Transcript of the Chair's opening statement

22 November 2023

On 30th August 2023, shortly after the verdicts in the trial of Lucy Letby, the then Secretary of State for Health and Social Care announced that there would be a public inquiry into events at the Countess of Chester Hospital, and the implications of those events. On 4th September I was appointed the Inquiry Chair and I began work immediately.

Today the Inquiry website goes live and this is the time to say something about our work so far and how we intend to proceed.

The Terms of Reference are on the website. They are the result of discussions between the Secretary of State and me and were produced after consultation with the parents of the babies named on the indictment at Letby's trial and with other organisations and people who can help. They were published on 19 October. That was the official start date of this inquiry, almost exactly a month ago.

Our work is in three parts. In brief

Part A is about the experience at the hospital, and elsewhere, of the parents of the babies named on the indictment,

Part B considers the conduct of people working at the hospital and how Letby was able repeatedly to kill and harm babies on the neonatal unit,

Part C will look at the wider NHS, examining relationships between the various groups of professionals, the culture within our hospitals and how these affect the safety of newborns in neonatal units.

We all know that there have been many inquiries into events in hospitals and other health care settings over the last thirty years. The case of Beverley Allitt who murdered babies at Grantham Hospital in the 1990s comes to mind. Everyone was determined that it would not happen again. It has happened again. This is utterly unacceptable. I want to know what recommendations were made in all these inquiries, I want to know whether they were implemented? What difference did they make? Where does accountability lie for errors that are made?

I intend to call experts to give evidence about this. Their details will appear, in due course, on the website.

A wide-ranging and detailed questionnaire has been sent to every hospital in England with a neonatal unit. It is to be completed by both the Medical Director and a senior non clinical manager at each hospital. It includes questions about whether there is CCTV on neonatal units and, if not, whether consideration has been given to installing it in the light of the Letby case. Those particular questions arise from suggestions made by some of the parents and I am grateful for their help on this and so many other matters.

A short survey is to be sent to all midwives, doctors, nurses and managers in hospitals with neonatal units. Responses will be anonymous. It will ask directly for their views on the culture in their units. I hope and expect that those who receive it will find the few minutes needed to complete it. Each response will play an important part in telling the inquiry what people on the ground really think.

Detailed requests for information have already been sent to over 20 organisations. A list of the organisations will be on the website. The Inquiry rules require them to reply. Statements and key materials are being sought.

I am often asked: when will the hearings start? The answer is that are working towards a start date in September of 2024. Why not sooner? Because there are four other events that we have to work around.

First, a large police team is still investigating the actions of Lucy Letby.

Second, the police are also investigating whether there may be a case of corporate manslaughter against the hospital trust. My team are in regular contact with Cheshire police who keep us informed as to their progress.

Third, you may be aware that Letby has lodged an application for leave to appeal against her convictions. I don't expect the application to be determined before the spring of 2024. It may be later.

Fourth, a retrial on a count of attempted murder is listed to take place at the end of June 2024.

If all of those dates hold, there is no realistic prospect of hearing evidence in the inquiry until the autumn, and that's why we are working towards hearings in September. The Secretary to the Inquiry is searching for premises in Chester where hearings can take place. I can't say yet how long the hearings will be. That will be clearer once we have determined how much oral evidence will be called.

As matters currently stand it is likely that we will hear evidence about part A first, then part C, followed by part B. That may change.

In the meantime, I will continue to deal with applications for core participant status. The inquiry team will seek, receive, redact and analyse the documents, instruct experts and decide which evidence (written and oral) will form part of the inquiry. It's imperative that we maintain the significant momentum we have achieved in this last month so that we are ready to start the hearings as soon as we can.

This website will be kept up to date. It's our principal form of communication. You should find here the answer to most of your questions, including details of all the orders made in the Crown Court restricting publicity about the first trial and about the identities of parents, babies and others. Those orders are all in force and they all apply to the Inquiry.

Just two more matters. Both are important.

No one can argue with the proposition that babies in neonatal units must be kept safe and well cared for. What is needed is the practical application of that proposition everywhere. In many units it will require profound changes in relationships and culture. This may not be easy to achieve but it is necessary and long overdue. The barriers to change must be identified if that hasn't been done

already and those barriers must be removed. Where there is good practice, that must be shared. Bringing about necessary change will require the cooperation and will of all those who are involved in and who are responsible for the babies in our neonatal units – from the ward to the boardroom. The inquiry relies on that cooperation as we work on this profoundly important task.

The parents of the babies who were murdered or suffered injuries, some life long, live with the consequences every day. On top of their grievous loss they endured years of uncertainty about what had caused death or injury. And for some, uncertainty remains. All have made it plain to me that they want to do all they can to make sure that no one else suffers as they do. I've already mentioned one of the suggestions they have made as to how this may be achieved. With the help of the inquiry team and all those who will contribute to the inquiry I will do all I can to make sure that no one else suffers as they have. It is unconscionable that this situation would ever occur again.

Rt Hon Lady Justice Thirlwall DBE
Inquiry Chair