Terms of reference

Introduction

On 21 August 2023, after a trial at Manchester Crown Court, Lucy Letby was sentenced to life imprisonment and a whole life order on each of 7 counts of murder and 7 counts of attempted murder. The offences took place at the Countess of Chester Hospital, part of the Countess of Chester Hospital NHS Foundation Trust.

Terms of reference

The inquiry will investigate 3 broad areas:

A. The experiences of the Countess of Chester Hospital and other relevant NHS services, of all the parents of the babies named in the indictment.

B. The conduct of those working at the Countess of Chester Hospital, including the board, managers, doctors, nurses and midwives with regard to the actions of Lucy Letby while she was employed there as a neonatal nurse and subsequently, including:

(i) whether suspicions should have been raised earlier, whether Lucy Letby should have been suspended earlier and whether the police and other external bodies should have been informed sooner of suspicions about her

(ii) the responses to concerns raised about Lucy Letby from those with management responsibilities within the trust

(iii) whether the trust's culture, management and governance structures and processes contributed to the failure to protect babies from Lucy Letby

C. The effectiveness of NHS management and governance structures and processes, external scrutiny and professional regulation in keeping babies in hospital safe and well looked after, whether changes are necessary and, if so, what they should be, including how accountability of senior managers should be strengthened. This section will include a consideration of NHS culture.

A non-exhaustive list of questions arising out of the terms of reference is set out in the annex.

Procedure

The inquiry will operate within the legal framework of the Inquiries Act 2005. The procedure and conduct of the inquiry will be directed by the inquiry chair. The terms of reference are decided by the Secretary of State after consultation with the chair.

The order in which the issues are to be considered has not yet been decided. The priority is to conduct a thorough inquiry as swiftly as possible. The length and timing

of the hearings and where they take place will depend on the extent and nature of the live evidence that is required and upon the actions of the police and Crown Prosecution Service.

Report and recommendations

The inquiry chair will provide a final report (and if appropriate, interim reports) to the Secretary of State as soon as is practically possible. She will make recommendations as she considers appropriate.

Annex: questions

This is a non-exhaustive list of questions which the inquiry intends to seek answers to. This annex does not form part of the terms of reference.

A. The experiences of all the parents whose babies were named on the indictment at the criminal trial

1. During their involvement with the Countess of Chester Hospital and elsewhere what were the parents of each child told when and by whom about the condition of their baby, what was being done to treat them and what the prognosis was?

2. How and when were deteriorations (sudden or otherwise) in their babies' conditions explained to them?

3. Where parents raised concerns about the condition and/or care of their babies, what was done and what were the parents told?

4. When were they given access to their babies' medical records?

5. What information were the parents given by the hospital regarding concerns about Letby's conduct and when? What were they told was being done about the concerns?

6. What were the parents of each child told about the likely cause of death or injuries? When and by whom?

7. When were the parents of each child told that Letby was suspected of causing the death or injury to their child? Was the trust sufficiently candid with the parents throughout?

8. What are the views of the parents of each child as to the adequacy of the information they were given at each stage?

9. What was the parents' experience of the Patient Advice and Liaison Service (PALS)?

10. What are their suggestions for keeping babies safe on the neonatal unit?

B. The conduct of those working at the Countess of Chester Hospital including the board, managers, doctors, nurses and midwives during the period from the arrival of Lucy Letby at the hospital on 4 January 2012 to date

11. What was known and what should have been known about Letby's previous work as a nurse when she began employment at the Countess of Chester Hospital?

12. What concerns were raised and when about the conduct of Letby? By whom were they raised? What was done?

13. Should concerns, including about hospital or clinical data, have been raised earlier than they were? When? What should have been done then?

14. Were existing processes and procedures for raising concerns used, including whistleblowing and freedom to speak up guardians? Were they adequate?

15. What was the culture within the hospital? To what extent did it influence the effectiveness of the processes and procedures at question 14?

16. Whether systems, including security systems relating to the monitoring of access to drugs and babies in neonatal units, would have prevented deliberate harm being caused?

17. Were existing processes used for reporting concerns to external scrutiny bodies where appropriate? If so, when and what happened? Such bodies may include NHS England (and its regional bodies), local commissioners, Monitor, NHS Improvement, child death overview panels, the Care Quality Commission, the police and the successor of any of these organisations.

18. When was consideration given to reporting Letby to the police? When was she in fact reported to the police and by whom?

19. What information about each of the deaths was provided to the coroner? Was the trust's provision of information to the coroner appropriate?

20. Did the relationship between clinicians and managers, nurses, midwives and managers and between medical professionals (doctors, nurses, midwives and others) at the Countess of Chester Hospital contribute to any failure to protect babies on the neonatal unit from the actions of Letby? How did professional relationships affect the management and governance of the hospital?

21. Did the structures and processes for the management and governance of the hospital contribute to a failure to protect the babies on the neonatal unit from the actions of Letby? Is the management structure and governance typical of neonatal settings in other hospitals?

22. What was the board's involvement in the way concerns about Letby were dealt with by the hospital?

23. What was the board's oversight of clinical and corporate governance?

24. How was Letby managed once concerns were raised about her?

25. Was Letby reported to the Nursing and Midwifery Council (NMC)? When? What information, if any, was provided to the NMC, royal colleges and any other external scrutiny bodies? What was done by the bodies to whom the actions were referred? What happened as a result?

26. What information, if any, was provided to the General Medical Council (GMC) and what information was requested by the GMC? What was the result of any referral or discussions with the GMC?

27. What happened to those who raised concerns about Letby?

C. Wider NHS

28. Whether recommendations to address culture and governance issues made by previous inquiries into the NHS have been implemented into wider NHS practice? To what effect?

29. What concerns are there about the effectiveness of the current culture, governance management structures and processes, regulation and other external scrutiny in keeping babies in hospital safe and ensuring the quality of their care? What further changes, if any, should be made to the current structures, culture or professional regulation to improve the quality of care and safety of babies? How should accountability of senior managers be strengthened?

30. Would any concerns with the conduct of the board, managers, doctors, nurses and midwives at the Countess of Chester Hospital have been addressed through changes in NHS culture, management and governance structures and professional regulation?