The paediatric consultants have given evidence that trust execs were very resistant to their concerns about murder, and resisted getting police involved right up until May 2017.

Tony Chambers:
In February 2016 there was a comprehensive CQC inspection at the hospital, including paediatrics and neonates. I am not aware that the consultants escalated any concerns with the CQC inspection team; nothing was reported to me at the time, or in any post-inspection feedback or report.

A thematic review by a multi-professional team [including the Cheshire and Mersey neonatal network lead], into neonatal mortality 2015 – Jan 2016 was undertaken February/ March 2016. No common themes were identified in all of the cases, however, some themes occurred in more than one baby.

This resulted in a meeting between the Medical Director, Director of Nursing and Quality, the neonatal lead and senior neonatal nursing staff on 11th May 2016. At this meeting the results of the thematic review were discussed. It also highlighted that there was one member of the nursing staff who had been present at more cases than any other member of staff. There was no evidence other than coincidence and what was described as 'gut feeling'.

Various actions were agreed. Concerns were further exacerbated following the unexplained collapses of two babies in June 2016. In June 2016, when these serious concerns were escalated to me for the first time (and therefore to the Board of Directors), prompt action was taken to maintain Neonatal Unit safety – including:

− The unit being redesignated to Special Care Unit (SCU) caring for infants from a minimum of 32 weeks gestation.

− A comprehensive review of the Neonatal Unit to include, activity, acuity and staffing levels.

− A review of babies who collapsed unexpectedly (led by Dr John Gibbs).

− Invited review from Royal College of Paediatrics and Child Health (RCPCH).

− Nurse LL redeployed off the unit.

No further unexpected deaths were reported after this time.

The Royal College of Paediatrics and Child Health RCPCH review (published 8th February 2017) recommended the need for a secondary external case review. This review identified the need for further explanations in 4 cases.

A meeting [March 2017] between the Governance and Neonatal Leads to align reporting processes led to this number being increased to 8.

This led to a meeting [28th March 2017] between trust executives, including me, senior consultants and neonatal network leads to agree next steps.

A meeting was arranged by the Medical Director with the chair of the Child Death Overview Panel (CDOP). This meeting took place, April 28th 2017 and included senior paediatricians and a Chief Superintendent who was representing Cheshire police.

This subsequently led to the first meeting between trust executives and Cheshire Police on May 5th, 2017.

Trust internal reports in 2016 highlighted issues such as increases in acuity levels and activity, without contemplating what the consultants were really worried about all along. Subsequent work for Facere Melius has cited various flaws in those reviews.

TC: I can't comment on an unpublished report that I have not seen.

The review in question was supported by one of our own senior paediatricians, Dr Gibbs and a senior nurse, Anne Martyn (Children's Unit Manager). They reviewed all unexplained collapses. The relationship between LL and the incidents was taken as fact. The reviews focussed on demand, acuity and staffing.

Two of the babies died from synthetic insulin, which should have been picked up in post-mortems and clinical governance processes and investigated fully at a much earlier point.

TC: Insulin was never raised with me at the time or at any time afterwards.

The responsibility for ordering and interpreting a blood test is a clinical one, the oversight of which lies with the named consultant…

These blood test results were the only strong evidence of potential harm and would have materially altered the focus of subsequent inquiries and actions if they had been raised with me or any other senior manager in August 2015.

Although the RCHPH were commissioned to review the unit in late 2016, the consultants felt at the time this review was too general and not asking the right questions. RCPCH concluded that further detailed reviews of each case were needed, including looking at obstetric/pathology/post mortem indicators and nursing care. Ian Harvey arranged for Dr Jane Hawdon to carry out further review, but the paed consultants claim her work did not meet the criteria set by RCPCH. Dr Hawdon's report did not identify any common or unnatural causes in the deaths, but called for further investigation into 4 of the cases. The paed consultants say there was no further investigation.

TC: The terms of reference for the Royal College of Paediatrics and Child Health (RCPCH) review RCPCH review were agreed with regulators, Board and shared with the paediatricians.

The RCPCH review (published 8th February 2017) recommended the need for a secondary external case review. This review identified the need for a broader investigation of 4 cases.

A meeting [March 2017] between the Governance and Neonatal Leads to align reporting processes led to this number being increased to 8.

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This subsequently led to the first meeting between trust executives and Cheshire police on May 5th 2017.

Instead, in February 2017, the trust published a redacted version of the RCPCH report. Ian Harvey said the reviews had met the royal college recommendations, which the consultants claim was incorrect and misleading. According to board minutes, you told the Feb board meeting: "The independent case review highlighted some areas for improvement but did not identify a single causal factor or raise concerns regarding unnatural causes."

TC: At the completion of the RCPCH report this was factually correct.

After this, the consultants say you and other Execs pushed to get LL back to work, noting that she'd already had a grievance upheld. They said you mentioned they could be referred to the GMC if they resisted, and arranged for them to write an apology letter to LL as part of a mediation process. It's claimed you said she'd done nothing wrong and there would be consequences if they didn't draw a line under it. The consultants felt bullied and intimidated. In a letter to LL in 2016, you had also accused consultants of orchestrating a campaign against LL, accusing them of being dishonest and unprofessional.

TC: It is incorrect to state that I said Ms Letby had done nothing wrong. I would have quoted the view of her father that his daughter had done nothing wrong.

In the meeting with the family (following the grievance) I explained that upholding a grievance wasn't the same as an exoneration; Ms Letby continued to insist she'd done nothing wrong; I made no comment.

At the January 2017 meeting, my notes show that Dr Jayaram (one of the paediatricians) thanked the Board and said that they "looked forward to working together and there is a need to understand each other's position." He went on, "we have not been as good at that as we could have been".

I made the point that emotions had been running high and we needed to live the values of the Trust.

I have no record of writing to Ms Letby in the terms described. She would have received a letter from the Chair of the grievance panel.

After a further review arranged by Stephen Brearley in around Feb 2017, the consultants met with you and insisted on taking the concerns to the police. They say you agreed, but first had them meet with a barrister to stress the difficulty around that. The consultants then raised the issue through the Child Death Overview Panel.

TC: The QC input was to help prepare for the police inquiry – on his suggestion a meeting was arranged by the Medical Director with the chair of the Child Death Overview Panel (CDOP). This meeting included senior paediatricians and a Chief Superintendent who was representing Cheshire police.

This subsequently led to the first meeting between trust executives and Cheshire police on May 5th 2017.

The consultants also allege that Execs became too close to LL when she was moved into non-clinical duties, and claim you inappropriately met her in a local café.

TC: It was very important (and as part of the Operation Hummingbird actions) that regular welfare meetings were maintained with LL both prior to and during the police investigation.

It is incorrect to state that I met Ms Letby personally - all meetings were formal ones.

She happened to be in the same coffee shop I was in with some senior colleagues. We said nothing other than hello.

It is wrong to characterise such a brief and chance encounter as "inappropriate".

By Sept 2018, the consultants had raised concerns with Duncan Nichol, who arranged for consultants from across the hospital to meet and discuss their experiences of raising concerns with management. The consultants say there was due to be a vote of no confidence in your leadership at that meeting, but that you resigned as CEO beforehand.

TC: The decision to step down was a joint one involving the Chair and myself.

The consultants claim there was a strategy from the beginning to avoid a police investigation and to instead put the spotlight on them to suggest they were trying to cover up poor care.

TC: These were very complex matters.

From the outset, I was focused on working with the senior doctors and the Board to establish what had happened. We followed a process that led to the first meeting with the police.

The best place for such issues to be examined would be an inquiry that would have the ability to establish the truth.