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".

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

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,

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

front of you, that the paediatricians have raised?
A. I believe that potentially, at that time, being faced with an increased mortality of unknown origin, it was perfectly reasonable to explore with neonatal experts, both medical and nursing, the full range of potential causes, and I think that was reflected in the Terms of Reference.
Q. You referred then in your answer to the increase in mortality. Can we please have INQ0010256, page 1. It's the Terms of Reference for this review and, again, we see at bullet point 4 "apparent increase" in mortality being described. It was an increase in mortality; why did you say "apparent increase" in the Terms of Reference?
A. "Apparent", as I think I gave in evidence yesterday, was used in terms of, whilst I accepted that the increase -- there was an absolute increase in the number, that we had not subjected it to statistical analysis and, whilst appreciating the significance of each individual death, I described it as "apparent" because it was not proven to be statistically significant. There was no other significance to the use of that word.
Q. You were steering a wide-ranging review, weren't you, in the knowledge that it was never going to

be able to exclude the possibility that Letby had harmed babies?
A. I was commissioning this review on the basis that we had an unexplained increase in mortality. I believed it would be an opportunity for the paediatricians to discuss. I, at the outset, anticipated and we had prepared all the documentation for the team to review the individual cases but, having initiated the process, I felt that it was still appropriate and valid to fully explore the full range of potential contributory factors.
Q. It wasn't the full range because they couldn't explore the one that the paediatricians had raised: whether a nurse was responsible for causing the deaths. That was the very option they could not review?
A. I was not under that impression at the time that this was commissioned and at the time we prepared for the report.
Q. Was that because you didn't listen to what was being said to you?
A. I don't believe so, no.
Q. You instructed them on 7 July 2016, you received a draft report 18 October 2016 and a final report 28 November 2016. This was a long period of time, this review?

A. It was.
Q. During that time, there was no proper investigation taking place into Letby and her role in respect of the deaths, was there?
A. We were following the process that had been initiated with the College. We were following the process that they had recommended in terms of a further Casenote Review, and I would have to say that the basis of the College report, after they had consulted with the paediatricians, did nothing to raise the level of concern because of the terms that they used in their report.
Q. Let's look at how you managed the receipt of the report. Doctors Brearey and Jayaram were given one hour to read the draft report in November 2016, weren't they?
A. I don't believe that that time limit was imposed. I gave Dr -- and this was on the College's advice, that it should be shared with some of the senior members but that was purely for a fact checking and confirmation, so --
Q. They could only check facts if they saw the whole report and there were parts of it that they weren't shown, weren't there?
A. On -- the implication from the advice from the

College was that the "green text", as they described it, was confidential and not for wider sharing.
Q. Well, let's put the green text, so people know what you are saying here. INQ0005273, pages 8 and 9. I take the point in your statement, Mr Harvey, you don't like the use of the word "redacted". What you are saying there is the green text was something they had highlighted as different and you took that out, that's why you took it out before people saw the report?
A. On the College advice, yes.
Q. You had commissioned the report though, you could share it with who you wanted to, they couldn't tell you what to do about that, could they: you are the person paying for it, you are the person who knows who needs to see what within your organisation?
A. That -- that is true but, having commissioned that report from a Royal College, having had a team that was a team of experts and that team included a lay member, who was, albeit inactive, but a barrister.
Q. So what did you draw from the fact that she was described as a barrister, albeit a non-practising barrister?
A. From that and her -- the description of her activities with the NMC and NCAS, I took it that what was being presented was reasonable and appropriate

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

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

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

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

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

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

A. That that's correct.

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

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

this review."

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

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

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

A. Yes.

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

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

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

have a read of that:

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

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

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

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

A. I -- I believe so.

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

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

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

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

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

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

A. I am unable to answer that question.

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

A. It did.

Q. So why didn't you?

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

Q. Well, there's no documents --

A. I can't recall.

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"In the light of information ..."

Do you see that paragraph below the green text?

A. Yes.

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

It wasn't an investigation you could conduct, they couldn't conduct it but the police could conduct it. That was another moment when it should have been obvious that you contacted the police; do you agree?

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

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

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

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

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

Q. What needed clarifying?

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

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

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

Q. Of every death because --

A. Yes.

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

A. Yes.

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

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

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

If we can make it larger, thank you.

You are giving a verbal update and you say:

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

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

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

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

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

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

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

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

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

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

explicit.

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

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

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

Q. What would you say then?

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

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

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

A. I -- I do.

Q. Why didn't you know that then?

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

Q. That can --

A. And that would influence how we would view the situation.

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

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

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

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

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

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

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

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

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

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

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

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

A. Given the expertise of the College Reviewers, yes.

Q. What expertise, can you expand on that?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. I cannot recall, based on that email.

Q. Don't worry about the email.

A. Yes.

Q. You know now. Had you done that?

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

Q. I'm sorry?

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

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

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

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

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

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

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

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

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

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

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

Q. Well, you apologised at the beginning

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

A. I did.

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

A. Yes.

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

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

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

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

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

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

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

Q. The Royal College had suggested that:

"When these further forensic Casenote Reviews were conducted with expertise in neonatology and pathology, it should ideally have case notes, and electronic records should ideally be paginated to facilitate reference and triangulation."

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

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

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

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

A. Yes?

Q. Proper consultation between clinicians and pathologists?

A. Yes.

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

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

A. No, I didn't.

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

the paediatricians, did you?
A. No.
Q. We know Baby A had died and was a Twin and his sister had also deteriorated and collapsed, and we know Baby E had died, and he also had a twin, Baby F, and you know that O and P were part of triplets. So, at the time you were asking Dr Hawdon to look at this review the concept must have become clearer that multiple births were being affected two pairs of twins and triplets as well.
Whilst Dr Hawdon was asked to look at Baby A and E, she was not asked to look at babies B and F was she?
A. No.
Q. Had she been invited and someone given thought to the fact, well, let's have the twins, in both cases, it may have been much more value. Even at that stage, with just a Casenote Review, looking at E and F would have been much greater value, wouldn't it?
A. Yes, it would.
Q. You said yesterday you had gone through the notes and seen the insulin report and where it was. As night follows day, Dr Hawdon would have done, wouldn't she?
A. She would.
Q. You had also in your Silver Command got

different people looking at case notes and reviews and yet somehow Baby F wasn't looked at, in your Silver Command exercise.
So when you say yesterday it was a collective failure or the paediatricians didn't spot it, neither did your Silver Command exercise, did it?
A. No, and the Silver Command exercise, I believe, the identification of the notes for review was carried out by Dr John Gibbs and by -- I believe Ann Fisher, the nurse who assisted him in reviewing.
Q. If they looked at Baby F, you don't know that either. It doesn't seem to be very clear. They were looking at babies that were transported out, I think is their explanation?
A. Yes.
Q. It's not clear what the focus was on any review or why various babies were chosen. That's something that required the police, didn't it, who look at all the babies forensically, carefully and get independent expert evidence to do so. That is what this cried out for?
A. At the time, this was primarily about reviewing the babies who died, so they were part of the Jane Hawdon review. I believe that the baby -- the four babies that she reviewed who had collapsed were those

that had been identified in the course of Ruth Millward's earlier review of incident reports and absent incident reports.
Q. Can we go now, please, to INQ0058920, page 1. This is moving forward in time, February 2017, and you write to Dr Subhedar and say:
"As you are probably aware, the RCPCH Review has leaked to The Sunday Times. I believe that we have forwarded embargoed copies to Commissioners, regulators and the network."
Embargoed copies: do you mean the ones without the green text?
A. I would imagine so, yes.
Q. Yes, so your Commissioners are not aware of that or your regulators either; might they have been interested to know that?
A. Yes.
Q. That there was a misconduct allegation that needed investigation, somebody who's commissioning services from the hospital might want to know that, on behalf of the mothers that are going into that hospital and having babies; do you agree?
A. Yes.
Q. So why did they get the embargoes or not that information: what were you hiding there Mr Harvey?

A. I don't believe that we were hiding anything at that time. I think that we were going through the process of trying to get a complete picture of the position. I think that, as I have already alluded to, we were influenced by the nature of the Royal College report and the reference to gut feeling, which underplayed the situation and didn't do anything other than, I think, push us in the direction of trying to get more information.
Q. That was your view. Others were entitled to make their own professional assessments on a proper, full, transparent basis of the information that you had, weren't they? You deprived them of that, the Commissioners, the regulators?
A. And I -- I think as I said yesterday, yes, I should have had a conversation with Specialised Commissioning at an earlier time.
Q. When we look, please, at INQ0103192, page 1, we see Dr Subhedar's response to you, in respect of the RCPCH Report and Jane Hawdon's review, and you say you respected Dr Subhedar, the Inquiry has heard from Dr Subhedar. He points out at paragraph 2:
"My own interpretation of the 13 deaths included in her review suggests there were four cases in which there is no clearly identified cause of collapse death, and

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

He then says:

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

That was a recommendation where she said:

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

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

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

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

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

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

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

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

Q. Did it take you away?

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

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

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

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

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

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

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

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

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

something out generically?

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

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

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

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

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

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

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

A. In terms of a general request, with regard to the likelihood of identifying air embolus as a cause of death, yes.

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

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

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

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

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

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

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

A. Yes.

Q. -- the impact, the clinical impact?

A. Well, both size and --

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

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

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

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

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

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

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

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

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

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

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

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

deaths around the deaths?

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

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

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

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

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

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

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

Q. Page 26, you have added various details:

"Letby: Registrar Harkness called and in attendance."

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

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

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

A. Yes.

Q. So why are you doing this? That can go down

now, thank you.

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

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

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

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

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

A. I was looking to try and establish the causes of death. I -- as a doctor, as a clinician, would commonly be faced with those -- those scenarios in terms of obviously, most commonly, natural causes of death and this was, to a large degree, a clinical review. It was the fact that, despite all that, we couldn't come to an answer and these documents were prepared really to try and understand the whole detail that we had regard, with regard to every baby to discuss with the paediatricians, to discuss with Dr Subhedar and, on the back of those conversations, it was apparent that we had to speak to the police.

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

A. No.

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

A. I am -- I'm not sure that that is supported by the documentation. There are multiple meetings that

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

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

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

Q. Can we have on screen, please, INQ0003135, page 1, and this is an email to you from Dr McPartland, and it indicates how little time she was under the impression she needed to give to this review that was happening about the postmortems and she says clearly:

"It's not a full and formal medico-legal review. That would involve a second report and take about four hours of work per case."

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

A. Yes.

Q. Had no idea what you were really interested in:

"If you require an analysis of this depth, it is probably best performed independently by someone from another centre."

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

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

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

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

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

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

A. I do not believe that they were misled.

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

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

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

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

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

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

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

A. I --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Sorry?

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

A. Dr Brearey and Dr Jayaram were threatened with

the GMC by Letby's father. At no point did I threaten any of the paediatricians that I would consider or was going to report them to the GMC, nor did I have a conversation with the liaison adviser of the GMC who I met on a regular basis that I was even considering that, although I might have highlighted that there was a risk that they could be reported by someone else.

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

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

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

"I do clearly recall that almost his parting words, I had put away my notes and was standing to leave, were, 'You need to refer those paediatricians to the GMC'. I replied by asking why he had not done so and he

retorted jokingly that he had not wanted to spoil his clean sheet."

Do you remember saying that to Susan Gilby?

A. I did not say that.

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

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

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

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

"Potential deal with Steve."

What did that refer to? Here he is the lead neonatologist, her going back on the ward. That was

going to cause problems, wasn't it? So what does "potential deal with Steve" refer to?

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

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

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

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

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

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

A. At no point was I party to a conversation about how we would manage out any of the paediatricians from the unit.

Q. Did you know whether other members of the Executive Team had had those conversations?

A. I wasn't aware of any conversations with regard to that, no.

Q. Well, let's have a look at INQ0015642, page 48. It's a bit later in time. This is by May 2017. It's a note of a meeting, Mr Chambers, Mrs Hodkinson. We see there:

"Plan re management: GMC; actions from grievance; action plan to manage out; follow up call."

Dr Brearey, as lead neonatologist, was becoming a problem, wasn't he, when you all wanted to get Letby back on the unit?

A. I didn't see him as a problem.

Q. Did you know that Mr Chambers and Mrs Hodkinson were discussing that?

A. No.

Q. Really?

A. Really, I did not.

MS LANGDALE: I think that might be a convenient moment for a break, my Lady.

LADY JUSTICE THIRLWALL: Very well. We will come back in 11.45.

(11.26 am)

(A short break)

(11.44)

MS LANGDALE: Mr Harvey, we were examining or moving on to the treatment of the Consultants. The grievance process: what did you understand the grievance was about at the time?

A. My understanding was that the grievance was about the way Letby had been managed with regard to being taken off the unit.

Q. Was it about what she was told about why she was moved off the unit or what she had allegedly done: what was it, as far as you were concerned?

A. As far as I was -- as far as I understood, it was with regard to how the -- the Trust had managed her off the unit, with the information that she was given with regard to why she had been moved.

Q. Had the Trust been open with her or transparent about why she had been moved, as far as you were aware?

A. As I understood it, the basis of the grievance was that she -- she hadn't been.

Q. Did you know at the time how the letters had gone out to her about how she was being moved off the unit?

A. I wasn't aware of those, no.

Q. But you understood the grievance was about

those kinds of letters, what she was told?

A. Yes.

Q. Did you at any time think that the grievance was about what the doctors had done or said and how they had behaved?

A. That wasn't how I perceived the grievance, no.

Q. Who were you relying on for information about the grievance before it started, around the time it started?

A. Ultimately, because it involved Letby, the information I was getting was from HR, so Sue Hodkinson, and from nursing, so Alison Kelly.

Q. So at no time did you think, from talking to them, that the grievance was about how the doctors had behaved or what they had done or said?

A. That wasn't my perception at the time, no.

Q. We see your interview for the grievance, INQ0003156, page 1, and, if we can go to page 2, we see halfway down, Dr Green asks you:

"In the analysis table, the column showing 'Doctors removed', were you aware?"

So everyone understands, there was a table, wasn't there, that Eirian Powell had attached to the Thematic Review, highlighting the nurses present on duty or on the shift before, and then another column had been added

to that: which doctors were --

A. Yes.

Q. -- around at the time?

So when you were asked, "The column showing 'Doctors removed', were you aware", you say, "I wasn't aware of that", because, as far as you were concerned, you had seen both, had you, whether doctors and nurses were there or what?

A. At this -- at -- currently today, I'm unsure but I -- given that this was a timely comment, I can only stand by the comment I made there.

Q. Yes. So were you aware the doctors were removed, and you say, "I wasn't aware of that". So whatever he was referring to wasn't something -- did you understand the question?

A. Well, only insofar as he was asking if I had known that a column with the doctors had been removed.

Q. You then say:

"There's been a number of behaviours on the ward that do not reflect too well. I had to go and speak to RJ that some of the trainees had been making reference to 'angel of death' but no specific person was named. There was behaviour in clinic, it's being heard talking about killing babies on the unit. Had to speak to Ravi about comments and killing babies. This was not denied

and RJ did accept that it was inappropriate."

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

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

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

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

Q. Who told you that?

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

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

A. Quite possibly, yes.

Q. Well, which one?

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

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

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

Q. So no specific person named?

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

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

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

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

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

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

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

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

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

there isn't anything to find."

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

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

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

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

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

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

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

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

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

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

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

A. Ravi Jayaram had concerns about the increase in mortality.

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

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

a public place.
Q. Was it ever suggested to you it was in a public place, talking to another member of staff in a clinic?
A. Well --
Q. It doesn't mean it is overheard, does it, suggested?
A. If it's in a clinic, it has potential to be overheard.
Q. Yes, but it has not been stated that it has, but speaking to go a colleague about safeguarding concerns is a totally valid thing to do, isn't it?
A. In those circumstances yes. But --
Q. Well, that was the circumstance.
A. But, well, that wasn't as described to me when I spoke to Dr Jayaram.
Q. You, at the top of this page, make a comment, Mr Harvey:
"There are issues with nursing with regards to investigations compared to medical staffing. We have measures specifically supported by the GMC and NCAS, if there are doubts speak to them. RC then would manage resistance from the Consultants. If I were a doctor, then there would be a period of supervised practice and development but there was a block on that as the

Consultants were not prepared to have the nurse on the unit and, if we do, they said the police would be called."
You are trying to make that their concerns about her coming back on the unit an issue between doctors and nurses, that they are treated differently; do you see the top paragraph?
A. I do.
Q. Why are you saying that?
A. I am saying that because that was my perception at the time. I would accept that I have put in a factual inaccuracy in saying there was a block by the Consultants. I did not at the time understand that, in fact, there couldn't be supervised practice because the nursing staff didn't have the numbers to be able to support that as an option.
Q. If you go to the page before, you are telling him as well:
"There was a threat to go to the police from the Consultants. Execs considered do we go to the police?"
You are describing these Consultants as, in some way, high-handed doctors, Consultants, who think they are different from nurses in processes and procedures. You are creating an impression, aren't you, that there is a chasm between the Consultants and the nurses --

A. I --
Q. -- in the way the Consultants think about nurses?
A. I don't believe that that's what I was doing and, in fact, directly after that, it all, I also say that the Executives had considered should we go to the police.
Q. You have told us a moment ago what you thought this grievance was about. Why is it that you are talking at all about the Consultants and how they thought there was a difference, you say, between how doctors and nurses were treated and not recognising it; why is that even a feature in this interview?
A. Simply because that was my interpretation of the answers that were going with the questions that were put to me.
Q. So the questions that were put to you were getting you to criticise the doctors, and that's what you comfortably, it would appear, do, don't you? Look at your answers.
A. I wasn't specifically aiming to criticise the doctors in the course of this.
Q. Did you appreciate your comments were relied upon to do that very fact at the end of it?
A. I would accept that they -- they could be

interpreted in that way.
Q. You accept that you criticised the Consultants and that was used against them; is that what you accept?
A. I accept that there was comments with regard to behaviour. I, again, would simply say that the sentence that's highlighted with regard to the threat to go to the police is also associated with the fact that we also, as Executives, had considered should we go to the police.
Q. Look at the next question on page 2 from Dr Green:
"Did you hear about Jim McCormack telling Eirian Powell she was harbouring a murderer.
"No, I hadn't heard that."
What did you think you were being asked that for? What's the relevance of that to the issue about how Letby had been managed?
A. I -- the only interpretation of that is that it's extending into the medical staff.
Q. The grave irony, of course, about that comment, upon the focus, of which was being used here against the Consultants, is that it was true: she was in the hospital and you were harbouring a murderer. She wasn't being investigated by the police. But this comment is being used in a different context, isn't it,

to seek to invite criticism of the Consultants, including Mr McCormack now; do you agree?

A. It could be interpreted that way, yes.

Q. It's the only way, isn't it, Mr Harvey? I gave you a chance, and you took it fully, to explain what you thought this grievance was about and here you are, on page 2, criticising the attitudes of Consultants towards the nurses and being asked about comments and whether they are inappropriate when, in fact -- in fact -- whether they are inappropriate or not, they have turned out to be true: she was killing babies and the hospital was harbouring a murderer?

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

Q. At the time you knew the suspicion.

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

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

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

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

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

Q. They say:

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

Then you are effectively saying:

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

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

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

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

A. Sorry, when?

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

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

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

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

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

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

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

This is you in November:

"Have you had any previous cases like this?

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

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

A. No.

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

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

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

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

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

Or did you just answer the questions?

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

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

"I am emailing yet again."

Did she often directly email you?

A. No.

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

A. Very few.

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

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

A. No.

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

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

Q. So you get an email.

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

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

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

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

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

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

A. Yes.

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

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

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

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

A. That is absolutely not the case.

Q. Well, we have gone to the documents.

A. As I have stated I was reliant on the expertise of the advice of the Royal College. I accepted what they said on face value because it appeared to be backed up by appropriate expertise and knowledge and I took that as what was normal practice.

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

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

Q. Why did you have Mrs Hodkinson there?

A. Because I believe that, actually, it was Mrs Hodkinson who had advised that we needed to meet with him.

Q. So if we go to INQ0003094, we see your letter in response, subsequent to that meeting. Mrs Hodkinson gave evidence that you were heavy handed in your approach or this letter was heavy handed; do you agree? Particularly if we highlight paragraph 3, and the last two sentences of the one above?

A. I -- I accept that that could be read as heavy handed, yes.

Q. "The final report, will be shared with the clinical teams as well as others but this will be done in a controlled way, by which I mean as an order of priority and sharing the information whilst ensuring appropriate support for those with whom it is being shared."

Your order of priority was Executives first, to look at the documents, the RCPCH Report; two Consultants for a limited period of time thereafter; and the full report to Consultants, many months after. That was your controlled way, wasn't it?

A. That wasn't what I was implying at that point, no. It was simply making sure that we had an appropriate order of priority. It was important that

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

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

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

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

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

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

A. Yes.

Q. Justified?

A. Yes.

Q. Then we see at paragraph 7:

"No party refutes that concerns were raised by the Consultants, in particular Stephen Brearey, to the Executive Team around a perceived commonality between

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

Was that accurate?

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

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

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

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

A. I think eventually it was, yes.

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

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

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

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

A. I don't believe it is.

Q. What about:

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

Was that justified?

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

Q. Did you see this at the time?

A. No.

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

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

Q. Do you agree, leaving the grievance now, you contributed to criticisms unjustifiably of the Consultants in the context of the grievance process? That's where your contributions ended up: adding to the criticisms of them, that they had made various remarks, including Jim McCormack, that they shouldn't have made, and somehow, at the end of that grievance process, Consultants were being asked to apologise to Letby?

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

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

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

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

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

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

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

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

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

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

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

A. I'm sorry?

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

A. I wasn't.

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

A. I wasn't.

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

A. No.

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

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

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

A. Yes.

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

A. No.

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

A. I accept that.

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

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

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

A. Yes.

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

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

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

"Have you spoken to Ravi?"

You say:

"It's not appropriate behaviour. Not had it reported to me subsequently. SH [Mrs Hodkinson] and

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

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

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

Q. Who asked you to be in that meeting?

A. I'm not sure whether it was Tony Chambers or Sue Hodkinson.

Q. Can we go to INQ00 --

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

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

MS LANGDALE: Sorry.

LADY JUSTICE THIRLWALL: No, that's --

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

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

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

A. Yes.

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

"Dear Ian ..."

So we now have Ms Letby emailing the Medical Director:

"Dear Ian ..."

Read the content of the email before I ask a question. She says:

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

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

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

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

Q. What did you do with it?

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

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

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

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

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

A. Yes.

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

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

Q. What made you think it was inappropriate?

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

Q. What is it about the tone?

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

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

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

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

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

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

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

Q. So you received that. What did you make of

all of that coming your way?

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

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

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

That is what you say to them: why?

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

Q. Were you bullying and intimidating them, Mr Harvey? If they are accepting in conversation with

you anything they have done is inappropriate, I suggest you were bullying and intimidating them?

A. I wasn't intentionally doing that.

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

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

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

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

"As Steve and I are the only paediatricians named in the grievance, we alone have been asked to engage in mediation process. However, if the mediation process is

to facilitate the reintegration of Letby and to be an enabler for safety in working, we suggested all seven Consultants should be part of the process, as all of us have expressed the same sentiments explicitly. You explained the recommendation for only two of us to be involved came from the external person who had been asked to review the whole grievance."

He concludes:

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

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

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

Q. Dr Jayaram says he spoke to you in an unscheduled face-to-face discussion, at some point between his initial meeting with the mediator and the planned meeting, and he again expressed concerns about

the mediation process and Letby returning to work. That's right, he did have a follow-up discussion, didn't he --

A. Yes.

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

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

Do you remember that?

A. I don't.

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

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

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

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

"Thanks for coming in."

You say:

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

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

A. Yes.

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

A. Um.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. I don't recall making that comment.

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

"Wondered what they are plotting."

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

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

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

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

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

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

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

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

You tell us in your statement at paragraph 609:

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

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

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

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

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

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

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

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

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

What did you mean by that?

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

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

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

A. I was subsequently aware of that letter.

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

an answer to the concerns raised --

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What's "the case"?

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

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

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

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

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

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

reviews and investigations had been completed.

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

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

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

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

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

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

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

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

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

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

Over the page:

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

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

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

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

A. To the board, no.

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

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

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

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

agrees."

Dr Jayaram replied:

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

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

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

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

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

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

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

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

LADY JUSTICE THIRLWALL: Yes, certainly, 45 minutes?

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

(1.06 pm)

(The luncheon adjournment)

(1.48 pm)

LADY JUSTICE THIRLWALL: Yes.

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

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

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

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

A. I -- I will have done.

Q. Was it true?

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

had been deliberately harmed?

A. I do not believe that it was deceptive. I believe that it was stating the position as we understood it at that time.

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

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

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

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

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

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

Q. Duty of care to who?

A. Well, duty of care to staff.

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

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

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

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

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

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

A. She did.

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

A. I do.

Q. You do: you do remember that?

A. Yes.

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

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

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

A. Yes.

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

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

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

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

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

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

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

Q. You never did, did you?

A. I fully accept that that communication was

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

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

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

A. It is now apparent, yes.

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

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

have contributed.

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

A. No, absolutely not.

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

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

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

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

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

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

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

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

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

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

If we go over the page, Mr Chambers states:

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

You attended the meeting on 15 February 2017 with

the Coroner, yes?
A. Yes.
Q. Can we have that on screen, please, INQ0002048_0102. You will no doubt have seen this attendance note. Can you just cast your eye over that and tell us if you agree that's an accurate note of that? *(Pause)*
A. I believe so.
Q. That is an accurate note? We will be hearing from Mr Rheinberg next week and, whilst it may be the case the green text went through to the Coroner's office, he has no recollection of reading that before the meeting and was reliant on what was said in the meeting. There is nothing that's said verbally that puts centre front, does it, that there are suspicions and concerns of a nurse deliberately harming a baby?
A. I recall that either Mr Cross or I, in passing the paediatricians' letter across to Mr Rheinberg explained the background to that letter and the paediatricians' concerns. I'm also aware that there is documentation within the Inquiry that confirms that part of the bundle that Mr Rheinberg received was actually the full RCPCH Report, which included reference to the paediatricians' concerns.
Q. Thank you that can go down now.

If we move then to a meeting on 27 March 2017, INQ0003150, page 1, and, to put it in context when it comes up, this is when the paediatricians describe feeling desperate with their jobs under threat. Dr Brearey says he's looking for another position in another hospital, and Letby had come on to the ward to have tea and reorientation updates. That's where we are at in the timeline.
We see on page 1, Dr Jayaram:
"There have been deaths ..."
Then the next page:
"JM [Julie Maddocks]: given the information on the balance of probability, illegal activity has caused the deaths."
You say:
"Or reasonable doubt."
Then over the page, page 3, you say:
"You have had access to everything, including the reference to the HR processes that were redacted."
You are referring there, they have seen the green print of the RCPCH:
"Refer [over the next page, at page 4] with three options: contact the police; internal with NS support ..."
What does "NS" mean?

A. I can't say, sorry.
Q. "... or other experts conduct further review, eg Janet Rennie, if anything to be gained.
"Dr Jayaram: What would be the level of depth?"
Then page 5, you say at the bottom:
"Stephen Cross and I have expressed and advised the teams concerned. We met the Coroner. This is the second occasion we have met with Mr Rheinberg and Alan Moore. We have shared the review and a copy of your letter and specifically called out the team's concerns.
"NR advised we should leave it with him as he was reviewing his jurisdiction. It's been one definite Inquest and two potential. No indication of reopening any of the cases.
"Mr Chambers: he phoned police or acted within normal Inquest process. He has had everything we and you have had."
Over the page, you saying:
"Absolutely, why we met with him. At some point we need to meet with the parents."
At that stage, what were you thinking you needed to meet with the parents to say?
A. At that point, I was recognising that we had not had the opportunity to meet with the parents to discuss that -- the reviews that we had had to date.

I believe the background of this meeting is that it followed the meeting that I had had with Dr Subhedar and some or all of the paediatricians having met the Coroner, which they expressed their continuing concerns, at which they presented those babies for whom they still had major concerns and, on the back of which meeting, I felt that there was nothing further for us to do, short of speaking to the police. And I believe it was on the back of me describing that situation to my Executive colleagues and to Tony Chambers that this meeting, with some of the paediatricians and with the network, was scheduled.
Q. The conference with Mr Medland was scheduled, wasn't it, for the paediatricians to meet him and, if we go to INQ0014378, page 1, we see your background summary document that was sent to Mr Medland, as part of his instructions. We see on page 2, at the top:
"Two Triplets born, died on 23rd and 24th. Exacerbated the concerns there being no obvious cause for the babies' collapse and it was alleged that the nurse referred to above was involved in the care of these babies."
Why do you say "alleged"?
A. Because I didn't know for sure what level of care, whilst -- had -- had been associated with her at

that time.
Q. The 30 June meeting made it very clear to you that she was looking after Babies O and P and, indeed, she had entered the Datix, which was the incident reported for P. You knew that she was the nurse who was present with O and P., so why do you say "alleged" and that you didn't know about the association: were you minimising it, playing it down?
A. No, absolutely not.
Q. So you had forgotten when you wrote that, is that the explanation: you had forgotten?
A. Sorry.
Q. You had forgotten that she was the nurse caring for O and P when you wrote it?
A. I was aware that she was on the unit. I -- I wasn't and hadn't checked to what extent she was responsible for their care but was making clear that she -- she was there.
Q. On page 4, at the end the summary:
"In summary, we can demonstrate we have taken the concerns raised seriously. We have open and transparent with the Coroner, our regulators, parents and the public."
Pausing there, I think you accept you weren't open and transparent with the regulators or the parents and,

therefore, the public; is that right? You now accept that you were not open and transparent with the regulators, parents and the public; you say you were with the Coroner?
A. I -- I -- I -- I accept that we -- we weren't as open as we should have been. I believe that we were open and transparent with the Coroner. I believe that we did pass on all the information to him.
Q. You covered up from the parents and the regulators the suspicions and concerns about Letby?
A. I wouldn't describe that as covering up. I believe that was based on the -- the conflicting cares that we were associated with at a time when we still weren't completely sure what the situation was.
Q. That was what you describe as motivating the cover up but you agree you withheld that information and concealed it because of the reasons, you say, that you had a duty of care to a member of staff?
A. I wouldn't describe that as a cover up.
Q. Mr Cross' document, INQ0006123, page 1, he summarises it thus for Mr Medland, on 3 April:
"No evidence to justify criminal investigation. However, in the spirit of openness and transparency the matter is being reported to the police."
Was it your view at this time that it simply needed

to be reported to the police with a view to excluding any unnatural causes. Rather than reporting concerns, you just wanted to exclude unnatural causes, something like that?
A. No. I wasn't -- I wasn't aware of this rationale document. I hadn't seen it until this Inquiry. I think my view was summarised in the last paragraph of the document that has just been taken down, my summary, and that was that we required the assistance of the police.
Q. 13 April 2017 is a board meeting. If we can have, please, INQ0003236, page 1, Mr Medland attends. Page 3, Mr Wilkie is concerned, look at the top:
"... if we can truthfully argue there has not been a delay and it has not been possible to do sooner."
You say:
"Due process. We have done everything in a reasonable and explicable order but are beholden to other delay."
Sir Duncan said:
"The board need to decide if we feel the work took too long. Did it answer Dr Hawdon's report?"
Mr Harvey said:
"That's why I met with the Consultants with the review, to come to one view. Their view doubles the

number of cases where there are concerns and they could not define what they felt was a forensic view."
So you are saying there you know that Dr Hawdon's report -- the Consultants are still concerned and they have more cases where there are concerns, just as Dr Subhedar said. Then you say they could not define what they felt was a forensic review. Who are you suggesting didn't know how to define what was a forensic review?
A. I suspect that that is probably a typo and probably reflects Dr Hawdon's response that Mr Medland -- excuse me -- had picked up on. Dr Hawdon had made reference to a forensic review and Mr Medland had advised that we ask what was meant by a forensic review, in her opinion, and the response from Dr Hawdon was, "Well, it can, effectively be whatever you want it to mean".
Q. If you look at page 5:
"Mr Harvey stated he met with one of the sets of parents and their concern was that we will turn their world on its head and they would start grieving all over again."
To be clear, that wasn't any of the parents of the babies named on indictment, but you are saying that you spoke to some parent, did you? You don't give us

a name; tell us what you mean there, who have you spoken to?

A. I'm sorry, how do you mean?

Q. You are telling the meeting you had spoken with a set of parents who was concerned that their world would be turned over and they would start grieving all over again.

A. Yes. It was a concern that had been expressed on the back of fresh revelations that had come out in the press. The story in The Times had reopened their wounds, their grieving process, and I was simply highlighting the impact that all of this was having and would continue to have on the parents, and that we needed to be aware of that.

Q. It would be inevitable that that would turn their world on its head but no one had suggested to you they wouldn't want to know the truth, would they?

A. And I wasn't suggesting there that we should hide it to protect them.

Q. So why were you suggesting it at all in this context?

A. I wasn't. I was highlighting that this was an issue that we needed to be aware of in approaching the parents, that it was going to be a very difficult and a very stressful time. This wasn't an implication

that we should be paternalistic and protect them.

Q. It's clear over the page, page 6, to complete it:

"Sir Duncan added we are still searching for explanations. Not saying she's still in the frame but it is a legitimate point that the forensic review be conducted."

So there is still the need for investigation, that is what the Chair of the board says?

A. Yes, and my understanding from before Mr Medland was instructed, through to this, was this was all a prelude to contacting the police.

Q. So your view is that, on 13 April, the plan was to go to the police; is that what you thought was going to happen?

A. My view was that, prior to the instruction of Mr Medland, we were going to the police and I think that is borne out by the final paragraph of the summary document I prepared for Mr Medland.

Q. Then after this meeting, did you still think that was the case, after this board meeting?

A. As far as I was concerned, that was our only option.

Q. Can we go please to INQ0101091, page 739. This is a meeting between Executive Directors,

Mr Harvey, on 19 April 2017 and Financial Officer, Simon Holden. This is his note, Chief of Finance. We see halfway down Executive Directors:

"A broader forensic review of four cases recommended, similar to CDOP [Child Death Overview review] to investigate."

Were you discussing the Child Death Overview Panel investigating those cases, was that a plan at that point?

A. I think that is a reflection of one of Mr Medland's recommendations, that a way to approach the police would be through CDOP, on which Mr Wenham sat.

Q. Why does it mention four cases recommended then. It looks as though there is a discussion of investigating cases or not?

A. I think that relates to Dr Hawdon's review.

Q. Next document INQ0003076, page 5. Meeting, Friday, 12 May with the police. If we look halfway down the page:

"Ian Harvey has repeatedly challenged the clinicians, asking if there has been any acts which Countess of Chester needed to be aware of which would effectively give a case but repeatedly they have said no."

Why did you contribute that to the meeting?

A. In meeting with the police, I felt it was important that we presented a comprehensive picture.

Q. Is that comprehensive?

A. Well, I think the whole document ends up comprehensive. I mean, a single sentence in isolation is never going to be comprehensive but I feel that in subsequent paragraphs there is further detail.

This is simply calling out that they had their concerns about the repeated presence of Letby in relation to deaths and collapses but, to that point, they had not, at any point seen, nor did they report, any other evidence that was definitive or even indicative of a malicious act.

Q. Next page, Mr Harvey. Page 6, third paragraph down:

"Ian Harvey added Countess of Chester are mindful they do not want to use Cheshire Constabulary as a HR process for staff. If you place yourself in the mindset of paediatricians to see what the motivation is, there is a strong sense of personal accountability that a clinician feels and when there is no clinical explanation they feel uncomfortable. It is unusual that they have a collective mindset. This is a problem which the Countess of Chester need to manage as it is not a criminal issue."

Why did you say that?
A. I suspect that the last sentence is a typo, in saying that it would be a problem we would have to manage if -- if it was not a criminal issue.
I am initially paraphrasing the Coroner in saying -- he told us that he wasn't a QA process for the hospital. I was recognising that we weren't relying on the police to help us with staff but I was also calling out that the paediatricians felt that strong sense of personal accountability when they were faced with a situation which they can't directly explain and with which they are extremely uncomfortable. In this particular situation, the high mortality.
Q. Page 8, please. You wish to raise two issues at the top.
"When the issues were first raised by Stephen Brearey, it was held under the Speak Out Safely policy that he had protection as a whistleblower."
Not true, would you agree?
A. I accept that that was only actually enacted later on in the process, yes.
Q. Why was it even relevant to raise that?
A. I -- I think it was just part of a comprehensive conversation and it was to indicate that, certainly, albeit later than should have been the

process, Stephen Brearey had that protection.
Q. Mr Wenham gave evidence to say that, at the meeting on 12 May, it appeared that the Executives were trying to shut the doors on the investigation; do you accept that?
A. No, absolutely not.
Q. When you read the contributions you made now, do you understand why that may be the impression given?
A. No, I don't because, if you read the notes as a totality, I believe it is clear that Mr Chambers was pushing the police to proceed.
Q. Your contributions, I am asking you about. As a Medical Director, when you read all of your contributions?
A. I was simply providing factual background, and I was not trying to influence them one way or the other. I was giving them the basis of coming, and I wouldn't accept that I was actually trying to dissuade them.
Q. If we go to, please, INQ0014678, page 1, you update Margaret Kitching, NHS England on 12 May:
"Just wanted to update you ... they are minded not to hold an investigation. Firstly, they don't feel there is evidence of criminal activity and, secondly, they are mindful of the effects on families."
In the second paragraph, you say:

"My own feeling is that, unless there is something that the paediatricians haven't disclosed previously that evidences criminal activity, there will not be an investigation and the police will assist us in a message that will allow us to close down the speculation here and deal with the issues of culture."
That sums up the contribution you made to the meeting and what you thought would be the effect of the meeting, doesn't it?
A. No, it doesn't. That sums up the feeling that I and, I believe he reported yesterday, Tony Chambers had from the conversations that we had had with the police with their what seemed to be reluctance to initiate an investigation, their asking if there was any other organisation that we could take this to and, at the close of that meeting, as Tony Chambers had alluded to, that uncertainty that led to him saying that, before you make a final decision, it is imperative that you speak with the paediatricians.
Q. Fortunately, of course, Dr Jayaram had communicated directly and, pursuant to a meeting with the paediatricians, the investigation was launched and the paediatricians' concerns were as they had been relayed to the Executives. What do you think was different: why did they understand the need for forensic

investigation and you did not?
A. I believe that they were in a position both to -- I believe they received further information. I hadn't, at this time, been aware of the reports with regard to Baby K, although I believe others did. I am also aware that, when we went to the police, we were in a position to say, "Well, whilst it falls short of a police inquiry, we have taken every reasonable step that a hospital could do and we cannot explain the increased mortality to the satisfaction of, at this point, the most important people", that being the paediatricians.
Q. INQ0107034, page 35. It is a statement of Michael Gregory, Medical Director for Specialised Commissioning. You have accepted, Mr Harvey, that you were not frank with the Commissioners of Specialised Services. Can we just read, please, the reflections from 136 to 141 of this statement. *(Pause)*
He says that he wasn't informed, you weren't open. He said, at paragraph 138:
"Specialised Commissioning was not informed that the Consultant paediatrician concerns related to one individual. If I knew this in hindsight I could have pressed the hospital further. However, it's difficult to press on something that I was not informed about and

I had limited authority in my role when dealing with the hospital Medical Director. When I raised the possibility of an individual having disproportionate involvement, this was dismissed by Ian Harvey who informed me that they had undertaken multiple reviews and discounted this as a possibility."

Paragraph 140:

"Throughout the relevant period, Specialised Commissioning was willing to offer the hospital support, however what support we did offer was not being taken. By April 2017, I was growing increasingly frustrated. The Royal College report had a section missing and did not contain the individual case reviews that I thought Ian Harvey had agreed to provide. I felt there was a lack of transparency from the hospital, avoidance of answers and wanting to defer the issues we raised. We were still in email contact with the hospital in April 2017 but, when we asked questions, we did not receive straight answers. My sense was that the hospital was intent in conducting its own process through their board and were evasive in response to our questions. The message that kept coming from the hospital was that we had to wait until they had done things internally. However, what that involved was not relayed to us."

Do you accept, from his perspective, that was the

impact of the failure to be open with them?

A. In the first instance, I would dispute his assertion that he had raised the possibility of an individual with disproportionate involvement. I believe that, in the meeting with him, I had described that. I have accepted that we were slow in sharing information with Specialised Commissioning but I would also dispute the degree to which they pressured to obtain information.

It was not a desire to hide anything from them. It was perhaps an inappropriate degree of concern about documents leaking into the public domain before we had had the opportunity to share them with the people who needed to see them, for example the parents.

Q. We see at paragraph 104 and 105, if that assists you, when he says:

"When I pushed Ian Harvey [paragraph 104] on the involvement of an individual staff member, he stated he did not want to go into any more detail until the hospital had made a significant announcement about the decision they had taken to speak to an appropriate body on the following Monday. He did not indicate what that announcement was, nor what the appropriate body was he was referring to. I don't believe an announcement was made on the Monday. Ian Harvey told me he was handling

a very difficult situation and was asking for more time so that he could handle matters within the hospital. When I pressed him as to what this difficult situation was he indicated that the hospital were having issues with the paediatricians."

In paragraph 105:

"Ian Harvey also seemed to suggest that one clinician had some sort of agenda."

Is that accurate?

A. I don't believe it is accurate, no.

Q. Why would he suggest that? You did have an issue with the paediatricians and you did have a particular concern about how your lead neonatologist on a ward was going to be able to work with somebody he wouldn't mediate with and didn't think should be there. We have gone through the documents, I don't need to repeat them?

A. I was -- I was looking at both paragraphs and I would dispute the extent to which I was pushed. I believe that, given that a more senior Medical Director working with Specialised Commissioning was involved, he was in a position to actually enforce if he felt it was appropriate and I -- I wouldn't have, in those circumstances, withheld anything.

Q. Can we go back to 97 and 98, finally, on this

statement. Paragraphs 97 and 98, which is page 25. It says:

"On 10 January, extraordinary board meeting. I did not know about the meeting. My understanding the board papers were not made public or shared with NHS England. I do not believe the board papers for the meeting were public at that stage. I was not aware that an individual was involved or that a nurse had ever been taken out of the unit [this is 10 January]. Had Specialised Commissioning North been told that an individual had been moved off the neonatal unit due to concerns from clinicians, we would also have expected to have been informed of the decision to reinstate her on the unit.

"We were never informed there were concerns with regard to an individual nurse. In my role, I had experiences with other Medical Directors in hospitals who have rung me up to inform me about concerns with particular individuals. Informing of these concerns and decisions is part of having an open and transparent culture of patient safety, which I came to believe was lacking at the hospital."

He says there he has had experiences of other Medical Directors. Did you ever share concerns with Specialist Commissioners about members of staff, if you

had them?
A. In other circumstances, no.
Q. No. This can go down, thank you.
In the end, Mr Harvey, whatever the systems are in place, it's important, isn't it, in the NHS that the culture is such that people can speak out without fear or concern when they are worried about patients, and do you accept now that you weren't listening to concerns raised and you weren't acting on them, as you should have done in your time as Medical Director?
A. I believe that I was listening.
I accept that I didn't act in, in the way that others wanted me to and I accept that there were actions that I should have taken in a much more timely fashion than I did.
MS LANGDALE: Those are my questions, thank you.
LADY JUSTICE THIRLWALL: Thank you very much, Ms Langdale.
Mr Baker?

Questions by MR BAKER

MR BAKER: Mr Harvey, I ask questions on behalf of the Families of a number of harmed and murdered babies, including, for these purposes, Family C and Family D.
Can I begin by taking you back to something that you said to Ms Langdale, not too long ago. You

described competing duties between the duty of candour and the duty to staff and that isn't quite what Mr Medland said, when he talked about not always well aligned or not always aligned duties of care.
He spoke about a dichotomy, apparently, between patient safety and reputational management.
Now, is that not a perfectly credible interpretation of what he saw in the Trust by April 2017: a tension between candour and safety on one hand and reputational harm on the other hand?
A. I don't recall that Mr Medland actually described reputation in the way that you are perhaps implying.
Q. He said it wasn't in evidence, he wasn't describing it in a superficial way, just pure bad publicity but reputation was part of what he observed.
A. And I refer to one of my earlier answers, that, certainly as far as I am concerned, the reputation of a hospital or a hospital Trust is not some standalone character that one can protect. It is inherently reliant on the safety and the quality of the care that that organisation provides and at no point did I and I am sure any of my Executive colleagues have a level of concern purely about the reputation of the Trust because that's just a house built on shifting sand. That is

never going to work.
It is always going to be underpinned by how safe you are and how good your care is.
Q. You see, I suggest you reached the point by small increments, but by April 2017 a situation had developed whereby the Executives were desperate that the Consultants' concerns do not become public. That is what had happened, isn't it?
A. I don't think this was a desire to obscure their concerns or hide their concerns. Our concern was always how we would be able to come to a consensus with regard to what had caused, if anything, the deaths of all the babies that we were reviewing. And I would say at that point, in April 2017, certainly from my perspective, the decision was that we had to go to the police.
Q. You see, you have been questioned about whether that was actually what the Trust Executives were wanting to do in April 2017, and I won't repeat questions that have been just put to you by Ms Langdale on that point, but I would say the Families do not accept that, that even in April 2017 you were still trying to cover things up, weren't you?
A. No, absolutely not.
Q. In that case, can I take you to a letter that

you wrote to Mother C on 28 April 2017. Now, Mother C, you will recall, you had already had interactions with previously in February and throughout the early part of 2017 because you had been -- you had reached a point where you were having to communicate with her about the RCPCH Report and Hawdon investigations, firstly because she had contacted you or the Trust in July 2016 and then because of The Times *exposé* regarding the Hawdon Report, the RCPCH Report.
You wrote to her on 28 April 2017 and this is at INQ0008973. Now, if what you say is correct, that in April 2017 you had reached the point where you knew that the police were going to be called, and you wanted that to happen, then can you explain to the Inquiry why none of that appears at all within your letter to Mother C?
A. That is because, at that point, that was my own personal view. As is apparent, despite that a being my own personal view, Mr Medland had been commissioned for a report and --
Q. This is 28 April, Mr Medland had been and gone.
A. Yes, and at this point, it was my view that we were. I was waiting, and I can only surmise I was waiting, until we had had the confirmation that we had met and were going to meet with the police.

Q. Those words are weak, aren't they, because it would have been open to you to write to Mother C on 28 April if it were the view of you and all the Executives -- because Tony Chambers told the Inquiry yesterday, and the day before, it was also his view as well in April 2017 that the police were going to be called -- it would have been open to write to her and to say, "I cannot update you at the moment because there are further matters which need to be confirmed and I will write to you soon". Instead, you wrote to her providing her with extracts from the Hawdon Report, which you describe as "An independent external review regarding the care of your baby".

Mother C could have come away from reading that letter with a sense that the Countess of Chester had entirely fulfilled its duties, investigated the death of her baby carefully and that nobody had any concerns beyond those recorded within the pages that follow. That would have been utterly misleading -- I go further, a lie -- wouldn't it?

A. I would say that I was fully anticipating, firstly, that there would be a follow-up meeting because there would be a need, given the nature of the contents of that report, to discuss the contents in detail and I would also -- I think also in the background of my

mind was that I had previously sent one, two letters that had again simply passed on a message of it being a holding message.

Q. Can I give you some words from Mother C that preceded your letter. I'm about to give you some insight into her level of desperation at this time. It's INQ0008971. If we go on to the next page, please:

"Dear Mr Harvey ..."

This is 19 April, some nine days earlier:

"Thank you for your letter dated 3 March. I am sure you are aware that being informed that there were areas of further investigation required regarding our son's case was a surprise to us, given the information we had been given by yourself and Sian Williams up to this point."

I pause there to say that the information that had been given to her by Sian Williams and yourself to this point was that there were no real concerns and nothing required investigating:

"Whilst I am aware that things don't happen instantly and reports and results take time, I really would like to point out how awful this is for us. We are still waiting. Our son would have been two in June. It has been six and a half weeks since your last letter. I really cannot tolerate any further delays. I have

never wanted to seek legal advice over all of this because, as I said in my original letter, we want to move forward. However, this really is prolonging our suffering.

"I would be grateful if you could send me a copy of the report from the Royal College of Paediatrics' review and a copy of the subsequent investigations regarding [Child C]. This really is the least that we deserve at this stage."

Mother C was begging you for answers by this point, having been fobbed off on previous occasions. Now, your response to her was dishonest, if you believed at that point the only solution was to call the police; do you agree?

A. I don't. This letter is heart-rending.

Q. Is what, sorry?

A. Heart-rending.

Q. Yes.

A. It captures an emotion that many will not know, fortunately, and, in reading this, in fact it served to reinforce the effects of delays, and I believe that that would influence how I might write, taking this into account to suggest that there were going to be further delays again.

I -- I -- I wouldn't accept that the letter I wrote

was dishonest.

Q. But how awful, you would have known, it would be to receive that letter from you, which suggests nothing but minor issues relating to care and to find out a few weeks later that the Trust were contacting the police because they believed crimes had been committed. You must have known that when you wrote the letter?

A. I didn't know at that point that -- what the result of a police conversation was going to be and I was mindful of -- and, again, it's that clash with regard to the extent of the duty of candour -- I was mindful of introducing additional distress that might not actually have a basis.

Q. You were hedging your bets that she would never find out about the police?

A. Absolutely not.

Q. What about Mother D? The Hawdon Report for Mother D describes issues relating to the care that was provided to Child D. An Inquest was due to be happening fairly soon. The Trust had been advised by Hill Dickinson in the run-up to the Inquest to admit liability, you had Jane Hawdon's report identifying areas of care. The Trust didn't even fulfil the basic level of candour in coming forward and saying, "We are concerned that breaches of duty, let alone murder, have

contributed to harm to your child". Was there an institutional lack of candour in the Countess of Chester at this time?

A. I don't believe that there was, no.

Q. Can I go back then to the start of the chronology, insofar as you were concerned. The opening statement on behalf of the Executives states that the first time that concerns about Letby were raised with senior managers, including yourself, was at the end of June 2016, after the sad deaths of Child O and P. That's not correct, insofar as you, is it? You knew before the death of O and P that concerns had been raised regarding Letby?

A. I was aware that an association had been reported. I -- at that point, before June/July, didn't view it as any more than that and I believe that that's supported by the tone and the content of the meeting of the 11 May 2016, and the actions that came out of that, and the subsequent email from Dr Brearey in terms of summary of the meeting.

Q. Let's go through those. We can go to them in a moment but can we begin, first of all, with your knowledge about the Thematic Review.

If we go please to INQ0003140. Now, an issue in Dr Brearey's evidence is that he says that he had asked

you for a meeting in February 2016. Now, you emailed Stephen Brearey on 15 February at 10.22 in the morning. The letter begins at the bottom of this page "Dear Steve", but if we go on to the next page:

"Am I correct in thinking that you commissioned an external review of recent neonatal deaths? If so, is there any early feedback ahead of this week's visit."

That is the CQC visit. How did you find out about the Thematic Review?

A. I believe through Alison Kelly.

Q. So as of 15 February 2015, Alison Kelly knew that a Thematic Review was under way because she told you about it?

A. I -- I believe that she was aware of a review, whether it was termed a Thematic Review, I wouldn't know.

Q. Yes, I mean her evidence was somewhat different to that, but your recollection is that she informed you of a Thematic Review. I mean, somebody had: you clearly had prior knowledge when you emailed Stephen Brearey?

A. Well, I -- I wasn't told by Dr Brearey.

Q. No.

A. It would have to have come either through Eirian Powell and thereby Alison Kelly.

Q. Yes. Okay. Well, if we go up to Dr Brearey's response to you on the next page:

"Hi, Ian. It wasn't an external review but we did have a review of all the cases from 2015."

He attaches the draft minutes and actions from the meeting and says that he's only circulated it on to attendees.

Then at the top of this page, you email Alison Kelly, and you say:

"FYI, in the light of Sarah's earlier graph [it is actually the second paragraph that's the important one], I queried with Steve the sharing of joint work with obs and their previous review, and he said they will get joined up at the Women and Children's Governance Board."

Now, nowhere in your email to Stephen Brearey or his response does that information appear about querying with Steve the shared work and his response "They will get joined up to Women and Children's Governance Board", so it must follow that, either there were additional emails that we haven't seen, which is what Dr Brearey says, or you had a conversation with Dr Brearey about this?

A. I -- I believe that there is reference in another email to Dr Brearey talking about that sharing your joint work.

Q. So what Dr Brearey says in his evidence is that he communicated with you that he hasn't been able to find the email confirming this but that you told him that you would be -- he would be to merge the obstetric and neonatal reviews but, at the same time, he asked you for a meeting: a meeting with you and Alison Kelly. So:

"My recollection is that I also asked for a meeting with him and Alison Kelly at this time. He replied to say that the report and the obstetric report completed in November 2015 should be amalgamated but did not indicate when we would meet to discuss."

So your email to Alison Kelly relaying information from Stephen Brearey, which isn't in his email to you, does sort of suggest, doesn't it that that exchange had taken place?

A. I would also point out that there are some factual inaccuracies in Dr Brearey's recollection of the initiation of this email trail.

Q. Well --

A. In his statement Dr Brearey says that --

Q. Could you answer the question, please?

A. Well, I -- yes, I am doing, sir.

Q. The question I asked is: does your comment not imply, as Dr Brearey says, that there were further discussions between you and him of the sort that he

described?
A. I do not believe so because I think his memory is faulty on certain issues with regard to these email trails.
Q. So you deny that he asked you for a meeting in February 2016?
A. I have no recollection and, certainly, based on the order of events in Dr Brearey's statement, I have no reason to believe that he did.
Q. No, but your answer is you have no collection. Thank you.
We then have emails to between Eirian Powell and Alison Kelly in March 2016. I can take you to them if necessary but it provides a request to Alison Kelly for a meeting and provides a copy of the Thematic Review subsequently, but refers to high mortality and a commonality with a particular nurse.
Were you aware of those emails and the sending on of the Thematic Review in March 2016?
A. Without seeing whether I am on the circulation list, I -- I can't answer that.
Q. You are not on the circulation list of this email chain but what I am asking you is did Alison Kelly make you aware that there were further emails regarding the Thematic Review?

A. Not at that time. If she -- if she did it would have been by forwarding them to me.
Q. So if we come on to May 2016. If we go, please, to INQ0003138, and this is an email from Alison Kelly, 3 May 2016, which includes you and Stephen Brearey. This is at the very bottom, onto the next page. We see here there's an original appointment at the bottom there which has your name on it as well, "To Ian Harvey", and it is being cancelled and they are looking for an alternative date for the meeting. What did you understand the purpose of that email meeting to be: to discuss the Thematic Review and concerns that had been raised?
A. My, my understanding was, yes, it was to discuss the Thematic Review.
Q. INQ0003087, please. Again, we have an email from Stephen Brearey, which is referring to, as you have been asked already:
"Quite a few of the deaths and arrests. Eirian has sensibly put her on day shifts at the moment but can't do this indefinitely."
You are being emailed by Alison Kelly there saying:
"Please see Steve's comments below which alarmed me!"
What did you understand her to be alarmed by?

A. My interpretation was alarmed that there was a nurse who had been moved on to day shifts.
Q. Because you thought that might be inconvenient for her or ...?
A. Well, given the tone of Dr Brearey's email, and his description of Eirian "sensibly" putting her on to day shifts and more a concern with regard to staffing numbers, I didn't read that as a particular concern other than for the well-being of the nurse. I didn't read that as an indication he was concerned about that nurse's performance in some way.
Q. Really?
A. And I -- and I believe that was reflected in my response to Alison Kelly's email that, as I read it, it may well just be that he was concerned regarding her welfare or words to that effect.
Q. So you thought that Alison Kelly was alarmed in the context of high number of deaths and other arrests and a nurse who was present for those who's been moved on to day shifts, only for the moment -- you thought her alarm related to concern for the nurse's well-being, not that correlation?
A. I believe that is reflected in my email response to Alison Kelly's, yes.
Q. Did you not realise, I suggest to you you must

have done, that Stephen Brearey's concerns related to the correlation, by this time, between sudden unexpected collapses, a nurse being present on the ward at the point when these happened, and concern about what was causing these collapses, how they might be connected?
A. As it was expressed in his email of 4 May, no.
Q. Not how it was expressed in his email on 4 May but based on everything that you had heard up until that point?
A. Based on everything that I had heard ...?
Q. Up until that point?
A. No, I hadn't picked it up. It hadn't been expressed in that sort of way in any of the communications that I -- I had seen, nor do I believe that it was explicitly referred to in the meeting that we subsequently had.
Q. So your evidence is that, at this point in May 2016, you had no clue at all about any concerns regarding the connection between Lucy Letby and sudden, unexpected and unexplained collapses on the ward and deaths?
A. At this time, with the Thematic Review, I was aware that there were concerns with regard to an increased number of deaths, that they were being investigated, that whilst one member of staff had been

on duty more frequently, the individual case reviews, whilst highlighting some themes, had not caused any major concerns to be raised.

Q. If we go then to the meeting that occurred on 11 May 2016 and we look at the handwritten note of that, which is INQ0003181. So there is a little more information here. Again, the Thematic Review is discussed, and it says about deteriorations:

"Deteriorated 9.00 pm - 6 times, midnight to 4."

Did you not see anything significant about the fact that all of these deteriorations were occurring at night shifts?

A. As I believe I gave in evidence yesterday, there is evidence that standards of care are lower at weekends and at night and, in seeing that, that would have been my initial concern.

Q. Well, we can go to that issue because it's down the bottom of the page. Can you see where it says "sub optimal care". It describes one case, where there were concerns about the care that had been provided and the pharmacist's poor decision-making. So can you take from that that, in all of the cases being described, in only one was Stephen Brearey able to identify evidence of sub optimal care; that's what's being recorded here, isn't it?

A. That's what's been reported there, yes.

Q. So questions about care being poorer at night may be generic but, in this case, that issue has already been looked at, hasn't it?

A. I am not sure that there was sufficient detail in the Thematic Review to be able to say for sure. I am aware that one of the actions coming out of the Thematic Review was that there was to be a further review by Stephen Brearey and Eirian Powell into observations in the time leading up to the collapses.

Q. You see, Stephen Brearey's description of this meeting is that he was trying to get across concerns about this connection between the strange timing of the collapses and deaths which had changed since the nurse had switched shifts, the fact that she was always on duty when it happened, the fact these were sudden, unexpected, unexplained collapses, for which no cause could be found on the Thematic Review and other reviews and he says that, in effect, Eirian Powell argued the case for Lucy Letby and that shifted or diverted the decision making within the meeting away from looking at those questions of sudden, unexpected, unexplained collapses.

It's a fair description of what happened, isn't it, that Eirian Powell came out fighting for Lucy Letby?

A. I think that some of the language that Stephen Brearey has used in describing how Eirian Powell and Anne Martyn behaved in that meeting is at the very least inappropriate.

Q. Well --

A. I -- I would accept that Eirian Powell put a number of points that would indicate why Lucy Letby might be more commonly either associated with these babies or --

Q. We can see what she said because there are some sentences or words here that have the hallmarks of what she said in evidence and elsewhere:

"Absolutely no issues with nurse."

Yes, can you see that; it is about halfway down the page?

A. Yes.

Q. "Circumstantial. One doctor also named across number of cases. Six babies Nurse Lucy Letby, sudden deterioration."

Then at the bottom:

"Trained at Chester."

These were all words that Eirian Powell has used elsewhere and she is coming out here, isn't she, and saying there is absolutely no issues with Lucy Letby. It's all circumstantial, there is also a doctor

involved.

Now, Dr Harkness who I think is the other doctor who appears regularly, doesn't appear for all the cases and he had left by this point. But here she is, Eirian Powell, arguing the corner for Lucy Letby?

A. I think that she was simply countering some of the points that had been made and Stephen Brearey highlighted the time frame of some of the collapses. He called out the fact that Lucy Letby was on duty more often than others but, certainly, my recollection is that he is overstating the degree to which he presented this data and how he presented it.

Certainly at the end of the meeting, he gave the impression of being comfortable with the conversation that we had had, with the opportunity that he had had to be listened to and that he agreed with what was decided, was which -- which was that we would implement a much closer monitoring of babies who collapsed thereafter.

Q. But not a much closer monitoring of Lucy Letby, was there?

A. Well, based on the conversation that we would -- we had had, at that point, there did not appear to be a basis for that.

Q. Well, there was a reference to suggest there was more than enough in sudden, unexpected and

unexplained deaths, with a nurse present at all of them and concerns being raised by a paediatrician, to warrant some sort of safeguarding exercise?

A. I -- I'm not sure that the sudden and unexpected actually associated Letby present at all of those.

Q. Well, it was. By this time, a table had been drawn up with Lucy Letby's name highlighted in red across it?

A. In terms of those babies, we had both indictment and non-indictment babies and, obviously, if one simply takes out the indictment babies one's presented with a very different picture.

Q. Well, she was present for all of the collapses and unexplained and sudden collapses that were highlighted within the Thematic Review, and there was a concern being raised about her potential connection to this, not necessarily in terms of homicide but certainly in terms of competence. The effect here is really just to kick the can down the road, isn't it?

A. I'm sorry?

Q. The effect is to kick the can down the road. No safeguarding is put in place in respect of her practice in any way, following this meeting?

A. No, I accept that safeguarding wasn't put in

place.

Q. And --

A. I don't believe that it was just kicking the can down the road. We felt that we needed that monitoring of any further unexpected events. I believe that there was one and that wasn't actually reported, despite the action plan and the guidance that was coming from this meeting.

Q. If we --

A. I would also comment with regard to the email that Stephen Brearey subsequently sent with regard to how he viewed the meeting.

Q. Sorry, could you repeat the last bit, sorry, I didn't quite catch you -- oh, how he viewed the meeting, thank you.

Can we come on to what happens after O and P collapse, please. I think on behalf of the parents of O and P, they would regard the meeting in May 2016 as an opportunity and a missed opportunity to avoid the deaths of their sons. Would you accept that action could have been taken between February and May 2016 to prevent Lucy Letby causing harm to Babies O and P and all those who fell after February 2016?

A. No, I -- I cannot accept that there was sufficient in between February and May for that to be

the case.

Q. It was there to be found though, wasn't it?

A. Pardon?

Q. It was there to be found, the evidence, with investigation. You have already said the insulin results for F were there to be found?

A. Well, the insulin result was there dependent on a doctor doing the right thing with that result.

Q. That, that had happened already. What I am talking about is steps that you could have taken, further investigations, further scrutiny between February and May 2016 could have highlighted the insulin results could, indeed have brought in the stories of the parents who had witnessed --

A. I would say that that is by no means likely. It was only after the police inquiry was instituted that, in fact, Dr ZA remembered that there might have been this result. I would suggest that the biggest missed opportunity there was actually in August 2015 when, having considered that insulin result, Dr ZA excluded accidental administration, actually considered deliberate administration.

Q. We understand the point, Mr Harvey. It's been made --

A. Absolutely, but I think this needs to be clear

because --

Q. Can I come on to things, though, that you can give direct evidence about. Please, we do understand the point about the insulin and Dr ZA.

Your reaction after being informed of the concerns surrounding the death of Child O and Child P was that the police should be called. That was your first reaction upon seeing Dr Saladi's email, was that the police should be called?

A. It was.

Q. If we go to INQ0047571, and down on to page 2, please, we can see Dr Saladi's email here to you and to Alison Kelly. Now, you must have read this in light of the meeting in May 2016 and the information you had had up until that point?

A. Yes.

Q. If we go up a page, we can see Alison Kelly's email to you beginning "Hi Ian":

"I am not at Execs this AM but have briefed Sian fully. I have discussed reactions we are taking and I know we are commissioning an extra clinical review but Sian and I did also discuss the police. I know this is a big step but it's something we need to consider in light of heightened concerns."

So Alison Kelly saying to you that she thought

a discussion regarding the police needed to take place. Then Ian Harvey:

"I have already emailed Stephen to meet ahead of the Execs. I will keep you updated. My own feeling, the police having been raised, I think we will have to."

In other words, "We will have to call the police"?

A. Yes.

Q. If we then go on to the same day, you had a meeting with Stephen Cross and, if we go to INQ0003360, this is Stephen Cross' note but it is a note of a meeting with you, 29 June. Now, at the bottom, it says:

"Deaths of Triplets has raised concern. Nurse was on duty at deaths. Sufficient level of concern that illegal activity in neonates."

In the first paragraph at the bottom, it said.

"Advice: police need to be involved now."

At the end of the first paragraph.

Who is giving the advice that the police need to be involved now; is that you or Stephen Cross?

A. I believe that the timing of that entry is incorrect. I think this reflects me going to Stephen Cross, having seen the copy of Dr Saladi's email, which I think was timed on the email system a couple of minutes after the time Stephen Cross has --

Q. Oh, yes, yes. So, I mean, it -- Dr Saladi's email is 8.17 --

A. Yes.

Q. -- and this note is at 8.15 --

A. Yes.

Q. -- and your email to Alison Kelly was at 8.31. So let's put aside the precise time of maybe 8.19 that's written on the note --

A. Yes.

Q. -- but it clearly is a note written fairly soon after you have received Dr Saladi's email and you have been to see Stephen Cross?

A. Yes, and my reading of that is that that is from Dr Saladi's email.

Q. Sorry, could you explain that, please? So you are saying that, where Stephen Cross has written, "Ian Harvey neonatal issue. Emails from Consultants escalating concerns. Email this AM from further Consultant. Advice: police need to be involved now"; are you saying that's just a recital of what Dr Saladi said in his email?

A. I -- I believe that is either that or that is a reflection of what I had said and had indicated in the email that I had sent to Alison Kelly.

Q. Well, what about the bit right at the end

then, where it says:

"Nurse was on duty at deaths. Sufficient level of concern that illegal activity in neonatal."

I mean, who is saying that; is that you or Stephen Cross saying that?

A. I am unsure where that's come from.

Q. Well, given that you had emailed Alison Kelly shortly before saying that you thought the police did need to be called, your evidence to the Inquiry is you thought then the police needed to be called, either this is you advising Stephen Cross the police need to be called or it is Stephen Cross agreeing with you that the police need to be called?

A. I -- I'm unable to remember which way. All I can say is that the earlier emails indicate that my initial response was that we needed to speak to the police.

Q. Yes, I mean there is no record of any disagreement from Stephen Cross regarding this, so does it follow that he agreed with you the police need to be called, or are you saying that there was a dispute as to whether the police needed to be called?

A. I -- I can't speak for Stephen Cross and I can't recall the full detail of that conversation.

Q. Was it not a fairly uncommon conversation to

be having with a legal director?

A. Absolutely.

Q. Are you saying you don't recall anything about this conversation?

A. I am saying that because these are events that occurred eight years ago.

LADY JUSTICE THIRLWALL: Mr Baker, just before you continue, we will need to take a break.

MR BAKER: Yes, of course.

LADY JUSTICE THIRLWALL: How much longer do you think you have got? I am not going to suggest you do it now, I just want to know.

MR BAKER: No. Let me come on to -- actually that probably is a convenient moment. I am about to come on to the next meeting.

LADY JUSTICE THIRLWALL: Very good. We will come back at 3.50.

(3.34 pm)

(A short break)

(3.50 pm)

LADY JUSTICE THIRLWALL: Mr Baker.

MR BAKER: Thank you, my Lady.

We had just dealt with discussions whereby it appeared to have reached a point where you wanted to call the police, Alison Kelly wanted to call the police,

and Stephen Cross, at least, appeared to agree to that or acquiesced to it.

The next meeting on 29 June involves the Consultants and now Tony Chambers, and it's INQ0003371. You can see Tony Chambers, Alison Kelly, Ian Harvey and then we have Stephen Brearey, Ravi Saladi and others.

Stephen Brearey's evidence is that when we went to the meeting with the Executives, the Executives were looking for reasons to either not go to the police or to defer the decision. Now, insofar as you were concerned and insofar as Stephen Cross was concerned and insofar as Alison Kelly was concerned, prior to this meeting you had all seemingly come to the view that the police were going to be called; what caused your change in mind?

A. I have read through these documents in detail, I have tried to recall the conversations that went on and I am unable to explain the change in approach.

Q. Can I help you with it. If we begin with some of the background. We have Stephen Brearey here:

"Steve B, some PM reports but not all. Inconclusive. Some not satisfactorily giving answers. Inconsistent Datix reports."

A little further down the page:

"Unexpected collapses. Perhaps should have a Datix. A lot of complexity around reporting."

Further down the page:

"Pseudomonas grown from taps but not evident in incidents."

Then Ravi Jayaram:

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

Stephen Brearey:

"Disturbing thing twin survived and got better at Arrowe Park. Babies coming back to Countess of Chester, babies deteriorate. Nurse 7 out of 9 between 12 noon and 4 am, and since then none."

On the following page:

"More than just an association with this nurse.

"Ravi: how? Cannula? Air embolism? Crystal ball? Unquestionably got something going on in the Countess of Chester but what?"

Then Saladi:

"Preterm babies. Two steps forward and one step back. Don't suddenly deteriorate."

So here we have this sort of very clear expression of something, more than just an association, quite significant concerns by paediatricians being put

forwards.

Do you agree that that's closer from that note that this isn't just people saying she's always there when people collapse?

A. Yes.

Q. It's paediatricians saying, "There's something more to this, there's something more unusual about this"?

A. That is certainly something that comes out of those notes.

Q. Then we have the first statement from the Executives. "TC", Tony Chambers:

"Why did we call the police? If Twins/Triplets why did the Trust take them on. Can we explore more before police?"

It's Tony Chambers calming down the idea of going to the police, isn't it? That's clear from the note?

A. I'm not sure that that reads as him calming down. I think --

Q. I am not suggesting he was calm but I mean that's him raising the issue of why don't we defer calling the police?

A. No, I think he is simply putting in a challenge with regard to is there something that we need to explore before the police? He was asking those

in the room whether the police was the next step, where they -- did they have a degree of concern that it was the police.

I don't read that, knowing how Tony Chambers ran his meetings and was keen to hear from everyone in the meeting and give everyone the opportunity, I believe that this was just a request to explore the full range of the options. I don't believe that he was actually specifically leaning towards --

Q. He's the new person in the room. You had talked about calling the police, Alison Kelly had talked about calling the police, Dr Saladi had talked about calling the police, and here we have Ravi Jayaram and Stephen Brearey raising their concerns very clearly about criminality. Tony Chambers is the new person in the room here, and that's what changes the dynamic, isn't it, that is why the police aren't called?

A. I -- I would simply say that he was exploring all the options and, as the Chief Executive, that's what I would expect him to do.

Q. Yes, and if we look at the reasons why the police aren't called, or one of the reasons, on to page 3:

"Police consequences. Balance needed."

Is it the concern about the consequences of calling

the police, reputational harm, that is acting as the deterrent to doing it?

A. I don't believe that reputation was one of the consequences that was discussed and I believe that the consequences were with regard to the effect on the unit.

Q. Well, let's balance that. The effect on the unit, if Lucy Letby is still working there, and she was at this point, is she murders more babies; isn't that more serious?

A. Again, using hindsight, yes.

Q. Before I conclude, I mean, I would suggest on behalf of the families that this sets the tone, this marks the sea change between you wanting to call the police and the police not being called, and you becoming party to, a supporter of or at least acquiescent to that decision. But that decision at that point not to call the police you accept was wrong. The consequence is that it defers justice for the Families for another year; do you accept that?

A. I -- I accept, on the basis that I have already said that I believe we should have been in touch with the police earlier, that had the potential to delay things, yes.

Q. Finally, just to clarify a point. It was implied in questions to Alison Kelly that Alison Kelly

and Sian Williams might not have met with Mother C in July 2016. Can I take you please to INQ0008969, and to the next page, please.

This is a letter to you from Mother C in February 2017, raising her concerns. If we go on to the next page, in the second paragraph she describes having read about the article in the Chester Chronicle in July 2016 and then mentions that she met with Sian Williams and Alison Kelly "when I turned up at the Bereavement Office". So you agree that Mother C wrote to you in the early part of 2017, recalling having met Sian Williams and Alison Kelly in the Bereavement Office?

A. I -- I do on seeing this document, yes.

Q. Yes. You know that there are no notes of the meeting between Sian Williams, Alison Kelly and Mother C, and it was suggested that that was unusual. You agree that you met Mother C in 2017, don't you?

A. Yes.

Q. There are no notes of that meeting either, are there?

A. There aren't, no.

Q. No. Is there any reason why notes weren't being taken of meetings between Sian Williams, Alison Kelly, you and parents?

A. No. I would say that it would be unusual for

Alison Kelly, who kept very good notes but that may have been a feature of the circumstance of the meeting. To my regret, I was a very poor note keeper, and I think that's probably evident to the Inquiry, in comparison with some of my colleagues.

Q. Thank you. My Lady, it occurs to me I just need to go back, very briefly, to Mrs Hodkinson's note and then that is my final question.

If we go back, please, to INQ0015639, and to page 58, please, again, a point was made to Tony Chambers about this meeting on 30 June -- you were present, this is Sue Hodkinson's note of it -- that Tony Chambers asked Stephen Brearey the question:

"If we remove Letby from the ward, will unit be safe?"

He responded that the risk would be reduced. It was suggested to Tony Chambers that that meant that Stephen Brearey didn't really believe that Lucy Letby was behind the incidents. If you could look over, please, to the right-hand side, right-hand column here, I don't know if you recall the conversation but it begins, "TC: direct LL removed. Unit safe?", and Stephen Brearey is noted to answer, "Risk removed". Do you recall that exchange?

A. I don't, no.

Q. No, so you can't say whether it was risk reduced, according to Stephen Cross's notes, or risk removed?

A. I'm sorry, I can't clarify that, no.

MR BAKER: Thank you.

Thank you, my Lady, I have no more questions.

LADY JUSTICE THIRLWALL: Thank you very much, Mr Baker.

Mr Kennedy?

Questions by MR KENNEDY

MR KENNEDY: Mr Harvey, I have some questions on behalf of the Countess of Chester Trust. Can I just pick matters up, on 29 June, where Mr Baker just left them. At that stage, as you have just agreed with him, your state of mind is, "We need to call the police". You agree that the paediatricians in the meeting are saying that there is something more than simple commonality, and they are talking about criminal activity as one explanation, agreed?

A. I -- I would need to see the notes in front of me to remind me, I'm sorry.

Q. We can look at the notes again. It's INQ0003371, but it's the note about air embolus; do you remember that note?

A. Yes.

Q. I'm trying to move as quickly as I can through this, so that your counsel has an opportunity to ask you questions, so if we don't need to revisit matters, then that will help us. But it's that note towards the foot of the page.

Over on to the next page, where you see:

"Ravi: how? Cannula air embolism?"

We have looked at it on a number of occasions now.

The thrust was that they were concerned about criminal activity?

A. I'm not sure that that was entirely clear as criminal activity. Cannula air embolism can be accidental as well as deliberate.

Q. Every message you had from the nursing team was that Letby was a competent nurse, wasn't it?

A. Yes.

Q. Right. So you had to have in mind the possibility of criminal activity?

A. I would, in terms of what is most common, irrespective of what might be said have competence as an issue or a concern.

Q. Would you have also had in mind criminal activity?

A. Yes.

Q. Thank you. Your task and the Execs' generally

task was now to manage the risk, correct?

A. Yes.

Q. The impact of getting it wrong, given what was being told to you and given your view, at least at that stage of the police needing to be called, the impact of getting it wrong was catastrophic, wasn't it?

A. Yes.

Q. So when you formulated how it was you were to test the hypothesis, you had to formulate it in such a way that it was the most exacting question, didn't you?

A. Yes.

Q. That is consistent with medical practice: can I exclude the most sinister diagnosis, rather than can I include a less sinister one?

A. I'm not sure that you could apply that across to making a medical diagnosis.

Q. All right. But it's a familiar test to a doctor?

A. One is interested --

Q. A patient presents with a particular condition. What you are looking to do is can I rule out a sinister cause for that condition?

A. I would suggest that this is probably not an appropriate analogy because one would be looking to

exclude the common things first.

Q. Very well. Well, let's move on. Whether you are trying to exclude the common things, you have to have in mind the most serious?

A. Yes.

Q. Okay. So when you are setting the question, if I can put it like this, or formulating the hypothesis, does it not have to be as follows: can I confidently say that the paediatric Consultants' concerns are misplaced?

A. I would -- I would say with retrospect, our balance on that was incorrect.

Q. Do I take it from, from that, your answer, that you agree that that is how the test should have been formulated?

A. I have already agreed that my initial feelings on this were the ones that I should have acted on.

Q. I'm not now concerned about simply whether the police were called. This now builds into how you manage things going forwards. You should have managed them going forwards on the basis of asking yourself the question: can I confidently exclude criminal activity, is another way of formulating it?

A. I think our initial concern was: is the unit safe?

Q. You are -- please, I am really short of time, so if you could just answer my question. Looking forwards, your question had to be, "However I formulate it, can I confidently say that the paediatricians' concerns are misplaced?"

A. I'm not sure I can answer that without putting it as trying to understand the level of their concern.

Q. That may be part and parcel of the same?

A. Yes.

Q. Of the same exercise but what you are trying to do is confidently say that their concerns are misplaced whether it's because of the level or because of the evidence?

A. We are trying to confidently establish what is fact, yes.

Q. All right. Now, again, trying to just cut through this.

You agreed with Mr Skelton last night that the Royal College of Paediatricians' report could not exclude criminal activity?

A. I -- I agreed that it was unlikely that it would, yes.

Q. Well, it couldn't do because it wasn't charged with that task or, alternatively, they told you they hadn't done that?

A. Yes, that's correct.
Q. So, either way, it couldn't exclude criminal activity?
A. Yes.
Q. Likewise, again trying to cut through this, Dr Hawdon couldn't exclude criminal activity?
A. Couldn't exclude but could identify --
Q. Right.
A. -- because --
Q. If she was --
A. -- at the end, at the trial, the prosecution experts were able to identify matters based on the Casenote Review. So that, whilst Dr Hawdon might not be able to exclude, I believe that there was the potential that she would be able to confirm.
Q. We can look at her letter but what she told you was, within the time that was permitted to her and that she could devote to the task, she simply couldn't do it; that was the gist of her letter?
A. I think it was to the fact that it wouldn't be as comprehensive.
Q. All right let me frame it another way: she told you she hadn't done it?
A. She hadn't done it to the -- a level of detail.

Q. All right. She hadn't done it to a level, put it another way, where you could be confident that criminal activity could be excluded?
A. No, which was why the reviews continued but then nor did she identify anything where said there were -- there was criminal activity.
Q. Well, now we are into evidence of absence being absence of evidence, aren't we?
A. Yes.
Q. So it's, at best, neutral?
A. Yes.
Q. Can we agree that?
A. Yes.
Q. All right. The same of the Royal College?
A. Yes.
Q. It doesn't, at best, from your perspective, it doesn't give you the answer either way?
A. No.
Q. Okay. You had undertaken the local investigation as part of the Silver Command, correct?
A. Undertaken a?
Q. A local investigation as part of the Silver Command?
A. Yes.
Q. That too didn't give you the answer to either

of the questions we have been talk about, did it?
A. No.
Q. Right. In those circumstances, if we now look at the 10 January meeting, the extraordinary Board of Directors meeting -- and I think now we probably do need to bring up some documents. So can we start with INQ0003239, and that's your presentation. Now, recall this?
A. Yes.
Q. This was circulated to the board, along with the College report at the meeting; can we agree that?
A. I'm not sure of the timings that the documents were circulated.
Q. If we go to the second page of this document, we can see that you have dated it 10 January?
A. Yes.
Q. Now, unless you forward date documents, does it look like this document was prepared and was presented to the Board of Directors on 10 January?
A. It will -- it was presented on the day. I can't say whether they actually had the opportunity to see it before the meeting, which took part -- took place late morning.
Q. Well, we can see the meeting was 11.00 am --
A. Yes.

Q. -- from page 1. So the most opportunity they would have had is, if they had been in the hospital first thing, if it had been delivered to them then?
A. Yes.
Q. All right. We can see also, if we go to the second page, Mrs Killingback, that the report of the Invited Review is attached?
A. Yes.
Q. That is the RCPCH Report?
A. I believe so, yes.
Q. All right. So they have got 30 pages odd of the RCPCH, plus your document distilling it, correct?
A. Yes.
Q. Okay. Now, you are inviting in this document the Board to accept two things for my purposes: firstly at A, to accept the RCPCH Report; and then at C you are asking them to support the Executive Team in assisting the staff member's return to work on the neonatal unit, correct?
A. Yes.
Q. We can look if we need to, we know from the board minutes that they accepted your recommendations, correct?
A. Yes.
Q. Okay. Given the significance of this, so

putting somebody who the paediatricians thought was killing babies back on the neonatal unit, this was a decision that required real care, wasn't it?

A. It is. My recollection of the meeting is that there -- there were questions with regard to the continuing reviews and my own feeling was that, until those reviews were completed, it wouldn't have been appropriate for Letby to return to the unit, irrespective of the recommendation there that has my name to it.

Q. That was your recommendation and it was that recommendation the board adopted, wasn't it?

A. It, it was. But, in the discussion, I believe there was discussion that actually that would not take place until the completion of all the reviews. The reviews outstanding, and despite that recommendation to support her return, that was pending the results of the outstanding Hawdon and McPartland review.

Q. Indeed, because, at that stage, you were chasing McPartland for her report, weren't you?

A. That's right.

Q. Okay, and you hadn't completed the exercise that Dr Hawdon had suggested?

A. No.

Q. Okay. You were aware at that stage that there

was there had been an unequivocal rise in mortality?

A. Yes.

Q. We take that from your local review where you say it's not down to chance; correct?

A. I don't think we ever actually said it's not down to chance because I don't think we ever submitted it to statistical analysis, which, by definition, would be required to say it was or wasn't chance. But it was an increase that was sufficiently high that it was of concern and certainly isn't something we would have subjected to statistical testing to assess whether it was sufficient to need investigation.

Q. What you said in the review -- and this is INQ0001888, I don't suggest we need to get it up. What you said was:

"Fluctuation due to common cause variation cannot account for the increased mortality seen in the neonatal unit."

Common cause variation is effectively chance, isn't it?

A. Yes.

Q. Okay. Also, in addition to the unequivocal rise, you knew what the paediatricians' concerns were, you knew that, since Letby had been off the unit, there had been no deaths or -- well, no deaths, correct?

A. Yes.

Q. The board knew at least the first and second of those propositions, didn't they?

A. Yes.

Q. Okay. When you put it in your recommendation, we still have it on screen, the reviews having found no evidence of a single person's culpability, that went beyond, as we have just discussed, what could properly be concluded from any of your reviews, correct?

A. I think it was a much more complex picture. Everyone -- a lot of people seemed to be looking at this purely in terms of pre and post-Letby on the unit. The fact is that a lot of other actions were put in place, the unit was redesignated. The unit was subject to micromanagement. The unit was subject to much more scrutiny. There was, in addition, a fortuitous reduction in the level of activity. The unit was extremely quiet. So there were potentially a whole number of reasons why the picture would change.

Q. But you weren't in your recommendations here saying, "for a variety of reasons". You specifically refer to the reviews having found no evidence of a single person's culpability correct?

A. It is a limited report, yes.

Q. Sorry?

A. It is a limited report.

Q. I'm sorry, I am not hearing you: it is a limited?

A. The report is limited.

Q. Well, as we have agreed, the reports, including your local report, doesn't establish that proposition, does it?

A. It doesn't describe all the detail, no.

Q. It doesn't?

A. Describe all the detail.

Q. No, but you can't derive that conclusion from the report; we have agreed that?

A. I would accept that.

Q. Okay. Now, as I said to you earlier, this was the gravest decision or potentially the gravest decision that the board were being asked to take, wasn't it?

A. Yes.

Q. It required extreme care on your part, and also on Mr Chambers' part, that the board were presented with an accurate picture, agreed?

A. I believe they were being present with a picture that summed up the situation as it was at that time.

Q. What you said there, that the reviews having found no evidence of a single person's culpability, that

was not accurate, was it?
A. It was accurate insofar as those reports. What it didn't do was, was call out the fact that that potential was still there.
Q. Well, it needed -- let's say it needed a full and accurate explanation?
A. Yes, and --
Q. All right, and --
A. -- I think that was part of the conversation that took part, actually, in the board around this paper, that we were waiting for that further information that was pending.
Q. But you are talking in those terms, Mr Chambers is talking in the terms of allegations being unsubstantiated. You are not, on the face of the minutes, really allowing for any other possibilities, are you?
A. I believe, in terms of the discussion that we had, I was calling out that this paper was written as of that time but that it wasn't complete because the reviews weren't complete, and that there was more to follow.
Q. A full and accurate summary of the reviews would have been that they don't help us one way or another in determining whether there's been criminal

activity; that would have been a full and accurate summary, wouldn't it?
A. I -- I wasn't in a position to say that, until I had received the full and final reports including those of Hawdon and of McPartland.
Q. Well, you were reporting to the board on the basis of the material available to you at the time?
A. Yes.
Q. On the basis of that material, you could say no more than, to be full and accurate, the reports don't assist us either way in determining whether there's been criminal activity?
A. The report is not accurate in those terms but I believe that that was discussed as part of the discussion around this document.
Q. Insofar as it was presented in that way, can we agree that it was misleading?
A. I would say that it told the picture as of that time but it wasn't a complete picture. It wasn't designed to mislead, I don't think it did mislead because I believe that the conversation that went around it in the meeting highlighted the gaps.
Q. Last time: as at 10 January, a full and accurate picture would have been the reviews that we have undertaken cannot tell us either way whether there

is a single person's culpability, or responsibility on the part of a single individual, correct?
A. As I have agreed, this is that picture at that time. It doesn't describe the full picture but that came up in the conversation around this report.
Q. I am going to move on because of time. Just to this: you have said on a couple of occasions in the course of your evidence today that what you were endeavouring to do was to help build a consensus and, I take it, with the Consultant paediatricians as to the cause for the increased mortality, correct?
A. Yes.
Q. You were then talking, I think, about probably your ethos in 2017?
A. Yes.
Q. Yes. Do you agree that the wise thing to have done would have been to share your reviews at the earliest possible opportunity with the Consultant paediatricians because they could have assisted you as to how you were interpreting them?
A. I -- I believe that I have already conceded that point, yes.
Q. All right. You had had the offer of help much earlier on from Dr Brearey when he had tried to give you some guidance as to what material should be provided to

the College?
A. Yes.
Q. Okay. Do you appreciate now that the way that, in fact, you handled it, which was to hold back both reports until February and to present the outcome of the board meeting on 11 January to the paediatricians on 26 January, as something of a *fait accompli*, that was never going to achieve that end of seeking a consensus?
A. Sorry, I am struggling to follow that.
Q. It's been a long day. The way that, in fact, you approached it had the opposite effect of building consensus because you held back material from the paediatricians?
A. I have, I've already agreed that we didn't share it in a -- in as timely a fashion as we should, yes.
Q. Because when they saw it on 3 February, you had had Dr Hawdon's report since the end of October, correct?
A. Initial, but then there was the ongoing work that was required to fill in the gaps, yes.
Q. All right. But you had had the initial report since the end of October --
A. Yes.
Q. -- and similarly you had RCPCH's report for

some months?
A. Yes.
Q. To the extent that that approach soured relations between the Executive Team and the paediatricians, that is something, presumably, that you are apologetic for?
A. I believe that I have already apologised for that.
Q. Very well.
A. I would also say that part of their anger was with regard to the perception that what they had said to the College wasn't reflected in the report, and I take on board that the weight I put on the instructions that we received with regard to sharing the full report or the report for publication, probably aggravated that situation.
Q. Another part of their anger was that, when they read the RCPCH and Hawdon, they couldn't see the justification for letting Letby back on to the unit?
A. Yes.
MR KENNEDY: Okay. Mr Harvey, thank you.
My Lady, I will leave it there.
LADY JUSTICE THIRLWALL: Thank you very much indeed, Mr Kennedy.
Ms Scolding?

Mr Harvey, are you all right to continue?
A. Absolutely fine, my Lady, thank you.

Questions by MS SCOLDING

MS SCOLDING: Good afternoon, Mr Harvey. I ask questions on behalf of the Royal College of Paediatrics and Child Health.
I have just got two areas of questioning for you this afternoon, the first one which is about the reference of which you made numerous references to it first thing this morning, about the words "gut feeling" --
A. Yes.
Q. -- saying in the RCPCH Report they had used the terms "gut feeling" and that was what you went towards. Now, can I ask you to have a quick look at the only place I can find "gut feeling" appears in the various drafts of the report. So this is the final report and this is INQ0009618_0009, and it's the third paragraph, once we have got it up.
Right. Now, this is the full report, and this is the green text. So the only place I can find "gut instinct" is, if you look, it's the penultimate sentence:
"The Consultants explained that their allegation was based on Nurse L being on shift on each occasion,

combined with gut feeling."
So this is part and parcel of what you have called today the green text, and so the first question to ask you really is: this isn't the RCPCH saying there was just a gut feeling; this is the RCPCH reporting what they say the Consultants told them?
A. Yes.
Q. But, of course, the Consultants didn't see this part of the report, did they? Because this was the part of the report that was redacted, however you want to call it?
A. That's correct.
Q. So, of course, they had no opportunity to then look at that and say to the Royal College, "Actually, you have got that wrong, that isn't what we said", because, in fact, what the Consultants said to the Royal College during the course of their review was pretty much what they had said to you in June and July 2016, they had gone through a series of factors, not just gut feeling; that's right, isn't it?
A. Yes.
Q. So, in fact, your actions prevented the paediatricians being able to correct a factual inaccuracy and, therefore, led to you and others relying upon something which, in fact, wasn't right?

A. I'm sorry, my action ...?
Q. Your actions in preventing the paediatricians from seeing the full report therefore meant that you and others proceeded upon an erroneous basis as to what the Consultants had or hadn't said during the course of the report; that's right, isn't it?
A. Well, my understanding is that I was following the instructions received from the College with regard to how the report should be circulated.
Q. Yes. Well, I am going to come on to that.
So if we then come on to the issue of what was or wasn't confidential. So, if I can take you first to the contract, so this was something that arrived on 2 August 2016. It's INQ0009597, and could we get up the second page. Can we have a look at number 3 and number 4. So you signed this document and sent it back to the College, and this is the basis of the agreement to carry out the review:
"Within the requirements of confidentiality under the DPA, the review must proceed in an open manner enabling discussions by the review team with all parties involved."
Then number 4:
"The final review report should be made available to those involved in the review."

So that's the starting point that you will have seen or that you, one hopes, will have read carefully, which is everybody who, in effect, contributes to the review should have an opportunity to see it, it being identified that one of the purposes of the RCPCH Review, as the reviewers in the evidence that they have given to this Inquiry have said, was a sort of peer review process which involved a degree of openness and candour between all involved.

So that's the process. I then can't find any reference to confidentiality in any written information until the document that Ms Langdale showed you this morning, which is INQ0003403, page 1.

This is the email to the final draft report, if I put it this way:

"Please find attached draft report, it does provide some fairly strong recommendations, so I would be grateful if you and Alison can have a first read through then once you are happy, perhaps you can share it with a few selected people, including, I would guess, Ravi, Stephen and Eirian, to check for any obvious accuracy sees or misunderstandings."

Sue Eardley then says further down:

"She has put together a chronology. That could be Appendix 4 but it's fairly sensitive, might be of use to

Jane and Martin [which is Jane Hawdon and Martin McPartland] as they do the detailed reviews."

So, in fact, contrary to what you say, it is absolutely clear -- and this report at this stage, this was not a kind of dissemination version, green text/non-green text, this was just one report, including what then got excluded. This plainly identifies that it should be seen by Ravi, Stephen and Eirian to check for any obvious inaccuracies and misunderstanding.

So where does that say, "Please do not give Ravi and Stephen the redacted or the green text"?

A. I -- I believe that there was a further email that actually did say that.

Q. Right, let's get that further email up. INQ0003132, which is your response to this email, sorry, and then we will come to the further email. Could we go to the second page, please. Right. This is your return email, so Sue Eardley sends you the full report, if I am going to put it that way, on 18 October. You, on 15 November say:

"Please find attached an amended report. It has been seen by the Execs, Steve Brearey, Ravi Jayaram and Anne Murphy, and their comments have been taken into account."

So, in fact, what you say to the Royal College and

what the Royal College would have assumed is that those particular Consultants would have seen the full copy, including the green text?

A. I'm not completely clear in my mind that that first report that was sent through included the green text.

Q. I think it all included the green text, unless and until you came to the final version, which we are going to come on to now, which is the email from Sue Eardley, which is INQ0009617.

So, again, can I just clarify there is nothing in there about you talking about confidentiality or discussing anything with Sue Eardley about confidentiality. So this is the letter which encloses the two reports, and I think Ms Eardley has already given evidence that, you know, with hindsight, she should not have produced two reports, she should only have produced one. So let's leave that to one side:

"Please find attached a close out letter. I have made the changes as suggested below in your email. Please let me know if there is anything else that can assist. There is one confidential, which includes the HR issues and is our formal version, the other omits these and would perhaps be suitable for wider dissemination amongst those who contributed."

Now, this email has to be seen in the light of the previous chain of emails we have seen, which is:

"Can you make sure that Ravi and Steve see the full version for factual accuracy."

You send the email back saying that they have seen it and there are these two reports. Nowhere in that email does it say we are telling you not to send it to anybody.

It says it perhaps would be suitable for wider dissemination amongst those who contributed. Do you think you could have misread that email as saying something which it didn't mean to say or do you think that it just suited your intentions to have it read that the full report shouldn't be seen by the Consultants?

A. My reading of that email is that the confidential one, with the HR issues, was for very limited circulation and the formal version was the one for dissemination to those who had contributed. I --

Q. But --

A. -- still am not clear in my mind that the very first report that we received actually included the green text because there was no reference to that being called out as something -- something different at that point.

Q. Okay. But can I ask you to note the words,

"would perhaps be suitable". So this isn't an instruction or a direction. It's a suggestion; that's right, isn't it?

A. Yes.

Q. Okay. Can we then look at the letter which was attached to this email, which was the close out letter, that's INQ0009620. It's the second paragraph I would like you to look at, please, Mr Harvey:

"Aware of the personnel issues, we have provided two reports, one including the full details and one omitting the confidential HR issues. To continue our expectation of openness, I hope you will share the dissemination copy of the report in confidence, if necessary, with those who contributed. It remains your report though and we will not distribute or share it more widely without your permission."

So the point that Ms Langdale made to you repeatedly this morning was in fact made to you by the Royal College of Paediatrics at the time that the final report was sent to you, which was, "It is your report, distribute it as you wish, we have tried to do something to help you". In no way does it say there, there is any injunction, prevention, direction or refusing to disclose the report to, in particular, those people who had made their concerns known to you about Letby.

A. I would say that the use of the phrase "confidential HR issues" was something that might cause that thought in my mind. I accept that it was our report. But, in considering the content, in considering the recommendations, I was also mindful of those who constituted the expert team that came to visit.

Q. Yes. But you had already had a conversation with them, both on 2 September and then a letter had been sent very quickly afterwards on 5 September, at which they had said, "You need to get on with the disciplinary process", and Ms Langdale took you to those various discussions this morning.

So you already were aware of the fact that the Royal College had assumed that you would have been in the process of undertaking a disciplinary investigation, which the witness, who have given evidence on behalf of Royal College, Ms McLaughlan, said she would have assumed that meant that you would have called the police. So surely it is in that context you have to take it? Not, "We don't think that anyone should see this", but maybe, "Not everyone who doesn't know what already has been going on should see it"?

A. I would suggest that a lot of the communications from the College and their report as well is couched in vague language. It is full of

assumptions. You have just described an assumption. At no point is there anything explicit and, given the nature of the concerns that led to the invitation to review, given the expertise of the team I would have expected, if they anticipated that there was something that serious, that it would be explicit.

And I find it very difficult to accept that the lay member, as an inactive barrister who contributes to NCAS and the NMC is talking in terms of vagueness, and this really didn't help us.

Q. Okay. Well, you are perfectly entitled to your perspective on that. Obviously, the Royal College doesn't agree with that but that's -- but it doesn't really help answer the question that I asked, which was: there is nothing in this letter which identifies that you should be keeping HR matters in respect of Letby confidential to those who made their concerns known to you?

A. Not, not explicitly no. The use of "Confidential HR issues" would mean that I would be seeking advice with regard to what we would do there.

MS SCOLDING: Yes. Thank you. I have no further questions, thank you very much.

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

Ms Blackwell?

Questions by MS BLACKWELL

MS BLACKWELL: Mr Harvey, it's been put to you by Counsel to the Inquiry as a fact that Child O and Child P should never have died after the 11 May meeting when Letby could have been off the ward and referred to the police, and she put that allegation to you, the implication being that you, as the Medical Director, are responsible in part for that taking place.

It has also been alleged that you, as the Medical Director of the hospital were part of harbouring a murderer, that's been put to you by Counsel to the Inquiry. As this Inquiry is a search for the truth, I want to take you through what evidence there is before the Inquiry and that you would have known about in order to see whether there is evidence in order to support those allegations?

A. Yes.

Q. Now, what lay behind the 11 May meeting was the Thematic Review?

A. Yes.

Q. So I would like to take you, first of all, please, to the Thematic Review itself, the one that was discussed during the course of the 11 May meeting, and it's at INQ0003400. Now, as that's being brought up,

let's remind ourselves that the first copy of the Thematic Review that you received from Dr Brearey was sent to you, you having asked him for details of what you believed was an external review --

A. That's correct.

Q. -- and he sent you the draft document on 15 February?

A. He did.

Q. Yes. What we are looking at now is the final document.

A. Yes.

Q. If we can look at page 2, please. We can see that this is the document that was created following the meeting on 8 February 2016. We see that at the foot of the left-hand corner. The purpose of that review was to deal with the higher than expected mortality rate on the NNU during the course of 2015?

A. That's correct.

Q. Now, there were 10 cases considered during the Thematic Review. Those cases were chosen by Dr Brearey, weren't they?

A. They were.

Q. Yes. We can take these fairly quickly, I hope. The first death was of a child on 5 April of 2015, a child that had severe hypoxic ischemic

encephalitis, a death for which Lucy Letby was not on duty?

A. Yes.

Q. Yes. Over the page, please. There are then three further deaths, we now know them as Child A Child C and Child D. Of course, when this review was prepared, they were referred to by their names, weren't they?

A. That's correct, yes.

Q. Yes, and we know, as we can see, that Child A died on 8 June 2015, there was a Coroner's postmortem, which was unascertained. We know that the Inquest there is listed as taking place on 23 March 2016 but, in fact, we now know that was delayed until 10 October 2016.

A. That's correct.

Q. I will come back to that at the end of my questions. We also know that Child A had a Twin, Child B?

A. Yes.

Q. It was suggested to you by Counsel to the Inquiry that at no time did you suggest that Child B and Child B's collapse should be looked at. Was that ever something that Dr Brearey raised, as far as you are aware?

A. No, it wasn't.

Q. Thank you. Child C, we can see had a postmortem. We see what the results of that postmortem were. The concern in relation to Child C was that there was no cause for the deterioration identified. Child D died on 22 June 2015. Again, there was a postmortem with a reason given for death.

Can we go over the page, please. Child E died on 4 August 2015. There was no postmortem but there were two causes of death given.

Then on 4 September 2015, another child died. It appears that that child might have undergone a sudden collapse. There was a postmortem, there were reasons given for the death. Lucy Letby was on duty, we know from the appendix, at the time of that collapse and death.

Over the page, please. Thank you. 27 September 2015, another child died. There was a postmortem with reasons given for the death. Lucy Letby was on duty when that child collapsed and died.

Then Child I died on 23 October 2015. At the time that this review took place, there was a postmortem awaiting and we know that that was the child, Child I, who had undergone multiple transfers.

We can see that the information provided in this review is that there were arrests on 13, 14 and

15 October but with rapid improvement after each arrest.

Did it come to your attention as to whether or not that improvement had taken place within the Countess of Chester Hospital or outside of it?

A. That wasn't clear, no.

Q. Thank you. On 13 December 2015 another child died. There was no postmortem but two reasons given for the cause of death. Lucy Letby was on duty at the relevant time.

Over the page, please, thank you. On 8 January another child died. At the time that the review took place, the postmortem was being awaited and there was probable prematurity and sepsis being suggested.

In relation to this child, there had been what appears to be a sudden arrest on day two and Lucy Letby was not on duty during the course of that arrest.

Now, if we go over to the next page, please. We can see --

LADY JUSTICE THIRLWALL: I am very sorry to interrupt you, Ms Blackwell, but I noticed when we were looking at Child A -- it's nothing to do with you or the witness -- the details of the mother's condition have not been redacted. They should have been. I'm not sure how that's happened, but that first line of the mother's medical condition must not be reported.

MS BLACKWELL: Thank you very much, my Lady.
LADY JUSTICE THIRLWALL: Not at all.
MS BLACKWELL: These were the themes as we see them in the final report, so the first, sudden deterioration, the second, the timings of the arrests.
Now, in the draft report which you saw on 15 February, those -- well, sudden deterioration didn't appear at all, the timing of the arrests was number 4 of the themes identified, and top of the themes identified was delayed cord clamping. That was the report that was sent by Dr Brearey to the others who had been present within the meeting in order for them to comment upon.
A. That's correct.
Q. Yes. We know that it was following suggestions from Dr Subhedar that these amendments were made?
A. Yes.
Q. But you didn't see the amended report until it was sent to you via Alison Kelly on, I think, 17 March 2016 or thereabouts; is that right?
A. I think that's probably correct, yes.
Q. Yes. There were a series of outstanding actions set out in a summary action plan. Could we go to page 9, please. Thank you. Did you see these actions set out in the action plan prior to the meeting

on 11 May?
A. I believe they were attached, yes.
Q. Thank you. If we could just go back to page 7, please, we can see that one of the actions at page 7 was that Stephen Brearey and Eirian Powell were to review all the cases focusing on nursing observations in the four hours before the arrests. Were you aware that that was an action that had been set out and was being undertaken?
A. When I received the final version of this, yes.
Q. Right. Thank you. Now, you understood when you read the Thematic Review, going into the meeting on 11 May, that there were problems on the ward; is that right?
A. Yes. Primarily concern about an increased number of deaths.
Q. It's been suggested to you today that it must have been obvious to you, given the sudden deterioration as we see it under the themes identified, and the timings of arrests, that deliberate harm was being suggested both on the face of the document and later in the meeting of 11 May, which we will come to; is that right?
A. Sorry, is that right in terms of I would

appreciate that or --
Q. Was deliberate harm obvious to you from the face of the document?
A. It, it wasn't either in terms of the overall tone of the document, nor was it specifically called out.
Q. Could we have up please the email that you received from Alison Kelly on 6 May. It's INQ0107818. It has been suggested to you that when you read this email from Alison Kelly, it must have been obvious to you what she meant when she suggested that she had some alarm, and I think it's at page 2, please.
If we look at the email on 4 May from Dr Brearey. You have already been taken to this today:
"There is a nurse on unit who has been present for quite a few of the deaths. Eirian has sensibly put her on day shifts", and he talks about the pressure on staffing numbers.
Was that brought to your attention?
A. Was I -- no, at that point, I wasn't on the circulation list.
Q. Can we go back to page 1, please. At the bottom of the page, we can see that Alison Kelly, I think, has forwarded that email on to you?
A. That's correct.

Q. She has said:
"Please see Steve's comments below which alarmed me."
It was that to which you were taken, I think, by Mr Baker. Your response, which you weren't taken to, later on that day appears above it:
"I see what you mean, although perhaps he just meant that he was concerned for her. I am fine to meet for this next Wednesday."
A. Yes.
Q. So what was your take on what was being suggested?
A. My take from the description of her having been sensibly removed, together with just the expression of concern with regard to staffing, was that this had been a supported move. My interpretation was that Dr Brearey supported that move but was concerned about how that shift of that member of staff was going to affect the staffing balance on the unit.
Q. Thank you. Mr Baker also questioned you about the request for a meeting from Dr Brearey?
A. Yes.
Q. You know that his evidence to the Inquiry was that, soon after completing the Thematic Review, he was keen to meet with you and had asked for an urgent

meeting?
A. That's correct.
Q. Could we have up on screen, please, INQ0038966? It was suggested to you that there must have been a conversation or another email that had gone between you and Dr Brearey because, further on down the line, you had made it clear that he had made a request of you that the Thematic Review be aligned with the obstetric review?
A. Yes.
Q. Yes. Now, if we look at the middle of that page, we can see on 15 February you are emailing Dr Brearey in these terms:
"That's helpful. I note that you state an obstetric thematic review did not identify any common themes or identifiers that might be responsible for the rising mortality in 2015 and now you have carried out a review, where do the two get joined up?"
A. Yes.
Q. Yes. We can see his response to you at the top of that page:
"They will get joined up at the Women and Children's Governance Board. It's not easy working across Urgent and Planned Care Divisions. I have copied this into Jo Davies for her info."

A. Yes.
Q. Which would appear to be the missing email, so far as that piece of the jigsaw is concerned?
A. That would appear to fill in the gap.
Q. Yes. There is no request for an urgent meeting is there?
A. No.
Q. Did he ever make one of you?
A. No.
Q. Thank you, we can take that down, please. Now the meeting itself on 11 May, we have looked at the notes; I don't intend to take you back to them. But just to confirm your recollection of what was being said there.
In terms of anything that Dr Brearey might have said, did he provide to you any information over and above what we have just seen on the face of the written document?
A. No, he didn't.
Q. Did he challenge Eirian Powell and Anne Murphy when they spoke in terms that the Inquiry has heard that we see in their written note which they brought to the meeting?
A. No, he didn't.
Q. Right. We have seen the email that he sent

following that meeting in which he referred to it as a helpful meeting and he was grateful for the work that had been done and for the actions that were flowing from that. And did you take that on face value?
A. Absolutely.
Q. Now, one of the additional matters that was set out in that email is -- and of course it was sent to his fellow clinicians, was this instruction: if you do come across a baby who deteriorates suddenly or unexpectedly or needs resuscitation on the NNU, please can you let me and Eirian know?
A. Yes.
Q. You were aware of that?
A. That was one of the action plans from the meeting.
Q. So between 11 May and 27 June did anybody any of the clinicians, including Dr Brearey and Dr Jayaram, bring anything to your attention?
A. No, they didn't.
Q. No. Not the deterioration *(redacted)* of Child N on 15 June of 2016?
A. No.
Q. No. As you have told the Inquiry, the first you know you knew of the deaths of O and P was on 27 June?

A. Yes, that's correct.
Q. I am not going to take you again to the meeting notes of the 29 June. You have already given your evidence as to what you took Dr Jayaram to mean when he posed the question:
"How? Cannula? Air embolism? Crystal ball? Unquestionably got something going on in the Countess of Chester but what?"
You took that to mean either a deliberate harm or a competency issue?
A. Yes.
Q. Yes. You have already been taken to the comments made by Tony Chambers in the middle of that page. I suggest in accordance with the evidence he's given to the Inquiry that the note is wrong and that it should be: why did we not call the police?
A. Yes.
Q. Of course you have been taken to the fact that Dr Brearey's response to that is can we move the member of staff? If no, then we should go to the police.
And Dr Jayaram's response:
"Why not earlier, call the police: reviews."
A. Yes.
Q. Is that your level of knowledge, that there had been reviews undertaken on the ward, including

Dr Subhedar who was an outside external Consultant and that's why there hadn't been a decision thus far to go to the police?

A. Yes, that's correct.

Q. There was a meeting the following day on 30 June, again I am not going to take you again to the -- to the record that we have had up twice, possibly three times today.

Do you recollect whether or not when Tony Chambers suggested if the nurse be removed, the deaths would stop, the response from Dr Brearey was either: risk would be reduced or risk would be removed?

A. I can't recall which answer was given.

Q. Do you accept that by the end of the meeting on 30 June there was at least the prospect in your mind that deliberate harm might have been being caused?

A. Yes.

Q. Were there other matters that were also within your mind as the possible cause of the increased mortality?

A. Absolutely. Common -- common things are common and one is going to be concerned about quality of care, be that collective, be that individual and the effect that that would have on the safety and the level of care that is delivered.

Q. So when it was suggested to you this morning by Counsel to the Inquiry that you should get off the word "association" and that what was being said loud and clear was deliberate harm and murder, is that a fair reflection of your memory of that meeting?

A. No. It -- it doesn't reflect what I heard from what was a very wide-ranging and I believe very honest conversation amongst all those present.

Q. When it was put to you by Counsel to the Inquiry that at the end of the 30 June meeting there was no substance in saying that it was only a possibility of there being deliberate harm, does that reflect your memory of the meeting?

A. That it was only a possibility?

Q. That it was --

A. Yes.

Q. -- something more than a possibility?

A. No.

Q. There was no substance in saying it was only a possibility?

A. No, no.

Q. You have given evidence today about the Silver Command that was set up on 7 and 8 July and you have told the Inquiry that you regret that you did not stick with your initial view that the police should be

contacted if only to provide an oversight to the other work that you were doing?

A. That's correct.

Q. Does that remain your position?

A. It does, yes.

Q. Thank you.

My learned friend Ms Scolding has asked you about the RCPCH Report and given the answers that you have provided to her questions, I don't seek to ask you anything further about that.

But it was suggested to you that only -- and this was by Counsel to the Inquiry, not Ms Scolding, that only the police could provide independent expert evidence.

Do you agree with that statement?

A. No, I don't. Ultimately the police will rely on clinical experts to provide that evidence. I'm aware of the criticism of relying on Dr Hawdon, but I would point out that actually the evidence presented at trial was coming from clinical experts based on Casenote Reviews and those experts found sufficient evidence for her to be found guilty.

Q. I think that was what you were trying to say when you were prevented from giving a complete answer to a question that was posed by Mr Baker; is that right?

A. That's correct.

Q. Yes, thank you.

It was also suggested to you by Counsel to the Inquiry that Dr Subhedar in his letter to you very clearly indicated that you should go to the police.

Now, could we have a look at that letter please. It is an email at INQ0006890 and it's page 188.

LADY JUSTICE THIRLWALL: Choose your moment for a break.

MS BLACKWELL: I have nearly finished, my Lady.

LADY JUSTICE THIRLWALL: Very good.

MS BLACKWELL: If we just take a moment to look at the various points made by Dr Subhedar in this letter. He talks about the Terms of Reference not being clear, his own interpretation of the 13 deaths, he's broadly in agreement with the recommendation of Dr Hawdon. He questions the fifth recommendation on the basis of her review.

He adds an additional seven cases and he says:

"I would like to make one further observation in relation to the RCPCH Report and recommendations. Many of them relate to governance arrangements."

He says that those are matters which are common, not just at the Countess of Chester Hospital and he hopes that the letter is helpful and that he would like

to share his findings with Stephen Brearey.
Did you read anything in that letter as being a very clear indication that you should go to the police?
A. No, I didn't.
Q. Thank you.
The final matter that I would like to ask you about is Child A. Child A, as we know, had an Inquest eventually on 10 October 2016. This Inquiry has heard from Dr Jayaram who gave evidence to the Coroner and indeed you were asked questions yesterday by Mr Skelton about the evidence that Dr Jayaram gave to the Coroner.
Dr Jayaram told this Inquiry that he didn't mention to the Coroner anything about concerns that by then were being held that there was a possibility at least of deliberate harm at the Countess of Chester Hospital.
He gave evidence to the Inquiry that rather than making anything explicit to the Coroner, he laid what he described as "breadcrumbs":
"I was trying to sort of throw as many breadcrumbs as possible for the Coroner to pick up without explicitly saying what the suspicion was. I appreciate [he told the Inquiry] that this was the wrong judgement", given that Baby A's parents were sitting 10 feet away and that he had failed in his duty of

candour.
Now, you were asked by Mr Skelton whether or not you thought that that was adequate for somebody to on oath give that evidence?
A. Yes.
Q. What was your response to this Inquiry?
A. I believe my response was that that was wholly inadequate.
Q. It was suggested to you that you may have in some way interfered with the statements that were provided to the Coroner. Did you do that?
A. I didn't.
Q. It has also been suggested that you did not bring to the attention of either the Coroner or the Assistant Coroner the concerns of the Consultants.
Now, in answer to questions from Counsel to the Inquiry today, it has been confirmed that in fact what had been provided to the Coroner in written form was the letter from the Consultants, Dr Hawdon's report and also the green text from the RCPCH Report?
A. That's correct.
Q. That is the green text of course which sets out the allegations that Nurse Letby had been involved in some way --
A. Yes, that's correct.

Q. -- in what had gone on.
So what do you say, Mr Harvey, was the topic of the conversation between yourself and the two Coroners at that meeting in February of 2017?
A. The topic of conversation was with regard to the events surrounding the paediatricians writing their letter to Tony Chambers requesting that we approach and spoke with the Coroner to investigate with him whether he would consider reopening any of the cases or undertake further investigation.
By that very nature, we would have to explain and provide documentation to support why they had written that later -- letter and why we were requesting that meeting with the Coroner.
Q. Is there any doubt in your mind that that conversation took place?
A. Absolutely not.
MR BAKER: Thank you, my Lady. That is all I have.
LADY JUSTICE THIRLWALL: Thank you very much, Ms Blackwell.
Further questions by MS LANGDALE
MS LANGDALE: My Lady there is one document I should have put, if I can introduce that.
LADY JUSTICE THIRLWALL: Yes, of course. Just let Ms Blackwell get to her place.

MS LANGDALE: Mr Harvey, can we have a look please INQ0014405, page 1. It is a document I should have referred you to earlier. It relates to the CQC.
If we see it, it's reflection of a CQC document 17 February 2017, "Strategic update from the Trust." Do you see that in box 3?
A. Yes.
Q. Does that reflect your meeting and update in February 2017 with the CQC? *(Pause)*
A. I -- I believe so, yes.
Q. The CQC say they didn't receive the Thematic Review report, you say you sent them -- you said in evidence you say you sent the Thematic Review to the CQC, but in your statement you said you couldn't recollect. Do you know now whether you sent the Thematic Review report and if so, when?
A. I'm -- I'm basing that on the fact that in February 2016, in the email that I sent to Stephen Brearey requesting a copy of the thematic or asking if the review was available.
Q. I don't think it was available then to you. We have heard?
A. He sent me a draft copy but that was very specifically with regard to the forthcoming CQC visit and I haven't seen an email but in doing that

specifically, I am sure that on receipt of that, I would have forwarded it to whoever was responsible for sending the documentation through to the CQC ahead of their visit.

Q. We will follow that up, Mr Harvey. It looks like the CQC may have had the Brigham review but not the Thematic Review and the minutes may have been attached to Dr Brearey's email, you had asked for it, but from what your counsel says today you had this in March I think yourself, but we will follow that up in any event. You didn't recollect in your statement and you don't have a firm memory; we can follow the paper trail?

A. I -- I -- I can't -- I can't recollect. I would have to rely on the paper trial, but I am simply surmising based on the fact that I had very specifically asked him for that with the forthcoming CQC visit, that having received that from him that would have been forwarded to the CQC for consideration during their visit.

MS LANGDALE: Thank you. Those are my questions.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Thank you, Ms Langdale. Just one or two from me, if I may, Mr Harvey.

A. Yes, my Lady.

LADY JUSTICE THIRLWALL: First of all, one of the

things you have been asked to comment on by various people at various stages was the pattern of deaths that are picked up in the Thematic Review occurring between 12 o'clock at night and 4 o'clock in the morning.

A. Yes.

LADY JUSTICE THIRLWALL: You said that -- well, you referred I think to an Imperial College paper, a research paper. You did refer to an Imperial College paper.

A. I did, that paper was actually very specifically with regard to increased mortality at the weekend.

LADY JUSTICE THIRLWALL: Yes.

A. But it is accepted that the risk is also greater at night. That almost certainly reflects different staffing levels.

LADY JUSTICE THIRLWALL: Just before you continue, because the reference you gave us yesterday was to the Imperial College paper, which, as you rightly say, deals with weekends.

A. Yes.

LADY JUSTICE THIRLWALL: You say it's generally accepted and that's based on what?

A. That is based on clinical experience, experience of the patterns of mortality in other groups

that I saw in my job and from the publications and the data that we get from NHS England.

LADY JUSTICE THIRLWALL: Thank you. That is not something, I don't think you mentioned, in any of the meetings, or "That is nothing to worry about, it's to be expected". I don't think it is.

A. I'm not sure I would describe it as to be expected but it is a factor that one recognises, yes.

LADY JUSTICE THIRLWALL: Yes. So just so I understand your thinking. You weren't discounting it but you were saying that you need to bear in mind this particular factor?

A. I wasn't discounting it but there was potentially another factor that would play into it, yes.

LADY JUSTICE THIRLWALL: Thank you. Then I just wanted to ask you a little bit about the GMC --

A. Yes.

LADY JUSTICE THIRLWALL: -- because you made it very clear to us that the experience of a doctor even just receiving a letter from the GMC --

A. Yes.

LADY JUSTICE THIRLWALL: -- can be extremely damaging, even just the first letter?

A. I -- I would describe it, in some cases, as devastating.

LADY JUSTICE THIRLWALL: Devastating, yes. Can you offer any thoughts as to how we have got to a situation where a first letter from a regulator can have that effect?

A. I had cause to complain to the GMC on a number of occasions because they gave no thought to how or when they sent their letters out.

LADY JUSTICE THIRLWALL: You mentioned a weekend, I think, didn't you, sent on a Friday.

A. That's right. I would get doctors contacting me late on a Friday night or at the weekend because they just opened the letter.

The GMC in its letter will often offer -- and obviously I am now speaking of practice six years ago --

LADY JUSTICE THIRLWALL: Some years ago, yes.

A. -- will offer areas of support but, at the weekend, those areas of support aren't available and I'm aware the GMC have done a lot of work because of the recognition of the increased rate of suicide amongst doctors who are under investigation. But just simply getting that letter is sufficient to cause a huge amount of anxiety to not every doctor but to -- to most, I would suggest.

LADY JUSTICE THIRLWALL: Because one of the things that's very striking from the evidence, and it's been

said to you is, well, the evidence about fear --
A. Yes.
LADY JUSTICE THIRLWALL: -- in various contexts but clearly fear about what will happen with the GMC. That seems to me to be a theme.
A. Absolutely. And there will be word of mouth amongst the medical body with regard to the -- what those who have been through the process have actually gone through. It was, for that very reason, that I was keen to do everything that I could to avoid that happening to those doctors to whom I could see no reason why they -- they should be referred.
LADY JUSTICE THIRLWALL: Yes. Thank you. I am not going to ask you about the detail of that. It was rather the sort of broader picture. Thank you very much.
So is this a fair summary: by January 2017, the doctors have given their evidence and I can make my decision about the effect upon them but Lucy Letby was writing to you directly --
A. Yes.
LADY JUSTICE THIRLWALL: -- with a number of requests, presumably with which she hoped you might comply.
A. Yes.

LADY JUSTICE THIRLWALL: Did it occur to you, and I appreciate you don't remember the email, now you have had a chance to see it several times, I am sure, in the preparation for this Inquiry.
A. Yes.
LADY JUSTICE THIRLWALL: But it appears from it, doesn't it, that Karen Rees, who was the Divisional Director of nursing, had given her information that she had received from a nurse about what a doctor had said in a meeting?
A. Yes.
LADY JUSTICE THIRLWALL: That's what she was wanting to get to the bottom of?
A. Yes, that's correct.
LADY JUSTICE THIRLWALL: Did it occur to you that that had any echoes of what had happened with the grievance, that there had been a sort of conduit and then a grievance from Letby about something that had been said?
A. I saw it as an extension of that existing situation. As I think I said, I was uncomfortable with that email from the tone and the content. I can't say what I did with it but I am sure that I would have escalated it to either Alison Kelly or Sue Hodkinson in those circumstances. I certainly wouldn't have

responded and I certainly wouldn't have forwarded any of the information that she was requesting.
LADY JUSTICE THIRLWALL: No, you have made that quite clear.
A. No.
LADY JUSTICE THIRLWALL: One last thing, and I'm afraid I don't have an absolutely clear recollection of the name of the witness, so I'm sorry about that, somebody else might know it, but when the CQC were in, in February 2016 --
A. Yes.
LADY JUSTICE THIRLWALL: -- one of the -- I think she was a Specialist Adviser, rather than an inspector but she was overseeing a focus group with the Consultants, not the paediatric Consultants, the Consultants generally --
A. Yes.
LADY JUSTICE THIRLWALL: -- and a reasonably large number of the Consultants turned up, and she doesn't have many notes but she had a note in her diary which referred to the Consultants complaining about bullying of the Consultants by the medical management and she said that she had come immediately to you to talk about that; do you have any memory of that?
A. I have no recollection of a conversation to

that effect at all.
LADY JUSTICE THIRLWALL: What would you have thought had she come to you with that information?
A. Well, my initial reaction would have been huge concern. That wasn't how I viewed the relationship that we had with the Consultant body, and I would have taken steps to -- to investigate it further. In the first instance, I would probably have approached Dr Jameson as the Chair of the Medical Staff Committee --
LADY JUSTICE THIRLWALL: Staff-Side, yes.
A. -- and Dr Tighe, as the *(unclear)* BMA Local Negotiating Committee and probably also my senior medical management team, the Divisional Medical Directors. I have to say, I'm surprised that that assertion was made because it was contrary to an independent, validated medical engagement survey that we had undertaken, I believe, in 2015, which actually scored highly in terms of engagement with the Consultant body.
LADY JUSTICE THIRLWALL: All right. Well, thank you. That is -- sorry, did you want to say something else?
A. Well, I was just going to say that, in turn, I suppose, had they reported that to me, would have actually caused even heightened concern because

something had obviously changed in a very short period.

LADY JUSTICE THIRLWALL: Yes, thank you.

Does anybody want to correct anything?

Good. Well, it's very late but it's not as late as it might have been, which is scant consolation but thank you very much indeed, Mr Harvey. You are free to go.

A. Thank you.

LADY JUSTICE THIRLWALL: We will rise and start again 10.00 Monday morning.

(5.25 pm)

(The Inquiry adjourned until 10.00 am, on Monday, 2 December 2024)

I N D E X