remember that note?

25 **A.** Yes.

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1 Q. I'm trying to move as quickly as I can through  
2 this, so that your counsel has an opportunity to ask you  
3 questions, so if we don't need to revisit matters, then  
4 that will help us. But it's that note towards the foot  
5 of the page.

6 Over on to the next page, where you see:  
7 "Ravi: how? Cannula air embolism?"  
8 We have looked at it on a number of occasions now.

9 The thrust was that they were concerned about  
10 criminal activity?

11 A. I'm not sure that that was entirely clear as  
12 criminal activity. Cannula air embolism can be  
13 accidental as well as deliberate.

14 Q. Every message you had from the nursing team  
15 was that Letby was a competent nurse, wasn't it?

16 A. Yes.

17 Q. Right. So you had to have in mind the  
18 possibility of criminal activity?

19 A. I would, in terms of what is most common,  
20 irrespective of what might be said have competence as  
21 an issue or a concern.

22 Q. Would you have also had in mind criminal  
23 activity?

24 A. Yes.

25 Q. Thank you. Your task and the Execs' generally  
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1 exclude the common things first.

2 Q. Very well. Well, let's move on. Whether you  
3 are trying to exclude the common things, you have to  
4 have in mind the most serious?

5 A. Yes.

6 Q. Okay. So when you are setting the question,  
7 if I can put it like this, or formulating the  
8 hypothesis, does it not have to be as follows: can  
9 I confidently say that the paediatric Consultants'  
10 concerns are misplaced?

11 A. I would -- I would say with retrospect, our  
12 balance on that was incorrect.

13 Q. Do I take it from, from that, your answer,  
14 that you agree that that is how the test should have  
15 been formulated?

16 A. I have already agreed that my initial feelings  
17 on this were the ones that I should have acted on.

18 Q. I'm not now concerned about simply whether the  
19 police were called. This now builds into how you manage  
20 things going forwards. You should have managed them  
21 going forwards on the basis of asking yourself the  
22 question: can I confidently exclude criminal activity,  
23 is another way of formulating it?

24 A. I think our initial concern was: is the unit  
25 safe?

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1 task was now to manage the risk, correct?

2 A. Yes.

3 Q. The impact of getting it wrong, given what was  
4 being told to you and given your view, at least at that  
5 stage of the police needing to be called, the impact of  
6 getting it wrong was catastrophic, wasn't it?

7 A. Yes.

8 Q. So when you formulated how it was you were to  
9 test the hypothesis, you had to formulate it in such  
10 a way that it was the most exacting question, didn't  
11 you?

12 A. Yes.

13 Q. That is consistent with medical practice: can  
14 I exclude the most sinister diagnosis, rather than can  
15 I include a less sinister one?

16 A. I'm not sure that you could apply that across  
17 to making a medical diagnosis.

18 Q. All right. But it's a familiar test to  
19 a doctor?

20 A. One is interested --

21 Q. A patient presents with a particular  
22 condition. What you are looking to do is can I rule out  
23 a sinister cause for that condition?

24 A. I would suggest that this is probably not  
25 an appropriate analogy because one would be looking to  
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1 Q. You are -- please, I am really short of time,  
2 so if you could just answer my question. Looking  
3 forwards, your question had to be, "However I formulate  
4 it, can I confidently say that the paediatricians'  
5 concerns are misplaced?"

6 A. I'm not sure I can answer that without putting  
7 it as trying to understand the level of their concern.

8 Q. That may be part and parcel of the same?

9 A. Yes.

10 Q. Of the same exercise but what you are trying  
11 to do is confidently say that their concerns are  
12 misplaced whether it's because of the level or because  
13 of the evidence?

14 A. We are trying to confidently establish what is  
15 fact, yes.

16 Q. All right. Now, again, trying to just cut  
17 through this.

18 You agreed with Mr Skelton last night that the  
19 Royal College of Paediatricians' report could not  
20 exclude criminal activity?

21 A. I -- I agreed that it was unlikely that it  
22 would, yes.

23 Q. Well, it couldn't do because it wasn't charged  
24 with that task or, alternatively, they told you they  
25 hadn't done that?

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1 A. Yes, that's correct.  
 2 Q. So, either way, it couldn't exclude criminal  
 3 activity?  
 4 A. Yes.  
 5 Q. Likewise, again trying to cut through this,  
 6 Dr Hawdon couldn't exclude criminal activity?  
 7 A. Couldn't exclude but could identify --  
 8 Q. Right.  
 9 A. -- because --  
 10 Q. If she was --  
 11 A. -- at the end, at the trial, the prosecution  
 12 experts were able to identify matters based on the  
 13 Casenote Review. So that, whilst Dr Hawdon might not be  
 14 able to exclude, I believe that there was the potential  
 15 that she would be able to confirm.  
 16 Q. We can look at her letter but what she told  
 17 you was, within the time that was permitted to her and  
 18 that she could devote to the task, she simply couldn't  
 19 do it; that was the gist of her letter?  
 20 A. I think it was to the fact that it wouldn't be  
 21 as comprehensive.  
 22 Q. All right let me frame it another way: she  
 23 told you she hadn't done it?  
 24 A. She hadn't done it to the -- a level of  
 25 detail.

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1 of the questions we have been talk about, did it?  
 2 A. No.  
 3 Q. Right. In those circumstances, if we now look  
 4 at the 10 January meeting, the extraordinary Board of  
 5 Directors meeting -- and I think now we probably do need  
 6 to bring up some documents. So can we start with  
 7 INQ0003239, and that's your presentation. Now, recall  
 8 this?  
 9 A. Yes.  
 10 Q. This was circulated to the board, along with  
 11 the College report at the meeting; can we agree that?  
 12 A. I'm not sure of the timings that the documents  
 13 were circulated.  
 14 Q. If we go to the second page of this document,  
 15 we can see that you have dated it 10 January?  
 16 A. Yes.  
 17 Q. Now, unless you forward date documents, does  
 18 it look like this document was prepared and was  
 19 presented to the Board of Directors on 10 January?  
 20 A. It will -- it was presented on the day.  
 21 I can't say whether they actually had the opportunity to  
 22 see it before the meeting, which took part -- took place  
 23 late morning.  
 24 Q. Well, we can see the meeting was 11.00 am --  
 25 A. Yes.

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1 Q. All right. She hadn't done it to a level, put  
 2 it another way, where you could be confident that  
 3 criminal activity could be excluded?  
 4 A. No, which was why the reviews continued but  
 5 then nor did she identify anything where said there  
 6 were -- there was criminal activity.  
 7 Q. Well, now we are into evidence of absence  
 8 being absence of evidence, aren't we?  
 9 A. Yes.  
 10 Q. So it's, at best, neutral?  
 11 A. Yes.  
 12 Q. Can we agree that?  
 13 A. Yes.  
 14 Q. All right. The same of the Royal College?  
 15 A. Yes.  
 16 Q. It doesn't, at best, from your perspective, it  
 17 doesn't give you the answer either way?  
 18 A. No.  
 19 Q. Okay. You had undertaken the local  
 20 investigation as part of the Silver Command, correct?  
 21 A. Undertaken a?  
 22 Q. A local investigation as part of the Silver  
 23 Command?  
 24 A. Yes.  
 25 Q. That too didn't give you the answer to either

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1 Q. -- from page 1. So the most opportunity they  
 2 would have had is, if they had been in the hospital  
 3 first thing, if it had been delivered to them then?  
 4 A. Yes.  
 5 Q. All right. We can see also, if we go to the  
 6 second page, Mrs Killingback, that the report of the  
 7 Invited Review is attached?  
 8 A. Yes.  
 9 Q. That is the RCPCH Report?  
 10 A. I believe so, yes.  
 11 Q. All right. So they have got 30 pages odd of  
 12 the RCPCH, plus your document distilling it, correct?  
 13 A. Yes.  
 14 Q. Okay. Now, you are inviting in this document  
 15 the Board to accept two things for my purposes: firstly  
 16 at A, to accept the RCPCH Report; and then at C you are  
 17 asking them to support the Executive Team in assisting  
 18 the staff member's return to work on the neonatal unit,  
 19 correct?  
 20 A. Yes.  
 21 Q. We can look if we need to, we know from the  
 22 board minutes that they accepted your recommendations,  
 23 correct?  
 24 A. Yes.  
 25 Q. Okay. Given the significance of this, so

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1 putting somebody who the paediatricians thought was  
 2 killing babies back on the neonatal unit, this was  
 3 a decision that required real care, wasn't it?  
 4 **A.** It is. My recollection of the meeting is that  
 5 there -- there were questions with regard to the  
 6 continuing reviews and my own feeling was that, until  
 7 those reviews were completed, it wouldn't have been  
 8 appropriate for Letby to return to the unit,  
 9 irrespective of the recommendation there that has my  
 10 name to it.  
 11 **Q.** That was your recommendation and it was that  
 12 recommendation the board adopted, wasn't it?  
 13 **A.** It, it was. But, in the discussion, I believe  
 14 there was discussion that actually that would not take  
 15 place until the completion of all the reviews. The  
 16 reviews outstanding, and despite that recommendation to  
 17 support her return, that was pending the results of the  
 18 outstanding Hawdon and McPartland review.  
 19 **Q.** Indeed, because, at that stage, you were  
 20 chasing McPartland for her report, weren't you?  
 21 **A.** That's right.  
 22 **Q.** Okay, and you hadn't completed the exercise  
 23 that Dr Hawdon had suggested?  
 24 **A.** No.  
 25 **Q.** Okay. You were aware at that stage that there

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1 **A.** Yes.  
 2 **Q.** The board knew at least the first and second  
 3 of those propositions, didn't they?  
 4 **A.** Yes.  
 5 **Q.** Okay. When you put it in your recommendation,  
 6 we still have it on screen, the reviews having found no  
 7 evidence of a single person's culpability, that went  
 8 beyond, as we have just discussed, what could properly  
 9 be concluded from any of your reviews, correct?  
 10 **A.** I think it was a much more complex picture.  
 11 Everyone -- a lot of people seemed to be looking at this  
 12 purely in terms of pre and post-Letby on the unit. The  
 13 fact is that a lot of other actions were put in place,  
 14 the unit was redesignated. The unit was subject to  
 15 micromanagement. The unit was subject to much more  
 16 scrutiny. There was, in addition, a fortuitous  
 17 reduction in the level of activity. The unit was  
 18 extremely quiet. So there were potentially a whole  
 19 number of reasons why the picture would change.  
 20 **Q.** But you weren't in your recommendations here  
 21 saying, "for a variety of reasons". You specifically  
 22 refer to the reviews having found no evidence of  
 23 a single person's culpability correct?  
 24 **A.** It is a limited report, yes.  
 25 **Q.** Sorry?

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1 was there had been an unequivocal rise in mortality?  
 2 **A.** Yes.  
 3 **Q.** We take that from your local review where you  
 4 say it's not down to chance; correct?  
 5 **A.** I don't think we ever actually said it's not  
 6 down to chance because I don't think we ever submitted  
 7 it to statistical analysis, which, by definition, would  
 8 be required to say it was or wasn't chance. But it was  
 9 an increase that was sufficiently high that it was of  
 10 concern and certainly isn't something we would have  
 11 subjected to statistical testing to assess whether it  
 12 was sufficient to need investigation.  
 13 **Q.** What you said in the review -- and this is  
 14 INQ0001888, I don't suggest we need to get it up. What  
 15 you said was:  
 16 "Fluctuation due to common cause variation cannot  
 17 account for the increased mortality seen in the neonatal  
 18 unit."  
 19 Common cause variation is effectively chance, isn't  
 20 it?  
 21 **A.** Yes.  
 22 **Q.** Okay. Also, in addition to the unequivocal  
 23 rise, you knew what the paediatricians' concerns were,  
 24 you knew that, since Letby had been off the unit, there  
 25 had been no deaths or -- well, no deaths, correct?

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1 **A.** It is a limited report.  
 2 **Q.** I'm sorry, I am not hearing you: it is  
 3 a limited?  
 4 **A.** The report is limited.  
 5 **Q.** Well, as we have agreed, the reports,  
 6 including your local report, doesn't establish that  
 7 proposition, does it?  
 8 **A.** It doesn't describe all the detail, no.  
 9 **Q.** It doesn't?  
 10 **A.** Describe all the detail.  
 11 **Q.** No, but you can't derive that conclusion from  
 12 the report; we have agreed that?  
 13 **A.** I would accept that.  
 14 **Q.** Okay. Now, as I said to you earlier, this was  
 15 the gravest decision or potentially the gravest decision  
 16 that the board were being asked to take, wasn't it?  
 17 **A.** Yes.  
 18 **Q.** It required extreme care on your part, and  
 19 also on Mr Chambers' part, that the board were presented  
 20 with an accurate picture, agreed?  
 21 **A.** I believe they were being present with  
 22 a picture that summed up the situation as it was at that  
 23 time.  
 24 **Q.** What you said there, that the reviews having  
 25 found no evidence of a single person's culpability, that

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1 was not accurate, was it?

2 **A.** It was accurate insofar as those reports.

3 What it didn't do was, was call out the fact that that  
4 potential was still there.

5 **Q.** Well, it needed -- let's say it needed a full  
6 and accurate explanation?

7 **A.** Yes, and --

8 **Q.** All right, and --

9 **A.** -- I think that was part of the conversation  
10 that took part, actually, in the board around this  
11 paper, that we were waiting for that further information  
12 that was pending.

13 **Q.** But you are talking in those terms,  
14 Mr Chambers is talking in the terms of allegations being  
15 unsubstantiated. You are not, on the face of the  
16 minutes, really allowing for any other possibilities,  
17 are you?

18 **A.** I believe, in terms of the discussion that we  
19 had, I was calling out that this paper was written as of  
20 that time but that it wasn't complete because the  
21 reviews weren't complete, and that there was more to  
22 follow.

23 **Q.** A full and accurate summary of the reviews  
24 would have been that they don't help us one way or  
25 another in determining whether there's been criminal

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1 is a single person's culpability, or responsibility on  
2 the part of a single individual, correct?

3 **A.** As I have agreed, this is that picture at that  
4 time. It doesn't describe the full picture but that  
5 came up in the conversation around this report.

6 **Q.** I am going to move on because of time. Just  
7 to this: you have said on a couple of occasions in the  
8 course of your evidence today that what you were  
9 endeavouring to do was to help build a consensus and,  
10 I take it, with the Consultant paediatricians as to the  
11 cause for the increased mortality, correct?

12 **A.** Yes.

13 **Q.** You were then talking, I think, about probably  
14 your ethos in 2017?

15 **A.** Yes.

16 **Q.** Yes. Do you agree that the wise thing to have  
17 done would have been to share your reviews at the  
18 earliest possible opportunity with the Consultant  
19 paediatricians because they could have assisted you as  
20 to how you were interpreting them?

21 **A.** I -- I believe that I have already conceded  
22 that point, yes.

23 **Q.** All right. You had had the offer of help much  
24 earlier on from Dr Brearey when he had tried to give you  
25 some guidance as to what material should be provided to

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1 activity; that would have been a full and accurate  
2 summary, wouldn't it?

3 **A.** I -- I wasn't in a position to say that, until  
4 I had received the full and final reports including  
5 those of Hawdon and of McPartland.

6 **Q.** Well, you were reporting to the board on the  
7 basis of the material available to you at the time?

8 **A.** Yes.

9 **Q.** On the basis of that material, you could say  
10 no more than, to be full and accurate, the reports don't  
11 assist us either way in determining whether there's been  
12 criminal activity?

13 **A.** The report is not accurate in those terms but  
14 I believe that that was discussed as part of the  
15 discussion around this document.

16 **Q.** Insofar as it was presented in that way, can  
17 we agree that it was misleading?

18 **A.** I would say that it told the picture as of  
19 that time but it wasn't a complete picture. It wasn't  
20 designed to mislead, I don't think it did mislead  
21 because I believe that the conversation that went around  
22 it in the meeting highlighted the gaps.

23 **Q.** Last time: as at 10 January, a full and  
24 accurate picture would have been the reviews that we  
25 have undertaken cannot tell us either way whether there

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1 the College?

2 **A.** Yes.

3 **Q.** Okay. Do you appreciate now that the way  
4 that, in fact, you handled it, which was to hold back  
5 both reports until February and to present the outcome  
6 of the board meeting on 11 January to the paediatricians  
7 on 26 January, as something of a *fait accompli*, that was  
8 never going to achieve that end of seeking a consensus?

9 **A.** Sorry, I am struggling to follow that.

10 **Q.** It's been a long day. The way that, in fact,  
11 you approached it had the opposite effect of building  
12 consensus because you held back material from the  
13 paediatricians?

14 **A.** I have, I've already agreed that we didn't  
15 share it in a -- in as timely a fashion as we should,  
16 yes.

17 **Q.** Because when they saw it on 3 February, you  
18 had had Dr Hawdon's report since the end of October,  
19 correct?

20 **A.** Initial, but then there was the ongoing work  
21 that was required to fill in the gaps, yes.

22 **Q.** All right. But you had had the initial report  
23 since the end of October --

24 **A.** Yes.

25 **Q.** -- and similarly you had RCPCH's report for

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1 some months?

2 **A.** Yes.

3 **Q.** To the extent that that approach soured  
4 relations between the Executive Team and the  
5 paediatricians, that is something, presumably, that you  
6 are apologetic for?

7 **A.** I believe that I have already apologised for  
8 that.

9 **Q.** Very well.

10 **A.** I would also say that part of their anger was  
11 with regard to the perception that what they had said to  
12 the College wasn't reflected in the report, and I take  
13 on board that the weight I put on the instructions that  
14 we received with regard to sharing the full report or  
15 the report for publication, probably aggravated that  
16 situation.

17 **Q.** Another part of their anger was that, when  
18 they read the RCPCH and Hawdon, they couldn't see the  
19 justification for letting Letby back on to the unit?

20 **A.** Yes.

21 **MR KENNEDY:** Okay. Mr Harvey, thank you.

22 My Lady, I will leave it there.

23 **LADY JUSTICE THIRLWALL:** Thank you very much  
24 indeed, Mr Kennedy.  
25 Ms Scolding?

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1 combined with gut feeling."

2 So this is part and parcel of what you have called  
3 today the green text, and so the first question to ask  
4 you really is: this isn't the RCPCH saying there was  
5 just a gut feeling; this is the RCPCH reporting what  
6 they say the Consultants told them?

7 **A.** Yes.

8 **Q.** But, of course, the Consultants didn't see  
9 this part of the report, did they? Because this was the  
10 part of the report that was redacted, however you want  
11 to call it?

12 **A.** That's correct.

13 **Q.** So, of course, they had no opportunity to then  
14 look at that and say to the Royal College, "Actually,  
15 you have got that wrong, that isn't what we said",  
16 because, in fact, what the Consultants said to the Royal  
17 College during the course of their review was pretty  
18 much what they had said to you in June and July 2016,  
19 they had gone through a series of factors, not just gut  
20 feeling; that's right, isn't it?

21 **A.** Yes.

22 **Q.** So, in fact, your actions prevented the  
23 paediatricians being able to correct a factual  
24 inaccuracy and, therefore, led to you and others relying  
25 upon something which, in fact, wasn't right?

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1 Mr Harvey, are you all right to continue?

2 **A.** Absolutely fine, my Lady, thank you.

3 **Questions by MS SCOLDING**

4 **MS SCOLDING:** Good afternoon, Mr Harvey. I ask  
5 questions on behalf of the Royal College of Paediatrics  
6 and Child Health.

7 I have just got two areas of questioning for you  
8 this afternoon, the first one which is about the  
9 reference of which you made numerous references to it  
10 first thing this morning, about the words "gut  
11 feeling" --

12 **A.** Yes.

13 **Q.** -- saying in the RCPCH Report they had used  
14 the terms "gut feeling" and that was what you went  
15 towards. Now, can I ask you to have a quick look at the  
16 only place I can find "gut feeling" appears in the  
17 various drafts of the report. So this is the final  
18 report and this is INQ0009618\_0009, and it's the third  
19 paragraph, once we have got it up.

20 Right. Now, this is the full report, and this is  
21 the green text. So the only place I can find "gut  
22 instinct" is, if you look, it's the penultimate  
23 sentence:

24 "The Consultants explained that their allegation  
25 was based on Nurse L being on shift on each occasion,

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1 **A.** I'm sorry, my action ...?

2 **Q.** Your actions in preventing the paediatricians  
3 from seeing the full report therefore meant that you and  
4 others proceeded upon an erroneous basis as to what the  
5 Consultants had or hadn't said during the course of the  
6 report; that's right, isn't it?

7 **A.** Well, my understanding is that I was following  
8 the instructions received from the College with regard  
9 to how the report should be circulated.

10 **Q.** Yes. Well, I am going to come on to that.  
11 So if we then come on to the issue of what was or  
12 wasn't confidential. So, if I can take you first to the  
13 contract, so this was something that arrived on 2 August  
14 2016. It's INQ0009597, and could we get up the second  
15 page. Can we have a look at number 3 and number 4. So  
16 you signed this document and sent it back to the  
17 College, and this is the basis of the agreement to carry  
18 out the review:

19 "Within the requirements of confidentiality under  
20 the DPA, the review must proceed in an open manner  
21 enabling discussions by the review team with all parties  
22 involved."

23 Then number 4:

24 "The final review report should be made available  
25 to those involved in the review."

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1 So that's the starting point that you will have  
2 seen or that you, one hopes, will have read carefully,  
3 which is everybody who, in effect, contributes to the  
4 review should have an opportunity to see it, it being  
5 identified that one of the purposes of the RCPCH Review,  
6 as the reviewers in the evidence that they have given to  
7 this Inquiry have said, was a sort of peer review  
8 process which involved a degree of openness and candour  
9 between all involved.

10 So that's the process. I then can't find any  
11 reference to confidentiality in any written information  
12 until the document that Ms Langdale showed you this  
13 morning, which is INQ0003403, page 1.

14 This is the email to the final draft report, if  
15 I put it this way:

16 "Please find attached draft report, it does provide  
17 some fairly strong recommendations, so I would be  
18 grateful if you and Alison can have a first read through  
19 then once you are happy, perhaps you can share it with a  
20 few selected people, including, I would guess, Ravi,  
21 Stephen and Eirian, to check for any obvious accuracy  
22 sees or misunderstandings."

23 Sue Eardley then says further down:

24 "She has put together a chronology. That could be  
25 Appendix 4 but it's fairly sensitive, might be of use to  
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1 what the Royal College would have assumed is that those  
2 particular Consultants would have seen the full copy,  
3 including the green text?

4 **A.** I'm not completely clear in my mind that that  
5 first report that was sent through included the green  
6 text.

7 **Q.** I think it all included the green text, unless  
8 and until you came to the final version, which we are  
9 going to come on to now, which is the email from Sue  
10 Eardley, which is INQ0009617.

11 So, again, can I just clarify there is nothing in  
12 there about you talking about confidentiality or  
13 discussing anything with Sue Eardley about  
14 confidentiality. So this is the letter which encloses  
15 the two reports, and I think Ms Eardley has already  
16 given evidence that, you know, with hindsight, she  
17 should not have produced two reports, she should only  
18 have produced one. So let's leave that to one side:

19 "Please find attached a close out letter. I have  
20 made the changes as suggested below in your email.  
21 Please let me know if there is anything else that can  
22 assist. There is one confidential, which includes the  
23 HR issues and is our formal version, the other omits  
24 these and would perhaps be suitable for wider  
25 dissemination amongst those who contributed."  
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1 Jane and Martin [which is Jane Hawdon and Martin  
2 McPartland] as they do the detailed reviews."

3 So, in fact, contrary to what you say, it is  
4 absolutely clear -- and this report at this stage, this  
5 was not a kind of dissemination version, green  
6 text/non-green text, this was just one report, including  
7 what then got excluded. This plainly identifies that it  
8 should be seen by Ravi, Stephen and Eirian to check for  
9 any obvious inaccuracies and misunderstanding.

10 So where does that say, "Please do not give Ravi  
11 and Stephen the redacted or the green text"?

12 **A.** I -- I believe that there was a further email  
13 that actually did say that.

14 **Q.** Right, let's get that further email up.  
15 INQ0003132, which is your response to this email, sorry,  
16 and then we will come to the further email. Could we go  
17 to the second page, please. Right. This is your return  
18 email, so Sue Eardley sends you the full report, if I am  
19 going to put it that way, on 18 October. You, on  
20 15 November say:

21 "Please find attached an amended report. It has  
22 been seen by the Execs, Steve Brearey, Ravi Jayaram and  
23 Anne Murphy, and their comments have been taken into  
24 account."

25 So, in fact, what you say to the Royal College and  
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1 Now, this email has to be seen in the light of the  
2 previous chain of emails we have seen, which is:

3 "Can you make sure that Ravi and Steve see the full  
4 version for factual accuracy."

5 You send the email back saying that they have seen  
6 it and there are these two reports. Nowhere in that  
7 email does it say we are telling you not to send it to  
8 anybody.

9 It says it perhaps would be suitable for wider  
10 dissemination amongst those who contributed. Do you  
11 think you could have misread that email as saying  
12 something which it didn't mean to say or do you think  
13 that it just suited your intentions to have it read that  
14 the full report shouldn't be seen by the Consultants?

15 **A.** My reading of that email is that the  
16 confidential one, with the HR issues, was for very  
17 limited circulation and the formal version was the one  
18 for dissemination to those who had contributed. I --

19 **Q.** But --

20 **A.** -- still am not clear in my mind that the very  
21 first report that we received actually included the  
22 green text because there was no reference to that being  
23 called out as something -- something different at that  
24 point.

25 **Q.** Okay. But can I ask you to note the words,  
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1 "would perhaps be suitable". So this isn't  
2 an instruction or a direction. It's a suggestion;  
3 that's right, isn't it?

4 **A.** Yes.

5 **Q.** Okay. Can we then look at the letter which  
6 was attached to this email, which was the close out  
7 letter, that's INQ0009620. It's the second paragraph  
8 I would like you to look at, please, Mr Harvey:

9 "Aware of the personnel issues, we have provided  
10 two reports, one including the full details and one  
11 omitting the confidential HR issues. To continue our  
12 expectation of openness, I hope you will share the  
13 dissemination copy of the report in confidence, if  
14 necessary, with those who contributed. It remains your  
15 report though and we will not distribute or share it  
16 more widely without your permission."

17 So the point that Ms Langdale made to you  
18 repeatedly this morning was in fact made to you by the  
19 Royal College of Paediatrics at the time that the final  
20 report was sent to you, which was, "It is your report,  
21 distribute it as you wish, we have tried to do something  
22 to help you". In no way does it say there, there is any  
23 injunction, prevention, direction or refusing to  
24 disclose the report to, in particular, those people who  
25 had made their concerns known to you about Letby.

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1 assumptions. You have just described an assumption. At  
2 no point is there anything explicit and, given the  
3 nature of the concerns that led to the invitation to  
4 review, given the expertise of the team I would have  
5 expected, if they anticipated that there was something  
6 that serious, that it would be explicit.

7 And I find it very difficult to accept that the lay  
8 member, as an inactive barrister who contributes to NCAS  
9 and the NMC is talking in terms of vagueness, and this  
10 really didn't help us.

11 **Q.** Okay. Well, you are perfectly entitled to  
12 your perspective on that. Obviously, the Royal College  
13 doesn't agree with that but that's -- but it doesn't  
14 really help answer the question that I asked, which was:  
15 there is nothing in this letter which identifies that  
16 you should be keeping HR matters in respect of Letby  
17 confidential to those who made their concerns known to  
18 you?

19 **A.** Not, not explicitly no. The use of  
20 "Confidential HR issues" would mean that I would be  
21 seeking advice with regard to what we would do there.

22 **MS SCOLDING:** Yes. Thank you. I have no further  
23 questions, thank you very much.

24 **LADY JUSTICE THIRLWALL:** Thank you very much  
25 indeed, Ms Scolding.

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1 **A.** I would say that the use of the phrase  
2 "confidential HR issues" was something that might cause  
3 that thought in my mind. I accept that it was our  
4 report. But, in considering the content, in considering  
5 the recommendations, I was also mindful of those who  
6 constituted the expert team that came to visit.

7 **Q.** Yes. But you had already had a conversation  
8 with them, both on 2 September and then a letter had  
9 been sent very quickly afterwards on 5 September, at  
10 which they had said, "You need to get on with the  
11 disciplinary process", and Ms Langdale took you to those  
12 various discussions this morning.

13 So you already were aware of the fact that the  
14 Royal College had assumed that you would have been in  
15 the process of undertaking a disciplinary investigation,  
16 which the witness, who have given evidence on behalf of  
17 Royal College, Ms McLaughlan, said she would have  
18 assumed that meant that you would have called the  
19 police. So surely it is in that context you have to  
20 take it? Not, "We don't think that anyone should see  
21 this", but maybe, "Not everyone who doesn't know what  
22 already has been going on should see it"?

23 **A.** I would suggest that a lot of the  
24 communications from the College and their report as well  
25 is couched in vague language. It is full of

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1 Ms Blackwell?

2 **Questions by MS BLACKWELL**

3 **MS BLACKWELL:** Mr Harvey, it's been put to you by  
4 Counsel to the Inquiry as a fact that Child O and  
5 Child P should never have died after the 11 May meeting  
6 when Letby could have been off the ward and referred to  
7 the police, and she put that allegation to you, the  
8 implication being that you, as the Medical Director, are  
9 responsible in part for that taking place.

10 It has also been alleged that you, as the Medical  
11 Director of the hospital were part of harbouring  
12 a murderer, that's been put to you by Counsel to the  
13 Inquiry. As this Inquiry is a search for the truth,  
14 I want to take you through what evidence there is before  
15 the Inquiry and that you would have known about in order  
16 to see whether there is evidence in order to support  
17 those allegations?

18 **A.** Yes.

19 **Q.** Now, what lay behind the 11 May meeting was  
20 the Thematic Review?

21 **A.** Yes.

22 **Q.** So I would like to take you, first of all,  
23 please, to the Thematic Review itself, the one that was  
24 discussed during the course of the 11 May meeting, and  
25 it's at INQ0003400. Now, as that's being brought up,

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1 let's remind ourselves that the first copy of the  
2 Thematic Review that you received from Dr Brearey was  
3 sent to you, you having asked him for details of what  
4 you believed was an external review --

5 **A.** That's correct.

6 **Q.** -- and he sent you the draft document on  
7 15 February?

8 **A.** He did.

9 **Q.** Yes. What we are looking at now is the final  
10 document.

11 **A.** Yes.

12 **Q.** If we can look at page 2, please. We can see  
13 that this is the document that was created following the  
14 meeting on 8 February 2016. We see that at the foot of  
15 the left-hand corner. The purpose of that review was to  
16 deal with the higher than expected mortality rate on the  
17 NNU during the course of 2015?

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

19 **Q.** Now, there were 10 cases considered during the  
20 Thematic Review. Those cases were chosen by Dr Brearey,  
21 weren't they?

22 **A.** They were.

23 **Q.** Yes. We can take these fairly quickly,  
24 I hope. The first death was of a child on 5 April of  
25 2015, a child that had severe hypoxic ischemic

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1 **Q.** Thank you. Child C, we can see had  
2 a postmortem. We see what the results of that  
3 postmortem were. The concern in relation to Child C was  
4 that there was no cause for the deterioration  
5 identified. Child D died on 22 June 2015. Again, there  
6 was a postmortem with a reason given for death.

7 Can we go over the page, please. Child E died on  
8 4 August 2015. There was no postmortem but there were  
9 two causes of death given.

10 Then on 4 September 2015, another child died. It  
11 appears that that child might have undergone a sudden  
12 collapse. There was a postmortem, there were reasons  
13 given for the death. Lucy Letby was on duty, we know  
14 from the appendix, at the time of that collapse and  
15 death.

16 Over the page, please. Thank you. 27 September  
17 2015, another child died. There was a postmortem with  
18 reasons given for the death. Lucy Letby was on duty  
19 when that child collapsed and died.

20 Then Child I died on 23 October 2015. At the time  
21 that this review took place, there was a postmortem  
22 awaiting and we know that that was the child, Child I,  
23 who had undergone multiple transfers.

24 We can see that the information provided in this  
25 review is that there were arrests on 13, 14 and

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1 encephalitis, a death for which Lucy Letby was not on  
2 duty?

3 **A.** Yes.

4 **Q.** Yes. Over the page, please. There are then  
5 three further deaths, we now know them as Child A  
6 Child C and Child D. Of course, when this review was  
7 prepared, they were referred to by their names, weren't  
8 they?

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

10 **Q.** Yes, and we know, as we can see, that Child A  
11 died on 8 June 2015, there was a Coroner's postmortem,  
12 which was unascertained. We know that the Inquest there  
13 is listed as taking place on 23 March 2016 but, in fact,  
14 we now know that was delayed until 10 October 2016.

15 **A.** That's correct.

16 **Q.** I will come back to that at the end of my  
17 questions. We also know that Child A had a Twin,  
18 Child B?

19 **A.** Yes.

20 **Q.** It was suggested to you by Counsel to the  
21 Inquiry that at no time did you suggest that Child B and  
22 Child B's collapse should be looked at. Was that ever  
23 something that Dr Brearey raised, as far as you are  
24 aware?

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

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1 15 October but with rapid improvement after each arrest.  
2 Did it come to your attention as to whether or not  
3 that improvement had taken place within the Countess of  
4 Chester Hospital or outside of it?

5 **A.** That wasn't clear, no.

6 **Q.** Thank you. On 13 December 2015 another child  
7 died. There was no postmortem but two reasons given for  
8 the cause of death. Lucy Letby was on duty at the  
9 relevant time.

10 Over the page, please, thank you. On 8 January  
11 another child died. At the time that the review took  
12 place, the postmortem was being awaited and there was  
13 probable prematurity and sepsis being suggested.

14 In relation to this child, there had been what  
15 appears to be a sudden arrest on day two and Lucy Letby  
16 was not on duty during the course of that arrest.

17 Now, if we go over to the next page, please. We  
18 can see --

19 **LADY JUSTICE THIRLWALL:** I am very sorry to  
20 interrupt you, Ms Blackwell, but I noticed when we were  
21 looking at Child A -- it's nothing to do with you or the  
22 witness -- the details of the mother's condition have  
23 not been redacted. They should have been. I'm not sure  
24 how that's happened, but that first line of the mother's  
25 medical condition must not be reported.

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1 **MS BLACKWELL:** Thank you very much, my Lady.

2 **LADY JUSTICE THIRLWALL:** Not at all.

3 **MS BLACKWELL:** These were the themes as we see them  
4 in the final report, so the first, sudden deterioration,  
5 the second, the timings of the arrests.

6 Now, in the draft report which you saw on  
7 15 February, those -- well, sudden deterioration didn't  
8 appear at all, the timing of the arrests was number 4 of  
9 the themes identified, and top of the themes identified  
10 was delayed cord clamping. That was the report that was  
11 sent by Dr Brearey to the others who had been present  
12 within the meeting in order for them to comment upon.

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

14 **Q.** Yes. We know that it was following  
15 suggestions from Dr Subhedar that these amendments were  
16 made?

17 **A.** Yes.

18 **Q.** But you didn't see the amended report until it  
19 was sent to you via Alison Kelly on, I think, 17 March  
20 2016 or thereabouts; is that right?

21 **A.** I think that's probably correct, yes.

22 **Q.** Yes. There were a series of outstanding  
23 actions set out in a summary action plan. Could we go  
24 to page 9, please. Thank you. Did you see these  
25 actions set out in the action plan prior to the meeting

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1 appreciate that or --

2 **Q.** Was deliberate harm obvious to you from the  
3 face of the document?

4 **A.** It, it wasn't either in terms of the overall  
5 tone of the document, nor was it specifically called  
6 out.

7 **Q.** Could we have up please the email that you  
8 received from Alison Kelly on 6 May. It's INQ0107818.  
9 It has been suggested to you that when you read this  
10 email from Alison Kelly, it must have been obvious to  
11 you what she meant when she suggested that she had some  
12 alarm, and I think it's at page 2, please.

13 If we look at the email on 4 May from Dr Brearey.

14 You have already been taken to this today:

15 "There is a nurse on unit who has been present for  
16 quite a few of the deaths. Eirian has sensibly put her  
17 on day shifts", and he talks about the pressure on  
18 staffing numbers.

19 Was that brought to your attention?

20 **A.** Was I -- no, at that point, I wasn't on the  
21 circulation list.

22 **Q.** Can we go back to page 1, please. At the  
23 bottom of the page, we can see that Alison Kelly,  
24 I think, has forwarded that email on to you?

25 **A.** That's correct.

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1 on 11 May?

2 **A.** I believe they were attached, yes.

3 **Q.** Thank you. If we could just go back to  
4 page 7, please, we can see that one of the actions at  
5 page 7 was that Stephen Brearey and Eirian Powell were  
6 to review all the cases focusing on nursing observations  
7 in the four hours before the arrests. Were you aware  
8 that that was an action that had been set out and was  
9 being undertaken?

10 **A.** When I received the final version of this,  
11 yes.

12 **Q.** Right. Thank you. Now, you understood when  
13 you read the Thematic Review, going into the meeting on  
14 11 May, that there were problems on the ward; is that  
15 right?

16 **A.** Yes. Primarily concern about an increased  
17 number of deaths.

18 **Q.** It's been suggested to you today that it must  
19 have been obvious to you, given the sudden deterioration  
20 as we see it under the themes identified, and the  
21 timings of arrests, that deliberate harm was being  
22 suggested both on the face of the document and later in  
23 the meeting of 11 May, which we will come to; is that  
24 right?

25 **A.** Sorry, is that right in terms of I would

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1 **Q.** She has said:

2 "Please see Steve's comments below which alarmed  
3 me."

4 It was that to which you were taken, I think, by  
5 Mr Baker. Your response, which you weren't taken to,  
6 later on that day appears above it:

7 "I see what you mean, although perhaps he just  
8 meant that he was concerned for her. I am fine to meet  
9 for this next Wednesday."

10 **A.** Yes.

11 **Q.** So what was your take on what was being  
12 suggested?

13 **A.** My take from the description of her having  
14 been sensibly removed, together with just the expression  
15 of concern with regard to staffing, was that this had  
16 been a supported move. My interpretation was that  
17 Dr Brearey supported that move but was concerned about  
18 how that shift of that member of staff was going to  
19 affect the staffing balance on the unit.

20 **Q.** Thank you. Mr Baker also questioned you about  
21 the request for a meeting from Dr Brearey?

22 **A.** Yes.

23 **Q.** You know that his evidence to the Inquiry was  
24 that, soon after completing the Thematic Review, he was  
25 keen to meet with you and had asked for an urgent

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1 meeting?

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

3 **Q.** Could we have up on screen, please,  
4 INQ0038966? It was suggested to you that there must  
5 have been a conversation or another email that had gone  
6 between you and Dr Brearey because, further on down the  
7 line, you had made it clear that he had made a request  
8 of you that the Thematic Review be aligned with the  
9 obstetric review?

10 **A.** Yes.

11 **Q.** Yes. Now, if we look at the middle of that  
12 page, we can see on 15 February you are emailing  
13 Dr Brearey in these terms:

14 "That's helpful. I note that you state  
15 an obstetric thematic review did not identify any common  
16 themes or identifiers that might be responsible for the  
17 rising mortality in 2015 and now you have carried out  
18 a review, where do the two get joined up?"

19 **A.** Yes.

20 **Q.** Yes. We can see his response to you at the  
21 top of that page:

22 "They will get joined up at the Women and  
23 Children's Governance Board. It's not easy working  
24 across Urgent and Planned Care Divisions. I have copied  
25 this into Jo Davies for her info."

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1 following that meeting in which he referred to it as  
2 a helpful meeting and he was grateful for the work that  
3 had been done and for the actions that were flowing from  
4 that. And did you take that on face value?

5 **A.** Absolutely.

6 **Q.** Now, one of the additional matters that was  
7 set out in that email is -- and of course it was sent to  
8 his fellow clinicians, was this instruction: if you do  
9 come across a baby who deteriorates suddenly or  
10 unexpectedly or needs resuscitation on the NNU, please  
11 can you let me and Eirian know?

12 **A.** Yes.

13 **Q.** You were aware of that?

14 **A.** That was one of the action plans from the  
15 meeting.

16 **Q.** So between 11 May and 27 June did anybody any  
17 of the clinicians, including Dr Brearey and Dr Jayaram,  
18 bring anything to your attention?

19 **A.** No, they didn't.

20 **Q.** No. Not the deterioration (*redacted*) of  
21 Child N on 15 June of 2016?

22 **A.** No.

23 **Q.** No. As you have told the Inquiry, the first  
24 you know you knew of the deaths of O and P was on  
25 27 June?

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1 **A.** Yes.

2 **Q.** Which would appear to be the missing email, so  
3 far as that piece of the jigsaw is concerned?

4 **A.** That would appear to fill in the gap.

5 **Q.** Yes. There is no request for an urgent  
6 meeting is there?

7 **A.** No.

8 **Q.** Did he ever make one of you?

9 **A.** No.

10 **Q.** Thank you, we can take that down, please. Now  
11 the meeting itself on 11 May, we have looked at the  
12 notes; I don't intend to take you back to them. But  
13 just to confirm your recollection of what was being said  
14 there.

15 In terms of anything that Dr Brearey might have  
16 said, did he provide to you any information over and  
17 above what we have just seen on the face of the written  
18 document?

19 **A.** No, he didn't.

20 **Q.** Did he challenge Eirian Powell and Anne Murphy  
21 when they spoke in terms that the Inquiry has heard that  
22 we see in their written note which they brought to the  
23 meeting?

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

25 **Q.** Right. We have seen the email that he sent  
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1 **A.** Yes, that's correct.

2 **Q.** I am not going to take you again to the  
3 meeting notes of the 29 June. You have already given  
4 your evidence as to what you took Dr Jayaram to mean  
5 when he posed the question:

6 "How? Cannula? Air embolism? Crystal ball?  
7 Unquestionably got something going on in the Countess of  
8 Chester but what?"

9 You took that to mean either a deliberate harm or  
10 a competency issue?

11 **A.** Yes.

12 **Q.** Yes. You have already been taken to the  
13 comments made by Tony Chambers in the middle of that  
14 page. I suggest in accordance with the evidence he's  
15 given to the Inquiry that the note is wrong and that it  
16 should be: why did we not call the police?

17 **A.** Yes.

18 **Q.** Of course you have been taken to the fact that  
19 Dr Brearey's response to that is can we move the member  
20 of staff? If no, then we should go to the police.

21 And Dr Jayaram's response:

22 "Why not earlier, call the police: reviews."

23 **A.** Yes.

24 **Q.** Is that your level of knowledge, that there  
25 had been reviews undertaken on the ward, including  
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1 Dr Subhedar who was an outside external Consultant and  
2 that's why there hadn't been a decision thus far to go  
3 to the police?

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

5 **Q.** There was a meeting the following day on  
6 30 June, again I am not going to take you again to  
7 the -- to the record that we have had up twice, possibly  
8 three times today.

9 Do you recollect whether or not when Tony Chambers  
10 suggested if the nurse be removed, the deaths would  
11 stop, the response from Dr Brearey was either: risk  
12 would be reduced or risk would be removed?

13 **A.** I can't recall which answer was given.

14 **Q.** Do you accept that by the end of the meeting  
15 on 30 June there was at least the prospect in your mind  
16 that deliberate harm might have been being caused?

17 **A.** Yes.

18 **Q.** Were there other matters that were also within  
19 your mind as the possible cause of the increased  
20 mortality?

21 **A.** Absolutely. Common -- common things are  
22 common and one is going to be concerned about quality of  
23 care, be that collective, be that individual and the  
24 effect that that would have on the safety and the level  
25 of care that is delivered.

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1 contacted if only to provide an oversight to the other  
2 work that you were doing?

3 **A.** That's correct.

4 **Q.** Does that remain your position?

5 **A.** It does, yes.

6 **Q.** Thank you.

7 My learned friend Ms Scolding has asked you about  
8 the RCPCH Report and given the answers that you have  
9 provided to her questions, I don't seek to ask you  
10 anything further about that.

11 But it was suggested to you that only -- and this  
12 was by Counsel to the Inquiry, not Ms Scolding, that  
13 only the police could provide independent expert  
14 evidence.

15 Do you agree with that statement?

16 **A.** No, I don't. Ultimately the police will rely  
17 on clinical experts to provide that evidence. I'm aware  
18 of the criticism of relying on Dr Hawdon, but I would  
19 point out that actually the evidence presented at trial  
20 was coming from clinical experts based on Casenote  
21 Reviews and those experts found sufficient evidence for  
22 her to be found guilty.

23 **Q.** I think that was what you were trying to say  
24 when you were prevented from giving a complete answer to  
25 a question that was posed by Mr Baker; is that right?

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1 **Q.** So when it was suggested to you this morning  
2 by Counsel to the Inquiry that you should get off the  
3 word "association" and that what was being said loud and  
4 clear was deliberate harm and murder, is that a fair  
5 reflection of your memory of that meeting?

6 **A.** No. It -- it doesn't reflect what I heard  
7 from what was a very wide-ranging and I believe very  
8 honest conversation amongst all those present.

9 **Q.** When it was put to you by Counsel to the  
10 Inquiry that at the end of the 30 June meeting there was  
11 no substance in saying that it was only a possibility of  
12 there being deliberate harm, does that reflect your  
13 memory of the meeting?

14 **A.** That it was only a possibility?

15 **Q.** That it was --

16 **A.** Yes.

17 **Q.** -- something more than a possibility?

18 **A.** No.

19 **Q.** There was no substance in saying it was only  
20 a possibility?

21 **A.** No, no.

22 **Q.** You have given evidence today about the Silver  
23 Command that was set up on 7 and 8 July and you have  
24 told the Inquiry that you regret that you did not stick  
25 with your initial view that the police should be

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1 **A.** That's correct.

2 **Q.** Yes, thank you.

3 It was also suggested to you by Counsel to the  
4 Inquiry that Dr Subhedar in his letter to you very  
5 clearly indicated that you should go to the police.

6 Now, could we have a look at that letter please.  
7 It is an email at INQ0006890 and it's page 188.

8 **LADY JUSTICE THIRLWALL:** Choose your moment for  
9 a break.

10 **MS BLACKWELL:** I have nearly finished, my Lady.

11 **LADY JUSTICE THIRLWALL:** Very good.

12 **MS BLACKWELL:** If we just take a moment to look at  
13 the various points made by Dr Subhedar in this letter.  
14 He talks about the Terms of Reference not being clear,  
15 his own interpretation of the 13 deaths, he's broadly in  
16 agreement with the recommendation of Dr Hawdon. He  
17 questions the fifth recommendation on the basis of her  
18 review.

19 He adds an additional seven cases and he says:

20 "I would like to make one further observation in  
21 relation to the RCPCH Report and recommendations. Many  
22 of them relate to governance arrangements."

23 He says that those are matters which are common,  
24 not just at the Countess of Chester Hospital and he  
25 hopes that the letter is helpful and that he would like

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1 to share his findings with Stephen Brearey.

2 Did you read anything in that letter as being  
3 a very clear indication that you should go to the  
4 police?

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

6 **Q.** Thank you.

7 The final matter that I would like to ask you about  
8 is Child A. Child A, as we know, had an Inquest  
9 eventually on 10 October 2016. This Inquiry has heard  
10 from Dr Jayaram who gave evidence to the Coroner and  
11 indeed you were asked questions yesterday by Mr Skelton  
12 about the evidence that Dr Jayaram gave to the Coroner.

13 Dr Jayaram told this Inquiry that he didn't mention  
14 to the Coroner anything about concerns that by then were  
15 being held that there was a possibility at least of  
16 deliberate harm at the Countess of Chester Hospital.

17 He gave evidence to the Inquiry that rather than  
18 making anything explicit to the Coroner, he laid what he  
19 described as "breadcrumbs":

20 "I was trying to sort of throw as many breadcrumbs  
21 as possible for the Coroner to pick up without  
22 explicitly saying what the suspicion was. I appreciate  
23 [he told the Inquiry] that this was the wrong  
24 judgement", given that Baby A's parents were sitting  
25 10 feet away and that he had failed in his duty of

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1 **Q.** -- in what had gone on.

2 So what do you say, Mr Harvey, was the topic of the  
3 conversation between yourself and the two Coroners at  
4 that meeting in February of 2017?

5 **A.** The topic of conversation was with regard to  
6 the events surrounding the paediatricians writing their  
7 letter to Tony Chambers requesting that we approach and  
8 spoke with the Coroner to investigate with him whether  
9 he would consider reopening any of the cases or  
10 undertake further investigation.

11 By that very nature, we would have to explain and  
12 provide documentation to support why they had written  
13 that later -- letter and why we were requesting that  
14 meeting with the Coroner.

15 **Q.** Is there any doubt in your mind that that  
16 conversation took place?

17 **A.** Absolutely not.

18 **MR BAKER:** Thank you, my Lady. That is all I have.

19 **LADY JUSTICE THIRLWALL:** Thank you very much,  
20 Ms Blackwell.

21 **Further questions by MS LANGDALE**

22 **MS LANGDALE:** My Lady there is one document  
23 I should have put, if I can introduce that.

24 **LADY JUSTICE THIRLWALL:** Yes, of course. Just let  
25 Ms Blackwell get to her place.

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1 candour.

2 Now, you were asked by Mr Skelton whether or not  
3 you thought that that was adequate for somebody to on  
4 oath give that evidence?

5 **A.** Yes.

6 **Q.** What was your response to this Inquiry?

7 **A.** I believe my response was that that was wholly  
8 inadequate.

9 **Q.** It was suggested to you that you may have in  
10 some way interfered with the statements that were  
11 provided to the Coroner. Did you do that?

12 **A.** I didn't.

13 **Q.** It has also been suggested that you did not  
14 bring to the attention of either the Coroner or the  
15 Assistant Coroner the concerns of the Consultants.

16 Now, in answer to questions from Counsel to the  
17 Inquiry today, it has been confirmed that in fact what  
18 had been provided to the Coroner in written form was the  
19 letter from the Consultants, Dr Hawdon's report and also  
20 the green text from the RCPCH Report?

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

22 **Q.** That is the green text of course which sets  
23 out the allegations that Nurse Letby had been involved  
24 in some way --

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

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1 **MS LANGDALE:** Mr Harvey, can we have a look please  
2 INQ0014405, page 1. It is a document I should have  
3 referred you to earlier. It relates to the CQC.

4 If we see it, it's reflection of a CQC document  
5 17 February 2017, "Strategic update from the Trust." Do  
6 you see that in box 3?

7 **A.** Yes.

8 **Q.** Does that reflect your meeting and update in  
9 February 2017 with the CQC? *(Pause)*

10 **A.** I -- I believe so, yes.

11 **Q.** The CQC say they didn't receive the Thematic  
12 Review report, you say you sent them -- you said in  
13 evidence you say you sent the Thematic Review to the  
14 CQC, but in your statement you said you couldn't  
15 recollect. Do you know now whether you sent the  
16 Thematic Review report and if so, when?

17 **A.** I'm -- I'm basing that on the fact that  
18 in February 2016, in the email that I sent to Stephen  
19 Brearey requesting a copy of the thematic or asking if  
20 the review was available.

21 **Q.** I don't think it was available then to you.  
22 We have heard?

23 **A.** He sent me a draft copy but that was very  
24 specifically with regard to the forthcoming CQC visit  
25 and I haven't seen an email but in doing that

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1 specifically, I am sure that on receipt of that, I would  
2 have forwarded it to whoever was responsible for sending  
3 the documentation through to the CQC ahead of their  
4 visit.

5 **Q.** We will follow that up, Mr Harvey. It looks  
6 like the CQC may have had the Brigham review but not the  
7 Thematic Review and the minutes may have been attached  
8 to Dr Brearey's email, you had asked for it, but from  
9 what your counsel says today you had this in March  
10 I think yourself, but we will follow that up in any  
11 event. You didn't recollect in your statement and you  
12 don't have a firm memory; we can follow the paper trail?

13 **A.** I -- I -- I can't -- I can't recollect.  
14 I would have to rely on the paper trail, but I am simply  
15 surmising based on the fact that I had very specifically  
16 asked him for that with the forthcoming CQC visit, that  
17 having received that from him that would have been  
18 forwarded to the CQC for consideration during their  
19 visit.

20 **MS LANGDALE:** Thank you. Those are my questions.

21 **Questions by LADY JUSTICE THIRLWALL**

22 **LADY JUSTICE THIRLWALL:** Thank you, Ms Langdale.  
23 Just one or two from me, if I may, Mr Harvey.

24 **A.** Yes, my Lady.

25 **LADY JUSTICE THIRLWALL:** First of all, one of the  
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1 that I saw in my job and from the publications and the  
2 data that we get from NHS England.

3 **LADY JUSTICE THIRLWALL:** Thank you. That is not  
4 something, I don't think you mentioned, in any of the  
5 meetings, or "That is nothing to worry about, it's to be  
6 expected". I don't think it is.

7 **A.** I'm not sure I would describe it as to be  
8 expected but it is a factor that one recognises, yes.

9 **LADY JUSTICE THIRLWALL:** Yes. So just so  
10 I understand your thinking. You weren't discounting it  
11 but you were saying that you need to bear in mind this  
12 particular factor?

13 **A.** I wasn't discounting it but there was  
14 potentially another factor that would play into it, yes.

15 **LADY JUSTICE THIRLWALL:** Thank you. Then I just  
16 wanted to ask you a little bit about the GMC --

17 **A.** Yes.

18 **LADY JUSTICE THIRLWALL:** -- because you made it  
19 very clear to us that the experience of a doctor even  
20 just receiving a letter from the GMC --

21 **A.** Yes.

22 **LADY JUSTICE THIRLWALL:** -- can be extremely  
23 damaging, even just the first letter?

24 **A.** I -- I would describe it, in some cases, as  
25 devastating.

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1 things you have been asked to comment on by various  
2 people at various stages was the pattern of deaths that  
3 are picked up in the Thematic Review occurring between  
4 12 o'clock at night and 4 o'clock in the morning.

5 **A.** Yes.

6 **LADY JUSTICE THIRLWALL:** You said that -- well, you  
7 referred I think to an Imperial College paper,  
8 a research paper. You did refer to an Imperial College  
9 paper.

10 **A.** I did, that paper was actually very  
11 specifically with regard to increased mortality at the  
12 weekend.

13 **LADY JUSTICE THIRLWALL:** Yes.

14 **A.** But it is accepted that the risk is also  
15 greater at night. That almost certainly reflects  
16 different staffing levels.

17 **LADY JUSTICE THIRLWALL:** Just before you continue,  
18 because the reference you gave us yesterday was to the  
19 Imperial College paper, which, as you rightly say, deals  
20 with weekends.

21 **A.** Yes.

22 **LADY JUSTICE THIRLWALL:** You say it's generally  
23 accepted and that's based on what?

24 **A.** That is based on clinical experience,  
25 experience of the patterns of mortality in other groups  
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1 **LADY JUSTICE THIRLWALL:** Devastating, yes. Can you  
2 offer any thoughts as to how we have got to a situation  
3 where a first letter from a regulator can have that  
4 effect?

5 **A.** I had cause to complain to the GMC on a number  
6 of occasions because they gave no thought to how or when  
7 they sent their letters out.

8 **LADY JUSTICE THIRLWALL:** You mentioned a weekend,  
9 I think, didn't you, sent on a Friday.

10 **A.** That's right. I would get doctors contacting  
11 me late on a Friday night or at the weekend because they  
12 just opened the letter.

13 The GMC in its letter will often offer -- and  
14 obviously I am now speaking of practice six years ago --

15 **LADY JUSTICE THIRLWALL:** Some years ago, yes.

16 **A.** -- will offer areas of support but, at the  
17 weekend, those areas of support aren't available and I'm  
18 aware the GMC have done a lot of work because of the  
19 recognition of the increased rate of suicide amongst  
20 doctors who are under investigation. But just simply  
21 getting that letter is sufficient to cause a huge amount  
22 of anxiety to not every doctor but to -- to most,  
23 I would suggest.

24 **LADY JUSTICE THIRLWALL:** Because one of the things  
25 that's very striking from the evidence, and it's been  
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1 said to you is, well, the evidence about fear --

2 **A.** Yes.

3 **LADY JUSTICE THIRLWALL:** -- in various contexts but  
4 clearly fear about what will happen with the GMC. That  
5 seems to me to be a theme.

6 **A.** Absolutely. And there will be word of mouth  
7 amongst the medical body with regard to the -- what  
8 those who have been through the process have actually  
9 gone through. It was, for that very reason, that I was  
10 keen to do everything that I could to avoid that  
11 happening to those doctors to whom I could see no reason  
12 why they -- they should be referred.

13 **LADY JUSTICE THIRLWALL:** Yes. Thank you. I am not  
14 going to ask you about the detail of that. It was  
15 rather the sort of broader picture. Thank you very  
16 much.

17 So is this a fair summary: by January 2017, the  
18 doctors have given their evidence and I can make my  
19 decision about the effect upon them but Lucy Letby was  
20 writing to you directly --

21 **A.** Yes.

22 **LADY JUSTICE THIRLWALL:** -- with a number of  
23 requests, presumably with which she hoped you might  
24 comply.

25 **A.** Yes.

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1 responded and I certainly wouldn't have forwarded any of  
2 the information that she was requesting.

3 **LADY JUSTICE THIRLWALL:** No, you have made that  
4 quite clear.

5 **A.** No.

6 **LADY JUSTICE THIRLWALL:** One last thing, and I'm  
7 afraid I don't have an absolutely clear recollection of  
8 the name of the witness, so I'm sorry about that,  
9 somebody else might know it, but when the CQC were in,  
10 in February 2016 --

11 **A.** Yes.

12 **LADY JUSTICE THIRLWALL:** -- one of the -- I think  
13 she was a Specialist Adviser, rather than an inspector  
14 but she was overseeing a focus group with the  
15 Consultants, not the paediatric Consultants, the  
16 Consultants generally --

17 **A.** Yes.

18 **LADY JUSTICE THIRLWALL:** -- and a reasonably large  
19 number of the Consultants turned up, and she doesn't  
20 have many notes but she had a note in her diary which  
21 referred to the Consultants complaining about bullying  
22 of the Consultants by the medical management and she  
23 said that she had come immediately to you to talk about  
24 that; do you have any memory of that?

25 **A.** I have no recollection of a conversation to

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1 **LADY JUSTICE THIRLWALL:** Did it occur to you, and  
2 I appreciate you don't remember the email, now you have  
3 had a chance to see it several times, I am sure, in the  
4 preparation for this Inquiry.

5 **A.** Yes.

6 **LADY JUSTICE THIRLWALL:** But it appears from it,  
7 doesn't it, that Karen Rees, who was the Divisional  
8 Director of nursing, had given her information that she  
9 had received from a nurse about what a doctor had said  
10 in a meeting?

11 **A.** Yes.

12 **LADY JUSTICE THIRLWALL:** That's what she was  
13 wanting to get to the bottom of?

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

15 **LADY JUSTICE THIRLWALL:** Did it occur to you that  
16 that had any echoes of what had happened with the  
17 grievance, that there had been a sort of conduit and  
18 then a grievance from Letby about something that had  
19 been said?

20 **A.** I saw it as an extension of that existing  
21 situation. As I think I said, I was uncomfortable with  
22 that email from the tone and the content. I can't say  
23 what I did with it but I am sure that I would have  
24 escalated it to either Alison Kelly or Sue Hodgkinson in  
25 those circumstances. I certainly wouldn't have

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1 that effect at all.

2 **LADY JUSTICE THIRLWALL:** What would you have  
3 thought had she come to you with that information?

4 **A.** Well, my initial reaction would have been huge  
5 concern. That wasn't how I viewed the relationship that  
6 we had with the Consultant body, and I would have taken  
7 steps to -- to investigate it further. In the first  
8 instance, I would probably have approached Dr Jameson as  
9 the Chair of the Medical Staff Committee --

10 **LADY JUSTICE THIRLWALL:** Staff-Side, yes.

11 **A.** -- and Dr Tighe, as the (*unclear*) BMA Local  
12 Negotiating Committee and probably also my senior  
13 medical management team, the Divisional Medical  
14 Directors. I have to say, I'm surprised that that  
15 assertion was made because it was contrary to  
16 an independent, validated medical engagement survey that  
17 we had undertaken, I believe, in 2015, which actually  
18 scored highly in terms of engagement with the Consultant  
19 body.

20 **LADY JUSTICE THIRLWALL:** All right. Well, thank  
21 you. That is -- sorry, did you want to say something  
22 else?

23 **A.** Well, I was just going to say that, in turn,  
24 I suppose, had they reported that to me, would have  
25 actually caused even heightened concern because

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1 something had obviously changed in a very short period.

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

3 Does anybody want to correct anything?

4 Good. Well, it's very late but it's not as late as

5 it might have been, which is scant consolation but thank

6 you very much indeed, Mr Harvey. You are free to go.

7 **A.** Thank you.

8 **LADY JUSTICE THIRLWALL:** We will rise and start

9 again 10.00 Monday morning.

10 **(5.25 pm)**

11 **(The Inquiry adjourned until 10.00 am,**

12 **on Monday, 2 December 2024)**

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106/20 107/19 142/14	<b>wouldn't [29]</b> 19/11	46/10 47/1 48/15	92/10 93/22 94/7 95/3	
142/17 170/1 170/8	24/23 29/18 29/22	48/25 52/6 55/17	96/6 96/14 100/15	
170/11 170/15 170/23	37/18 38/7 42/22 47/7	57/18 59/5 59/24	105/25 106/17 107/18	
<b>willing [1]</b> 133/9	50/16 83/8 91/24 92/6	63/20 63/23 71/20		
<b>wise [1]</b> 187/16	94/22 107/9 114/20	71/21 71/23 72/18		
<b>wish [2]</b> 129/14	122/11 122/19 125/17	73/4 73/6 73/18 73/21		
197/21	130/17 135/15 135/23	75/1 76/18 77/6 79/19		
<b>wished [1]</b> 92/17	141/20 143/25 146/15	81/5 82/8 86/1 86/20		
<b>withheld [2]</b> 122/16	177/20 181/7 186/2	92/10 93/22 94/7 95/3		
135/24	226/25 227/1	96/6 96/14 100/15		
	<b>wounds [1]</b> 125/11	105/25 106/17 107/18		