

Tuesday, 10 September 2024

(10.00 am)

Opening Remarks by LADY JUSTICE THIRLWALL

**LADY JUSTICE THIRLWALL:** Good morning. Today, just over a year after the jury delivered its verdicts in the case of R v Letby, we begin hearings in this public inquiry, set up by the Secretary of State for Health and Social Care on 19 October last year.

In about ten minutes, I will ask Ms Langdale, King's Counsel, Counsel to the Inquiry, to begin her opening statement. This will take Ms Langdale and Mr de la Poer, King's Counsel, until the end of tomorrow. On Thursday and Friday we will hear short opening statements from the advocates for Core Participants. None of the opening statements is evidence, but rather an indication of what the Inquiry is going to be invited to consider in the course of the coming months.

I'm not going to repeat what I said in my opening remarks at the end of November last year, nor what I said in the preliminary hearing in this year. Those remarks are on the record and can be found on the Inquiry's website, along with a clear statement to the Inquiry's terms of reference. At the heart of this Inquiry are the babies who died, who were injured and

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Some parents sat through the entire lengthy criminal trial.

It was against the background of that trial that this Inquiry was announced in September last year, after a very few weeks during which consultation took place, including with the parents and with me, the terms of reference were set, by the then Secretary of State.

The Inquiry bears my surname so that the parents do not see repeatedly the name of the person who has been convicted of killing and maiming their children in every reference to the Inquiry, in the hearing room, on the website, in the media.

The verdicts did not bring immediate closure for the parents on the question of what happened to their babies. First, there was an application for leave to appeal against the convictions, which was refused and then renewed.

It was heard earlier this year over three days by a full Court of Appeal. The court dismissed the application. In the meantime, a retrial took place in respect of one count of attempted murder, one of those upon which the jury had not reached a verdict in the first trial.

She was convicted. She has lodged a further application for leave to appeal that conviction.

3

their parents.

I do not presume to describe the feelings and emotions that those parents have already experienced, nor those that lie ahead. But I will remind you of what has happened since the birth of their children.

First, each parent celebrated the birth of each child. Then, when things seemed to be going well for these tiny babies, each one of them collapsed, suddenly and unexpectedly. Some of the babies recovered, some survived, but with lifelong consequences. Some died.

Deaths and injuries occurred in 2015 and in 2016. The parents were told that natural causes were the reason for the death or lifelong difficulties. And so each parent grieved the loss of a new life and all that it promised and lived with that profound sorrow.

In 2018, so two or three years later, they learned that their babies may have been deliberately harmed; a nurse who'd been looking after their babies in hospital had been arrested. In November 2020, she was charged with murder and attempted murder. Nearly three years later she was convicted of seven counts of murder and seven of attempted murder, seven or eight years after those babies had been born. She was acquitted of two counts of attempted murder and the jury couldn't agree about a further six counts of attempted murder.

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On the day after that conviction, the Court of Appeal released a lengthy judgment dismissing her application. It runs to 58 pages. It explains in detail why the Court of Appeal dismissed the application for leave to appeal. For the parents, that judgment marked a watershed. They could now turn their attention to this Inquiry, which is as important today as it was the day it was set up. The Inquiries Act 2005 requires me to act fairly and to avoid unnecessary cost. The terms of reference require me to conduct the Inquiry as swiftly as possible.

The aim of the Inquiry team was to begin the hearings no later than September of 2024, and to complete them at latest in early 2025. We have worked to that end, as have the legal teams, for all the Core Participants. As a result, we are now able to hear the three parts of the Inquiry in their natural sequence: A, B, C.

After the hearings, it will be for me to write the report. I cannot tell now precisely how long that will take; much depends on the nature and volume of the evidence. I can say that I expect the report to be published by late autumn next year.

I should add that the reason we are able to begin the hearings today is because of the extraordinary help

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1 and assistance the Inquiry has received from Liverpool  
2 City Council and its staff. At short notice, they have  
3 made it possible for the openings to be heard in this  
4 Council Chamber and for the evidence to be heard in  
5 other parts of this historic building in due course.

6 Like the Inquiry team, they have put the parents at the  
7 heart of their planning and I am very grateful to them.

8 I mentioned a few moments ago that the decision of  
9 the Court of Appeal was a watershed. At last, the  
10 parents had finality, or so it seemed. But it was not  
11 to be.

12 In the months since the Court of Appeal handed down  
13 its judgment, there has been a huge outpouring of  
14 comment from a variety of quarters on the validity of  
15 the convictions. So far as I'm aware, it has come  
16 entirely from people who were not at the trial. Parts  
17 of the evidence have been selected and criticised, as  
18 has the conduct of the defence at trial, about which  
19 those defence lawyers can say nothing.

20 All of this noise has caused enormous additional  
21 distress to the parents who have already suffered far  
22 too much. I make it absolutely clear that it's not for  
23 me as Chair of this public inquiry to set about  
24 reviewing the convictions. The Court of Appeal has done  
25 that, with a very clear result.

5

1 who survived. Most of these tests proved negative. On  
2 12 April 1991, however, a blood test result showed that  
3 one of the children whose blood sugar had fallen  
4 dramatically and inexplicably on three occasions had  
5 wrongly been injected with insulin. The possibility  
6 that this had happened accidentally was eliminated and  
7 the suspicion grew that someone was deliberately harming  
8 children on Ward 4.

9 On 30 April 1991, the police were called to  
10 investigate. As events were pieced together, a picture  
11 emerged of one person, nurse Beverly Allitt, as the  
12 likely culprit. She was first questioned in May 1991,  
13 and she was brought to trial in May 1993, she was  
14 convicted of four babies or children, three attempted  
15 murders, and causing grievous bodily harm against six  
16 others. She was sentenced to life imprisonment on every  
17 count.

18 Virginia Bottomley, now Baroness Bottomley, was  
19 Secretary of State for Health at the time. In  
20 a statement to this Inquiry, Baroness Bottomley says:

21 "I commissioned an independent inquiry to establish  
22 the facts behind this horrific case in the most rigorous  
23 and effective way possible and to ensure that the NHS  
24 learned any lessons it could to prevent similar events  
25 in future."

7

1 The convictions stand.

2 It's my responsibility to focus the Inquiry on the  
3 questions asked in the terms of reference, and leading  
4 counsel will tell us how that is to be done in a few  
5 moments.

6 The parents of the babies named on the indictment  
7 have awaited for years for the answers to their  
8 questions. It's time to get on with this Inquiry.

9 Ms Langdale.

10 Opening statement by MS LANGDALE

11 **MS LANGDALE:** Between February and April 1991, three  
12 children died suddenly on Ward 4 of Grantham Hospital,  
13 and a baby died at home not long after discharge. Nine  
14 other babies and children collapsed unexpectedly, some  
15 more than once.

16 In many of the cases it seemed to the doctors  
17 involved that what had happened was unusual, but could  
18 be explained on the basis of each child's medical  
19 history. Nevertheless, as time went by, and more  
20 children collapsed unexpectedly, medical and nursing  
21 staff in Grantham, bewildered by these events, grew  
22 deeply alarmed.

23 Postmortem examinations were carried out on the  
24 children who died, tests to try to determine the causes  
25 of collapses were carried out on each of the children

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1 She asked Sir Cecil Clothier QC to conduct the  
2 Inquiry. Sir Cecil had been the Health Service  
3 Commissioner for England, Wales and Scotland between  
4 1974 and 1984, and Baroness Bottomley tells us she  
5 believed he could be trusted to produce a thorough,  
6 independent and timely report. He did so. Nevertheless  
7 and distressingly, 25 years later, another nurse working  
8 in another hospital killed and harmed babies in her  
9 care.

10 In August 2023, Letby was convicted of seven counts  
11 of murder and seven counts of attempted murder involving  
12 13 babies in total. This Inquiry was ordered by the  
13 then Secretary of State in the light of those  
14 convictions. In the July of this year, Letby was  
15 convicted of a further count of attempted murder against  
16 another baby, Baby K, in respect of which the first jury  
17 could not agree.

18 Letby qualified as a nurse at the University of  
19 Chester in 2011. You will hear about her training and  
20 qualification in due course.

21 In a statement to the Inquiry, a Senior Lecturer on  
22 the Child Nursing Programme at the University of Chester  
23 tells us that the case of Beverly Allitt formed part of  
24 student training and learning on the common foundation  
25 programme. Whether, and if so how, corporate lessons

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1 were learned from the Clothier Inquiry is something this  
2 Inquiry will explore.

3 It is uncontroversial that a hospital's neonatal  
4 unit should be a place where babies are cared for by  
5 doctors and nurses, where newborns are protected and  
6 nurtured. Instead, at the Countess of Chester between  
7 June 2015 and June 2016, the neonatal unit was a place  
8 where babies were murdered and injured by someone  
9 entrusted to care for them, a nurse working on the unit.

10 Letby's victims, the babies and their families, are  
11 protected from public identification by virtue of orders  
12 made in the Crown Court. They will be referred to by  
13 initials rather than names throughout this Inquiry.  
14 Their suffering must not be compounded by being  
15 identified to the public. There must be no further  
16 intrusion into their private and family lives.

17 Within the first part of this Inquiry, Part A,  
18 my Lady, you will receive heartbreaking and thoughtful  
19 evidence about the experiences of the parents whose  
20 babies were named on the indictments. You will hear how  
21 their lives have been impacted forever. It is  
22 imperative that each of them, through their own written  
23 or oral evidence, should be able to tell you what  
24 happened in their words and from their unique  
25 perspectives.

9

1 involved in a lengthy criminal investigation and  
2 process. The parents then endured a long criminal  
3 trial; the parents of Child K went through a retrial  
4 too.

5 Letby is now serving 15 life sentences with 15 whole  
6 life terms. She sought leave to appeal against the  
7 convictions in her first trial, the written application  
8 to appeal was dismissed. She renewed her application at  
9 a hearing before a full Court of Appeal which included  
10 the President of the King's Bench Division and the Vice  
11 President of the Court of Appeal Criminal Division.

12 After a three-day hearing, leave to appeal was  
13 refused. This was because the Court of Appeal  
14 considered that the appeal had no prospect of success.  
15 We recommend a careful reading of the Appeal Court's  
16 detailed judgment.

17 My Lady, we also say this: there is a requirement in  
18 every case to take into account all of the evidence and  
19 to consider each piece of evidence in the context of all  
20 the other evidence. Medical or scientific evidence in  
21 a case should never be compartmentalised or examined in  
22 isolation from the wider canvas. Those who do this will  
23 be less likely to see the picture as a whole and in  
24 failing to see the picture as a whole, they may reach  
25 conclusions that are not only wrong, but are speculative

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1 As Counsel to the Inquiry, we say only this: the  
2 provision of written or oral evidence to you is  
3 testament to the enormous courage of the parents. In  
4 the midst of their pain they have demonstrated selfless  
5 commitment to the principle that others in the future  
6 should not suffer as they do. It is all the more  
7 troubling that they should be facing this ordeal, given  
8 that the Clothier Inquiry came before us, and yet here  
9 we are again, an Inquiry examining how to keep babies  
10 safe from the criminal acts of a nurse.

11 One aspect of the parents' evidence involves what  
12 they were and were not told about the likely cause of  
13 deaths or injuries of their babies. What information  
14 were they given by the hospital in respect of any  
15 concerns about Letby's conduct? What were they told was  
16 being done about any concerns? Was the hospital candid  
17 with the parents? If not, why not? Was there a  
18 cover-up? If so, why? Was it more important to protect  
19 the reputation of the hospital than to take steps to  
20 protect babies or to get to the bottom of who might have  
21 harmed them?

22 It is already clear that parents of the babies named  
23 on the indictment did not know that their babies had  
24 been murdered or injured by Letby for years. When they  
25 discovered their children had been attacked, they became

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1 and damaging.

2 The evidence we will hear is directed to the terms  
3 of reference and within three specific areas, Parts A, B  
4 and C. Part A, as I have said, will consider the  
5 experiences of the parents named on the indictment at  
6 the Countess of Chester Hospital and their experience of  
7 other relevant NHS services. The parents' evidence will  
8 be heard from the beginning of next week. Transcripts  
9 of their evidence will be available to read on the  
10 Inquiry website in due course, when the content has been  
11 appropriately redacted to prevent their identification.

12 The media are able to report this evidence, subject  
13 to the reporting restrictions orders made in the Crown  
14 Court and the restriction orders made in this Inquiry.

15 In part B, we will examine the conduct of those  
16 working at the hospital, including the board, managers,  
17 doctors and nurses. We will consider whether Letby's  
18 crimes could have been prevented and whether Letby  
19 should have been removed from the neonatal unit or  
20 suspended earlier. We will ask whether relevant  
21 external bodies should have been informed sooner about  
22 any concerns about Letby, whether safeguarding or other  
23 reporting procedures were followed at any point, and  
24 when the police should have been contacted.

25 It is important that we stress at this early stage

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1 that the Inquiry's unwavering focus will not be  
2 examining the convictions, but rather what the response  
3 of those at the time was and should have been to what  
4 they knew or should have known at that time.

5 Doctors, managers and the board were presented with  
6 a developing situation which called for a careful and  
7 thoughtful response.

8 We will be investigating how individuals went about  
9 this task and whether their thought processes had at the  
10 forefront the need to keep babies safe. By taking this  
11 approach, your Inquiry, my Lady, will serve the vital  
12 purpose of keeping babies safe in the future from those  
13 rare cases when a healthcare professional intends them  
14 harm.

15 During this Inquiry, we will hear oral evidence from  
16 a number of doctors, nurses and managers. You have  
17 received written evidence, my Lady, from many more.  
18 Where witnesses have not been called to give oral  
19 evidence, aspects of their evidence will likely be read  
20 in or summarised at various points in the hearing. The  
21 fact that some evidence will be dealt with in this way  
22 does not make it of any less value, but it is important  
23 that we focus the oral evidence on matters which are the  
24 subject of dispute.

25 All of the witnesses from whom we have received  
13

1 wider NHS. These include concerns about the current  
2 culture, governance, management structures, regulation,  
3 and other external scrutiny when fulfilling the  
4 obligation that the NHS has to keep babies in hospitals  
5 safe.

6 Within Part C, my Lady has also been asked to  
7 consider whether and to what effect previous  
8 recommendations of inquiries in respect of the NHS have  
9 been implemented.

10 The Inquiry legal team has prepared a detailed table  
11 of the relevant inquiries and their recommendations. It  
12 has been circulated to Core Participants, and is  
13 available for viewing on the Inquiry website. It is  
14 a sobering read and we will return to the failure to  
15 implement recommendations and why this is the case in  
16 oral evidence.

17 May I turn now to chapter 1 of this opening, an  
18 outline of suspicions and concerns in respect of the  
19 babies named on the indictment, when they were raised,  
20 and the responses from those with management  
21 responsibilities.

22 Before outlining this evidence, we emphasise this:  
23 history tells us that serial killers are deceptive,  
24 manipulative, and skilled at hiding in plain sight. In  
25 2005, Dame Janet Smith DBE, found in the Shipman Inquiry  
15

1 statements were sent detailed requests for evidence by  
2 the Inquiry legal team. They were provided with  
3 extensive documentation in some cases, in order to  
4 assist their recollection of events. We have sought to  
5 ensure that all of the witnesses give their best  
6 evidence to you, and we will continue to do this.

7 By "best evidence", we mean truthful, reflective  
8 evidence without fear of any impact or consequence for  
9 themselves or others when answering questions. Some  
10 have been granted special measures such as being  
11 screened from public view to enable them to do this.

12 The Inquiry legal team recognise that those who give  
13 evidence at this Inquiry do so with the benefit of  
14 hindsight. None of them would wish to be here and will  
15 have been affected themselves in many ways by events at  
16 the Countess of Chester. I know you, my Lady, expect  
17 witnesses to tell the truth, however difficult that may  
18 be.

19 The purpose of this Inquiry to reduce the risk of  
20 this happening again. None of those giving evidence to  
21 you can change the past, but they can have an impact on  
22 the future. They can help this Inquiry to fulfill its  
23 purpose. It is their obligation to do so.

24 Part C of the terms of reference require  
25 consideration of a number of matters relevant to the  
14

1 that GP Dr Shipman killed 250 patients. Dame Janet  
2 sought to examine Dr Shipman's character and motive.  
3 Nevertheless, she concluded thus:

4 "I regret to say that I can shed very little light  
5 on why Shipman killed his patients."

6 She found that Shipman enjoyed a high reputation as  
7 an attentive, caring doctor. He was also able to kill  
8 undetected over many years. A major reason for his  
9 popularity was his willingness to visit his elderly  
10 patients at home. As the judge who sentenced him,  
11 Mr Justice Forbes remarked:

12 "None of his victims realised that Shipman brought  
13 death, death which was disguised as the caring attention  
14 of a good doctor."

15 For ordinary, decent, right-thinking people, the  
16 actions of Letby will remain unfathomable. We will not  
17 be inviting speculation from witnesses about her motive  
18 or mindset. We will be examining why detailed,  
19 rigorous, medical analysis of sudden, unexpected deaths  
20 and collapses did not take place earlier, and why  
21 attacks on babies were able to continue to hospital for  
22 a year. We will be questioning whether and how bias in  
23 favour of Letby, conscious or otherwise, influenced the  
24 hospital's response that the sudden and unexpected  
25 deaths did not need timely, in-depth, forensic  
16

1 investigation, independent from the hospital, and those  
2 who worked there.

3 Instead, it was not until April 2017, almost two  
4 years after the first murder, that the hospital made  
5 a referral to the police and detailed,  
6 multi-disciplinary medical scrutiny and analysis was  
7 finally conducted.

8 Child A. On 8 June 2015, just before 9 pm, a baby  
9 died in Nursery 1, the intensive care nursery on the  
10 neonatal ward at the Countess of Chester Hospital.  
11 Child A was a twin. He'd been born 24 hours earlier at  
12 31 weeks and two days gestation, weighing just over  
13 1.66 kilograms. Letby was his designated nurse. In  
14 August 2023, Letby was found guilty of his murder.

15 In June 2015, deaths on the neonatal unit were  
16 infrequent. It should be emphasised that the hospital  
17 had a Level 2 neonatal unit. It cared for vulnerable  
18 and premature babies but babies who required higher  
19 levels of care or with extreme prematurity born earlier  
20 than 27 weeks would generally be cared for or  
21 transferred to a Level 3 unit. The mortality rate at  
22 the Countess of Chester's Level 2 neonatal unit was two  
23 to three deaths a year.

24 Dr David Harkness was present at the death of  
25 Child A. He was a Registrar. His response to the death

17

1 "I remember standing there in a daze thinking what  
2 is happening ... I was in complete shock."

3 Nurse Taylor's statement to the police describes how  
4 during the day on 8 June, Child A was doing really well.  
5 Her view was echoed by Nurse Caroline Bennion, an  
6 experienced Band 6 neonatal nurse who was on duty at the  
7 time of Child A's death and assisted in the  
8 resuscitation attempts. In her police statement,  
9 Nurse Bennion said:

10 "Child A's deterioration was a real shock; he was  
11 born in a better condition than his sister. He had been  
12 stable throughout the day ... I have worked in neonatal  
13 for 22 years. I have experienced sudden collapses  
14 before, babies are very vulnerable ... Child A was an  
15 exception ... he deteriorated within minutes, within  
16 half an hour he had deteriorated, then died. What an  
17 absolute shock!"

18 The shift leader was Nurse T, another Band 6 nurse.  
19 She described the death of Child A as completely  
20 unexpected. In her statement to the Inquiry she says:

21 "We were all really shocked by the death as Baby A  
22 had been well and had had a period off respiratory  
23 support earlier in the day. Personally, I'd never seen  
24 a baby collapse that quickly".

25 Also, she said:

19

1 as given in evidence at the criminal trial of Letby is  
2 telling:

3 "This was one of my first neonatal deaths that I'd  
4 had to deal with as a registrar; it was incredibly  
5 upsetting for me."

6 He took time off as result.

7 It was also the first neonatal death that  
8 Dr Christopher Wood, a trainee GP, had experienced. He  
9 too refers to his distress at the death.

10 Deaths on the neonatal unit were to become more  
11 frequent. Letby was to be convicted of murdering seven  
12 babies between June 2015 and June 2016 prior to her  
13 removal from the unit in July 2016.

14 Child A's death was not just unusual because deaths  
15 on the neonatal unit were there an infrequent  
16 occurrence, it was also unexpected. Child A had been  
17 stable and was considered stronger than his twin. His  
18 death shocked both nurses and doctors on the unit.

19 Nurse Melanie Taylor was the designated nurse for  
20 Child A on the day shift of 8 June. She was an  
21 experienced neonatal nurse who had completed her  
22 intensive care training. Nurse Taylor was still on the  
23 ward writing up notes having just completed her handover  
24 to Letby for the night shift when Child A collapsed and  
25 died. Nurse Taylor describes her response thus:

18

1 "There was an overwhelming sense of shock with  
2 nobody having any clear idea as to the cause of the  
3 death."

4 The doctors, like the nurses, commented on the  
5 stable condition of Child A prior to the sudden  
6 collapse. Dr Harkness, who had attended to Child A at  
7 5pm and 6pm said in his statement to the Inquiry:

8 "Child A's deterioration and death was certainly  
9 unexpected. He appeared to thrive and was making steady  
10 progress with his respiratory support and was breathing  
11 by himself. He was in a very stable condition making  
12 very good progress."

13 Dr Wood, who acted as a scribe during the  
14 resuscitation noting down all the actions taken and  
15 drugs given, commented:

16 "Child A's death came as a shock. This was a child  
17 that was considered fairly stable with no major  
18 concerns."

19 Dr Wood goes on to say:

20 "In the days that followed, I recalled as a team we  
21 discussed what had happened. We asked ourselves, was  
22 there anything as a team [we] could have done  
23 differently? Were there any warning signs we had  
24 missed, what has caused his death?"

25 Shock was also felt by those who had cared for

20

1 Child A after his birth and came on duty to be informed  
2 he had died. Dr Sally Ogden's evidence, like that of  
3 Nurse Bennion, was that Child A was the stronger of the  
4 twins. In her statement to the Inquiry she described  
5 him as, "stable for a pre-term baby with stable blood  
6 results and requiring relatively moderate support."

7 Dr Ogden went off duty at the end of the day shift  
8 on 8 June, handing over to Dr Harkness. She said this  
9 in her evidence to the police:

10 "The following morning ...I came on duty for a  
11 normal day shift, starting at 8.30am. I received a  
12 handover from the night registrar, Dr Rachel Lambie. She  
13 informed the team that Child A had died during the  
14 evening."

15 She remembered:

16 "... this came as a big surprise, it was completely  
17 out of the blue and very upsetting. Child A showed no  
18 signs throughout the day of any problems, he was  
19 handling well and I had no concerns at all for either  
20 him or his twin, Child B. That morning I was in clinic  
21 with some of the other consultants, Child A's death came  
22 as a surprise to us all."

23 Dr Teresa MacCarrick, a more junior doctor, had  
24 assisted the Registrar, Dr Ogden in her care for  
25 Child A. She too said that, "the overall feeling

21

1 10 years, I had never seen that pattern of  
2 discolouration on the skin prior to collapse."

3 The rash was something Dr Harkness says he discussed  
4 in "multiple conversations following Child A's death",  
5 with Registrars, Senior House Officers, and "possibly  
6 the consultants."

7 Dr Gail Beech recalls that Dr Harkness mentioned the  
8 rash on Child A to her. Dr Harkness also spoke with  
9 Dr Lambie about the rash. This was a conversation of  
10 particular significance as Dr Lambie was present at the  
11 death of Child A and was subsequently to witness  
12 a similar unusual discolouration of the skin when  
13 Child B collapsed the following evening on 9 June.

14 Dr Lambie describes the rash on Child B in similar  
15 terms to Dr Harkness:

16 "This was not something I had ever seen before or  
17 witnessed since ... I recall the consultants were fully  
18 aware of this unusual rash/blotching of the skin and  
19 I remember them being equally troubled."

20 The unusual rash on both -- oh, I think we need to  
21 break, my Lady. The link, there's a problem with the  
22 link.

23 **LADY JUSTICE THIRLWALL:** Very well. I'm sorry about this,  
24 everyone. We will adjourn for a few moments and see if  
25 it can be sorted out.

23

1 expressed by the team was shock. Child A's death was  
2 not expected."

3 Dr Emily Thomas had assisted at the birth of the  
4 twins. In her police interview she spoke of her  
5 surprise at the death of Child A. She was off duty on  
6 the day Child A died but says:

7 "I remember coming back and someone telling me  
8 Child A had died and I was really surprised."

9 In her statement to the Inquiry, Dr Thomas recalls  
10 speaking to the mother of Child A prior to the birth  
11 about what to expect when the twins were born. She  
12 says:

13 "Not surviving before going home was not something  
14 we discussed because it was not something we expected."

15 The sense of surprise that a baby, considered  
16 "stable", and about whom there had been no concerns, had  
17 deteriorated and died with such rapidity was compounded  
18 by the fact that shortly prior to his death, Child A was  
19 noted to have an unusual rash over his body.

20 Dr Harkness described the rash as:

21 "An unusual blotchy pattern of well perfused pink  
22 skin over the whole of Child A's body, coupled with  
23 patches of white and blue skin."

24 Dr Harkness said in his police witness statement:

25 "In my professional career, this spans over

22

1 (10.32 am)

(A short break)

2 (10.33 am)

3 **LADY JUSTICE THIRLWALL:** Right, I think the problem has been  
4 resolved. We are all ready to start. I wonder if  
5 everyone might just go back to their places and we can  
6 continue.

7 Thank you all very much. I gather it was resolved  
8 almost at the moment that we rose, which is always the  
9 way. I am sorry about that.

10 Ms Langdale.

11 **MS LANGDALE:** The unusual rash on both Child A and Child B  
12 seems to have been a topic of wider discussion amongst  
13 consultants. Dr Lambie emphasises this in her police  
14 statement:

15 "I recall at the time that there were definitely  
16 conversation amongst the doctors and consultants  
17 regarding any possible links between Child A and Child B  
18 as the two incidents were so close together, along with  
19 this very unusual rash that appeared."

20 Dr Katherine Lyddon, now a consultant paediatrician,  
21 but then in her own words "a very inexperienced doctor",  
22 was aware of the concerns that were also being discussed  
23 at a more junior level on the unit:

24 "I do recall discussions between the paediatric

24

1 trainees and NNU nursing staff that the rashes/skin  
2 changes between both babies was unusual and nobody had  
3 seen anything similar before."

4 Despite the recollections of members of the medical  
5 team about the discussion of the unusual rashes on  
6 Child A and Child B, the mother of Child A and Child B  
7 says this information was never shared with her at the  
8 time. However, whilst no one had seen these rashes  
9 before or could think of a diagnosis, Dr Harkness says  
10 so that at the time no one considered the death of  
11 Child A was "caused by anything malicious".

12 The consultant who had attended to assist with the  
13 attempted resuscitation of Child A was Dr Ravi Jayaram,  
14 the lead clinician for children's services. In his  
15 statement to the Inquiry, Dr Jayaram says he had an  
16 "informal debrief" with Dr Harkness, talked to him in  
17 detail about the sequence of events but did not run  
18 a formal hot debrief that evening.

19 In a police statement Dr Jayaram comments on the  
20 rash:

21 "It would flit, then reappear and diasppear. It  
22 didn't fit with anything I'd ever seen before."

23 In his oral evidence at the criminal trial,  
24 Dr Jayaram said he did not realise the clinical  
25 significance of the rash at the time. It was not

25

1 the neonatal unit at half past midnight. She attended  
2 and assisted in the ventilation of Child B. Dr Lambie  
3 recorded in the medical notes:

4 "Had acute apnoea with no warning. Widespread  
5 purple discolouration of the skin with white patches."

6 Doctor V, the consultant on call, was contacted at  
7 home soon after midnight. Her clinical notes record as  
8 follows:

9 "Upon my arrival, purple blotchiness."

10 Later, at 2.40 am the record in the clinical notes  
11 again makes reference to a rash:

12 "Purple discolouration - almost resolved -- ??  
13 cause -- stabilised at present."

14 Query of course is double question mark.

15 In oral evidence at Letby's trial, Doctor V  
16 explained her entries in the medical notes as follows:

17 "So I have noted that, and it looks like I'm quite  
18 puzzled by what happened because I've put two question  
19 marks there."

20 She went on to describe the rash in her oral  
21 evidence:

22 "This rash was so florid, it came out of nowhere."

23 Child B was successfully intubated by Dr Lambie and  
24 improved. At the time of the incident, Nurse T had been  
25 working on the NNU for about 15 years. In her police

27

1 referred to in his notes and he did not refer to it in  
2 his statement to the Coroner on 24 July 2015.

3 However, a year later, Dr Jayaram, having been by  
4 them seen a similar rash on Child M, read an academic  
5 paper "Pulmonary vascular air embolism in the newborn by  
6 SK Lee and A K Tansell" and made a possible connection  
7 between air embolism and the rash. Dr Jayaram forwarded  
8 the article to colleagues on 30 June 2016.

9 Child B. Child B was the twin sister of Child A,  
10 born weighing just over 1.66 kilograms.

11 On 9 and 10 June, the night shift following the  
12 death of Child A, Child B collapsed and required  
13 resuscitation. Letby was convicted of the attempted  
14 murder of Child B.

15 Child B was being cared for in Nursery 1. The  
16 designated nurse for Child B for the night shift of  
17 ninth and 10 July was Nurse T. Letby was on night duty  
18 as the designated nurse for another baby in Nursery 1.  
19 Nurse T recalls the monitor alarm sounding just after  
20 midnight to indicate Child B had stopped breathing and  
21 both she and Letby attended to the baby.

22 The last entry in the notes by Nurse T at 2000 hours  
23 said:

24 "All obs satisfactory, active and handling well."

25 Dr Lambie recalls receiving a crash bleep to attend

26

1 statement, Nurse T described a visual colour change  
2 present in Child B which she had not seen before in her  
3 nursing career.

4 Like Dr Lambie, Nurse T had been present when  
5 Child B had died and she too made the connection between  
6 the rash on Child A and the rash on Child B. In her  
7 statement to the Inquiry, Nurse T says:

8 "In terms of similarities to her brother, she looked  
9 exactly like Child A had done even though she had been  
10 wriggly, active, and had had good colour before."

11 Both nurses and doctors had made a connection  
12 between the similarity of the rashes on the two babies.  
13 Nurse Laura Eagles, a Band 6 nurse, came on duty with  
14 the day shift on 10 June. She was to be Child B's  
15 designated nurse for the day shift. At handover she  
16 recalls being told by Nurse T that Child B:

17 "... had been intubated overnight, she was restarted  
18 on antibiotics due to the purple blotches or rash that  
19 had appeared during the collapse. This was something  
20 that could not be explained."

21 Within a 36-hour period there had been the death of  
22 Child A who had been considered stable beforehand, and  
23 the unexpected collapse of Child B. The response by all  
24 of those who were involved in the resuscitations of the  
25 babies, or their care prior to collapse, was one of

28

1 a shock. The sudden and unexpected death of a baby  
2 triggers a number of reports and administrative acts.  
3 The Inquiry will be considering the steps that were or  
4 should have been taken following the deaths of the  
5 babies named on the indictment and how these assisted or  
6 failed to assist in the identification of concerns or  
7 the raising of an alarm about an increased number of  
8 deaths at the hospital, where established process is  
9 followed, and if not, why not.

10 In his statement to the Inquiry, Dr Stephen Brearey,  
11 the neonatal clinical lead, sets out his view that:

12 "Child death review processes are disparate and  
13 inconsistent [and that] clinicians need a simple unified  
14 process with clarity regarding requirements after  
15 a neonatal term and pre-term death occurs outside normal  
16 working hours."

17 Scheduled debriefs a few days or weeks after  
18 a neonatal death provided an opportunity to reflect on  
19 aspects of both good and bad practice. The Inquiry is  
20 aware of an email exchange between the ward manager Ms  
21 Eirian Powell and Dr Jayaram on Thursday 2 July 2015,  
22 three weeks after the death of Child A. The emails  
23 sought to set up a debrief for the following week.

24 Ms Powell refers to difficulties with the  
25 availability of Letby and Nurse Taylor, Dr Jayaram

29

1 required."

2 Neonatal Mortality Review meetings were generally  
3 held quarterly to consider any deaths in the preceding  
4 three months. There was also a Neonatal Incident Review  
5 group within the hospital which could act as a further  
6 forum for discussion.

7 A review of Child A's case was held on 24 June 2015.  
8 It is not apparent from the notes of the meeting which  
9 doctors or nurses attended, but generally medical staff  
10 who had been involved in the baby's care at the time of  
11 death would attend, along with Dr Brearey.

12 Dr Jayaram was unable to attend the perinatal  
13 mortality meeting on 24 June as he was teaching on  
14 professional leave. He tells us that the case would  
15 have been presented by one of the medical staff, usually  
16 one of the Tier 2 doctors or a consultant.

17 Child A's death was reported by Dr Saladi and  
18 referred to the coroner. A postmortem was conducted for  
19 Child A on 25 June 2015 by Dr Shukla, a consultant  
20 paediatric pathologist at Alder Hey Hospital.

21 Child A's case was also eventually referred to the  
22 external Child Death Overview Panel who completed  
23 a review on 24 March 2017. However, the Inquiry  
24 understand the death was not reported as a Sudden  
25 Unexpected Death in Childhood. Of the seven indictment

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1 responds that it was important to make sure the doctors  
2 involved could also attend.

3 It is unclear whether that debrief was held.

4 Dr Harkness recalls Dr Jayaram being supportive and  
5 sitting with him immediately following the death, but he  
6 cannot recall any specific debrief.

7 Similarly, neither Dr Wood nor Nurse Taylor who  
8 assisted at the resuscitation are able to recall if  
9 there was a debrief. If a debrief did take place it  
10 appears that no notes were taken and that it had no  
11 impact on those who attended.

12 Following the death of Child A, a Datix record was  
13 filled in by Nurse Lappalainen. Datix is the system  
14 used by staff in many hospitals to report deaths,  
15 incidents and risks.

16 Nurse Lappalainen, a Band 6 nurse, came on duty the  
17 morning after the death of Child A. The Datix entry she  
18 made was:

19 "Sudden and unexpected deterioration and death of  
20 a patient on the neonatal unit after full resuscitation.  
21 Requiring post mortem."

22 Three days later a recommend was added by  
23 Ms Ruth Millward, the Head of Risk and Patient Safety,  
24 "to be forwarded to SI (Serious Incident) Panel for  
25 review and to determine the level of investigation

30

1 babies who died, it seems only that in the case of  
2 Child C did a doctor, Dr John Gibbs, attend a Sudden  
3 Unexplained Death in Childhood meeting.

4 We will return to the issue of external reviews of  
5 child deaths, the subject of inquests, the  
6 investigations of the coroner, and the role of the Child  
7 Death Overview Panel later in this opening. The  
8 unexpectedness of the death of Child A, the unusual rash  
9 and the similarity of the circumstances of the collapses  
10 of Child A and B were not overlooked by doctors or  
11 nurses on the unit. On the contrary, these issues were  
12 recorded in clinical notes and discussed at the time  
13 both at consultant and more junior level. However, when  
14 the further deaths of Child C and Child D occurred, the  
15 significance of these discussions in relation to Child A  
16 and Child B appear to have been lost.

17 My Lady, you will no doubt want to consider whether,  
18 and if so how, a prompt and comprehensive note of  
19 a debrief or record of a debrief reflecting the clinical  
20 concerns held about Child A's sudden death and Child B's  
21 deterioration might have impacted upon the analysis of  
22 the two deaths which followed.

23 Child C.

24 Child C was born at 30 weeks' gestation at the  
25 Countess of Chester Hospital weighing 800 grams, a low

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1 weight for a baby of his gestation. However, he was  
2 born in good condition, no resuscitation was needed, and  
3 he was taken to Nursery 1 on the neonatal unit.

4 On the 14 June during the night shift, Child C died.  
5 Six days after the death of Child A, and four days after  
6 the collapse of Child B. Letby was convicted of his  
7 murder.

8 The designated nurse for Child C in Nursery 1 on the  
9 night shift of 13/14 June was Nurse Sophie Ellis.  
10 Nurse Taylor, a Band 6 nurse, was also working in  
11 Nursery 1 caring for a different baby and overseeing  
12 Nurse Ellis who was less experienced. Letby was also  
13 working on the night shift but was caring for  
14 a different baby in a different nursery.

15 Nurse Ellis's evidence in her police statement was  
16 that she was at the nurse's station when the alarm  
17 sounded for Child C. Nurse Ellis went straight back  
18 into Nursery 1 to find Letby standing next to the cot of  
19 Child C:

20 "I don't know whether Letby had gone into Nursery 1  
21 because she'd heard the alarms or whether she was  
22 already in there when they went off, just that she was  
23 in there when I went in."

24 Child C then suffered a further collapse, and  
25 Nurse Ellis explains in her police statement:

33

1 Nurse Taylor assisted in the resuscitation of  
2 Child C. In her oral evidence at the criminal trial,  
3 Nurse Taylor recalled that it was Letby who suggested  
4 using a plastic tube called a guedel to open up  
5 Child C's airway. Nurse Taylor told the court she had  
6 never used a guedel before and said of Letby:

7 "I remember being surprised how cool she was at the  
8 time and very calm."

9 Nurse W says Letby taking the lead to use a piece of  
10 equipment that was rarely used on the unit and to do so  
11 at an early stage in a resuscitation was unusual.

12 Nurse W was the team leader for the night shift. In  
13 her police statement she describes having "the  
14 impression at the start of the shift that [Letby] would  
15 have preferred to have been in Nursery 1 as opposed to  
16 Nursery 3 as she was 'above' Sophie in the ranks."  
17 Nurse W went on to explain that following her assistance  
18 with the resuscitation, Letby "kept trying to help  
19 Melanie Taylor, who is more senior than her, and more  
20 than capable."

21 Nurse W notes that on several occasions she had to  
22 in assist that Letby returned to care for her allocated  
23 baby. In her Inquiry statement, Nurse W says that she  
24 felt Letby "was distracted by Child C" and says she was  
25 "surprised, shocked and frustrated that Letby had

35

1 "A short time later, a matter of minutes, Child C  
2 had a prolonged period of bradycardia and desaturation  
3 which required us to start resuscitation and put out the  
4 crash call for the on-call doctors to come and assist  
5 us. Again, Lucy Letby was in the room with me and  
6 I think it was her who told me I needed to go out of the  
7 room and put out a crash call. I recall her saying  
8 'he's going!'"

9 Nurse Ellis was stunned by the collapse and death of  
10 Child C:

11 "Not for one moment did I expect him to die."

12 The fact that Child C had been stable earlier in the  
13 shift is confirmed by Nurse Taylor:

14 "I would say that Child C was definitely a stable  
15 baby on the 13th when we began the shift. If he had not  
16 been, I would have been his designated nurse instead of  
17 Sophie as I am more experienced and qualified."

18 Whilst acknowledging that Child C was a vulnerable  
19 neonate due to his small size, prematurity, and  
20 requirement of oxygen, Dr Beech says in her statement to  
21 the Inquiry:

22 "Child C's death was an unexpected event to me  
23 personally as he had overall been making progress and  
24 the last time I'd seen him on 12 June he had been very  
25 stable."

34

1 refused to comply with (her) instructions to return to  
2 care for another baby."

3 Nurse W was concerned about Letby assisting nurse  
4 Melanie Taylor with the taking of Child C's hand and  
5 footprints following his death, rather than caring for  
6 her allocated baby, and said she discussed this "with  
7 Melanie during the night and my manager Eirian [Powell]  
8 the next morning".

9 Nurse W explains that she informed Eirian Powell  
10 that Letby "repeatedly did not follow instructions from  
11 myself and Melanie" and that the baby's care in  
12 Nursery 3 who Letby was allocated to look after "was  
13 compromised as a result".

14 Nurse Taylor, meanwhile, in her statement to the  
15 Inquiry, says Letby:

16 "... was helping me because she wanted to and she  
17 told me she previous experience of doing so".

18 Dr Katherine Davis, then a Registrar on the night  
19 shift, had received a crash call to attend to Child C at  
20 about 11 pm. When she arrived, resuscitation was  
21 already under way. As the senior doctor she then took  
22 over leading the resuscitation attempt and asked for the  
23 on-call consultant, Dr Gibbs, to be alerted and to  
24 attend.

25 Dr Davis sets out her observations on arrival at of

36

1 the unit in her statement to the police:  
2 "He had gone from being fine and well to nothing in  
3 a very short space of time."

4 She went on to describe the "totally unexpected  
5 nature of the collapse" and that:

6 "... it was also odd that we had no idea what had  
7 caused the collapse. The concerning factor in this case  
8 was that there was no triggering event. This was  
9 a collapse out of nowhere."

10 Dr Gibbs was the consultant who attended. He  
11 describes how Child C failed to respond to resuscitation  
12 and was then given a "limited form of resuscitation" in  
13 order to await attendance of a minister to conduct  
14 a christening. Dr Gibbs noted that during this period  
15 Child C "began to make occasional, abnormal gasping  
16 respiratory efforts and a slow heart rate was heard  
17 intermittently." However, after discussion with his  
18 parents, it was agreed that no further full  
19 resuscitation be offered.

20 Dr Gibbs comments that Child C:

21 "... had been stable during the first three days of  
22 his life and none of the medical problems for which he  
23 needed (some respiratory support and intravenous  
24 feeding) nor the findings at his postmortem, would have  
25 been expected to have caused him to die."

37

1 stage Dr Gibbs accepted the postmortem finding that  
2 Child C had died from myocardial ischaemia.

3 Child C was the second baby to die on the neonatal  
4 unit within a week. The deaths of Child A and C were  
5 unexpected. The clinical signs in relation to both  
6 deaths were, in the view of highly experienced  
7 consultants, unusual.

8 Dr Jayaram, along with more junior colleague  
9 Dr Harkness, referred to the unusual rash on Child A as  
10 something they'd never seen before. Dr Gibbs,  
11 meanwhile, referred to the unusual response to  
12 resuscitation he observed in the case of Child C as  
13 being something he could not explain, and his more  
14 junior colleague, Dr Davis, referred to it as "a  
15 collapse out of nowhere".

16 Perhaps unsurprisingly, Dr Davis explains in her  
17 statement to the police that some staff were beginning  
18 to ask questions:

19 "At the time [she says] some of us began to question  
20 why this was happening. Although I wasn't present at  
21 other similar deaths, I was aware of other babies who  
22 had suddenly arrested in the same manner, which was odd.  
23 It was something that was on the 'grapevine' when  
24 working at other locations, people would say things  
25 like, 'have you heard about Chester?' I would respond

39

1 Dr Gibbs was surprised by the fact that Child C  
2 showed no response to resuscitation, but then later,  
3 when the family were awaiting for the arrival of  
4 a minister, showed some minimal signs of life. The  
5 judge at the trial summed it up in this way for the  
6 jury:

7 "Dr Gibbs could not think of any natural disease  
8 process that would allow a heart to restart later on  
9 when you had not been able to get that heart to restart  
10 with full intensive care and multiple doses of  
11 adrenaline. Whatever catastrophic event led to his death  
12 was reversing or had reversed after they stopped  
13 resuscitation."

14 Dr Gibbs's surprise at the death of Child C was  
15 something he spoke about openly with the parents of C.  
16 The mother of Child C and Dr Gibbs will tell you,  
17 my Lady, about the conversations they had at the time.

18 A referral was made for a postmortem examination to  
19 determine the cause of death. This was carried out at  
20 the Royal Liverpool Children's Hospital on 16 June 2015  
21 by Dr George Kokai and a written report was produced  
22 dated 25 September.

23 Dr Gibbs had a discussion with Dr Kokai prior to  
24 meeting with Child C's parents and he subsequently  
25 received the postmortem examination report. At that

38

1 that, yes, there had been several odd and unexplained  
2 arrests but that there was no obvious answer or any  
3 suspicion towards any one factor."

4 Following the death of Child C, it seems that there  
5 was both an informal debrief at the end of the shift and  
6 a more formal debrief led by Dr Gibbs some weeks later  
7 on 2 July.

8 Dr Gibbs recalls that Dr Davis and Ms Powell  
9 attended. An email was sent out by ward manager  
10 Ms Powell to other managers on duty inviting them to  
11 attend "only if you want to".

12 Nurse Ellis did attend. She recalls this debrief as  
13 she was worried that as Child C's designated nurse she  
14 might have missed something and said:

15 "The debrief reassured me that I had done nothing  
16 wrong."

17 Child C's death was recorded in a Datix report which  
18 refers to "the sudden deterioration of an infant  
19 following full resuscitation". The death was referred  
20 to an internal Serious Incident review to be held on  
21 2 July at the same time as a review of the death of  
22 Child A. The death of Child C was also considered at a  
23 quarterly Neonatal Mortality Meeting on 29 July 2015 at  
24 the same time as Child D, who died eight days after  
25 Child C.

40

1 Child C's death was reported as a Sudden Unexpected  
2 Death in Infancy. However, at an initial strategy  
3 meeting, held in the hospital on 2 July 2015, and  
4 attended by Dr Gibbs, it was agreed that the case did  
5 not meet the threshold for consideration for a Serious  
6 Case review.

7 It appears that Child C's death was the only  
8 indictment death that was reported as a Sudden  
9 Unexpected Death in Infancy. This was a matter which we  
10 will return to later.

11 Externally, the death of Child C was reported to the  
12 Child Death Overview Panel and reviewed on 23 March 2016  
13 (by which date a further two babies had been killed by  
14 Letby). The Panel identified no issues, made no  
15 recommendations and identified no learning points or  
16 actions.

17 A Coronial investigation was commenced for Child C  
18 on 14 July 2015, but was discontinued following  
19 a postmortem report by Dr Kokai suggesting a natural,  
20 medical cause of death.

21 Child D.

22 On 22 June 2015, eight days after the death of  
23 Child C, Child D died during the night shift. Child D  
24 was born at 37 weeks and one day gestation weighing just  
25 over 3 kilograms. Letby was convicted of her murder.

41

1 notes:

2 "I was not overly concerned for Child D at this  
3 time."

4 However, later that shift, he was paged to attend  
5 the neonatal unit at about 0140 hours with a request to  
6 examine Child C. Dr Brunton attended immediately. At  
7 this time, he tells us:

8 "... she was requiring 60% oxygen and she had areas  
9 of really dark and light patches on her stomach. The  
10 patches were like a marble effect and were quite diffuse  
11 and were also tracking in an upward direction over her  
12 trunk. I had not seen anything like this before."

13 This rash is noted as followed in the medical  
14 records:

15 "... became extremely mottled +++ Also noted to have  
16 tracking lesions -- dark brown/black across the trunk  
17 ... areas of discolouration -- light brown across  
18 trunk."

19 Dr Thomas, who was also on the night shift, recalls  
20 being called by Dr Brunton from the children's ward  
21 because Child D had a very unusual rash. Dr Brunton  
22 informed her that he had never seen a rash like this  
23 before and asked if she had. In her statement to the  
24 Inquiry, Dr Thomas, now a consultant paediatrician,  
25 confirms:

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1 Nurse Caroline Oakley was the designated nurse for  
2 Child D for the night shift 21 to 22 June. Child D was  
3 being cared for in Nursery 1 where Letby was also  
4 working, caring for a different baby. Nurse Oakley  
5 describes Child D as stable, having been reviewed by  
6 Dr Andrew Brunton at 2110 hours on 21 June. At  
7 0130 hours, Child D unexpectedly collapsed for the first  
8 time. There would be two further collapses.

9 Nurse Oakley was called back to the nursery by  
10 Nurse Kathryn Percival-Calderbank who had been covering  
11 her break.

12 Both Nurse Oakley and Nurse Percival-Calderbank  
13 refer to the unusual skin discolouration of Child D,  
14 described by Nurse Oakley as blotchy and appearing over  
15 the trunk and top of her legs.

16 Nurse Oakley also comments in her police statement  
17 that:

18 "Around that time there was a cluster of similar  
19 rashes that had appeared on other babies on the unit."

20 Nurse Oakley describes Child D's death as  
21 "unexpected" stating that:

22 "I remember feeling happy with her at the start of  
23 the shift ... I remember thinking she looked well."

24 Dr Brunton, then a Registrar, was working on the  
25 night shift. He had reviewed Child D at 2110 hours and

42

1 "I haven't, and I have not seen such a rash since."

2 Dr Brunton, now a consultant neonatologist, gave  
3 evidence at Letby's trial that he called  
4 Dr Elizabeth Newby, the consultant on call, "because  
5 this was a completely unusual situation that I had never  
6 seen before."

7 He went on to say:

8 "... by 1.40, until the time of her death, she had  
9 dramatic deteriorations over different points. It was  
10 completely unclear to me why that was occurring ... I've  
11 never seen a baby behave in that manner prior to this  
12 and I've never seen a baby behave in that manner after  
13 this."

14 Dr Brunton's inability to explain the rash was  
15 echoed by Dr Newby's evidence at the trial. She said  
16 that when she arrived at 2 am she saw:

17 "Two ... bruised areas on her abdomen, like evolving  
18 purpura ... they were quite hard to describe in a way.  
19 It was almost like a sort of brown discolouration ... we  
20 didn't know what to make of them, to be honest ... It  
21 was quite unusual ..."

22 Dr Brunton describes in his police statement how he  
23 requested abdominal X-rays and blood tests but that none  
24 of these tests pinpointed what was causing the rashes.

25 Child D initially improved and was considered stable

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1 by Dr Brunton at 02.35 hours.  
2 At 3.15 am she deteriorated again, and Dr Brunton  
3 was recalled. Again, she stabilised. However, at  
4 3.45 am, Child D collapsed for a third time and stopped  
5 breathing.

6 Nurse Oakley called Letby to help with the  
7 resuscitation of Child D. Dr Thomas was already on the  
8 unit and she assisted with the resuscitation. At  
9 0355 hours Dr Brunton was called back to the unit. He  
10 attended and asked for Dr Newby the consultant, to be  
11 recalled. Child D did not recover and at 04.25 hours on  
12 22 June, died.

13 A Datix entry was made recording the death of  
14 Child D. This noted the mottled skin prior to death.  
15 Child D's death was referred to a Serious Incident  
16 Panel, held on 2 July at the same time as the reviews of  
17 the death of Child A and Child C. The death of Child D  
18 was also considered at a Neonatal Mortality Meeting on  
19 29 July 2015 when Child C's death was also discussed.

20 Dr Newby explains that she spoke to Child D's  
21 parents about her uncertainty as the cause of death.  
22 She says:

23 "It appeared unexplained. [Child D] had collapsed  
24 very suddenly so I discussed with [her parents] that  
25 would need to speak to the coroner, who would require  
45

1 and CPR for previous twin death; surviving twin had  
2 successful CPR."

3 A postmortem, carried out by Dr McPartland,  
4 consultant paediatric pathologist at Alder Hey dated  
5 26 August 2015, concluded that the cause of death was  
6 pneumonia with acute lung injury. In her statement to  
7 the Inquiry, Dr McPartland says that she did not see the  
8 X-Ray report of Child D that had been requested by  
9 Dr Brunton. The X-Ray report would have been needed to  
10 consider death caused by air embolism. Furthermore, she  
11 was not informed of any concern that the same staff  
12 member had been involved in a series of deaths.

13 Dr McPartland will give evidence to the Inquiry and  
14 whether, and to what extent, there was any contact  
15 between clinicians and pathologists about Child D will  
16 be investigated.

17 As the Court of Appeal judgment makes clear,  
18 Dr Bohin's evidence at the criminal trial was that  
19 Baby D had been born in good condition; her pneumonia  
20 had stabilised and she was recovering at the time of her  
21 collapse. Dr Bohin is a currently practising  
22 neonatologist.

23 It appears that Dr Newby wanted to arrange a staff  
24 debrief regarding the death of Child D and wanted  
25 Nurse Oakley, Letby, Dr Thomas and Dr Brunton to attend.  
47

1 a postmortem examination given the circumstances of the  
2 collapse."

3 The letter to the parents of Child D from Dr Newby  
4 discusses the rash:

5 "We discussed the aetiology of the rash, which is  
6 documented to have appeared during Child D's first  
7 episodes of deterioration. This appeared to look like  
8 bruising under the skin and we discussed that this was  
9 likely a sign of the effect the infection was having  
10 upon Child D's circulation."

11 Child D's death was referred to the Coroner on  
12 22 June 2015. We will return to the outcome of the  
13 referral letter later in this opening. However, it is  
14 relevant to note that in the referral, Dr Newby stated:

15 "Doctor cannot offer COD [cause of death] - sudden  
16 and unexpected."

17 The additional information given to the Coroner  
18 included:

19 "Just before 4am, she went profoundly mottled and  
20 apnoeic, lost heart rate."

21 Significantly the referral also informed the Coroner  
22 of the deaths of Child A, C and the collapse of B,  
23 noting:

24 "Reported that this had been third death in 12 days  
25 for neonatal. Also a further episode of apnoeic event  
46

1 Emails suggest that there were difficulties finding  
2 a date to accommodate nursing staff attendance but it  
3 appears that it was decided to go ahead with the debrief  
4 on 6 July. If that debrief did go ahead, Dr Brunton  
5 cannot recall attending one. Once again, there do not  
6 appear to be minutes. If concerns were raised at this  
7 meeting about the unusual rash or the unexplained nature  
8 of the collapse, these were not recorded; nor do they  
9 appear to have been raised at the quarterly neonatal and  
10 morbidity meeting held on 29 July 2015 attended by  
11 Dr Newby and Dr Brearey, with a follow-up meeting on  
12 10 September. We will explore this in oral evidence.

13 The death of Child D was the third neonatal death in  
14 under two weeks. This exceeded the total number of  
15 deaths in 2013, two deaths, and equalled the total  
16 deaths in 2014, three deaths. In addition to three  
17 deaths, there had also been the near fatal collapse of  
18 Child B, the twin of Child A.

19 The Inquiry will examine whether there was any  
20 suspicion of wrongdoing at this stage. Dr Gibbs says  
21 this:

22 "From informal discussion between us consultants  
23 around July 2015, several of whom had each been involved  
24 with a death on the NNU, it was recognised that Letby  
25 had been present on each occasion and that this was also  
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1 noted at the Serious Incident Meeting on 2 July 2015.  
 2 Letby worked more shifts than other neonatal nurses and  
 3 I felt, as did my consultant colleagues at the time,  
 4 that she was merely unfortunate to have been involved in  
 5 the cluster of deaths. I was not suspicious of  
 6 deliberate patient harm to either Child C or the other  
 7 babies who died in June 2015."

8 However, it was apparent that there was  
 9 understandable concern that three sudden and unexpected  
 10 deaths occurring in such close succession, my Lady,  
 11 certainly there was sufficient concern for Dr Newby to  
 12 draw to the Coroner's attention the fact that Child D's  
 13 was the third in 12 days.

14 Concern about the trio of deaths was also felt by at  
 15 least one of the nurses. Nurse T expressed her concerns  
 16 in a WhatsApp message to Letby. She messaged:

17 "There's something odd about that night and the  
 18 other three that went so suddenly."

19 Letby responded to this question with the following:

20 "Odd that we lost three and in different  
 21 circumstances?"

22 Nurse T responded:

23 "Were they that different? Ignore me. I'm  
 24 speculating."

25 In her statement to the Inquiry Nurse T explains her  
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1 due to the similar and unexpected nature of their  
 2 collapses and appearance of the unusual rash.

3 She goes on to say:

4 "As further babies became unexpectedly seriously  
 5 ill/collapsed or died, I recall medical or nursing staff  
 6 reporting to each other that they were nervous at the  
 7 start of their shifts."

8 She says she personally recalls being nervous at the  
 9 starts of night shifts:

10 "I was almost expecting something bad to happen."

11 The fact of three sudden and unexpected deaths  
 12 within a month of June did not go unnoticed. On the  
 13 contrary, on 22 June, the same day that Child D died,  
 14 Dr Brearey, the clinical lead of the neonatal unit sent  
 15 an email to Dr Jayaram, the children's services clinical  
 16 lead, suggesting a review of the recent deaths and  
 17 a meeting with the director of nursing Ms Alison Kelly.

18 This email said the following:

19 "Just to confirm that I've met with Eirian and  
 20 reviewed the case notes of Child D, who died in the  
 21 early hours of this morning. We have also discussed  
 22 whether there are any other issues to address in view of  
 23 the two of the recent sudden deaths on the NNU. There  
 24 does not seem to be any staff, medical or nursing  
 25 members present at all episodes other than one nurse who  
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1 messaging as follows:

2 "When I said there was something odd about that  
 3 night and the other three that went to suddenly, I was  
 4 referring to the night of the 9 and 10 June when Child B  
 5 collapsed as well as the deaths of Child A, Child C and  
 6 child; I didn't mean that I had suspicions, just that  
 7 the situation was unusual and unexplained. There was  
 8 something not sitting comfortably with me but I couldn't  
 9 work out what was going on. I wasn't speculating that  
 10 there was anything sinister at play. If the four  
 11 incidents involving Child A, B, C and D had anything in  
 12 common, I would say that they were all sudden and  
 13 unexplained. Between Child A and Child B the  
 14 discolouration was also the same ... A common factor  
 15 amongst the four incidents was that they all happened to  
 16 babies who were stable and generally improving/doing  
 17 well."

18 Nurse T's evidence is that she did not share her  
 19 thoughts with anyone other than Letby noting:

20 "There were no in-depth conversations or formal  
 21 meetings or debriefs."

22 This sense of unease is also referred to by  
 23 Dr Lambie in her statement to the Inquiry. She  
 24 describes increasing levels of anxiety following the  
 25 death of Child A and collapse of Child B soon afterwards  
 50

1 was not the nurse responsible for [Child D] on that  
 2 shift."

3 The email then set out details of Child D's care.  
 4 And then this:

5 "I'd be very surprised if [Child D's] death is  
 6 linked in any way to the previous recent deaths of  
 7 [Child A] and [Child C]. We have agreed an action plan,  
 8 however."

9 There was a five-point action plan, my Lady, the  
 10 first point being Dr Brearey saying:

11 "I will review [Child A] and [Child C's] case notes  
 12 in detail this week. Secondly, I will review  
 13 [Child A's] preliminary postmortem report which I have  
 14 not seen yet."

15 It is clear therefore that by 22 June, the day of  
 16 the third death, Dr Brearey had identified an unusual  
 17 increase in deaths on the unit and identified the need  
 18 for a review. Since it was to be a review of deaths,  
 19 the unexpected collapse of Child B was not referred to.  
 20 Dr Brearey had also addressed specific deaths of  
 21 commonality of staffing as something to be considered  
 22 and had observed that one nurse was, "present for all  
 23 three episodes" albeit noting that it, "was not the  
 24 nurse responsible for [Child D] on the shift."

25 In advance of the meeting to discuss the three  
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1 deaths, Dr Brearey met with Ms Debbie Peacock, Risk and  
2 Patient Safety Lead and the neonatal ward manager,  
3 Eirian Powell. He produced a report dated 1 July in  
4 relation to Child A. In his one-page report Dr Brearey  
5 also considered the collapse of Child B. However,  
6 neither the similarity of the rashes nor the unexpected  
7 nature of the collapses was highlighted in this report  
8 which was subsequently sent to the Coroner.

9 Dr Brearey notes his regret at not paying more  
10 attention to the rashes.

11 On 2 July 2015, there was a meeting to discuss  
12 Child A, Child C, and Child D. This meeting was attended  
13 by Dr Brearey, Ms Millward and Ms Fogarty, Head of  
14 Midwifery, Ms Kelly, Director of Nursing, and  
15 Ms Peacock. The 2 July meeting was subsequently  
16 referred to an "Extraordinary Executive Serious Incident  
17 Panel" to "identify if there was any commonality which  
18 linked the deaths."

19 In his statement to the Inquiry, Dr Brearey states  
20 that at this meeting, Ms Powell set out that Letby had  
21 been on the neonatal unit on the three occasions when  
22 the babies had collapsed. Dr Brearey recalls that  
23 whilst the association remained in his mind following  
24 the meeting, he was not at that stage overly concerned,  
25 and recalled commenting, "Not Lucy, not nice Lucy".

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1 will be scrutinised in oral evidence.

2 Ms Millward, Head of Risk and Safety, recognises in  
3 her statement to the Inquiry that "it would have been  
4 appropriate for the hospital to have reported the  
5 overall increase in neonatal deaths had occurred in  
6 June 2015 as a Serious Incident. This would have then  
7 triggered a comprehensive investigation into the  
8 increased mortality rate at a much earlier stage."

9 The Inquiry will be looking at why the decision on  
10 2 July, that no further investigation was warranted, was  
11 reached. With hindsight, this decision may represent  
12 a significant opportunity missed.

13 My Lady, I wonder if that's a convenient moment.

14 **LADY JUSTICE THIRLWALL:** Yes, thank you very much indeed,

15 Ms Langdale. So we will break for 15 minutes, and will  
16 be back ready to start at 11.30. Thank you.

17 (11.14 am)

(A short break)

19 (11.30 am)

20 **LADY JUSTICE THIRLWALL:** Ms Langdale, I think we will do  
21 another one hour and 15 minutes, so we will break at  
22 about quarter to 1 and then we will have an hour's break  
23 and then we will continue this afternoon with two  
24 one-hour 15-minute segments.

25 **MS LANGDALE:** Thank you.

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1 We will explore whether bias or stereotyping played  
2 a part in terms of what investigations or inquiries did  
3 or did not happen next.

4 According to Dr Brearey, Ms Kelly's reaction  
5 regarding the association with Letby was to say "We'll  
6 have to keep an eye on it".

7 A decision was taken to report Child D's case under  
8 the Strategic Executive Information System (known as  
9 STEIS, a system used to report and monitor the progress  
10 of Serious Incident investigations across the NHS).  
11 This decision was taken due to a delay in recognising  
12 signs of sepsis in starting antibiotics, although it was  
13 not thought this was contributed to Child D's death.

14 A STEIS report was completed by Ms Peacock and  
15 shared as required by the Regional Commissioning Group.

16 It would appear that Mr Harvey, the Medical  
17 Director, was on leave and did not attend the Serious  
18 Incident Panel meeting on 2 July 2015. However, despite  
19 his non-attendance, reference is made in the documents  
20 to the fact that matters had "escalated to the medical  
21 director."

22 The 2 July meeting, "agreed that no further  
23 investigation was warranted at this stage as there were  
24 no concerns highlighted in the obstetric or neonatal  
25 reviews." This decision, my Lady, made at this stage

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1 My Lady, we were looking at 2 July 2015 and the  
2 meeting and we will be examining whether there was  
3 a significant opportunity missed for further  
4 investigation at that stage.

5 As well as failing to recommend further  
6 investigation due to the number of unexpected neonatal  
7 deaths, the meeting on 2 July also failed to consider or  
8 document which staff were present at each resuscitation,  
9 whether, in addition to the deaths, there had been any  
10 unexpected collapses over the same period. Had they  
11 done so, the collapse of Child B would have been  
12 included in the index of concerns, and also, whether the  
13 doctors or nurses who had assisted at the resuscitation  
14 attempts or in the care of the babies had any concerns  
15 and if so, what these concerns were.

16 Had these factors been considered, it seems likely  
17 at this stage in July 2015, as a minimum, Letby's  
18 presence at each sudden and unexpected death, and her  
19 presence at the collapse of Child B, would have been  
20 highlighted.

21 In addition, the surprise and shock that doctors and  
22 nurses felt at the deaths, and the prevalence of unusual  
23 clinical features including the rashes, would have been  
24 considered in greater detail.

25 In fact, it was to take the sudden and unexpected

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1 deaths of another two babies, Child E and Child I, in  
2 August and October 2015, before the issue of commonality  
3 of staffing was revisited and a further investigation  
4 was considered necessary.

5 One of the most striking features of the meeting of  
6 2 July you may think is that no one at the meeting had  
7 actually been present at the deaths or collapses or  
8 involved in the resuscitation attempts.

9 Dr Brearey was the only doctor at the meeting and he  
10 had not personally been involved in any of the  
11 resuscitations of the babies being considered. It's  
12 clear that by the 22 June 2015, all of the consultants  
13 who had assisted at the resuscitations (Dr Jayaram in  
14 respect of Child A, Dr V in respect of Child B, Dr Gibbs  
15 - Child C and Dr Newby regarding Child D) had concerns  
16 about the unexpected nature and surprising clinical  
17 features of the deaths or collapses. The consultant  
18 concerns were echoed by registrars, junior doctors, and  
19 nurses who had witnessed the collapses. It appears that  
20 they were being discussed informally at the time.

21 However, at the meeting on 2 July, it appears those  
22 concerns were not considered. This raises the issue as  
23 to the efficacy of Serious Incident Panels. Did their  
24 composition and method of investigation take sufficient  
25 account of the views of the doctors and nurses involved

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1 to consider the deaths of Child C, and D. Child A's  
2 case had already been considered in the review held on  
3 24 June.

4 Unlike the Serious Incident Meeting of 2 July, the  
5 Neonatal Mortality Meeting on 29 July was attended by  
6 doctors and nurses directly involved in the care of the  
7 babies at the time of their deaths. Consultants  
8 Dr Gibbs and Dr Newby, who had been involved in the  
9 resuscitations of Child C and D, were both present at  
10 this meeting, as were other doctors and nurses from the  
11 neonatal unit including Dr Thomas, Dr Beech, Dr Wood,  
12 Dr Lyddon, Nurse Taylor and Nurse Yvonne Griffiths.  
13 Risk and Patient Safety Lead, Ms Peacock also attended.

14 Whilst the meeting notes contained summary of the  
15 case of Child C and Child D and explicitly address  
16 "discussion and learning", the notes express no concerns  
17 regarding the unexpected nature of the deaths.

18 There is reference in the notes to Child C being  
19 "unresponsive to resuscitation for 25 minutes" but no  
20 mention of the later restarting of Child C's heart that  
21 Dr Gibbs said he was unable to explain.

22 In the case of Child D, there is a comment "purpura  
23 in evening that resolved", presumably an allusion to the  
24 rash, although there is no reference to the rash being  
25 unusual or being similar to the rash being seen in other

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1 in the events discussed? How might their views have  
2 been collated in advance?

3 The Inquiry will be looking at all aspects of how  
4 deaths were reported and investigated, including the  
5 examination of committees within the hospital, of risk  
6 registers and the governance structure.

7 As set out in the terms of reference, we will  
8 address the question: "did the structures and processes  
9 for the management and governance of the hospital  
10 contribute to a failure to protect the babies on the  
11 neonatal unit?"

12 Neonatal Mortality Meetings.

13 Although at the meeting of 2 July, it was concluded  
14 that no further investigation was required into the  
15 occurrence of the three deaths, these deaths were  
16 nevertheless discussed at the regular quarterly Neonatal  
17 Mortality Meetings. The Inquiry has seen the Hospital's  
18 Neonatal Mortality Meeting records since 2010. Prior to  
19 2015, meetings were infrequent, generally only once or  
20 twice a year, given the low mortality numbers.

21 In 2015, however, there were six mortality meetings  
22 held with two in under two months, in June and  
23 July 2015.

24 With three deaths occurring in June 2015, a decision  
25 appears to have been made to hold a meeting on 29 July

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1 babies that had collapsed.

2 Under the heading "Discussion and Learning" there is  
3 no explicit reference to clinical observations being  
4 considered unusual or to any consideration of whether  
5 there's any correlation between the deaths.

6 No reference is made to the previous death in June  
7 of Child A or the unexpected collapse of Child B,  
8 neither is there any record of discussions as to  
9 similarities between the June deaths or wider concerns  
10 as to the increased mortality rate.

11 As a mechanism to explore and record concerns about  
12 deaths on the unit or identify trends, the Neonatal  
13 Mortality Meetings do not appear to have been effective.  
14 It also appears that discussions may have been hampered  
15 by the lack of prompt postmortem results. For example,  
16 in the case of Child D, it is clear from the notes of  
17 the Neonatal Mortality Meeting that the lack of  
18 a postmortem result led to an assumption that the dead  
19 was likely due to sepsis.

20 My Lady a number of questions arise that you may  
21 wish to consider: were these Neonatal Mortality Meetings  
22 held at an appropriate interval after any death? What  
23 dictated the attendance list and ensured attendance?  
24 Were doctors and nurses given sufficient time to  
25 prioritise and prepare for these meetings? Who was

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1 responsible for scheduling the meetings and following up  
2 the meetings with any actions? How did these meetings  
3 relate to risk registers or the flagging of safeguarding  
4 concerns?

5 Following both the Neonatal Mortality Review on  
6 29 July and the 2 July Serious Incident Review, there  
7 was a "Case Review" specifically related to Child D.  
8 This report is described as:

9 "a report made following review of the clinical  
10 notes by each specialty in relation to care provided to  
11 the mother and baby."

12 Dr Brearey was the only paediatrician on the initial  
13 Neonatal Review Team for Child D's case. Whilst there's  
14 reference to what appeared to be "bruises" or "evolving  
15 purpura" on the baby's abdomen, there is no concern  
16 about the clinical signs being unusual.

17 Following the production of the postmortem for  
18 Child D, which gave the cause of deaths as pneumonia  
19 with acute lung injury, Dr Newby had been involved in  
20 the attempted resuscitation of Child D attended the  
21 follow-up meeting on 12 October and no further  
22 investigations were recommended.

23 Child E and Child F.

24 Child E and Child F were identical twins born by  
25 caesarian section at 29 weeks and five days gestation.

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1 a sound she described at the criminal trial as "more of  
2 a scream than a cry". She saw blood coming out of her  
3 baby's mouth. She asked Letby why her son was bleeding  
4 and was told that it was caused by the feed tube rubbing  
5 his throat and the doctor would be informed.

6 In his evidence to the Inquiry Dr Harkness describes  
7 being asked to review Child E by Letby on the evening of  
8 3rd August 2015 as Child E had suffered a vomit with  
9 blood. Approximately half an hour later Child E  
10 developed sudden substantial bleeding. Dr Harkness, who  
11 is now a consultant paediatrician, said:

12 "I noted this to be unusual. This was then followed  
13 by a further episode of substantial bleeding which I  
14 commented to be 'out of nowhere' and something I had not  
15 seen before or since."

16 In his witness statement to the Inquiry, Dr Harkness  
17 describes seeing a colour change over the abdomen with  
18 "purple and pale patches". The only other time he saw  
19 these patches was in the case of Child A. Dr ZA was  
20 called. Child E subsequently suffered a sudden  
21 collapse, resuscitation was attempted, during which  
22 a large amount of blood came from Child E's nose and  
23 mouth. The resuscitation was unsuccessful. Child E  
24 died at 1.40 on 4 August 2015.

25 A Datix report was opened by Letby on 4 August, and

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1 Both twins were born in good condition weighing  
2 1.327 kilograms and 1.430 kilograms respectively.

3 Less than six days after their birth, during the  
4 night shift on Tuesday 4 August, Child E died. Child E  
5 was the fourth baby to die on the neonatal unit within  
6 a two-month period. The prosecution case was that Letby  
7 damaged Child E's gastrointestinal tract leading to  
8 severe bleeding, injected air into his vessels and that  
9 Child E died of acute bleeding air embolus.

10 Letby was convicted of his murder. Child E, like  
11 Child A, was a twin. Following the murder of Child E,  
12 Letby attempted to murder his twin brother, Child F. In  
13 his sentencing remarks, Mr Justice Goss noted that Letby  
14 "specifically targeted twins and latterly, triplets."

15 The Registrar on duty for that night shift was  
16 Dr Harkness, the senior house officer was Dr Woods, and  
17 the consultant paediatrician on call was Dr ZA.

18 Letby was the designated nurse for Child E and  
19 Child F, both of whom were being cared for in Nursery 1.  
20 The shift leader was Nurse Oakley.

21 On the night shift of the 3/4 August 2015, Child E  
22 suffered a gastrointestinal bleed and subsequently  
23 collapsed. The mother of Child E took some expressed  
24 milk down to the unit, arriving just before 9 pm. As  
25 she approached the ward she heard Child E crying,

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1 recorded, "an unexpected death following a GI,  
2 [gastrointestinal] bleed. Full resus[citation].  
3 Unsuccessful."

4 A Serious Incident Panel meeting was held on  
5 13 August 2015, Mr Harvey, the Medical Director,  
6 Ms Kelly, Director of Nursing, and Ms Harper-Lea, Head  
7 of Legal, attended. It was noted that the death of  
8 Child E would be discussed in the quarterly Neonatal  
9 Mortality Review. In fact, it appears that this never  
10 happened.

11 A Neonatal Mortality Meeting was held on  
12 26 November 2015 to discuss the death of four babies,  
13 including Child E, but there was insufficient time to  
14 discuss Child E and it is unclear if a further meeting  
15 was ever convened.

16 Dr Brearey was on leave when Child E died. However,  
17 he was subsequently briefed by Dr ZA and completed his  
18 own review of the death of Child E dated October 2015.  
19 Dr Brearey records "persisting discoloured abdomen". He  
20 recorded the likely cause of death as a perforated bowel  
21 secondary to Necrotising Enterocolitis. This report  
22 pertains solely to Child E and contains no reference to  
23 the rise of neonatal death or any discussion of any  
24 possible link or commonality between the deaths.

25 Doctor ZA's view at the time was that Child E's

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1 death was due to Necrotising Enterocolitis, a serious  
2 intestinal condition that mainly affects premature  
3 babies. Dr ZA fully accepted in her evidence at the  
4 criminal trial that with hindsight she ought to have  
5 requested a postmortem but at the time in an attempt to  
6 save Child E's parents from further distress, no  
7 postmortem was pursued. As the cause of death was  
8 considered natural, there was no inquest.

9 Dr Harkness, in his statement to the Inquiry,  
10 accepts that at the time he too had thought that the  
11 cause of death could have been Necrotising  
12 Enterocolitis. Dr Harkness notes however that from the  
13 knowledge and experience he has now and in his current  
14 position as named doctor for safeguarding, were he faced  
15 with a similar circumstance now, he would initiate a  
16 Sudden Unexpected Death in Infancy and Childhood  
17 procedure which would involve a postmortem.

18 However, he tells the Inquiry:

19 "I do not think that decisions to undertake these  
20 procedures in inpatient deaths was common at the time  
21 although in light of the events at the hospital, it has  
22 affected the practice in my health board, and I am sure  
23 it has affected practice elsewhere."

24 Child E died on Dr Wood's last day at the hospital  
25 as a GP trainee. Dr Woods said in relation to Child E's

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1 to the Steering Group.

2 We will return in evidence to consider the role of  
3 the neonatal network and whether it could or should have  
4 raised concerns about the unexpected deaths and events  
5 at the Countess of Chester.

6 Child E's death, as well as being referred to the  
7 neonatal network, was also referred to the Child Death  
8 Overview Panel on 5th August 2015 by Doctor ZA. It  
9 appears that there was a meeting on 18 December 2015 at  
10 which the cause of death was recorded Prematurity and  
11 Necrotising Enterocolitis and no recommendations were  
12 made.

13 Although the death of Child E was the fourth  
14 unexpected death in under two months, it did not prompt  
15 any reconsideration of the decision made in July 2015  
16 that no further investigation was necessary.

17 Ruth Millward accepts in her statement to the  
18 Inquiry that the death of Child E was a further missed  
19 opportunity to report the increase in neonatal deaths  
20 since June 2015 as a serious incident. This would have  
21 triggered a comprehensive investigation into the  
22 increased mortality rate at an earlier stage.

23 Child F was the twin brother of Child E. He was  
24 born in good condition and cried at birth, weighing  
25 1.43 kilograms, the slightly heavier of the twins. When

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1 death:

2 "It really seemed to come out of the blue. Child E  
3 had seemed well leading up to this and wasn't 'on the  
4 radar' as a child of particular concern."

5 In his statement to the Inquiry, Dr Wood goes on to  
6 say:

7 "I was worried about the number of deaths only  
8 because it was suggested that they were more numerous  
9 than normal and perhaps occurring in babies who seemed  
10 to be doing well."

11 Child E's death was referred to and discussed at  
12 the Cheshire and Merseyside Neonatal Network Clinical  
13 Effectiveness Group meeting held on 12 November 2015,  
14 attended by Dr Brearey and Ms Powell.

15 It appears that the three previous June deaths,  
16 Children A, C and D, had also been referred for  
17 discussion at earlier meetings of the same network group  
18 meetings. The Cheshire and Merseyside neonatal network  
19 brought together representatives from eight hospitals  
20 and had both the Steering Group and a Clinical  
21 Effectiveness Group and held quarterly meetings.  
22 A summary of the mortality reviews conducted at  
23 individual hospitals was presented to the Clinical  
24 Effectiveness Group and quarterly data reports,  
25 including data on the number of deaths, were presented

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1 admitted to the neonatal unit shortly after his birth,  
2 he had a low blood glucose level of 1.9. The following  
3 day, his blood glucose rose to the very high level of  
4 15.1. At 03.40 on 31 July, manufactured insulin was  
5 administered. He responded well to the insulin and his  
6 blood glucose dropped within an hour to 8.7.

7 The prosecution case was that on 5th August,  
8 Child F, who at that stage had no further need for  
9 insulin, was maliciously given manufactured synthetic  
10 insulin via two total parenteral nutrition bags (TPN)  
11 bags. The notes show that the first bag was signed for  
12 by Letby and Nurse T and hung up during the night shift  
13 of 4 and 5 August, and the next bag was hung up at  
14 midday on 5 August. The prosecution case was that this  
15 second bag had previously been tampered with by Letby  
16 who had added insulin to both bags.

17 Letby was found guilty of the attempted murder of  
18 Child F. Letby agreed at trial that Child F and Child L  
19 had been poisoned eight months apart by insulin but  
20 denied that she was the poisoner.

21 During the night of 4 and 5 August 2015, Dr Harkness  
22 was called to attend to Child F. As Dr Harkness notes  
23 in his statement to the Inquiry, he was "concerned about  
24 both Child F's increased heart rate and low blood  
25 sugars" and he discussed this on the phone with

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1 Dr Gibbs, the consultant on call.  
 2 The low blood sugar persisted the following day,  
 3 despite glucose being administered. Blood samples were  
 4 taken and, on 5 August 2015, sent for analysis. When  
 5 the intravenous feeds were stop and the TPN bag was  
 6 taken down, the blood sugars started to increase.  
 7 Analysis of the blood samples showed low C peptide  
 8 to insulin. This caused the Laboratory Senior Clinical  
 9 Scientist, Heather Wilshaw-Jones, to call the Trust and  
 10 speak to the "Countess of Chester Biochemist." The  
 11 laboratory were not in possession of the clinical  
 12 details and did not know whether insulin had been  
 13 prescribed for Child F. The note made by  
 14 Ms Wilshaw-Jones of her call states:  
 15 "Low C peptide to insulin? Exogenous - suggest send  
 16 sample to Guildford for Exogenous insulin."  
 17 The results were reviewed by Dr Lyddon, who in turn  
 18 discussed the results with Doctor ZA. The results were  
 19 recorded in the medical records on 13 August 2015, with  
 20 an indication, shown by vertical arrows, that the  
 21 insulin levels was high and the C peptide level was low.  
 22 Doctor ZA in her statement to the Inquiry noted that  
 23 the results were confusing, as they suggested, "... that  
 24 Child F was given exogenous insulin (ie insulin injected  
 25 externally)." She recalls that she checked and

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1 problem in babies in early life, more so in premature  
 2 babies. Blood results in Child F indicated that the low  
 3 blood glucose was likely to have been caused by the  
 4 administration of synthetic insulin. These blood  
 5 results were only available several days after being  
 6 taken, by which time the low blood glucose had resolved.  
 7 The results were not interpreted correctly at the time  
 8 and, so highly regrettably, an indication that someone  
 9 was deliberately harming patients was overlooked. Not  
 10 being aware of these insulin results meant that Child F  
 11 did not cause me to be suspicious of deliberate harm on  
 12 the NNU."  
 13 Dr Gibbs did not know about Child F's insulin and  
 14 C peptide results at the time they were received but  
 15 notes that each of the consultants was responsible for  
 16 the patients on their NNU when on-call or undertaking  
 17 consultant of the week duties. As such, he accepts that  
 18 he and his consultant colleagues had the opportunity at  
 19 various times to review results on any of the babies,  
 20 although this would normally only be done if there was  
 21 a concern about a baby.  
 22 Dr Gibbs characterises it as a "collective failure"  
 23 on the part of the paediatric team to have not  
 24 recognised the significance of the insulin and C peptide  
 25 results in Child F in mid-August 2015.

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1 established that no other baby on the neonatal unit had  
 2 been prescribed insulin, making accidental  
 3 administration unlikely.  
 4 She states that:  
 5 "I felt the most likely explanation for the results  
 6 was some sort of inaccuracy with the test and I would  
 7 have liked to repeat them, but Child F had no further  
 8 periods of hypoglycaemia and was transferred back to his  
 9 local unit. It is our usual practice to repeat neonatal  
 10 bloods that do not fit with the expected clinical  
 11 picture."  
 12 Doctor ZA notes that she did consider whether  
 13 insulin could have been delivered deliberately and says:  
 14 "But this seemed absurd and ridiculously unlikely,  
 15 so the tests being wrong seemed the only possible  
 16 explanation."  
 17 Doctor ZA accepted in her police statement that:  
 18 "With hindsight, I should have flagged up this  
 19 unexpected result."  
 20 Dr Gibbs, like Doctor ZA, also accepts that the  
 21 results were not interpreted correctly. In his  
 22 statement to the Inquiry, Dr Gibbs says:  
 23 "I helped during the initial management of Child F's  
 24 low blood glucose in August 2015, at which time  
 25 infection was suspected. Low blood glucose is a common

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1 The medical director, Mr Ian Harvey, said in his  
 2 statement to the Inquiry:  
 3 "This situation, the insulin result, was not  
 4 reported to me at any time before my retirement. It  
 5 should have been. I feel strongly that had this been  
 6 reported to me, this would have alerted me to an urgent  
 7 problem and significantly altered my perception of the  
 8 events on the neonatal unit."  
 9 It was not until 2017 that the issue of deliberate  
 10 administration of insulin seems to have been raised.  
 11 Doctor ZA says:  
 12 "When I was on maternity leave in 2017, it occurred  
 13 to me that the intentional administration that seemed  
 14 impossible at the time could have happened."  
 15 On 6 June 2017, Doctor ZA sent an email to  
 16 Dr Brearey raising her concerns about insulin. By this  
 17 stage, the police had been contacted and investigations  
 18 were taken forward.  
 19 My Lady, in light of what we know about the facts of  
 20 this case, and indeed the facts of the Allitt case and  
 21 others, where the deliberate administering of insulin  
 22 has been used to cause harm, you may consider that this  
 23 is an area that requires particularly careful  
 24 consideration.  
 25 Both Dr Gibbs and Dr Brearey reflect on this issue

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1 and raise questions as to whether guidance is needed in  
2 relation to restricting access to insulin on neonatal  
3 units, whether and how the possible presence of  
4 exogenous insulin should be flagged in blood results, or  
5 whether the NHS should consider making a blood test  
6 result from a baby on a neonatal unit of a raised  
7 insulin and low C peptide level a never event which  
8 would mandate an urgent Serious Incident Review in all  
9 cases.

10 On 1 September 2015, just under a month after the  
11 death of Baby E, the board of directors met. The  
12 minutes indicate that medical director, Mr Harvey,  
13 presented the hospital's mortality report to the board.  
14 However, there is no reference in the minutes to the  
15 increase in the mortality rate on the neonatal unit,  
16 which had reached four deaths within two months.

17 Neither had the 3 June 2015 deaths been mentioned at  
18 the previous 7 July board meeting. The board was  
19 informed that, "Mr Harvey now personally reviews every  
20 death in the Trust and then refers cases for further  
21 review where appropriate." In his statement to the  
22 Inquiry, Mr Harvey says that this minute is inaccurate;  
23 it should say he would review every adult death, and he  
24 was confident that there was a process in place for  
25 children.

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1 was that after Child G had been given her feed at 2 am  
2 by Nurse Z and whilst Nurse Z was on her break, Letby  
3 injected milk and air by a syringe into Child G.

4 On the day shift of 21 September, Child G was being  
5 cared for in nursery 4, with Letby as her designated  
6 nurse. Shortly after a feed at 0900 hours, Child G had  
7 two large projectile vomits which caused her to stop  
8 breathing temporarily and desaturate. Child G was moved  
9 to nursery 1 midmorning and Nurse W took over her care.

10 Letby was found guilty of attempting to murder  
11 Child G on two occasions: during the night shift of 6 to  
12 7 September and on the morning of 27 September. Letby  
13 was found not guilty of a further charge of attempted  
14 murder on the afternoon of 21 September.

15 Child H. Child H was born at 34 weeks and 4 days  
16 gestation, weighing 2.33 kilograms. She experienced  
17 sudden collapses during two consecutive night shifts at  
18 0322 on 26 September and 0055 am on 27 September.  
19 Child H was being cared for in Nursery 1 with  
20 Shelley Tomlins as her designated nurse. Letby was also  
21 working in Nursery 1 caring for other babies. The jury  
22 delivered a not guilty verdict in relation to the count  
23 of attempted murder in relation to the first collapse  
24 and they could not reach a verdict in relation to the  
25 second collapse. After the collapses, Child H was

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1 Interesting, my Lady, at this same board meeting it  
2 was noted that the levels of staff who had received  
3 safeguarding training was under expected levels.

4 We will return later to the role of the board and  
5 the important issue of whether they provided an  
6 effective form of oversight.

7 Child G and Child H. Between 7 and 27 September  
8 2015, two more babies, Child G and Child H, suffered  
9 a number of unexpected collapses whilst Letby was on  
10 duty. Child G was born in Arrowse Park Hospital at 23  
11 weeks and 6 days weighing 535 grams. She spent  
12 approximately 11 weeks at Arrowse Park and, in  
13 August 2015, at a gestational age of just over 34 weeks,  
14 she was transferred to the Countess of Chester in  
15 a stable condition.

16 By 6 September 2015, Child G was considered  
17 a special care baby and was being cared for in nursery  
18 2. Dr Brearey reviewed Child G on 6 September and  
19 confirmed she was stable and improving and preparations  
20 for her discharge home continued.

21 Nurse Z was the designated nurse for Child G for the  
22 night shift of 6 7 September. Nurse Ailsa Simpson was  
23 the shift leader and Dr Alison Ventress was the  
24 registrar on duty. Letby was working on the night shift  
25 caring for a baby in nursery 1. The prosecution case

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1 transferred to Arrowse Park on 27 September 2015.

2 The handover sheet for Child H was found in  
3 a plastic bag under Letby's bed at her home after her  
4 arrest. Handover sheets for Child G and Child I were  
5 also found. Letby kept 231 handover sheets stored at  
6 her home and 21 of those sheets related to babies on the  
7 indictment.

8 Child I. It appears that it was the pattern of  
9 repeated collapse of Child I whilst Letby was on duty  
10 that caused the first explicit concerns to be raised  
11 about the correlation between Letby's shifts and the  
12 unexpected collapse or death of babies.

13 Child I was born at 27 weeks' gestation weighing  
14 970 grams at Liverpool Women's Hospital. She was moved  
15 to the Countess of Chester on 18 August 2015. Following  
16 a deterioration in her condition, Child I returned to  
17 Liverpool Women's Hospital from 6 to 13 September before  
18 being moved back to the Countess of Chester. On  
19 30 September, she collapsed suffering a desaturation and  
20 a fall in her heart rate. On 13 October, she suffered  
21 a further collapse. Child I was transferred to Arrowse  
22 Park from 15 to 17 October but again returned to the  
23 Countess of Chester.

24 Dr Matthew Neame was involved in the care of Child I  
25 on a number of night shifts in October 2015. In his

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1 police statement, Dr Neame says that he considered the  
2 rapid deterioration of Child I in the early hours of  
3 13 October to be unusual.

4 Dr Rachel Chang was on day shifts at this time and  
5 frequently took handovers from Dr Neame. She commented:

6 "[Child I] had had almost regular events where she  
7 would be really sick and then 'bounce back'. Matt Neame  
8 had been resuscitating poor [Child I] at night shift and  
9 every morning at handover, I'd be like 'Oh my god, poor  
10 [Child I] and poor you.' and then we'd have a day shift  
11 of where we'd say, 'Oh, she's not been too bad' as she  
12 had seemingly recovered quite quickly'."

13 On the night shift of 22 and 23 October,  
14 Ashleigh Hudson was the designated nurse for Child I who  
15 was being cared for in Nursery 1. Letby was also on  
16 duty and caring for babies in Nursery 2 and Nursery 3.  
17 When Child I collapsed just prior to midnight,  
18 Nurse Hudson called for help and Letby came to assist.  
19 A crash call was made, Dr Chang attended and Dr Gibbs  
20 was called. Child I was ventilated and stabilised.  
21 Later, in the early hours, Child I collapsed again.  
22 Nurse Hudson re-entered Nursery 1 at about 1 am. Letby  
23 was with the Child I and, within about a minute, Child I  
24 had collapsed. Nurse Taylor and Nurse Christopher Booth  
25 attended to assist and Dr Chang was contacted.

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1 Child A, Child C and Child D, and concluded that there  
2 was no linking factor. Dr Brearey had then reviewed  
3 Child E's death in August 2015. However, it appears to  
4 have been the death of Child I in October 2015 that  
5 first led Dr Brearey to raise in writing his concerns  
6 about Letby.

7 Dr Brearey contacted Eirian Powell on the day  
8 Child I died and raised the association with Letby due  
9 to his concerns regarding the repeated nature of  
10 Child I's collapses and the apparent improvement when  
11 Child I was admitted to Liverpool Women's and Arrowe  
12 Park Hospitals.

13 Ms Powell responded to Dr Brearey by email on  
14 Friday, 23 October, copying in the Risk and Patient  
15 Safety Lead, Ms Peacock, the lead nurse of Children's  
16 Services, Ms Anne Murphy, and the Deputy Ward Manager,  
17 Yvonne Griffiths, with the subject "Mortality 2015".

18 This email from Ms Powell bears reading because, in  
19 many ways, it sets the tone that was to follow in the  
20 subsequent months. Concerns, despite being raised by  
21 the consultant lead of the neonatal unit, were not seen  
22 as urgent and assumptions surrounding the underlying  
23 medical evidence were made.

24 Ms Powell responded to Dr Brearey as follows:

25 "Just to say that I've discussed the above with Anne

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1 She attended and assisted with resuscitation and  
2 Dr Gibbs was called. Despite their efforts to  
3 resuscitate Child I, they were unsuccessful. Child I  
4 died at 2.30 am and Letby was convicted of her murder.

5 Dr Gibbs could not understand why Child I had died.  
6 He contacted the Coroner's Office as he was unable to  
7 provide a cause of death, and he arranged for a debrief  
8 meeting to be held on 9 November 2015. The Coroner  
9 referred Child I for a post-mortem by Dr Kokai at Alder  
10 Hey Children's Hospital. The postmortem concluded that  
11 Child I died of natural causes and, as such, no inquest  
12 was necessary.

13 Following Child I's death, Dr Brearey, who as  
14 clinical lead had an overview of all deaths that had  
15 occurred since June 2015, had concerns. Dr Jayaram  
16 meanwhile tells the Inquiry that when he returned to  
17 work in early November 2015 and became aware of the  
18 death of Child I and the repeated associated presence of  
19 Letby, he became concerned for the first time that Letby  
20 could somehow be causing inadvertent or even deliberate  
21 harm.

22 Child I's death was the fifth death in under five  
23 months. Dr Brearey had been the only doctor involved in  
24 the initial July 2015 investigation. This investigation  
25 had considered the first three deaths in June 2015,

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1 Murphy and on reflection it was decided to leave this  
2 until Monday. Alison Kelly was not in the hospital and  
3 Sian Williams, Deputy Director of Nursing, had just left  
4 as well. I have devised a document [Ms Powell says] to  
5 reflect the information clearly and it is unfortunate  
6 that she, [Letby], was on. However, each cause of death  
7 was different. Some were poorly prior to their arrival  
8 on the unit and the others were query Necrotising  
9 Enterocolitis or gastric bleeding/congenital  
10 abnormalities. I've attached the document for your  
11 perusal. See you Monday, I'll discuss further with  
12 Debbie on Monday."

13 A table attached to the email identified all of the  
14 babies who died between April 2015 and 23 October 2015  
15 and all the nursing staff on duty during the shift when  
16 the babies died. This document was devised by  
17 Ms Powell, who, as you will hear, at the time held Letby  
18 in high regard as a nurse. It was compiled starting  
19 with a list of the babies, then working out what staff  
20 were on shift at the time of death. We will come back  
21 to versions of this document, my Lady, in oral evidence  
22 on a number of occasions and we will be considering what  
23 it does and does not signify.

24 On Tuesday, 27 October, Ms Powell sent a further  
25 email to Dr Brearey, reporting that she'd spoken to

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1 Ms Peacock at length in relation to the mortality rate  
2 for this year, and that they had decided to create  
3 a modified table that also included doctors as well as  
4 nurses. She ends the email:

5 "Debbie was of the same opinion: that we did not  
6 think there was a connection. However, we would be  
7 highlighting the issues once the report has been  
8 completed."

9 What was meant, and the evidence for the assertion  
10 "We did not think there was a connection", will be  
11 explored in oral evidence. In spite of the views of  
12 Ms Powell and Ms Peacock, it seems that by October 2015,  
13 Dr Brearey was sufficiently concerned to pursue a more  
14 detailed investigation of the unexpected deaths on the  
15 unit.

16 Dr Brearey produced a review of Child I's case on  
17 31 October 2015, and I's case was discussed at  
18 a quarterly Neonatal Mortality Review meeting held on  
19 26 November 2015. From the record of that meeting, it  
20 does not appear that the possibility that staffing  
21 factors might have something to do with the death of  
22 Child I was raised. The meeting notes state:

23 "SB [presumably Stephen Brearey] to take case to  
24 neonatal network and surgical case review."

25 There is no indication of any wider discussion at

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1 This report by Dr Sara Brigham, a consultant  
2 obstetrician and gynaecologist at the hospital, looked  
3 at stillbirths and neonatal deaths during 2015.  
4 However, this review was from an obstetric perspective.  
5 Dr Brearey, the neonatal clinical lead, was not even  
6 aware that this review was taking place at the time and  
7 was only sent a copy of the report after he requested  
8 a copy in late December 2015.

9 At the request of the Director of Nursing and  
10 Quality, Ms Alison Kelly, Dr Brigham's report was  
11 presented at the Quality Safety and Patient Experience  
12 Committee on 14 December. It was an extremely brief  
13 report, amounting to just over two pages excluding the  
14 two appendices. The background section set out that the  
15 report was in response to a perceived increase in the  
16 number of stillbirths and neonatal deaths at the  
17 hospital and that a panel had been set up to  
18 independently review all of the cases to identify any  
19 common themes, trends, and lessons to be learnt.

20 Under the heading "Results", the report stated that  
21 all of the relevant cases had been, or would be, subject  
22 to a multi-disciplinary review, and that the external  
23 reviewer felt that our review process was extremely  
24 robust and open and transparent. No new issues were  
25 identified from the review. The Conclusion was:

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1 the meeting about concerns generally surrounding the  
2 death of Child I or to the fact that this was the fifth  
3 unexpected death in under five months.

4 Across the wider hospital and the neonatal network  
5 at this time, it appears that the concerns noted by  
6 Dr Brearey were not being examined. There was  
7 a Cheshire and Merseyside Neonatal Network Clinical  
8 Effectiveness Group meeting on 12 November, chaired by  
9 Dr Subhedhar, and attended by Ms Powell and Dr Brearey  
10 where it appears neonatal deaths were not discussed in  
11 any detail.

12 Dr Subhedhar tells the Inquiry that the Clinical  
13 Effectiveness Group was a forum for learning for  
14 mortality reviews, not to monitor outcomes or mortality  
15 rate. The Trust's Quality Safety and Patient Experience  
16 Committee met on 16 November 2015. There is no  
17 indication that unexpected neonatal deaths or the  
18 mortality rate were discussed there either.

19 The fact that neonatal deaths were not being  
20 discussed at the Neonatal Network or at the Quality  
21 Safety and Patient Experience Committee during  
22 November 2015 is not to say that no action was being  
23 taken. In November 2015, a report entitled "Review of  
24 neonatal deaths and stillbirths at Countess of Chester  
25 Hospital January 2015 to November 2015" was completed.

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1 "Continue to review each case of stillbirth or  
2 neonatal death on an individual basis within the  
3 multi-disciplinary review process."

4 Despite the title, which referred to the report as  
5 a review of neonatal deaths and stillbirths, neonatal  
6 care of the babies who died on the unit in 2015 was not  
7 examined within the Dr Brigham review. In her evidence  
8 to the Inquiry, Dr Brigham says that she was asked to  
9 undertake a thematic review of obstetric and maternal  
10 care which therefore did not involve the neonatal team.  
11 It was not until February 2016, following the unexpected  
12 collapse of Child J and the deaths of two further  
13 non-indictment babies, that any review of the neonatal  
14 care of the babies who died during 2015 took place.

15 Child J. On a date in late November 2015, Child J  
16 collapsed unexpectedly. Child J was born at the  
17 Countess of Chester at 32 weeks' gestation and taken to  
18 Alder Hey Hospital for an operation on a perforated  
19 bowel, returning to the Countess of Chester Hospital on  
20 10 November 2015. Child J progressed well, eventually  
21 moving into Nursery 4. The plan was for Child J to go  
22 home at the end of November 2015.

23 During a night shift in late November, Child J had  
24 a number of sudden and unexpected desaturations which  
25 required resuscitations and were associated with

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1 seizures. Letby was on night duty caring for two babies  
2 in Nursery 2. Nicola Dennison, a nursery nurse with  
3 them, with almost 30 years' experience, was Child J's  
4 designated nurse in Nursery 4.

5 Both Letby and Nurse Mary Griffith assisted with the  
6 collapses. Dr Verghese was the senior house duty on  
7 duty and he consulted a registrar, Dr Austin. Dr Gibbs  
8 was also called and Child J was moved to Nursery 2.

9 The jury were unable to reach a verdict in relation  
10 to the attempted murder in respect of Child J.

11 As I have said, in addition to the unexpected  
12 collapse of Child J, there were two further deaths on  
13 the unit in December 2015 and January 2016. The deaths  
14 were not babies named on the indictment. Dr Brearey  
15 says these further deaths prompted him to ask Ms Powell  
16 to produce an updated staff analysis.

17 On 19 January, Ms Powell emailed Dr Brearey stating  
18 that she had conducted a further staff analysis, which  
19 confirmed that Letby was present for all of the  
20 subsequent deaths since the last staffing analysis (in  
21 October 2015).

22 On 22 January 2016, an email chain comprising  
23 Dr Brearey, Ms Peacock, Dr Jayaram, Ms Murphy, Yvonne  
24 Griffiths, and consultant obstetrician Dr Joanne Davies,  
25 circulated Ms Powell's table showing the correlation

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1 expected to occur at any time of day or night."

2 It is currently unclear whether the possibility that  
3 Letby might have had something to do with the deaths of  
4 babies was explicitly discussed or whether anyone at  
5 this meeting raised the issue of an association with any  
6 nurse being removed from the unit. This will be  
7 explored in oral evidence, my Lady.

8 A report dated 8 February 2016 was produced  
9 following the meeting entitled "Thematic review of  
10 neonatal mortality 2015, January 2016." The report  
11 contains no reference to Letby by name nor does it refer  
12 to any consideration of whether the deaths could have  
13 been caused by incompetence or deliberate harm.

14 This thematic review document was sent by Dr Brearey  
15 to Mr Harvey on 15 February 2016. Attached to the  
16 report sent to Mr Harvey was appendix 1, which listed  
17 the nursing staff allocated and/or on duty at the time  
18 of the deaths. It identified Letby in respect of nine  
19 out of the ten babies, including the five indictment  
20 babies. Mr Harvey has said of this email and report in  
21 his statement to the Inquiry:

22 "Having reviewed this appendix in detail since,  
23 Letby was the allocated nurse for three of the ten  
24 deaths and on duty (but not the allocated nurse) for  
25 a further six. However, this is a dense report and, in

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1 between Letby's shifts and the deaths of babies under  
2 the title of "NNU mortality 2015". The email chain  
3 sought to arrange an initial half-day meeting to discuss  
4 and review the cases of the deceased babies where the  
5 diagnosis was uncertain, with an external reviewer  
6 attending.

7 The external reviewer was to be Dr Subhedar,  
8 a neonatologist from Liverpool Woman's Hospital NHS  
9 Foundation Trust and the Neonatal Network Clinical Lead.  
10 The review was held on 8 February 2016. Ten babies were  
11 the subject of the review, including Children A, C, D, E  
12 and I. Attendees were Dr Brearey, Dr Powell,  
13 Dr Subhedar, Ms Peacock, Ms Murphy, Doctor V and Nurse  
14 Laura Eagles.

15 Dr Brearey says that the meeting reviewed the care  
16 of all of the babies who died in 2015 and January 2016,  
17 and the previous reviews that had been undertaken and  
18 looked for any common themes. Dr Brearey explains that  
19 after all the cases had been discussed, he then raised  
20 the issue of staffing analysis, the association with  
21 a nurse, and the fact that six of the nine babies had  
22 collapsed between midnight and 4 am.

23 Dr Brearey says:

24 "This seemed significant to me because if babies had  
25 collapsed due to natural causes, then this would be

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1 the absence of anyone specifically drawing this to my  
2 attention, I do not think I would have noticed this.  
3 The tone and content of Dr Brearey's email attaching the  
4 thematic review did not cause me any concern."

5 Dr Brearey's recollection is that at this time, that  
6 is to say mid-February 2016, he sought a meeting with  
7 Mr Harvey and Ms Kelly to discuss the report. The  
8 Inquiry has not yet identified any written requests for  
9 such a meeting and it is a matter we will examine  
10 further.

11 A Care Quality Commission inspection of the hospital  
12 took place between 16 to 19 February 2016. We will  
13 return to that later, my Lady, in this opening.

14 As part of his preparation for the inspection visit,  
15 Mr Harvey had emailed Joanne Davies, consultant  
16 obstetrician, on 25 January 2016. Mr Harvey's email was  
17 to the effect that he wanted to know if there were any  
18 significant concerns, outliers or actions outstanding  
19 following the most recent MBRRACE audit report.  
20 MBRRACE, of course, my Lady, collects mortality data  
21 across the UK and provides reports to hospitals.

22 In the body of her response, Dr Davis stated in  
23 terms:

24 "We have had an increase in stillbirth and neonatal  
25 death for 2015."

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1 She went on to explain that an additional review had  
2 been undertaken as a result and provided a copy of  
3 Dr Brigham's report.

4 Mr Harvey forwarded Dr Davis's email to Ms Kelly on  
5 12 February. It is clear that both Mr Harvey and  
6 Ms Kelly, at the very least, knew that the mortality  
7 rate on the neonatal unit had increased in 2015.

8 Child K. On 17 February 2016, at the very time the  
9 CQC inspection was taking place, Child K suddenly and  
10 unexpectedly deteriorated. Child K was born at 25  
11 weeks' gestation. There was no bed available at  
12 Arrowe Park, and she was born at the Countess of Chester  
13 weighing 692 grams. She was later transferred to Arrowe  
14 Park where she died.

15 The prosecution case was that Letby attempted to  
16 kill Child K by dislodging her breathing tube. The jury  
17 were unable to reach a verdict in the first criminal  
18 trial and the case of Child K was subject to a retrial.  
19 Letby was found guilty of the attempted murder of  
20 Child K in the retrial.

21 In his statement to the police, dated 18 September  
22 2017, Dr Jayaram said of the event on 17 February 2016  
23 as follows:

24 "The nurse in charge of the baby [Child K], Jo  
25 Williams, had gone to speak to the parents in the labour  
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1 deterioration". Under this heading, it noted:

2 "Some of the babies suddenly and unexpectedly  
3 deteriorated and there was no clear cause for the  
4 deterioration. Death identified at postmortem."

5 The report, however, did not refer to Letby's  
6 presence at the sudden and unexpected deaths or  
7 deteriorations. Dr Brearey explains this as follows:

8 "I knew the report was going to be widely shared and  
9 I thought that this fact was a concern that was better  
10 discussed confidentially with the executives who I was  
11 expecting to meet soon. I also thought Eirian Powell  
12 might raise objections if it was included. In  
13 retrospect, I regret this decision."

14 The March 2016 version of the thematic review of the  
15 summary action plan was circulated to paediatric  
16 consultants on 2 March 2016. Although Letby was not  
17 named in the review, it is clear Dr Brearey still held  
18 concerns. As well as circulating his report to fellow  
19 consultants, Dr Brearey also sent an email to Ms Powell  
20 on the same date, copying in Dr Jayaram, saying:

21 "I think we still need to talk about Lucy. Maybe  
22 when you are back and free, the three of us can meet to  
23 talk about it?"

24 Dr Jayaram says this proposed meeting between the  
25 three of them never took place. However, from  
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1 ward."

2 Dr Jayaram says he was aware that Letby was  
3 supervising Child K and adds:

4 "I just became uneasy. By this time, I was aware  
5 that she'd been present at a large number of our  
6 collapses."

7 Dr Jayaram records how he entered the ward to find  
8 Letby standing by the incubator. He noticed that oxygen  
9 levels of Child K were dropping. He drew the conclusion  
10 that the tube had become dislodged and goes on to say:

11 "Due to this baby's prematurity and the nurse  
12 involved, I was concerned that this may not have  
13 dislodged by accident" but said nothing at the time.

14 Dr Jayaram acknowledges in his police statement,  
15 dated 17 April 2018:

16 "I was aware of the particular issue on the unit  
17 regarding the mortality rate and the number of collapses  
18 the unit had been suffering and the possibility of an  
19 association with Lucy Letby being present at the time of  
20 those collapses."

21 Thematic review of neonatal mortality, Version 2,  
22 March 2016.

23 In March 2016, Dr Brearey produced his second  
24 version of the February thematic review. This report,  
25 at the suggestion of Dr Subhedar, added a theme "Sudden  
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1 November 2015, Dr Jayaram says he had several "corridor  
2 conversations" with both Dr Brearey and other consultant  
3 colleagues about his concerns.

4 On 17 March 2016, Ms Powell emailed Ms Kelly, the  
5 Director of Nursing Quality, requesting a meeting and  
6 stating that there was "high mortality" on the neonatal  
7 unit and that a particular nurse was a "commonality" and  
8 that "nothing obvious" had been identified to explain  
9 the high mortality rate.

10 Ms Kelly has told the Inquiry in her witness  
11 statement that "there was nothing to suggest to her in  
12 that email that there were grave concerns about Letby."  
13 She has also said that "the tone and content of the  
14 email did not suggest the need for an immediate  
15 meeting."

16 Ms Kelly replied to Ms Powell's email of 17 March on  
17 21 March asking her to send the report to her and  
18 Mr Harvey. Less than an hour later, Ms Powell sent the  
19 thematic review of neonatal mortality document to  
20 Ms Kelly. She had copied in Mr Harvey.

21 By 21 March 2016, therefore, my Lady, it's clear  
22 from the email correspondence that both Ms Kelly and  
23 Mr Harvey had received a copy of the thematic review of  
24 neonatal mortality. As at that date, Mr Harvey had been  
25 sent it twice, having received it almost exactly a month  
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1 earlier from Dr Brearey.

2 On 18 April 2016, Ms Kelly took action in relation  
3 to the thematic review and contacted Mr Harvey  
4 suggesting a meeting with Dr Brearey and Ms Powell in  
5 early May. The meeting took place on 11 May and I will  
6 return to that shortly.

7 In the intervening period between Ms Powell's email  
8 of 17 March and the meeting on 11 May, three events of  
9 considerable significance occurred: Letby was moved to  
10 day shifts; Letby attacked Child L and Child M in the  
11 days which followed her move to day shifts.

12 We will consider the move to day shifts first.

13 One of the themes that Dr Brearey had identified in  
14 the February 2016 review was that most of the babies had  
15 died at night. Letby was moved to day shifts on  
16 7th April, 2016. In her police statement, Ms Powell  
17 said:

18 "It was my decision to bring Lucy off night shifts  
19 for two reasons really, that if what Steve and the  
20 others were intimating, we needed to have more eyes  
21 watching as well to make sure Lucy was all right and  
22 also to make sure there was no wrongdoing anywhere.  
23 There was nothing specific put into place when we  
24 changed Lucy to day shifts as we didn't want to change  
25 anything, we just wanted to support her. It wasn't

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1 continue to work some night shifts, working a string of  
2 four night shifts at the end of May/beginning of June.

3 Child L and Child M. Child L and M were twin  
4 brothers born at 33 weeks and 2 days' gestation. Both  
5 babies weighed about 1.36 kilograms. Letby was working  
6 on the day shift on the day the twins were born. In  
7 fact, she worked four day stay shifts between 6 April to  
8 9 April. The prosecution case was that Letby attempted  
9 to kill Child L by putting insulin into bags of dextrose  
10 solution, the first of which was put up two hours after  
11 he was born.

12 Child L, as was common for premature babies, had  
13 a low blood sugar level. Plasma from a blood sample  
14 taken by Nurse Mary Griffiths later in the afternoon  
15 provided readings that indicated that Child L had been  
16 given exogenous insulin. Letby was found guilty of  
17 attempting to murder Child L by insulin poisoning.

18 At the criminal trial, Professor Hindmarsh,  
19 a consultant paediatric endocrinologist, was of the  
20 opinion that Child L's hypoglycaemic event continued  
21 from 9 April until about 3 pm on 11 April with the  
22 insulin being infused intravenously having been added to  
23 bags that had been made up.

24 A blood sample taken from Child L on 9 April 2016  
25 was sent to the Royal Liverpool Hospital for testing.

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1 meant to be a punishment but a support system in place".

2 Dr Brearey states that he was not informed of this  
3 decision at the time and only learnt of it in May 2016.  
4 Similarly, Ms Kelly, Letby's overall line manager as  
5 Director of Nursing, says she was not told about this  
6 change until 4 May 2016.

7 The decision to put Letby on day shifts was  
8 supported by Ms Karen Rees, Head of Nursing, Urgent Care  
9 Division. In her statement to the Inquiry, Ms Rees  
10 said:

11 "I supported Eirian Powell's decision as there were  
12 more staff on day duty, so Letby's clinical practice  
13 could be observed more closely."

14 The decision to move Letby to day shifts raises  
15 serious questions which we will be investigating. If  
16 there was sufficient concern to take Letby off night  
17 shifts, then how could a decision that left Letby in  
18 sole charge of neonatal babies during the day be  
19 justified? Who was consulted about this decision?

20 The falsity of the suggestion that "more eyes  
21 watching" was an adequate safeguard against harm being  
22 caused is demonstrated by the fact that Letby was found  
23 guilty of the attempted murder of twins, Child L and  
24 Child M, on the day shift of 9 April. It also appears  
25 that, due to staff shortages, Letby did in any event

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1 It was received on 11 April. The testing indicated that  
2 most of the insulin in Child L's blood was manufactured  
3 synthetic insulin. Dr Sarah Davis, concerned at the  
4 results, rang them through to the Countess of Chester  
5 duty biochemist on 14 April 2016. A note of the phone  
6 call records that the advice given was:

7 "Difficult to interpret without the concurrent  
8 glucose but may be inappropriate if patient was  
9 hypoglycaemic at time of collection."

10 Child L was indeed hypoglycaemic. The duty  
11 biochemist, Dr Shirley Bowles, entered the results on to  
12 Child L's electronic lab record at 9.38 on 14 April. It  
13 appears that the significance of these results were not  
14 picked up on the ward round on 15 April by the clinical  
15 team.

16 Dr Gibbs says that the insulin record was on  
17 Child L's notes and the failure to recognise the  
18 potential significance of the result was "a collective  
19 failure on the part of us paediatricians" and that "our  
20 failure to recognise the potential significance of the  
21 insulin results in Child A, just as earlier in Child F,  
22 meant that an important opportunity was missed to  
23 identify, and thus try to prevent, harm to patients in  
24 the NNU".

25 Mr Harvey has stated of Child L's insulin result

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1 that:

2 "There should have been cross-reference with  
3 Child F.

4 "I think if this had been identified and reported,  
5 it would have influenced our decision to go to the  
6 police."

7 Child M was the twin brother of Child L. In  
8 relation to Child M, the prosecution case was that on  
9 9 April 2016, Letby injected air into his abdomen.  
10 Letby was found guilty of attempted murder of Child M.

11 Child M collapsed unexpectedly at about 4 pm on  
12 9 April 2016. At the request of Letby, a resuscitation  
13 crash call was put out. Nurse W assisted Letby in  
14 giving resuscitation breaths to Child M until the  
15 doctors arrived. Dr Anthony Ukoh, Dr Cassandra Barrett  
16 and Dr Jayaram attended. The resuscitation continued  
17 for approximately 30 minutes and reached a point where  
18 withdrawing support needed to be considered. However,  
19 at this point, Child M suddenly recovered. Dr Jayaram's  
20 evidence was that, whilst he did not make a note of this  
21 in the clinical notes, he observed the same blotches or  
22 patches appear and disappear on Child M's skin at the  
23 start of the resuscitation, noting this to be similar to  
24 the rash he'd observed on Child A.

25 A paper towel with the drug administration notes  
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1 concerns about potential inadequate use of the incident  
2 reporting system. It is a topic across all of the  
3 babies who were murdered or harmed that the Inquiry will  
4 be investigating carefully.

5 However, it does appear that some records were being  
6 kept of babies that died and babies that collapsed and  
7 survived. Ms Powell commends the schedule on  
8 15 April 2016 that listed babies from 18 February who  
9 had died or collapsed and survived. It records the  
10 collapse of Child M on 8 April during a day shift when  
11 Letby was on duty. It is currently unclear what, if  
12 any, action was taken in response to this or who this  
13 information was shared with. The schedule includes M,  
14 N, O, P and Q in due course.

15 Dr Brearey in his statement to the Inquiry comments:

16 "So much focus on mortality throughout 2015 and 2016  
17 did mean that we had very little time to consider and  
18 review morbidity, babies who did not die. Much of this  
19 morbidity evidence, if time allowed us to review it  
20 thoroughly, might have led to earlier action being  
21 taken, better support from the Trust, particularly the  
22 Risk and Patient Safety Department, and more time  
23 allocated to my risk role, away from my clinic duties,  
24 might have given me or my colleagues more time and space  
25 to consider important morbidity cases."

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1 relating to Child M was found at Letby's home and she  
2 recorded in her diary for 9 April:

3 "LD [meaning long day] extra twin resus."

4 My Lady, we note here that whereas the deaths of  
5 babies were variously discussed, however briefly, at  
6 quarterly neonatal mortality reviews, in Serious  
7 Incident Review Panels, and also formed part of the  
8 thematic review initiated by Dr Brearey, there is little  
9 by way of review or report of unexpected collapses where  
10 the babies survived. And yet the Clothier Report  
11 recommended over 30 years ago that, "reports of serious  
12 untoward incidents to district and regional health  
13 authorities should be made in writing and through  
14 a single channel which is known to all involved".

15 Ms Millward, the Head of Risk and Patient Safety, in  
16 her statement to the Inquiry says that such incidents,  
17 "were not reported within the incident reporting  
18 system". Had there been greater consideration of  
19 non-fatal and unexpected collapses, it seems likely the  
20 extent of the correlation between Letby's presence and  
21 the deterioration of babies would have been more  
22 apparent and the significance of the unusual rash and  
23 the number of unexpected collapses would have been  
24 highlighted at an earlier stage.

25 Ms Millward is not the only witness to raise  
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1 A matter the Inquiry will be exploring is the  
2 apparent delay in the Thematic Review of the Neonatal  
3 Mortality document being considered at the Quality,  
4 Safety and Patient Experience committee. You will  
5 remember, my Lady, that the first version was completed  
6 on 8 February. This Committee met on 15 February.  
7 There was a further meeting on 21 March, which took  
8 place nearly three weeks after the second version of the  
9 thematic review of neonatal mortality documents  
10 completion.

11 For reasons we'll be exploring in evidence, Ms Kelly  
12 was, by 18 April, saying that this document would not be  
13 presented at the April meeting but would be presented in  
14 May. In fact, it doesn't appear to have been discussed  
15 in either the May or June meeting.

16 May I turn back now, my Lady, to a meeting  
17 I mentioned earlier, the one that took place on 11 May  
18 2016. This is the meeting that was requested by  
19 Ms Powell in March 2016 to discuss high mortality and  
20 the commonality of the presence of a nurse.

21 Prior to the 11 May meeting, Dr Brearey sent the  
22 following message to Ms Kelly:

23 "There is a nurse on the unit who has been present  
24 for quite a few of the deaths and other arrests. Eirian  
25 has sensibly put her on day shifts only at the moment,

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1 but can't do this indefinitely. It would be very  
2 helpful to meet before she's due to go back on night  
3 shifts. There is some pressure regarding staffing  
4 numbers with this at the moment. Best wishes, Steve."

5 Pausing there for a moment, this is the first  
6 occasion which the Inquiry has identified to date that  
7 a member of the Executive Directors Group was informed  
8 in writing that the concern about a nurse had resulted  
9 in a member of staff's shift pattern being adjusted.

10 Ms Kelly has told the Inquiry that when she received  
11 this email, the reference to "pressure on staffing  
12 numbers" was the reason for the need to hold the meeting  
13 as soon as possible and the impact of moving Letby upon  
14 the nursing rota, rather than any concerns about deaths  
15 being from unnatural causes. Ms Kelly had already been  
16 told in March 2016 by Ms Powell about the commonality of  
17 the same nurse being on duty for what were an increased  
18 number of baby deaths and had been sent the thematic  
19 review. She had also, according to Dr Brearey, been  
20 informed back as far as July 2015, about the fact that  
21 Letby had been present at the deaths of Child A, Child C  
22 and Child D.

23 However, it appears to be this email of 4 May 2016  
24 from Dr Brearey that caused an immediate response.  
25 Within four minutes of receipt, Ms Kelly had forwarded

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1 Ms Murphy says that the discussion took place because  
2 they felt unable to manage the situation further and it  
3 had become a matter of urgency. Following the meeting,  
4 Ms Powell sent number of documents to Ms Rees, copying  
5 in Yvonne Griffiths, Dr Brearey and Ms Murphy. One of  
6 the documents was the now familiar schedule of deaths  
7 and the staff on duty dated 9 January that highlighted  
8 Letby's names in red. There was also a document  
9 produced by Ms Powell and dated 5 May 2016, which says,  
10 or starts:

11 "There's no evidence whatsoever against LL other  
12 than coincidence. LL works full time and has the  
13 Qualification in Specialty. She is therefore more  
14 likely to be looking after the sickest infants on the  
15 unit. LL also avails herself to work overtime when the  
16 acuity or unit is over capacity."

17 In the covering email, Ms Powell stated:

18 "Obviously we would like to have a meeting with  
19 Alison Kelly and Ian Harvey as a matter of urgency,  
20 primarily for reassurance and to ensure that we've  
21 covered all the relevant action."

22 The day after, 6 May 2016, Ms Kelly forwards  
23 Dr Brearey's email about the shift changes of Letby to  
24 Mr Harvey. In the body of her email Ms Kelly wrote:

25 "Hi Ian, please see Steve's comments below, which

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1 Dr Brearey's email (that I've read) to Ms Rees, copying  
2 in Ms Sian Williams, Deputy Director of Nursing, with  
3 the following message:

4 "Aah!! Can you please look into this with Anne M,  
5 and Eirian - if there is a staff trend here and we've  
6 already changed her shift patterns because of this, then  
7 this is potentially very serious!! I will check the  
8 report they sent through. I did not notice that there  
9 was a staff trend!!"

10 Less than two hours later, Ms Kelly again emailed  
11 Ms Rees. She wrote:

12 "Hi Karen. Please see attached. I'm not sure you  
13 will have had previous sight of this. Lucy Letby  
14 highlighted in red! I had not noticed this when I first  
15 reviewed. Can you please look into this as per my  
16 previous email?"

17 The attachment was the table dated 19 January 2016  
18 prepared by Eirian Powell and to which I referred  
19 earlier. Ms Kelly has told the Inquiry that she was,  
20 "quite alarmed" when she typed this email, as she,  
21 "assumed that the shift patterns had been changed as  
22 a direct result of the staffing trend identified". We  
23 will be exploring this further in oral evidence.

24 It would appear that there was a preliminary meeting  
25 between Ms Powell, Ms Rees and Ms Murphy on 5 May.

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1 alarm me. Since receiving this I have asked Karen Rees  
2 to liaise with Eirian regarding this particular nurse.  
3 Eirian's further review is attached for further info.  
4 I am currently reassured there are no issues but I think  
5 this is worthy of a wider review, hence our planned  
6 meeting. This has been arranged for next Wednesday to  
7 review all the issues with us. Something we need to  
8 discuss at our one-to-one on Monday. Thanks, Alison."

9 Ms Kelly has explained to the Inquiry what lay  
10 behind this email. She states that she can:

11 "... recall Karen Rees conveying to me that Eirian  
12 did not feel that there were any issues of concern with  
13 Letby and that she had changed her shift for reasons  
14 connected to her wellbeing rather than anything more  
15 serious."

16 I will return to the reviews initiated by the  
17 executives and what they did and did not address  
18 shortly.

19 Meanwhile the meeting was in fact held on 11 May,  
20 and when the issue of Letby was discussed at the most  
21 senior level between Medical Director of the Hospital  
22 Mr Harvey and Alison Kelly.

23 From handwritten notes of the meeting it would  
24 appear that the full list of attendees at the meeting  
25 was Ms Powell, Ms Murphy Dr Brearey, Mr Harvey and Ms

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1 Kelly, and the notes of the meeting include the  
 2 comments, "absolutely no issue with nurse" and  
 3 "circumstantial".  
 4 Dr Brearey has said of this meeting in his written  
 5 evidence to the Inquiry:  
 6 "I felt that the number of deaths in 2015 and early  
 7 2016 were exceptional. I highlighted that six of the  
 8 nine deaths occurred between midnight and 4 am, which  
 9 was unusual. I highlighted that there seemed to be  
 10 a disproportionately high number of sudden and  
 11 unexpected collapses. We had reviewed care on multiple  
 12 occasions including with an external neonatologist and  
 13 the only common theme was with Letby being on duty. We  
 14 needed guidance on help to take this forward. I also  
 15 made it clear these were concerns of my colleagues and  
 16 were not mine in isolation".  
 17 Ms Kelly described Ms Powell as being vociferous at  
 18 this meeting saying there were no issues with Letby  
 19 whatsoever. Dr Brearey gives a similar account, noting  
 20 that, "Eirian Powell was very defensive of Letby at the  
 21 meeting". Also that Ms Murphy and Eirian Powell  
 22 countered his concerns "forcibly and with great  
 23 emotion".  
 24 In his statement to the Inquiry, meanwhile,  
 25 Mr Harvey has said of this meeting:

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1 upon the supervision. While Letby was present, the  
 2 hours she worked, what staff may have thought of her,  
 3 and the fact that coincidences can and clearly do occur.  
 4 Ms Harvey has said of his and of the position at the  
 5 conclusion of this meeting:  
 6 "We were dealing with a spike in deaths on the NNU  
 7 which were unexplained despite thorough review and we  
 8 were assuring Dr Brearey we, the executives, were aware  
 9 and supported the actions being undertaken by the  
 10 clinical team. At no stage during this meeting did  
 11 I feel that it was being reported because there was  
 12 worry that Letby was responsible for the deaths."  
 13 Ms Kelly has told the Inquiry:  
 14 "Based on the information provided at the meeting,  
 15 there was nothing at all to justify an immediate  
 16 suspension of Letby. Had I been told that she'd been  
 17 seen doing anything that compromised the safety of any  
 18 patient or that there was evidence of potential  
 19 intentional harm being caused to any of the babies,  
 20 I would have immediately moved to have her suspended  
 21 from the unit."  
 22 Ms Kelly recorded in her notes of this meeting at  
 23 the time that the action plan which was agreed was that  
 24 a review would be conducted of any further babies who  
 25 suddenly collapsed or deteriorated to conduct a further

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1 "There had been no suggestion to me that a meeting  
 2 was required urgently and I did not try to schedule it  
 3 faster."  
 4 He goes on to say:  
 5 "The tone of the meeting was calm and I don't recall  
 6 anyone being aggravated or forthright about a concern  
 7 about Letby."  
 8 In her statement to the Inquiry, Ms Kelly speaks  
 9 about Ms Powell talking through the notes which  
 10 Ms Powell had prepared on 5 May. Ms Kelly states:  
 11 "The overall impression I got from this note was  
 12 that there was a reasonable explanation for Letby being  
 13 on shift for more of the deaths than other nurses due to  
 14 the hours she worked and that she was a well-regarded  
 15 nurse."  
 16 This is an important meeting, my Lady, and the  
 17 Inquiry will be examining closely the accounts from  
 18 different witnesses about what was said, what was  
 19 decided, and upon what basis. Whether deliberate harm  
 20 had been caused to babies by the nurse they had  
 21 identified as having an opportunity to do so could only  
 22 be understood by detailed, forensic investigation and  
 23 medical analysis of deaths and collapses on the unit.  
 24 Instead of ensuring that in-depth analysis was  
 25 undertaken, however, the focus appears to have rested

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1 deep dive into neonatal deaths which had taken place  
 2 during the night, and have a follow-up meeting in July.  
 3 Ms Kelly's notes are in contrast to Dr Brearey's  
 4 recollection that other than meeting again in two  
 5 months, there seemed no actions from the meeting.  
 6 Dr Brearey has told the Inquiry he felt the response  
 7 from Mr Harvey and Ms Kelly was inadequate.  
 8 As a follow-up to the meeting on 11 May, Dr Brearey  
 9 sent an email on 16 May to his fellow paediatric  
 10 consultants copying in Ms Powell and Ms Murphy. His  
 11 request to his fellow consultants was as follows:  
 12 "If you do come across a baby who deteriorates  
 13 suddenly or unexpectedly, or needs resuscitation on the  
 14 NNU, please could you let me and Eirian know. We will  
 15 keep a record of these cases and will review them as  
 16 soon as practicable."  
 17 This email accords with part of Ms Kelly's  
 18 handwritten note of the action plan and what Mr Harvey  
 19 has told was his expectation following the meeting. It  
 20 says:  
 21 "In addition to this, following this meeting,  
 22 I would have expected to have been made aware of any  
 23 concerning issues on the NNU by the neonatal team."  
 24 According to Ms Powell's interview, given as part of  
 25 Letby's grievance process, there was an urgent care

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1 meeting on 16 May at which Dr Brearey intimated that he  
2 thought a member of staff was increasing the increase in  
3 mortality. It was at this meeting there was allegedly  
4 reference to there being "a murderess on the neonatal  
5 unit". There is a dispute in the facts here as to what  
6 was said by who at that meeting, and that will be  
7 explored in oral evidence.

8 **LADY JUSTICE THIRLWALL:** Perfect timing, Ms Langdale. We  
9 will adjourn now until quarter to 2.

10 (12.43 pm)

11 (The Short Adjournment)

12 **LADY JUSTICE THIRLWALL:**

13 (The Short Adjournment)

14 (1.45 pm)

15 **LADY JUSTICE THIRLWALL:** Ms Langdale.

16 **MS LANGDALE:** Child N. It is clear that no steps were taken  
17 as a result of the meeting on 11 May 2016 to reduce  
18 Letby's access to patients or to place her under any  
19 formal supervision, and unexpected collapses continued  
20 to occur while she was on shift.

21 Child N collapsed on 3 June, an incident that  
22 Child N's father says he and Child N's mother were not  
23 informed of at the time, and twice on 15 June. Letby  
24 was convicted of attempted murder in relation to the  
25 collapse on 3 June, the jury couldn't reach a verdict in  
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1 messaging with Dr U, who was a paediatric registrar at  
2 the hospital. Over 1,300 Facebook messages were  
3 exchanged between Letby and Dr U between mid-June 2016  
4 and September 2016.

5 Some of those messages referred to babies named on  
6 the indictment. On 22 June 2016, the day Letby returned  
7 from a holiday abroad, and the day before the death of  
8 the first triplet, child O, Letby asked Dr U, "What  
9 gestation are the trips?"

10 In his Inquiry statement Dr U states:

11 "I did not report this as unusual interest, as  
12 I thought that the questions by Letby were based on  
13 professional curiosity. In the case of Children O and P,  
14 when Letby asked about the gestation of the triplets,  
15 I thought these questions were being asked out of  
16 general interest and in preparation for her returning to  
17 work from annual leave."

18 Child O, P and R, June 2016. It was the unexpected  
19 death of two babies from a set of triplets born at the  
20 Countess of Chester in June 2016 at 33 weeks and two  
21 days' gestation that finally led to Letby being removed  
22 from the ward.

23 Child O died suddenly and unexpectedly at 5.47 pm on  
24 23 June. Letby was convicted of the murder of Child O.

25 This was a death that shocked those on duty.  
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1 relation to the incidence on 15 June.

2 Mr Harvey has told the Inquiry:

3 "I do not recall being made aware of Child N's  
4 collapse at the time, given that one of the actions  
5 arising from the meeting on 11 May was to consider  
6 deteriorations, I would have expected to have been  
7 informed about this.

8 In a similar vein, Ms Kelly's statement to the  
9 Inquiry on this point reads:

10 "I was not aware of this and believe I should have  
11 been, given that we agreed a period of enhanced  
12 monitoring of collapses."

13 This apparent lack of reporting to the executive  
14 directors in relation to Child N's two separate  
15 deteriorations is of particular concern given  
16 Dr Brearey's email of 16 May to his fellow consultants,  
17 Nurse Powell and Nurse Murphy.

18 Furthermore, there seemed to be no wider concern or  
19 discussion within the relevant hospital committees at  
20 the time. We will return to the board and governance  
21 tomorrow.

22 The Inquiry has considered the various messages that  
23 Letby was sending insofar as they give any insight that  
24 fall within the Inquiry's terms of reference. From  
25 May 2016, Letby was involved in frequent Facebook  
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1 Nurse Taylor was the day shift leader on 23 June. In  
2 her statement to the Inquiry she says:

3 "I was very surprised at Child O's passing as he was  
4 a relatively well baby and I could not have predicted  
5 a collapse."

6 Nurse Bennion's evidence is similar:

7 "I was personally alarmed or alerted to the number  
8 of child deaths when one of the triplets died. It was  
9 completely unexpected. They were mature babies born at  
10 33 weeks, good weight, and although they were receiving  
11 respiratory support, they were very stable. I wondered  
12 if there was significant infection on the unit that we  
13 were missing."

14 Dr Brearey was aware that Letby was involved in the  
15 resuscitation. He did not notice, "... any outwardly  
16 suspicious actions" but describes being very worried at  
17 this stage and refers to his intention to discuss the  
18 matter with Ms Powell and escalate to executives. He  
19 said that he could not conceive that senior staff would  
20 allocate Letby to care for the surviving triplets, but  
21 that he deeply regrets not escalating his concerns  
22 urgently on the evening of 23 June.

23 On Friday 24 June, Ms Rees was called to the office  
24 of Ms Karen Townsend, the Director of Urgent Care.  
25 Child O had died the previous evening. Ms Rees said  
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1 that in that meeting she was told that Dr Brearey and  
2 Dr Jayaram "both thought that Lucy was purposely harming  
3 babies".

4 It had been Ms Rees, the Head of Nursing for the  
5 Urgent Care Division, who Ms Kelly had turned to in  
6 early May 2016, when she first reacted with shocked  
7 emails about the 'staff trend' revealed in the documents  
8 forwarded by Ms Powell. Ms Rees had met also with  
9 Ms Powell, at Ms Kelly's request, in May 2016 to discuss  
10 the issue.

11 Having had the issue of Letby raised again,  
12 Ms Rees's evidence is that she proceeded to meet with  
13 Dr Jayaram, Brearey, Ms Kelly and Ms Powell on Friday,  
14 24 June. She says Dr Jayaram told her that Letby "may  
15 be harming babies" and that Dr Brearey shared these  
16 concerns. Ms Rees says that she went to speak to  
17 Ms Kelly and reported her conversations with Townsend,  
18 Dr Jayaram and Dr Brearey. According to Ms Rees.  
19 Ms Kelly said she was going to speak to Mr Harvey.

20 Ms Rees says that she had decided not to exclude  
21 Letby from the neonatal unit on Friday as she had been  
22 given no detail in support of the concerns by Dr Brearey  
23 and Dr Jayaram.

24 She had received substantial reassurance from  
25 Ms Powell and had not been instructed to exclude Letby

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1 conversation with Ms Rees on 24 June 2016, which we  
2 dealt with a moment ago, was dealt with until after  
3 Child P collapsed. It will be as important to determine  
4 the timing of this conversation with as much certainty  
5 as possible.

6 After the deaths of the two triplets, the father of  
7 O, P and R was so worried that something was going to  
8 happen to Baby R that he requested that Baby R be taken  
9 to Liverpool Women's Hospital. R, a well baby, was  
10 taken there. As Mr Baker, King's Counsel, says on  
11 behalf of the parents of O,P and R in his opening  
12 submissions, "Mother O, P and R, and Father O, P and R  
13 believed, justifiably, that this decision saved the life  
14 of Child R."

15 Child Q. Letby remained on the shift rota and  
16 worked on Saturday 25 June. On 25 June, a further baby,  
17 Child Q, collapsed unexpectedly. His heart rate dropped  
18 and he required assistance with breathing with  
19 a neopuff, a collapse that the child's mother says she  
20 was not informed about at the time. Letby was charged  
21 with his attempted murder. The jury were unable to  
22 reach a verdict.

23 Ms Kelly has told the Inquiry that she was not told  
24 about Child Q's collapse, despite what she says was  
25 agreed in the main meeting.

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1 in her conversation with the Director of Nursing and  
2 Quality, Ms Kelly.

3 In her statement to the Inquiry, Ms Kelly says that  
4 Ms Rees was, "very upset" and that it came as complete  
5 shock to be told that two consultants thought that Letby  
6 was intentionally harming babies.

7 Ms Kelly reports that she agreed with Ms Rees that  
8 the concerns were very worrying but that there was  
9 insufficient basis to remove Letby.

10 Mr Harvey has said of Ms Rees's statement about him:  
11 "She suggests that she escalated concerns to Alison  
12 and that she is aware Alison immediately found me and  
13 discussed them with me. I do not think this is correct.  
14 I do not remember a conversation about this on that  
15 day."

16 Despite the expression of concerns from the two most  
17 senior consultant paediatricians, no decision was made  
18 to remove Letby from the unit during the Friday.

19 1600 hours on Friday 24 June Child P, the brother of  
20 Child O, suddenly and unexpectedly deteriorated and  
21 died. Letby was found guilty of his murder. Following  
22 this second death of a triplet within two days,  
23 Dr Brearey telephoned Ms Rees at home, requesting that  
24 Letby be taken off the ward. This was not done.

25 Ms Kelly says she does not believe that her

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1 On Sunday 26 June, Dr Brearey emailed Ms Kelly  
2 referring to "the two mortalities last week" and  
3 inviting Ms Kelly and Mr Harvey to a senior  
4 paediatricians' meeting at 12.00 on 27 June at which the  
5 mortalities would be discussed.

6 The next day, the senior paediatricians met.  
7 Dr Brearey has stated that he telephoned Mr Harvey after  
8 the meeting to inform him that the meeting agreed that  
9 Mr Harvey should be asked to remove Letby from the NNU  
10 until the cause of the deaths had been adequately  
11 investigated.

12 There were five executive directors who were to play  
13 prominent roles in the management of concerns about  
14 Letby. The Medical Director, Mr Harvey, and the  
15 Director of Nursing, Ms Kelly, were already very much  
16 sighted on the issue concerning Letby prior to  
17 June 2016. As already noted, they had discussed the  
18 issue as recently as the 11 May with Dr Brearey.

19 However, from June 2016, the Chief Executive  
20 Officer, Mr Chambers, by background a qualified nurse,  
21 Mr Stephen Cross, Director for Corporate and Legal  
22 Services, who had a background in policing, and  
23 Ms Susan Hodgkinson, Director of People and  
24 Organisational Development, became increasingly involved  
25 in the hospital to concerns about Letby.

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1 Every week there was a meeting of the Executive  
2 Directors Group to which all Executive Directors were  
3 invited. The records of their meeting suggest that  
4 there had been no discussion about unexplained instances  
5 of infant mortality or concerns about a rise in the  
6 death rate on the neonatal unit prior to June 2016.

7 That was to change. The deaths of two of the  
8 triplets, Child O and Child P, catapulted the issue of  
9 Letby and neonatal mortality to the top of the Executive  
10 Team agenda. Whether it should have been there before,  
11 of course, my Lady, will be a matter for you to  
12 determine in due course.

13 On 26 June 2016, Dr Brearey had emailed Ms Kelly to  
14 invite her and Mr Harvey to a meeting of the senior  
15 paediatricians in order to discuss the deaths of Child O  
16 and Child P.

17 On the morning of 27 June, Ms Kelly reports that she  
18 met with Mr Harvey, Ms Powell, Nurse Murphy and  
19 Dr Jayaram. The meeting had been scheduled to talk  
20 about improving the environment on the NNU. According  
21 to Ms Kelly, Ms Powell was, "adamant" in this meeting  
22 that there were no concerns about Letby. By contrast,  
23 Dr Jayaram was saying that the two deaths the previous  
24 week were, "very worrying".

25 Later that day there was a meeting of the  
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1 of nursing staff at these episodes. There has been  
2 a watchful waiting approach since our last meeting with  
3 Ian and Alison in March. However, since the episodes  
4 and deaths last week, there was a consensus at the  
5 Senior Paediatricians Meeting that we felt that on the  
6 basis of ensuring patient safety on the NNU, this member  
7 of staff should not have any further patient contact on  
8 the NNU."

9 The message was unambiguous. The senior  
10 paediatricians were in agreement: Letby should be  
11 removed from the ward on the grounds of patient safety.

12 The disbelief of Dr Brearey that despite these  
13 concerns, the suggestion was that Letby remain working  
14 on the neonatal unit, is apparent in the tone of  
15 Dr Brearey's email of 28 June to Karen Townsend, CC'ing  
16 Dr Jayaram and Eirian Powell, and said:

17 "Just to confirm, then, Ian Harvey and Alison Kelly  
18 are happy for LL to work on the NNU in the same capacity  
19 as last week, despite the paediatric consultant body  
20 expressing our concerns that this may not be safe and  
21 that we would prefer her not to have further patient  
22 contact."

23 By contrast, Mr Harvey's view of this issue is set  
24 out in the statement he has provided to the Inquiry. He  
25 says:

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1 paediatricians following which Ms Kelly and Mr Harvey  
2 met with the nursing team, including Ms Powell and  
3 Ms Murphy. Ms Kelly sent an email summarising the  
4 action points agreed at this meeting.

5 This included three significant decisions.  
6 Mr Harvey and Ms Kelly were to meet with the consultants  
7 to discuss their concerns; Mr Harvey was to pursue the  
8 route of instructing the Royal College of Paediatrics  
9 and Child Health to conduct an external review of the  
10 neonatal unit; and Letby was to remain on days until her  
11 leave commenced with a review of actions to be conducted  
12 on 1 July 2016.

13 Notwithstanding the concerns of the consultants and  
14 notwithstanding the unexpected deaths of Child O and  
15 Child P over the previous few days, the position as at  
16 28 June was that Letby was to be permitted to remain in  
17 a patient contact role limited to day shifts.

18 Unsurprisingly, this did not meet the concerns of  
19 the consultants. Dr Brearey sent an email on 28 June.  
20 It's worth reading extracts of that email due to the  
21 clarity or its message.

22 "We, the senior paediatricians, have significant  
23 concerns about the increased mortality on the neonatal  
24 unit, the sudden deterioration of apparently well babies  
25 with no cause identified and the presence of one member  
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1 "With regard to Letby remaining on the unit, this  
2 was a difficult balance as it was difficult at this  
3 stage to understand what the issue or issues were, and  
4 whether it might relate to her competency or performance  
5 or was completely unrelated to her practice. As far as  
6 I can recall, Letby was on annual leave so we had some  
7 time to figure out what we were going to do before she  
8 would be patient-facing again. My general recollection  
9 of the days that followed is that the clinicians became  
10 more vociferous about her being removed whilst the  
11 nurses wanted her to remain on the unit. My  
12 recollection is that ultimately, Letby returned to the  
13 unit."

14 Just over two weeks later on 14 July Ms Powell and  
15 Ms Williams, the deputy Director of Nursing, met with  
16 Letby, who had just returning from annual leave. In  
17 that meeting Letby was informed that she would be able  
18 to return to her duties on the neonatal unit under  
19 clinical supervision until the Trust received feedback  
20 from the external review. Ultimately, this did not take  
21 place due partially it appears to an alleged lack of  
22 resources to provide supervision and Letby was removed  
23 from the unit.

24 Nevertheless, the above suggests that Mr Harvey and  
25 Ms Kelly were content for Letby to continue in

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1 a patient-facing role notwithstanding what was being  
2 said by the consultants. If this was the case, the  
3 Inquiry will be investigating why.

4 One of the questions expressly arising from the  
5 terms of reference is: when was consideration given to  
6 reporting Letby to the police? The first recorded  
7 mention of involvement of the police that the Inquiry  
8 has so far identified appears on 29 June 2016. We will  
9 be looking closely at whether this possibility was  
10 raised earlier, and why, even after it was raised in  
11 June 2016, it was not taken forward for nearly a year.

12 A number of meetings were held on 29 June.  
13 Mr Cross, the director of Corporate and Legal Services,  
14 recalls Mr Harvey coming into his office and informing  
15 him of emails he'd received from the neonatal  
16 consultants escalating concerns about neonatal deaths  
17 within the NNU, a common factor was a nurse, and there  
18 was concern that there may have been illegal activity on  
19 the NNU.

20 Mr Cross's evidence to the Inquiry is that his view  
21 at the time was that the police should be involved  
22 immediately. Mr Cross notes his view that his  
23 involvement of the police was not informal advice as he  
24 was not aware of all the detail. His contemporaneous  
25 notes of the meeting record:

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1 with the baby who passed away in each incident but might  
2 have cared for baby during the staff breaks) at the time  
3 of all of those deaths. This is highly unreliable  
4 information and further clinical input is unlikely to  
5 shed more light on the relevance of this information.  
6 However, we do seem to be acting on this unreliable  
7 information.

8 "However we do seem to be acting on this unreliable  
9 information. We have moved this particular staff member  
10 from night shifts to day shifts and from ITU care to  
11 HDU/SCBU care. When the pattern of deaths changed, we  
12 are becoming (at least those who dealt with babies  
13 during resuscitation and those who participated in the  
14 investigation till now & aware of the outcome) even more  
15 worried about patient safety and their own mental  
16 wellbeing ..."

17 Dr Saladi concludes:

18 "I believe we need help from outside agencies who  
19 can deal with suspicion. At the moment we are all under  
20 suspicion and the only agency who can investigate all of  
21 us I believe is the police. That is the only agency who  
22 can know our past history, our life outside the hospital  
23 which might shed more light. I think we should  
24 proactively seek their help before we are forced because  
25 of further deaths."

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1 "Advice: police need to be involved now  
2 [underlined].

3 "Death of triplets has raised concern.

4 "Nurse was on duty at deaths.

5 "Sufficient level of concern that illegal activity  
6 in neonatal."

7 Mr Harvey is unable to recall the meeting but says  
8 in his statement to the Inquiry that he does not  
9 remember anyone giving him advice at that point that the  
10 police should be contacted. The Inquiry intends to  
11 investigate what was said and by whom, in particular,  
12 what discussion was there about the police and  
13 potential, "illegal activity".

14 At around the same time as the meeting between  
15 Mr Cross and Mr Harvey, the consultants were having  
16 a discussion over email about the same subject: namely  
17 whether the police should be involved. Also copied in  
18 were Mr Harvey and members of the nursing team.

19 At 8.16 on 29 June, Dr Saladi, a consultant  
20 paediatrician, began the email conversation.

21 A substantial part of it bears repetition now:

22 "We investigated these deaths adds much as we can  
23 which included seeking clinical input from outside. The  
24 only thing that came out of it (as I understand) is one  
25 member of staff was working in the unit (not necessarily

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1 Dr Jayaram replied to Dr Saladi, thanking him for  
2 his input saying that after he, Dr Jayaram and  
3 Dr Brearey were trying to speak to the senior executives  
4 as soon as possible but "they did not seem to see the  
5 same degree of urgency as we do".

6 In response to Dr Jayaram's email, the Medical  
7 Director Mr Harvey wrote back saying:

8 "Ravi, this is absolutely being treated with the  
9 same degree of urgency. It has already been discussed  
10 and action is being taken. All emails cease forthwith."

11 In his Inquiry witness statement Mr Harvey has said  
12 of this email:

13 "It was not intended to stop the discourse but to  
14 dampen down some of the theories which seemed to me to  
15 be appearing out of nowhere. However, on reflection,  
16 I do accept this email could have been worded better.  
17 I regret the language used and accept that this could  
18 have affected the appetite of the consultants to come  
19 forward with their concerns. That was not my  
20 intention."

21 Notwithstanding Mr Harvey's instructions to stop  
22 emailing, the email thread continued as between the  
23 consultants with Dr Gibbs stating among other things:

24 "We are all agreed that something has to be done  
25 fairly quickly to try and ensure our neonatal patients

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1 are protected."

2 Dr Gibbs' email continued with an analysis of the  
3 clinical picture in relation to two patients, and  
4 concluded:

5 "I suggest this makes it mandatory that the police  
6 are involved ASAP alongside any other action that may be  
7 deemed appropriate."

8 Dr Jayaram replied:

9 "The Trust are contacting the police soon. Once  
10 some information gathering has taken place, which is why  
11 Ian asked for the chit-chat to stop for now."

12 In his witness statement Mr Harvey expresses  
13 surprise about this email:

14 "I cannot explain why Dr Jayaram had said this as  
15 I cannot recall having discussed approaching the police  
16 at this stage."

17 As you know, my Lady, the Cheshire Police were not  
18 in fact contacted by the trust until nearly a year later  
19 in April 2017.

20 On 29 June there was a meeting between Executive  
21 Directors including the Chief Executive Mr Chambers and  
22 a number of the consultants. This was followed by  
23 meetings on 30 June of the Executive Directors attended  
24 by the board chairman, Sir Duncan Nichol, and a meeting  
25 attended also by consultants. These were key meetings

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1 including whether there was a third participant in the  
2 call, namely Ms Hodkinson. As this call has the  
3 potential to be significant in terms of both the Nursing  
4 and Midwifery Council's response to that initial contact  
5 and the Executive Directors' actions subsequent to that  
6 contact, events on 6 July will be the subject of  
7 considerable scrutiny in the oral evidence.

8 Later in this opening, we will look in greater  
9 detail at the involvement of external bodies, including  
10 the NMC. For present purposes we simply highlight that  
11 Letby's registration was not subject to any restriction,  
12 whether by way of conditions or suspension, until she  
13 was charged with murder at the conclusion of the police  
14 investigation.

15 The Inquiry will be seeking to understand why this  
16 was the case, noting that although the Trust had the  
17 power to impose supervision or other restrictions on  
18 Letby's work at the Countess of Chester Hospital, it had  
19 no power to prevent her seeking patient-facing work  
20 elsewhere, only the NMC had that power.

21 Internal reviews.

22 And so pausing here for a moment, what is clear from  
23 the evidence gathered today is that during a number of  
24 meetings over 27 to 30 June, contacting the police was  
25 discussed. However, the decision of the senior managers

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1 and we will inquire in detail how they shaped the  
2 Trust's response.

3 On 30 June, an "NNU action planning meeting" was  
4 also convened. It was attended by number of people  
5 including Ms Kelly, Sue Hodkinson, Ms Williams,  
6 Ms Millward, Head of Risk and Patient Safety. It seems  
7 likely that this meeting was to discuss what action be  
8 taken regarding Letby's continued presence on the unit.

9 Four days later, on 4 July 2016, Ms Kelly contacted  
10 Letby's regulator, the Nursing and Midwifery Council,  
11 and asked to book a slot with the Employer Link Service  
12 to speak about, "allegations against a nurse" adding "No  
13 referral made to the NMC at present".

14 It would appear this led to a conversation two days  
15 later which the Employer Link Service Advisor from the  
16 NMC summarised in an email later that day:

17 Notably the summary, as corrected by Ms Kelly,  
18 included.

19 "Some clinicians are concerned the registrant [ie,  
20 Letby] may present a serious risk to public safety  
21 although no evidence is available at this time."

22 The advisor with whom Ms Kelly was in contact with  
23 that day has provided a statement at the request of the  
24 Inquiry. It would appear that what was or wasn't said  
25 in that call may be the subject of some dispute,

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1 appears to have been not to approach the police at this  
2 stage, but rather to commission reviews in the neonatal  
3 unit and inquire into the circumstances of the deaths on  
4 the unit.

5 The neonatal unit was also downgraded from Level 2  
6 to Level 1. By 6 July the Trust had established  
7 something it described as Silver Command. This refers  
8 to the hospital's emergency planning and response, an  
9 incident room was opened in the hospital and meetings  
10 were held in the morning and evening to take stock of  
11 what was being done.

12 In terms of the reviews that were decided upon, as  
13 well as deciding to involve the Royal College of  
14 Paediatric Child Health, an internal review was  
15 commissioned. This included what was described as  
16 a forensic review by Mr Harvey, the Medical Director,  
17 a review by Dr Gibbs and a senior nurse, Ms Anne Martyn,  
18 into babies who collapsed and were transferred out of  
19 the hospital, a review by the Deputy Director of  
20 Nursing, Ms Williams, into the staffing pattern and  
21 a review of the neonatal unit mortality by Ms Kelly and  
22 Ms Millward.

23 Mr Harvey describes his review in his witness  
24 statement as follows:

25 "I believe the reference to a review being conducted

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1 allocated to me was a review of NNU data. I was  
 2 assisted in this by Robert Cheetham, a data analyst."  
 3 He goes on to state:  
 4 "This took place during the two weeks that Letby was  
 5 an annual leave in July 2016. This was not a clinical  
 6 review of each death as I am not a neonatologist.  
 7 I undertook an overarching service review looking at  
 8 intensity levels, the number and nature of admissions.  
 9 This involved tasking the data team with compiling the  
 10 relevant data for me to look at and feed back to the  
 11 Board. The purpose of this review was to see if there  
 12 were any potential issues contributing to the rise in  
 13 neonatal mortality such as an increase in acuity or  
 14 difficulties on the NNU."  
 15 The review by Dr Gibbs and Nurse Martyn.  
 16 Dr Gibbs and Nurse Martyn were also commissioned to  
 17 review a number of babies that had been on the neonatal  
 18 unit between 2015 and 2016. Dr Gibbs of course was  
 19 a consultant paediatrician and Nurse Martyn, who is now  
 20 Anne McGlade, was the Ward Manager for the children's  
 21 ward and a qualified children's nurse. Nurse Martyn was  
 22 involved as she was the most senior nurse in the Trust  
 23 in the absence of her line manager, Nurse Murphy, the  
 24 Lead Children's Nurse, who was off work at the time.  
 25 Nurse Martyn was not a neonatal nurse, it appears to

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1 was that "it would not identify any non-fatal collapses  
 2 where the baby remained on the NNU in Chester".  
 3 Of the indictment babies, this review included  
 4 Child F and Child Q.  
 5 It would appear that of the 17 babies reviewed,  
 6 Dr Gibbs and Nurse Martyn identified six cases in which  
 7 it appeared that something or unexpected or unusual  
 8 occurred. Of these six, Letby had been involved with  
 9 three babies at the time concerned and had been involved  
 10 in prior care for one further baby. We'll be  
 11 considering whether the parameters of this review were  
 12 appropriate to address the concerns raised by the  
 13 consultants and investigating what, if anything, was  
 14 done as a result of its conclusions.  
 15 In July 2016 the Director of Nursing and Quality,  
 16 Ms Kelly, and Ms Millward, prepared what they described  
 17 as a "position paper" for the Executive Team. This  
 18 document looked at the "key mortality data", and  
 19 provided:  
 20 "A supplementary narrative to enable an assessment  
 21 of the patient safety concerns identified by the  
 22 neonatal clinicians relating to an apparent increase in  
 23 the number of neonatal deaths during 2015 to 2016 and  
 24 2016 to 2017."

We will not look at the detail of this position

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1 have been the view of Dr Gibbs that involving a neonatal  
 2 nurse may have caused potential conflict in terms of  
 3 being involved in reviewing colleagues' practice and  
 4 that Nurse Martyn was an experienced and respected  
 5 children's nurse.  
 6 Nurse Martyn says she was informed by Dr Gibbs that  
 7 the purpose of their review was to, "see if anything  
 8 unusual or unexpected of the collapses or deaths  
 9 presented itself" and to look at, "discrepancies in  
 10 care".  
 11 The babies including in this review were those who  
 12 had collapsed or deteriorated in the neonatal unit and  
 13 needed to be transferred out of the hospital. Dr Gibbs  
 14 in his statement to the Inquiry notes:  
 15 "Non-fatal collapses were not well defined and were  
 16 not monitored and reviewed on our NNU. Concentrating on  
 17 the cohort of babies who required transfer from the NNU  
 18 would identify some of the babies who had suffered  
 19 non-fatal collapses. It had been my impression, and that  
 20 of my consultant paediatric colleagues, that Letby had  
 21 been involved in many of the non fatal collapses but  
 22 I did not have, nor was I aware of anyone else having,  
 23 data against which to assess staff involvement in  
 24 non-fatal collapses."  
 25 As Dr Gibbs accepts, a limitation of the exercise

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1 paper at this stage but simply note the findings.  
 2 The document considers the significance of the  
 3 change in mortality levels. It concludes:  
 4 "Fluctuation due to common cause variation cannot  
 5 account for the increased mortality seen in the neonatal  
 6 unit."  
 7 The document considers whether a general increase in  
 8 activity on the neonatal unit might explain the increase  
 9 in mortality levels. It concludes:  
 10 "Similar periods of increased activity recorded in  
 11 previous years have not been associated with an  
 12 increased mortality. Therefore, activity levels alone  
 13 cannot account for the increase but may be  
 14 a contributory factor."  
 15 The document considers whether an increase in  
 16 patient acuity, that is to say whether the neonatal unit  
 17 was dealing with babies who were more gravely ill than  
 18 in previous years, was the cause of the increase in  
 19 mortality. It concludes:  
 20 "An increase in sustained acuity level may be  
 21 a contributory factor."  
 22 The document considers whether staffing levels were  
 23 a contributory factor, reaches no conclusion on this,  
 24 but points to the fact that the neonatal unit did not  
 25 consistently meet the British Association of Perinatal

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1 Medicines recommended level. Under the heading  
2 "Recommendations" the document says only this:  
3 "The Executive Team is asked to note the challenges  
4 to the analysis undertaking and the findings of this  
5 mortality review."

6 In her statement, Ms Millward says by this latter  
7 entry she was acknowledging the data discrepancies  
8 between the different systems in place and the  
9 non-recording of incidents of sudden deterioration. She  
10 says that it was a considerable challenge to complete  
11 the review in the timeframe set by Ms Kelly.

12 On the face of the findings of this report the only  
13 firm conclusion it drew is that the rise in mortality  
14 could not be explained by ordinary fluctuations. It  
15 suggests that the level of activity at the time could  
16 not have explained this but could have contributed. It  
17 suggests that an increase in how sick the babies were  
18 may be a contributory factor.

19 Mr Harvey's summary of in his witness statement to  
20 the Inquiry is as follows:

21 "Overall the conclusions of the report indicated  
22 that there had been an increase in workload intensity  
23 and acuity on the NNU and that those factors may partly  
24 have explained the increase in mortality. It was not  
25 a satisfactory explanation for the increase in the sense

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1 Whether or not this was a balanced and accurate  
2 summary of what conclusions the internal reviews had  
3 reached is a matter which we will be investigating and  
4 which my Lady will determine in due course.

5 I will return now to what steps were being taken on  
6 the ward following Letby's return from annual leave.

7 On 14 July, Letby met Ms Powell and Ms Williams, the  
8 Deputy Director of Nursing. Letby was informed that she  
9 would be able to return to her duties on the neonatal  
10 unit under, "clinical supervision until the Trust  
11 received feedback from the external review".

12 Also on 14 July, an extraordinary meeting of the  
13 Board of Directors of the Trust took place. Dr Brearey  
14 and Dr Jayaram were invited to this board meeting. The  
15 plan which the Executive Directors had come up with was  
16 outlined to the board.

17 The minutes record that Dr Jayaram said:

18 "The concerns we had was not only the number of  
19 deaths rising, but these babies were not the ones we  
20 were expecting to die. These babies may have been  
21 premature but were stable. There was no reason to  
22 explain the collapse and then when they didn't respond  
23 to what was an entirely and timely and correct  
24 intervention. This, as well as the numbers, made us  
25 worry."

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1 that it was clear those factors were not the whole  
2 answer, but were potential contributing factors."

3 As we have referred to already,  
4 Deputy Nurse Williams completed a piece of work she had  
5 been commissioned to do as part of the hospital's  
6 internal response to the death of Child O and Child P.  
7 That piece of work involved an analysis of the staffing  
8 on the neonatal unit. The remit of that task was to  
9 review the duty rosters of the nursing staff who were  
10 present on the shift before and the actual shift when  
11 a baby had collapsed. Supporting her in this task was  
12 Ms Fogarty, the Associate Director of Risk and Safety.

13 As a result of her analysis, Nurse Williams tells us  
14 that she concluded that the hospital should go to the  
15 police and that she spoke to executives about this. We  
16 will explore the conclusions she drew and why, and who  
17 she spoke to about going to the police and whether she  
18 did so.

19 As we leave the topic of internal reviews, we note  
20 Ms Kelly's characterisation of the outcomes of the  
21 reviews to the NMC on 31 August. In an email in which  
22 she provides an update, Ms Kelly stated:

23 "As previously mentioned, we undertook a thorough  
24 internal review. Nothing of significance was identified  
25 with this."

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1 One of the Non-Executive Directors, Mr Wilkie, is  
2 recorded as making a contribution to the effect that,  
3 "he accept[ed] that there is no evidence to say it is  
4 due to an individual, but there is no evidence to say  
5 the contrary" and that he, "wanted to better understand  
6 the critical issues that mean it is not appropriate to  
7 engage the police, as he could see disquiet".

8 Mr Chambers the Chief Executive, was recorded in the  
9 minutes as having said:

10 "If we believe that this is the only explanation,  
11 then we phone the police."

12 The Inquiry will be investigating whether this is  
13 what Mr Chambers said and if so, whether this was the  
14 correct approach when considering any referral to the  
15 police.

16 The minutes also record that Dr Jayaram asked for  
17 one matter not to be minuted. A handwritten note of the  
18 same meeting may provide a clue as to what he said.  
19 That handwritten note says "As a clinical body  
20 uncomfortable with nurse LL", something which does not  
21 appear in the official minutes.

22 This Extraordinary Board Meeting appears to be  
23 another significant meeting which will require detailed  
24 scrutiny by the Inquiry in evidence.

25 On 18 July the Executive Directors met. The

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1 handwritten notes of the meeting record that  
 2 Sue Hodgkinson, the HR Director, reported:  
 3 "Pressures on unit/cannot guarantee [one to one]  
 4 supervision/redeploy to risk team/'no investigation'  
 5 reiterate/explain done all data work."  
 6 It appears that the view that Letby could return to  
 7 the ward had been changed. Ms Millward reports in her  
 8 witness statement that Letby was allocated adult low  
 9 level complaints and that she does not recall Letby  
 10 having direct patient contact between July 2016 and  
 11 March 2017. Ms Millward also considers that, "in  
 12 retrospect it would have been more appropriate to  
 13 redeploy Letby to another service".  
 14 The transfer of Letby to the Risk and Safety Team  
 15 was always intended to be a temporary measure. At this  
 16 stage we highlight just three instances in the five  
 17 months following her transfer to illustrate what was  
 18 being said about that transfer while it was occurring.  
 19 In September 2016 the issue of where Letby was to  
 20 work was raised. Ms Rees, the Head of Nursing for the  
 21 Urgent Care Division wrote to Ms Kelly. Ms Rees  
 22 described the decision to delay allowing Letby return  
 23 back to the neonatal unit as "wrong and immoral". She  
 24 went on to suggest that it was "based on a senior  
 25 clinical having a 'gut feeling' with no evidence",

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1 aware of a change that had been agreed in regards to the  
 2 decision-making process for your reinstatement back into  
 3 your role within the neonatal unit. As we had  
 4 previously discussed, the decision had been previously  
 5 agreed as sitting at broad level. However, it has been  
 6 agreed that this should be delegated to Alison as your  
 7 professional nursing lead. Alison explains she had no  
 8 concerns in you returning back to the neonatal unit and  
 9 that we were going to plan for this with Karen in the  
 10 coming weeks."

11 In his witness statement to the Inquiry Mr Chambers  
 12 has said of the suggestion that there were, "no  
 13 concerns" in respect of Letby returning to the NNU that  
 14 he would have had some concerns at that particular time  
 15 due to the outstanding investigations.

16 Mr Chambers goes on to say that he agrees with what  
 17 he describes as the spirit of what Ms Kelly was saying,  
 18 "... in that none of the information arising from all  
 19 the review work to date was suggestive of any wrongdoing  
 20 on the part of Letby."

21 The following week, another support meeting took  
 22 place. Again, discussion about her return to the  
 23 neonatal unit is recorded in a letter sent to Letby  
 24 after the meeting. Letby was told:

25 "Karen [that's Karen Rees] advised that she was keen

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1 adding:

2 "This allegation is massive and if this clinician  
 3 and anyone is of this belief, then why have the police  
 4 not been called?"

5 Whether "gut feeling" is a justifiable  
 6 characterisation of the clinical concerns raised will be  
 7 investigated in oral evidence. Furthermore, and as we  
 8 have said, the question of why the police were not  
 9 called is one we will be examining closely. As this  
 10 email makes clear, it was a question which was post at  
 11 the time.

12 Ms Kelly has told the Inquiry that she was,  
 13 "sympathetic to the position that Ms Rees found herself  
 14 in as she was the main point of contact with Letby".  
 15 Ms Kelly goes on to say:

16 "However, I felt stuck in the middle and was faced  
 17 with an impossible situation."

18 During the period Letby was working in the Risk and  
 19 Safety Team she was provided with regular support  
 20 meetings. One such meeting took place on 15 November.  
 21 A letter was sent to Letby summarising what was said at  
 22 that meeting regarding Letby's return to the neonatal  
 23 unit. The letter included the following:

24 "Alison [Kelly] explained that further to our  
 25 previous discussions, it was important that we made you

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1 to create a supportive environment for you to return to  
 2 the unit and that she was working with you in planning  
 3 for you to return to the unit in early January 2017."

4 The Inquiry will be investigating why it was, before  
 5 all of the external investigations were completed, the  
 6 decision had apparently been made to permit Letby to  
 7 return to the neonatal unit.

8 We turn now to look at the first of the external  
 9 investigations, that one that was commissioned from the  
 10 Royal College of Paediatrics and Child Health. We will  
 11 return later to consider the involvement of the RCPCH in  
 12 some detail. At this point we will simply headline some  
 13 of the key facts as they have been established today.

14 First, it is clear from the documentation that  
 15 before the end of June 2016, there were steps in train  
 16 to arrange for what was known as an invited review by  
 17 the recollection.

18 Secondly, by 7 July, the terms of reference for the  
 19 invited review were under discussion between the RCPCH  
 20 and Mr Harvey and on 2 August the terms of reference  
 21 were confirmed.

22 Third, on 1 and 2 September, a team from the RCPCH  
 23 attended the Trust and interviewed a number of people,  
 24 including Letby.

25 Fourth, and most significantly at this stage, on

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1 5 September the RCPCH wrote to Mr Harvey providing  
2 number of recommendations. These recommendations  
3 included:

4 "To this end we recommend that alongside the HR  
5 investigation, a detailed forensic case note review of  
6 each of the deaths in July 2015 should be undertaken,  
7 ideally using at least two senior doctors with expertise  
8 in neonatology pathology in order to determine all the  
9 factors around the deaths."

10 This recommendation goes on to say:

11 "This investigation should include as a minimum the  
12 following elements:

13 "A full systematic chronology for each case  
14 including all interventions and details of nursing and  
15 medical observations activities;

16 "A view on whether escalation of each case at an  
17 earlier stage to involve more senior opinion locally,  
18 a more expert opinion from a regional centre, would have  
19 potentially made a difference to the outcome;

20 "Examination (with the relevant paediatric  
21 pathologist) of the postmortem findings and any  
22 additional information available on their files which  
23 might identify cause of death, including rare conditions  
24 such as air embolism and severe metabolic derangement;

25 "Details of all staff with access to the unit from  
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1 The terms of the instruction appear to have been lifted  
2 from the five elements which were set out in the RCPCH's  
3 letter of recommendation.

4 On 14 October, materials were sent to Dr Hawdon. We  
5 will be investigating the basis upon which babies were  
6 selected for review, given that a number of indictment  
7 babies were not included. We will ask whether parents  
8 of babies whose medical records were released to  
9 Dr Hawdon were informed of this.

10 On 29th October Dr Hawdon wrote back to Mr Harvey.  
11 This letter was the covering letter to her report. Her  
12 letter bears some repetition at this stage. Dr Hawdon  
13 begins by rehearsing that she was provided with a total  
14 of 17 cases: 13 deaths and four "near misses".

15 Dr Hawdon stated she did not have the capacity to  
16 create a systematic chronology as recommended by the  
17 RCPCH. She had however, as requested, commented upon  
18 whether if the case was escalated to a more senior  
19 practitioner this would have made a difference to the  
20 outcome.

21 Dr Hawdon states she was not in a position to  
22 consult with a perinatal pathologist and proposed that  
23 an independent perinatal pathologist be instructed when  
24 she had completed her report.

25 Neither was Dr Hawdon in a position to set out  
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1 four hours before the death of each infant. Ancillary  
2 and facility staff should be included."

3 And finally:

4 "Consideration of any other 'near-miss' cases with  
5 similar chronology presentation where the child  
6 survived."

7 One of the areas the Inquiry will be investigating  
8 is the degree to which the Trust followed this  
9 recommendation.

10 On 18 October 2016, the draft RCPCH report was  
11 received by Mr Harvey. Dr Brearey provided feedback  
12 from the draft report on 10 November and the RCPCH sent  
13 the trust its final report on 28 November. I should say  
14 "final reports". That is because two versions were  
15 sent: one version of the report marked confidential  
16 including references to Letby; the other version did  
17 not.

18 Three days after the RCPCH's recommendation of the  
19 5 September 2016, Mr Harvey emailed Dr Jane Hawdon to  
20 enquire if she would assist in carrying out, "a detailed  
21 case note review". Dr Hawdon was a name provided to the  
22 Trust by the RCPCH as a consultant neonatologist who may  
23 be able to be instructed by the Trust.

24 Approximately one month later on 5 October,  
25 Mr Harvey sent a letter of instruction to Dr Hawdon.  
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1 details of all staff with access to the unit from four  
2 hours before the death of each infant, as had been  
3 requested. She proposed that this work was done at the  
4 local level and should include the period before  
5 a collapse rather than the period before death.

6 In relation to consideration of any other near miss  
7 cases, Dr Hawdon stated she could only consider the  
8 cases she was supplied with.

9 Dr Hawdon concluded her letter by saying:

10 "It would be useful to review copies of [Serious  
11 Incident] Reviews and reports for these cases, and  
12 findings of the CDOP [Child Death Overview Panel] and  
13 triangulate findings with independent review. Was this  
14 cluster noted and investigated by the Trust or coroner?  
15 Has the pattern persisted?"

16 Dr Hawdon's final report was dated October 2016. In  
17 that report she concluded that in the case of five  
18 children, Child O, A, P, D and I, the death collapse was  
19 unexplained. The report recommended that those five  
20 cases be the subject of, "local forensic review".

21 It goes on to say that:

22 "Subject to the Coroner's postmortem reports there  
23 should be broader forensic review" of each of these five  
24 cases, because, "after independent clinical review,  
25 these deaths remain unexpected and unexplained".  
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1 In the case of Child I, Dr Hawdon advised that,  
2 "cause of death as given in postmortem report should be  
3 reviewed given babies stable in air days preceding  
4 collapse".

5 Subsequent to finalising her report, Dr Hawdon was  
6 sent postmortem reports which had not been included in  
7 her original paperwork. These related to Child O, P, A  
8 and D; that is to say four of the five babies whom  
9 Dr Hawdon had identified as having unexplained deaths.

10 On 25 November 2016, Dr Hawdon emailed Mr Harvey.  
11 Her conclusions were in the case of Child O, the deaths  
12 remained unexplained. In the case of Child P, the  
13 collapse and death were unexplained. In the case of  
14 Child A, the cause of death was unascertained. In the  
15 case of Child D, a delay in the provision of antibiotics  
16 may have been contributory to death.

17 Dr Hawdon concluded her email by repeating her  
18 recommendation that an, "expert perinatal pathology  
19 review be conducted".

20 On 21 December 2016, a little under a month after  
21 Dr Hawdon's email, Mr Harvey contacted Dr McPartland.  
22 Dr McPartland is a Consultant Paediatric Pathologist  
23 based at Alder Hey Children's Hospital. In his email to  
24 Dr McPartland, Mr Harvey said that, "Dr Hawdon had  
25 advised local forensic review to include pathology,

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1 the cause of death could have been submitted as,  
2 "unexplained/unascertained" but this would be  
3 a subjective decision.

4 We consider that both Dr Hawdon and Dr McPartland  
5 played important roles in the investigations which were  
6 being carried out by the Trust. A number of issues  
7 appear to arise on the information the Inquiry currently  
8 has. In the first instance it will be important to  
9 understand the degree to which Dr Hawdon's and  
10 Dr McPartland's report represent any fulfilment of the  
11 RCPCH's recommendation.

12 On the face of the information, Dr Hawdon appears to  
13 have told Mr Harvey in terms that she was not able to  
14 fulfil the RCPCH's recommendation.

15 The review of the staffing trend was not addressed  
16 at all by Dr Hawdon. She recommended this be carried  
17 out locally. Mr Harvey has said of this element:

18 "To the best of my knowledge this had already been  
19 investigated internally by Eirian Powell and later as  
20 part of the Silver Command Review."

21 Dr Hawdon requested copies of a number of further  
22 documents. In her witness statement to the Inquiry she  
23 reports that she didn't receive any such documentation  
24 in reply. Mr Harvey has said of this:

25 "I believe it is likely that Dr Hawdon was provided

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1 histopathology of four cases".

2 Mr Harvey then provided information taken from Dr  
3 Hawdon in relation to Child O, P, A and Child I.  
4 Dr McPartland does not appear to have been asked to  
5 review Child D. We will ask why.

6 On 25 January 2017, following further emails between  
7 them, Dr McPartland wrote to Mr Harvey providing  
8 a summary of the conclusions of her and her colleagues  
9 in relation to the four babies she'd been asked to  
10 review, Child O, P, A and I. In the body of the email  
11 Dr McPartland stated:

12 "Please note this is not a full and formal  
13 medico-legal review. This would involve a second report  
14 and take about four hours of work per case with  
15 a subsequent lengthy report. If you require analysis of  
16 this depth it is probably best performed independently  
17 by someone from another centre."

18 In her report, Dr McPartland and her colleagues  
19 concluded in the case of Child A they agreed the cause  
20 of death was unascertained. In the case of Child I they  
21 provided a cause of death attributed to extreme  
22 prematurity. In the case of Child O, they provided  
23 a cause of death attributed to prematurity but noted  
24 that the cause of the initial collapse remained  
25 unexplained. In the case of Child P, they stated that

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1 with the other documents she requested but I cannot be  
2 certain about this."

3 Further, Dr Hawdon recommended that a local forensic  
4 review be conducted specifically in relation to the five  
5 babies she'd identified as having died for reasons which  
6 were unexplained. While Dr McPartland looked at four of  
7 these babies from a pathologist's point of view, she had  
8 made it clear that she was not conducting a full and  
9 formal medico-legal review and if such an analysis was  
10 required, it would be better done from someone at  
11 another centre.

12 Dr Hawdon also queried whether there had been any  
13 further deaths or collapses. In fact, there had been no  
14 further deaths on the neonatal unit between July 2016  
15 and her query in late October 2016. She was not  
16 provided with an answer to her question. In her witness  
17 statement, Dr Hawdon says that if she had been told that  
18 the pattern had stopped, she'd have enquired as to what  
19 changes had been made. She goes on to say that if she  
20 had been made aware of the suspicions and the patterns  
21 stopped when the person was removed, she'd have made  
22 urgent personal contact with Mr Harvey and urged him to  
23 follow appropriate safeguarding and governance  
24 processes.

25 Mr Harvey has said of what he told Dr Hawdon about

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1 Letby:  
2 "My recollection is that I alluded to a concern  
3 being raised about the commonality of one member of  
4 staff in an early conversation with her but I do not  
5 think I would have provided a name or gone any further  
6 than that."

7 In relation to Dr Hawdon's report, the Inquiry holds  
8 three different versions of this report. In one of  
9 those versions Child D was no longer listed as an  
10 unexplained death for whom she recommended local  
11 forensic investigation. In her witness statement,  
12 Dr Hawdon stated that she did not submit a report in  
13 this form. The possibility that Dr Hawdon's report may  
14 have been altered after she sent it to change her  
15 conclusions in relation to Child D is of considerable  
16 concern to the Inquiry team. We will be investigating  
17 this with substantial rigour.

18 In terms of what she meant by "local forensic  
19 review", Dr Hawdon has told the Inquiry that she meant  
20 a detailed review by an appropriately skilled team of  
21 the entire circumstances of care of each baby including  
22 around the times of deterioration and death. This, she  
23 stated, would require presence on site of suitably  
24 skilled professionals to align the clinical  
25 circumstances to the local environment, workload and  
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1 been difficult for families to understand and could have  
2 added to confusion and grief."

3 This is a matter that the Inquiry considers to be of  
4 a high degree of importance, and is one which will be  
5 scrutinised in the course of the oral hearings as part  
6 of the Inquiry's overarching investigation into what and  
7 when families were told, and the hospital's duty of  
8 candour.

9 In relation to its view overall of how communication  
10 with the parents of the babies who died or collapsed is  
11 concerned, Mr Harvey has told the Inquiry this:

12 "In short, I think we got this wrong. Families were  
13 let down and the communications we had with them should  
14 have been better. Families did not receive the support  
15 they should have."

16 The Inquiry will be exploring this with Mr Harvey  
17 and others.

18 In terms of Dr McPartland's involvement, in her  
19 statement, she has told the Inquiry that she was not  
20 informed that there were concerns that a person appeared  
21 to be a common factor in the deaths. She stated that  
22 she believed she should have been told, describing this  
23 as, "vital information". She stated that it would have  
24 indicated to her that the police should be involved and  
25 that a forensic pathologist, that is to say a specialist  
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1 staffing.

2 Finally, in relation to Dr Hawdon's report, we will  
3 be looking at the decision to send it to families of  
4 those babies Letby attacked. This occurred on  
5 28 April 2017. Dr Hawdon's report does not on its face  
6 appear to have been written for the benefit of  
7 a non-medical audience. It consists of annotations and  
8 technical language which is unexplained.

9 The Director of Nursing, Alison Kelly, has told the  
10 Inquiry of her experience reading the report.

11 "I can recall that a lot of the report was written  
12 in a style that would be most readily understood by  
13 another clinician. I did not understand some of the  
14 coding used."

15 Dr Hawdon herself has commented in her witness  
16 statement to the Inquiry that:

17 "Based on my own experiences as a neonatologist and  
18 having held medical leadership roles, it is my personal  
19 opinion that there was insufficient covering information  
20 and explanation provided to the families to accompany my  
21 reports. It is my opinion that it was appropriate to  
22 share the reports but with accompanying information and  
23 explanation, preferably in a face-to-face meeting,  
24 especially at a time of grief. It is my personal  
25 opinion that the case review reports alone would have  
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1 pathologist trained and experienced in investigating  
2 deaths which may have been caused by a criminal act,  
3 should have been instructed.

4 By contrast to Dr McPartland's position, Mr Harvey  
5 has told the Inquiry:

6 "I think I had discussed with Dr McPartland verbally  
7 that clinicians had raised concerns over a member of  
8 staff and their presence on the ward at relevant times."

9 Dr McPartland meanwhile has also observed that she  
10 was not invited to conduct the review alongside  
11 Dr Hawdon as recommended by the RCPCH, nor did she  
12 regard herself as "independent" as advised by Dr Hawdon.

13 We will be investigating in detail the involvement  
14 of both Dr Hawdon and Dr McPartland with a view to  
15 examining whether they were provided with the  
16 information they should have been, and if they weren't,  
17 how this impacted upon the advice and opinions that they  
18 offered to the Trust.

19 On 7 September 2016, Letby registered a grievance.  
20 We will be considering the grievance procedure in  
21 greater detail later in this opening.

22 Overall and for now, the grievance was upheld in  
23 part. The hearing was chaired by Annette Weatherley on  
24 1 December 2016. Ms Weatherley was the Deputy Chief  
25 nurse at the nearby University Hospital South  
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1 Manchester. She proposed that Dr Brearey and Dr Jayaram  
2 engage in mediation with Letby and that all the  
3 consultants who had made allegations apologise with  
4 disciplinary action being recommended against anyone who  
5 did not comply. Furthermore provided the RCPCH report  
6 contained no reference to Letby, she, Letby, should be  
7 given written confirmation that there was, "no case to  
8 answer".

9 There is evidence which may suggest that the  
10 grievance came to dominate the thinking of members of  
11 the Executive Directors Group. Furthermore, once  
12 completed, that the grievance process was reviewed as  
13 having "exonerated" Letby when in fact it contained no  
14 investigation into her actions whatsoever.

15 We will be examining this issue with care. The use  
16 of a grievance process as a means to avoid scrutiny is  
17 something that the system must be capable of recognising  
18 and preventing.

19 On 22 December 2016, Letby and her parents met with  
20 Mr Chambers, Mr Harvey, Ms Kelly, Ms Rees, the Head of  
21 Urgent Care, and Ms Hodgkinson, Director of People and  
22 Organisational Development.

23 At the start of the meeting, Letby's mother read out  
24 a statement. There followed a discussion of the  
25 concerns which had been raised. This meeting took place

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1 a line. Anyone steps over that, the full disciplinary  
2 policy may be used."

3 The phrase "drawing a line" was used in later  
4 meetings and conversations. It is of note that the  
5 decision to reach this point, including bringing to play  
6 potential disciplinary proceedings against those who  
7 cross the "line", appears to have been made before the  
8 investigation commissioned by the Trust regarding the  
9 deaths and collapses of the babies was completed. We  
10 will be investigating whether this was so, and if it  
11 was, why.

12 Given where this meeting was in the timeline, it is  
13 of note that the meeting concluded with Mr Chambers  
14 saying:

15 "Our commitment is now to meet with the consultants,  
16 get you back on the unit, and meet with you all again in  
17 the future".

18 My Lady, I notice the time.

19 **LADY JUSTICE THIRLWALL:** Thank you, Ms Langdale. We'll take  
20 a break for 15 minutes and start again at 3.00.

21 **(2.42 pm)**

22 **(A short break)**

23 **(2.58 pm)**

24 **LADY JUSTICE THIRLWALL:** Thank you all for the super prompt  
25 attendance. I think we're two minutes early.

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1 the day after Mr Harvey emailed Dr McPartland to ask for  
2 four cases to be the subject of a pathology review.

3 Mr Chambers is recorded as saying at the meeting "We  
4 are within our rights to phone the police but we didn't  
5 believe it". And later "our judgement was that this was  
6 not a criminal investigation".

7 Of the first comment, Mr Chambers has told the  
8 Inquiry that he believes the record is incomplete and  
9 that what he, "would have meant by this is that he did  
10 not believe it to have been a criminal issue without  
11 further investigation".

12 The Inquiry will be looking at what was said in this  
13 meeting and consider the following issues:

14 Were the Executive Directors or any of them  
15 operating on the basis that the concerns about Letby had  
16 to be proved before calling the police? If so, this set  
17 far too high a threshold for police involvement and  
18 ignored the safeguarding obligations the hospital had.

19 Second, we will be asking whether and how the  
20 Executive Directors' personal opinions and views of  
21 Letby influenced the reports which were commissioned by  
22 the hospital and the interpretation of those reports.

23 During the meeting with Letby and her parents,  
24 Mr Harvey is recorded as saying:

25 "Part of this sharing is as an organisation drawing

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1 Ms Langdale.

2 **MS LANGDALE:** Thank you, my Lady. I turn now if I may to an  
3 Extraordinary Meeting of the Board of Directors,  
4 10 January. In a meeting of Executive Directors and  
5 Sir Duncan Nichol on 30 December 2016 a decision was  
6 made to call an Extraordinary Meeting of the Board on  
7 10 January 2017. We will return to this in greater  
8 detail but for present purposes, we draw my Lady's  
9 attention to the following.

10 The first is that, in the course of his presentation  
11 to the board, Mr Harvey is recorded as stating:

12 "In one of the cases the cause of death is  
13 unascertained, which is not uncommon."

14 The phrase "draw a line" is again used by Mr Harvey  
15 and repeated by Mr Chambers.

16 When characterising the position which had been  
17 reached, Mr Chambers was recorded as saying:

18 "There was an unsubstantiated explanation that there  
19 was a causal link to an individual. This is not the  
20 case and the issues were around leadership and timely  
21 clinical interventions."

22 In his witness statement to the Inquiry, Mr Chambers  
23 states that he, "cannot recall being this emphatic about  
24 the matter, but the spirit of this sentence does align  
25 with his understanding of the position".

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1 Ms Kelly is recorded at the meeting as saying:  
 2 "We were trying to protect the individual in some  
 3 ways as our feelings were that we really believed an  
 4 individual was the causal factor of change of survival  
 5 rates on the unit we would have called the police.  
 6 However, we didn't feel this was the case."

7 Mr Chambers is recorded as saying, "The grievance  
 8 exonerates her".

9 As I have just said, we will return to this meeting  
 10 when we consider the actions of the board. But one of  
 11 those matters is on what basis, given the reports which  
 12 had been undertaken to that point, Mr Chambers appears  
 13 to have told the board that concerns about Letby were  
 14 not true, and that the grievance process exonerated her.

15 Following this meeting, Mr Chambers met with Letby  
 16 and informed her, "... the Board were absolutely clear  
 17 in their support for [her] to return to the neonatal  
 18 unit in the requirement of the doctors to make an  
 19 apology to you and in supporting the recommendations of  
 20 your grievance."

21 The claim that by this time, that is to say early  
 22 January 2015, that Letby had been "exonerated", was not  
 23 confined to a single meeting. The day after the  
 24 Extraordinary Meeting of the Board, the Executive  
 25 Directors Group met. In the notes to that meeting it is

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1 Over and above the external reviews, there remained  
 2 the concerns which had arisen during the internal work  
 3 done in July 2016, namely Ms Williams' staffing analysis  
 4 and Dr Gibbs' review of those patients who had been  
 5 transferred.

6 In these circumstances, the Inquiry will be looking  
 7 closely at how it was in January 2017 that the Executive  
 8 Directors Group was apparently proceeding on the basis  
 9 that Letby had been "exonerated". In particular, the  
 10 Inquiry will be seeking to understand how it could be  
 11 said that the grievance procedure which was an  
 12 investigation of a complaint by Letby as to how she had  
 13 been treated could reasonably be interpreted as  
 14 exonerating her.

15 On 26 January 2017 a meeting was convened between  
 16 consultants and members of the Executive Directors  
 17 Group. Mr Chambers chaired the meeting. In the course  
 18 of the meeting, Mr Chambers is recorded as stating,  
 19 "that the Speak Out Safely process has been  
 20 professionally managed". What he meant by this is  
 21 something the Inquiry will be investigating. So far as  
 22 the Inquiry has been able to establish to date, it was  
 23 not until 20 February 2017, so nearly a month later,  
 24 that the Speak Out Safely Committee discussed the  
 25 consultants' concern in a meeting in which it was

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1 recorded "apology letter, making explicit review,  
 2 exonerates Lucy".

3 Mr Chambers has commented in the witness statement  
 4 he has provided to the Inquiry about the use of the word  
 5 "exonerates" on 11 January. He states:

6 "I am not sure who made this comment. In my view,  
 7 whilst the review work did not provide any evidence of  
 8 wrongdoing on the part of Letby, I would not have said  
 9 it was capable of completely 'exonerating' her."

10 As we have already noted, the minutes of the board  
 11 meeting the day before record Mr Chambers using exactly  
 12 this word about the grievance post.

13 For Letby to have been exonerated whatever work that  
 14 had been undertaken would necessarily have needed to  
 15 investigate the question of whether she was responsible  
 16 for the deaths or conclusively found an alternative  
 17 explanation, neither of these things were true in  
 18 January 2017. One of the investigations, that is to say  
 19 the work of Dr McPartland, was still ongoing. Further,  
 20 the RCPCH had recommended that a further review was  
 21 conducted. Dr Hawdon, who'd been instructed to carry  
 22 out that further work, had expressly stated she'd not  
 23 undertaken much of what the RCPCH had recommended, and  
 24 had recommended further investigation of particular  
 25 cases.

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1 decided not to formally record those concerns and of the  
 2 Speak Out Safely policy.

3 Mr Harvey is recorded as having told the doctors  
 4 that "the review by a high-powered team does not call  
 5 out a criminal act but does raise other issues". The  
 6 minutes go on to record "there is a need to draw a line  
 7 under the Lucy issue".

8 It was then recorded that the board in its meeting  
 9 on 10 January 2017 had noted that an apology would be  
 10 quote from the consultants. Mr Chambers is then  
 11 recorded as saying:

12 "Let's be clear that we need to draw a line on the  
 13 past."

14 The way in which Mr Chambers conducted that meeting  
 15 has been described by number of witnesses to the  
 16 Inquiry. It appears to stand out in number of  
 17 attendees' minds long after it took place. The Inquiry  
 18 will explore this in oral evidence and will examine  
 19 whether it provides any insight into the thinking of any  
 20 of the decision-makers at that time.

21 Following the meeting with the consultants that day,  
 22 Ms Kelly and Ms Hodgkinson met with Letby. The record of  
 23 the meeting indicates that Letby was told, "the  
 24 expectations were that we were drawing a line under  
 25 this". Letby was also told that the intention remained

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1 for her to return to the neonatal unit.

2 Less than one week later, Ms Kelly and Ms Hodgkinson  
3 met with Letby again. In the course of that meeting  
4 Letby is recorded as saying that she had "been liaising  
5 with a colleague based at Alder Hey to view theatre  
6 lists and to have an observational contract." It was  
7 agreed at the meeting that Letby would work with Ms Rees  
8 about this.

9 Letby attending Alder Hey Children's Hospital in any  
10 capacity during the period she was excluded from the  
11 neonatal unit is an area of particular concern for the  
12 Inquiry. To better understand how this arrangement came  
13 about, we need to turn to the evidence of Dr U.

14 As is plain from the use of the cipher, the Crown  
15 Court Order requires that nothing is said that might  
16 identify Dr U as having been a witness in the criminal  
17 proceedings.

18 Accordingly we will not provide any information  
19 about Dr U's background, less that leads to his  
20 identification. We can say that in December 2016, Dr U  
21 was working as a locum at Alder Hey Children's Hospital.  
22 He knew Letby and the two had exchanged many messages  
23 after the period in which she was excluded from the  
24 neonatal unit. Accordingly, Dr U knew that  
25 investigations were being undertaken into the mortality

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1 a restriction on Letby's registration by the NNC. The  
2 appropriateness of such a restriction, which was not  
3 applied for until much later, is a matter we will be  
4 investigating.

5 It would not be until the 3 June 2017 that Letby was  
6 told by the hospital that she could no longer go to  
7 Alder Hey.

8 Returning to events in early 2017, on  
9 6 February 2017, a second meeting involving members of  
10 the Executive Directors Group and Letby and her parents  
11 took place. At the start of the meeting, Letby was  
12 informed that the consultants would write her a joint  
13 letter of apology and that mediation would take place.

14 In response, Letby appears to have pressed for four  
15 apologies rather than the whole consultant team, namely  
16 from Doctors Brearey, Jayaram, McCormack and Dr V. The  
17 Inquiry will be in requiring whether through these  
18 meetings Letby continued to take control of events and  
19 place pressure on the Executive Directors. We will be  
20 exploring whether, if this occurred, it influenced any  
21 of the thinking around how the situation should be  
22 resolved.

23 In the course of the meeting, Letby's father is  
24 recorded as suggesting that the consultants had "got  
25 away with calling my daughter a murderer". In response,

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1 rate on the neonatal unit. He knew that Letby had been  
2 identified as a common factor in the deaths and he knew  
3 that Letby had been moved to non-clinical duties.

4 On 8 December 2016, Dr U contacted the Clinical Lead  
5 for Training and Development at Alder Hey in order to  
6 arrange a period of "observership". He did so because  
7 Letby asked him to. Dr U has told the Inquiry in his  
8 witness statement that the request was known to and  
9 approved by the senior management team.

10 We pause to observe that at this time the  
11 investigations into Letby that the Trust had  
12 commissioned were still incomplete.

13 Dr U reports in his witness statement that Letby had  
14 attended Alder Hey for a number of supervised clinics at  
15 patient clinics, ward rounds and team meetings. He  
16 states:

17 "To my knowledge Letby had no unsupervised patient  
18 contact."

19 As we have said, this is an area of concern for the  
20 Inquiry. The extent to which Alder Hey were informed of  
21 the concerns which had been expressed about Letby and  
22 the fact that she had been moved to a non-clinical role  
23 six months earlier are matters which need to be clearly  
24 to be understood. One way in which this behaviour may  
25 have been formally prevented is by the imposition of

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1 Mr Chambers is recorded as saying:

2 "Trust me, they haven't. Ian [Harvey] and I have  
3 drawn the line, a different conversation will come  
4 next."

5 Pressing his point, Letby's father is recorded as  
6 saying, "You should have called the police or told them  
7 to go away." Mr Chambers's response is recorded as  
8 including:

9 "Allegations made did not sufficiently explain the  
10 deaths rates in the unit. We had a choice to make. One  
11 option was a police investigation, the other option was  
12 a clinical investigation."

13 Later, Mr Chambers is recorded as saying that:

14 "The easy thing would have been to phone the police  
15 but that could have been the end of your career."

16 No doubt it was not the meaning he was intending,  
17 but Mr Chambers's statement was borne out by what  
18 happened as a result of the police being contacted.

19 Mr Chambers is also recording as saying of the  
20 review process "It's only vindicated you". In his  
21 witness statement to the Inquiry, Mr Chambers has  
22 candidly accepted that this was, "not a good choice of  
23 words". He goes on to say that he wanted to convey the  
24 message that there was nothing in the reports which  
25 pointed to any wrongdoing and that Letby had been

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1 successful with her grievance.

2 On the 28 February 2017, eight consultants,  
3 including Doctors Brearey and Jayaram, signed a letter  
4 of apology addressed to Letby. The apology acknowledged  
5 how stressful Letby must have found the period of  
6 reviews and apologised for "any inappropriate comments  
7 which may have been made during this difficult period".  
8 it also apologised for the stress and upset that Letby  
9 had experienced.

10 As Dr V has said in her witness statement to the  
11 Inquiry the letter was "carefully worded 'so as not to  
12 accept that Letby was innocent'."

13 The following day, 1 March 2017, the weekly meeting  
14 between Letby and members of senior management took  
15 place. The notes of the meeting record that the plan  
16 was for Letby to return to the neonatal unit on either  
17 3 April 2017 or the 10 April 2017.

18 It appears that the delay was substantially to  
19 permit the proposed mediation between Letby on the one  
20 hand and Dr Brearey and Dr Jayaram on the other to take  
21 place.

22 In the event, Letby was not permitted to return to  
23 the neonatal unit. We're going to turn now to look at  
24 the reasons for this. To do so requires a review of the  
25 key events which were taking place involving the

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1 unexpected and unexplained deaths. Seemingly, in  
2 response to this, on 6 February 2017, the Trust gave  
3 a press release. In that press release given in the  
4 name of Mr Harvey, the Medical Director, it was asserted  
5 that of the 13 babies reviewed, "there remained two  
6 cases of babies that died, where the cause is  
7 unascertained".

8 Given the content of Dr Hawdon and Dr McPartland's  
9 reports the basis for this statement is a matter the  
10 Inquiry is seeking to understand.

11 On the same day as the press release, 6 February,  
12 Mr Chambers wrote to all members of staff. In that  
13 letter Mr Chambers acknowledged that since changes were  
14 made on the neonatal unit, there'd been no deaths. He  
15 went on to say that a recommendation had been made to  
16 conduct a thorough independent review into each neonatal  
17 death to determine any factors which could have changed  
18 the outcomes. Of this review, he stated that had been  
19 concluded within the last two weeks.

20 As we have made plain, one of the matters the  
21 Inquiry will be investigating is whether the Trust had,  
22 in fact, fulfilled the requirements of the  
23 recommendations which had been made to it by the RCPCH.

24 One of those with whom the RCPCH report and  
25 Dr Hawdon's review was shared was Dr Subhedar.

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1 Executive Directors.

2 We move on, my Lady, from events which directly  
3 concerned Letby and return to how the Trust was managing  
4 things internally during early 2017, culminating in the  
5 instruction of lawyers and Queen's Counsel in  
6 April 2017.

7 We take up this penultimate period on 30 January, so  
8 moving slightly back from where we'd reached in the  
9 chronology, this was just five days after Dr McPartland  
10 had sent her report to Mr Harvey four days after the  
11 difficult meeting between the consultants and  
12 Mr Chambers.

13 On 30 January the neonatal unit's consultants wrote  
14 to Mr Chambers. In their letter, the seven signatories  
15 referred to the meeting on 26 January at which the  
16 apology to Letby was discussed. They stated that they  
17 agreed that it was appropriate to provide Letby with  
18 that apology but sought "the board's understanding of  
19 the reason for the increased number of unexpected and  
20 unexplained deaths on the neonatal unit between June and  
21 July".

22 They also requested to see a copy of the RCPCH  
23 report, and a copy of Dr Hawdon's report.

24 On 3 February 2017, the Sunday Times emailed the  
25 Trust regarding an article it proposed to run on

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1 Dr Subhedar had been involved in the February 2016  
2 Thematic Review of Neonatal Mortality. The Inquiry's  
3 understanding is that Dr Subhedar was sent these reports  
4 as a representative of the local Neonatal Network.

5 On 10 February, Dr Subhedar emailed Mr Harvey about  
6 the reports and the review. He began by querying what  
7 Dr Hawdon's terms of reference were. This was  
8 a prescient question given that what Dr Hawdon had asked  
9 to do and what it is said she did do were not the same  
10 thing. Dr Subhedar went on to say:

11 "My own interpretation of the 13 deaths included in  
12 [Dr Hawdon's] review suggests there were four cases in  
13 whom there is no clearly identified cause of  
14 collapse/death, and a further three cases where the  
15 cause of the initial collapse leading ultimately to the  
16 baby's death remain unexplained."

17 He went on:

18 "The single most important and relevant  
19 recommendation is (6) which advises 'broader forensic  
20 review' of the cases in whom the death/collapse remains  
21 unexplained."

22 Pausing there for a moment, it will be recalled that  
23 Dr Hawdon included four babies in this category in her  
24 report.

25 Dr Subhedar went on: "I would recommend extending

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1 this to the seven cases that I have identified."

2 Dr Subhedar then identified seven babies, including  
3 Child O, Child A, Child P, Child D and Child I.

4 He concludes his email by pointing out that the  
5 neonatal unit was by no means an outlier in terms of  
6 processes around mortality review, consultant presence,  
7 and supervision.

8 One interpretation of this is that Dr Subhedar was  
9 implicitly saying that these factors did not provide an  
10 explanation for the increase in the mortality rate.  
11 This is a matter we will be exploring with him in  
12 evidence.

13 We will also be exploring with Mr Harvey what his  
14 reaction to this email was. In particular, we will be  
15 exploring what steps, if any, he had taken since  
16 Dr Hawdon's recommend three months earlier to conduct  
17 a broader forensic review in some cases.

18 In early February 2017, Dr Hawdon's report was  
19 released to the neonatal consultants. This prompted  
20 a letter from seven consultants. That letter was  
21 addressed to the Chief Executive, Mr Chambers. The  
22 consultants stated that they were not reassured by the  
23 reports that the deaths and collapses were explicable by  
24 natural causes. They said that they agreed with  
25 Dr Hawdon that there were four babies which required

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1 any of them had truly broken down.

2 Mr Chambers is recorded as raising what the  
3 awareness of the Coroner and Dr Hawdon was of the "Lucy  
4 issue". The note of the meeting indicates that  
5 Mr Harvey intended to go through the clinical notes and  
6 look again at the rota. It is recording that more  
7 detail would be sought from Ms Williams and Ms Fogarty,  
8 the two people who had carried out the analysis of the  
9 rota in July 2016.

10 In the course of the meeting on 14 February,  
11 Ms Kelly is recorded as noting that the plan for Letby's  
12 return to the neonatal unit was being finalised that  
13 week. The note records Mr Chambers as saying, "Carry on  
14 with plan."

15 During the rest of the month of February 2017 it  
16 appears that there was a concerted effort by Mr Harvey  
17 and Mr Chambers to resolve matters, or in their own  
18 language, "draw a line". Mr Harvey contacted Dr Hawdon  
19 asking how unusual it was for a neonate to collapse  
20 unexpectedly. She responded that this was rare.

21 At the same time Mr Chambers wrote to the  
22 consultants on 16 February informing them that the  
23 Coroner had been fully briefed on all matters and  
24 reminder the consultants of their agreement to provide  
25 an apology. He concluded his letter by saying of the

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1 broader forensic review, but there were two additional  
2 cases over and above the four identified about which the  
3 consultants were concerned. They request that  
4 Mr Chambers urgently ask the Coroner to conduct a full  
5 investigation of all deaths and unexpected collapses  
6 between June 2015 and July 2016.

7 The letter went on to say that:

8 "The RCPCH report had not identified a cause for the  
9 sudden increase in neonatal mortality."

10 It concluded by saying:

11 "We hope that a comprehensive external investigation  
12 will be in the best interests of the bereaved families  
13 and those affected by these sad events."

14 Four days after the date of the consultants' joint  
15 letter and Dr Subhedar's email, the Executive Directors  
16 Group met. The meeting began according to the note made  
17 of it with Mr Chambers observing that as a result of the  
18 consultants' letter, matters "seemed to have gone  
19 backwards".

20 Mr Harvey is recorded as replying "Wondered what  
21 they were plotting".

22 Mr Harvey has told the Inquiry that he does not  
23 recall saying this. If this was said, the Inquiry will  
24 be investigating whether by this stage a relationship of  
25 trust between the consultants and Executive Directors or

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1 various reviews and reports which had been completed:

2 "All conclude that there is no single causal factor  
3 to explain the change in mortality rates, nor to  
4 substantiate the allegations you have made."

5 Throughout the rest of February and March, meetings  
6 and correspondence continued. The consultants did  
7 provide the apology letter but Dr Brearey and Dr Jayaram  
8 refused to engage in a suggested mediation process,  
9 saying it was "inappropriate to be undertaking the  
10 mediation process when the Trust is still investigating  
11 the cause for the increased neonatal mortality between  
12 June 2015 and July 2016".

13 Throughout these weeks, the consultants' position  
14 appears to have been a consistent reiteration of the  
15 fact that Dr Hawdon had concluded that four cases were  
16 unexplained, that the RCPCH review did not specifically  
17 investigate the cause of the deaths and unexpected  
18 collapses and that, "these events had not been fully  
19 investigated as recommended by the RCPCH review team and  
20 by Dr Hawdon".

21 On 16 March 2017, the Executive Directors met. This  
22 meeting discussed a one-to-one which was held between  
23 Dr Jayaram and Ms Hodgkinson the previous day, and the  
24 course of the Executive Directors meeting, Ms Hodgkinson  
25 relayed what she had discussed with Dr Jayaram.

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1 The note of the meeting records this as:  
 2 "Three deaths. Lucy at cot. Real concerns. Lucy  
 3 moved valves."  
 4 Mr Chambers described this as a "new and highly  
 5 concerning disclosure" and one which had not been raised  
 6 with him or any of the other Executives previously.  
 7 Ms Kelly is noted as having said, "Why not before?  
 8 Serious allegations", which Mr Chambers has told the  
 9 Inquiry was his further reaction to hearing this  
 10 information.  
 11 Mr Chambers goes on in his statement to draw  
 12 attention to the fact that incident had not been  
 13 recorded on the Datix system and had not been the  
 14 subject of any investigation at the time. He states in  
 15 his witness statement:  
 16 "If a prompt report of this incident had been made  
 17 to me, I would have spoken to Alison Kelly and  
 18 Ian Harvey and it is the likely outcome would have been  
 19 made to make a report to the police. Who knew this  
 20 information and when will need to be established in  
 21 evidence.  
 22 It will also be important to understand why, when  
 23 provided with this information, there was not a prompt  
 24 notification of the police by the hospital. What is  
 25 more, although reported in this meeting, the allegation  
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1 Later in the meeting, Mr Chambers is recorded as  
 2 asking "Why have you not phoned the police?"  
 3 Dr Jayaram's reply is recorded as being:  
 4 "Our career would be on the line if we contact (the)  
 5 police, it would be whistleblowing. Following BMA advice  
 6 if there is an alternative of a deeper dive we should go  
 7 for it. But this is a worry."  
 8 Dr Jayaram's response if correctly recorded is  
 9 a matter which will need to be important to understand.  
 10 Discussion about involving the police continued,  
 11 including, according to the note of the meeting,  
 12 Dr Brearey saying, "This needs to escalate to the  
 13 police".  
 14 Mr Harvey recalls Dr Brearey saying this and says  
 15 that it was his view that it was likely the police would  
 16 need to be consulted but he remained concerned that we  
 17 had nothing to give to the police to support the  
 18 concerns of paediatricians.  
 19 Towards the end of the meeting Mr Chambers is  
 20 recorded as saying, "We need to think about the  
 21 conversation with the police." It's recorded that  
 22 Mr Chambers concluded by saying, "You need to leave this  
 23 with us."  
 24 The following day on 28 March 2017 the Executive  
 25 Directors met with the Chair of the Board of Directors,  
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1 does not appear to have been the subject of any  
 2 discussion or record in the subsequent six weeks,  
 3 neither does it appear that any of the Executive  
 4 Directors sought further information or even  
 5 confirmation from Dr Jayaram about it.  
 6 On 27 March 2017, an important meeting took place.  
 7 Present at it were a number of Executive Directors,  
 8 Dr Brearey, Dr Jayaram and Dr Subhedar. Also present  
 9 was Julie Maddocks, the Chair of the Local Neonatal  
 10 Network Steering Group. Mr Harvey provided an update  
 11 and spoke about an earlier meeting at which 13 deaths  
 12 were reviewed by him, Dr Brearey, Dr Jayaram and  
 13 Dr Subhedar. He was recorded as saying there was eight  
 14 cases where there were still concerns and in which  
 15 relation to which the staff rotas were to be reviewed  
 16 alongside the case notes.  
 17 In the course of the discussion Mr Chambers is  
 18 recorded as saying, "I need to know if we do an  
 19 individual case note review or phone the police."  
 20 Ms Maddocks is recorded as replying:  
 21 "Given the information on the balance of  
 22 probability, illegal activity has caused deaths."  
 23 Mr Chambers is record as going on to saying:  
 24 "If that is where we are, then phone the police.  
 25 You can call the police."  
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1 Sir Duncan Nichol. The notes of the meeting summarised  
 2 the position of the consultants as being:  
 3 "Position now only independent, robust investigation  
 4 is police investigation."  
 5 It was at this meeting that Mr Cross is recorded as  
 6 saying that Letby could not return to the unit the  
 7 following week as had been the plan, by reason of the  
 8 potential police investigation. At this time the  
 9 hospital also consulted lawyers, DAC Beachcroft, in  
 10 relation to whether and how to liaise with the police,  
 11 who were considering in more detail what instructions  
 12 were given to lawyers and what advice was given  
 13 regarding contacting the police and the reason for this.  
 14 Although it was recorded in the meeting on 28 March  
 15 that Mr Cross would contact the police on 31 March, it  
 16 does not appear that this in fact occurred. By 3 April,  
 17 he had completed a document setting out why there was,  
 18 "no evidence to justify a criminal investigation".  
 19 In his witness statement to the Inquiry, Mr Cross  
 20 says that this document was a record of a discussion  
 21 between Mr Chambers and Sir Duncan Nichol and is  
 22 a reflection of their views which was to be presented to  
 23 the Executive Team.  
 24 By contrast in his witness statement, Mr Chambers  
 25 says that the purpose of this note is unclear. He goes  
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1 on to suggest that, "it looks like to be an aide memoire  
2 for Stephen Cross".

3 The phrase "No evidence to justify a criminal  
4 investigation" forms part of the opening sentence of  
5 a document entitled "Rationale", which began:

6 "In our view, there is no evidence to justify  
7 a criminal investigation. However, in the spirit of  
8 openness and transparency, the matter is being reported  
9 to the police having regards to the fact that a number  
10 of consultant paediatricians are not satisfied with the  
11 very thorough investigations and reviews undertaken."

12 We will be looking at the content of this document  
13 in greater detail during the hearing in terms of what it  
14 may reveal about the thinking of the Executive Directors  
15 at this time. We note only at this stage that it does  
16 not appear to make any mention of the information  
17 Dr Jayaram disclosed on her account to Ms Hodgkinson on  
18 15 March 2017 and which was subsequently discussed by  
19 the Executive Directors the following day.

20 On the same day, 3 April 2017, Mr Harvey also wrote  
21 a document. His was entitled "Neonatal services at the  
22 Countess of Chester Hospital NHS FT". Although more  
23 detailed than Mr Cross's rationale, it contained many of  
24 the same points. It was prepared, Mr Harvey has  
25 informed the Inquiry, in anticipation of the review by

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1 review the position after the Easter break."

2 The explanation she was given was, "due to the work  
3 ongoing in relation to the clinical concerns that have  
4 been raised".

5 Also discussed in the meeting were Letby's "visits"  
6 to the neonatal unit. She was advised that these should  
7 also be paused. This appears to be a reference to the  
8 fact that prior to this date, Letby had been attending  
9 the neonatal unit. Whether and how often this occurred,  
10 and if it did, who sanctioned it, our matters the  
11 Inquiry will be investigating.

12 In early April, Simon Medland QC was instructed by  
13 the hospital. Exactly what the purpose of his  
14 instruction was is the subject of some uncertainty at  
15 present. Mr Harvey has stated that Mr Medland's role  
16 was, "to collate all the information, meet with the  
17 paediatricians and advise on the best approach and with  
18 what information to go to the police".

19 On 12 April, Mr Medland met with the consultants.  
20 Mr Medland's minutes of the meeting begin by setting out  
21 why he was meeting them, namely "to bring an independent  
22 objective view to the present situation and see if  
23 a formal report to the police were presently merited".

24 Mr Cross has told the Inquiry that this was the  
25 purpose of his instruction. However, like Mr Harvey,

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1 Simon Medland QC. It is of note that the list of  
2 actions following the death of Child O included,  
3 "A comprehensive review of the unit to include activity,  
4 acuity and staffing levels". Ms Williams' staffing  
5 analysis and Dr Gibbs' review are not expressly  
6 mentioned. Mr Harvey has told the Inquiry that this was  
7 intended, "as a high-level summary of the investigations  
8 which had been undertaken" and, "was not meant to be  
9 comprehensive".

10 We note, as with the rationale document I've just  
11 referred to, that this also does not appear to include  
12 any reference to the disclosure Dr Jayaram had made to  
13 Ms Hodgkinson less than three weeks earlier.

14 The document concludes by saying:

15 "However, despite extensive and intensive review,  
16 the paediatric consultants still feel that there are  
17 questions to be answered and we feel that we need to  
18 share the details and circumstances with the police."

19 Despite Mr Harvey and Mr Cross's documents of  
20 3 April both saying that the police would be contacted,  
21 this did not take place formally for another month.

22 On 5 April 2017, a meeting with Letby was held.  
23 Ms Kelly and Ms Rees both attended. In the course of  
24 the meeting, Letby was told that "it was felt we should  
25 pause your return to the neonatal unit at this time and

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1 Mr Chambers has told the Inquiry that this is at odds  
2 with why he understood Mr Medland had been instructed.  
3 Mr Chambers said he understood the decision to contact  
4 the police had been made and Mr Medland was helping with  
5 how that would happen in practice.

6 Mr Medland's minutes record that he gave his view  
7 "that the police, being strapped for resources ... can  
8 only sensibly investigate cases where there is -- at the  
9 very least -- reasonable grounds for suspecting that a  
10 criminal offence has been committed. He emphasised that  
11 this was very different from there being mere  
12 suspicion ..."

13 Mr Medland noted that adverse publicity would be  
14 incurred and that it would raise matters for the  
15 families of the neonates which might be seriously  
16 disturbing. He concluded by saying:

17 "As things stand he did not see that there was such  
18 material as might give rise to reasonable grounds for  
19 suspecting that a criminal offence had been committed."

20 He encouraged the consultants to make a list of  
21 their best points. He also raised the possibility of  
22 a private discussion with Detective Chief Superintendent  
23 Nigel Wenham on the basis that DCS Wenham sat on the  
24 Child Death Overview Panel.

25 One important matter that does not appear to have

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1 been raised with Mr Medland was the information  
2 Dr Jayaram had given Ms Hodkinson. This is the position  
3 the Inquiry will be exploring the reasons for this  
4 omission.

5 The following day, an Extraordinary Meeting of the  
6 Board was convened. Mr Medland was invited to attend  
7 and his record of the meeting the day before was  
8 provided to the board members. The minutes of the board  
9 meeting record that Mr Medland reported the consultants'  
10 concerns as being that they could not see anyone else  
11 who could investigate. He repeated his view there was  
12 no evidence for a crime and his proposal that DCS Wenham  
13 be contacted in the context of his role on the Child  
14 Death Overview Panel. He suggested that Dr Hawdon be  
15 asked what she meant by "forensic review".

16 In the course of the meeting Sir Duncan appears to  
17 have referred to the case of Beverly Allitt. That  
18 meeting will be returned to in greater detail in our  
19 consideration of the board's role in the governance of  
20 the hospital, and the test to be applied for referral to  
21 the police.

22 Mr Harvey emailed Dr Hawdon to ask what she meant by  
23 "forensic review". She responded and commented that  
24 "completely unexplained death on a neonatal unit is rare  
25 so by definition, more than one unexplained death does

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1 "On the advice of Detective Chief Superintendent  
2 Nigel Wenham, I am writing formally requesting  
3 Cheshire Police conduct a forensic investigation into  
4 the circumstances surrounding the deaths with a view to  
5 excluding any unnatural causes."

6 The Board of Directors were updated about this later  
7 that day in a further Extraordinary Meeting. Three days  
8 later, the first meeting of Operation Hummingbird, the  
9 name given to the police investigation, took place.

10 On 10 May 2017, a document was provided to the  
11 police compiled by seven consultants who worked on the  
12 NNU. This is a 22-page document which sets out  
13 a reasoned analysis of the concerns which existed in  
14 relation to each baby. It brings together Dr Hawdon's  
15 conclusions, with additional cases identified by the  
16 consultants and Dr Subhedra from the Neonatal Network.

17 The Inquiry will be referring this document to  
18 understand the extent to which concerns expressed could  
19 have been gathered previously. Could Letby have been  
20 stopped sooner than she was? Were opportunities for  
21 detection missed? Should concerns have resulted in  
22 actions sooner? These actions go to the very heart of  
23 whether lives could have been saved and injury  
24 prevented.

25 As I have said, the police were not contacted until

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1 arouse suspicion".

2 She concluded that unexplained death in hospitals  
3 should follow the same process as unexplained death at  
4 home. She advised that Mr Harvey consult with the local  
5 Child Death Overview Panel team if he was unsure.

6 Mr Chambers has told the Inquiry that he considered  
7 this to be new information from Dr Hawdon, which  
8 supported the decision to go to the police.

9 On 19 April the Executive Directors Group met. It  
10 was agreed that contact with the police should be made  
11 through the Child Death Overview Panel. A discussion  
12 took place the following day between Mr Harvey and  
13 Hayley Frame, the Chair of the Pan Cheshire Child Death  
14 Overview Panel.

15 A week later on 27 April, Mr Harvey spoke to  
16 DCS Wenham. Following this conversation, DCS Wenham  
17 emailed to Mr Harvey inviting him to write a formal  
18 letter to the Chief Constable of Cheshire Constabulary.

19 On 2 May, Mr Chambers wrote to the Chief Constable.  
20 In the letter he stated:

21 "No single factor has been identified by these  
22 reviews, however, there are four cases in which a cause  
23 for collapse and/or death cannot be ascertained which  
24 the independent expert tells us is unusual."

25 He continued:

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1 April 2017. In that time, Letby worked without formal  
2 restriction on her registration from her regulator, the  
3 NMC. Whilst she was eventually removed from  
4 a patient-facing role, whether and if so how she was  
5 able to obtain any placement elsewhere or to visit the  
6 neonatal unit at the hospital will be explored in oral  
7 evidence.

8 Furthermore, the fact that Letby was excluded from  
9 the neonatal unit may have been to some degree chance.  
10 The initial plan was that she was supervised, and this  
11 was only abandoned due to resourcing. Later that year  
12 it was being communicated that she would be returning to  
13 the ward despite the fact that investigations were  
14 ongoing. Her planned return to the ward on 3 April 2017  
15 only appears to have been stopped because of the  
16 tenacious lobbying of the consultants. But for their  
17 determined approach, it appears likely that she would  
18 have been permitted to return to dealing with babies.

19 My Lady, I turn now to Chapter 2, whistleblowing.  
20 Speaking up, whistleblowing, and Letby's grievance.

21 **LADY JUSTICE THIRLWALL:** Thank you.

22 **MS LANGDALE:** In February 2015, Sir Robert Francis,  
23 King's Counsel, published his Freedom to Speak Up  
24 Review. At an early stage in the oral evidence we will  
25 be hearing from Sir Robert about the main conclusions of

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1 his watershed report. Sir Robert recommended the  
2 creation of the role of "Freedom to Speak Up Guardian"  
3 in all NHS organisations. He proposed there should also  
4 "be a range of others to whom people can go for advice  
5 and support. This should include at least one executive  
6 director, which may be the person responsible for safety  
7 and/or the medical director ..."

8 The hospital's Speak Out Safely (Raising concerns  
9 about Patient Care) and Whistleblowing Policy, which  
10 applied for the period June 2015 to the end of 2015  
11 predated Sir Robert's Freedom to Speak Up Review.  
12 Nevertheless it identified number of people termed  
13 designated officers who were the initial point of  
14 contact for disclosures to be made.

15 At the hospital, those people included a number of  
16 executive directors, including Mr Harvey, Ms Kelly and  
17 Ms Hodkinson.

18 In January 2016, the hospital reissued its "Speak  
19 Out Safely" Policy. The same people were identified as  
20 "designated officers".

21 Both policies applied to situations in which there  
22 was a reasonable belief, that is to say an honestly held  
23 belief, which was objectively reasonable, that  
24 a criminal offence had been committed or that there was  
25 a danger of health and safety of any individual.

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1 whistle on a serious risk to patient safety.  
2 Whistleblowing is governed by the Protected Disclosures  
3 Provisions contained in part IVA of the Employment  
4 Rights Act 1996.

5 As I've mentioned, the hospital had a whistleblowing  
6 policy and we will examine whether it was implemented.

7 On 14 July Ms Sian Williams the Deputy Director for  
8 Nursing Quality, met Letby, together with her line  
9 manager, Ms Powell.

10 Letby was told that a review had been undertaken  
11 which was unable to explain the collapse or  
12 deterioration of a number of babies on the neonatal  
13 unit. It was of serious concern to the hospital  
14 requiring investigation. Letby was informed that the  
15 review had identified her as, "being more regularly  
16 involved in the care of babies concerned". Letby was  
17 informed that she would be placed under clinical  
18 supervision pending the completion of an external review  
19 by the Royal College. The period of supervised practice  
20 was due to commence on 18 July until which date Letby  
21 was due to be on authorised leave.

22 Ms Powell emailed all nurses on the NNU on 15 July  
23 stating that:

24 "In preparation for the external review it has been  
25 decided that all members of staff need to undertake

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1 A Speak Out Safely Committee appears to have met  
2 monthly during the period in which we are focused. Its  
3 members appear to be those named as designated officers  
4 under the Speak Out Safely policy. The only exception  
5 to this appears to be Mr Harvey who is not recorded as  
6 attending any of these meetings. The Inquiry will be  
7 investigating whether any of the consultants asked for  
8 their concerns to be formally logged under the Speak Out  
9 Safely Policy, and if they did, the Inquiry will be  
10 seeking to understand the apparent resistance recorded  
11 on the face of the minutes to recording their concerns  
12 as search, by the Speak Out Safely Committee. The Speak  
13 Out Safely Committee provided a clear and established  
14 route to involve the local authority designated officer.  
15 This route was not taken by the hospital, and it's  
16 important to understand why this did not happen.

17 There are a number of employment law issues to  
18 consider in respect of the management of Letby and  
19 treatment of those who raised concerns about her. We  
20 will hear evidence from an expert in employment law,  
21 Professor John Bowers, King's Counsel, at a later stage  
22 in the Inquiry.

23 You may think, my Lady, that the concerns made by  
24 the paediatric consultants, principally Drs Brearey and  
25 Jayaram, were a primary example of doctors blowing the

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1 a period of clinical supervision ... we have decided  
2 that it would be useful to commence with staff who have  
3 been involved in many of the acute events ... Therefore  
4 Lucy has agreed to undergo this supervision first."

5 A further meeting was held on 18 July. Letby was  
6 told that it was not possible to provide a full-time  
7 supervised practice because of staffing levels on the  
8 NNU. A decision had therefore been taken to redeploy  
9 her to Risk Management Team instead, where she would be  
10 line-managed by Ms Ruth Millward. This was said to be,  
11 "temporary" and, "a neutral act taken in the best  
12 interest of all parties and in the interests of patient  
13 care pending completion of the external review".

14 Letby was told that she could maintain social  
15 contact with her colleagues on the NNU but that she,  
16 "should be mindful of discussion of any matters which  
17 may be sensitive in nature relating to the RCPCH review  
18 of the NNU".

19 On the same day, Ms Hodkinson obtained advice from  
20 Mr Pace and Ms Slingo, lawyers at DAC Beachcroft on two  
21 issues: Letby's redeployment and whether the police  
22 should be called. We will hear evidence about the  
23 advice sought and obtained from Ms Slingo and her  
24 colleague at the time, Mr Pace.

25 The first of many meetings between managers at the

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1 trust, in his case Ms Rees, Head of Nursing, and Letby,  
2 took place on 5 August 2016. The purpose of this  
3 meeting was to update Letby and check on her welfare.  
4 Letby was accompanied by her Royal College of Nursing  
5 representative, Ms Cooper. Letby was told that the  
6 review by the RCPCH had been deferred until the first  
7 week of September 2016.

8 On 2 September, Mr Tony Millea, a Royal College of  
9 Nursing officer, emailed Ms Rees stating that he  
10 believed that "Letby has grounds to action a grievance".  
11 Mr Millea earlier wrote that he had two concerns.

12 First, it had become apparent in the course of  
13 Letby's interview by the RCPCH the previous day that  
14 contrary to the indication given in the meetings in  
15 July 2016, "the terms of reference for this  
16 investigation does not seem to address the concerns in  
17 relation to the unacceptable high mortality rate on the  
18 NNU, and our member's involvement".

19 Instead the review appeared to be around more  
20 general matters and therefore that the review "will not  
21 solve the issues for Letby personally".

22 Second, Letby's redeployment was "a result of the  
23 Trust response to consultant's comments about our  
24 member's practice. I would like to request to see the  
25 Trust's evidence to substantiate their actions."

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1 on what grounds?". Letby felt that she was being  
2 "targeted and blamed for incidents that even the review  
3 report will not address".

4 The following day, 8 September, Ms Hodkinson  
5 compiled an NNU options appraisal document marked  
6 "Strictly Private and Confidential". The options set  
7 out in this document were for Letby to remain in  
8 redeployment for an extended period, or for a 12 month  
9 period; to reintegrate her back within the NNU; to  
10 undertake a disciplinary investigation; to engage the  
11 Speak out Safely policy; and finally for Letby to  
12 resign. Various "considerations" in respect of each  
13 option were set out.

14 On 9 September Ms Kelly and Ms Hodkinson appeared to  
15 have attended a conference call with lawyer Mr Pace.  
16 Mr Pace noted that Letby had been "removed from the  
17 neonatal unit, following a correlation of baby deaths  
18 when she was on the unit" and that the decision to  
19 redeploy her to the Risk Team had been taken "because it  
20 was not possible to place her under close supervision,  
21 and because of the ongoing concerns that had been raised  
22 by the consultant." It appears that the advice received  
23 was that there was a high risk of constructive  
24 dismissal, but it was also noted that "justified in  
25 decision to remove ... remove risks to babies". Under a

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1 Mr Millea concluded that "the allegations made by  
2 the hospital would have a detrimental affect on our  
3 member's career which may constitute professional  
4 slander resulting in our member being constructively  
5 dismissed".

6 He asked that the hospital reinstate Letby to her  
7 substantive role on the NNU. At no point did Mr Millea  
8 refer to principles of safeguarding. His focus was on  
9 the apparent treatment of Letby.

10 Letby filed a written grievance on 7 September 2016.  
11 This echoed the concerns expressed in Mr Millea's email  
12 of 2 September, and raised the following issues.

13 Contrary to what Letby had been told in July 2016,  
14 no other member of staff had been placed under  
15 supervised practice or redeployed. Letby had been  
16 "singled out" and felt that she was "being discriminated  
17 against".

18 The RCPCH reviewers told Letby that it would take up  
19 to eight weeks for them to complete their report. Letby  
20 wished to know what was "expected to happen with me  
21 during this period as I am keen to return to work on the  
22 NNU as soon as possible".

23 Consultants had raised allegations about Letby. She  
24 wished to know what evidence there was against her "and  
25 if there is to be an investigation into my practice then

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1 list headed "Options", it was noted that suspension was  
2 "not appropriate in (the) circumstances".

3 Ms Cooper, Letby's Royal College of Nursing  
4 representative, emailed Ms Hodkinson on  
5 20 September 2016 to chase the progress of Letby's  
6 grievance. A number of internal emails were exchanged  
7 in the trust in response. In particular, on  
8 21 September, Ms Appleton-Cairns, the Deputy Director of  
9 Human Resources of the hospital, emailed Ms Kelly and  
10 Ms Hodkinson to say that:

11 "we were going to ask Ian to speak to SB (presumably  
12 Dr Brearey) and ask him to formally voice his concerns  
13 under Speak Out Safely. I think we need to do this in  
14 parallel -- any thoughts?"

15 Ms Hodkinson and Ms Kelly both replied stating that  
16 they were unsure whether this had happened.

17 Ms Appleton-Cairns considered Letby's case and her  
18 grievance on 28 September. She made a list of the nine  
19 key questions which she believed Letby, "wants  
20 answering". These included:

21 "What are the issues the consultants have raised?  
22 What is the Trust doing about it? What evidence does  
23 the Trust have? If there is going to be an  
24 investigation into a practice, then on what grounds?  
25 Why has she been singled out for redeployment? When can

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1 she return to the NNU?"

2 Ms Appleton-Cairns wrote that an independent Chair  
3 had been appointed "but at the moment we do not have  
4 a modicum of defence for this". She suggested that an  
5 investigating officer be appointed, and noted that they  
6 "would have to ask very difficult questions of the  
7 consultants".

8 She also referenced again that the plan was for the  
9 consultants "to explain their concerns in writing and to  
10 Speak Out Safely". She considered that this would be  
11 a softer approach than question the consultants under  
12 the grievance procedure. She concluded that after the  
13 accountants had explained their concerns:

14 "We can investigate any statements of evidence and  
15 be able to respond to LL ... This is now time pressured  
16 as we are failing to respond under our own policy  
17 timeframes which is an unnecessary risk should it go  
18 further."

19 Ms Hodgkinson met with Letby on 5 October. It was  
20 explained that this was an informal meeting and was  
21 separate from the grievance process, that the findings  
22 of the formal review into the NNU were being awaited and  
23 in the meantime, Letby's redeployment would continue  
24 with weekly support meetings in place.

25 It was noted that Letby was receiving clinical  
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1 We will look at those interviews in oral evidence.

2 On 28 October, Ms Powell emailed Dr Green saying:

3 "This is the article and email that I was alluding  
4 to in our discussion", and included emails that  
5 Dr Jayaram and Dr Gibbs had exchanged on 30 June 2016  
6 surrounding the possibility that air embolus was  
7 involved in some of the neonatal deaths.

8 Ms Hodgkinson continued to consult with external  
9 lawyer Mr Pace, and the RCPCH review, which had  
10 recommended clear processes for investigating  
11 allegations, was discussed.

12 On 28 October, Mr Pace advised Ms Hodgkinson that  
13 Letby's continued redeployment away from the NNU should  
14 in his view be continued because "my ultimate concern  
15 was the potential for patient safety."

16 Dr Green conducted the remainder of his grievance  
17 investigation interviews in the first half of November.  
18 Mr Harvey was interviewed on 7 November, and Doctors  
19 Brearey and Jayaram were both interviewed on the 11th.

20 Dr Green produced a draft investigation report on  
21 12 November. He concluded the following: that the Trust  
22 generally intended to place Letby on a period of  
23 supervision of practice and repetition of competences;  
24 that although no such instruction was given to her,  
25 Letby felt she was not permitted to have normal social  
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1 updates from the NNU, and that the "best outcome would  
2 be to get you back working on the neonatal unit." Letby  
3 was asked whether she still required the formal  
4 grievance process to continue. Letby confirmed that she  
5 did. It was explained that there had been delays in  
6 identifying an interpreting Chair for the grievance  
7 hearing "to provide objectivity and independence to the  
8 process".

9 During this period, a number of steps took place.  
10 The hospital consulted external lawyers and the risk of  
11 constructive dismissal was discussed.

12 The issue of whether the consultants had voiced  
13 their concerns under Speak Out Safely was raised, but it  
14 seems not resolved. And by October 2016, Dr Christopher  
15 Green, Director of Pharmacy, was appointed as  
16 investigating officer in relation to the grievance  
17 process.

18 Dr Green began conducting the grievance  
19 investigation interviews on 14 October. Letby was the  
20 first to be interviewed. The interview appears to have  
21 been fairly short. Letby said that she had not received  
22 any formal allegations, it was, "all verbal". On the  
23 same day, Dr Green interviewed Ms Kelly, Ms Rees and  
24 Ms Williams. Ms Hodgkinson was interviewed on  
25 21 October, and Ms Powell was interviewed on 28 October.  
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1 contact with her colleagues on the NNU; that the purpose  
2 of the RCPCH and Dr Hawdon reviews were to "explore  
3 circumstances and detail around patient safety on the  
4 neonatal unit, with respect to the commonality  
5 identified between [Letby] being on duty and the  
6 collapses/deaths of the babies on the neonatal unit, I  
7 concluded that the Exec teams feel that the review would  
8 provide confirmation and reassurance that there is no  
9 direct link between the two", and finally that the Trust  
10 had not been open with Letby regarding the nature of the  
11 consultants' informal allegations regarding her.

12 Dr Green also found that:

13 "The drive to remove LL from the neonatal unit  
14 appears to have come from the consultant [Dr Brearey]  
15 and to a lesser extent, [Dr Jayaram]. Whilst it is  
16 important that the Trust has a culture that allows  
17 members of staff to raise concerns about colleagues,  
18 I find it a concern that these concerns are based on  
19 'gut feel', and do not accept that this provides a basis  
20 on which to make the accusations that appear to have  
21 been made. I am therefore concerned as to whether this  
22 warrants further investigation under the Trust's  
23 Bullying and Harassment Policy.

24 Even more surprisingly, you may think, my Lady, in a  
25 section headed "Recommendations", Dr Green said that  
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1 pending the outcome of the "final reports", Letby should  
2 be "given the opportunity to return to the NNU."

3 Dr Green met with Mr Stephen Cross, Director of  
4 Corporate and Legal Services, on 16 November. From  
5 notes the Inquiry has seen, it appears that the  
6 grievance was discussed, and we will ask questions about  
7 this meeting in oral evidence.

8 On 18 November, Ms Hodgkinson spoke again with the  
9 lawyer, Mr Pace. She told him that:

10 "The external and internal reviews have both been  
11 completed, and there is nothing to implicate Letby in  
12 any of the events. The board has decided that she  
13 should return to the neonatal unit.

14 Mr Pace replied that this "all sounded very  
15 positive, and we need to take steps to ensure that  
16 proper steps are made to reintegrate her back into the  
17 workplace."

18 He is also noted as explaining that Dr Brearey had  
19 explained whistleblowing concerns which needed to be  
20 investigated, but Ms Hodgkinson explained that:

21 "The Trust had taken the view that the internal and  
22 external investigations had been sufficient, and that we  
23 would provide the outcome of these investigations to the  
24 consultants who had raised the whistleblowing concern."

25 On 22 November 2016, Dr Green produced the final  
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1 been aware that any external reviews were going on into  
2 neonatal deaths.

3 There was discussion about the fact that the nature  
4 of the allegations against Letby was that she had  
5 "deliberately set out to harm babies", but Dr Green is  
6 recorded as saying that there was "no evidence to  
7 suggest that this is the case".

8 Dr Green explained that he had concluded that  
9 Dr Brearey and Dr Jayaram had threatened to call the  
10 police, and that the issue was, with this, "If the  
11 consultant had called the police, the ward would have  
12 been declared a crime scene, and LL would have been  
13 arrested. It is my take that the police would come and  
14 arrest LL."

15 Dr Brearey and Dr Jayaram were discussed in the  
16 course of the grievance hearing. Ms Weatherley is  
17 recorded as saying that:

18 "It is clear that the two consultants call the  
19 shots, and have put pressure on the Exec Team in making  
20 this decision."

21 And Dr Green stated:

22 "I was disgusted by their behaviour. It is likely  
23 that they lied."

24 Dr Green will be required by the Inquiry to explain  
25 how he arrived at this and other conclusions that he  
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1 draft of his investigation report. This largely  
2 mirrored the conclusions in his draft report of  
3 12 November 2016, save that the section dealing with the  
4 allegations against Letby was rewritten. We will ask  
5 why Dr Green now concluded that:

6 "Concerns raised by the consultants [in particular  
7 Dr Brearey], were raised through the appropriate  
8 channels in line with both the Trust Speak Out Safely  
9 policy, and the guidance proffered by the General  
10 Medical Council, (ie through the Executive Team).  
11 However, I do not find that the consultant concerns,  
12 when reiterated to the Executive Team, were 'clear,  
13 honest and objective'. I conclude that the Trust have  
14 considered the concerns of the consultants in line with  
15 both the disciplinary and Speak Out Safely policies, and  
16 believe that there was insufficient basis on which to  
17 undertake either a formal internal investigation, or to  
18 initiate a police investigation."

19 Letby's grievance hearing was heard on 1 December.  
20 The hearing manager was Annette Weatherley, Deputy Chief  
21 Nurse at University Hospital, South Manchester.  
22 Dr Green was present at the hearing.

23 The meeting began with Ms Weatherley stating that  
24 she had only received the papers for the hearing  
25 48 hours ago. It also appears that she may not have  
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1 made.

2 Ms Weatherley produced a written outcome of the  
3 grievance on 1 December, the same day as the grievance  
4 hearing. She concluded that Letby could have been  
5 supervised and her competencies repeated, as she had  
6 been told was the plan on 14 July. That the Trust's  
7 intention was that Letby cease professional, rather than  
8 social, contact with members of the NNU, but the  
9 miscommunication had resulted in Letby thinking that she  
10 was required to cease both, that the remit of the  
11 external reviews was not explained to Letby, and that  
12 the Trust generally had not been "as open and honest  
13 with Letby as they could be".

14 With regards to the evidence against Letby,  
15 Ms Weatherley concluded that:

16 "I have not seen, nor has there been any allusion  
17 to, any evidence relating to any alleged wrongdoing by  
18 yourself", although reference was made to "commonality  
19 between the dates and times that you were on duty, and  
20 the collapses/deaths of a significant number of a  
21 babies, but there is nothing to support that there is  
22 additional information or data beyond this that has not  
23 been shared with you."

24 Ms Weatherley adopted and quoted extensively from  
25 Dr Green's report regarding the allegations made by  
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1 Dr Brearey and Dr Jayaram, and in particular that their  
2 concerns were not "clear, honest and objective".

3 She concluded that a number of steps would be taken:  
4 one, the CEO and a non-executive representative would  
5 apologise to Letby in the presence of her parents; two,  
6 after the "final report" was received, and provided it  
7 contained, "no references to Letby", Letby would be  
8 informed in writing that she had, "no case to answer",  
9 and; three, mediation would take place with Dr Brearey  
10 and Dr Jayaram, and there would also be, "an apology  
11 from both consultants".

12 In line with Ms Weatherley's first step, a meeting  
13 was held on 22 December with Letby, her parents,  
14 Mr Chambers and Mr Harvey. Mr Chambers explained that  
15 a meeting with executives and consultants was planned to  
16 take place in the new year, "at which behaviours we  
17 expect to see will be clearly described, and then  
18 disciplinary action may follow if not followed."

19 Letby was also told that after this meeting, she  
20 could, "come back to the unit" when she was ready.

21 On 26 January 2017, a meeting took place between  
22 Mr Chambers, Mr Harvey and the Paediatric Consultant  
23 Body. Mr Chambers explained that the Speak Out Safely  
24 process had been "professionally managed" and there was  
25 no problem with "raising concerns, as that is fine".

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1 the wording sent out today, if possible."

2 However, the Inquiry has not seen any evidence to  
3 suggest that anyone at the hospital responded to Letby's  
4 email to correct her and to clarify that she had in fact  
5 not been investigated at all, let alone exonerated.

6 Mediation.

7 As already set out, the consultants complied with  
8 the request to send a letter of apology to Letby. This  
9 was sent on 28 February 2017. On the same day, a number  
10 of consultants met Mr Harvey and expressed their view  
11 that their professional opinions had not been given due  
12 regard, and that increased mortality was still  
13 unexplained.

14 Dr Brearey, Dr Gibbs and Dr Jayaram all stated that  
15 mediation was "occurring far too early, in view of the  
16 fact that there's still a great deal of uncertainty as  
17 to the cause of the rise in neonatal mortality and  
18 unexpected collapses."

19 On 1 March 2017, Mr Harvey emailed Dr Jayaram to ask  
20 him to make, "every effort" to engage in mediation with  
21 Letby, and wrote that:

22 "I think that this gesture would also go a long way  
23 to protect you from a possible referral to the GMC from  
24 other parties which, having supported many doctors, have  
25 done no wrong through, [sic] even then isn't

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1 However, a review by a "high-powered team does not call  
2 out a criminal act", and that there was now "a need to  
3 draw a line under the Lucy issue."

4 The consultants were expected to issue an apology to  
5 Letby and to engage in mediation.

6 This was followed up on 30 January 2017, by the  
7 letter that I've previously referred to from the  
8 paediatric consultants asking for written clarification  
9 on what the board understood the reason to be for  
10 increased mortality on the NNU, and to be allowed the  
11 opportunity to read the RCPCH and Dr Hawdon reviews  
12 prior to their publication.

13 On 31 January 2017, Letby emailed all staff on the  
14 NNU stating this:

15 "I was redeployed from the unit in July 2016  
16 following serious and distressing allegations of  
17 a personal and professional nature made by some members  
18 of the medical team. After a thorough investigation, it  
19 was established that all the allegations were unfounded  
20 and untrue, and I have therefore been fully exonerated.  
21 I have received a full apology from the Trust. I will  
22 begin making my return to the unit in the coming weeks."

23 The hospital appears to have been aware of Letby's  
24 email. On the same day, Ms Hodgkinson emailed Ms Cooper,  
25 the RCN rep, and Letby, asking for, "the final copy of

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1 a comfortable process."

2 A very similar email was sent to Dr Brearey on the  
3 same day.

4 Dr Jayaram responded the following day, stating that  
5 in his view, at least eight deaths and collapses were  
6 still unexplained, and he "really can't see how any  
7 effective mediation can take place at the present time  
8 but if you feel it's the right thing to do, I will  
9 attend the preliminary meeting after seeking advice from  
10 my BMA representative."

11 On 6 March 2017 Ms Rees emailed Ms Kelly, pointing  
12 out that Dr Brearey had pulled out of an initial  
13 mediation meeting, and seeking assurance that he would  
14 attend one on 16 March. This email was forwarded to  
15 Letby's RCN representative, Mr Millea, who followed it  
16 up on 7 March, suggesting that if Dr Brearey failed to  
17 attend a mediation, he ought to be "disciplined for  
18 breaching the terms of our grievance."

19 Dr Brearey emailed Ms Hodgkinson on the same day to  
20 explain that he was not available on 7 March, and  
21 emailed on 9 March saying:

22 "I would like to reiterate that I think it's  
23 inappropriate to be undertaking this process now, when  
24 the Trust is still investigating the cause of the  
25 increased neonatal mortality between June 2015 and

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1 July 2016."

2 Dr Jayaram attended initial an meeting with the  
3 mediator on 7 March. Following this, Dr Jayaram wrote  
4 to Ms Hodkinson on 13 March stating that he felt  
5 "extremely uncomfortable with this whole process", and  
6 that, whereas the mediator told him that the process was  
7 entirely voluntary, that contradicted the impression  
8 given by the Board, in particular Mr Harvey, "who  
9 intimated that by not engaging, I could increase the  
10 chances of being reported to the GMC for whatever I'm  
11 alleged to have done."

12 On 14 March, Ms Rees asked Ms Hodkinson to see that  
13 Dr Jayaram attended a mediation with Letby, as the plan  
14 was for Letby to be placed back on the NNU on  
15 3 April 2017.

16 Dr Jayaram met with Ms Hodkinson to discuss his  
17 concerns about the mediation process on 15 March. He  
18 explained he could not see how the process was helpful,  
19 whilst he remained of the opinion that Letby had harmed  
20 babies. He also mentioned that he had "heard from  
21 others ... possible disciplinary action, but also told  
22 by Ian there could be repercussions from others re GMC  
23 referral."

24 Dr Jayaram expressed his view that the board were  
25 not being given an accurate portrayal of the picture and  
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1 least Ms Kelly, Ms Hodkinson and Ms Rees.

2 Letby attended a tea party on the unit, in company  
3 with Nurse Z, which Yvonne Griffiths, Deputy Unit  
4 Manager, explained to staff was to welcome Letby back on  
5 to the unit.

6 Nursery nurse Jean Peers, in her evidence to the  
7 Inquiry, describes as the event as follows:

8 "I was on at the weekend. So was Yvonne Griffiths.  
9 She said that Letby was coming with Nurse Z, and that we  
10 would do a tea party to welcome her. We did cakes and  
11 tea, and she came in and we were all talking, and she  
12 did not say a word to us. Yvonne were talking a lot to  
13 make it nice and relaxed, and when she went, we both  
14 said, 'Oh my god, she's going to make it hard for us  
15 when she returns, she seems angry."

16 On 18 April, Letby had a conversation with  
17 Ms Hodkinson which she followed up with an email on  
18 19 April. In this email, she asked that an amended  
19 record of the 5 April meeting be sent to her  
20 specifically clarifying whether pausing her return to  
21 the NNU, and her ability to visit the NNU, constituted,  
22 "advice or a management instruction".

23 An amended record of the 5 April 2017 meeting was  
24 duly sent to Letby on the 24th, clarifying that this was  
25 provided "as a management instruction", and "to support  
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1 were not being advised by a neonatologist, and as a  
2 result, they were "going down a path and set on a path."

3 Ms Hodkinson reassured him that his concerns had  
4 been treated under the Speak Out Safely policy.

5 Dr Jayaram explained that he was concerned the Board  
6 was more concerned about a possible employment claim by  
7 Letby than patient safety.

8 Dr Jayaram attended a mediation session with Letby  
9 on 28 March. He wrote an email to Ms Hodkinson on  
10 30 March stating that during this mediation session, he  
11 felt "as if I'd been hung out to dry there."

12 He had been asked whether he was "happy to move on",  
13 and whether he "still thought there was a possibility  
14 [Letby] may have done something."

15 He also objected to the fact that Letby had been led  
16 to believe that he and Dr Brearey had orchestrated a  
17 campaign against her, and that they had given an  
18 ultimatum to the Trust that if she was not suspended,  
19 they would call the police. He asked for minutes of  
20 board meetings and copies of grievance documents.

21 On 5 April, Letby was informed that her return to  
22 the NNU was to be paused, and that it was recommended  
23 that she ceased to visit the unit. It appears that  
24 Letby had visited the NNU unsupervised on one occasion  
25 in the last week of February 2017 with the knowledge of  
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1 your successful transition back to the unit, we would  
2 advise, as a management instruction, that we again pause  
3 with these visits at this time."

4 From his point of view as the Medical Director,  
5 Mr Harvey has told the Inquiry:

6 "I do not think the grievance process was conducted  
7 to the highest standard, and I think it resulted in  
8 a lot of grief and angst for the consultants. I feel  
9 the grievance strayed into the rights of members of  
10 staff to raise concerns, rather than some of the  
11 behaviours that occurred subsequently. I think this  
12 contributed to the distrust the consultants had in the  
13 executives."

14 Ms Kelly, the Director of Nursing and Quality, has  
15 said in her statement:

16 "I have reflected on the appointment of Chris Green  
17 to lead the investigation into the grievance, and in  
18 hindsight, I think we should have selected someone who  
19 was completely independent from the hospital."

20 My Lady, there are a number of obvious and  
21 intertwined issues which arise from the sequence of  
22 events we have referred to.

23 Was it right that, as a result of them raising their  
24 concerns, pressure was brought to bear on Dr Brearey and  
25 Dr Jayaram in a number of ways: the mention of possible  
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1 referral to the GMC; the suggestion that action might be  
 2 taken under the bullying and harassment and disciplinary  
 3 policies; the requirement to apology to Letby and to  
 4 attend mediation sessions with her?

5 The grievance manager was a nurse from  
 6 a neighbouring trust. Was she truly independent in her  
 7 role? Was the grievance manager given sufficient time  
 8 to prepare for the grievance hearing? And did she have  
 9 sufficient time to reflect carefully on her decision?  
 10 Was she fully appraised of, and did she fairly take into  
 11 account, all of the paediatric consultants' concerns  
 12 about the unexplained deaths?

13 Was the investigating officer, Dr Green, the right  
 14 person for the job, in light of the concerns raised by  
 15 Dr Brearey about a prescribing error in relation to one  
 16 of the deceased babies, which Dr Green agrees in his  
 17 statement led to a degree of tension between the two of  
 18 them in April 2016? Was any pressure brought to bear on  
 19 Dr Green to change his conclusions he held in a meeting  
 20 with Mr Cross between the production of the draft and  
 21 final versions of his investigation report that I have  
 22 read? If not, how and why do these changes appear?

23 Why was the Trust Speak Out Safely policy not  
 24 complied with? In particular, why weren't  
 25 investigations, as required by the policy, carried out?

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1 all very much.

2 (4.04 pm)

3 (The hearing adjourned until 10.00 am the following day)

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1 Was any consideration given to the referrals set out in  
 2 the policy to the Local Authority Designated Officer?  
 3 If not, why not?

4 Were executives at the Trust fearful of constructive  
 5 dismissal proceedings being brought by Letby, and did  
 6 this affect, or potentially affect, their decision  
 7 making?

8 Why was legal advice from DAC Beachcroft  
 9 commissioned by the Executive Director of Human  
 10 Resources rather than the Trust's legal department? Why  
 11 was legal advice from DAC Beachcroft obtained an *ad hoc*  
 12 manner, and why were documents not sent to  
 13 DAC Beachcroft when requested by them? Why was so  
 14 little legal advice seemingly obtained regarding the  
 15 investigation and grievance processes?

16 And above all, does this evidence reveal an abject  
 17 failure by those investigating and supporting Letby to  
 18 engage with basic principles of safeguarding and the  
 19 need to keep babies in hospital safe?

20 My Lady, I think that's a natural moment to conclude  
 21 because Mr de la Poer will be taking us to the board  
 22 tomorrow.

23 **LADY JUSTICE THIRLWALL:** Very well. Thank you very much  
 24 indeed, Ms Langdale.

25 We will resume tomorrow morning at 10.00. Thank you  
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<b>2</b>	165/17 205/15 <b>3 June [1]</b> 109/21 <b>3 June 2017 [1]</b> 163/5 <b>3 kilograms [1]</b> 41/25 <b>3.00 [1]</b> 155/20 <b>3.15 [1]</b> 45/2 <b>3.45 am [1]</b> 45/4 <b>3/4 [1]</b> 62/21 <b>30 [9]</b> 7/9 26/8 32/24 85/3 97/17 127/24 166/7 166/13 202/6 <b>30 December 2016 [1]</b> 156/5 <b>30 June [2]</b> 125/23 126/3 <b>30 June 2016 [1]</b> 195/5 <b>30 March [1]</b> 206/10 <b>30 September [1]</b> 76/19 <b>30 years [1]</b> 98/11 <b>31 [4]</b> 17/12 68/4 176/15 202/13 <b>31 August [1]</b> 134/21 <b>31 October 2015 [1]</b> 81/17 <b>32 [1]</b> 84/17 <b>33 [3]</b> 95/4 111/20 112/10 <b>34 [2]</b> 74/13 75/15 <b>37 [1]</b> 41/24 <b>3rd [1]</b> 63/8	<b>60 [1]</b> 43/8 <b>692 grams [1]</b> 89/13 <b>6pm [1]</b> 20/7	<b>7</b>	72/19 76/11 77/22 77/23 79/6 82/1 91/21 91/23 92/3 92/12 94/5 94/19 95/5 95/21 97/11 99/1 101/8 101/14 101/16 101/20 103/23 106/6 106/7 106/9 106/18 110/7 111/14 113/7 114/10 114/14 115/20 115/24 116/13 116/25 117/4 117/5 117/20 117/22 118/23 120/10 121/16 122/12 122/16 123/15 125/13 126/12 134/15 134/17 137/18 139/22 146/14 148/2 148/25 149/3 154/15 156/23 157/13 158/4 158/12 161/8 161/13 161/19 162/21 168/5 170/2 174/5 174/11 175/10 175/20 177/14 183/6 184/25 185/9 186/19 188/22 189/23 190/23 192/22 196/17 197/6 199/3 205/17 206/6 209/12 209/15 <b>above [5]</b> 79/25 120/24 159/1 170/2 210/16 <b>abroad [1]</b> 111/7 <b>absence [2]</b> 88/1 129/23 <b>absolute [1]</b> 19/17 <b>absolutely [4]</b> 5/22 105/2 124/8 157/16 <b>absurd [1]</b> 70/14 <b>academic [1]</b> 26/4 <b>accept [5]</b> 124/16 124/17 136/3 165/12 196/19 <b>accepted [4]</b> 39/1 65/3 70/17 164/22 <b>accepts [5]</b> 65/10 67/17 70/20 71/17 130/25 <b>access [4]</b> 73/2 109/18 141/25 144/1 <b>accident [1]</b> 90/13 <b>accidental [1]</b> 70/2 <b>accidentally [1]</b> 7/6 <b>accommodate [1]</b> 48/2 <b>accompanied [1]</b> 189/4 <b>accompany [1]</b> 150/20 <b>accompanying [1]</b> 150/22 <b>according [7]</b> 54/4 101/19 108/24 113/18 117/20 170/16 175/11 <b>Accordingly [2]</b>	161/18 161/24 <b>accords [1]</b> 108/17 <b>account [7]</b> 11/18 57/25 105/19 132/5 132/13 177/17 209/11 <b>accountants [1]</b> 193/13 <b>accounts [1]</b> 106/17 <b>accurate [2]</b> 135/1 205/25 <b>accusations [1]</b> 196/20 <b>acknowledged [2]</b> 165/4 167/13 <b>acknowledges [1]</b> 90/14 <b>acknowledging [2]</b> 34/18 133/7 <b>acquitted [1]</b> 2/23 <b>across [7]</b> 43/16 43/17 54/10 82/4 88/21 99/2 108/12 <b>act [8]</b> 4/8 4/9 31/5 152/2 160/5 187/4 188/11 202/2 <b>acted [1]</b> 20/13 <b>acting [2]</b> 123/6 123/8 <b>action [20]</b> 52/7 52/9 82/22 91/15 93/2 99/12 99/20 103/21 107/23 108/18 118/4 124/10 125/6 126/3 126/7 153/4 189/10 201/18 205/21 209/1 <b>actions [17]</b> 16/16 20/14 41/16 61/2 88/18 107/9 108/5 110/4 112/16 118/11 127/5 153/14 157/10 178/2 183/22 183/22 189/25 <b>active [2]</b> 26/24 28/10 <b>activities [1]</b> 141/15 <b>activity [9]</b> 121/18 122/5 122/13 132/8 132/10 132/12 133/15 174/22 178/3 <b>acts [2]</b> 10/10 29/2 <b>actual [1]</b> 134/10 <b>actually [1]</b> 57/7 <b>acuity [6]</b> 103/16 129/13 132/16 132/20 133/23 178/4 <b>acute [5]</b> 27/4 47/6 61/19 62/9 188/3 <b>ad [1]</b> 210/11 <b>ad hoc [1]</b> 210/11 <b>adamant [1]</b> 117/21 <b>add [1]</b> 4/24 <b>added [5]</b> 30/22 68/16 90/25 95/22 151/2	
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<b>3</b>	<b>4</b>	<b>9</b>	<b>A</b>	<b>970 grams [1]</b> 76/14	<b>9</b>	<b>970 grams [1]</b> 76/14
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<b>A</b>	65/22 65/23 124/18 170/13	<b>aim [1]</b> 4/12	72/20 181/17	<b>although [16]</b> 39/20 54/12 58/13 59/24 65/21 67/13 71/20 91/16 112/10 126/21 127/16 173/25 176/14 177/22 195/24 200/18
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