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

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.

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.

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

and assistance the Inquiry has received from Liverpool City Council and its staff. At short notice, they have made it possible for the openings to be heard in this Council Chamber and for the evidence to be heard in other parts of this historic building in due course. Like the Inquiry team, they have put the parents at the heart of their planning and I am very grateful to them.

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

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

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

The convictions stand.

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

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

Ms Langdale.

Opening statement by MS LANGDALE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

and damaging.

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

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

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

It is important that we stress at this early stage

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

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

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

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

All of the witnesses from whom we have received

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

He took time off as result.

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

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

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

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

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

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

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

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

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

Also, she said:

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

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

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

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

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

Dr Wood goes on to say:

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

Shock was also felt by those who had cared for

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

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

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

She remembered:

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

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

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

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

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

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

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

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

Dr Harkness described the rash as:

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

Dr Harkness said in his police witness statement:

"In my professional career, this spans over

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

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

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

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

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

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

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

(10.32 am)

(A short break)

(10.33 am)

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

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

Ms Langdale.

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

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

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

"I do recall discussions between the paediatric

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

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

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

In a police statement Dr Jayaram comments on the rash:

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

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

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

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

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

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

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

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

"All obs satisfactory, active and handling well."

Dr Lambie recalls receiving a crash bleep to attend

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

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

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

"Upon my arrival, purple blotchiness."

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

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

Query of course is double question mark.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

It is unclear whether that debrief was held. Dr Harkness recalls Dr Jayaram being supportive and sitting with him immediately following the death, but he cannot recall any specific debrief.

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

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

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

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

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

required."

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

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

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

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

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

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

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

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

Child C.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr Davis sets out her observations on arrival at of

the unit in her statement to the police:

"He had gone from being fine and well to nothing in a very short space of time."

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

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

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

Dr Gibbs comments that Child C:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Child D.

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

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

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

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

Nurse Oakley also comments in her police statement that:

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

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

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

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

notes:

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

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

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

This rash is noted as followed in the medical records:

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

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

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

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

He went on to say:

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

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

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

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

Child D initially improved and was considered stable

by Dr Brunton at 02.35 hours.

At 3.15 am she deteriorated again, and Dr Brunton was recalled. Again, she stabilised. However, at 3.45 am, Child D collapsed for a third time and stopped breathing.

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

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

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

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

a postmortem examination given the circumstances of the collapse."

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

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

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

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

The additional information given to the Coroner included:

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

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

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

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

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

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

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

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

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

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

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

"From informal discussion between us consultants around July 2015, several of whom had each been involved with a death on the NNU, it was recognised that Letby had been present on each occasion and that this was also

noted at the Serious Incident Meeting on 2 July 2015. Letby worked more shifts than other neonatal nurses and I felt, as did my consultant colleagues at the time, that she was merely unfortunate to have been involved in the cluster of deaths. I was not suspicious of deliberate patient harm to either Child C or the other babies who died in June 2015."

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

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

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

Letby responded to this question with the following:

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

Nurse T responded:

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

In her statement to the Inquiry Nurse T explains her

messaging as follows:

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

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

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

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

due to the similar and unexpected nature of their collapses and appearance of the unusual rash.

She goes on to say:

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

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

"I was almost expecting something bad to happen."

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

This email said the following:

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

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

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

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

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

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

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

In advance of the meeting to discuss the three

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

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

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

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

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

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

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

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

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

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

will be scrutinised in oral evidence.

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

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

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

LADY JUSTICE THIRLWALL: Yes, thank you very much indeed, Ms Langdale. So we will break for 15 minutes, and will be back ready to start at 11.30. Thank you.

(11.14 am)

(A short break)

(11.30 am)

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

MS LANDGALE: Thank you.

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

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

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

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

In fact, it was to take the sudden and unexpected

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

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

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

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

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

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

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

Neonatal Mortality Meetings.

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

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

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

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

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

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

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

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

babies that had collapsed.

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

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

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

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

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

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

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

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

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

Child E and Child F.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

However, he tells the Inquiry:

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

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

death:

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

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

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

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

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

to the Steering Group.

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

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

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

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

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

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

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

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

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

Dr Gibbs, the consultant on call.

The low blood sugar persisted the following day, despite glucose being administered. Blood samples were taken and, on 5 August 2015, sent for analysis. When the intravenous feeds were stop and the TPN bag was taken down, the blood sugars started to increase.

Analysis of the blood samples showed low C peptide to insulin. This caused the Laboratory Senior Clinical Scientist, Heather Wilshaw-Jones, to call the Trust and speak to the "Countess of Chester Biochemist." The laboratory were not in possession of the clinical details and did not know whether insulin had been prescribed for Child F. The note made by Ms Wilshaw-Jones of her call states:

"Low C peptide to insulin? Exogenous - suggest send sample to Guildford for Exogenous insulin."

The results were reviewed by Dr Lyddon, who in turn discussed the results with Doctor ZA. The results were recorded in the medical records on 13 August 2015, with an indication, shown by vertical arrows, that the insulin levels was high and the C peptide level was low.

Doctor ZA in her statement to the Inquiry noted that the results were confusing, as they suggested, "... that Child F was given exogenous insulin (ie insulin injected externally)." She recalls that she checked and

established that no other baby on the neonatal unit had been prescribed insulin, making accidental administration unlikely.

She states that:

"I felt the most likely explanation for the results was some sort of inaccuracy with the test and I would have liked to repeat them, but Child F had no further periods of hypoglycaemia and was transferred back to his local unit. It is our usual practice to repeat neonatal bloods that do not fit with the expected clinical picture."

Doctor ZA notes that she did consider whether insulin could have been delivered deliberately and says:

"But this seemed absurd and ridiculously unlikely, so the tests being wrong seemed the only possible explanation."

Doctor ZA accepted in her police statement that:

"With hindsight, I should have flagged up this unexpected result."

Dr Gibbs, like Doctor ZA, also accepts that the results were not interpreted correctly. In his statement to the Inquiry, Dr Gibbs says:

"I helped during the initial management of Child F's low blood glucose in August 2015, at which time infection was suspected. Low blood glucose is a common

problem in babies in early life, more so in premature babies. Blood results in Child F indicated that the low blood glucose was likely to have been caused by the administration of synthetic insulin. These blood results were only available several days after being taken, by which time the low blood glucose had resolved. The results were not interpreted correctly at the time and, so highly regrettably, an indication that someone was deliberately harming patients was overlooked. Not being aware of these insulin results meant that Child F did not cause me to be suspicious of deliberate harm on the NNU."

Dr Gibbs did not know about Child F's insulin and C peptide results at the time they were received but notes that each of the consultants was responsible for the patients on their NNU when on-call or undertaking consultant of the week duties. As such, he accepts that he and his consultant colleagues had the opportunity at various times to review results on any of the babies, although this would normally only be done if there was a concern about a baby.

Dr Gibbs characterises it as a "collective failure" on the part of the paediatric team to have not recognised the significance of the insulin and C peptide results in Child F in mid-August 2015.

The medical director, Mr Ian Harvey, said in his statement to the Inquiry:

"This situation, the insulin result, was not reported to me at any time before my retirement. It should have been. I feel strongly that had this been reported to me, this would have alerted me to an urgent problem and significantly altered my perception of the events on the neonatal unit."

It was not until 2017 that the issue of deliberate administration of insulin seems to have been raised. Doctor ZA says:

"When I was on maternity leave in 2017, it occurred to me that the intentional administration that seemed impossible at the time could have happened."

On 6 June 2017, Doctor ZA sent an email to Dr Brearey raising her concerns about insulin. By this stage, the police had been contacted and investigations were taken forward.

My Lady, in light of what we know about the facts of this case, and indeed the facts of the Allitt case and others, where the deliberate administering of insulin has been used to cause harm, you may consider that this is an area that requires particularly careful consideration.

Both Dr Gibbs and Dr Brearey reflect on this issue

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

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

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

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

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

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

By 6 September 2915, Child G was considered a special care baby and was being cared for in nursery 2. Dr Brearey reviewed Child G on 6 September and confirmed she was stable and improving and preparations for her discharge home continued.

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

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

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

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

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

transferred to Arrowe Park on 27 September 2015.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ms Powell responded to Dr Brearey as follows:

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

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

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

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

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

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

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

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

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

There is no indication of any wider discussion at

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr Brearey says:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"The nurse in charge of the baby [Child K], Jo Williams, had gone to speak to the parents in the labour

ward."

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

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

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

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

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

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

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

In March 2016, Dr Brearey produced his second version of the February thematic review. This report, at the suggestion of Dr Subhedar, added a theme "Sudden

deterioration". Under this heading, it noted:

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

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

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

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

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

Dr Jayaram says this proposed meeting between the three of them never took place. However, from

November 2015, Dr Jayaram says he had several "corridor conversations" with both Dr Brearey and other consultant colleagues about his concerns.

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

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

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

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

earlier from Dr Brearey.

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

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

We will consider the move to day shifts first.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr Harvey has stated of Child L's insulin result

that:

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

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

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

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

A paper towel with the drug administration notes

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

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

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

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

Ms Millward is not the only witness to raise

concerns about potential inadequate use of the incident reporting system. It is a topic across all of the babies who were murdered or harmed that the Inquiry will be investigating carefully.

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

Dr Brearey in his statement to the Inquiry comments:

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

A matter the Inquiry will be exploring is the apparent delay in the Thematic Review of the Neonatal Mortality document being considered at the Quality, Safety and Patient Experience committee. You will remember, my Lady, that the first version was completed on 8 February. This Committee met on 15 February. There was a further meeting on 21 March, which took place nearly three weeks after the second version of the thematic review of neonatal mortality documents completion.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In the covering email, Ms Powell stated:

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

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

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

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

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

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

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

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

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

Kelly, and the notes of the meeting include the comments, "absolutely no issue with nurse" and "circumstantial".

Dr Brearey has said of this meeting in his written evidence to the Inquiry:

"I felt that the number of deaths in 2015 and early 2016 were exceptional. I highlighted that six of the nine deaths occurred between midnight and 4 am, which was unusual. I highlighted that there seemed to be a disproportionately high number of sudden and unexpected collapses. We had reviewed care on multiple occasions including with an external neonatalologist and the only common theme was with Letby being on duty. We needed guidance on help to take this forward. I also made it clear these were concerns of my colleagues and were not mine in isolation".

Ms Kelly described Ms Powell as being vociferous at this meeting saying there were no issues with Letby whatsoever. Dr Brearey gives a similar account, noting that, "Eirian Powell was very defensive of Letby at the meeting". Also that Ms Murphy and Eirian Powell countered his concerns "forcibly and with great emotion".

In his statement to the Inquiry, meanwhile, Mr Harvey has said of this meeting:

"There had been no suggestion to me that a meeting was required urgently and I did not try to schedule it faster."

He goes on to say:

"The tone of the meeting was calm and I don't recall anyone being aggravated or forthright about a concern about Letby."

In her statement to the Inquiry, Ms Kelly speaks about Ms Powell talking through the notes which Ms Powell had prepared on 5 May. Ms Kelly states:

"The overall impression I got from this note was that there was a reasonable explanation for Letby being on shift for more of the deaths than other nurses due to the hours she worked and that she was a well-regarded nurse."

This is an important meeting, my Lady, and the Inquiry will be examining closely the accounts from different witnesses about what was said, what was decided, and upon what basis. Whether deliberate harm had been caused to babies by the nurse they had identified as having an opportunity to do so could only be understood by detailed, forensic investigation and medical analysis of deaths and collapses on the unit. Instead of ensuring that in-depth analysis was undertaken, however, the focus appears to have rested

upon the supervision. While Letby was present, the hours she worked, what staff may have thought of her, and the fact that coincidences can and clearly do occur.

Ms Harvey has said of his and of the position at the conclusion of this meeting:

"We were dealing with a spike in deaths on the NNU which were unexplained despite thorough review and we were assuring Dr Brearey we, the executives, were aware and supported the actions being undertaken by the clinical team. At no stage during this meeting did I feel that it was being reported because there was worry that Letby was responsible for the deaths."

Ms Kelly has told the Inquiry:

"Based on the information provided at the meeting, there was nothing at all to justify an immediate suspension of Letby. Had I been told that she'd been seen doing anything that compromised the safety of any patient or that there was evidence of potential intentional harm being caused to any of the babies, I would have immediately moved to have her suspended from the unit."

Ms Kelly recorded in her notes of this meeting at the time that the action plan which was agreed was that a review would be conducted of any further babies who suddenly collapsed or deteriorated to conduct a further

deep dive into neonatal deaths which had taken place during the night, and have a follow-up meeting in July.

Ms Kelly's notes are in contrast to Dr Brearey's recollection that other than meeting again in two months, there seemed no actions from the meeting. Dr Brearey has told the Inquiry he felt the response from Mr Harvey and Ms Kelly was inadequate.

As a follow-up to the meeting on 11 May, Dr Brearey sent an email on 16 May to his fellow paediatric consultants copying in Ms Powell and Ms Murphy. His request to his fellow consultants was as follows:

"If you do come across a baby who deteriorates suddenly or unexpectedly, or needs resuscitation on the NNU, please could you let me and Eirian know. We will keep a record of these cases and will review them as soon as practicable."

This email accords with part of Ms Kelly's handwritten note of the action plan and what Mr Harvey has told was his expectation following the meeting. It says:

"In addition to this, following this meeting, I would have expected to have been made aware of any concerning issues on the NNU by the neonatal team."

According to Ms Powell's interview, given as part of Letby's grievance process, there was an urgent care

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

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

(12.43 pm)

(The Short Adjournment)

LADY JUSTICE THIRLWALL:

(The Short Adjournment)

(1.45 pm)

LADY JUSTICE THIRLWALL: Ms Langdale.

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

Child N collapsed on 3 June, an incident that Child N's father says he and Child N's mother were not informed of at the time, and twice on 15 June. Letby was convicted of attempted murder in relation to the collapse on 3 June, the jury couldn't reach a verdict in

relation to the incidence on 15 June.

Mr Harvey has told the Inquiry:

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

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

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

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

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

The Inquiry has considered the various messages that Letby was sending insofar as they give any insight that fall within the Inquiry's terms of reference. From May 2016, Letby was involved in frequent Facebook

messaging with Dr U, who was a paediatric registrar at the hospital. Over 1,300 Facebook messages were exchanged between Letby and Dr U between mid-June 2016 and September 2016.

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

In his Inquiry statement Dr U states:

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

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

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

This was a death that shocked those on duty.

Nurse Taylor was the day shift leader on 23 June. In her statement to the Inquiry she says:

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

Nurse Bennion's evidence is similar:

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

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

On Friday 24 June, Ms Rees was called to the office of Ms Karen Townsend, the Director of Urgent Care. Child O had died the previous evening. Ms Rees said

that in that meeting she was told that Dr Brearey and Dr Jayaram "both thought that Lucy was purposely harming babies".

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

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

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

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

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

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

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

Mr Harvey has said of Ms Rees's statement about him:

"She suggests that she escalated concerns to Alison and that she is aware Alison immediately found me and discussed them with me. I do not think this is correct. I do not remember a conversation about this on that day."

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

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

Ms Kelly says she does not believe that her

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

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

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

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

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

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

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

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

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

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

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

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

Later that day there was a meeting of the

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

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

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

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

"We, the senior paediatricians, have significant concerns about the increased mortality on the neonatal unit, the sudden deterioration of apparently well babies with no cause identified and the presence of one member

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

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

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

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

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

"With regard to Letby remaining on the unit, this was a difficult balance as it was difficult at this stage to understand what the issue or issues were, and whether it might relate to her competency or performance or was completely unrelated to her practice. As far as I can recall, Letby was on annual leave so we had some time to figure out what we were going to do before she would be patient-facing again. My general recollection of the days that followed is that the clinicians became more vociferous about her being removed whilst the nurses wanted her to remain on the unit. My recollection is that ultimately, Letby returned to the unit."

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

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

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

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

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

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

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

"Death of triplets has raised concern.

"Nurse was on duty at deaths.

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

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

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

At 8.16 on 29 June, Dr Saladi, a consultant paediatrician, began the email conversation. A substantial part of it bears repetition now:

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

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

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

Dr Saladi concludes:

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

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

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

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

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

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

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

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

are protected."

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

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

Dr Jayaram replied:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Internal reviews.

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

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

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

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

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

"I believe the reference to a review being conducted

allocated to me was a review of NNU data. I was assisted in this by Robert Cheetham, a data analyst."

He goes on to state:

"This took place during the two weeks that Letby was an annual leave in July 2016. This was not a clinical review of each death as I am not a neonatologist. I undertook an overarching service review looking at intensity levels, the number and nature of admissions. This involved tasking the data team with compiling the relevant data for me to look at and feed back to the Board. The purpose of this review was to see if there were any potential issues contributing to the rise in neonatal mortality such as an increase in acuity or difficulties on the NNU."

The review by Dr Gibbs and Nurse Martyn.

Dr Gibbs and Nurse Martyn were also commissioned to review a number of babies that had been on the neonatal unit between 2015 and 2016. Dr Gibbs of course was a consultant paediatrician and Nurse Martyn, who is now Anne McGlade, was the Ward Manager for the children's ward and a qualified children's nurse. Nurse Martyn was involved as she was the most senior nurse in the Trust in the absence of her line manager, Nurse Murphy, the Lead Children's Nurse, who was off work at the time. Nurse Martyn was not a neonatal nurse, it appears to

have been the view of Dr Gibbs that involving a neonatal nurse may have caused potential conflict in terms of being involved in reviewing colleagues' practice and that Nurse Martyn was an experienced and respected children's nurse.

Nurse Martyn says she was informed by Dr Gibbs that the purpose of their review was to, "see if anything unusual or unexpected of the collapses or deaths presented itself" and to look at, "discrepancies in care".

The babies including in this review were those who had collapsed or deteriorated in the neonatal unit and needed to be transferred out of the hospital. Dr Gibbs in his statement to the Inquiry notes:

"Non-fatal collapses were not well defined and were not monitored and reviewed on our NNU. Concentrating on the cohort of babies who required transfer from the NNU would identify some of the babies who had suffered non-fatal collapses. It had been my impression, and that of my consultant paediatric colleagues, that Letby had been involved in many of the non fatal collapses but I did not have, nor was I aware of anyone else having, data against which to assess staff involvement in non-fatal collapses."

As Dr Gibbs accepts, a limitation of the exercise

was that "it would not identify any non-fatal collapses where the baby remained on the NNU in Chester".

Of the indictment babies, this review included Child F and Child Q.

It would appear that of the 17 babies reviewed, Dr Gibbs and Nurse Martyn identified six cases in which it appeared that something or unexpected or unusual occurred. Of these six, Letby had been involved with three babies at the time concerned and had been involved in prior care for one further baby. We'll be considering whether the parameters of this review were appropriate to address the concerns raised by the consultants and investigating what, if anything, was done as a result of its conclusions.

In July 2016 the Director of Nursing and Quality, Ms Kelly, and Ms Millward, prepared what they described as a "position paper" for the Executive Team. This document looked at the "key mortality data", and provided:

"A supplementary narrative to enable an assessment of the patient safety concerns identified by the neonatal clinicians relating to an apparent increase in the number of neonatal deaths during 2015 to 2016 and 2016 to 2017."

We will not look at the detail of this position

paper at this stage but simply note the findings.

The document considers the significance of the change in mortality levels. It concludes:

"Fluctuation due to common cause variation cannot account for the increased mortality seen in the neonatal unit."

The document considers whether a general increase in activity on the neonatal unit might explain the increase in mortality levels. It concludes:

"Similar periods of increased activity recorded in previous years have not been associated with an increased mortality. Therefore, activity levels alone cannot account for the increase but may be a contributory factor."

The document considers whether an increase in patient acuity, that is to say whether the neonatal unit was dealing with babies who were more gravely ill than in previous years, was the cause of the increase in mortality. It concludes:

"An increase in sustained acuity level may be a contributory factor."

The document considers whether staffing levels were a contributory factor, reaches no conclusion on this, but points to the fact that the neonatal unit did not consistently meet the British Association of Perinatal

Medicines recommended level. Under the heading "Recommendations" the document says only this:

"The Executive Team is asked to note the challenges to the analysis undertaking and the findings of this mortality review."

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

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

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

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

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

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

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

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

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

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

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

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

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

The minutes record that Dr Jayaram said:

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

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

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

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

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

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

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

On 18 July the Executive Directors met. The

handwritten notes of the meeting record that Sue Hodkinson, the HR Director, reported:

"Pressures on unit/cannot guarantee [one to one] supervision/redeploy to risk team/'no investigation' reiterate/explain done all data work."

It appears that the view that Letby could return to the ward had been changed. Ms Millward reports in her witness statement that Letby was allocated adult low level complaints and that she does not recall Letby having direct patient contact between July 2016 and March 2017. Ms Millward also considers that, "in retrospect it would have been more appropriate to redeploy Letby to another service".

The transfer of Letby to the Risk and Safety Team was always intended to be a temporary measure. At this stage we highlight just three instances in the five months following her transfer to illustrate what was being said about that transfer while it was occurring.

In September 2016 the issue of where Letby was to work was raised. Ms Rees, the Head of Nursing for the Urgent Care Division wrote to Ms Kelly. Ms Rees described the decision to delay allowing Letby return back to the neonatal unit as "wrong and immoral". She went on to suggest that it was "based on a senior clinical having a 'gut feeling' with no evidence",

adding:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Fourth, and most significantly at this stage, on

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

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

This recommendation goes on to say:

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

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

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

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

"Details of all staff with access to the unit from

four hours before the death of each infant. Ancillary and facility staff should be included."

And finally:

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

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

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

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

Approximately one month later on 5 October, Mr Harvey sent a letter of instruction to Dr Hawdon.

The terms of the instruction appear to have been lifted from the five elements which were set out in the RCPCH's letter of recommendation.

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

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

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

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

Neither was Dr Hawdon in a position to set out

details of all staff with access to the unit from four hours before the death of each infant, as had been requested. She proposed that this work was done at the local level and should include the period before a collapse rather than the period before death.

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

Dr Hawdon concluded her letter by saying:

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

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

It goes on to say that:

"Subject to the Coroner's postmortem reports there should be broader forensic review" of each of these five cases, because, "after independent clinical review, these deaths remain unexpected and unexplained".

In the case of Child I, Dr Hawdon advised that, "cause of death as given in postmortem report should be reviewed given babies stable in air days preceding collapse".

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

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

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

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

histopathology of four cases".

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

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

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

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

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

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

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

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

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

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

"I believe it is likely that Dr Hawdon was provided

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

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

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

Mr Harvey has said of what he told Dr Hawdon about

Letby:

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

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

In terms of what she meant by "local forensic review", Dr Hawdon has told the Inquiry that she meant a detailed review by an appropriately skilled team of the entire circumstances of care of each baby including around the times of deterioration and death. This, she stated, would require presence on site of suitably skilled professionals to align the clinical circumstances to the local environment, workload and

staffing.

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

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

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

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

"Based on my own experiences as a neonatologist and having held medical leadership roles, it is my personal opinion that there was insufficient covering information and explanation provided to the families to accompany my reports. It is my opinion that it was appropriate to share the reports but with accompanying information and explanation, preferably in a face-to-face meeting, especially at a time of grief. It is my personal opinion that the case review reports alone would have

been difficult for families to understand and could have added to confusion and grief."

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

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

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

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

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

pathologist trained and experienced in investigating deaths which may have been caused by a criminal act, should have been instructed.

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

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

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

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

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

Overall and for now, the grievance was upheld in part. The hearing was chaired by Annette Weatherley on 1 December 2016. Ms Weatherley was the Deputy Chief nurse at the nearby University Hospital South

Manchester. She proposed that Dr Brearey and Dr Jayaram engage in mediation with Letby and that all the consultants who had made allegations apologise with disciplinary action being recommended against anyone who did not comply. Furthermore provided the RCPCH report contained no reference to Letby, she, Letby, should be given written confirmation that there was, "no case to answer".

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

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

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

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

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

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

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

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

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

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

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

"Part of this sharing is as an organisation drawing

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

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

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

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

My Lady, I notice the time.

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

(2.42 pm)

(A short break)

(2.58 pm)

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

Ms Langdale.

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

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

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

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

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

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

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

Ms Kelly is recorded at the meeting as saying:

"We were trying to protect the individual in some ways as our feelings were that we really believed an individual was the causal factor of change of survival rates on the unit we would have called the police. However, we didn't feel this was the case."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

for her to return to the neonatal unit.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr Chambers is recorded as saying:

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

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

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

Later, Mr Chambers is recorded as saying that:

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

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

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

successful with her grievance.

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

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

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

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

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

Executive Directors.

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

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

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

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

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

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

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

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

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

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

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

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

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

He went on:

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

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

Dr Subhedar went on: “I would recommend extending

this to the seven cases that I have identified."

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

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

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

We will also be exploring with Mr Harvey what his reaction to this email was. In particular, we will be exploring what steps, if any, he had taken since Dr Hawdon's recommend three months earlier to conduct a broader forensic review in some cases.

In early February 2017, Dr Hawdon's report was released to the neonatal consultants. This prompted a letter from seven consultants. That letter was addressed to the Chief Executive, Mr Chambers. The consultants stated that they were not reassured by the reports that the deaths and collapses were explicable by natural causes. They said that they agreed with Dr Hawdon that there were four babies which required

broader forensic review, but there were two additional cases over and above the four identified about which the consultants were concerned. They request that Mr Chambers urgently ask the Coroner to conduct a full investigation of all deaths and unexpected collapses between June 2015 and July 2016.

The letter went on to say that:

"The RCPCH report had not identified a cause for the sudden increase in neonatal mortality."

It concluded by saying:

"We hope that a comprehensive external investigation will be in the best interests of the bereaved families and those affected by these sad events."

Four days after the date of the consultants' joint letter and Dr Subhedar's email, the Executive Directors Group met. The meeting began according to the note made of it with Mr Chambers observing that as a result of the consultants' letter, matters "seemed to have gone backwards".

Mr Harvey is recorded as replying "Wondered what they were plotting".

Mr Harvey has told the Inquiry that he does not recall saying this. If this was said, the Inquiry will be investigating whether by this stage a relationship of trust between the consultants and Executive Directors or

any of them had truly broken down.

Mr Chambers is recorded as raising what the awareness of the Coroner and Dr Hawdon was of the "Lucy issue". The note of the meeting indicates that Mr Harvey intended to go through the clinical notes and look again at the rota. It is recording that more detail would be sought from Ms Williams and Ms Fogarty, the two people who had carried out the analysis of the rota in July 2016.

In the course of the meeting on 14 February, Ms Kelly is recorded as noting that the plan for Letby's return to the neonatal unit was being finalised that week. The note records Mr Chambers as saying, "Carry on with plan."

During the rest of the month of February 2017 it appears that there was a concerted effort by Mr Harvey and Mr Chambers to resolve matters, or in their own language, "draw a line". Mr Harvey contacted Dr Hawdon asking how unusual it was for a neonate to collapse unexpectedly. She responded that this was rare.

At the same time Mr Chambers wrote to the consultants on 16 February informing them that the Coroner had been fully briefed on all matters and reminder the consultants of their agreement to provide an apology. He concluded his letter by saying of the

various reviews and reports which had been completed:

"All conclude that there is no single causal factor to explain the change in mortality rates, nor to substantiate the allegations you have made."

Throughout the rest of February and March, meetings and correspondence continued. The consultants did provide the apology letter but Dr Brearey and Dr Jayaram refused to engage in a suggested mediation process, saying it was "inappropriate to be undertaking the mediation process when the Trust is still investigating the cause for the increased neonatal mortality between June 2015 and July 2016".

Throughout these weeks, the consultants' position appears to have been a consistent reiteration of the fact that Dr Hawdon had concluded that four cases were unexplained, that the RCPCH review did not specifically investigate the cause of the deaths and unexpected collapses and that, "these events had not been fully investigated as recommended by the RCPCH review team and by Dr Hawdon".

On 16 March 2017, the Executive Directors met. This meeting discussed a one-to-one which was held between Dr Jayaram and Ms Hodkinson the previous day, and the course of the Executive Directors meeting, Ms Hodkinson relayed what she had discussed with Dr Jayaram.

The note of the meeting records this as:

"Three deaths. Lucy at cot. Real concerns. Lucy moved valves."

Mr Chambers described this as a “new and highly concerning disclosure” and one which had not been raised with him or any of the other Executives previously.

Ms Kelly is noted as having said, "Why not before? Serious allegations", which Mr Chambers has told the Inquiry was his further reaction to hearing this information.

Mr Chambers goes on in his statement to draw attention to the fact that incident had not been recorded on the Datix system and had not been the subject of any investigation at the time. He states in his witness statement:

"If a prompt report of this incident had been made to me, I would have spoken to Alison Kelly and Ian Harvey and it is the likely outcome would have been made to make a report to the police. Who knew this information and when will need to be established in evidence.

It will also be important to understand why, when provided with this information, there was not a prompt notification of the police by the hospital. What is more, although reported in this meeting, the allegation

does not appear to have been the subject of any discussion or record in the subsequent six weeks, neither does it appear that any of the Executive Directors sought further information or even confirmation from Dr Jayaram about it.

On 27 March 2017, an important meeting took place. Present at it were a number of Executive Directors, Dr Brearey, Dr Jayaram and Dr Subhedar. Also present was Julie Maddocks, the Chair of the Local Neonatal Network Steering Group. Mr Harvey provided an update and spoke about an earlier meeting at which 13 deaths were reviewed by him, Dr Brearey, Dr Jayaram and Dr Subhedar. He was recorded as saying there was eight cases where there were still concerns and in which relation to which the staff rotas were to be reviewed alongside the case notes.

In the course of the discussion Mr Chambers is recorded as saying, "I need to know if we do an individual case note review or phone the police."

Ms Maddocks is recorded as replying:

"Given the information on the balance of probability, illegal activity has caused deaths."

Mr Chambers is record as going on to saying:

"If that is where we are, then phone the police. You can call the police."

Later in the meeting, Mr Chambers is recorded as asking "Why have you not phoned the police?"

Dr Jayaram's reply is recorded as being:

"Our career would be on the line if we contact (the) police, it would be whistleblowing. Following BMA advice if there is an alternative of a deeper dive we should go for it. But this is a worry.”

Dr Jayaram's response if correctly recorded is a matter which will need to be important to understand.

Discussion about involving the police continued, including, according to the note of the meeting, Dr Brearey saying, "This needs to escalate to the police".

Mr Harvey recalls Dr Brearey saying this and says that it was his view that it was likely the police would need to be consulted but he remained concerned that we had nothing to give to the police to support the concerns of paediatricians.

Towards the end of the meeting Mr Chambers is recorded as saying, "We need to think about the conversation with the police." It's recorded that Mr Chambers concluded by saying, "You need to leave this with us."

The following day on 28 March 2017 the Executive Directors met with the Chair of the Board of Directors,

Sir Duncan Nichol. The notes of the meeting summarised the position of the consultants as being:

"Position now only independent, robust investigation is police investigation."

It was at this meeting that Mr Cross is recorded as saying that Letby could not return to the unit the following week as had been the plan, by reason of the potential police investigation. At this time the hospital also consulted lawyers, DAC Beachcroft, in relation to whether and how to liaise with the police, who were considering in more detail what instructions were given to lawyers and what advice was given regarding contacting the police and the reason for this.

Although it was recorded in the meeting on 28 March that Mr Cross would contact the police on 31 March, it does not appear that this in fact occurred. By 3 April, he had completed a document setting out why there was, "no evidence to justify a criminal investigation".

In his witness statement to the Inquiry, Mr Cross says that this document was a record of a discussion between Mr Chambers and Sir Duncan Nichol and is a reflection of their views which was to be presented to the Executive Team.

By contrast in his witness statement, Mr Chambers says that the purpose of this note is unclear. He goes

on to suggest that, "it looks like to be an aide memoire for Stephen Cross".

The phrase "No evidence to justify a criminal investigation" forms part of the opening sentence of a document entitled "Rationale", which began:

"In our view, there is no evidence to justify a criminal investigation. However, in the spirit of openness and transparency, the matter is being reported to the police having regards to the fact that a number of consultant paediatricians are not satisfied with the very thorough investigations and reviews undertaken."

We will be looking at the content of this document in greater detail during the hearing in terms of what it may reveal about the thinking of the Executive Directors at this time. We note only at this stage that it does not appear to make any mention of the information Dr Jayaram disclosed on her account to Ms Hodkinson on 15 March 2017 and which was subsequently discussed by the Executive Directors the following day.

On the same day, 3 April 2017, Mr Harvey also wrote a document. His was entitled "Neonatal services at the Countess of Chester Hospital NHS FT". Although more detailed than Mr Cross's rationale, it contained many of the same points. It was prepared, Mr Harvey has informed the Inquiry, in anticipation of the review by

Simon Medland QC. It is of note that the list of actions following the death of Child O included, "A comprehensive review of the unit to include activity, acuity and staffing levels". Ms Williams' staffing analysis and Dr Gibbs' review are not expressly mentioned. Mr Harvey has told the Inquiry that this was intended, "as a high-level summary of the investigations which had been undertaken" and, "was not meant to be comprehensive".

We note, as with the rationale document I've just referred to, that this also does not appear to include any reference to the disclosure Dr Jayaram had made to Ms Hodkinson less than three weeks earlier.

The document concludes by saying:

"However, despite extensive and intensive review, the paediatric consultants still feel that there are questions to be answered and we feel that we need to share the details and circumstances with the police."

Despite Mr Harvey and Mr Cross's documents of 3 April both saying that the police would be contacted, this did not take place formally for another month.

On 5 April 2017, a meeting with Letby was held. Ms Kelly and Ms Rees both attended. In the course of the meeting, Letby was told that "it was felt we should pause your return to the neonatal unit at this time and

review the position after the Easter break."

The explanation she was given was, "due to the work ongoing in relation to the clinical concerns that have been raised".

Also discussed in the meeting were Letby's "visits" to the neonatal unit. She was advised that these should also be paused. This appears to be a reference to the fact that prior to this date, Letby had been attending the neonatal unit. Whether and how often this occurred, and if it did, who sanctioned it, our matters the Inquiry will be investigating.

In early April, Simon Medland QC was instructed by the hospital. Exactly what the purpose of his instruction was is the subject of some uncertainty at present. Mr Harvey has stated that Mr Medland's role was, "to collate all the information, meet with the paediatricians and advise on the best approach and with what information to go to the police".

On 12 April, Mr Medland met with the consultants. Mr Medland's minutes of the meeting begin by setting out why he was meeting them, namely "to bring an independent objective view to the present situation and see if a formal report to the police were presently merited".

Mr Cross has told the Inquiry that this was the purpose of his instruction. However, like Mr Harvey,

Mr Chambers has told the Inquiry that this is at odds with why he understood Mr Medland had been instructed. Mr Chambers said he understood the decision to contact the police had been made and Mr Medland was helping with how that would happen in practice.

Mr Medland's minutes record that he gave his view “that the police, being strapped for resources ... can only sensibly investigate cases where there is -- at the very least -- reasonable grounds for suspecting that a criminal offence has been committed. He emphasised that this was very different from there being mere suspicion ..."

Mr Medland noted that adverse publicity would be incurred and that it would raise matters for the families of the neonates which might be seriously disturbing. He concluded by saying:

“As things stand he did not see that there was such material as might give rise to reasonable grounds for suspecting that a criminal offence had been committed."

He encouraged the consultants to make a list of their best points. He also raised the possibility of a private discussion with Detective Chief Superintendent Nigel Wenham on the basis that DCS Wenham sat on the Child Death Overview Panel.

One important matter that does not appear to have

been raised with Mr Medland was the information Dr Jayaram had given Ms Hodkinson. This is the position the Inquiry will be exploring the reasons for this omission.

The following day, an Extraordinary Meeting of the Board was convened. Mr Medland was invited to attend and his record of the meeting the day before was provided to the board members. The minutes of the board meeting record that Mr Medland reported the consultants' concerns as being that they could not see anyone else who could investigate. He repeated his view there was no evidence for a crime and his proposal that DCS Wenham be contacted in the context of his role on the Child Death Overview Panel. He suggested that Dr Hawdon be asked what she meant by "forensic review".

In the course of the meeting Sir Duncan appears to have referred to the case of Beverly Allitt. That meeting will be returned to in greater detail in our consideration of the board's role in the governance of the hospital, and the test to be applied for referral to the police.

Mr Harvey emailed Dr Hawdon to ask what she meant by "forensic review". She responded and commented that "completely unexplained death on a neonatal unit is rare so by definition, more than one unexplained death does

arouse suspicion".

She concluded that unexplained death in hospitals should follow the same process as unexplained death at home. She advised that Mr Harvey consult with the local Child Death Overview Panel team if he was unsure.

Mr Chambers has told the Inquiry that he considered this to be new information from Dr Hawdon, which supported the decision to go to the police.

On 19 April the Executive Directors Group met. It was agreed that contact with the police should be made through the Child Death Overview Panel. A discussion took place the following day between Mr Harvey and Hayley Frame, the Chair of the Pan Cheshire Child Death Overview Panel.

A week later on 27 April, Mr Harvey spoke to DCS Wenham. Following this conversation, DCS Wenham emailed to Mr Harvey inviting him to write a formal letter to the Chief Constable of Cheshire Constabulary.

On 2 May, Mr Chambers wrote to the Chief Constable. In the letter he stated:

"No single factor has been identified by these reviews, however, there are four cases in which a cause for collapse and/or death cannot be ascertained which the independent expert tells us is unusual."

He continued:

"On the advice of Detective Chief Superintendent Nigel Wenham, I am writing formally requesting Cheshire Police conduct a forensic investigation into the circumstances surrounding the deaths with a view to excluding any unnatural causes."

The Board of Directors were updated about this later that day in a further Extraordinary Meeting. Three days later, the first meeting of Operation Hummingbird, the name given to the police investigation, took place.

On 10 May 2017, a document was provided to the police compiled by seven consultants who worked on the NNU. This is a 22-page document which sets out a reasoned analysis of the concerns which existed in relation to each baby. It brings together Dr Hawdon's conclusions, with additional cases identified by the consultants and Dr Subhedar from the Neonatal Network.

The Inquiry will be referring this document to understand the extent to which concerns expressed could have been gathered previously. Could Letby have been stopped sooner than she was? Were opportunities for detection missed? Should concerns have resulted in actions sooner? These actions go to the very heart of whether lives could have been saved and injury prevented.

As I have said, the police were not contacted until

April 2017. In that time, Letby worked without formal restriction on her registration from her regulator, the NMC. Whilst she was eventually removed from a patient-facing role, whether and if so how she was able to obtain any placement elsewhere or to visit the neonatal unit at the hospital will be explored in oral evidence.

Furthermore, the fact that Letby was excluded from the neonatal unit may have been to some degree chance. The initial plan was that she was supervised, and this was only abandoned due to resourcing. Later that year it was being communicated that she would be returning to the ward despite the fact that investigations were ongoing. Her planned return to the ward on 3 April 2017 only appears to have been stopped because of the tenacious lobbying of the consultants. But for their determined approach, it appears likely that she would have been permitted to return to dealing with babies.

My Lady, I turn now to Chapter 2, whistleblowing. Speaking up, whistleblowing, and Letby's grievance.

LADY JUSTICE THIRLWALL: Thank you.

MS LANGDALE: In February 2015, Sir Robert Francis, King's Counsel, published his Freedom to Speak Up Review. At an early stage in the oral evidence we will be hearing from Sir Robert about the main conclusions of

his watershed report. Sir Robert recommended the creation of the role of "Freedom to Speak Up Guardian" in all NHS organisations. He proposed there should also "be a range of others to whom people can go for advice and support. This should include at least one executive director, which may be the person responsible for safety and/or the medical director ..."

The hospital's Speak Out Safely (Raising concerns about Patient Care) and Whistleblowing Policy, which applied for the period June 2015 to the end of 2015 predated Sir Robert's Freedom to Speak Up Review. Nevertheless it identified number of people termed designated officers who were the initial point of contact for disclosures to be made.

At the hospital, those people included a number of executive directors, including Mr Harvey, Ms Kelly and Ms Hodkinson.

In January 2016, the hospital reissued its "Speak Out Safely" Policy. The same people were identified as "designated officers".

Both policies applied to situations in which there was a reasonable belief, that is to say an honestly held belief, which was objectively reasonable, that a criminal offence had been committed or that there was a danger of health and safety of any individual.

A Speak Out Safely Committee appears to have met monthly during the period in which we are focused. Its members appear to be those named as designated officers under the Speak Out Safely policy. The only exception to this appears to be Mr Harvey who is not recorded as attending any of these meetings. The Inquiry will be investigating whether any of the consultants asked for their concerns to be formally logged under the Speak Out Safely Policy, and if they did, the Inquiry will be seeking to understand the apparent resistance recorded on the face of the minutes to recording their concerns as search, by the Speak Out Safely Committee. The Speak Out Safely Committee provided a clear and established route to involve the local authority designated officer. This route was not taken by the hospital, and it's important to understand why this did not happen.

There are a number of employment law issues to consider in respect of the management of Letby and treatment of those who raised concerns about her. We will hear evidence from an expert in employment law, Professor John Bowers, King's Counsel, at a later stage in the Inquiry.

You may think, my Lady, that the concerns made by the paediatric consultants, principally Drs Brearey and Jayaram, were a primary example of doctors blowing the

whistle on a serious risk to patient safety. Whistleblowing is governed by the Protected Disclosures Provisions contained in part IVA of the Employment Rights Act 1996.

As I've mentioned, the hospital had a whistleblowing policy and we will examine whether it was implemented.

On 14 July Ms Sian Williams the Deputy Director for Nursing Quality, met Letby, together with her line manager, Ms Powell.

Letby was told that a review had been undertaken which was unable to explain the collapse or deterioration of a number of babies on the neonatal unit. It was of serious concern to the hospital requiring investigation. Letby was informed that the review had identified her as, "being more regularly involved in the care of babies concerned". Letby was informed that she would be placed under clinical supervision pending the completion of an external review by the Royal College. The period of supervised practice was due to commence on 18 July until which date Letby was due to be on authorised leave.

Ms Powell emailed all nurses on the NNU on 15 July stating that:

"In preparation for the external review it has been decided that all members of staff need to undertake

a period of clinical supervision ... we have decided that it would be useful to commence with staff who have been involved in many of the acute events ... Therefore Lucy has agreed to undergo this supervision first."

A further meeting was held on 18 July. Letby was told that it was not possible to provide a full-time supervised practice because of staffing levels on the NNU. A decision had therefore been taken to redeploy her to Risk Management Team instead, where she would be line-managed by Ms Ruth Millward. This was said to be, "temporary" and, "a neutral act taken in the best interest of all parties and in the interests of patient care pending completion of the external review".

Letby was told that she could maintain social contact with her colleagues on the NNU but that she, "should be mindful of discussion of any matters which may be sensitive in nature relating to the RCPCH review of the NNU".

On the same day, Ms Hodkinson obtained advice from Mr Pace and Ms Slingo, lawyers at DAC Beachcroft on two issues: Letby's redeployment and whether the police should be called. We will hear evidence about the advice sought and obtained from Ms Slingo and her colleague at the time, Mr Pace.

The first of many meetings between managers at the

trust, in his case Ms Rees, Head of Nursing, and Letby, took place on 5 August 2016. The purpose of this meeting was to update Letby and check on her welfare. Letby was accompanied by her Royal College of Nursing representative, Ms Cooper. Letby was told that the review by the RCPCH had been deferred until the first week of September 2016.

On 2 September, Mr Tony Millea, a Royal College of Nursing officer, emailed Ms Rees stating that he believed that "Letby has grounds to action a grievance". Mr Millea earlier wrote that he had two concerns.

First, it had become apparent in the course of Letby's interview by the RCPCH the previous day that contrary to the indication given in the meetings in July 2016, "the terms of reference for this investigation does not seem to address the concerns in relation to the unacceptable high mortality rate on the NNU, and our member's involvement".

Instead the review appeared to be around more general matters and therefore that the review "will not solve the issues for Letby personally".

Second, Letby's redeployment was "a result of the Trust response to consultant's comments about our member's practice. I would like to request to see the Trust's evidence to substantiate their actions."

Mr Millea concluded that "the allegations made by the hospital would have a detrimental affect on our member's career which may constitute professional slander resulting in our member being constructively dismissed".

He asked that the hospital reinstate Letby to her substantive role on the NNU. At no point did Mr Millea refer to principles of safeguarding. His focus was on the apparent treatment of Letby.

Letby filed a written grievance on 7 September 2016. This echoed the concerns expressed in Mr Millea's email of 2 September, and raised the following issues.

Contrary to what Letby had been told in July 2016, no other member of staff had been placed under supervised practice or redeployed. Letby had been “singled out” and felt that she was “being discriminated against”.

The RCPCH reviewers told Letby that it would take up to eight weeks for them to complete their report. Letby wished to know what was "expected to happen with me during this period as I am keen to return to work on the NNU as soon as possible".

Consultants had raised allegations about Letby. She wished to know what evidence there was against her “and if there is to be an investigation into my practice then

on what grounds?”. Letby felt that she was being “targeted and blamed for incidents that even the review report will not address”.

The following day, 8 September, Ms Hodkinson compiled an NNU options appraisal document marked "Strictly Private and Confidential". The options set out in this document were for Letby to remain in redeployment for an extended period, or for a 12 month period; to reintegrate her back within the NNU; to undertake a disciplinary investigation; to engage the Speak out Safely policy; and finally for Letby to resign. Various "considerations" in respect of each option were set out.

On 9 September Ms Kelly and Ms Hodkinson appeared to have attended a conference call with lawyer Mr Pace. Mr Pace noted that Letby had been “removed from the neonatal unit, following a correlation of baby deaths when she was on the unit” and that the decision to redeploy her to the Risk Team had been taken “because it was not possible to place her under close supervision, and because of the ongoing concerns that had been raised by the consultant.” It appears that the advice received was that there was a high risk of constructive dismissal, but it was also noted that “justified in decision to remove ... remove risks to babies”. Under a

list headed “Options”, it was noted that suspension was “not appropriate in (the) circumstances".

Ms Cooper, Letby's Royal College of Nursing representative, emailed Ms Hodkinson on 20 September 2016 to chase the progress of Letby's grievance. A number of internal emails were exchanged in the trust in response. In particular, on 21 September, Ms Appleton-Cairns, the Deputy Director of Human Resources of the hospital, emailed Ms Kelly and Ms Hodkinson to say that:

"we were going to ask Ian to speak to SB (presumably Dr Brearey) and ask him to formally voice his concerns under Speak Out Safely. I think we need to do this in parallel -- any thoughts?"

Ms Hodkinson and Ms Kelly both replied stating that they were unsure whether this had happened.

Ms Appleton-Cairns considered Letby's case and her grievance on 28 September. She made a list of the nine key questions which she believed Letby, "wants answering". These included:

"What are the issues the consultants have raised? What is the Trust doing about it? What evidence does the Trust have? If there is going to be an investigation into a practice, then on what grounds? Why has she been singled out for redeployment? When can

she return to the NNU?"

Ms Appleton-Cairns wrote that an independent Chair had been appointed "but at the moment we do not have a modicum of defence for this". She suggested that an investigating officer be appointed, and noted that they "would have to ask very difficult questions of the consultants".

She also referenced again that the plan was for the consultants "to explain their concerns in writing and to Speak Out Safely". She considered that this would be a softer approach than question the consultants under the grievance procedure. She concluded that after the accountants had explained their concerns:

"We can investigate any statements of evidence and be able to respond to LL ... This is now time pressured as we are failing to respond under our own policy timeframes which is an unnecessary risk should it go further."

Ms Hodkinson met with Letby on 5 October. It was explained that this was an informal meeting and was separate from the grievance process, that the findings of the formal review into the NNU were being awaited and in the meantime, Letby's redeployment would continue with weekly support meetings in place.

It was noted that Letby was receiving clinical

updates from the NNU, and that the "best outcome would be to get you back working on the neonatal unit." Letby was asked whether she still required the formal grievance process to continue. Letby confirmed that she did. It was explained that there had been delays in identifying an interpreting Chair for the grievance hearing "to provide objectivity and independence to the process".

During this period, a number of steps took place. The hospital consulted external lawyers and the risk of constructive dismissal was discussed.

The issue of whether the consultants had voiced their concerns under Speak Out Safely was raised, but it seems not resolved. And by October 2016, Dr Christopher Green, Director of Pharmacy, was appointed as investigating officer in relation to the grievance process.

Dr Green began conducting the grievance investigation interviews on 14 October. Letby was the first to be interviewed. The interview appears to have been fairly short. Letby said that she had not received any formal allegations, it was, "all verbal". On the same day, Dr Green interviewed Ms Kelly, Ms Rees and Ms Williams. Ms Hodkinson was interviewed on 21 October, and Ms Powell was interviewed on 28 October.

We will look at those interviews in oral evidence.

On 28 October, Ms Powell emailed Dr Green saying:

"This is the article and email that I was alluding to in our discussion", and included emails that Dr Jayaram and Dr Gibbs had exchanged on 30 June 2016 surrounding the possibility that air embolus was involved in some of the neonatal deaths.

Ms Hodkinson continued to consult with external lawyer Mr Pace, and the RCPCH review, which had recommended clear processes for investigating allegations, was discussed.

On 28 October, Mr Pace advised Ms Hodkinson that Letby's continued redeployment away from the NNU should in his view be continued because "my ultimate concern was the potential for patient safety."

Dr Green conducted the remainder of his grievance investigation interviews in the first half of November. Mr Harvey was interviewed on 7 November, and Doctors Brearey and Jayaram were both interviewed on the 11th.

Dr Green produced a draft investigation report on 12 November. He concluded the following: that the Trust generally intended to place Letby on a period of supervision of practice and repetition of competences; that although no such instruction was given to her, Letby felt she was not permitted to have normal social

contact with her colleagues on the NNU; that the purpose of the RCPCH and Dr Hawdon reviews were to "explore circumstances and detail around patient safety on the neonatal unit, with respect to the commonality identified between [Letby] being on duty and the collapses/deaths of the babies on the neonatal unit, I concluded that the Exec teams feel that the review would provide confirmation and reassurance that there is no direct link between the two", and finally that the Trust had not been open with Letby regarding the nature of the consultants' informal allegations regarding her.

Dr Green also found that:

"The drive to remove LL from the neonatal unit appears to have come from the consultant [Dr Brearey] and to a lesser extent, [Dr Jayaram]. Whilst it is important that the Trust has a culture that allows members of staff to raise concerns about colleagues, I find it a concern that these concerns are based on 'gut feel', and do not accept that this provides a basis on which to make the accusations that appear to have been made. I am therefore concerned as to whether this warrants further investigation under the Trust's Bullying and Harassment Policy.

Even more surprisingly, you may think, my Lady, in a section headed "Recommendations", Dr Green said that

pending the outcome of the "final reports", Letby should be "given the opportunity to return to the NNU."

Dr Green met with Mr Stephen Cross, Director of Corporate and Legal Services, on 16 November. From notes the Inquiry has seen, it appears that the grievance was discussed, and we will ask questions about this meeting in oral evidence.

On 18 November, Ms Hodkinson spoke again with the lawyer, Mr Pace. She told him that:

"The external and internal reviews have both been completed, and there is nothing to implicate Letby in any of the events. The board has decided that she should return to the neonatal unit.

Mr Pace replied that this "all sounded very positive, and we need to take steps to ensure that proper steps are made to reintegrate her back into the workplace."

He is also noted as explaining that Dr Brearey had explained whistleblowing concerns which needed to be investigated, but Ms Hodkinson explained that:

"The Trust had taken the view that the internal and external investigations had been sufficient, and that we would provide the outcome of these investigations to the consultants who had raised the whistleblowing concern."

On 22 November 2016, Dr Green produced the final

draft of his investigation report. This largely mirrored the conclusions in his draft report of 12 November 2016, save that the section dealing with the allegations against Letby was rewritten. We will ask why Dr Green now concluded that:

"Concerns raised by the consultants [in particular Dr Brearey], were raised through the appropriate channels in line with both the Trust Speak Out Safely policy, and the guidance proffered by the General Medical Council, (ie through the Executive Team). However, I do not find that the consultant concerns, when reiterated to the Executive Team, were 'clear, honest and objective'. I conclude that the Trust have considered the concerns of the consultants in line with both the disciplinary and Speak Out Safely policies, and believe that there was insufficient basis on which to undertake either a formal internal investigation, or to initiate a police investigation."

Letby's grievance hearing was heard on 1 December. The hearing manager was Annette Weatherley, Deputy Chief Nurse at University Hospital, South Manchester. Dr Green was present at the hearing.

The meeting began with Ms Weatherley stating that she had only received the papers for the hearing 48 hours ago. It also appears that she may not have

been aware that any external reviews were going on into neonatal deaths.

There was discussion about the fact that the nature of the allegations against Letby was that she had "deliberately set out to harm babies", but Dr Green is recorded as saying that there was "no evidence to suggest that this is the case".

Dr Green explained that he had concluded that Dr Brearey and Dr Jayaram had threatened to call the police, and that the issue was, with this, "If the consultant had called the police, the ward would have been declared a crime scene, and LL would have been arrested. It is my take that the police would come and arrest LL."

Dr Brearey and Dr Jayaram were discussed in the course of the grievance hearing. Ms Weatherley is recorded as saying that:

"It is clear that the two consultants call the shots, and have put pressure on the Exec Team in making this decision."

And Dr Green stated:

"I was disgusted by their behaviour. It is likely that they lied."

Dr Green will be required by the Inquiry to explain how he arrived at this and other conclusions that he

made.

Ms Weatherley produced a written outcome of the grievance on 1 December, the same day as the grievance hearing. She concluded that Letby could have been supervised and her competencies repeated, as she had been told was the plan on 14 July. That the Trust's intention was that Letby cease professional, rather than social, contact with members of the NNU, but the miscommunication had resulted in Letby thinking that she was required to cease both, that the remit of the external reviews was not explained to Letby, and that the Trust generally had not been "as open and honest with Letby as they could be".

With regards to the evidence against Letby, Ms Weatherley concluded that:

"I have not seen, nor has there been any allusion to, any evidence relating to any alleged wrongdoing by yourself", although reference was made to "commonality between the dates and times that you were on duty, and the collapses/deaths of a significant number of a babies, but there is nothing to support that there is additional information or data beyond this that has not been shared with you."

Ms Weatherley adopted and quoted extensively from Dr Green's report regarding the allegations made by

Dr Brearey and Dr Jayaram, and in particular that their concerns were not "clear, honest and objective".

She concluded that a number of steps would be taken: one, the CEO and a non-executive representative would apologise to Letby in the presence of her parents; two, after the "final report" was received, and provided it contained, "no references to Letby", Letby would be informed in writing that she had, "no case to answer", and; three, mediation would take place with Dr Brearey and Dr Jayaram, and there would also be, "an apology from both consultants".

In line with Ms Weatherley's first step, a meeting was held on 22 December with Letby, her parents, Mr Chambers and Mr Harvey. Mr Chambers explained that a meeting with executives and consultants was planned to take place in the new year, "at which behaviours we expect to see will be clearly described, and then disciplinary action may follow if not followed."

Letby was also told that after this meeting, she could, "come back to the unit" when she was ready.

On 26 January 2017, a meeting took place between Mr Chambers, Mr Harvey and the Paediatric Consultant Body. Mr Chambers explained that the Speak Out Safely process had been "professionally managed" and there was no problem with "raising concerns, as that is fine".

However, a review by a "high-powered team does not call out a criminal act", and that there was now "a need to draw a line under the Lucy issue."

The consultants were expected to issue an apology to Letby and to engage in mediation.

This was followed up on 30 January 2017, by the letter that I've previously referred to from the paediatric consultants asking for written clarification on what the board understood the reason to be for increased mortality on the NNU, and to be allowed the opportunity to read the RCPCH and Dr Hawdon reviews prior to their publication.

On 31 January 2017, Letby emailed all staff on the NNU stating this:

"I was redeployed from the unit in July 2016 following serious and distressing allegations of a personal and professional nature made by some members of the medical team. After a thorough investigation, it was established that all the allegations were unfounded and untrue, and I have therefore been fully exonerated. I have received a full apology from the Trust. I will begin making my return to the unit in the coming weeks."

The hospital appears to have been aware of Letby's email. On the same day, Ms Hodkinson emailed Ms Cooper, the RCN rep, and Letby, asking for, "the final copy of

the wording sent out today, if possible."

However, the Inquiry has not seen any evidence to suggest that anyone at the hospital responded to Letby's email to correct her and to clarify that she had in fact not been investigated at all, let alone exonerated.

Mediation.

As already set out, the consultants complied with the request to send a letter of apology to Letby. This was sent on 28 February 2017. On the same day, a number of consultants met Mr Harvey and expressed their view that their professional opinions had not been given due regard, and that increased mortality was still unexplained.

Dr Brearey, Dr Gibbs and Dr Jayaram all stated that mediation was "occurring far too early, in view of the fact that there's still a great deal of uncertainty as to the cause of the rise in neonatal mortality and unexpected collapses."

On 1 March 2017, Mr Harvey emailed Dr Jayaram to ask him to make, "every effort" to engage in mediation with Letby, and wrote that:

"I think that this gesture would also go a long way to protect you from a possible referral to the GMC from other parties which, having supported many doctors, have done no wrong through, [sic] even then isn't

a comfortable process."

A very similar email was sent to Dr Brearey on the same day.

Dr Jayaram responded the following day, stating that in his view, at least eight deaths and collapses were still unexplained, and he "really can't see how any effective mediation can take place at the present time but if you feel it's the right thing to do, I will attend the preliminary meeting after seeking advice from my BMA representative."

On 6 March 2017 Ms Rees emailed Ms Kelly, pointing out that Dr Brearey had pulled out of an initial mediation meeting, and seeking assurance that he would attend one on 16 March. This email was forwarded to Letby's RCN representative, Mr Millea, who followed it up on 7 March, suggesting that if Dr Brearey failed to attend a mediation, he ought to be "disciplined for breaching the terms of our grievance."

Dr Brearey emailed Ms Hodkinson on the same day to explain that he was not available on 7 March, and emailed on 9 March saying:

"I would like to reiterate that I think it's inappropriate to be undertaking this process now, when the Trust is still investigating the cause of the increased neonatal mortality between June 2015 and

July 2016."

Dr Jayaram attended initial an meeting with the mediator on 7 March. Following this, Dr Jayaram wrote to Ms Hodkinson on 13 March stating that he felt "extremely uncomfortable with this whole process", and that, whereas the mediator told him that the process was entirely voluntary, that contradicted the impression given by the Board, in particular Mr Harvey, "who intimated that by not engaging, I could increase the chances of being reported to the GMC for whatever I'm alleged to have done."

On 14 March, Ms Rees asked Ms Hodkinson to see that Dr Jayaram attended a mediation with Letby, as the plan was for Letby to be placed back on the NNU on 3 April 2017.

Dr Jayaram met with Ms Hodkinson to discuss his concerns about the mediation process on 15 March. He explained he could not see how the process was helpful, whilst he remained of the opinion that Letby had harmed babies. He also mentioned that he had "heard from others ... possible disciplinary action, but also told by Ian there could be repercussions from others re GMC referral."

Dr Jayaram expressed his view that the board were not being given an accurate portrayal of the picture and

were not being advised by a neonatologist, and as a result, they were "going down a path and set on a path."

Ms Hodkinson reassured him that his concerns had been treated under the Speak Out Safely policy.

Dr Jayaram explained that he was concerned the Board was more concerned about a possible employment claim by Letby than patient safety.

Dr Jayaram attended a mediation session with Letby on 28 March. He wrote an email to Ms Hodkinson on 30 March stating that during this mediation session, he felt "as if I'd been hung out to dry there."

He had been asked whether he was "happy to move on", and whether he "still thought there was a possibility [Letby] may have done something."

He also objected to the fact that Letby had been led to believe that he and Dr Brearey had orchestrated a campaign against her, and that they had given an ultimatum to the Trust that if she was not suspended, they would call the police. He asked for minutes of board meetings and copies of grievance documents.

On 5 April, Letby was informed that her return to the NNU was to be paused, and that it was recommended that she ceased to visit the unit. It appears that Letby had visited the NNU unsupervised on one occasion in the last week of February 2017 with the knowledge of

least Ms Kelly, Ms Hodkinson and Ms Rees.

Letby attended a tea party on the unit, in company with Nurse Z, which Yvonne Griffiths, Deputy Unit Manager, explained to staff was to welcome Letby back on to the unit.

Nursery nurse Jean Peers, in her evidence to the Inquiry, describes as the event as follows:

"I was on at the weekend. So was Yvonne Griffiths. She said that Letby was coming with Nurse Z, and that we would do a tea party to welcome her. We did cakes and tea, and she came in and we were all talking, and she did not say a word to us. Yvonne were talking a lot to make it nice and relaxed, and when she went, we both said, 'Oh my god, she's going to make it hard for us when she returns, she seems angry."

On 18 April, Letby had a conversation with Ms Hodkinson which she followed up with an email on 19 April. In this email, she asked that an amended record of the 5 April meeting be sent to her specifically clarifying whether pausing her return to the NNU, and her ability to visit the NNU, constituted, "advice or a management instruction".

An amended record of the 5 April 2017 meeting was duly sent to Letby on the 24th, clarifying that this was provided "as a management instruction", and "to support

your successful transition back to the unit, we would advise, as a management instruction, that we again pause with these visits at this time."

From his point of view as the Medical Director, Mr Harvey has told the Inquiry:

"I do not think the grievance process was conducted to the highest standard, and I think it resulted in a lot of grief and angst for the consultants. I feel the grievance strayed into the rights of members of staff to raise concerns, rather than some of the behaviours that occurred subsequently. I think this contributed to the distrust the consultants had in the executives."

Ms Kelly, the Director of Nursing and Quality, has said in her statement:

"I have reflected on the appointment of Chris Green to lead the investigation into the grievance, and in hindsight, I think we should have selected someone who was completely independent from the hospital."

My Lady, there are a number of obvious and intertwined issues which arise from the sequence of events we have referred to.

Was it right that, as a result of them raising their concerns, pressure was brought to bear on Dr Brearey and Dr Jayaram in a number of ways: the mention of possible

referral to the GMC; the suggestion that action might be taken under the bullying and harassment and disciplinary policies; the requirement to apology to Letby and to attend mediation sessions with her?

The grievance manager was a nurse from a neighbouring trust. Was she truly independent in her role? Was the grievance manager given sufficient time to prepare for the grievance hearing? And did she have sufficient time to reflect carefully on her decision? Was she fully appraised of, and did she fairly take into account, all of the paediatric consultants' concerns about the unexplained deaths?

Was the investigating officer, Dr Green, the right person for the job, in light of the concerns raised by Dr Brearey about a prescribing error in relation to one of the deceased babies, which Dr Green agrees in his statement led to a degree of tension between the two of them in April 2016? Was any pressure brought to bear on Dr Green to change his conclusions he held in a meeting with Mr Cross between the production of the draft and final versions of his investigation report that I have read? If not, how and why do these changes appear?

Why was the Trust Speak Out Safely policy not complied with? In particular, why weren't investigations, as required by the policy, carried out?

Was any consideration given to the referrals set out in the policy to the Local Authority Designated Officer? If not, why not?

Were executives at the Trust fearful of constructive dismissal proceedings being brought by Letby, and did this affect, or potentially affect, their decision making?

Why was legal advice from DAC Beachcroft commissioned by the Executive Director of Human Resources rather than the Trust's legal department? Why was legal advice from DAC Beachcroft obtained an *ad hoc* manner, and why were documents not sent to DAC Beachcroft when requested by them? Why was so little legal advice seemingly obtained regarding the investigation and grievance processes?

And above all, does this evidence reveal an abject failure by those investigating and supporting Letby to engage with basic principles of safeguarding and the need to keep babies in hospital safe?

My Lady, I think that's a natural moment to conclude because Mr de la Poer will be taking us to the board tomorrow.

LADY JUSTICE THIRLWALL: Very well. Thank you very much indeed, Ms Langdale.

We will resume tomorrow morning at 10.00. Thank you

all very much.

(4.04 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X