

Wednesday, 11 September 2024

(9.58 am)

**LADY JUSTICE THIRLWALL:** Good morning, everyone. We will adopt the same timing today as we did yesterday, so an hour and a quarter also before the break. However, I have said to Mr de la Poer if it is more convenient to break a bit later or a bit earlier, we will take his lead.

Mr de la Poer.

Opening statement by MR DE LA POER

**MR DE LA POER:** My Lady.

We turn now to the role of governance and the board. We have heard about concerns and suspicions raised by clinical staff on the neonatal unit. We have heard about the response of managers. One question you will be considering, my Lady, is whether the structures and processes for the management and governance of the hospital contributed to a failure to protect babies on the neonatal unit from the actions of Letby? What was the board's oversight of corporate and clinical governance?

By way of background, the Countess of Chester Hospital NHS Trust operated two hospitals: the Countess of Chester Hospital and the Ellesmere Port Hospital. The vast majority of the Trust services were provided at

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Letby was a common factor in the case of most deaths.

Ms Lawrence, having sought the advice of Janet McMahon who had been her predecessor in the role, then went to her boss, Ms Millward, the Head of Risk and Safety, about what she had read.

Ms Lawrence's recollection of the conversation in her witness statement is that Ms Millward was "dismissive of her findings".

Ms Millward's recollection in her witness statement is that Ms Lawrence raised the fact that "one nurse was present at all or most of the deaths", and that she'd cautioned Ms Lawrence, speaking about it more publically, as it had been "unproven at this time".

Ms Millward says she took from the conversation that the concerns had been escalated to the executive team and were being looked at. Ms Millward says that at no point was there any suggestion that this was a deliberate act by the nurse. Instead, she took the implication to be that there may be clinical competence issues which needed to be raised with the nursing leadership or human resources.

Ms Millward states that she did not view this as a Risk and Patient Safety Team issue.

In that role as Head of Risk and Patient Safety, Ms Millward reported to Ms Kelly as Director of Nursing

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the Countess of Chester Hospital. It was the main Trust serving West Cheshire and also provided services to many Welsh patients.

The hospital has been authorised as a Foundation Trust by Monitor in April 2004. It was in fact one of the first ten hospitals to be given Foundation Trust status.

As a Foundation Trust, the hospital had a degree of independence from Central Government control. It was not subject to the performance management requirements of the Department of Health and had greater control over its own strategy and finances.

As a replacement for central control, accountability was meant to be provided locally, through members of the Trust and governors holding the hospital to account.

We turn now to consider risk management. The effectiveness or otherwise of risk management within the hospital is something that the Inquiry will be considering in some detail. And I pause only to note one example here. In May 2016, Ms Annemarie Lawrence took up the role of Risk Midwife. When Ms Lawrence became aware of the thematic review of neonatal mortality she requested a copy and one was provided to her. Having read this document she describes going through the table and noting, using a highlighter, that

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and Quality. Ms Millward has explained to the Inquiry in her witness statement how she understood the system of risk and patient safety to operate. At the ward level, it was expected risks would be discussed. It was then the responsibility of local managers to add risks to the Datix system. The Datix system involves an electronic record which provides a risk-scoring methodology.

The use and lack of use of this reporting system in the case of babies named on the indictment is a matter commented upon by number of witnesses and is an area of investigation for the Inquiry.

The Risk and Patient Safety Lead aligned to the division, which in the case of the neonatal unit was the Urgent Care Division, was expected to provide a monthly report for discussion and approval at the monthly Divisional Governance Group.

Risk Registers existed for each ward or department and were known as Local Risk Registers. Above those were the Divisional Risk Registers. Any risk-scoring above 16 was referred to a senior level in the hospital, and added to the Executive Risk Register. For most of the period for which the Inquiry is concerned, the most senior committee responsible for the risk management was called the Corporate Directors Group.

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1 This group was chaired by the Chief Executive,  
2 Mr Chambers, who was described in the Risk Management  
3 Strategy and Operational Policy as "the accountable  
4 officer".

5 The Corporate Directors Group met monthly. Its  
6 attendees included the Medical Director, Mr Harvey, the  
7 Director of Nursing and Quality, Ms Kelly, and the  
8 Director for Corporate and Legal Affairs, Mr Cross.

9 The Inquiry has identified that the neonatal unit  
10 concerns were referred to in the July 2016 Urgent Care  
11 Risk Register. However, the risk was characterised as  
12 follows:

13 "Potential damage to reputation of the neonatal  
14 service and wider Trust due to apparent increased  
15 mortality within the neonatal unit."

16 In other words, the risk was characterised in terms  
17 of reputational harm, rather than in terms of a risk to  
18 the safety of babies.

19 It is also noteworthy that the risk was only added  
20 in July 2016, six months after the February 2016  
21 thematic review had clearly identified a "higher than  
22 expected mortality rate on the NNU in 2015".

23 Concerns regarding the mortality in the neonatal  
24 unit were not referred to in the Executive Risk Register  
25 until July 2016. In the minutes of the July 2016

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1 recorded in these forums.

2 The Inquiry will be investigating whether the Trust  
3 developed a comprehensive risk management plan in  
4 a timely manner, recorded it in a single place, reviewed  
5 it and updated it as appropriate in accordance with its  
6 procedures.

7 If this proves not to have been the case, the  
8 Inquiry will be looking to understand whether this  
9 impacted upon the speed and manner in which the hospital  
10 addressed the increase in mortality on the neonatal unit  
11 and the concerns of the doctors about it.

12 I move from the topic of risk to the board.

13 As a Foundation Trust, the hospital's management  
14 structure was in part prescribed by statute; that is the  
15 National Health Service Act of 2006. The hospital was  
16 required to have a Board of Directors made up of  
17 Executive and Non-Executive Directors. The Board of  
18 Directors had the power and the overarching  
19 responsibility to run the hospital. These powers could  
20 be delegated to the board committees or individual  
21 Executive Directors. Ultimately, the board was  
22 responsible for the performance of the hospital.

23 The Board of Directors was a unitary board. That  
24 meant its Directors were supposed to make decisions as  
25 whole, sharing between them the responsibilities and

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1 Corporate Directors Group meeting, underneath the  
2 heading "Executive Risk Register Overview", it is  
3 recorded:

4 "RM [that is to say Ruth Millward] noted that there  
5 were seven current risks on the register, having added  
6 two associated with the neonatal unit."

7 The minutes do not specify what these two risks are,  
8 and there is no record of a discussion taking place  
9 regarding the risks. However, examination of the  
10 July 2016 Executive Risk Register informs that the two  
11 recorded risks were firstly "Temporary change to  
12 admission arrangements for NNU" along with "Independent  
13 review of the neonatal service from the Royal College of  
14 Paediatrics and Child Health" and second "Clinical lead  
15 has highlighted an apparent increased mortality within  
16 the NNU for 15/16".

17 We note that there is no record of the consultants'  
18 concerns of deliberate harm to babies in the Urgent Risk  
19 Register, the Executive Risk Register, nor the Corporate  
20 Directors Group meeting minutes.

21 The Inquiry will be seeking to understand why this  
22 is, and also why it appears that it took until  
23 July 2016, one year and one month after the first  
24 indictment baby death, and five months after the  
25 thematic review, for the concerns to be formally

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1 liability.

2 The hospital Board of Directors was made up of six  
3 Non-Executive Directors, including its Chair, and seven  
4 Directors, including its Chief Executive Officer.

5 The chair of the hospital board from 2012 to 2020  
6 was Sir Duncan Nichol. Sir Duncan first joined the NHS  
7 in 1968 and was Chief Executive of the NHS Management  
8 Executive from 1989 to 1994.

9 As we will hear in greater detail, Sir Duncan's time  
10 as the NHS Chief Executive coincided with the murders  
11 and attacks committed by Beverley Allitt at  
12 Grantham Hospital.

13 Following the Clothier Inquiry into Allitt's  
14 attacks, Sir Duncan was responsible for the distribution  
15 of the Clothier Report across the NHS, writing to all  
16 health authorities and Trusts to draw it to their  
17 attention.

18 The Inquiry is interested to hear from Sir Duncan  
19 about the lessons he and the wider NHS learnt from the  
20 Allitt case, and why the parallel between Letby and  
21 Allitt was not drawn earlier at the hospital.

22 As Chair of the hospital board, Sir Duncan was  
23 responsible for leading the board and the Council of  
24 Governors. Sir Duncan's role was to be the agenda  
25 setter for both. He had particular responsibility for

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1 ensuring the Directors and the Governors received  
2 accurate, timely and clear information which enabled  
3 them to perform their roles effectively.

4 In addition to Sir Duncan, there were five other  
5 Non-Executive Directors. Their role was to monitor,  
6 scrutinise and constructively challenge the management  
7 of the hospital.

8 The Inquiry has obtained witness statements from  
9 Mr Andrew Higgins, Mr James Wilkie, Mr Ed Oliver,  
10 Ms Rachel Hopwood and Ms Rosalind Fallon, each of whom  
11 sat as Non-Executive Directors for all or part of the  
12 period we are examining. They will give oral evidence  
13 to this Inquiry.

14 Mr Higgins also held, for part of his time on the  
15 board, the role of Senior Independent Non-Executive  
16 Director and Vice Chair. That role involved providing  
17 a sounding-board for Sir Duncan, and acting as an  
18 intermediary for the other Directors where necessary.

19 Ms Fallon, previously a nurse and midwife, was the  
20 sole Non-Executive Director with clinical experience.

21 In terms of the operational management of the  
22 hospital, that was a task for the Executive Director,  
23 headed by Chief Executive Mr Tony Chambers.

24 During the period the Inquiry is focused on, that is  
25 to say 2015 to 2017, the other Executive Directors, some

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1 was through meetings of the board itself. A typical  
2 format for board meetings was for Executive Directors to  
3 present papers or reports, usually relating to their own  
4 areas of responsibility. The Non-Executive Directors  
5 might ask questions and discussion might follow about  
6 what had been presented.

7 Where actions required board approval, an Executive  
8 Director would typically recommend the steps which were  
9 proposed to be taken, and the board would give its  
10 approval, or on seemingly rare occasions, its rejection.

11 The second mechanism was through the board  
12 committees, which we will turn to in more detail  
13 shortly. Board committees sat below the board, were  
14 chaired by Non-Executive Directors and were responsible  
15 for providing assurance to the board on matters within  
16 their remit.

17 Corporate governance is an area in which the NHS has  
18 spent some time focusing on, not least following the  
19 recommendations of the Mid Staffordshire Inquiry.

20 Now, we've just referred to the NHS Code of  
21 Governance. NHS bodies also published guidance and  
22 codes. Monitor, for example, published guidance for  
23 NHS Trust boards in 2013 on how to govern effectively.  
24 The guidance built upon earlier guidance issued by the  
25 National Quality Board. It was titled "Quality

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1 of whom Ms Langdale identified yesterday were as  
2 follows: Ms Ian Harvey, the Medical Director;  
3 Ms Alison Kelly, the Director of Nursing and Quality;  
4 Ms Debbie O'Neill, the Chief Finance Officer, that role  
5 was also filled by Mr Simon Holden on an interim basis  
6 from January 2016 to July 2016, and again from  
7 February 2017; Ms Susan Hodgkinson, the Director of Human  
8 Resources and Organisational Development;  
9 Mr Stephen Cross, the Director of Corporate and  
10 Legal Services; Ms Lorraine Burnett, the Director of  
11 Operations, and Mr Mark Brandreth, the director of  
12 planning, partnerships and development. Mr Brandreth  
13 left the hospital around April 2016.

14 The NHS Foundation Code of Governance set out the  
15 board responsibility. First, for ensuring the quality  
16 and safety of healthcare services at the hospital;  
17 second, for applying the principles and standards of  
18 clinical governance as set out by external bodies; and  
19 third, for oversight of the effectiveness of the  
20 hospital's risk management and internal controls.

21 All members of the board, but particularly the  
22 Non-Executive Directors, had a duty to challenge and  
23 scrutinise.

24 There were two key mechanisms by which the board at  
25 the Trust discharged its responsibilities. The first

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1 Governance: How Does a Board Know That Its Organisation  
2 Is Working Effectively to Improve Patient Care?".

3 The guidance was couched in the language of  
4 "quality", by which it meant safe and effective services  
5 with positive patient experience.

6 The guidance was organised around a series of  
7 questions posed to NHS trust boards, including: does  
8 quality drive the Trust strategy? Is the board  
9 sufficiently aware of potential risks to strategy? Does  
10 the board have the necessary leadership skills and  
11 knowledge to ensure delivery of the quality agenda?  
12 Does the board promote a quality-focused culture  
13 throughout the Trust? Are there clear roles and  
14 responsibilities in relation to quality governance?

15 Turning from the board to the Council of Governors.  
16 The hospital was also required, by virtue of its  
17 foundation trust status, to have a Council of Governors.

18 As with the Board of Directors, meetings of the  
19 Council of Governors were chaired by Sir Duncan Nichol.  
20 The Council of Governors sat above the board in the  
21 governance structure of the hospital. Their function  
22 was prescribed by statute. It was:

23 "To hold the Non-Executive Directors individually  
24 and collectively to account for the performance of the  
25 Board of Directors, and to represent the interests of

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1 the members of the [Trust] as a whole and the interests  
2 of the public."

3 The Council were thus required to perform an  
4 accountability role and to ensure a link between leaders  
5 of the hospital and members of the public the hospital  
6 served.

7 Turning from the Council of Governors to the board  
8 committees.

9 The board sat the board committees. From around  
10 mid-2013 to mid-2019, there were seven board committees,  
11 and each was chaired by a Non-Executive Director. This  
12 included three committees chaired by Sir Duncan Nichol.  
13 The membership of committees was varied but generally  
14 consisted of a mix of Non-Executive and Executive  
15 Director, and managerial, clinical and administrative  
16 staff.

17 Ms Killingback, can I please invite you to put on  
18 screen INQ0002607. This shows the committee structure  
19 at the hospital. There are four board committees which  
20 the Inquiry is principally interested in.

21 The first is the Quality, Safety and Patient  
22 Experience Committee, often referred to as QSPEC.

23 The second is the Finance and Integrated Governance  
24 Committee.

25 The third is the Audit Committee.

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1 once.

2 The only occasion on which mortality rates on the  
3 neonatal unit appear to have been raised was in  
4 a presentation to the committee on 14 December 2015.  
5 This was not followed up in the next meeting, which took  
6 place on 15 February 2016 or the subsequent meetings in  
7 March, April, May or June 2016.

8 One of the matters the Inquiry will be seeking to  
9 get to the bottom of is why was this so, given that  
10 attendees at that committee were, from February 2016 at  
11 the latest, sighted on the fact that concerns existed in  
12 the neonatal unit?

13 I turn now to the Finance and Integrated Governance  
14 Committee. This committee was, in the words of  
15 Non-Executive Director Mr Higgins, a "bit of a catch-all  
16 committee". A draft of its terms of reference dated  
17 17 June 2015 put its remit in particularly broad terms,  
18 describing it as a committee as follows:

19 "With responsibility for gaining assurances in  
20 relation to risk controls for clinical risks,  
21 non-clinical risk, and corporate risk. It is the main  
22 committee through which the organisation is assured that  
23 risks are mitigated, through appropriate control  
24 mechanisms and adequate assurances provided that the  
25 hospital is able to achieve its objectives and to ensure

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1 The fourth is the People and Organisational  
2 Development Committee.

3 Thank you very much indeed, Ms Killingback, we can  
4 take that down.

5 Taking each of those four committees in turn, the  
6 Quality, Safety and Patient Experience Committee. This  
7 was responsible for the development, implementation and  
8 monitoring of matters relating to quality, safety and  
9 patient experience within the hospital.

10 The committee had terms of reference dated  
11 17 June 2013, which set out its purpose and duties.  
12 That purpose included the monitoring of serious untoward  
13 incidents, review of the hospital Risk Register and  
14 Board Assurance Framework regarding quality, safety and  
15 patient experience, also assurance in all matters to do  
16 with risk, governance, quality and patient experience,  
17 and the monitoring of implementation of recommendations  
18 from national reports.

19 The increase in neonatal mortality at the hospital  
20 and the concerns about Letby were matters which fell  
21 squarely within the Quality, Safety and Patient  
22 Experience Committee's remit. A seemingly striking  
23 feature of QSPEC's monthly meetings during the period  
24 June 2015 and June 2016 is that the increase in the  
25 mortality rate on the neonatal unit was discussed just

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1 that the safety and quality of care, treatment and  
2 services provided by the hospital, for patients, is of  
3 a high standard."

4 So it would seem the Finance and Integrated  
5 Governance Committee was the main committee which  
6 provided assurance to the hospital that risks were  
7 mitigated and that the safety and quality of care at the  
8 hospital was of a high standard.

9 Its responsibilities included overseeing the  
10 implementation, monitoring and review of the Board  
11 Assurance Framework, ensuring that governance systems  
12 were effective and utilised appropriately, and also  
13 quality assuring and ratifying all policies, procedures  
14 and guidelines.

15 The Finance and Integrated Governance Committee was  
16 chaired by Sir Duncan Nichol. The hospital's Directors  
17 made up a significant proportion of its membership.  
18 From the Executive Director, there were Mr Chambers,  
19 Mr Harvey, Ms Kelly, Ms Hodkinson, Ms O'Neill,  
20 Mr Holden, Mr Cross, and Ms Burnett. All the  
21 Non-Executive Directors were members of this committee.

22 At least one of the Non-Executive Directors has  
23 since described the Finance and Integrated Governance  
24 Committee as "discredited", that an informal consensus  
25 was reached amongst the board that the committee was not

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1 achieving its objectives, particularly in relation to  
2 risk assurance, with the committee meetings becoming  
3 dominated by operational performance and finance issues.  
4 We will examine its role during the evidence.

5 The third committee I have mentioned is the Audit  
6 Committee. The purpose of this committee was to provide  
7 assurance that appropriate systems of internal control  
8 and risk management were in place within the hospital.  
9 While much of the Audit Committee's work appears to have  
10 been focused on corporate and financial audit, its remit  
11 extended to clinical risk and audit too. The Audit  
12 Committee also had an independent scrutiny role over the  
13 other board committees. The Audit Committee was chaired  
14 by Non-Executive Director, Ms Rachel Hopwood. Its  
15 membership varied, but Mr Harvey, Mr Cross,  
16 Ms Hodkinson, Ms O'Neill, Ms Holden, Ms Kelly,  
17 Ms Burnett, Mr Higgins and Mr Wilkie were all members of  
18 the committee at some point.

19 And finally of those four committees that I have  
20 mentioned, the People and Organisational Development  
21 Committee. It had the purpose of setting out the  
22 relevant board committees -- forgive me. According to  
23 its terms of reference, the committee had delegated  
24 responsibility for managing and providing assurance for  
25 the workforce related risk. It was also responsible for

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1 Patient Experience Committee was in fact the only board  
2 committee where neonatal mortality was even discussed,  
3 and as we've already set out, during the period of  
4 Letby's attacks, QSPEC discussed the increase in the  
5 mortality rate on the neonatal unit just once. As we  
6 have said, the Inquiry will be asking why that was so.

7 While much of the Inquiry's focus will be on QSPEC  
8 due to its remit, the Inquiry will also examine the  
9 effectiveness of other board committees. Indeed, were  
10 or should those committees have been involved in  
11 identifying, raising or dealing with concerns regarding  
12 neonatal mortality at the hospital?

13 Indicators that there was ineffectiveness at board  
14 committee level have already been provided. In  
15 March 2019, a review into governance at the hospital,  
16 conducted by an organisation called Facere Melius found  
17 that the board committees were very operationally  
18 focused, and often left insufficient time for the  
19 consideration of individual items and tended to seek  
20 reassurance as opposed to forming an assurance function.

21 In his witness statement to the Inquiry, Mr Higgins  
22 has described that there was often a lack of time for  
23 discussion of board committee minutes in the meetings of  
24 the board Directors. Ms Fallon has told the Inquiry in  
25 her witness statement that the level of information

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1 ratification of new and existing human resource policies  
2 and procedures, and the review and implementation of  
3 national guidance on workforce related topics, such as  
4 the Nursing and Midwifery Council revalidation process.

5 The People and Organisational Development Committee  
6 was chaired by Non-Executive Director Mr Oliver. Its  
7 membership included Ms Hodkinson and Mr Harvey.

8 Dealing with the board committees collectively they  
9 formed an essential function in governance of the Trust.  
10 They had delegated responsibility for scrutiny and  
11 assurance within each of their respective remits. Much  
12 of the day-to-day business of the board appears to have  
13 been performed through the various board committees.  
14 The board committees were also supposed to act as  
15 funnels for the escalation of issues to the board as  
16 a whole. Groups, boards and committees lower down in  
17 the governance structure of the Trust could feed  
18 information and escalate issues to the relevant board  
19 committees. In turn, board committees could escalate  
20 issues to be considered by the board.

21 Minutes of the board committee meetings were  
22 received at subsequent board meetings.

23 In the period June 2015 to March 2017, no board  
24 committee ever escalated to the board issues relating to  
25 neonatal mortality or Letby. The Quality, Safety and

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1 provided to the non-executive directors was often  
2 a problem in that papers were long, and unwieldy, with  
3 lots of data and little analysis. The Inquiry will be  
4 exploring these various issues.

5 I turn now to the Executive Directors Group. The  
6 Executive Directors sat and met in a separate group  
7 invariably described as the "Executive Team" or the  
8 "Executive Directors Group".

9 As we have already heard, this group met weekly and  
10 its meetings appear to have been where the concerns  
11 regarding neonatal mortality and Letby were most  
12 frequently discussed.

13 Now, before moving on to other matters, I should  
14 deal with the other structures within the hospital.

15 Each department of the hospital was designated to  
16 one of three divisions. During the period that the  
17 Inquiry is focused on, the hospital had three divisions:  
18 the Urgent Care Division, the Planned Care and  
19 Diagnostics Division and the Pharmacy, Estates and  
20 Facilities Division. Paediatrics, which included  
21 Neonatal Care Services, formed part of the Urgent Care  
22 Division. We pause to note that obstetrics, which is  
23 plainly a specialty directly connected to neonatology  
24 sat in a different division: the Planned Care and  
25 Diagnostics Division.

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1 We will be investigating whether the placing of  
2 these two directly connected specialties into different  
3 divisions of the hospital had any impact on the speed at  
4 which action was taken.

5 Returning to Neonatal Care Services, could I please  
6 ask Ms Killingback to put on screen INQ0012232. What is  
7 on screen shows the purported operational management  
8 structure for the Paediatrics Department. The diagram  
9 suggests that Paediatrics contain three separate  
10 management hierarchies, one each for medical, nursing,  
11 and business performance.

12 Ms Karen Townsend, as Divisional Director -- and her  
13 name appears towards the top and in the centre, Ms Karen  
14 Townsend is depicted as the soul link between each of  
15 the management chain. The position appears to have been  
16 similar in December 2015.

17 You can take that down. Thank you very much.

18 Each division had a Medical Director. The Medical  
19 Director for the Urgent Care Division was  
20 Dr Martin Sedgwick, an acute cardiology consultant.  
21 Among Dr Sedgwick's responsibilities as Divisional  
22 Medical Director, was delegated responsibility for the  
23 implementation of risk management in relation to Urgent  
24 Care medical staff.

25 Below Dr Sedgwick sat the clinical leads for  
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1 stage.

2 Its duties and responsibilities included risk  
3 management assurance across its services, the monitoring  
4 of clinical incidents, and clinical performance and  
5 quality monitoring.

6 Minutes from its meetings were disseminated  
7 relatively widely. They were received by both the  
8 Urgent Care Divisional Board and the Planned Care  
9 Governance Board, as well as the Quality, Safety and  
10 Patient Experience Committee and Ms Kelly directly.

11 The Women and Children's Care Governance Board was  
12 chaired by Dr McCormack. Its membership from the Urgent  
13 Care Division included Dr Jayaram, Dr Brearey, Ms Rees  
14 and Ms Murphy.

15 A number of specialty review groups operated below  
16 the Women and Children's Care Governance Board to  
17 undertake first level review of incidents within their  
18 specialty. The Obstetrics Department had a primary  
19 review group and a secondary review group. The Neonatal  
20 Incident Review Group was the group responsible for the  
21 review of all neonatal incidents. It met monthly.  
22 Where it deemed appropriate, the Neonatal Incident  
23 Review Group could instigate further investigation of  
24 particular incidents.

25 Turning away from the local level and to the  
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1 paediatric services, Dr Jayaram, who we heard about  
2 yesterday, and also Ms Anne Murphy who fulfilled the  
3 equivalent nursing lead role for children's services.  
4 And then finally below Dr Jayaram were the neonatal team  
5 headed by Dr Brearey.

6 Moving forward to divisional boards. The Urgent  
7 Care Divisional Board was concerned with both strategic  
8 and operational issues affecting the Urgent Care  
9 Division. It met monthly. It received reports and  
10 feedback from the specialties and subgroups in its  
11 division. In turn, it was able to direct matters  
12 upwards to the Quality, Safety and Patient Experience  
13 Committee. The hospital's then policy for the reporting  
14 of incidents suggests that the divisional boards were  
15 meant to have an important role in risk management,  
16 including receipt of governance reports, which included  
17 incident data and other relevant governance/risk issues.

18 Sitting below the Urgent Care Divisional Board and  
19 the Planned Care Governance Board was the Women and  
20 Children's Care Governance Board. Its membership  
21 primarily comprised of medical and nursing staff from  
22 obstetrics, gynaecology, midwifery and paediatrics. As  
23 previously mentioned, it appeared that the Women and  
24 Children's Care Governance Board was a committee that  
25 did discuss neonatal mortality at a relatively early  
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1 Safeguarding Strategy Board. Now, the position of the  
2 Safeguarding Strategy Board in the governance structure  
3 of the hospital is currently unclear to the Inquiry  
4 legal team. But it reported directly to the Quality,  
5 Safety and Patient Experience Committee. Its basic  
6 function was to ensure that safeguarding was a strategic  
7 objective within the Trust and integral to the care it  
8 provided. What that meant in practice will be explored  
9 in evidence.

10 The Terms of Reference for the Safeguarding Strategy  
11 Board set out its duties. Those duties were expansive  
12 and included monitoring of safeguarding standards,  
13 ensuring that systems, processes and reporting  
14 mechanisms were in place to detect, prevent and respond  
15 to concerns about abuse or neglect. Also, approving  
16 safeguarding procedures and policies and ensuring the  
17 hospital reported safeguarding concerns to external  
18 agencies and ensuring improved communication occurred  
19 between teams through incident discussion and  
20 monitoring.

21 The increase in neonatal mortality at the hospital  
22 was not mentioned in the papers for meetings of the  
23 Safeguarding Strategy Board until November 2017, six  
24 months after the police investigation commenced.

25 The various groups, boards and committees we have  
24

1 set out are those most relevant to the Inquiry's  
2 investigation into the effectiveness of the governance  
3 structure of the Trust. Though numerous, they are not  
4 exhaustive of the large number of such associations  
5 which existed in the Trust.

6 It will not have escaped your attention, my Lady,  
7 that there seems to have been significant overlap in  
8 remit between these various groups. Every group we have  
9 described, save for the People and Organisational  
10 Development Committee, had an apparent direct role in  
11 management of clinical risk. The Inquiry will be  
12 investigating whether overlap of responsibilities  
13 affected how the hospital identified and dealt with  
14 concerns raised about neonatal mortality.

15 The structure we have described contained a number  
16 of routes for issues to be referred from groups near the  
17 bottom of the hospital's governance hierarchy all the  
18 way to the board. One might have expected, for example,  
19 issues relating to neonatal mortality to be identified  
20 first in the Neonatal Incident Review Group, then raised  
21 at the Women and Children's Care Governance Board, which  
22 would then be referred to the Quality, Safety and  
23 Patient Experience Committee, and eventually appear  
24 before the board.

25 That is not what happened.

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1 down the governance structure. The death of Child A was  
2 discussed at the Women and Children's Care Governance  
3 Board as early as its meeting on 18 June 2015. The  
4 minutes for that meeting noted the Datix incident report  
5 which had been opened in respect of Child A's death, as  
6 well as the obstetrics secondary review which had been  
7 undertaken.

8 However, it does not appear that the increase in the  
9 neonatal mortality, or consultants' concerns, were  
10 escalated quickly through this forum either. In  
11 October 2015 meeting of the Women and Children's Care  
12 Governance Board, the minutes quote:

13 "Moderate harm incidents related to neonates that  
14 sadly died ... and three unexpected neonatal deaths."

15 However, no substantive discussion of this is  
16 recorded and no resulting actions are identified.

17 The meeting of the Quality, Safety and Patient  
18 Experience Committee on 14 December 2015 was the first  
19 time that concerns about an increase in neonatal deaths  
20 were discussed at board committee level.

21 Mr Higgins chaired the meeting. Sir Duncan Nichol,  
22 Ms Hopwood, Ms Kelly and Ms Hodgkinson were in  
23 attendance. As Ms Langdale has already described,  
24 Ms Fogarty presented Dr Brigham's "Review of Neonatal  
25 Deaths and Stillbirths at the Countess of Chester

27

1 Indeed, one of the apparent features of the concerns  
2 about Letby is how they were raised outside these  
3 established processes and structures. Aside from the  
4 meetings of the Executive Directors Group, the increase  
5 in neonatal mortality and the concerns raised about  
6 Letby were rarely discussed. The Inquiry is very  
7 interested to learn why this was so.

8 Returning then to the board. The board met 16 times  
9 between June 2015 and May 2017. At five of those  
10 meetings the concerns regarding an increase in neonatal  
11 mortality were discussed. Four of those five meetings  
12 were Extraordinary Meetings of the Board of Directors  
13 held in private where the concerns regarding Letby were  
14 explicitly discussed.

15 The one public meeting where neonatal mortality was  
16 discussed took place in February of 2017. As we have  
17 already set out, a non-dissimilar picture seems to have  
18 played out in the board committees. From June 2015 to  
19 May 2017, the concerns about neonatal mortality were  
20 only evidence discussed in one board committee: the  
21 Quality, Safety and Patient Experience Committee. The  
22 concerns were never discussed in the Audit Committee,  
23 the Finance and Integrated Governance Committee, nor the  
24 People and Organisational Development Committee.

25 The position was perhaps slightly different lower

26

1 Hospital -- January 2015 to November 2015" at this  
2 meeting. While the minutes of the meeting referred to  
3 an increase in both stillbirths and neonatal deaths,  
4 there was no mention or query of the fact that the paper  
5 presented was an obstetric review only and did not  
6 consider neonatal aspects of care. The committee  
7 appeared to have been assured or perhaps reassured by  
8 the paper.

9 Following the meeting, the Quality, Safety and  
10 Patient Experience Committee action log was updated to  
11 record the issue of neonatal and stillbirth review as  
12 completed.

13 The same paper was referred to in the minutes for  
14 the meeting of the Women and Children's Care Governance  
15 Board four days later on 18 December 2015. It is unclear  
16 what exactly was discussed about the paper at that  
17 meeting. Nevertheless, the minutes of the meeting  
18 summarised the position that no themes had been  
19 identified in the paper and each case would continue to  
20 be reviewed at multi-disciplinary meetings.

21 The minutes for the December 2015 meeting of the  
22 Quality, Safety and Patient Experience Committee were  
23 received at the board meeting on 2 February 2016, though  
24 the minutes were indicated to be available on request  
25 only. Attendees of the board meeting, including

28

1 Sir Duncan Nichol, Ms Hopwood, Ms Kelly and  
2 Ms Hodgkinson, each of whom had been present at the  
3 December 2015 Quality, Safety and Patient Experience  
4 Committee meeting.

5 The minutes of the board meeting record no  
6 discussion of Dr Brigham's paper, nor neonatal  
7 mortality. It appears that although the increase in  
8 neonatal mortality had reached the attention of a board  
9 committee it had not yet made its way to discussion by  
10 the board itself.

11 As it transpired, the mortality rate on the neonatal  
12 unit did not appear as an item for discussion in board  
13 or board committee meetings for the rest of the period  
14 of Letby's attacks.

15 The minutes of the Women and Children's Care  
16 Governance Board during this period contained perhaps  
17 tangential reference to neonatal mortality. The minutes  
18 of the 14 January 2016 meeting noted a case review into  
19 Child D's death as well as an ongoing inquest into the  
20 death of Child A.

21 However, yet again, there appears to have been no  
22 substantive discussion of these matters.

23 At the meeting of the Women and Children's Care  
24 Governance Board on 21 April 2016, the action plan  
25 arising from the Stillbirth and Neonatal Death Review  
29

1 matter was eventually brought before the board by the  
2 Executive Directors. Between 24 June 2016 and  
3 30 June 2016, following the deaths of Child O and  
4 Child P, a significant number of meetings took place  
5 between the paediatric consultants and senior management  
6 at the hospital. Counsel to the Inquiry has already set  
7 out an outline of this series of meetings already and  
8 the heavy involvement of the Executive Directors.

9 By the 30 June 2016, the board chairman,  
10 Sir Duncan Nichol, was included, meeting with both the  
11 Executive Directors and the consultant paediatricians.

12 On 5 July 2016 it appears that the Non-Executive  
13 Directors were informed of the concerns raised. This  
14 was not, however, at the public meeting of the board on  
15 that day. In fact, there was no mention of neonatal  
16 mortality or the potential involvement of a nurse at  
17 that meeting. Rather, it seems that prior to the public  
18 convening of the board, a private meeting of the  
19 Non-Executive Directors was held. This private meeting  
20 was not minuted although Ms Fallon has provided to the  
21 Inquiry a copy of the brief handwritten note she took  
22 during it.

23 Those handwritten notes and Ms Fallon's witness  
24 statement to the Inquiry suggest that the Non-Executive  
25 Directors were informed at the private meeting about the  
31

1 was marked as complete. It was not until its  
2 16 June 2015 meeting that the thematic review of  
3 neonatal mortality, which, my Lady, you will recall took  
4 place on 8 February 2016, was discussed by the Women and  
5 Children's Care Governance Board.

6 The minutes of the meeting noted a higher than  
7 expected mortality rate on the neonatal unit in 2015 but  
8 stated that "no common theme was identified across the  
9 cases".

10 Letby's last shift on the neonatal unit was on  
11 30 June 2016. At no point during the period of Letby's  
12 attacks did the Women and Children's Care Governance  
13 Board escalate the issue of neonatal mortality to the  
14 Quality, Safety and Patient Experience Committee, nor  
15 did the Quality, Safety and Patient Experience Committee  
16 escalate the issue to the board.

17 The Inquiry will be seeking to understand why the  
18 concerns which were being expressed at the neonatal unit  
19 level were not escalated more quickly and clearly  
20 through the designated channels. And we will also be  
21 investigating if they had been, what should have  
22 happened.

23 My Lady, I turn now to the first involvement of the  
24 board.

25 It was following Letby's final attack that the  
30

1 concerns regarding neonatal mortality; also, about the  
2 plan to downgrade the neonatal unit and the proposal for  
3 an external review.

4 It is unclear whether the Non-Executive Directors  
5 were at this stage told about the concerns specifically  
6 raised about Letby. Ms Fallon states in her witness  
7 statement that she did not learn of the suspicions  
8 regarding a nurse on the neonatal unit until she and  
9 Mr Oliver asked Sir Duncan about it on 12 July 2016.

10 An extraordinary meeting of the Board of Directors  
11 was held on 14 July 2016. All the Directors except  
12 Ms Hodgkinson, Mr Higgins and Mr Oliver attended the  
13 meeting. Dr Stephen Brearey and Dr Jayaram were also  
14 present.

15 During the meeting Mr Chambers informed the board  
16 that there had been an unexplained increase in neonatal  
17 mortality at the Trust. The board were told that a peer  
18 review had been undertaken which was inconclusive and  
19 that Mr Harvey would undertake his own review of the  
20 data.

21 The official minutes record Dr Jayaram asking for  
22 one matter not to be minuted. In a set of handwritten  
23 notes for the meeting, Dr Jayaram was noted to set out  
24 Letby's association with the neonatal deaths refer to  
25 Letby as "the elephant in [the] room".  
32



1 Mr Chambers and Mr Harvey set out to the board the  
2 next steps to be taken. The neonatal unit was to be  
3 downgraded. The review was to be undertaken by the  
4 Royal College of Paediatrics and Child Health in  
5 August 2016. Mr Harvey told the board that the review  
6 team would be briefed on "the explicit concerns" which  
7 would be discussed as part of the references and  
8 interviews.

9 According to the minutes a number of questions were  
10 asked by the Non-Executive Directors of the meeting.  
11 Mr Wilkie queried the reasons for not involving the  
12 police and asked how confident the hospital were that  
13 all risks posed by Letby was being removed. Ms Fallon  
14 asked how long Letby had been on the unit and for how  
15 many of the babies Ms Letby had been on shift.  
16 Ms Hopwood asked about the practicality of Letby  
17 continuing to work under supervision.

18 The need for continued monitoring was raised at the  
19 meeting. Sir Duncan said that he and Mr Higgins as  
20 Chair of the Quality, Safety and Patient Experience  
21 Committee would be in very close contact with the Royal  
22 College review. Ms Hopwood stated that another board  
23 meeting should be held following the review as  
24 a minimum.

25 Following its 14 July 2016 Extraordinary Meeting,  
33

1 entered onto the Urgent Care Risk Register in the same  
2 terms. It appears that the Women and Children's Care  
3 Governance Board, whose remit specifically included  
4 clinical performance and risk management, did not query  
5 the fact that the risk was framed in terms of reputation  
6 as opposed to patient safety.

7 At the same meeting the deaths of Child O and  
8 Child P were recorded as National Patient Safety Alert  
9 Level 2 incidents. The Quality, Safety and Patient  
10 Experience Committee met on 15 August 2016. The meeting  
11 as usual was chaired by Mr Higgins. Sir Duncan Nichol  
12 and Ms Fallon also attended.

13 At the meeting, Ms Millward, the hospital's Head of  
14 Risk and Patient Safety, presented the document titled  
15 "Position Paper -- Neonatal Unit Mortality" prepared by  
16 herself and Ms Kelly.

17 The conclusions of this paper have previously been  
18 presented to the executive team. Counsel to the Inquiry  
19 has already outlined the findings of that position  
20 paper, namely that the only firm conclusion it drew was  
21 that the rise in neonatal mortality could not be  
22 explained by common cause fluctuations. It offered some  
23 possible explanation for at least part of the rise. The  
24 position paper made no mention of or attempt to consider  
25 the concerns raised about Letby. Nor were these  
35

1 the board did not discuss neonatal mortality nor the  
2 concerns raised about to be Letby again until the new  
3 year.

4 Lack of official discussion by the board does not  
5 appear to have been substituted by informal discussion.  
6 None of the Non-Executive Directors have recalled such  
7 informal discussions about neonatal mortality or the  
8 reviews undertaken. Mr Wilkie does, however, describe in  
9 his witness statement to the Inquiry, approaching  
10 Ms Kelly on 15 July 2016, the day after the  
11 Extraordinary Meeting of the board.

12 Mr Wilkie says he told Ms Kelly he was concerned  
13 about the decision that Letby should be supervised  
14 rather than removed from the neonatal unit. He asked  
15 that his concerns be passed on to Mr Chambers.

16 Neonatal mortality did appear as an item for  
17 discussion at the committees lower down the governance  
18 structure following this, however.

19 At the meeting of the Women and Children's Care  
20 Governance Board on 21 July 2016 a new risk was  
21 identified in the minutes, and we have referred to that  
22 already: "Potential damage to reputation of neonatal  
23 service and wider Trust due to apparent increased  
24 mortality within the neonatal unit".

25 This would seem to be a reference to the risk  
34

1 concerns raised or discussed at the meeting of the  
2 committee.

3 The minutes of the meeting were recorded by  
4 Mr Higgins and said there would be an official update  
5 and initial review in relation to neonatal mortality at  
6 the next meeting of the Quality and Safety Patient  
7 Experience Committee.

8 That meeting came the following month on the  
9 19 September 2016. It was chaired by Mr Higgins and  
10 with Sir Duncan Nichol, Mr Harvey, Ms Hodkinson,  
11 Ms Hopwood and Ms Fallon in attendance. At the meeting,  
12 Mr Harvey provided a verbal update on the review  
13 undertaken by the Royal College of Paediatrics and Child  
14 Health earlier that month. He told the committee that  
15 final report was awaited, but that the external review  
16 team had not raised any immediate concerns.

17 Mr Harvey also noted the recommendation for the  
18 hospital to commission a forensic review of the deaths.  
19 Neonatal mortality was not mentioned at subsequent  
20 meetings of the Quality, Safety and Patient Experience  
21 Committee until February 2017, after a version of the  
22 Royal College's report had been published. The question  
23 arises as to why, when Sir Duncan Nichol had identified  
24 an apparent need for himself and Mr Higgins, as chair of  
25 the Quality, Safety and Patient Experience Committee, to  
36

1 remain close with the external review.  
 2 Did that committee only ever consider the review  
 3 once it was published? And then, by way of an oral  
 4 update provided by Mr Harvey?  
 5 By the end of November 2016, following receipt of  
 6 a finalised Royal College report, and as Letby's  
 7 grievance procedure drew to a close, the executive team  
 8 appeared to have realised a need to return to the Board  
 9 of Directors. The minutes of the meeting of the  
 10 Executive Directors Group on the 30 November 2016 noted  
 11 that Mr Harvey was to talk with Sir Duncan Nichol about  
 12 next steps with the board. That conversation appears to  
 13 have taken place shortly afterwards, although Sir Duncan  
 14 says he cannot recall the details of it.  
 15 This brings us to the second Extraordinary Meeting  
 16 of the board. On 30 December 2016, Mr Chambers,  
 17 Mr Harvey and Sir Duncan met, it seems in preparation  
 18 for a proposed forthcoming Extraordinary Meeting of the  
 19 board. A handwritten note of the meeting recorded  
 20 discussion of the proposed distribution of the report of  
 21 the RCPCH, including the query:  
 22 "Unredacted version > [should] it go anywhere?"  
 23 The notes gave an apparent answer to that:  
 24 "Redacted version to be used."  
 25 The Inquiry will be investigating how the Royal  
 37

1 leadership, escalation, timely intervention and does not  
 2 highlight any single individual."  
 3 Mr Chambers told the board that once they had  
 4 received the final four cause of death reviews from  
 5 Alder Hey Hospital, a line could be drawn under them.  
 6 Mr Chambers described the concerns raised about Letby as  
 7 unsubstantiated. As Counsel to the Inquiry noted  
 8 yesterday, Mr Chambers is recorded as saying that the  
 9 grievance procedure had exonerated her. He told the  
 10 board: the hospital would do everything it could to  
 11 manage a safe transition of Letby back to the neonatal  
 12 unit. Ms Hodgkinson read Letby's statement to the board.  
 13 The board were asked to accept the Royal College  
 14 report, support the executive team in implementing the  
 15 recommendations described in the review, and support the  
 16 executive team in assisting Letby's return to the  
 17 neonatal unit. The minutes recorded that the board duly  
 18 ratified each of these decisions.  
 19 Sir Duncan Nichol has publicly said that the board  
 20 were misled by Mr Chambers and Mr Harvey at this  
 21 meeting. In his statement to the Inquiry,  
 22 Sir Duncan Nichol says this:  
 23 "At the time, I had no cause to question  
 24 Ian Harvey's reports. Subsequently, I felt that I and  
 25 the board had been misled by not being told about  
 39

1 College report was distributed and used by senior  
 2 management at the hospital.  
 3 It was at this meeting it appears that the roadmap  
 4 forward was set out.  
 5 First would be the board meeting, where the external  
 6 review would be formally accepted and an action plan  
 7 presented.  
 8 Second would be the meeting with the paediatric  
 9 consultants. The statement from Letby was to be shared  
 10 with the board and the paediatric consultants.  
 11 Third would be contact with the coroner, with  
 12 a meeting to take place by the end of January.  
 13 Fourth and finally, as recorded towards the end of  
 14 the handwritten note:  
 15 "Endorse transition of [Letby] into unit".  
 16 The Extraordinary Meeting of the board was held on  
 17 10 January 2017. All the Directors attended except  
 18 Mr Higgins. Mr Harvey presented a paper he had prepared  
 19 summarising his recommendations to the board. He told  
 20 the board about an in-depth review which had been  
 21 commissioned, namely a case review undertaken by  
 22 Dr Hawdon, the minutes recorded Mr Harvey's summary of  
 23 its findings:  
 24 "The case review very much reinforce[s] what is in  
 25 the [Royal College] review, it comes down to issue of  
 38

1 Dr Hawdon's lack of capacity to complete the case  
 2 reviews in sufficient depth. I had read the RCPCH's  
 3 (unredacted) report and Dr Hawdon's case review  
 4 summaries, and was relying on the advice of Ian Harvey,  
 5 Tony Chambers, and his fellow Executive Directors."  
 6 The Inquiry will be looking at the information  
 7 provided to the board on 10 January 2017, and how it was  
 8 presented to them. Were the Non-Executive Directors  
 9 misled? Was the information and were the documents they  
 10 were provided with sufficient and accurate to enable  
 11 them to perform their role? Why did the Non-Executive  
 12 Directors not ask to see copies of the grievance  
 13 outcome, or Dr Jane Hawdon's review, before supporting  
 14 Letby's return to the neonatal unit? Did the board  
 15 perform its function of challenging the actions  
 16 recommended by the Executives, or did it simply ratify  
 17 decisions already made?  
 18 It is notable that the same day as the board  
 19 meeting, Mr Chambers, Ms Kelly, Ms Rees, Letby and  
 20 Ms Cooper, the Royal College of Nursing representative  
 21 supporting Letby, met. Mr Chambers told Letby that the  
 22 board were clear in their support for her return to the  
 23 neonatal unit.  
 24 The second step in the roadmap, the meeting with the  
 25 paediatric consultants, took place on 26 January 2017.  
 40

1 Mr Chambers, Mr Harvey, Ms Kelly, Ms Hodgkinson and  
2 Mr Cross attended from the Executive team. Ms Hopwood  
3 was the sole Non-Executive Director present.

4 You will recall, my Lady, that this is the meeting  
5 where Mr Chambers and Mr Harvey both said that there was  
6 a need to draw a line under Letby. Ms Hopwood  
7 understood her role at the meeting to be merely one of  
8 observer. What function a Non-Executive Director was to  
9 perform as observer at this meeting is currently  
10 unclear.

11 The board met again on 7 February 2017. All the  
12 Directors were present except Mr Higgins and Ms Fallon.  
13 This was the only public meeting of the board in the  
14 period June 2015 to May 2017 where neonatal mortality  
15 was discussed. The minutes record that Mr Chambers  
16 provided an update to the board, informing them that  
17 Dr Hawdon's case review had been completed. Mr Chambers  
18 summarised that the review did not identify a single  
19 causal factor for the increase in neonatal mortality or  
20 raise concerns regarding unnatural causes.

21 There was no apparent mention of the fact that  
22 Dr Hawdon had recommended broader forensic review of the  
23 deaths of Child A, Child I, Child O and Child P, which  
24 she considered remained unexplained and unexpected.

25 We move forward in Spring 2017. As we've already  
41

1 the consultant paediatricians were assisting on a police  
2 investigation. There was no discussion of this at the  
3 board meeting on 4 April 2017.

4 Sir Duncan has suggested that around this time there  
5 would almost certainly have been informal contact  
6 between him and Non-Executive Directors, not least to  
7 explain the forthcoming Extraordinary Meeting of the  
8 Board of Directors, although he was unable to recall  
9 detail of any such contacts or discussions.

10 My Lady, this brings us to the third Extraordinary  
11 Meeting of the board. The third Extraordinary Meeting  
12 of the board was convened for 13 April 2017. The  
13 meeting was attended by all the Directors except  
14 Mr Holden.

15 Simon Medland QC, as he was then, the barrister whom  
16 the Trust had instructed to meet with the consultant  
17 paediatricians, also attended. The minutes of  
18 Mr Medland's meetings with the paediatricians the  
19 previous day were shared with the board. He relayed the  
20 consultants' view that the matter needed to be escalated  
21 to the police.

22 Although Mr Medland was recorded as stating that his  
23 view that there was no evidence of a crime, he told the  
24 board:

25 "You need to accept that if something is still  
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1 set out, it was from February 2017 that the consultant  
2 paediatricians increased further the pressure they were  
3 exerting to the Executives to investigate their concerns  
4 about neonatal mortality and its association with Letby.  
5 This was not seemingly reflected in the meetings of the  
6 Quality, Safety and Patient Experience Committee or the  
7 Women and Children's Care Governance Board.

8 The Quality, Safety and Patient Experience Committee  
9 met on 20 February 2017. The meeting was chaired by  
10 Mr Higgins, and attendees included Sir Duncan Nichol,  
11 Ms Kelly and Mr Harvey. Mr Harvey provided a verbal  
12 update on the reviews carry out into neonatal mortality,  
13 informing the committee that the Royal College's report  
14 had been published and an in-depth secondary mortality  
15 review had been carry out by Dr Hawdon. An action plan  
16 was to be formulated based on the recommendations of the  
17 references.

18 Three days later the Women and Children's Care  
19 Governance Board met and noted its receipt of the Royal  
20 College's report. There seems to have been no  
21 substantive discussion of the report. The minutes  
22 simply recording the Women and Children's Care  
23 Governance Board would await direction from the  
24 Executive team regarding next steps.

25 On 28 March 2017, Sir Duncan Nichol was told that  
42

1 unanswered or there are still genuine concerns in  
2 well-minded people, you should go to the police".

3 Mr Medland also suggested an alternative of  
4 approaching a police member of the Child Death Overview  
5 Panel. The cause of action the board appears to have  
6 agreed on was not yet to contact the police, but instead  
7 to return to Dr Hawdon to enquire what she meant by  
8 further forensic review.

9 However, at least some of the Non-Executive  
10 Directors did consider there remained genuine concerns  
11 on the part of the paediatricians. Delay also appears  
12 to have been on the mind of the board. Mr Wilkie asked  
13 whether the Trust could truthfully say that there had  
14 not been delay on its part.

15 Mr Higgins said that there was "A need for something  
16 bombproof as quickly as possible".

17 Ms Fallon asked about the timeline to speak with  
18 Dr Hawdon, and Ms Hopwood said she felt "it had got away  
19 from us".

20 During the meeting Sir Duncan referred to the  
21 Beverley Allitt case. You will recall, my Lady, that  
22 Sir Duncan was Chief of the NHS Management Executive at  
23 the time of Beverley Allitt's crimes and was tasked with  
24 the dissemination of the Clothier Inquiry Report across  
25 the NHS. There was no reference to the Allitt case in  
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1 the previous Extraordinary Meetings of the Board of  
2 Directors. The board also discussed communications with  
3 the parents of the babies who had died. Mr Harvey told  
4 the board that the hospital had endeavoured to keep the  
5 families up to date, although there were things to be  
6 learned. Mr Chambers stated that the hospital had  
7 written to the families advising them in an open and  
8 transparent way of what the hospital knew.

9 The Inquiry is concerned to understand the basis on  
10 which Mr Harvey and Mr Chambers made these assertions to  
11 the board. We will hear that parents of babies who were  
12 attacked by Letby were not contacted by the hospital in  
13 advance of the Royal College review; that parents  
14 received letters from the hospital informing them of the  
15 publication of the Royal College report hours before it  
16 was due to go live; that parents struggled to arrange  
17 meetings to talk with Mr Harvey; and that parents were  
18 never told by the Trust that concerns had been raised  
19 about the potential involvement of a particular nurse.

20 I now turn to the events which led to the police.

21 By the time the board next met on 2 May, the  
22 decision to invite a police investigation had all but  
23 been made by the Executive team. The board were updated  
24 both the meetings with the Child Death Overview Panel  
25 and Superintendent Nigel Wenham. There was also some

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1 should have been, but also about whether individuals  
2 were held to account. The Inquiry will be relentless in  
3 its focus on the people attending all of these many  
4 meetings: what they knew, what they should have known,  
5 what they said and what they didn't say, and, when all  
6 of that is established, why.

7 My Lady, that concludes the governance part of this  
8 opening statement.

9 I'm a little early so I would propose to move on to  
10 the next chapter, if that's convenient to you.

11 **LADY JUSTICE THIRLWALL:** Yes, it certainly is convenient.

12 If it suits you, then let's get on with it.

13 **MR DE LA POER:** So we turn now, my Lady, to consider the  
14 role and involvement of external bodies in the events at  
15 the Countess of Chester Hospital.

16 We will consider what information was raised, when  
17 it was raised, and what was done. And we shall start  
18 with an explanation of the role of the main external  
19 bodies to be considered.

20 A local authority has an overarching responsibility  
21 for safeguarding and promoting the welfare of all  
22 children and young people in their area. Every local  
23 authority was required by section 13 of the  
24 Children Act 2004 to establish a Local Safeguarding  
25 Children Board, which was responsible for developing

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1 discussion of communication with parents and the  
2 deterioration in the relationship between the  
3 paediatricians and the Executive team. The latter is  
4 another issue which the Inquiry intends to explore,  
5 namely when did the board, particularly the  
6 Non-Executive Directors, become aware of a deterioration  
7 in the professional relationships between the consultant  
8 paediatricians and the Executive team, and what did they  
9 do about it?

10 Why did it take until July 2016 for the increase in  
11 neonatal mortality to be discussed at a board meeting?

12 Why, when informed of the concerns about neonatal  
13 mortality, did the board take the actions that it did?

14 Although it did not in fact occur, in January 2017  
15 the board approved Letby's planned return to the  
16 neonatal unit. Sir Duncan Nichol knew about the  
17 grievance procedure and its outcome. The Trust did not  
18 formally invite a police investigation until May 2017.

19 We conclude the topic of governance and the role of  
20 the board with this final observation, my Lady: while it  
21 is right that the Inquiry scrutinises, whether  
22 collectively, each of these committees and the board  
23 operated as they should have, when doing so, we do not  
24 intend to lose sight of the fact that governance is both  
25 about whether control and direction was imposed as it

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1 policies and procedures for safeguarding children within  
2 its area.

3 Membership of the board was defined by the Act. In  
4 addition to representatives of the local authority,  
5 membership included the police, NHS England, and any NHS  
6 Trusts or Foundation Trusts that had most of their  
7 hospitals in that area.

8 The Countess of Chester Hospital was in the area of  
9 the Local Safeguarding Children Board of Cheshire West  
10 and Cheshire Council. Ms Kelly was one of its board  
11 members.

12 One of the duties of a Local Safeguarding Children  
13 Board was to collect and analyse information about child  
14 deaths. In England, Local Safeguarding Children Boards  
15 were required by statute to ensure that a review of each  
16 child death resident in their area was undertaken by  
17 a Child Death Overview Panel. These panels had a fixed  
18 core membership drawn from the same organisations  
19 represented on the Local Safeguarding Children Board.

20 The function of the Child Death Overview Panel was  
21 to review every child death, to determine whether that  
22 death was preventable, and whether action could be taken  
23 to prevent future deaths.

24 Patterns or trends in the local data were to be  
25 reported to the Local Safeguarding Children Board.

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1 Where neglect or abuse was suspected, a referral would  
2 be made to the board for consideration of whether  
3 a Serious Case review was required.

4 The Countess of Chester Hospital was in the area of  
5 the Pan Cheshire Child Death Overview Panel. That panel  
6 acted on behalf of the Local Safeguarding Children's  
7 Boards for Cheshire East, Cheshire West, Cheshire,  
8 Halton and Warrington. As we will describe, two of the  
9 seven deaths in respect of which Letby was convicted of  
10 murder were considered by the Pan Cheshire Death  
11 Overview Panel. The other five deaths were reviewed by  
12 panels in Lancashire, Merseyside, and a panel in Wales.

13 Local authorities were required to designate an  
14 officer or team of officers to manage allegations  
15 against people that work with children. These were  
16 known as Local Authority Designated Officers, or LADOs.  
17 The Local Authority Designated Officer for Cheshire West  
18 and Cheshire Council was Paul Jenkins. The Local  
19 Authority Designated Officer would oversee and direct  
20 investigations into an allegation. They would work with  
21 other agencies, such as the police and social care.  
22 Letby was not referred to the Local Authority Designated  
23 Officer until 29 March 2018.

24 NHS England is the commissioner of Neonatal Critical  
25 Care Services and has been since 2012. It is also the  
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1 a charity whose membership is made up of child health  
2 professionals, predominantly paediatricians. It  
3 provides the mandatory training pathways for doctors in  
4 the United Kingdom who wish to train in paediatrics.  
5 Its Royal Charter gives it the power to act as  
6 a consultative body on paediatrics. As stated  
7 previously, the Royal College of Paediatrics and Child  
8 Health undertook an invited review of the neonatal unit  
9 at the Countess of Chester Hospital on the 1 and  
10 2 September 2016, providing its report to the hospital  
11 on 28 November 2016.

12 The Care Quality Commission is the independent  
13 regulator of healthcare in England. It is responsible  
14 for regulating providers of care such as NHS Foundation  
15 Trusts. It monitors and inspects those it regulates and  
16 has the power to take civil or criminal enforcement  
17 action where regulatory standards are not met. The  
18 Countess of Chester Hospital NHS Foundation Trust was  
19 registered with the Care Quality Commission on  
20 1 April 2010. The Care Quality Commission carried out  
21 an inspection at the hospital in February and March 2016  
22 and published its inspection report on 29 June 2016.

23 The Nursing and Midwifery Council is the regulatory  
24 body for nursing and midwifery professionals in the  
25 United Kingdom. It was established by a statutory  
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1 successor of the Independent Regulator of Foundation  
2 Trusts, also known as Monitor, which was responsible for  
3 regulating the provision of healthcare services with  
4 a focus on board and committee level effectiveness.

5 In April 2016, Monitor and the NHS Trust Development  
6 Authority, were brought together under a formal joint  
7 working arrangement to create NHS Improvement. In  
8 February 2019, NHS England and NHS Improvement came  
9 together and in July 2022 officially merged as  
10 NHS England.

11 The neonatal unit at the Countess of Chester  
12 Hospital was one of nine neonatal units that formed the  
13 Cheshire and Merseyside Neonatal Network established in  
14 2004. As Counsel to the Inquiry explained yesterday,  
15 Ms Julie Maddocks was a director of the network and  
16 Dr Nimish Subhedhar was its clinical lead. The Neonatal  
17 Network had a Steering Group chaired by Ms Maddocks  
18 which met quarterly. Part of the role of the Steering  
19 Group was to monitor performance which included  
20 considering neonatal mortality.

21 The network also had a Clinical Effectiveness Group  
22 chaired by Dr Subhedhar. It met bimonthly. There would  
23 be discussion of mortality reviews across the network of  
24 those meetings.

25 The Royal College of Paediatrics and Child Health is  
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1 instrument, the Nursing and Midwifery Order 2001, which  
2 provides that its overarching objective is the  
3 protection of the public.

4 It operates a register of qualified nurses and  
5 misses and publishes the Code of professional standards  
6 applicable to them. It is required by the Code to act  
7 upon allegations made to it that the fitness to practise  
8 of a registrant is impaired. It has the power to seek  
9 disclosure from third parties, and to impose interim  
10 measures of conditions of practise or suspension whilst  
11 carrying out an investigation. Conditions of practise  
12 can include matters such as a requirement to work only  
13 under supervision, or avoid a particular area of  
14 practises.

15 Where the fitness to practise of a registrant is  
16 found to be impaired, sanctions included suspension and  
17 strike off. The NMC operated an employer-linked service  
18 that provided support to employers of nurses with  
19 fitness to practise concerns.

20 The Nursing and Midwifery Council was notified that  
21 there were concerns about Letby on 6 July 2016, but did  
22 not seek a fitness to practise referral until two years  
23 later on 3 July 2018 after she had been arrested. It  
24 did not impose an interim suspension order until more  
25 than two years after that on 20 November 2020, after she  
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1 had been charged.

2 The General Medical Council is the regulator of  
3 doctors in the United Kingdom. It operates a register  
4 and has the power to investigate concerns about the  
5 fitness to practise of its registrants. It publishes  
6 guidance on standards of professional conduct and  
7 performance, including in particular Good Medical  
8 Practice 2013, the professional standards applicable to  
9 doctors.

10 The Royal College of Nurses is a union and  
11 professional body for nurses. It has a membership in  
12 excess of 500,000 people. It is not a regulator. It  
13 provides advice, support and legal representation to its  
14 members.

15 Finally, in terms of those bodies providing external  
16 scrutiny, the British Medical Association, that is the  
17 trade union and professional body for doctors and  
18 medical students in the UK, and provides representation  
19 and support to them. It is not a regulator, its primary  
20 role is in employment matters.

21 My Lady, I wonder if that would be a convenient  
22 moment before we turn to a fresh topic?

23 **LADY JUSTICE THIRLWALL:** Very well, thank you very much

24 Mr de la Poer. We will resume at 11.32.

25 (11.17 am)

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1 on Sudden and Unexpected Infant Deaths which occurred in  
2 the community and does not mention such deaths occurring  
3 in hospital.

4 This version was in force throughout the period of  
5 June 2015 to July 2016, as such, it did not apply to the  
6 situation facing those working at the Countess of  
7 Chester Hospital where the deaths occurred.

8 Although the RCPCH and Royal College of  
9 Pathologists's Sudden and Unexpected Deaths in Infancy  
10 2004 Guidance did not apply to the situation with which  
11 we are concerned, we mention it because some of the  
12 language mirrored that used in a piece of statutory  
13 guidance in relation to child safeguarding which was  
14 published in 2013 and subsequently updated in 2015.

15 That statutory guidance was called Working Together  
16 to Safeguard Children: A Guide to Interagency Working to  
17 Safeguard and Promote the Welfare of Children. It is  
18 commonly referred to simply as "Working Together". The  
19 relevant edition during the time we are concerned with  
20 was dated March 2015.

21 The Working Together Guidance itself makes clear  
22 that it was to be complied with unless exceptional  
23 circumstances arose. The guidance expressly stated that  
24 it was to be read and followed by health services  
25 professionals. It set out the need for organisations to

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1 (A short break)

2 (11.33 am)

3 **LADY JUSTICE THIRLWALL:** Mr de la Poer.

4 **MR DE LA POER:** My Lady, I turn now to guidance aimed at  
5 keeping children safe.

6 There were number of duties imposed on the Trust and  
7 the professionals employed there that were applicable  
8 when children suffered or were at risk of suffering  
9 harm. The local practice in Cheshire at the time  
10 required all child deaths to be reported to the coroner,  
11 irrespective of the circumstances of death. All child  
12 deaths also had to be reported to the Child Death  
13 Overview Panel.

14 Unexpected or unintended events in a hospital that  
15 led to harm had to be reported to NHS England and the  
16 Care Quality Commission. Serious incidents and "Never  
17 Events" had to be reported as such to NHS England.  
18 "Never events" are a particular type of clearly defined  
19 and wholly preventable serious incidents, including  
20 those which have the potential to cause serious patient  
21 harm or death.

22 In 2004, the Royal College of Paediatrics and Child  
23 Health, together with the Royal College of Pathologists,  
24 co-published guidance in relation to Sudden and  
25 Unexpected Deaths in Infancy. That guidance was based

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1 have in place arrangements that reflected the importance  
2 of safeguarding and promoting the welfare of children.

3 There was specific guidance in Working Together as  
4 to the steps to be taken following an unexpected death  
5 of a child. The process also applied where  
6 professionals were uncertain whether the death was  
7 unexpected.

8 Working Together defined an unexpected death as  
9 follows:

10 "The death of an infant or child which was not  
11 anticipated as a significant possibility for example,  
12 24 hours before the death; or where there was an  
13 unexpected collapse or incident leading to or  
14 precipitating the events which lead to the death."

15 This language is used in the guidance published by  
16 the RCPCH in 2004. Under Working Together, following an  
17 unexpected death, the local designated paediatrician,  
18 the coroner and the police were to be informed. The  
19 guidance anticipated that police conducted an  
20 investigation, stating that:

21 "In any case of a sudden expected death of an infant  
22 or child, the police have a duty to investigate the  
23 death on behalf of the coroner."

24 A Senior Investigating Officer within the police  
25 retained overall responsibility for the investigation.

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1 The guidance anticipated the designated paediatrician  
2 initiating and information sharing and planning  
3 discussion between the lead agencies such as health,  
4 police and social care.

5 My Lady, the evidence we have obtained demonstrates  
6 that this guidance was not complied with. Unexpected  
7 deaths did not trigger a police investigation. The  
8 Senior Investigating Officer was not notified of the  
9 instances of unexpected death.

10 An important issue that we shall explore in  
11 evidence, and one that we will return to, is the extent  
12 to which this guidance on unexpected deaths was properly  
13 understood by those working at the hospital and by  
14 connected external agencies.

15 There is evidence of a failure to understand what  
16 process, if any, was to be followed for an unexpected  
17 child death in a hospital. It appears that there was  
18 a belief that an exception existed for unexpected deaths  
19 in hospital, and the guidance did not apply.

20 Working Together guidance makes no exception for  
21 unexpected deaths in hospital. The Inquiry will hear  
22 evidence from Dr Joanna Garstang, a Clinical Associate  
23 Professor of Child Protection. Her statement to this  
24 Inquiry explains that unexpected child deaths in  
25 hospital should have been investigated in the same way

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1 senior nurse on duty will inform the police, and the  
2 location where the child collapsed will be treated as  
3 a scene of Sudden Unexpected Death in Infancy and  
4 Childhood investigation.

5 A rapid response multi-disciplinary meeting was  
6 required within 72 hours. A local child death review  
7 was required within one to eight weeks.

8 A multi-disciplinary case discussion meeting was  
9 required within two to six months.

10 My Lady, there is little evidence demonstrating that  
11 the local guideline was adhered to, certainly not in  
12 respect of the unexpected and unexplained deaths the  
13 Inquiry will be considering. It would appear that only  
14 in the case of the death of Child C, where there was an  
15 initial strategy meeting some 18 days after the death,  
16 does there appear to have been some form of  
17 implementation of the guideline.

18 For those deaths that were unexpected but explained,  
19 the local guideline anticipated discussion with the  
20 parents and the coroner to decide an explanation for the  
21 death. The Inquiry will explore the extent to which  
22 such discussions were held. Where the parents or staff  
23 had any concerns about the child's management, the  
24 guidelines stated that thorough investigation was  
25 needed.

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1 as unexpected child deaths in the community were.

2 Although Working Together did not state explicitly  
3 that its guidance on unexpected deaths applied to deaths  
4 in hospital, local guidance did. The Pan Cheshire Local  
5 Safeguarding Childcare Board published its own  
6 guidelines for the management of sudden unexpected  
7 deaths in infancy and childhood.

8 These local guidelines divided unexpected deaths  
9 into those that were "unexpected and unexplained", and  
10 those which were "unexpected and explained", a division  
11 not found in Working Together to Safeguard Children.

12 For an unexpected and explained death, the  
13 guidelines did not need to be followed if a satisfactory  
14 explanation is determined. For an unexpected and  
15 unexplained death, the guideline was to be followed.

16 These guidelines had a dedicated section on  
17 unexpected deaths on a hospital ward or hospital  
18 setting. There was even a flowchart showing the steps  
19 to be taken following an unexpected death headed "Child  
20 Death in Hospital/Community".

21 You may consider, consistent with the evidence of  
22 Dr Garstang, that this made plain that the same process  
23 applied irrespective of location.

24 This local guideline provided that where there was  
25 an unexpected and unexplained death in a hospital, the

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1 Of note it provided that:

2 "The police will be involved if it is considered  
3 there were suspicious circumstances around the child's  
4 death or concerns have been raised about neglect or  
5 inappropriate medical or nursing care."

6 Before we leave the topic of Sudden and Unexpected  
7 Death in Infancy guidance, we note that in  
8 November 2016, the RCPCH and Royal College of  
9 Pathologists published updated guidance which brought it  
10 into line with the Working Together Guidance and the  
11 local Pan Cheshire guidance and expressly included  
12 reference to the sudden collapse and death of a child on  
13 a neonatal unit.

14 We turn from the sudden unexpected death in infancy  
15 guidance to a Memorandum of Understanding.

16 In addition to the guidance in relation to expected  
17 child deaths, there was a Memorandum of Understanding on  
18 investigating patient safety incidents involving  
19 unexpected death or serious untoward harm. On the face  
20 of the document, it appears to have been agreed in 2016  
21 between the Department of Health on behalf of the  
22 National Health Service, the Association of Chief Police  
23 Officers and the Health and Safety Executive, it was  
24 archived in the National Archives in 2013, and was not  
25 replaced. It was archived possibly because it referred

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1 to organisations abolished following restructuring of  
2 the National Health Service.  
3 The Memorandum of Understanding contained a protocol  
4 for the National Health Service patient safety incidents  
5 involving unexpected death or serious untoward harm  
6 requiring investigation by the police and/or the Health  
7 and Safety Executive. It was not specific to child  
8 deaths.

9 The foreword states that:

10 "Investigation should take place only where there is  
11 clear evidence of a criminal offence having been  
12 committed."

13 Paragraph 1.1 of the protocol stated that:

14 "The investigation would normally be required if an  
15 incident had arisen from or involved criminal intent,  
16 recklessness or gross negligence."

17 Paragraph 2.7 sets out the type of incident that  
18 might prompt the trust to involve the police. Included  
19 were those where there was evidence or suspicion that  
20 the actions leading to harm or adverse consequences were  
21 intended.

22 Guidelines to the NHS were issued to accompany the  
23 Memorandum of Understanding. We will look at this  
24 document in detail during the evidence. For the time  
25 being it is sufficient to observe that it provides what

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1 that some sort of proof of criminality was necessary  
2 before those with the responsibility to investigate  
3 concerns could be notified.

4 This is troubling, my Lady may think, because it is  
5 contrary to the clear guidance which safeguarding  
6 provides. Child protection, or safeguarding as it is  
7 now referred to, sets a low threshold for raising  
8 concerns in respect of child safety. It was not  
9 necessary for those with concerns about the safety of  
10 babies at the hospital to embark on their own  
11 investigation or evidence-gathering exercise before  
12 making referrals.

13 Working Together provided that any allegation that  
14 a person working with children had "behaved in a way  
15 that has harmed a child, or may have harmed a child, or  
16 that they may possibly have committed a criminal offence  
17 related to a child" should be reported immediately to  
18 a senior manager within the organisation, and the Local  
19 Authority Designated Officer should be informed within  
20 one working day. That provision was not, as we shall  
21 see, complied with.

22 The local guidance contained in the Pan Cheshire  
23 Child Death Overview Panel protocol stated that:

24 "Where, at any stage, a child may have been or  
25 likely to be harmed, there will need to be interagency

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1 are described as "case studies" which appear to be held  
2 up as examples of good practice.

3 In the first, it is suspected that a device had been  
4 tampered with and as a result, the police were called.

5 The Guidelines to the NHS were archived at the same  
6 time as the Memorandum of Understanding. Despite  
7 a recommend to this effect in 2018 by  
8 Professor Norman Williams in his "Gross Negligence in  
9 Healthcare" report, the Memorandum of Understanding and  
10 the guidelines have yet to be replaced.

11 The Inquiry has been informed by the Department of  
12 Health and Social Care that a working group established  
13 following Professor Williams' report is working on this,  
14 and "it is currently being finalised with a view to  
15 publishing as soon as possible."

16 The Inquiry Will be seeking to understand why there  
17 was no such guidance in place from 2015 to 2017, and why  
18 there is still no such guidance in place.

19 I turn now to consider the reports to external  
20 bodies. The Inquiry will explore the circumstances in  
21 which suspicions about Letby were raised externally.  
22 My Lady, you may consider that a troubling feature  
23 revealed by the evidence is that all too often, it  
24 appears that a high threshold was believed to exist for  
25 raising concerns of potential harm to babies, namely

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1 child protection and/or criminal investigation led by  
2 the police."

3 It also provided that where a suspicion arises that  
4 neglect or abuse may [and I stress the word 'may'] have  
5 been a factor in the child's death, the case should be  
6 highlighted to the chair of the relevant Local  
7 Safeguarding Children Board and Serious Case review  
8 procedures should be followed.

9 The Nursing and Midwifery Code of Professional  
10 Standards imposes on nurses a duty to "share information  
11 if you believed someone may be at risk of harm".

12 It required them to:

13 "Acknowledge and act on all concerns raised to you,  
14 investigating, escalating or dealing with those concerns  
15 where it is appropriate for you to do so."

16 The General Medical Council's Good Medical Practice  
17 required a doctor to "take prompt action" if they  
18 thought "patient safety, dignity, or comfort is or may  
19 be seriously compromised."

20 It provided that where a doctor had "concerns that a  
21 colleague may not be fit to practise and may be putting  
22 patients at risk", advice must be sought from  
23 a colleague, defence body or the General Medical  
24 Council. Where there were still concerns, it was  
25 necessary to report them.

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1 The General Medical Council published specific  
2 guidance in 2012 titled "Raising and acting on concern  
3 about patient safety" which stated that all doctors had  
4 a duty:

5 "... to raise concerns where they believed that  
6 patient safety or care is being compromised by the  
7 practice of colleagues."

8 And that a doctor did:

9 "... not need to wait for proof -- you will be able  
10 to justify raising a concern if you do so honestly on  
11 the basis of reasonable belief."

12 The General Medical Council also published in 2012  
13 guidance titled "Protecting children and young People.  
14 The responsibilities of all doctors".

15 It provided that:

16 "All doctors must act on any concerns they have  
17 about the welfare or safety of a child or young people."

18 It states that:

19 "... it is vital that all doctors have the  
20 confidence to act if they believe that a child or young  
21 person may be being abused or neglected. Taking action  
22 will be justified, even if it turns out that the child  
23 or young person is not at risk of suffering, abuse or  
24 neglect, as long as the concerns are honestly held and  
25 reasonable, and that the doctor takes action through

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1 point. It states:

2 "If you believe that something is wrong, you do not  
3 need proof. Speaking out early could stop the issue  
4 from becoming more serious, dangerous, or damaging."

5 In respect of patient safeguarding it identifies  
6 that:

7 "It is not the worker's responsibility to  
8 investigate or decide if abuse has happened, only to  
9 make sure that the appropriate agencies are told about  
10 their concerns or suspicions."

11 The Care Quality Commission published a guide on  
12 raising a concern with them. It stated that everyone  
13 working in health and social care had a duty to put  
14 patients first and protect their safety.

15 It encouraged and recommended attempting to resolve  
16 a concern within the organisation first. Where that  
17 could not be done or had already been tried, the  
18 guidance provided that:

19 "The concern could be raised in confidence with the  
20 Care Quality Commission."

21 It explained that raising a genuine concern about  
22 the safety of patients would be justified if done  
23 honestly and reasonably, even if the concern is  
24 mistaken.

25 The Inquiry will explore the extent to which all of

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1 appropriate channels."

2 This guidance requires doctors to "have a working  
3 knowledge of local procedures for protecting children  
4 and young people in their area" and requires them to  
5 know what to do when concerned that a child or young  
6 person is at risk of, or is suffering abuse or neglect.

7 It provides specific advice on sharing information  
8 stating this:

9 "You must tell an appropriate agency, such as your  
10 local authority children's services, the NSPCC or the  
11 police promptly if you are concerned that a child or  
12 young person is at risk of, or is suffering abuse or  
13 neglect unless it is not in their best interests to do  
14 so. You do not need to be certain ... the possible  
15 consequences of not sharing relevant information will,  
16 in the overwhelming majority of cases, outweigh any harm  
17 that sharing your concerns with an appropriate agency  
18 might cause."

19 It advises that "any decision to delay sharing  
20 information must be taken cautiously" and makes the  
21 point that "in sharing concerns about possible abuse or  
22 neglect, you are not making the final decision about how  
23 to best protect a child or young person."

24 The April 2014 Whistleblowing Guidance for Workers  
25 and Employers in Health and Social Care makes a similar

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1 this guidance was understood and complied with.

2 There were concerns about the increase in neonatal  
3 deaths, in particular unexpected deaths, and there were  
4 concerns that Letby might be harming children long  
5 before the disclosure to the police on 27 April 2017,  
6 the referral to the Local Authority Designated Officer  
7 on 29 March 2018, and the fitness to practise referral  
8 to the Nursing and Midwifery Council on 5 July 2018.

9 We turn now to consider the timeline of the  
10 involvement of external bodies.

11 We are going to look at when they became involved,  
12 as matters unfolded, and what information was provided  
13 to them. We begin with July 2015.

14 On 3 July 2015, a report concerning Child D was made  
15 on the NHS England Strategic Executive Information  
16 System. This was the mechanism for reporting Serious  
17 Incidents or Never Events. In his forth statement to  
18 the Inquiry, Professor Sir Stephen Powis, the National  
19 Medical Director of NHS England, explains that a death  
20 in itself would not constitute a Serious Incident. An  
21 act or omission in the delivery of healthcare that  
22 resulted in death or harm would lead to a Serious  
23 Incident being declared. We will examine where an  
24 unexpected death fits into this process.

25 The reason given for reporting Child D was

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1 documented by NHS England to be "unexpected/potentially  
2 avoidable death". However, the Serious Incident being  
3 reported was the delay in recognising signs of sepsis  
4 when Child D was born on 20 June 2015.

5 On 9 July 2015, the earlier death of Child A on  
6 8 June 2015 was reported to the NHS England's National  
7 Reporting and Learning System. This is the national  
8 database to which patient safety incident reports are  
9 uploaded.

10 Reporting to the National Reporting and Learning  
11 System satisfied the obligation on the Countess of  
12 Chester Hospital to report patient safety incidents  
13 resulting in severe harm or death to the Care Quality  
14 Commission as reports to this system were shared with  
15 the Care Quality Commission.

16 Incidents could be reported as "no harm", "low  
17 harm", "moderate harm", "severe harm", or "death/fatal".  
18 If a patient safety incident was recorded as resulting  
19 in severe harm or death and the report suggested an  
20 ongoing risk to patient safety,  
21 Professor Sir Stephen Powis explains in his fourth  
22 statement to the Inquiry that NHS England's National  
23 Patient Safety Team would look for evidence of  
24 escalation of concerns. The description in the report  
25 of Child A's death was:

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1 in the area where the death occurred would be notified  
2 of the death. For all deaths at the Countess of Chester  
3 Hospital, that would have resulted in the Pan Cheshire  
4 Child Death Overview Panel being notified of their  
5 deaths. The 2010 guidance envisaged there being liaison  
6 with the Child Death Overview Panel where the child  
7 resided, if different, to determine which would take  
8 responsibility for the review.

9 The obvious benefit of that system was that where  
10 there was a cluster or pattern of deaths in one area  
11 involving children who lived in different areas, the  
12 Child Death Review process would be better able to  
13 detect and interrogate that cluster.

14 However, this process of liaising between Child  
15 Death Overview Panels was not repeated in the 2015  
16 edition of Working Together. The 2015 edition simply  
17 stated that the Local Safeguarding Children Board was:

18 "... responsible for ensuring that a review of each  
19 death of a child normally resident in the LSCB's area is  
20 undertaken by a [Child Death Overview Panel]."

21 The Pan Cheshire Child Death Overview Panel Protocol  
22 published in July 2015 was not particularly clear on  
23 this point. Certainly the practice that appears to have  
24 been followed at the time was that only the panel in the  
25 area where the child resided was notified. The result

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1 "Sudden and unexpected deterioration and death or  
2 patient on the neonatal unit after full resuscitation  
3 requiring post-mortem".

4 The incident was categorised as being of the "no  
5 harm" severity. We will explore in evidence why this is  
6 death and others were categorised as "no harm" events  
7 and whether that was a proper categorisation.

8 On 16 July 2015 a review of the death of Child D was  
9 undertaken by a Death Review Panel in Wales chaired by  
10 Dr Lawrence Dixon. This was less than a month after  
11 Child D's death on 22 June 2015, which had been the  
12 third death on the neonatal unit within a fortnight.

13 We have explained that local authorities in England  
14 had a statutory duty to ensure that all child deaths  
15 were reviewed by a Child Death Overview Panel. This  
16 statutory duty did not apply in Wales. The panel that  
17 reviewed Child D's death had been set up informally and  
18 had no specific statutory footing. Its remit appears to  
19 have been narrower than that for Child Death Overview  
20 Panels in England.

21 Certainly its reviews appeared rather more succinct.

22 My Lady, you may query why the death of Child D in  
23 Cheshire was being reviewed by a panel in Wales. Prior  
24 to the 2015 edition of Working Together, the 2010  
25 edition had provided that the Child Death Overview Panel

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1 was that the seven deaths we are focusing upon were  
2 reported to four different panels. The ability of any  
3 one of them to detect a pattern was thereby diminished.  
4 This suggests there was a significant issue with the  
5 system, which requires to be addressed.

6 Returning to the review of the death of Child D. It  
7 was conducted before the post-mortem report was  
8 available, and before the Obstetric Secondary Review  
9 Team's case review. A panel in England would not  
10 usually undertake a review whilst other investigations  
11 were ongoing. The notes of the panel's review, which are  
12 extremely brief, do not refer to the fact that Child D  
13 was one of three deaths in less than a fortnight. They  
14 do not refer to the fact a serious incident had been  
15 reported to the Strategic Executive Information System.  
16 The note simply records that Child D died at the  
17 Countess of Chester Hospital two days after birth. The  
18 panel gave a cause of death of "complications of  
19 delivery".

20 (Pause) No further action was recommended. No  
21 further review was planned.

22 On 21 July 2015, the Care Quality Commission met  
23 with Mr Harvey, Mr Chambers, Ms Kelly and Ms Millward.  
24 The notes of this meeting do not indicate discussion of  
25 neonatal issues or the recent incidents of unexpected

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1 neonatal deaths. This will be explored in oral  
2 evidence.

3 We turn then to August 2015. The report of a death  
4 of Child C on 14 June 2015 was uploaded to the NHS  
5 England's National Reporting and Learning System on  
6 14 August 2015. It was reported as being in the "no  
7 harm" severity category.

8 Similarly, the reports of the death of Child E on  
9 4 August 2015 was uploaded to the National Reporting and  
10 Learning System on 24 August 2015 in the "no harm"  
11 severity category.

12 Moving to September 2015. On 9 September 2015, the  
13 report of a death of Child D was uploaded to NHS  
14 England's National Reporting and Learning System but it  
15 was categorised as "moderate harm" that categorisation  
16 is at odds with the draft report of the Obstetrics  
17 Secondary Review Team's review on 28 August 2015, which  
18 that characterised Child D's case as having a "severe  
19 severity level".

20 On 16 September 2015 there were meetings of both the  
21 Steering Group and the Clinical Effectiveness Group of  
22 the Cheshire and Merseyside Neonatal Network, both were  
23 attended by Dr Brearey.

24 Quarterly reports containing data on each neonatal  
25 unit in the network were supposed to be prepared for

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1 meetings. Dr Brearey's statement to the Inquiry is that  
2 the deaths of Child A, Child C, and Child D were  
3 discussed during the meeting.

4 He also states that he raised informally with  
5 Dr Subheddar after the meeting the fact that there had  
6 been five deaths on the unit since June 2015. But he  
7 did not mention any concerns about Letby.

8 Two days later on 18 September 2015, the Local  
9 Safeguarding Children Board had a meeting. This was  
10 attended by Ms Kelly and Dr Mittal as well as Detective  
11 Chief Superintendent Nigel Wenham of the Cheshire  
12 Police. The notes do not indicate that there was any  
13 discussion of or concerns raised in relation to neonatal  
14 mortality or incidences of unexpected death.

15 We move from September to November 2015.

16 There was a further meeting of the Clinical  
17 Effectiveness Group of the Cheshire and Merseyside  
18 Neonatal Network on 12 November 2015. This was attended  
19 by Ms Powell and Dr Brearey.

20 The discussion of mortality included three deaths at  
21 the Countess of Chester Hospital, one of which appears  
22 to be the death of Child E. The notes of the meeting do  
23 not expressly describe the death as unexpected. They do  
24 not describe any discussion of concerns of deliberate  
25 harm or increased mortality.

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1 Steering Group meetings. Those reports contained data  
2 on neonatal mortality. As I have indicated, part of the  
3 Steering Group role was to monitor performance of the  
4 neonatal units. That included, as Dr Subheddar's  
5 statement to the Inquiry explains Identifying:

6 "... variations in clinical outcomes which would be  
7 included in neonatal mortality."

8 However, no quarterly report was prepared for the  
9 meeting on 26 September 2015. Indeed, it appears no  
10 quarterly report had been prepared for the previous  
11 meeting on 4 June 2015 either.

12 The last quarterly report was prepared for the  
13 Steering Group meeting on 12 March 2015. It showed  
14 three deaths in 12 months at the Countess of Chester  
15 Hospital, with zero deaths in three of the four quarters  
16 covered.

17 The notes of the meeting on 16 September 2015 do not  
18 describe any discussion of the recent neonatal deaths at  
19 the Countess of Chester Hospital. The Inquiry will  
20 explore in evidence why that was the case, and whether  
21 there should have been discussion within that forum.

22 The notes of the meaning of the Clinical  
23 Effectiveness Group on the same day describe three  
24 deaths at the Countess of Chester Hospital that were  
25 "under review" and would be discussed at subsequent

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1 Dr Subheddar's evidence to the Inquiry is that if  
2 there had been concerns, he would have expected them to  
3 be raised at the Steering Group, rather than this  
4 Clinical Effectiveness Group. Indeed, he states he  
5 would have considered it inappropriate for staffing  
6 factors relating to the deaths to be discussed at the  
7 Clinical Effectiveness Group. Similarly, Dr Brearey's  
8 statement to the Inquiry is that he did not think the  
9 Clinical Effectiveness Group an appropriate forum to  
10 raise concerns about Letby.

11 He does state that he approached Dr Subheddar again  
12 after this meeting. The Inquiry will explore if and why  
13 there was a culture that deemed raising safeguarding  
14 concerns in a clinical effectiveness meeting was  
15 inappropriate.

16 On 27 November 2015 the report of the death of  
17 Child I on 23 October 2015 was uploaded to NHS England's  
18 National Reporting and Learning System. The severity  
19 categorisation was again "no harm".

20 We move forward to December 2015. There was  
21 a meeting of the Cheshire and Merseyside Neonatal  
22 Network Steering Group on 3 December 2015. My Lady, in  
23 the light of the points made by Dr Subheddar and  
24 Dr Brearey, it might be thought that this was  
25 an appropriate or alternative opportunity to raise the

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1 issue of increased mortality at the Countess of Chester  
2 Hospital, and any concerns relating to it. The notes do  
3 not indicate that this was done. They do not suggest  
4 any discussion of the increased mortality at the  
5 hospital.

6 At this meeting, unlike the previous two Steering  
7 Group meetings, a Quarterly Data Report had been  
8 prepared. It did not however contain mortality data  
9 from the Countess of Chester Hospital. This was a third  
10 meeting in a row without neonatal mortality data from  
11 the Trust.

12 On 18 December 2015, the Pan Lancashire Child Death  
13 Overview Panel, chaired by Mike Leaf, reviewed the death  
14 of Child E that had occurred on 4 August 2015. Some  
15 delay between a death and a review between a panel was  
16 not unusual. The Child Death Overview Panel review was  
17 the final stage of the review process, occurring after  
18 all other investigations were complete. This meant  
19 there could be a delay of months or years before a child  
20 death was reviewed by a panel.

21 Child E's death had been reported to the panel as  
22 one that was "unexpected" but with "a clear medical  
23 explanation for the death", discussed with and accepted  
24 by the coroner. The report to the panel did not  
25 identify any features of concern as to the circumstances

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1 a meeting with professionals from every hospital in the  
2 network present. Following this meeting, Dr Brearey  
3 again discussed the increased mortality with  
4 Dr Subhedar. He asked Dr Subhedar to act as an external  
5 panel member for the thematic mortality review that took  
6 place the following month.

7 Dr Subhedar does not recall any concern about the  
8 involvement of a member of staff being raised during  
9 this discussion. The Steering Group of the Cheshire and  
10 Merseyside Neonatal Network met on 29 January 2016. The  
11 Quarterly Data Report prepared for this meeting  
12 contained for the first time since March 2015, mortality  
13 data from the Countess of Chester Hospital. That data  
14 showed eight deaths in 12 months.

15 There were zero deaths in the fourth quarter of 2014  
16 to 15, but three deaths in the first and second quarters  
17 of 2015/16 and two deaths in the third quarter.

18 That data was in stark contrast to the last  
19 available Quarterly Data Report containing mortality  
20 data from the Countess of Chester Hospital, prepared for  
21 the meeting in March 2015, which showed three deaths in  
22 12 months with three of the four quarters having zero  
23 deaths. The disparity in data appears not to have been  
24 appreciated at the Steering Group meeting. Dr Yoxall  
25 was the director of the neonatal unit at the Liverpool

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1 of Child E's death.

2 Mr Leaf's statement to the Inquiry is that the Pan  
3 Lancashire Child Death Overview Panel was unaware that  
4 Child E was the fourth death at the hospital since the  
5 start of June 2015. It was unaware that there had been  
6 a further child death at the hospital since. The panel  
7 would not normally ask about the hospital neonatal  
8 mortality without a particular reason to do so. No  
9 ongoing concerns had been communicated to the panel.

10 The panel concluded that the death was an expected  
11 one with no modifiable factors identified. No  
12 recommendations were made, and no further steps were  
13 taken.

14 We move forward to 2016 and begin with January. On  
15 21 January 2016 the Clinical Effectiveness Group of the  
16 Cheshire and Merseyside Neonatal Network met. The notes  
17 indicate that the discussion of mortality included  
18 a review of the death of Child I. The notes of the  
19 meeting do not describe the death as having been  
20 unexpected and there is no evidence suggesting any  
21 concerns relating to neonatal mortality at the hospital  
22 were raised.

23 In his statement to the Inquiry, Dr Brearey explains  
24 that he did not think it appropriate to discuss the  
25 association of increased mortality with Letby at

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1 Women's Hospital. He sat on the Steering Group. He  
2 explains in his statement to the Inquiry that the  
3 presentation of the data did not include historic or  
4 expected death rates.

5 The quarterly reports only provided data over four  
6 quarters, so 12 months in total. Dr Yoxall states that  
7 if the data had been properly considered, it is likely  
8 it would have prompted a discussion and an explanation  
9 from the Countess of Chester Hospital would have been  
10 requested. In fact, the notes of the meeting do not  
11 indicate any discussion of increased mortality or any  
12 concerns relating to unexpected deaths or deliberate  
13 harm at the Countess of Chester Hospital.

14 We move then to February 2016. Dr Subhedar attended  
15 the Countess of Chester Hospital on 8 February 2016, to  
16 take part in the thematic review meeting. Counsel to  
17 the Inquiry addressed you yesterday about this meeting,  
18 and the report that was produced by Dr Brearey following  
19 it.

20 Dr Subhedar does not recall at the review there  
21 being any detailed discussion about nurse staffing, or  
22 about any one individual nurse. He states that this is  
23 his belief that Letby's potential involvement was either  
24 not discussed or was not discussed in any detail.

25 However, he also accepts that "some concerns must

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1 have been alluded to at the thematic remind meeting  
2 around members of staff being implicated in some way".

3 Dr Brearey's evidence on this point is that Letby  
4 was discussed at the meeting. After the individual  
5 deaths were discussed, he states he "raised the issue of  
6 staffing analysis and association with a nurse".

7 Dr Subhedar's evidence is that his view was that the  
8 correct approach was to perform an evaluation of  
9 staffing around each death before concluding that any  
10 individual staff member was implicated.

11 My Lady, you may question -- the question you may  
12 consider arises is why additional analysis was required  
13 to that already carried out and contained in the table  
14 of staff on duty that had already been prepared.

15 We pause now to acknowledge that we have reached the  
16 stage in the chronology where the Care Quality  
17 Commission carried out their inspection.

18 The Trust was inspected by the Care Quality  
19 Commission from 16 February 2016 to 19 February 2016,  
20 with unannounced visits on 26 February and 4 March.

21 Part of the inspection was of the Children and Young  
22 Person Service at the hospital including the neonatal  
23 unit. The head of the inspection, the Care Quality  
24 Commission, sought information from the Countess of  
25 Chester Hospital and third parties. It has proven

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1 the National Reporting and Learning System, amongst the  
2 green entries indicating no harm incidents were child  
3 deaths on the neonatal unit.

4 There are eight entries relating to deaths on the  
5 neonatal unit characterised this way. Two entries  
6 appear to reference to Child A's death on 8 June 2015,  
7 and describe "sudden and unexpected deterioration and  
8 death of a patient on the neonatal unit requiring  
9 post-mortem."

10 One appears to be a reference to the death of  
11 Child E, described as "unexpected death following GI  
12 bleed".

13 One appears to refer to the death of Child I.

14 In addition to this table and in any event, the  
15 reports of deaths to NHS England's National Reporting  
16 and Learning System are shared with the Care Quality  
17 Commission. They had a means then to be aware of the  
18 deaths that had occurred.

19 The inspection itself comprised focus groups, core  
20 interviews with senior members of staff and Executives  
21 conducted by the Trust-wide inspection team and  
22 interviews and observations in specific service areas  
23 such as Children and Young Person Services.

24 We have obtained a witness statement from  
25 Elizabeth Childs, who was part of the Trust-wide

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1 difficult for the Care Quality Commission to provide  
2 a clear and comprehensive account of what information  
3 was gathered prior to and at the inspection.

4 We are aware that data was obtained through Provider  
5 Information Returns and in response to Data Requests.

6 Of the data we do know that the Care Quality  
7 Commission received, there is a table prepared by  
8 Countess of Chester Hospital of Children and Young  
9 Person Service incidents. It contains analysis of some  
10 431 incidents in the Children and Young Person Service  
11 covering paediatric services in addition to the neonatal  
12 unit in the period of 1 December 2014 to  
13 30 November 2015.

14 The final page of the analysis states that 11 cases  
15 were subject to further investigation, one of which was  
16 an unexpected neonatal death.

17 The Care Quality Commission also received, in  
18 response to a data request made the day before the  
19 inspection on 15 February 2016, a 25-page table of  
20 neonatal unit paediatric incidents in the period  
21 1 December 2015 to 31 January 2016. This table had  
22 a column titled "Actual Harm" and entries were coloured  
23 green for "none", yellow for "low", orange for  
24 "moderate" and red for "severe".

25 As I have indicated when describing the reports to

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1 inspection team. She took part in the core interviews  
2 with senior staff including Mr Chambers, Mr Harvey,  
3 Ms Kelly and Ms Millward. Notes of the interviews with  
4 Mr Chambers and Ms Kelly and Ms Millward are yet to be  
5 located and provided by the Care Quality Commission.

6 Ms Childs does not recall a discussion in the cause  
7 of unexplained or unexpected neonatal deaths. She is  
8 certain that there was no mention of a suspicious  
9 correlation of those deaths with a member of staff. She  
10 explains that her expectation is that those with  
11 concerns about increased mortality rates would raise  
12 concerns with CQC inspectors.

13 There was a focus group for the consultants at the  
14 Trust. The full set of notes of this have not located  
15 or provided. The evidence that is available suggests  
16 that issues raised at this focus group by consultants  
17 included a lack of support for management and a bullying  
18 culture.

19 The inspection of Children and Young Persons  
20 services was led by Helen Cain, a children's nurse who  
21 was employed by the Care Quality Commission as an acute  
22 hospital inspector.

23 In addition, there were two specialist advisers,  
24 Benjamin Odeka, a consultant in paediatrics and  
25 gastroenterology, and Mary Potter, a registered

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1 children's nurse.  
 2 All three have provided statements to the Inquiry.  
 3 All three state that they would expect concerns about an  
 4 increase in neonatal mortality, concerns about in  
 5 expected or unexplained neonatal deaths, and any  
 6 correlation between the deaths and a member of staff to  
 7 be raised with them. All three state that they do not  
 8 recall such matters being raised.  
 9 We have been provided with notes made by these three  
 10 inspectors. They do not refer to increased mortality or  
 11 concerns about unexpected or unexplained deaths or  
 12 possible deliberate harm.  
 13 In his statement to the Inquiry, Dr Brearey states  
 14 that neonatal mortality was not brought up by the Care  
 15 Quality Commission inspectors. He describes that one of  
 16 his colleagues, Doctor ZA, told an inspector that "We  
 17 have some serious patient safety concerns and don't feel  
 18 like we are being listened to, but that this was  
 19 ignored", and the inspectors left before there was time  
 20 to expand upon the concerns.  
 21 My Lady may be concerned as to a system of  
 22 monitoring inspection that was not alert to the  
 23 increased mortality, despite Care Quality Commission  
 24 receiving reports to the National Reporting and Learning  
 25 System, and apparently tracking the Strategic Executive  
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1 evidence gathered appears to show that the Care Quality  
 2 Commission was oblivious to the rise in mortality, and  
 3 that the connected concerns relating to the unexpected  
 4 nature of the deaths and the suspicions relating to  
 5 Letby.  
 6 My Lady, that brings us to March 2016.  
 7 The Cheshire and Merseyside Neonatal Network  
 8 Clinical Effectiveness Group met on 16 March 2016. It  
 9 was attended by Dr Brearey and Ms Powell. Two deaths at  
 10 the Countess of Chester Hospital were considered in the  
 11 mortality review. Yet again, there is no indication in  
 12 the notes of this meeting that there was any discussion  
 13 of any concerns in relation to the rise in neonatal  
 14 deaths at the hospital.  
 15 On 23 March of 2016, the Merseyside Child Death  
 16 Overview Panel, chaired by David Hunter, a former  
 17 Detective Chief Superintendent, conducted a review of  
 18 the death of Child C. The death had been reported to  
 19 the panel as unexpected, but with a cause of death as  
 20 found by the pathologist Dr Kokai. No concerns or  
 21 suspicion is raised in the report.  
 22 The panel in that review did not identify any  
 23 modifiable factors and no modifications or  
 24 recommendations or learning points were identified. For  
 25 reasons that are unclear, the dead was classified as  
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1 Information System.  
 2 My Lady, we will explore in evidence why the Care  
 3 Quality Commission did not detect prior to or during the  
 4 inspection the concerns on the neonatal unit. It is  
 5 notable that Letby attempted to murder Child K in the  
 6 early hours of 17 February 2016, the second day of the  
 7 inspection.  
 8 The questions that arise are as to the adequacy of  
 9 the information obtained by the Care Quality Commission,  
 10 whether the information that was available was fully  
 11 considered, whether there was a missed opportunity by  
 12 the inspectors to discuss and ask questions that would  
 13 have elicited those concerns, or a missed opportunity by  
 14 the staff interviewed in not sharing those concerns.  
 15 My Lady will note in this context the recent  
 16 publication on 26 July of 2024 of Dr Penelope Dash's  
 17 interim report titled "Review into the operational  
 18 effectiveness of the Care Quality Commission".  
 19 Whilst this review is of the single assessment  
 20 framework introduced in 2023, one of the concerns  
 21 identified in that report was the lack of focus on  
 22 outcomes, it being noted that there was "surprisingly  
 23 little evidence of assessments and inspections  
 24 considering the outcomes of care".  
 25 In the case of the Countess of Chester Hospital, the  
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1 "perinatal/neonatal event" rather than unexpected death.  
 2 In this statement to the Inquiry, Mr Hunter states  
 3 that the panel was unaware of the increase in neonatal  
 4 mortality at the Countess of Chester Hospital. They  
 5 were unaware of any concerns about Letby.  
 6 Mr Hunter considers that Dr Brearey's concerns  
 7 should have been shared with the panel. The lack of  
 8 knowledge of the increase of deaths "denied the panel  
 9 vitally important information relevant to its role as an  
 10 independent scrutineer".  
 11 We move forward now to May 2016.  
 12 The Cheshire and Merseyside Neonatal Network  
 13 Steering Group met on 12 May 2016. Yet again there was  
 14 no Quarterly Data Report for the meeting. Had there  
 15 been, based on the previous and subsequent data report,  
 16 it would have shown 11 neonatal deaths over the previous  
 17 12 months at the Countess of Chester Hospital. Again,  
 18 the note of the meeting does not indicate that there was  
 19 any discussion of neonatal mortality at the meeting.  
 20 Two deaths at the Countess of Chester Hospital were  
 21 discussed at the Cheshire and Merseyside Neonatal  
 22 Network Clinical Effectiveness Group on 18 May 2016 .  
 23 There is no indication in the note of this meeting of  
 24 discussions, of concerns, in relation to neonatal  
 25 mortality at the Countess of Chester Hospital or the  
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1 matters that had arisen in the thematic review attended  
2 by Dr Subhedar.  
3 June 2016.

4 Following the deaths of Child O and Child P, on  
5 23 June and 24 June 2016, Ian Harvey contacted the Royal  
6 College of Paediatric and Child Health by email on  
7 28 June 2016 asking whether they offered an independent  
8 review service, "for individual practice or for  
9 departments where there are concerns".

10 The next day on 29 June 2016, the Care Quality  
11 Commission Inspection Report was published. Services  
12 for Children and Young People were rated as good  
13 overall, and good in the categories effective, caring,  
14 responsive, and well led. The rating in the safety  
15 category was "requires improvement". The issues raised  
16 relevant to the safety category related to staffing  
17 levels, storage space, safeguarding training and  
18 inconsistent recording of daily checks of resuscitation  
19 equipment and controlled medication.

20 The report found that:

21 "There were robust systems for reporting actual and  
22 near-miss incidents. Staff were familiar with, and  
23 encouraged and supported, to use the Trust's procedures  
24 for reporting incidents."

25 The report also found:

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1 record "Near miss incidents were not escalated. No  
2 Datix or individual case review."

3 The Inquiry will explore in evidence what approach  
4 was taken to the reporting of near miss incidents and  
5 asking where incidents were not reported and Datix forms  
6 not completed, why this was so.

7 Ms Kelly's conclusion at that meeting, in direct  
8 contradiction of the CQC finding was:

9 "It was clear from what the Head of Risk and Safety  
10 was saying that the NNU were not following the Trust's  
11 risk management processes and that incidents were not  
12 getting reported via Datix as they should have been."

13 The inspection report, that is to say the CQC  
14 inspection report, does not comment on neonatal  
15 mortality rates or the incidents of unexpected deaths.

16 In respect of safeguarding, the report found that  
17 policies and procedures were in place and staff were  
18 aware of their roles and responsibilities, and knew how  
19 to raise matters of concern appropriately.

20 My Lady, the basis for this finding will be explored  
21 in evidence.

22 As we have explained, the Inquiry will consider in  
23 detail the extent to which staff were in fact familiar  
24 with the requirements of national and local safeguarding  
25 procedures, given that they do not seem to have been

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1 "Incidents were reported appropriately with the  
2 majority being low or no harm", and that, "no 'never'  
3 events or serious incidents" were reported between  
4 November 2014 and January 2016 within Children's  
5 Services.

6 It is not clear how the CQC finding of "no serious  
7 incidents" was made given the report made to the  
8 Strategic Executive Information System, that is to say  
9 the system for reporting serious incidents, on  
10 3 July 2015, in respect of Child D.

11 Moreover, whilst the majority of incidents reported  
12 were "low harm" or "no harm" the Inquiry will need to  
13 consider whether an unexpected neonatal death ought  
14 properly to have been reported in such a manner.

15 It is also not clear what the basis for saying  
16 "incidents were reported appropriately", in  
17 circumstances in which number of senior management  
18 witnesses speak about an unsatisfactorily low level of  
19 reporting of incidents using Datix on the neonatal unit.

20 By way of example, this was a matter which was  
21 discussed just four months after the CQC inspection at  
22 an Executive Team Meeting, at which meeting the Head of  
23 Risk and Safety is recorded as raising her concern about  
24 the lack of Datix reporting on the neonatal unit.

25 The minutes of the relevant meeting in July 2016

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1 followed.

2 The report found that staff were noted to be  
3 unfamiliar with the term "duty of candour" but could  
4 describe the principle and the circumstances in which it  
5 was used.

6 On the day the inspection report was published,  
7 29 June 2016, Ms Kelly contacted the Care Quality  
8 Commission by telephone, reporting that the Trust had  
9 identified an increase in neonatal deaths in 2015/2016  
10 and 2016/2017, compared to previous years. She reported  
11 that there had been two neonatal deaths that weekend.

12 The next day, 30 June 2016, Ms Kelly followed up  
13 with an email to the Care Quality Commission reporting  
14 the increased neonatal mortality.

15 The email referred to the thematic review and  
16 asserted that it had been submitted as part of the  
17 Countess of Chester Hospital's "CQC inspection data  
18 pack". It is presently unclear whether the Care Quality  
19 Commission accepts that it received the review in  
20 advance of the inspection or not. Ms Kelly's email does  
21 not describe any concerns or suspicions in relation to  
22 Letby but does state that amongst the actions being  
23 taken was a "deep dive into staff rotas regarding staff  
24 on duty at the time of the deaths".

25 The deaths of Child O and Child P were reported to

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1 NHS England using the Strategic Executive Information  
2 System on 30 June 2016. The reasons state for reporting  
3 the deaths was that they were in the category of  
4 "unexpected/potentially avoidable death".

5 My Lady, you may take the view that this category  
6 applied to other unexpected deaths, not reported as  
7 serious incidents.

8 In his first statement to this Inquiry, Professor  
9 Sir Stephen Powis, on behalf of NHS England, states that  
10 this was the first time NHS England became aware of any  
11 specific concerns about the safety of neonatal services  
12 at the Countess of Chester Hospital.

13 However, he makes the point that NHS England were  
14 not aware at this stage of any concerns about any  
15 particular individual. The reports to the Strategic  
16 Executive Information System did not raise concerns of  
17 potential deliberate harm by Letby.

18 There was also, on 30 June 2016, a discussion and an  
19 exchange of emails between Mr Harvey and Sue Eardley.  
20 She was the Head of Invited Reviews at the Royal College  
21 of Paediatrics and Child Health.

22 Mr Harvey stated that he was keen that the review  
23 was "as soon as possible". Ms Eardley's email reply  
24 stated that a visit was planned in August and that the  
25 review team could give immediate feedback "if we see

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1 common factors to the death, and that in each case,  
2 there were no missed opportunities to take action that  
3 could have prevented or mitigated the situation."

4 There were four proposed terms of reference, the  
5 fourth of which was "Are there any possible common  
6 factors linking the recent neonatal deaths?"

7 We move, then, to July 2016.

8 On 1 July 2016, reports were made to NHS England's  
9 National Reporting and Learning System in respect of  
10 both Child O and Child P. The reports for each child  
11 stated that they had suffered a sudden collapse  
12 requiring resuscitation. These were not reports of the  
13 deaths. In respect of Child O, the report was of  
14 a delay in obtaining an intraosseous access. In  
15 respect of Child P, the report was a delay in obtaining  
16 a sodium bicarbonate infusion.

17 On the same day, Ms Kelly forward the email she sent  
18 to the CQC to Ms Paula Wedd, the NHS West Cheshire Care  
19 Commissioning Group's Director of Quality and  
20 Safeguarding.

21 In the body of the email, Ms Kelly explained that  
22 she had contacted the CQC before the CCG because of the  
23 impending release of the CQC inspection report.

24 On 4 July 2016, Ms Kelly send an email to the  
25 Nursing and Midwifery Council's Employer Link service

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1 anything of urgent concern". She attached a proposal  
2 for the review and draft terms of reference.

3 My Lady, the Royal College of Paediatrics and Child  
4 Health had developed the Invited Review Service in 2012.  
5 Reviews were undertaken in response to a request from  
6 a healthcare organisation. They were undertaken for  
7 a fee on behalf of an authorised individual of such an  
8 organisation, typically the Medical Director or Chief  
9 Executive.

10 There were different types of invited review. The  
11 type undertaken for the Countess of Chester Hospital was  
12 a service review. This was described in the guidance in  
13 place at the time as a "invitation to visit and comment  
14 upon a current service with terms of reference that were  
15 usually rooted in the quality, safety and efficiency of  
16 that service".

17 They were intended primarily to "Assess compliance  
18 with formal standards".

19 The proposal sent by Ms Eardley identified the  
20 concerns as being that the neonatal service was an  
21 "Adverse outlier for neonatal mortality in the last 12  
22 to 18 months".

23 It identified that staff at the unit were:

24 "Seeking a further independent review to consider  
25 the wider service, to provide assurance had there are no

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1 asking to book a call to discuss that service and to  
2 discuss allegations against a nurse.

3 This appears to be the first occasion on which it is  
4 documented that allegations relating to Letby were  
5 raised with an external body.

6 On 5 July 2016, Dee Appleton-Cairns from Human  
7 Resources at the Countess of Chester Hospital spoke to  
8 Ian Pace, an associate in the Employment and Pensions  
9 Group, at the solicitors' firm DAC Beachcroft LLP.

10 Ms Appleton-Cairns disclosed to Mr Pace the  
11 increased neonatal death rate and the fact staff were  
12 pointing interesting fingers at each other. She  
13 described a consultant making a reference to  
14 Beverley Allitt.

15 The note of the discussion indicates that  
16 Ms Appleton-Cairns was satisfied that there were "no  
17 malicious issues involved" but Mr Pace asked how she  
18 could be sure. He advised her that the employment  
19 aspects of the matter pale into insignificance given the  
20 potential issues involved and the suspicions that the  
21 death rate could be attributable to one in particular  
22 individual.

23 He advised Ms Appleton-Cairns that the priority was  
24 to investigate the issues that were arising, given the  
25 potential consequences and suspicions that have arisen.

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1 He made arrangements for the hospital to be advised  
2 by Corinne Slingo on how to take things forward from  
3 a regulatory perspective it is. Ms Slingo was the Head  
4 of Healthcare Regulatory and a partner at the firm.  
5 Ms Kelly spoke to Tony Newman, a regulation adviser at  
6 the Nursing and Midwifery Council on 6 July 2016. An  
7 email exchange that followed contains a note of the  
8 discussions discussed. It identifies that Ms Kelly told  
9 Mr Newman that there had been an increase in mortality  
10 and that analysis had identified that one nurse had been  
11 present at nearly all events.

12 Some clinicians were concerned that she "may present  
13 a serious risk to public safety although no evidence is  
14 available at this time".

15 The email identifies Letby by name as the nurse.  
16 Ms Kelly stated that there was to be a meeting that day  
17 to decide if she would be reported to the police to  
18 investigate.

19 My Lady, despite the matters disclosed and the  
20 indication that a report to the police was being  
21 considered, this discussion did not trigger any fitness  
22 to practise or safeguarding process. No referral to the  
23 Nursing and Midwifery Council was made by Ms Kelly, nor  
24 did Mr Newman recommend that one should be. He did not  
25 advise a referral to the Local Authority Designated

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1 Chester Hospital were alert to child safeguarding  
2 policies or principles, and whether they were aware of  
3 what to do where suspicions and concerns exist about  
4 a member of staff harming babies.

5 A recurring theme across much of the evidence the  
6 Inquiry has received is a potential misunderstanding of  
7 the evidential threshold required to report to external  
8 bodies or to trigger an external investigation. Having  
9 reviewed the Letby documentation recently, an Executive  
10 at the Nursing and Midwifery Council raised a concern  
11 internally as to the absence of any mention of  
12 safeguarding in that documentation. It was noted that  
13 there had been a failure to include clinical advisers in  
14 the process who could have provided a safeguarding lens  
15 to fitness to practise cases.

16 Returning to the chronology, on 7 July 2016, when  
17 the decision was made to downgrade the neonatal unit,  
18 the Countess of Chester Hospital made a Serious Incident  
19 report to NHS England's Strategic Executive Information  
20 System. The report gives the increase in neonatal  
21 mortality as the reason for the downgrade.

22 It asserts that the Trust was acting responsibly in  
23 requesting an external review, a reference to the  
24 involvement of the Royal College of Paediatric and Child  
25 Health. The report does not refer to the suspicions of

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1 Officer. His advice to Ms Kelly was that the Nursing  
2 and Midwifery Council would need to be advised of the  
3 decision to report the matter to the police and any  
4 action taken by the police.

5 Mr Newman's statement to the Inquiry explains that  
6 he realised that this was a unique situation. He  
7 checked with a lawyer, in the Fitness to Practise Team,  
8 who agreed with the advice he had given. He states that  
9 he was "clear at that time that there wasn't evidence  
10 yet to refer".

11 His statement does not explain, and the point will  
12 need to be explored in evidence, why he considered  
13 referral inappropriate, or what threshold he considered  
14 applied before a referral was made.

15 The email subsequent to this conversation between  
16 Mr Newman and Ms Kelly records that the Executive  
17 Directors at the Trust were due to discuss that day  
18 (that is to say 6 July 2016) whether to report Letby to  
19 the police.

20 What is less clear, as matters stand, is what  
21 consideration and discussion there was so far as the NMC  
22 was concerned if the decision to contact the police was  
23 deferred pending further investigation.

24 My Lady, a theme that will be explored in evidence  
25 is the extent to which those who advise the Countess of

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1 deliberate harm by Letby that had, within the previous  
2 two days, been raised with the Nursing and Midwifery  
3 Council and DAC Beachcroft LLP.

4 In his fourth statement to the Inquiry, Professor  
5 Sir Stephen Powis, on behalf of NHS England, states that  
6 it is unclear why the increased mortality was reported  
7 as a Serious Incident at any earlier point in 2016,  
8 following the completion of the thematic review "in  
9 light of the concern about the then unexplained spike in  
10 mortality". My Lady, you may conclude that there were  
11 grounds for reporting such concerns even prior to that.

12 Also, on 7 July 2016, Ian Harvey responded to  
13 Ms Eardley's invited review proposal in the draft terms.  
14 He confirmed that he wished to proceed with the review.  
15 He provided amended terms of reference which expanded  
16 significantly the fourth term dealing with mortality so  
17 that the terms of reference read, and I'll quote them in  
18 full:

19 "To consider concerns about the neonatal unit with  
20 specific reference to:

21 "Are there any identifiable common factors or  
22 failings that might in part, or in whole, explain the  
23 apparent increase in mortality in 2015 and 2016?"

24 "The reviewers will then make recommendations for  
25 the consideration of the Chief Executive and Medical

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1 Director of the Hospital as to:  
 2 "Whether there is a basis for concern about the  
 3 Neonatal Unit in light of the findings of the review;  
 4 [and]  
 5 "Possible courses of action which may be taken to  
 6 address any specific areas of concern which have been  
 7 identified."  
 8 These amendments were agreed by Ms Eardley, an issue  
 9 which will be explored in evidence is whether this was  
 10 an appropriate term of reference for an invited review.  
 11 As we have explained, such a review was concerned with  
 12 the extent to which a service complied with standards.  
 13 It was not a tool intended to be a forensic  
 14 investigation into increased mortality.  
 15 On 8 July 2016, Ms Kelly emailed Mr Newman at the  
 16 Nursing and Midwifery Council. She informed him that  
 17 a detailed review was under way and a meeting of the  
 18 Executive Team was planned for the following week. She  
 19 did not, as Mr Newman had previously requested, advised  
 20 him what conclusion had been reached at the meeting to  
 21 consider whether to report the matter to the police.  
 22 On 12 July 2016, he made a note stating he had  
 23 advised her to "investigate locally first".  
 24 The Cheshire and Merseyside Neonatal Network  
 25 Steering Group met on 13 July 2016. A quarterly data  
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1 the deaths had been through the coronial system with no  
 2 common features or issues arising.  
 3 Ms Slingo described the decision as to whether to  
 4 report the matter to be finely balanced and to be kept  
 5 under review with "a very low threshold for moving this  
 6 to a decision to notify the police".  
 7 Seemingly by way of an explanation of this  
 8 threshold, she gave the analogy of the Trust reaching  
 9 a position that there was enough evidence to exclude  
 10 Letby under their usual policy, as being a "key moment  
 11 to consider the level of evidence to report her to the  
 12 police too".  
 13 No advice was apparently requested or given as to  
 14 the safeguarding obligations on the hospital and its  
 15 staff, no advice was requested or given about any  
 16 referral to the Local Authority Designated Officer, or  
 17 Nursing and Midwifery Council. Working Together to  
 18 Safeguard Children required reports of "possible  
 19 criminal offending" to be made to the Local Authority  
 20 Designated Officer.  
 21 My Lady may consider that this safeguarding  
 22 threshold for referral to external bodies appears to  
 23 have been ignored.  
 24 My Lady, I just have one more paragraph to conclude  
 25 this, if I may. I'm conscious of the time.  
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1 report included mortality data from the Countess of  
 2 Chester Hospital was available for this meeting. It  
 3 showed a total of ten deaths over four quarters.  
 4 The notes of the Steering Group indicate that there  
 5 was a discussion as to the redesignation of the neonatal  
 6 unit and that the Trust was "reviewing the data/reviews  
 7 carried out relating to mortalities to identify any  
 8 missed factors".  
 9 There is nothing to indicate any specific discussion  
 10 about the deaths or any suspicions in respect of Letby.  
 11 On 18 July 2016, Ms Slingo, the partner at  
 12 DAC Beachcroft LLP, advised Susan Hodgkinson on whether  
 13 the concerns relating to Letby should be reported to the  
 14 police.  
 15 Ms Slingo's advice, as recorded in the follow-up  
 16 email, was that:  
 17 "There does not currently appear to be any reason to  
 18 formally alert the police to these issues as there is  
 19 nothing upon which one might reasonably base a suspicion  
 20 of a criminal offence having been committed."  
 21 The rationale for this was that the current evidence  
 22 of concern was "potentially circumstantial".  
 23 The fact of one nurse on shift on more occasions  
 24 than others, but that deaths, deteriorations, occurred  
 25 when the nurse was not on shift. She noted that 75% of  
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1 On 27 July 2016, the reports of the deaths of  
 2 Child O and Child P were uploaded to NHS England's  
 3 National Reporting and Learning System. Rather than  
 4 being characterised as "no harm" severity, they were  
 5 both characterised as "death". The characterisation of  
 6 severity on this system in the case of other babies who  
 7 were murdered is a matter the Inquiry will be  
 8 investigating.  
 9 **LADY JUSTICE THIRLWALL:** That's a convenient moment. Thank  
 10 you very much indeed, Mr de la Poer.  
 11 We will resume at quarter to 2.  
 12 **(12.47 pm)**  
 13 **(The Short Adjournment)**  
 14 **(1.44 pm)**  
 15 **LADY JUSTICE THIRLWALL:** Mr De la Poer.  
 16 **MR DE LA POER:** My Lady, we reach the point in the timeline  
 17 of the involvement of external bodies at August 2016.  
 18 And on 2 August 2016, Ms Kelly send an email to  
 19 Ms McGorry of NHS England, included within this email  
 20 were copies of the recent Neonatal Dashboard and  
 21 a summary of actions taken so far by the Trust.  
 22 On 31 August of 2016 Ms Kelly had further contact  
 23 with Mr Newman of the NMC. In her email to him, she  
 24 provided an update of the internal work which had been  
 25 undertaken, saying:  
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1 "Nothing of significance had been identified within  
2 this."  
3 The Inquiry will be investigating whether this was  
4 a reasonable and accurate summary of the internal work  
5 which included that both which Mr Gibbs and Nurse Martyr  
6 had undertaken and the staffing review conduct by  
7 Ms Kelly's deputy, Sian Williams.

8 In her email, Ms Kelly also stated:  
9 "There has been no indication to discuss this matter  
10 with the police at this time."

11 We now turn to look at the Royal College of  
12 Paediatrics and Child Health Invited Review in greater  
13 detail.

14 That Invited Review Team visited the Countess of  
15 Chester Hospital on 1 and 2 September 2016. In addition  
16 to Ms Eardley, the review team was made up of  
17 Dr David Milligan, a retired consultant paediatrician  
18 who acted as lead reviewer, Dr Graham Stewart,  
19 a consultant paediatrician, Alex Mancini, a neonatal  
20 nurse, and Claire MacLaughlan, a lay reviewer who had  
21 previously trained as an intensive care nurse.

22 It appears that some, but not all, members of the  
23 review team were aware of the suspicions in relation to  
24 Letby prior to the visit.

25 The review team had been given considerable  
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1 prior to the visit. He recalls seeing in the  
2 documentation provided ahead of the visit a list of  
3 seven or eight unexplained deaths together with the  
4 names of nursing staff on shift, and he noticed that  
5 Letby was present for all but one or two. This may be  
6 a reference to a spreadsheet that has already been  
7 described.

8 Dr Milligan emailed Ms Eardley on 26 August 2016  
9 stating that having looked at most of the documentation.

10 "A number of questions arise from that, not least  
11 that one individual appears to have been present for all  
12 but one of them."

13 Dr Stewart, however, does not recall any specific  
14 nursing concerns arising from the pre-visit information.  
15 His statement to the Inquiry is that if he had been  
16 aware of concerns about Letby, he would have questioned  
17 whether an invited review was appropriate, and he would  
18 have advised the Trust that the police should be  
19 involved if any criminality was suspected.

20 Similarly, the evidence of Claire MacLaughlan and  
21 Alex Mancini is that they were unaware of the concerns  
22 about Letby prior to the visit. Ms MacLaughlan states  
23 that if she had been aware, she would not have  
24 participated in the review and would have advised the  
25 RCPCH that the fourth term of reference which referred  
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1 documentation by the Trust for the purpose of their  
2 review. This included a spreadsheet showing staff on  
3 duty at the time of, or the shift prior to, ten deaths  
4 on the unit. It demonstrated that Letby was on duty for  
5 eight of the ten deaths and the shift before for the  
6 remaining two.

7 Ms Eardley's statement to the Inquiry is that  
8 Mr Harvey may have advised her of "the nurse issue"  
9 during their initial call on 30 June 2016, but that she  
10 cannot recollect.

11 It would appear from her statement that she will  
12 accept that at some point prior to the visit she was  
13 aware:

14 "... that there were suggestions of concern about  
15 a nurse in that the doctors had seen a pattern of  
16 attendance when studying the rotas."

17 Though she does not recall potential police  
18 involvement being discussed.

19 Mr Harvey's recollection as set out in the statement  
20 he provided to the Inquiry is that:

21 "I am sure that I mentioned to Sue Eardley over the  
22 phone that consultants had raised a concern about one  
23 individual."

24 Dr Milligan's evidence is that the review team had  
25 been made aware of concerns around potential criminality  
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1 to identifying common factors, which might explain the  
2 increase in mortality, was misleading.

3 Ms Mancini's statement to the Inquiry explains that  
4 she had seen the staff rota but did not assume, and saw  
5 no documents expressing, any concern or complaint about  
6 Letby.

7 My Lady the significance of any prior knowledge of  
8 suspicions relating to Letby is that the guide on  
9 Invited Reviews, both the 2014 and the 2016 edition,  
10 provides that the RCPCH would not take on cases where:

11 "... the expected scope includes behavioural,  
12 misconduct, bullying, harassment, or possible mental  
13 health concerns ..."

14 Or where the police were involved.

15 Whatever the extent of any advance warning the  
16 review team had of the concerns relating to Letby, those  
17 concerns dominated the first two interviews on  
18 1 September 2016, the first day of the visit.

19 The first interview was with Mr Harvey and Ms Kelly.  
20 Mr Harvey's first contribution as documented in the  
21 contemporaneous notes was:

22 "... correlation of one nurse -- paediatricians see  
23 as elephant in the room. Lucy Letby. Pattern of babies  
24 collapse doesn't seem to follow normal pattern and  
25 respond to resuscitation in normal way. Multifactorial.  
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1 Want to think the worst -- but nothing else is pointing  
2 to it. Director of corporate affairs was [detective  
3 chief inspector] before he retired. Huge nettle to  
4 grasp."

5 Mr Harvey was also noted to say during this initial  
6 interview, again I quote:

7 "... had to intervene with the neonatal lead as  
8 junior doctors had been referring to her as 'nurse  
9 death'. Ripples through the team and trying to function.  
10 Can't see how to conclude without calling the police.  
11 Unless there is something to satisfy the medical staff  
12 they can call the police."

13 Ms Kelly was noted to have had said:

14 "Paediatricians thinking she is the common  
15 denominator. No issues with competency of the nurse.  
16 No issues with training. Highly thought of by the  
17 unit."

18 And:

19 "Clinicians threatened to go to the police."

20 The notes indicate that Mr Harvey was asked either  
21 "what is the tipping point?" Or "what is the tipping  
22 point, not police"

23 To which he responded:

24 "Need to pull together before we press the nuclear  
25 button."

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1 "Went to senior execs ... said potentially foul play  
2 here ..."

3 And:

4 "Need to have the nurse off the unit till sorted out  
5 ... Implications of police -- service stops. Not sure on  
6 looking at it from inside ... would love to know the  
7 obvious reasons why they have happened."

8 And, finally:

9 "Expected exec to call the police."

10 Notwithstanding the disclosure of suspected  
11 criminality in these two initial meetings, the review  
12 team decided to continue with the review. The statement  
13 of Robert Okunnu, the Chief Executive of the Royal  
14 College of Paediatrics and Child Health queries "why the  
15 Invited Review Team did not stop the review after  
16 learning this information".

17 We have highlighted already that the Guide on  
18 Invited Reviews provided that cases where the scope  
19 included behavioural or misconduct issues would not be  
20 taken on. It provided that where such issues came to  
21 light during an invited review:

22 "... review should be completed in relation to its  
23 original remit unless advised to the contrary in order  
24 to avoid prejudicing other investigations by a public  
25 authority or regulator, but the reviewers cannot

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1 Ms Eardley recalls that Mr Harvey stated that  
2 a Non-Executive Director at the hospital who was  
3 a former senior ranking officer had advised against the  
4 police until all other avenues had been exhausted.

5 The next meeting was with Dr Brearey and Dr Jayaram.

6 There was a detailed discussion of the neonatal deaths.

7 Both doctors expressed their concern in respect of  
8 Letby. The notes indicate that they stated:

9 "... identified one nurse present at all collapses.  
10 Didn't think it was significant. Agreed to keep an eye  
11 on things. As the year progressed, each subsequent  
12 mortality not huge concern but by end 2015, numbers  
13 stacked up a little ..."

14 And later:

15 "... it's how the babies collapsed. No indication.  
16 Didn't respond physiologically how they should have  
17 done. Seven of them so not always the same one ... Nurse  
18 on shift at all times. Spoke to Ian [and] Alison ..."

19 And later:

20 "... decided to put the nurse on dayshifts not  
21 nights ... no [unexpected] collapses at night when she  
22 was on days but collapses happened in daytime -- all  
23 never individually realised they had all thought the  
24 same thing."

25 And:

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1 investigate or suggest solutions for any of the above."

2 It states that "clear scope boundaries should be  
3 agreed before further work takes place".

4 The evidence we have obtained demonstrates that the  
5 review team did give consideration as to whether to  
6 continue with the review. Dr Stewart explains that he  
7 expressed his view to the team that the commissioners of  
8 the review had not been honest and transparent, and that  
9 it may be better to leave at that stage.

10 Following discussion, it was agreed that the review  
11 could continue but would follow closely the terms of  
12 reference and could include recommendations on how to  
13 progress.

14 In her statement, Ms Eardley explains that  
15 consideration was given to aborting the review but as  
16 the interviews had been set up and staff prepared, the  
17 review team agreed to continue. She accepts that no  
18 consideration was given to specifying scope boundaries  
19 to avoid prejudicing other investigations as required by  
20 the guidance. She accepts with hindsight that the  
21 review should have been aborted when concerns of  
22 potential criminality were raised.

23 The RCPCH subsequently commissioned an external  
24 review of its Invited Review Service which resulted in  
25 a report by Helen Crisp in 2021. Ms Crisp spoke to

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1 Dr Milligan, Dr Stewart and Ms McLaughlan. The report  
2 states on this issue that the reviewers felt that they  
3 had a duty to complete the work, and would let the RCPCH  
4 down if they "walked out".

5 Not any did the review continue without any clear  
6 scope boundaries agreed but a decision was taken by the  
7 team to interview Letby. She had not been on the  
8 original list of interviewees, but was added to it  
9 during the first day of the visit. Ms Eardley's  
10 statement to the Inquiry explains that the review team  
11 felt strongly that she should have "an opportunity to  
12 give her perspective". It was decided, however, that  
13 she would only be interviewed by Claire McLaughlan and  
14 Alex Mancini. Dr Stewart explains that this was because  
15 "of their expertise and because they were both women,  
16 which might have been less threatening than bringing her  
17 before the complete panel".

18 Mr Okunnu's statement on behalf of the Royal College  
19 of Paediatrics and Child Health describes the interview  
20 of Letby as "highly unusual", and one that should not  
21 have taken place.

22 Letby was interviewed, along with her colleague  
23 acting as Royal College of Nursing representative,  
24 Nurse Hayley Griffiths. The note of the interview  
25 describes that Letby described being scapegoated and

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1 centrally."

2 Second, the interview with the senior nurses at  
3 which Ms Powell described the line taken on Letby as  
4 "unfounded and malicious", describing Letby as "clever,  
5 exceptional, and very professional".

6 The doctors were described as tunnel visioned about  
7 Letby's presence and their concerns were described as  
8 "wanted her off the unit. Just the presence -- gut  
9 instinct".

10 And third, the interviews with Andrew Higgins,  
11 Non-Executive Director, who explained that he was aware  
12 of the allegations, and that there had been long debates  
13 as to how to deal with them, including "involvement of  
14 police". After internal briefings, the Board instead  
15 agreed to get an external review. The notes appear to  
16 attribute to Mr Higgins the comment:

17 "Need to keep the shutters down and contain the  
18 situation, not sure where to go next."

19 We will ask whether that was said, and if so, what  
20 was meant by it. In his statement to the Inquiry,  
21 Mr Higgins does not recall saying that, but thinks that  
22 the comment related to "the need to contain the  
23 situation so that no further incidents could occur and  
24 the facts behind the recent deaths could be  
25 established".

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1 very vulnerable. She contended that there was no reason  
2 or evidence to redeploy her. The statement of  
3 Nurse Griffiths to the Inquiry describes the  
4 interviewers asking, after Letby had left the interview  
5 room distressed "Does she know what is going on here and  
6 what she is potentially being accused of?"

7 Contained in the disclosure of Letby's Facebook  
8 documents is a message she sent that evening in which  
9 she stated that the interviewers told her "off the  
10 record" that they thought an investigation into the  
11 deaths would be recommended and she needed to prepare  
12 herself, as she would play a big part.

13 Claire McLaughlan and Alex Mancini cannot recall  
14 having had such an off-the-record discussion with Letby  
15 and this will be explored in evidence with them.

16 The review team interviewed a significant number of  
17 people involved with the neonatal unit over the course  
18 of the two-day visit. These will be explored in  
19 evidence but of particular note were the following:  
20 first, the interview with a number of consultants.  
21 Dr V, Dr Gibbs, Dr Saladi, Dr Holt and Doctor ZA, where  
22 one of the noted comments was:

23 "What is striking is that the collapses were  
24 unexpected and did not respond to resuscitation.  
25 Several of the babies showed strange mottling

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1 At the start of the second day of the visit on  
2 2 September 2016, the review team met with Mr Harvey and  
3 Ms Kelly. Mr Milligan advised them that consideration  
4 had been given to aborting the review and starting  
5 again. There was said to be "big concern" about Letby,  
6 and a formal process was advised "so she knows where she  
7 is". Ms McLaughlan advised that a process was needed  
8 for the protection of Letby and the Trust and that Letby  
9 would have a good case for constructive dismissal if  
10 nothing happens.

11 An independent case note review of all the deaths by  
12 two independent people was recommended.

13 At the end of Day 2 there was a feedback session  
14 with Mr Chambers, Mr Harvey and Ms Kelly. The review  
15 team repeated their advice for an in-depth independent  
16 case review. They advised a human resources process for  
17 Letby.

18 The review visit was followed by a letter from the  
19 Royal College of Paediatrics and Child Health to the  
20 Countess of Chester Hospital dated 5 September 2016,  
21 setting out the recommendation for investigation against  
22 Letby. In respect of Letby it described:

23 "A process of investigation needs to be put in place  
24 which sets out the nature of the allegation and the  
25 process you will follow to investigate it."

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1 What it appears was being suggested was an internal  
2 investigation.

3 It also provided detail of the recommendation for  
4 a forensic case note review of the deaths. It advised  
5 that there should be a review of each death since  
6 July 2015 using at least two senior doctors with  
7 expertise in neonatology and pathology. The letter  
8 listed five "minimum elements" the investigation should  
9 comprise, including examination of the post-mortem  
10 findings, any additional information which might  
11 identify cause of death and details of all staff with  
12 access to the unit from four hours before the death of  
13 each infant.

14 My Lady, the Royal College of Paediatrics and Child  
15 Health Guide on Invited Reviews provided that where  
16 concerns were raised over safety or staffing, the  
17 expectation was that the client -- here the Trust --  
18 would notify the regulatory authorities promptly of the  
19 review, its recommendations and action plan.

20 If, during the review or follow-up period, it was  
21 seemed that insufficient action had been taken by the  
22 client, the Royal College of Paediatrics and Child  
23 Health could take further action, including reporting  
24 the findings directly to the appropriate regulatory or  
25 commissioning authority.

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1 at Bart's Health NHS Trust. Whereas the Royal College  
2 of Paediatrics and Child Health had recommended  
3 instructing two experts, she was the only expert  
4 initially instructed. Counsel to the Inquiry has  
5 already set out the work that she undertook earlier and  
6 will not repeat it here.

7 This brings us to September 2016. On  
8 12 September 2016, there was a board meeting of the  
9 Cheshire and Merseyside Neonatal Network. A paper was  
10 prepared for this meeting by Dr Subhedar titled  
11 "Neonatal Mortality at Countess of Chester Hospital".  
12 It explained that he had previously acted as an external  
13 reviewer of mortality reviews in 2015 but no major  
14 deficiencies in care or recurring themes were  
15 identified.

16 The paper explains that an operational delivery  
17 network management review of mortality rates benchmarked  
18 against other local neonatal units showed the Countess  
19 of Chester Hospital was 1.5 to twofold higher and  
20 appeared to be rising.

21 On 16 September 2016, the Pan Cheshire Child Death  
22 Overview Panel, chaired by Dr Mittal, and attended by  
23 Detective Sergeant Paul Hughes, the coroner's officer  
24 and other health and Local Authority representatives  
25 reviewed the death of Child I. This was the first of

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1 Nowhere in the notes of the interview or in the  
2 letter following the visit is there evidence that the  
3 Trust was advised to report the matter to the police,  
4 the Local Authority Designated Officer the Nursing and  
5 Midwifery Council, or any other external agency. There  
6 was no evidence the Invited Review Team considered doing  
7 this themselves.

8 In his statement to the Inquiry, Dr Stewart states  
9 that he gave verbal feedback, not documented in the  
10 notes, that:

11 "Any concerns of criminality should be addressed by  
12 involving the police."

13 The 2021 Crisp Report states that when Mr Harvey had  
14 been "reluctant to involve the police", the review team  
15 did not press him on it, and they were unclear of how  
16 far to take matters.

17 Ms Eardley accepts with hindsight that there should  
18 have been contact within the police, and that the review  
19 was probably not the appropriate course of action for  
20 senior management to follow.

21 The Royal College's recommendation for a forensic  
22 case note review led to the Countess of Chester Hospital  
23 instructed Dr Jane Hawdon to prepare a report. She is  
24 a consultant neonatologist at the Royal Free London NHS  
25 Foundation Trust. At the relevant time she was employed

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1 the seven deaths to be reviewed by this panel.

2 Despite the panel noting that Child I's case  
3 was subject to a review by the Royal College of  
4 Paediatrics and Child Health, it was decided that the  
5 case could be closed with the coroner reviewing the  
6 report on behalf of the panel. The death was classified  
7 as a perinatal/neonatal event, not an unexpected death.

8 My Lady, there was a discussion at the meeting that  
9 indicates a potential lack of understanding of the local  
10 Sudden Unexpected Death in Infancy and Childhood  
11 guidelines that we have already described.

12 The notes of the meeting contain a query that was  
13 raised as to whether there should be a Rapid Review  
14 Meeting for an unexpected child death in a hospital.

15 This may have arisen because of what the RCPCH  
16 National Guidance said at the time. However, a Rapid  
17 Review Meeting was a requirement for unexpected and  
18 unexplained child deaths in the local guidelines, and as  
19 we have explained, those guidelines applied irrespective  
20 of the location of death.

21 That this query was raised may demonstrate a lack of  
22 understanding in the guidance which should have been  
23 followed. The query raised at the meeting was not  
24 answered. The issue, was itemised for discussion at the  
25 next panel meeting.

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1 The statement to the Inquiry of Charles Massey,  
2 Chief Executive and Registrar of the General Medical  
3 Council, states that concerns relating to the neonatal  
4 unit were first raised with the GMC Employment Liaison  
5 Advisor on 30 September 2016.

6 This appears to have been to inform the GMC about  
7 the downgrading of the neonatal unit, the commissioning  
8 of the RCPCH review and to inform the GMC that there  
9 were no concerns at that time about any of the doctors  
10 involved.

11 We move now to October 2016.

12 On 10 October 2016 the deaths of Child O and Child P  
13 were reviewed by the same Welsh Death Review Panel that  
14 had reviewed the death of Child D on 16 July 2015. The  
15 reviews may have been conducted by email. The note of  
16 the reviews is extremely brief. The cause of death for  
17 each child is stated to be "extreme prematurity (one of  
18 triplets)".

19 There is no reference to the serious incident report  
20 or the wider issues on the unit.

21 Of the seven babies murdered by Letby at the  
22 hospital between June 2015 and June 2016, four were from  
23 English resident families and were reviewed by three  
24 different English Child Death Overview Panels. Three  
25 were from Welsh resident families and considered by

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1 didn't have any specific concerns but felt bound to  
2 raise these concerns with the Exec Team."

3 The plan was to refer to the awaited RCPCH report if  
4 further questions were asked.

5 It is notable, my Lady, that disclosure to yet  
6 another external agency had not provoked any  
7 consideration of, or advice on, safeguarding. There was  
8 no recommendation to make a referral to the Local  
9 Authority Designated Officer. There was no advice as to  
10 whether there was a need for a Nursing and Midwifery  
11 Council referral.

12 November 2016.

13 On 11 November 2016 Tom Carver of the British  
14 Medical Association accompanied Dr Jayaram to the  
15 grievance meeting. The notes of the meeting show that  
16 Dr Jayaram denied that there had been a push to move  
17 Letby, and denied that there had been a suggestion that  
18 if Letby was not moved, the police would be called.

19 And Dr Jayaram was asked whether "deliberate intent"  
20 by Letby was suggested, he responded that he was not  
21 there to speculate, and could "only say that the  
22 consultants had concerns and they escalated these to the  
23 Executive board". Mr Carver intervened at this point to  
24 say that speculation should be avoided and was unfair.

25 The Pan Cheshire Child Death Overview Panel met on

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1 Welsh Child Death Review Panels. We will explore in  
2 oral evidence how evidence was communicated and shared  
3 across the English and Welsh panels in practice, and  
4 whether the system was able to detect increases in  
5 neonatal deaths from the hospital.

6 Dr Jayaram contacted the British Medical Association  
7 on 24 October 2016. He was seeking support following  
8 the grievance raised by Letby. A note of his webchat  
9 with Hope Nisbet shows that he disclosed that all the  
10 consultants at the Countess of Chester Hospital had  
11 expressed concern at the significant increase in  
12 unexplained neonatal deaths and near misses when Letby  
13 was in charge of the babies or near the cot side.

14 Dr Jayaram wanted assistance as to what he may be  
15 asked at the Human Resources meeting and whether he  
16 would be putting himself at risk if he raising the  
17 possibility of deliberate harm by Letby.

18 Dr Jayaram's case was assigned to an employment  
19 advisor, Tom Carver. The two spoke on 25 October 2016.  
20 It appears to have been agreed that Dr Jayaram would not  
21 explicitly raise the possibility of deliberate harm at  
22 the grievance meeting and would instead restrict himself  
23 to saying that the consultant body had:

24 "... noticed a sudden spike in the deaths rates,  
25 only [link] was involvement of the complainant, we

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1 20 November 2016, and gave further consideration to the  
2 query raised at the previous panel meeting on  
3 16 September 2016, as to whether a Rapid Review Meeting  
4 was required following a sudden and unexpected death in  
5 hospital. It was noted that:

6 "The meeting felt that the response should be on  
7 a case-by-case basis, and the safeguarding doctor should  
8 be involved in the discussion with the designated doctor  
9 and a rapid response should be arranged if deemed  
10 appropriate."

11 It is currently unclear why the panel "felt" this  
12 way or what steps had been taken to consider the local  
13 guidelines, which appear clear and did not support  
14 an apparently *ad hoc* approach being taken in respect of  
15 unexpected and unexplained deaths where they occurred in  
16 hospital.

17 The Invited Review reports to the RCPCH were sent to  
18 the hospital on 28 November 2016. We say reports,  
19 because there were two versions. There was what was  
20 described as a "confidential report" which included  
21 references to the allegations made against Letby. There  
22 was then a "dissemination copy" in which the references  
23 to allegations against Letby were removed.

24 The confidential report, when dealing with the  
25 suspicions in respect of Letby, describes the neonatal

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1 lead and subsequently all of the consultant  
2 paediatricians had identified that Letby was rostered on  
3 shifts for all deaths and had, "become convinced by the  
4 link".

5 The report describes this as:

6 "... a subjective view with no other evidence or  
7 reports of clinical concerns about the nurse beyond this  
8 simple correlation"

9 And that:

10 "... the consultants explained that their allegation  
11 was based on Nurse L being on shift on each occasion an  
12 infant died (although not necessarily caring for the  
13 infant) combined with 'gut feeling'."

14 My Lady, this use of the term "gut feeling" appears  
15 to be a misattribution. It was in the interview with  
16 the nurses that the consultant concerns were described  
17 as a "gut feeling". The notes of the interviews do not  
18 suggest that the consultants themselves reported that  
19 this was a gut feeling at all.

20 Both versions of the report state that there were  
21 "no obvious factors which linked the deaths". A number  
22 of findings and recommendations were made as to  
23 staffing, neonatal reviews, transport and operational  
24 practice. The neonatal unit was found not to comply  
25 with professional standards on nurse and medical

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1 version of the reports recommended that concerns about  
2 Letby be escalated externally, whether to the police,  
3 the Local Authority Designated Officer, or the Nursing  
4 and Midwifery Council.

5 They do not make any reference to discussions during  
6 the review visit of potential police involvement. This  
7 appears to have been by design. Initial drafts of the  
8 report obtained by the Inquiry do contain some  
9 references. For instance, in one draft, there is the  
10 comment:

11 "Delayed to call police -- remember Stepping Hill".

12 "Stepping Hill" may be a reference to the Stepping  
13 Hill Hospital in Stockport where a nurse was wrongly  
14 accused of murder and another nurse, Victorino Chua, was  
15 subsequently convicted in May 2015 of murdering two  
16 patients, the poisoning of 19 other patients, and the  
17 attempted poisoning of seven more patients. We observe  
18 in passing that Chua committed these crimes by injecting  
19 insulin into saline solution bags which he left for  
20 other members of staff to administer. During a police  
21 search of Chua's house, a letter written by him was  
22 discovered in which he described himself as an "evil  
23 person".

24 Chua was sentenced on 19 May 2015. In his  
25 sentencing remarks, Mr Justice Openshaw described what

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1 staffing levels, environment, accommodation for parents,  
2 support from the community neonatal team and postnatal  
3 follow-up.

4 The report noted that the Child Death Overview Panel  
5 had not been alerted to the cluster of deaths and  
6 recommended that it considered its processes. The  
7 neonatal unit was noted to be less than systematic in  
8 incident reporting, and a recommendation was made that  
9 death/near-miss review required strengthening. The  
10 report repeated the recommend for an independent  
11 external review of unexpected deaths.

12 As to the preparation of two reports, a subsequent  
13 internal review carried out by Dr Mike Linney on  
14 11 April 2018 queried whether a report that needed  
15 separate redaction due to human resources issues had  
16 overstepped its brief. As Ms Eardley recognises in her  
17 statement to the Inquiry, a consequence of producing two  
18 reports, one of which was silent on the concerns raised  
19 in respect of Letby, was that it enabled the Trust to  
20 share only a sanitised version of the report with the  
21 concerned consultants. Indeed, it was the sanitised  
22 report that was shared with external agencies and was  
23 subsequently published by the Trust in response to the  
24 scrutiny the Trust was under.

25 Neither the disseminated nor the confidential

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1 Chua did as "inexplicable" and those remarks are  
2 available on the Judiciary website.

3 Returning to the confidential version of the draft  
4 RCPCH report, in another part it is stated that Letby  
5 was moved off the neonatal unit, "apparently due to the  
6 risk of the consultants approaching the police with the  
7 allegations". References to the police were removed by  
8 the time of the final draft.

9 As to why no recommendation was made to call the  
10 police, in her statement to this Inquiry, Ms Eardley  
11 explains that she:

12 "... considered that the responsibility for dealing  
13 with the concerns raised by the paediatricians and  
14 deciding whether to call the police lay in the hands of  
15 the Countess of Chester Hospital Trust board or the  
16 paediatricians who were close to the cases."

17 She acknowledges with hindsight that the review team  
18 should have recommended that the police be called. She  
19 acknowledges that they should have pressed harder for  
20 the management of the hospital or the consultants to do  
21 so.

22 When providing the report, the Royal College stated.

23 "It remains your report, though, and we will not  
24 distribute or share it more widely without your  
25 permission."

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1 There was no suggestion that the Royal College of  
2 Paediatrics and Child Health was reserving the right to  
3 report its findings directly to the appropriate  
4 regulatory or commissioning authorities if the Trust  
5 failed to do so as the guide on Invited Reviews allows.

6 A point that we will explore in evidence is the lack  
7 of any follow-up after the report was sent. The letter  
8 enclosing the report anticipated a follow-up  
9 conversation three months after the completion of the  
10 review. The guide on Invited Reviews provided for  
11 feedback, three to six months following a review, to  
12 discuss implementation of the recommendations. There  
13 appears to have been no such follow-up with the  
14 hospital.

15 On 29 November 2016, Tony Newman of the Nursing and  
16 Midwifery Council attended an introductory Employment  
17 Liaison Service meeting at the hospital with Ms Kelly  
18 and Ms Hodgkinson. This was some four months following  
19 the contact made with him for advice as to whether  
20 a fitness to practise referral was required.

21 The notes of the meeting demonstrate that Letby was  
22 discussed. It was noted that she had been "removed from  
23 the unit for her own protection".

24 It was determined that there were "no grounds for  
25 a referral" and that the hospital was "appropriately

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1 versions of the report had in fact already been received  
2 by the hospital at that stage.

3 So we turn to 2017.

4 On 3 January 2017, the North Regional Medical  
5 Director of NHS Improvement, Vincent Connolly, met with  
6 Mr Harvey. Mr Connolly's pocket notebook indicates he  
7 was told that paediatricians were concerned about an  
8 increase in neonatal deaths over the last 18 months but  
9 that the Royal College of Paediatrics and Child Health  
10 had done, "a very thorough report" and there were no  
11 immediate concerns. The note refers to an independent  
12 review by a neonatologist and suggests there would be  
13 a further review by a pathologist.

14 On 6 January 2017, Ian Harvey contacted Ms Eardley  
15 at the Royal College of Paediatrics and Child Health  
16 notifying her of the proposed publication of the report.  
17 He asked whether there was anything she would not want  
18 published. Ms Eardley replied, apparently after taking  
19 advice from the review team, stating that either version  
20 of the report could be published, but she suggested  
21 a conversation with Letby, Information Governance or  
22 Human Resources, if the confidential version were to be  
23 published.

24 On 27 January 2017, Ms Eardley spoke to Dr Brearey,  
25 who told her that Mr Harvey had not shared the

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1 managing this person with a view to a phased approach to  
2 return to the neonatal unit."

3 In his statement to the Inquiry, Mr Newman states  
4 his recollection is that there were:

5 "... no allegations or evidence to suggest [Letby  
6 had] caused deliberate harm at this point and the  
7 concern remained only that she was present at each  
8 incident."

9 My Lady, it might be difficult to reconcile that  
10 contention with the fact that Mr Newman had previously  
11 been told that clinicians were "concerned" that Letby  
12 may present a "serious risk" to public safety and  
13 consideration was being given as to whether she should  
14 be reported to the police. Why these concerns were  
15 deemed not to meet the threshold for referral or engage  
16 safeguarding processes, particularly in light of  
17 a proposal to return her to the neonatal unit, will be  
18 explored in evidence.

19 To complete our review of 2016, we turn to December.

20 On 16 December 2016, the Countess of Chester  
21 Hospital informed NHS England that it had received the  
22 draft Royal College of Paediatrics and Child Health  
23 Invited Review report in November 2016 for factual  
24 accuracy review, but that it was not "comfortable"  
25 sharing that draft. It will be observed that the final

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1 confidential report with the paediatricians; that is to  
2 say the version containing details about the allegations  
3 against Letby.

4 In her statement to the Inquiry, Ms Eardley states  
5 that she was "surprised and frustrated" that the  
6 confidential version had not been shared.

7 A chronology subsequently prepared by the RCPCH  
8 indicates that she contacted Mr Harvey on 31 January  
9 asking him whether and when the report would be shared  
10 with the paediatricians.

11 February 2017.

12 Ahead of its publication, the Royal College of  
13 Paediatrics and Child Health Invited Review report was  
14 sent to members of the Local Safeguarding Children's  
15 Board on 7 February 2017, including Councillor Nicola  
16 Meardon, Emma Taylor, Director of Children's Service,  
17 and Helen Brackenbury, Executive Director of Children  
18 and Families.

19 It is not clear whether any action was taken in  
20 response to receipt of the report by the Local  
21 Safeguarding Children's Board.

22 Dr Gibbs contacted the British Medical Association  
23 on 7 February 2017. He explained that there had been an  
24 increase in neonatal deaths and non-fatal patient  
25 collapses between June 2015 and July 2016 and that he

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1 and his consultant colleagues felt that the rise in  
2 mortality and morbidity had "not yet been adequately  
3 explained nor investigated sufficiently".

4 Dr Gibbs sent the same message to the Medical  
5 Defence Union.

6 The Trust published the dissemination version of the  
7 Royal College of Paediatrics and Child Health report on  
8 8 February 2017.

9 On the same date, Mr Jared Ross, medicolegal advisor  
10 at the Medical Defence Union, wrote to Dr Gibbs advising  
11 him on his obligations as contained in the General  
12 Medical Council's good medical practice. Mr Ross  
13 provided copies of the guidance published by the General  
14 Medical Council and by the Care Quality Commission on  
15 raising concerns, and he provided the following advice  
16 to Dr Gibbs: first, all doctors have a duty to act when  
17 they believe patient safety is at risk or patient care  
18 or dignity is being compromised.

19 Second: Dr Gibbs needed to follow GMC guidance on  
20 raising and acting on concerns, a copy of which was  
21 attached, by raising his concerns with the appropriate  
22 officer in his organisation.

23 Third: that he may wish to consider that it might be  
24 appropriate to go elsewhere if his concerns are not  
25 fully addressed, such as the GMC or the CQC.

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1 taking the matter externally before all internal  
2 processes had been exhausted."

3 Dr Jayaram was advised to seek legal support before  
4 considering doing anything other than writing to the  
5 Trust.

6 Mr Carver was sent on 13 February 2017 a draft of  
7 the consultants' letter requesting that the coroner be  
8 asked to undertake a full investigation of all deaths  
9 and unexpected collapses in the period June 2015 to  
10 July 2016. On 14 February 2017 a copy of the  
11 consultants' letter was sent by Mr Harvey to both  
12 Ms Eardley and Dr Hawdon.

13 Dr Hawdon was told that paediatricians had made  
14 allegations against a member of staff. She replied to  
15 Mr Harvey's email stating that she perceived there to be  
16 a combination of professional pride from the  
17 paediatricians along with concern over unexpected and  
18 unexplained events.

19 She explained that unexpected collapse in an  
20 otherwise stable baby was rare, and there had been more  
21 cases here than she would have expected. She had  
22 commented that was insufficient detail in the records as  
23 to whether collapse was purely out of the blue and  
24 unexplained, due to slow deterioration that was missed  
25 until collapse or due to a "sinister cause", ranging

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1 Fourth: that the General Medical Council suggests  
2 that they or other external bodies should be contacted  
3 if he couldn't raise the issue locally, or he was not  
4 satisfied adequate action had been taken having raised  
5 the issue locally, or there was an imminent serious risk  
6 to patients and the regulator or other external body had  
7 a responsibility to act or intervene.

8 The British Medical Association also responded to  
9 Dr Gibbs on 8 February 2017 asking if he would like his  
10 case to be added to a group case created through  
11 Dr Jayaram, which, after clarification, he agreed to on  
12 28 February 2017.

13 It does not appear that Dr Gibbs was given any  
14 further support or any safeguarding advice by the  
15 British Medical Association.

16 Dr Jayaram was also in contact with the British  
17 Medical Association on 8 February 2017. He told them  
18 that Letby was returning to her role, and the  
19 consultants wanted to push their concerns further.  
20 Dr Jayaram intended to write to the Trust setting at  
21 their concerns, "keeping it internal".

22 Mr Carver's advice to Dr Jayaram was that:  
23 "... neither he nor his consultant colleagues should  
24 speak to the media about this issue. It could create  
25 difficulties for them, as it was likely to be seen as

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1 from "not spotting or escalating the babies ... to  
2 active harm".

3 The Care Quality Commission attended an engagement  
4 meeting with Tony Chambers, Ian Harvey, Alison Kelly,  
5 Sian Williams and Ruth Millward on 17 February 2017.  
6 There was discussion of the recently published RCPCH  
7 report. Mr Harvey is noted to have stated in the  
8 meeting that there were lessons to be learned around  
9 transport processes and in the incident reporting  
10 system. The notes do not indicate that there was any  
11 disclosure to the CQC of the concerns in relation to  
12 Letby.

13 Mr Harvey met with Michael Gregory of NHS England on  
14 23 February 2017 to discuss progress following the  
15 publication of the Royal College of Paediatrics and  
16 Child Health report. Again, these notes indicate that  
17 there was no disclosure of the concerns in respect of  
18 Letby.

19 On 28 February 2017, Dr Jayaram sought advice from  
20 Mr Carver of the British Medical Association on the  
21 request that he engage in mediation with Letby.  
22 Mr Carver advised him that he could not be forced to  
23 engage but tactically "it may not be sensible to dismiss  
24 this option at this stage".

25 On 3 March 2017, Mr Carver advised him to attend the

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1 preliminary meeting. Dr Subhedar of the Cheshire and  
 2 Merseyside Neonatal Network joined the meeting between  
 3 Mr Harvey and the paediatricians at the Countess of  
 4 Chester Hospital on 28 February 2017. Dr Subhedar  
 5 declined to be a co-signatory to a follow-up email  
 6 subsequent to this meeting but provided text to the  
 7 consultants to be included in that email, which stated  
 8 that he supported Dr Hawdon's recommend of further  
 9 review for several cases where the cause of death or  
 10 deterioration remained unexplained.

11 His proposed text pointed out that staffing levels  
 12 could not explain the excess in neonatal mortality at  
 13 the Countess of Chester Hospital because it was not an  
 14 outlier in staffing, which suggested there was  
 15 a different explanation for the increased number of  
 16 unexplained deaths.

17 On 24 March 2017, the Pan Cheshire Child Death  
 18 Overview Panel chaired by Hayley Frame reviewed  
 19 Child A's death. The delay in undertaking the review  
 20 resulted from the fact that there have in inquest in  
 21 Child A's case, the panel "did not find any issues with  
 22 the death" of Child A and the case was closed.

23 Whilst the minutes described the death as unexpected  
 24 the form classifying the death does not. Instead,  
 25 recording it as "perinatal/neonatal death". No

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1 One of the attendees at the Child Death Overview  
 2 Panel was Detective Chief Superintendent Nigel Wenham.  
 3 In his statement to the Inquiry, he explains that it was  
 4 at this meeting that he first became aware of an  
 5 increase in neonatal deaths at the Trust. He describes  
 6 being very concerned, and was "absolutely clear" in his  
 7 own mind that further examination was required.

8 On 27 March 2017 there was a paediatrics meeting at  
 9 the hospital attended by Mr Chambers, Mr Harvey,  
 10 Ms Hodgkinson, Dr Jayaram and Dr Brearey, Dr Subhedar and  
 11 Ms Maddocks -- and here I need to correct myself, I had  
 12 previously identified Ms Maddocks as a "Dr Maddocks", I  
 13 understand that she a nurse -- that Nurse Maddocks from  
 14 the Cheshire Merseyside Neonatal Network also attended.

15 The notes record that in response to Mr Chambers  
 16 asking "I need to know if we do an individual case note  
 17 review or phone the police", Nurse Maddocks stated:

18 "Given the information, on the balance of  
 19 probability, illegal activity has caused the deaths".

20 Dr Subhedar was noted to say:

21 "We cannot see an alternative to the police review."

22 In his statement to the Inquiry however, Dr Subhedar  
 23 states that it was in fact his view that a forensic  
 24 detailed review was still required, and that the  
 25 information about nurse staffing in the thematic review

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1 modifiable factors are identified. The section on  
 2 whether or not referrals to the police or Serious Case  
 3 Review Panel were to be made was not completed.

4 There was discussion by the panel of the concern  
 5 expressed in the RCPCH report that it had not been  
 6 alerted to the cluster of neonatal deaths at the Trust.  
 7 It was noted that a trend would be difficult to identify  
 8 because deaths would come to the panel at different  
 9 times.

10 There was also discussion as to whether a sudden  
 11 unexpected death in a hospital was "not always treated  
 12 with the same concern". It was noted that "on a number  
 13 of occasions the rapid response process is not  
 14 followed". One person commented that, "the [sudden  
 15 unexpected death] process for hospital deaths should be  
 16 identified within the guidelines."

17 It was agreed that a discussion between  
 18 professionals should always occur and if there was  
 19 concern, then the Sudden and Unexpected Death in Infancy  
 20 and Childhood protocol should be followed.

21 My Lady, this may be yet another example of  
 22 misunderstanding of the local guidelines. Those  
 23 guidelines did already identify the processes for  
 24 unexpected death in a hospital as we have already set  
 25 out.

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1 report was insufficient to trigger police referral.

2 On 28 March 2017, Dr Jayaram informed Mr Carver at  
 3 the British Medical Association that he intended to take  
 4 a step back as the Trust had agreed to contact the  
 5 police, and "he would not look to contact the police  
 6 himself - he would let the Trust do this".

7 Disclosure from NHS England suggests that Nurse  
 8 Maddocks contacted them on 29 March 2017 disclosing that  
 9 the paediatricians at the Countess of Chester Hospital  
 10 felt additional cases required review and queried  
 11 whether a police investigation was required.

12 Dr Michael Gregory, NHS England's Regional Clinical  
 13 Director for Special Commissioning North, spoke to  
 14 Mr Harvey that afternoon. A subsequent email described  
 15 what was discussed. It stated that Dr Gregory told  
 16 Mr Harvey that there were "mounting concerns about what  
 17 we had heard".

18 Mr Harvey told him that the Countess of Chester  
 19 Hospital intended to make a "significant announcement"  
 20 on Monday. He explained that:

21 "There is a member of staff whose presence has been  
 22 seemingly disproportionate, but as we discussed when we  
 23 met, this was originally accounted for by rotas and  
 24 skill level.

25 "However, when pushed about staff members

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1 [Mr Harvey] stated that this matter was best dealt with  
2 when they make the significant announcement about the  
3 decision that they have taken to speak to an  
4 'appropriate body' on Monday".

5 Dr Gregory's email concludes:

6 "Clearly something very serious is going on, and  
7 they must have their hands tied somewhere, but it would  
8 be speculation to guess what."

9 NHS England state that this was:

10 "The first time they had understood that there was  
11 a concern held by the hospital's clinicians that there  
12 was a connection between a particular individual and  
13 neonatal deaths."

14 The following day on 30 March 2017 the Trust  
15 received advice from Corinne Slingo of DAC Beachcroft  
16 LLP. The note of the discussion she had with  
17 Ms Hodgkinson describes consultant concern regarding  
18 "a number of cases where unnatural, unnamed causes of  
19 death" and the "[consultants] think the Trust should  
20 call the police".

21 Ms Slingo's email to Ms Hodgkinson following the  
22 conversation dated 4 April 2017 summarises the advice  
23 given. Ms Slingo's advice was that if the matter was to  
24 be referred to the police, it would be more helpful for  
25 it to be "the Trust's decision than for the Trust to

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1 informing her that Queen's Counsel had been instructed  
2 to give a perspective on the reviews and next steps.

3 He asked her to clarify what she meant by "broader  
4 forensic review" as had been recommended in her report  
5 almost six months earlier. He also asked her whether  
6 she had concerns that there was anything other than  
7 natural causes in her review of the cases.

8 Dr Hawdon replied the same day explaining that  
9 a broader review would be along the lines recommended by  
10 the Royal College of Paediatrics and Child Health, eg  
11 "who was on duty, who was perhaps unattended with the  
12 babies, did observation charts alert to recurrent or  
13 incipient decline?"

14 As to whether she had concerns, she explained that  
15 completely unexplained death on a neonatal unit is rare,  
16 so, "by definition", more than one unexplained death  
17 does arouse suspicion. She observed that on some  
18 occasions the neonatologists had, she thought, been  
19 misled by the post-mortem report.

20 It would appear that by late April NHS England were  
21 becoming increasingly concerned by the situation at the  
22 hospital. Dr Gregory emailed Ian Harvey on  
23 19 April 2017 requesting an update to which Mr Harvey  
24 replied that as Dr Jane Hawdon had identified four cases  
25 of unexplained death. The hospital was:

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1 await a potential whistleblower situation".

2 She advised that the police may need to consider  
3 corporate manslaughter issues and would be prone to  
4 share information with the Care Quality Commission, who  
5 would need to explore potential regulatory breaches.

6 It was noted that "a full police investigation would  
7 be highly disruptive".

8 It does not appear that the advice was positively to  
9 report the matter to the police, but Ms Slingo advised  
10 how to engage the police in a "constructive way" if  
11 a decision was made actively to engage them, such as  
12 inviting a local police detective to a meeting with the  
13 coroner.

14 I turn now to April 2017.

15 On 11 April 2017 Dr Jayaram informed Mr Carver at  
16 the British Medical Association that the hospital was  
17 considering whether to make a referral to the police,  
18 and had been asked that the consultants meet with  
19 Simon Medland QC. Mr Carver advised that this was,  
20 "a reasonable request from an employer".

21 The British Medical Council had, through Mr Carver,  
22 provided much support to Dr Jayaram in his role as an  
23 employment advisor. The evidence does not indicate any  
24 regard to, or advice on, child safeguarding policy.

25 On 13 April 2017, Ian Harvey contacted Dr Hawdon,  
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1 "... following the process that would be [the] case  
2 in the event of an unexpected death out of hospital and  
3 are consulting with the Child Death Overview Panel."

4 There are three observations to make about this  
5 communication.

6 First, a point that we have made more than once:  
7 neither the local nor the national Working Together  
8 Statutory Guidance differentiated in the approach to be  
9 taken to unexpected deaths in and out of hospital.

10 Two, all child deaths had to be referred to the  
11 Child Death Overview Panel. And three: five months had  
12 elapsed since Dr Hawdon had identified cases of  
13 unexplained death having reviewed the outstanding  
14 post-mortem reports.

15 Dr Gregory forwarded Mr Harvey's email to colleagues  
16 at NHS England expressing his concern that the Trust  
17 were "avoiding the issue that we wished to see  
18 (contacting the police)."

19 There were a series of internal emails at NHS  
20 England as to escalating to the police. The view of  
21 Robert Cornall, Regional Director of Specialised  
22 Commissioning North on 26 April 2017 was "We should just  
23 refer to the police now".

24 Regional Chief Nurse Margaret Kitching's view was  
25 that the Trust should be given the opportunity to seek

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1 advice from the police first. She stated that  
2 Mr Chambers was unhappy at Dr Gregory's accusation of  
3 evasiveness and he wanted to exhaust internal processes  
4 first as involving the police could cause distress to  
5 the families.

6 On 27 April 2017, Hayley Frame, the chair of the Pan  
7 Cheshire Child Death Overview Panel and Detective Chief  
8 Superintendent Wenham attended a meeting at the Countess  
9 of Chester Hospital with Mr Harvey, Mr Cross,  
10 Dr Jayaram, Dr Holt and Dr Mittal.

11 Ms Frame's evidence to the Inquiry is that it was  
12 only during this meeting that she became concerned that  
13 deliberate harm had not been excluded. Detective Chief  
14 Superintendent Wenham recalls that the term "angel of  
15 death" was used at the meeting to describe Letby.

16 On 28 April 2017 Mr Harvey informed both Ms Eardley  
17 and Dr Jane Hawdon that "perhaps not surprisingly" the  
18 only route left was a police investigation.

19 And so we reach May 2017.

20 On 2 May 2017 Detective Chief Superintendent Wenham  
21 briefed senior officers at Cheshire Police headquarters.  
22 It was agreed that a letter would be secured from the  
23 Countess of Chester Hospital inviting the police to  
24 investigate the Neonatal Unit. Mr Chambers' letter to  
25 Chief Constable Simon Byrne formally requesting

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1 took place on 15 May 2017. It was attended by  
2 Dr Brearey Dr Holt and Dr Jayaram. They explained the  
3 basis for their concerns: that they were suspicious of  
4 an unnatural cause of death and felt they had excluded  
5 everything else. Detective Chief Superintendent Wenham  
6 describes this meeting as:

7 "... the most critical and important event following  
8 the Child Death Overview Panel meeting on 24  
9 March 2017."

10 That afternoon, Cheshire Constabulary deciding that  
11 there were sufficient grounds to suspect a criminal  
12 offence and to launch a criminal investigation.

13 Following the announcement of the police  
14 investigation, Kristian Garsed, Regulation Advisor in  
15 the Employer Linked Service at the Nursing and Midwifery  
16 Council, spoke to Ms Kelly on 18 May 2017.

17 Ms Kelly advised Mr Garsed that several medical  
18 colleagues were quite strong in their view that Letby  
19 may be the cause of the heightened neonatal mortality.  
20 She is noted to have described Letby's "very good  
21 professional history and high degree of clinical  
22 credibility". It was also noted that she stated that  
23 other staff were present on a senior number of relevant  
24 occasions, and we will explore in evidence the basis for  
25 and the accuracy of that assertion by Ms Kelly.

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1 a forensic investigation was dated the same day.

2 The police met with Mr Chambers, Mr Cross and  
3 Mr Harvey on 5 May 2017, when the name "Operation  
4 Hummingbird" was first used. Mr Harvey informed NHS  
5 England that day that there would be an investigation,  
6 but it would be described as "an invited police  
7 investigation to investigate unexplained deaths".

8 The police met with Mr Chambers, Mr Harvey and  
9 Mr Cross again on 12 May 2017. It was decided that the  
10 police would meet with Dr Jayaram following the letter  
11 he had sent to the police on behalf of the  
12 paediatricians dated 10 May 2017.

13 Effectively pointing the finger at one nurse.

14 Mr Harvey informed Margaret Kitching at NHS England  
15 that the police were minded not to hold an  
16 investigation, but the paediatricians had sent  
17 a document, "which was a very prejudiced view,  
18 effectively pointing the finger at one nurse". He  
19 stated that his "own feeling" was that there would not  
20 be an investigation unless there was something "new"  
21 disclosed by the Paediatricians. He anticipated that the  
22 police would assist "in a message that will allow us to  
23 close down the speculation here and deal with the issues  
24 of culture".

25 The meeting between the police and paediatricians

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1 Despite concerns communicated to Mr Garsed, and  
2 notwithstanding the launch of a police investigation, no  
3 fitness to practise referral was made by Ms Kelly nor  
4 requested or advised by Mr Garsed. Mr Garsed instead  
5 advised Ms Kelly that there was nothing that could  
6 amount to an identifiable or sustainable allegation of  
7 impairment of fitness to practise. Ms Kelly was advised  
8 to wait for the police investigation to develop.  
9 Mr Garsed commented that if Letby was "identified" as  
10 having been involved in deliberate endangerment or  
11 murder then a referral would be necessary.

12 My Lady, the Inquiry will be considering the  
13 appropriateness of the seemingly high threshold for  
14 undertaking a referral, and whether this was indicative  
15 of insufficient regard to challenged safety concerns.

16 Why the allegation which had provoked a police  
17 investigation due to there being grounds to suspect  
18 a criminal offence was not considered to be an  
19 "identifiable or sustainable allegation of impaired  
20 fitness to practise" is unclear. Without a referral,  
21 the Nursing and Midwifery Council were not in a position  
22 to, and did not, commence an investigation, obtained  
23 disclosure, or consider whether any interim measures  
24 were required to protect the public.

25 In her statement to the Inquiry, Andrea Sutcliffe,

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1 then Chief Executive and Registrar of the Nursing and  
2 Midwifery Council, observes that the impression that may  
3 have been given that a referral would any be required in  
4 the event of findings of deliberate endangerment, was  
5 too high a bar.

6 She acknowledges that the Nursing and Midwifery  
7 Council Employment Liaison Advisers could have provided  
8 greater critical scrutiny and done more to support  
9 Ms Kelly and the Trust to raise concerns with the police  
10 sooner.

11 Letby remained a registered nurse, free to work  
12 without any restriction imposed upon her by the Nursing  
13 and Midwifery Council, and had been since concerns were  
14 first raised to the NMC in July 2016.

15 As we will see, she remained free to work without  
16 restrictions imposed upon her by her regulator until  
17 November 2020 after she was charged.

18 Returning to 2017, we move to June.

19 On 5 June 2017, the Local Safeguarding Children  
20 Board met. Ms Kelly, who had been a member of the board  
21 throughout, presented a paper titled "Neonatal review  
22 and police investigation into the increase in neonatal  
23 mortality at the Countess of Chester Hospital Foundation  
24 Trust".

25 She briefed the board on its contents.

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1 progressing to the next stage, with interviews of  
2 a significant number of staff anticipated. After this,  
3 there was no contact between the hospital and the NMC in  
4 the nine months that followed.

5 We move forward to 2018, in particular March.

6 On 29 March 2018 Ms Kelly made a referral to the  
7 Local Authority Designated Officer. She had met with  
8 Emma Taylor, Director of Children's Services, and given  
9 her an envelope said to contain confidential information  
10 relating to the neonatal investigation. When Ms Taylor  
11 opened the envelope she saw Letby's name and date of  
12 birth. Ms Kelly asked whether "this referral" should  
13 have been sent earlier, and Ms Taylor confirmed it  
14 should have been. Ms Kelly was told that a formal  
15 referral was required.

16 In his statement to the Inquiry, Mr Jenkins, the  
17 Local Authority Designated Officer, comments that:

18 "What is concerning in this case is that when  
19 professionals have reached the point of thinking the  
20 unthinkable, the matter was not referred to the Local  
21 Authority Designated Officer Service."

22 He confirms that whilst referrals are normally made  
23 by a designated safeguarding lead at an organisation, an  
24 individual clinician who was concerned could make  
25 a referral if their organisation was not doing so.

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1 The paper describes the increase in neonatal deaths  
2 and the invited review by the RCPCH. It concluded:  
3 "In summary, the Trust can demonstrate that the  
4 concerns raised had been taken seriously and it has been  
5 open and transparent with the coroner, regulators,  
6 parents, wider stakeholders, and the public."

7 Neither the report nor the minutes of the meeting  
8 demonstrate any disclosure of the suspicions of  
9 deliberate harm by Letby.

10 The minutes of the meeting show that a query was  
11 raised as to why the Child Death Overview Panel had "not  
12 picked this up". Dr Mittal explained that the data was  
13 fragmented because of the time it took for a death to  
14 come to the panel and the cluster was masked because  
15 some of the children did not live in Cheshire.

16 Mr Garsed of the Nursing and Midwifery Council met  
17 with Ms Kelly on 15 June 2017. He was informed that  
18 Letby was still employed and working, but in  
19 a non-clinical role. Notwithstanding her continued  
20 employment and the absence of any formal restriction on  
21 her ability to work as a nurse, no fitness to practise  
22 referral was sought or advised.

23 October 2017.

24 On 9 October 2017 Alison Kelly notified the Nursing  
25 and Midwifery Council that the police investigation was

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1 Mr Jenkins spoke to Ms Kelly on 27 March 2018. He  
2 was assured that Letby was not working directly with  
3 children or families.

4 He told Ms Kelly that a referral was required. It  
5 followed on 29 March 2018. Whilst the police  
6 investigation was ongoing, and with Letby having been  
7 moved to administrative duties, no formal meeting was  
8 arranged by the Local Authority Designated Officer.

9 We move now to the Nursing and Midwifery Council  
10 referral.

11 Following the arrest of Letby, the Nursing and  
12 Midwifery Council contacted Ms Kelly on 3 July 2018.  
13 She confirmed a referral would be made. It was sent on  
14 5 July 2018. It contained a brief chronology and stated  
15 that Letby was on duty on a number of occasions when  
16 incidents had taken place.

17 A senior lawyer at the Nursing and Midwifery  
18 Council, Richard Reid, undertook an assessment of the  
19 referral. He concluded that there was little  
20 information with which to progress the referral, and  
21 insufficient grounds to obtain an interim order against  
22 Letby without her being charged. His view was that  
23 there was no prima facie case.

24 It is not clear that any formal requests for  
25 evidence were made upon receiving the referral, but

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1 Mr Reid did speak to Melissa Andrews, a police officer,  
2 on 26 July 2018. She confirmed that the only evidence  
3 was the correlation between Letby's presence and the  
4 deaths, and she'd been arrested to facilitate  
5 questioning.

6 On 6 July 2018, the Director of Fitness to Practise,  
7 Matthew McLelland, reached the same conclusion as  
8 Mr Reid: that there were no grounds to apply for an  
9 interim order due to a lack of evidence and because the  
10 "fact of the arrest is not in itself sufficient".

11 My Lady, the significance of an interim order for  
12 conditions or suspension was that it would have either  
13 restricted the circumstances in which Letby could work,  
14 such as by imposing a condition of "close supervision",  
15 or prevented Letby from working as a nurse. Without  
16 such an order, there were no restrictions on her ability  
17 to work beyond those imposed by her bail conditions. An  
18 obvious question that arises is whether the delay in  
19 waiting until Letby was arrested to seek a referral  
20 inhibited the ability to progress and investigate the  
21 referral.

22 It appears that any concerns the Nursing and  
23 Midwifery Council had about the absence of an interim  
24 suspension order were initially assuaged by their  
25 initial but mistaken understanding that Letby's bail

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1 On 30th May 2019, Angela Wilding, an investigation  
2 lawyer, echoed the original view of Richard Reid that  
3 there was insufficient evidence to establish  
4 a prima facie case. However, on 10 June 2019, she wrote  
5 that the Nursing and Midwifery Council was very anxious  
6 that there was not an interim order in place and she was  
7 more inclined to apply for one.

8 By 2 July 2019, the view she took was that an  
9 interim order should be sought. She considered, after  
10 further thought, that the fact of arrest would be  
11 sufficient to make an application given the severity of  
12 the allegations.

13 Others, however, remained of the view that the fact  
14 of arrest remained an insufficient evidential basis to  
15 justify an interim order in the absence of other  
16 evidence.

17 My Lady, the grounds for imposing an interim order  
18 were contained in Article 31(2) of the Nursing and  
19 Midwifery Order 2001. They were that such an order:

20 "... is necessary for the protection of members of  
21 the public or is otherwise in the public interest, or is  
22 in the interests of the person concerned, for the  
23 registration of that person to be suspended or be made  
24 subject to conditions."

25 The order itself does not establish any particular

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1 conditions prevented her working a nurse. On  
2 20 July 2018 a legal assistant at the Cheshire  
3 Constabulary informed the Nursing and Midwifery Council  
4 that Letby's bail conditions prevented her from working  
5 in any healthcare setting or having unsupervised contact  
6 with anyone under the age of 16.

7 It was not until May 2019, so approximately ten  
8 months later, that it was appreciated that Letby's bail  
9 conditions only prevented her working with babies or  
10 children in a healthcare setting, not working in  
11 a healthcare setting altogether. Assurance was,  
12 however, given by the police that there were system  
13 markers in place that would notify the police if there  
14 was a Disclosure and Barring Service check made in  
15 respect of Letby.

16 The discovery of the true position in respect of  
17 Letby's bail conditions coincided, and may have  
18 provoked, internal discussions at the Nursing and  
19 Midwifery Council as to whether an interim order should  
20 in fact be sought.

21 On 22 May 2019, Leeann Mohamed, a lawyer in case  
22 preparation and presentation, states that she was  
23 inclined to apply for an interim order on public  
24 interest grounds, given the seriousness of the  
25 allegations.

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1 evidential threshold but the Nursing and Midwifery  
2 Council's interpretation of the case law was that in  
3 order to obtain an interim order it was necessary first  
4 to show that there was a prima facie case against the  
5 registrant before the public interest or public  
6 protection grounds for an order could be considered.

7 The Nursing and Midwifery Council's guidance on  
8 interim orders had been updated on 2 October 2019 to  
9 reflect this interpretation. An example given on when  
10 there is sufficient evidence to establish a prima facie  
11 case was where an individual had been charged with  
12 a criminal offence.

13 The Council's guidance on the grounds for obtaining  
14 an order have since changed. It now states explicitly  
15 that there is no evidential threshold, but there must be  
16 some evidential basis that is cogent and not fanciful,  
17 frivolous, obviously contradicted, or entirely  
18 misconceived.

19 My Lady may consider that if such guidance was in  
20 place at the time, there would not have been any  
21 reluctance or hesitation to seek an interim order.

22 However, it is clear at the time the Nursing and  
23 Midwifery Council considered the lack of a criminal  
24 charge a hurdle to obtaining an interim order,  
25 notwithstanding Letby's arrest and a criminal

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1 investigation of the utmost seriousness.

2 Another hurdle may have been the lack of  
3 investigation or evidence gathered by the Nursing and  
4 Midwifery Council to support such an application.

5 On 23 July 2019 somewhat belatedly, you may  
6 conclude, my Lady, given it was more than three years  
7 after concerns about Letby were first raised with them,  
8 the Nursing and Midwifery Council requested documents  
9 from the Trust linking Letby to the deaths. The request  
10 was not a statutory disclosure request, and on  
11 30 July 2019 the Countess of Chester Hospital refused  
12 it.

13 It was not until Letby was charged in November 2020  
14 that the Nursing and Midwifery Council sought an interim  
15 order. An 18-month suspension order was imposed on  
16 20 November 2020 both on public protection and public  
17 interest grounds. The interim order remained in place  
18 thereafter.

19 Following her conviction, Letby was referred to the  
20 Fitness to Practise Committee. On 10 November 2023  
21 Letby indicated that she did not contest the application  
22 to remove her from the register and she did not want to  
23 attend the hearing. The hearing took place on  
24 12 December 2023. Letby was struck off.

25 My Lady, I wonder if that would be a convenient  
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1 (a) a failure to act appropriately or timely in  
2 response to concerns raised by clinicians about the  
3 neonatal mortality rate and the possibility of unnatural  
4 causes for collapses and deaths from February 2016;

5 (b) failing to act appropriately in 2017 to concerns  
6 that they raised about the lack of investigations into  
7 neonatal deaths and sudden collapses;

8 (c) failing to share and misrepresenting the Royal  
9 College of Paediatrics and Child Health review.

10 (d) misusing the Trust's grievance procedures as  
11 evidence of wrongdoing by the consultants, and the  
12 innocence of the nurse in question;

13 (e) threatening paediatricians who would not enter  
14 into mediation with Letby;

15 (f) misleading the Trust board;

16 (g) misleading the public in media statements;

17 (h) misleading the clinicians as to the reason for  
18 the meeting with Simon Medland QC.

19 A case examiner advised that further investigation  
20 was "inevitable" and that if Mr Harvey was "found to  
21 have failed to act appropriately when the staff were  
22 raising repeated serious possibly criminal concerns  
23 about patient safety, this would be a very serious  
24 matter".

25 On 14 September 2018 Mr Harvey told the General  
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1 moment?

2 **LADY JUSTICE THIRLWALL:** Yes, thank you. We'll resume again  
3 at 3.15.

4 **(2.58 pm)**

5 **(A short break)**

6 **(3.14 pm)**

7 **LADY JUSTICE THIRLWALL:** Mr De la Poer.

8 **MR DE LA POER:** My Lady, continuing with external bodies  
9 I deal briefly with the Royal College of Nursing.

10 The Inquiry have obtained a witness statement from  
11 Patricia Marquis, Director for England at the Royal  
12 College of Nursing. She states that the Royal College  
13 of Nursing is not aware of any enquiries being raised  
14 with them by their members in relation to the neonatal  
15 unit at the Countess of Chester Hospital.

16 Ian Harvey fitness to practise referral.

17 My Lady, the annex to the terms of reference for the  
18 Inquiry include at question 27, "What was the result of  
19 any referral or discussion with the GMC?"

20 On 20 July 2018 Dr Brearey, supported by a number of  
21 consultant paediatricians, Dr Jayaram, Dr Holt and  
22 Doctor ZA, referred Ian Harvey to the General Medical  
23 Council Fitness to Practise Team. The referral included  
24 documents setting out their concerns.

25 Those concerns included:  
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1 Medical Council that the allegations were "nothing new  
2 to him". He had retired and moved to France.

3 He queried what the process of voluntary erasure  
4 from the register was. The investigation proceeded.  
5 A detailed 26-page witness statement was obtained from  
6 Dr Brearey dated 29 January 2019.

7 Mr Harvey requested voluntary removal from the  
8 register on 29 July 2019 and repeated the request on  
9 11 June 2020, whilst commenting that he was prepared, if  
10 necessary, to defend himself vigorously.

11 He described as one of his greatest regrets the  
12 "breakdown in the relationship between the executives  
13 and the consultant paediatricians".

14 The application for voluntary erasure was refused.  
15 The default position is that voluntary erasure will not  
16 be allowed by the General Medical Council where there  
17 are serious allegations or an ongoing police  
18 investigation. The General Medical Council instructed  
19 an expert, namely a consultant in general and  
20 respiratory medicine to opine upon whether Mr Harvey's  
21 conduct fell below the standard to be expected of  
22 a reasonably competent Medical Director.

23 The expert's initial report was dated  
24 30 September 2020 but was caveated due to the  
25 significant evidence that was missing. His report,  
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1 following receipt of further evidence, is dated  
2 8 February 2022.

3 The GMC expert made one finding that Mr Harvey's  
4 standard of care may have fallen seriously below the  
5 standard to be expected of a reasonably competent  
6 Medical Director. This was the allegation that  
7 Mr Harvey had misled the grievance process that the  
8 paediatricians had threatened to contact police if Letby  
9 was not removed from the unit. The paediatricians  
10 denied making that threat.

11 The expert additionally found that Mr Harvey's  
12 communication with the paediatricians fell below the  
13 standard to be expected of a reasonably competent  
14 Medical Director, but not seriously below that standard.

15 They identified in particular the failure to provide  
16 more regular updates and the confusion that arose at the  
17 meeting on 26 January 2017 to discuss the Royal College  
18 of Paediatrics and Child Health Invited Review Report  
19 and the Dr Jane Hawdon Report.

20 As a result of the instructed experts' conclusions  
21 the GMC case examiners decided to close the referral  
22 with no action. Following this, Mr Harvey's application  
23 for voluntary erasure from the medical register was  
24 granted.

25 Alison Kelly, fitness to practise referral.  
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1 suspect a death in their area was violent or unnatural,  
2 or the cause of death is unknown. An inquest must be  
3 held if the coroner suspects a violent or unnatural  
4 cause unless the post-mortem reveals a cause of death  
5 and the coroner does not think it necessary to continue  
6 the investigation.

7 Nicholas Rheinberg was at the time the Senior  
8 Coroner for Cheshire. He remained so until his  
9 retirement in March 2017. Dr Janet Napier and  
10 Alan Moore, who became the Senior Coroner on  
11 Mr Rheinberg's retirement, were his assistant coroners.  
12 Mr Rheinberg had published local guidance titled  
13 "Reporting Deaths to the Coroner" which required "all  
14 child deaths in the area" to be reported, irrespective  
15 of the circumstances of death.

16 Once a death was reported, if there was reason to  
17 suspect a violent or unnatural death, an investigation  
18 would be commenced. Where preliminary inquiries  
19 satisfied the coroner that the death was naturally  
20 occurring, the coroner would discontinue the  
21 investigation and his involvement would come to an end.

22 If it was not possible to determine if the death was  
23 natural or not, a post-mortem would be arranged. If the  
24 cause of death could not be ascertained or was  
25 unnatural, an inquest would be opened.  
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1 On 18 May 2020, four consultant paediatricians at  
2 the Countess of Chester Hospital, Dr Brearey,  
3 Dr Jayaram, Doctor ZA and Dr Holt, referred Ms Kelly to  
4 the Nursing and Midwifery Council. The concerns raised  
5 included allegations that Ms Kelly mismanaged the  
6 concerns of the consultant body, failed to communicate  
7 effectively, failed to take appropriate action, made  
8 errors of judgement and damaging decisions and did not  
9 act with honesty and integrity at all times.

10 On 15 February 2021 the Nursing and Midwifery  
11 Council were asked to delay their investigation into  
12 Ms Kelly until after the conclusion of Letby's criminal  
13 trial.

14 Following Letby's conviction, four members of the  
15 public, one a nurse, also referred Ms Kelly to the  
16 Nursing and Midwifery Council. We understand that  
17 investigations are ongoing.

18 We turn now to the topic of the coroner.

19 The annex to the terms of reference for the Inquiry  
20 ask at question 19 what information about each of the  
21 deaths was provided to the coroner, and whether the  
22 Trust's provision of information to the coroner was  
23 appropriate.

24 The Coroners and Justice Act 2009 requires a coroner  
25 to conduct an investigation if there is reason to  
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1 Mr Rheinberg's evidence to the Inquiry is that where  
2 there was a suspicion of criminality, he would instruct  
3 a forensic pathologist to carry out the post-mortem. In  
4 child death cases involving suspicion of criminality the  
5 forensic pathologist would work alongside the paediatric  
6 pathologist. In such cases the coroner would also  
7 consult with the senior police officer to discuss what  
8 ancillary action might be taken.

9 I turn now to consider the coroner's service and the  
10 procedural history.

11 The death of Child A was reported to the coroner by  
12 Dr Saladi on 9 June 2015. No medical cause of death was  
13 given. The reported circumstances of death included the  
14 fact that X-ray had revealed that an umbilical line, and  
15 a percutaneous line had been inappropriately positioned,  
16 and some time later, Child A suffered an apnoeic event  
17 and went into arrest.

18 An investigation was commenced into Child A's death  
19 on 22 June 2015, and the inquest was opened on  
20 23 December 2015, after the post-mortem of Dr Shukla was  
21 unable to establish cause of death.

22 The inquest was heard on 10 October 2016 when the  
23 coroner recorded a narrative conclusion that stated:

24 "It cannot be determined what caused [Child A's  
25 collapse and subsequent death], and further, it cannot  
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1 be determined whether this was due to natural or  
2 unnatural event."

3 On 15 June 2015, a week after the report of the  
4 death of Child A, the death of Child C was reported to  
5 the coroner by Dr Gibbs. No cause of death was offered.  
6 It was reported that Child C had had a sudden collapse  
7 and died. An investigation was commenced on  
8 16 June 2015 by assistant coroner Dr Napier.

9 A post-mortem was conducted by Dr Kokai, who  
10 considered that there was a natural cause of death. The  
11 investigation was discontinued on 26 November 2015  
12 because the death had been found to be due to a natural  
13 cause.

14 On 22 June 2015, Child D's death was reported to the  
15 coroner by Dr Newby. It was reported that Child D had  
16 become profoundly mottled and apnoeic, losing heartrate  
17 and not responding to resuscitation. No cause of death  
18 was offered.

19 This marked the third reported death within  
20 a fortnight, and in none of them was a cause of death  
21 offered. No suspicion of potential deliberate harm was  
22 raised in any of the reports of these deaths.

23 Despite all three cases having been unexpected and  
24 unexplained, there was no police involvement on behalf  
25 of the coroner. The only limited evidence of engagement

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1 notifying the coroner that Letby was to stand trial  
2 charged with the murder of Child D.

3 The death of Child E was reported to the coroner on  
4 4 August 2015. Unlike the reports of the deaths of  
5 Child A, Child C and Child D, a cause of death was  
6 proposed by Doctor ZA of Necrotising Enterocolitis and  
7 prematurity. There was nothing in the reported  
8 circumstances of death raising suspicion or concern. In  
9 light of the reported natural cause of death, accepted  
10 by Dr Napier, there was no post-mortem and neither an  
11 investigation was commenced nor an inquest opened.

12 Child I's death was reported to the coroner on  
13 23 October 2015 by Dr Gibbs. No cause of death was  
14 offered. The reported circumstances of the death were  
15 that Child I had suffered an arrest the previous week,  
16 but had been resuscitated and ventilated and had been  
17 doing well for five days before having another arrest  
18 with resuscitation unsuccessful.

19 An investigation was opened by Dr Napier on  
20 28 October 2015. The post-mortem report of Dr Kokai  
21 concluded that there was a natural cause of death. The  
22 investigation was discontinued on 12 February 2016, the  
23 coroner being satisfied that the death was due to  
24 natural causes.

25 The deaths of Child O and Child P were reported to

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1 with the process in the Sudden Unexpected Death in  
2 Infants and Children Guidance was the minutes of an  
3 initial strategy meeting on 2 July 2015, provided to the  
4 coroner which concluded that Child C's death did not  
5 meet the threshold for a Serious Case Review.

6 As with Child A and Child C, on 25 June 2015 an  
7 investigation was commenced into the death of Child D.  
8 The report of the post-mortem conducted by  
9 Dr McPartland, which we will return to shortly,  
10 described a natural cause of death.

11 The view of the assistant coroner Mr Moore was that  
12 the investigation could be discontinued.

13 After representations from Child D's family,  
14 however, an inquest was opened on 8 January 2016.  
15 Independent expert evidence was obtained by the coroner,  
16 including from Dr Mecrow, a consultant paediatrician.  
17 The inquest was scheduled to be heard on 25 May 2017 but  
18 was adjourned and did not proceed on that day due to the  
19 coroner being informed that there was to be a police  
20 investigation.

21 The coronial investigation was subsequently  
22 suspended on 27 November 2020 by assistant coroner  
23 Peter Sigee so as not to prejudice the police  
24 investigation. This decision was confirmed on  
25 19 October 2021, following the Crown Prosecution Service

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1 the coroner by Dr V on 27 June 2016. No cause of death  
2 was offered. The reports of these two deaths did not  
3 raise any suspicions of deliberate harm. In respect of  
4 Child O, it was reported that the child initially did  
5 well following birth but became quite unwell, requiring  
6 ventilation, initially improving but then deteriorating  
7 and couldn't be resuscitated.

8 In respect of Child P, the reported circumstances of  
9 death were that the child was not extremely premature  
10 and had been doing well initially, but that the abdomen  
11 had become distended, oxygen levels and heartrate had  
12 decreased, and there had been several episodes of  
13 resuscitation. Investigations were opened by Mr Moore  
14 on 30 June 2016, post-mortems were conducted by Dr Kokai  
15 who concluded there were natural causes of death in both  
16 cases.

17 My Lady, the deaths of Child O and Child P were  
18 reported to the coroner in circumstances where (i) the  
19 independent paediatric experts in Child D's case,  
20 Dr Mecrow, had described the collapse there as "wholly  
21 unexplained"; (ii) the death of Child A was proceeding  
22 towards an inquest hearing in circumstances where there  
23 remained no cause of death after post-mortem; and (iii)  
24 the worrying increase in neonatal mortality at the unit.

25 Following receipt of Dr Mecrow's report on

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1 9 June 2016, Mr Rheinberg explains in his statement to  
2 the Inquiry that he will have shared the experts'  
3 puzzlement at Child D's wholly unexplained collapse. He  
4 did not suspect the possibility of criminality.

5 Upon receipt of the reports of the deaths of Child O  
6 and Child P, Mr Rheinberg's evidence to the Inquiry is  
7 that he discussed the matter with his officer,  
8 Christine Hurst, and they were both concerned about the  
9 number of neonatal deaths that had occurred and the  
10 deaths of Child O and Child P focused their concern.

11 Mr Rheinberg states in his evidence to the Inquiry  
12 that he would have sought a meeting with the Chief  
13 Executive of the Trust had it not been for the fact that  
14 a report from the Royal College of Paediatrics and Child  
15 Health had been commissioned. He was comforted by this  
16 report and anticipated it would have revealed any  
17 deficiencies in the neonatal department.

18 The contemporaneous documents show that prior to the  
19 report of the RCPCH being received, Mr Rheinberg was  
20 minded to discontinue the investigation into the deaths  
21 of Child O and Child P, after the post-mortem reports of  
22 Dr Kokai concluded that the causes of death were  
23 natural.

24 Mr Rheinberg's view as stated at the time was that  
25 the report of the Royal College of Paediatrics and Child

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1 Even after Dr Hawdon's report was provided to the  
2 coroner on 15 February 2017 no inquest was ever opened,  
3 and ultimately, the investigation into the deaths of  
4 Child O and Child P were suspended in June 2017  
5 following the commencement of the police investigation.

6 I turn now to the evidence that was gathered by the  
7 coroner in these cases.

8 In Child A's case the post-mortem reports of  
9 Dr Shukla did not establish a cause of death. Child A  
10 had not suffered typical complications associated with  
11 inappropriate line insertion. A cross-pulmonary artery  
12 was found at post-mortem but was an incidental finding  
13 and was not considered to be indicative of cause of  
14 death. The inquest was due to be heard on 23 March 2016  
15 but it was adjourned due to what Mr Rheinberg described  
16 as "particularly poor delays" by the Countess of Chester  
17 Hospital in providing evidence.

18 Mr Rheinberg had anticipated receiving a root cause  
19 analysis or Serious Incident report in respect of  
20 Child A. After waiting for such a report he was  
21 eventually, in September 2016, provided with a very  
22 brief summary report which Dr Brearey had written more  
23 than a year earlier on 1 July 2015.

24 Both Mr Rheinberg and those acting on behalf of  
25 Child A's family expressed disappointment at the

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1 Health was, "not instituted because of specific concerns  
2 about the death in this instance" and there was no  
3 "clinical mismanagement" in those cases.

4 Nonetheless, the investigation remained open pending  
5 receipt of the Royal College of Paediatrics and Child  
6 Health report.

7 On receipt of that report, Mr Rheinberg reiterated  
8 the view that the investigation should be discontinued.  
9 He wrote on 26 January 2017 that:

10 "Nothing in the report throws any light on the  
11 deaths in questions and these being natural deaths with  
12 nothing to indicate gross human failure, I have no  
13 jurisdiction to hold inquests. If [parents] have any  
14 representations to make I will of course listen, but  
15 other than that, I will discontinue."

16 The investigation remained open after the Countess  
17 of Chester Hospital indicated that a full independent  
18 review of the deaths of Child O and Child P were being  
19 undertaken.

20 If this was a reference to the review by Dr Hawdon,  
21 the Countess of Chester Hospital was already in  
22 possession of the report of Dr Hawdon, and her  
23 subsequent review of the post-mortems for Child O and  
24 Child P, which concluded that both deaths remained  
25 unexplained.

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1 apparent lack of a thorough investigation by the  
2 hospital. The evidence gathered for the inquest hearing  
3 on 10 October 2016 included statements from a number of  
4 doctors involved in Child A's care. It did not raise  
5 concerns in relation to Letby, nor was it suggestive of  
6 deliberate harm.

7 The Inquiry will be considering why the concerns  
8 about Letby that by this stage had led to Letby being  
9 removed from the ward and had led to the commission of  
10 the review by the RCPCH were not communicated to the  
11 coroner.

12 In Child C's case Dr Kokai, the paediatric  
13 pathologist, performed the post-mortem on 16 June 2015,  
14 and indicated on the same day that the death was  
15 naturally occurring.

16 The cause of death was withheld pending histology  
17 and bacteriology investigations.

18 Following investigations, the cause of death was  
19 given in a post-mortem report dated 3 November 2015.  
20 Dr Kokai's view was that lung immaturity had caused  
21 widespread hypoxic-ischaemic damage to the heart and  
22 myocardium.

23 In Child D's case the post-mortem was carried out by  
24 Dr Jo McPartland. Her initial post-mortem report was  
25 date 26 August 2015 and was updated on

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1 18 September 2015. She found acute pneumonia in the  
2 lungs which she concluded was likely present at birth  
3 although Child D had no levels of C reactive protein,  
4 suggesting an absence of inflammation. She considered  
5 there was a possibility of early onset sepsis. Her view  
6 was that the cause of death was pneumonia with acute  
7 lung injury.

8 An independent consultant paediatrician, Dr Mecrow,  
9 was instructed to comment on the adequacy of the care  
10 provided to Child D and Child D's mother. The  
11 "Opinions" section of Dr Mecrow's report starts:

12 "I feel I should start by commenting that Child D's  
13 death is disturbing. Not because I perceive there to be  
14 significant deficiencies in her care, but because her  
15 collapse was so sudden and unexpected."

16 Dr Mecrow went on to comment:

17 "Quite why Child D should have collapsed and become  
18 unwell after a period of more than 24 hours when she  
19 seemed to be making good progress is wholly  
20 unexplained."

21 Ultimately Dr Mecrow agreed with Dr McPartland's  
22 conclusions that pneumonia was likely present at birth  
23 and that on balance the cause of death was bacterial  
24 sepsis as a result of pneumonia. He explained however  
25 that there were a number of clinical and biochemical

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1 a ruptured subcapsular haematoma of the liver. He  
2 attributed this to prematurity.

3 My Lady will recall that Dr Hawdon's review of this  
4 case in the post-mortem led her to conclude that the  
5 death was unexplained. She considered that the  
6 intra-abdominal bleeding was secondary to chest  
7 compressions following collapse. It did not explain the  
8 collapse or the death.

9 In respect of Child P, Dr Kokai was unable to  
10 identify any underlying disease or pathological  
11 condition to explain the death. His view was that  
12 Child P's unexpected and progressive deterioration  
13 fulfilled the definition of "sudden unexpected postnatal  
14 collapse" but the cause of that condition "remained  
15 unexplained". He nevertheless gave a cause of death as  
16 prematurity which he described as a "very substantial  
17 risk factor for unexpected death of neonates".

18 My Lady may wonder if prematurity as a risk factor  
19 for death was being conflated with being a cause of  
20 death. It was a third occasion where death was  
21 essentially being attributed to prematurity by Dr Kokai.

22 Dr Hawdon's view was that Child P was only mildly  
23 pre-term and was not expected to collapse and die. She  
24 considered that the death remained unexplained.

25 I turn to concerns relating to Letby and the

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1 features at odds with this diagnosis.

2 In Child I's case the post-mortem report was  
3 prepared by Dr Kokai. It was dated 10 February 2016 and  
4 found early stage chronic lung disease and  
5 irregularities in the brain.

6 Dr Kokai considered it, "justifiable to conclude  
7 that [Baby I's] death was as a result of natural  
8 causes". Those natural causes were said to be a  
9 "combination of several underlying pathological  
10 processes as a consequence of prematurity". The finding  
11 of natural causes led to the discontinuation of the  
12 investigation.

13 My Lady, you will recall that this was a cause of  
14 death that Dr Hawdon advised should be reviewed as  
15 Child I had been stable in the days preceding collapse.

16 The post-mortems of Child O and Child P were both  
17 undertaken by Dr Kokai on 28 June 2016 and both reports  
18 were dated 10 October 2016.

19 In respect of Child O, Dr Kokai's examination  
20 investigations did not explain the cause of the sudden  
21 collapse and progressive deterioration. However,  
22 Dr Kokai considered that the collapse fitted the  
23 diagnostic features of the condition, "Sudden Unexpected  
24 Postnatal Collapse". He concluded that Child O died of  
25 natural causes due to intra-abdominal bleeding from

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1 coroner.

2 Mr Rheinberg's statement to the Inquiry is that up  
3 until his retirement on 10 March 2017, he had, "not the  
4 slightest inkling or suspicion that anyone had  
5 deliberately harmed the children". He states he is  
6 satisfied that he was not informed that Letby was under  
7 suspicion during his tenure. He expresses surprise that  
8 the concerns of the consultants were not shared with  
9 him; his "door was always open".

10 His expectation was that those with concerns would  
11 pass on details of possible suspicions to him.  
12 Similarly, Mr Moore in his statement states that at no  
13 stage was there ever any mention by the Countess of  
14 Chester Hospital of suspicions or concerns that an  
15 individual had been responsible for the death of any  
16 baby.

17 Mr Rheinberg met with Mr Harvey and Mr Cross at the  
18 Countess of Chester Hospital on 8 February 2017 and, at  
19 the coroner's office on 15 February 2017. The second  
20 meeting was also attended by Mr Moore.

21 At the second meeting, Mr Rheinberg was given a copy  
22 of Dr Hawdon's report and the letter from the  
23 paediatrician seeking a coronial investigation of all  
24 the deaths and unexplained collapses from June 2015 to  
25 July 2016. Mr Rheinberg's evidence is that at neither

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1 of these meetings or otherwise was he made aware of  
 2 suspicions or concerns relating to the involvement of  
 3 a nurse in relation to any of the deaths. His response  
 4 to the paediatrician's request was that he did not have  
 5 the power to conduct a broad investigation, and could  
 6 only revisit deaths that had been through the coronial  
 7 process if there was fresh evidence.

8 Amongst the documents said to be enclosed with the  
 9 letter provided to the coroner at the meeting of  
 10 15 February 2017, was a document titled "Observations  
 11 Additional to the RCPCH Review".

12 That letter refers to the fact a nurse had been  
 13 rostered on the shifts for all deaths. Mr Rheinberg's  
 14 evidence is that this document was not referred to  
 15 during the meeting and either it was not provided to him  
 16 or if it was, he may have overlooked it.

17 His evidence is that the suggestion that one nurse  
 18 had been rostered on shift or all the deaths would have  
 19 prompted him to ask the identity of the nurse in  
 20 question, and he would probably have spoken to a police  
 21 officer to determine if the police were aware of this  
 22 correlation.

23 My Lady, that concludes all that we will say at this  
 24 stage about the coroners.

25 I am going to ask you to invite Counsel to the  
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1 independent investigation into maternity and neonatal  
 2 services in East Kent, have looked at particular  
 3 services within hospitals. Others have focused upon  
 4 specific issues such as the Messenger review of NHS  
 5 leadership, and Tom Kark King's Counsel's examination of  
 6 the Fit and Proper Person test as it applies to  
 7 directors of hospitals.

8 However, what most of these Inquiries have in common  
 9 is that they have, in same form, and to differing  
 10 degrees, addressed issues of patient safety, culture,  
 11 and governance. They have all found substantial  
 12 failings and all made recommendations or identified  
 13 areas of action for implementation.

14 The cost of public inquiries and what they achieve  
 15 is a matter of public concern. Question 28 of a series  
 16 of questions posed by this Inquiry and appended to the  
 17 terms of reference is as follows:

18 "Whether recommendations to address culture and  
 19 governance issues made by previous Inquiries into the  
 20 NHS have been implemented into wider NHS practice?"

21 When beginning this Inquiry, you said, my Lady, in  
 22 a video address:

23 "We all know that there have been many inquiries  
 24 into events in hospitals and other healthcare settings  
 25 over the last 30 years. I want to know what  
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1 Inquiry to come forward to conclude this opening  
 2 address.

3 **LADY JUSTICE THIRLWALL:** Thank you very much indeed,  
 4 Mr De la Poer.

5 I will allow you just to move out of the way and  
 6 call on Ms Langdale.

7 Further opening statement by MS LANGDALE

8 **MS LANGDALE:** My Lady, Part C. The Terms of Reference for  
 9 Part C require the Inquiry to investigate the  
 10 effectiveness or otherwise of NHS management and  
 11 governance structures and processes for keeping babies  
 12 in hospitals safe and well looked after.

13 To do so, the Inquiry will examine NHS culture and  
 14 whether and how accountability of senior managers should  
 15 be improved upon. The Inquiry will also consider the  
 16 role of external scrutiny and professional regulation.  
 17 My Lady, you can then decide whether changes are  
 18 necessary and if so, what they should be.

19 This Inquiry does not exist in isolation. It is  
 20 preceded by over 30 inquiries that have arisen in  
 21 healthcare settings over the last 30 plus years.

22 Some, such as the Clothier Inquiry and the  
 23 Shipman Inquiry mentioned yesterday, have arisen from  
 24 cases where health professionals have deliberately  
 25 harmed or murdered patients. Some, such as the  
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1 recommendations were made in all these inquiries.  
 2 I want to know whether they were implemented? What  
 3 difference did they make? Where does accountability lie  
 4 for errors that are made?"

5 In order to fulfil that commitment, the Inquiry  
 6 legal team has prepared and published on the Inquiry  
 7 website a review of implementation of recommendations  
 8 from previous Inquiries into healthcare issues. The  
 9 review table is a continuing piece of work, and we are  
 10 grateful for the assistance of Sir Robert Francis via  
 11 his first expert report and to Core Participants for  
 12 their comments on our draft.

13 It is readily apparent on the face of the table how  
 14 many recommendations have not been implemented at all,  
 15 or have not been implemented effectively.

16 We will be asking witnesses giving evidence on  
 17 behalf of their organisations why these recommendations  
 18 have not been implemented, where they consider  
 19 responsibility lies for the failure to implement, and  
 20 what impact the failure to implement may have had.

21 We have also asked for and received statements on  
 22 this issue from two former Secretary of State:  
 23 Baroness Virginia Bottomley and the Right Honourable  
 24 Jeremy Hunt MP. We anticipate, my Lady, that upon the  
 25 conclusion of this Inquiry you will be in a position to  
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1 give a comprehensive answer to question 28.  
 2 The Inquiry's terms of reference include an explicit  
 3 commitment to consider NHS culture. The more detailed  
 4 question that is posed is, "What was the culture within  
 5 the Countess of Chester Hospital? To what extent did it  
 6 influence the effectiveness of the processes and  
 7 procedures for raising concerns?"

8 It is imperative that this Inquiry does not simply  
 9 repeat the work of previous inquiries, but rather,  
 10 builds upon that work.

11 As Sir Brian Langstaff said very recently in his  
 12 powerful report into the Infected Blood scandal:

13 "It is a sad fact that very few Inquiries into  
 14 aspects of the Health Service or parts of it have ended  
 15 without recognition that the culture needed to change."

16 He cited the example of the Inquiry into children's  
 17 heart surgery at the Bristol Royal Infirmary between  
 18 1984 and 1995.

19 The Bristol Report emphasised the need for a change  
 20 in culture. It also recognised that there was a link  
 21 between candour and safety, noting that being open and  
 22 transparent about a "sentinel event" enables possible  
 23 shortcomings to be treated as an opportunity to improve  
 24 the quality, that is the safety, of the NHS.

25 Over a decade after the Bristol Report in 2001, and  
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1 of whether there should be an extension of the duty of  
 2 candour forms part of that consideration, and witnesses  
 3 within Part C will be asked to give their views about  
 4 this.

5 The Nuffield Survey.

6 In addition to consideration of past recommendations  
 7 from previous Inquiries, the Inquiry has also  
 8 commissioned a report to shed light on to the current  
 9 effectiveness of NHS management and governance. This  
 10 should assist the Inquiry in establishing not only what  
 11 ought to be, but what is, so that any recommendations  
 12 you make, my Lady, are relevant to neonatal units as  
 13 they operate today.

14 A detailed questionnaire was sent to 120 NHS Trusts  
 15 in England with neonatal units to be completed by both  
 16 medical and non-clinical directors. Analysis of the  
 17 responses has been undertaken by the Nuffield Trust, an  
 18 independent health services organisation specialising in  
 19 health research and policy analysis. The Inquiry legal  
 20 team will summarise during Part C the evidence obtained  
 21 and analysed by the Nuffield authors.

22 Very briefly at this stage, most Trusts report  
 23 difficulties in meeting staffing requirements in  
 24 relation to both the number and the qualifications of  
 25 healthcare professionals. 99 Trusts reported that they  
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1 a year following the Mid Staffordshire Inquiry Report,  
 2 the Health and Social Care 2008 (Regulated Activities)  
 3 Regulations 2014 came into force.

4 Regulation 20 is headed "Duty of Candour" and  
 5 provides that NHS Trusts in England must act in an open  
 6 and transparent way in relation to care and treatment of  
 7 patients.

8 Whilst the duty of candour is a duty imposed on the  
 9 health service body, individual doctors, nurses and  
 10 midwives are also subject to professional obligations  
 11 and standards. The statutory duty of candour and the  
 12 professional duties of individuals have the same aim: to  
 13 put the patient first and to be both open and  
 14 transparent in a situation where something has gone  
 15 wrong.

16 Sir Brian's view expressed to the Infected Blood  
 17 Report was that whilst the legislative duties of candour  
 18 cover healthcare organisations and the professional  
 19 duties and professional regulators cover individual  
 20 healthcare professionals, there remains a gap. Many  
 21 leadership roles in the NHS Trusts are not subject to  
 22 individual accountability for candour.

23 This Inquiry has explicitly within its terms of  
 24 reference an obligation to consider how accountability  
 25 of senior managers should be strengthened, consideration  
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1 had nursing vacancies, and 68 Trusts reported that they  
 2 did not meet staffing standards for nurses.

3 The questionnaire asked about processes for raising  
 4 concerns and complaints. There was broad consistency  
 5 between the Trust's responses with the Patient Advice  
 6 and Liaison Services, PALS, being widely cited as the  
 7 mechanism available to families, and Freedom to Speak Up  
 8 Guardians being cited as the appropriate avenue for  
 9 staff.

10 Given the evidence obtained in Part B, PALS and  
 11 Freedom to Speak Up Guardians are topics upon which the  
 12 Inquiry has sought direct witness evidence.

13 108 respondents to the questionnaires reported  
 14 having at least one concern/complaint in the previous  
 15 year with 67 Trusts upholding at least one complaint.  
 16 24 Trusts had reported matters to a professional  
 17 regulator in the previous year, half of which involved  
 18 contacting the Nursing and Midwifery Council.

19 As you will know, my Lady, for children to be  
 20 safeguarded effectively in hospitals and in the wider  
 21 NHS, safeguarding policies need to accurately reflect  
 22 the statutory obligations and guidance which underpins  
 23 them.

24 Even more crucially, policies need to be practical  
 25 and accessible to staff working within the organisation.  
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1 Anybody confronted with a safeguarding concern in  
 2 relation to a staff member should be able to read  
 3 a policy and immediately know what to do, and who to  
 4 speak to. Policies are far easier to implement when  
 5 their requirements are expressed in concrete rather than  
 6 generic terms. Equally, however, adequately trained  
 7 staff should not need to read policies when confronted  
 8 with a safeguarding concern. They should know what to  
 9 do when presented with a situation which potentially  
 10 impacts upon the safety of a child.

11 We asked Trusts to provided us with their  
 12 safeguarding policies. We were also provided with  
 13 a wide variety of policies which included within them  
 14 reference to safeguarding concerns being raised in  
 15 relation to a member of staff. These policies typically  
 16 included complaints concerns policies, professional  
 17 standards or conduct policies, disciplinary policies,  
 18 and infrequently, freedom to speak up and whistleblowing  
 19 policies.

20 Knowledge and dissemination of safeguarding policies  
 21 will be explored during Part C with Core Participants.  
 22 Key to safeguarding is remembering that taking  
 23 protective steps to ensure a child is kept safe is  
 24 a neutral step designed to protect the child's welfare.  
 25 Organisations instituting safeguarding measures should  
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1 evidence after a death, including external reviews such  
 2 as Child Death Overview Panels. Feedback was also  
 3 sought on data collection and the national reporting and  
 4 monitoring of requirements relating to neonatal care.

5 As you have heard, these are all areas where the  
 6 Inquiry has sought additional evidence in the form of  
 7 witness statements in Part B.

8 The regulation of senior managers was a specific  
 9 matter about which the Inquiry legal team sought  
 10 information and views. To what extent could the  
 11 regulation of senior managers assist with safeguarding  
 12 and improve governance, either directly or indirectly?  
 13 As a general proposition, would such regulation improve  
 14 the quality and expedition of safeguarding, grievance,  
 15 and/or disciplinary investigations? Would it provide  
 16 a counterweight to the desire by some to prevent so  
 17 called reputational damage to the institution for which  
 18 they are working?

19 Would it prevent ineffective managers moving from  
 20 Trust to Trust and taking ineffectiveness with them?  
 21 Questionnaire response from NHS Trusts differed as to  
 22 regulating senior managers with positions in support of  
 23 regulation or against it, neutral or undecided. This is  
 24 a topic you will hear about, my Lady, in oral evidence.

25 Many of the Trusts refer to their current objectives  
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1 not assume that steps cannot be taken until an  
 2 allegation has been proved. It is wrong to do so.  
 3 Where suspicions or concerns about harm arise, the  
 4 protection of babies and children comes first.

5 It is essential that a safeguarding issue is  
 6 recognised and treated as safeguarding rather than as an  
 7 internal disciplinary matter or a grievance issue. But  
 8 arguably, that is easier said than done. There will be  
 9 consequences for a staff member who is moved from  
 10 frontline responsibilities, both in terms of reputation  
 11 and career development. Furthermore, will medical staff  
 12 draw attention to a safeguarding issue if they believe  
 13 that it will result in grievances and counter-grievances  
 14 being raised? Or when they realise the damage it may do  
 15 to a colleague or friend or to relationships in general?

16 How can the culture of the NHS change so that  
 17 safeguarding referrals and investigations are  
 18 expeditious and everyone appreciates that a safeguarding  
 19 issues involves managing potential risk? Does  
 20 employment law operate effectively in the context of  
 21 a safeguarding investigation, or does it in fact hinder  
 22 and not yet recognise that process?

23 Trusts were questioned about factors that might  
 24 inhibit raising and acting upon concerns. They were  
 25 also asked about the multiple routes for reviewing  
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1 to develop a positive safety culture and their  
 2 engagement with the NHS England Perinatal Leadership  
 3 Programme in accordance with the 2023 three-year  
 4 delivery plan for maternity and neonatal services.  
 5 Responses from Trusts indicate that many have processes  
 6 in place or are actively working towards these  
 7 objectives.

8 Indeed, for almost all the areas covered in the  
 9 questionnaire, there are existing regulations,  
 10 mechanisms or guidance in place in the NHS. Within  
 11 neonatal services there appear to be additional  
 12 reporting routes and requirements over and above those  
 13 which apply to the NHS as a whole. However, policies  
 14 and processes are not sufficient by themselves to ensure  
 15 services are safe and effective. Culture and leadership  
 16 are critical. It is for this reason that this Inquiry,  
 17 within its analysis of the wider NHS, and when choosing  
 18 which witnesses to call, has placed a particular  
 19 emphasis on culture.

20 The Picker Survey. In recognition of the critical  
 21 role of culture and leadership in the protection of  
 22 babies, a second piece of work was undertaken by the  
 23 Inquiry. To deepen understanding of the culture within  
 24 NHS neonatal units, midwives, doctors, consultants,  
 25 nurses and managers who work within, or in connection  
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1 with, neonatal units across the NHS were invited to give  
2 their views. This piece of work has been managed by the  
3 health research charity, Picker.

4 As with the Inquiry questionnaire, the Picker survey  
5 results will be set out in more detail during Part C,  
6 looking, for example, at some of the discrepancies; such  
7 as the fact that senior managers viewed their working  
8 relationships with other occupational groups much more  
9 positively than did those other groups view their  
10 working relationships with senior managers.

11 Experts.

12 The inquiry has also commissioned its own expert  
13 evidence within Part C.

14 Sir Robert Francis, King's Counsel, who has chaired  
15 a number of healthcare related public inquiries, most  
16 notably the Mid Staffordshire NHS Foundation Trust  
17 Inquiry, has been instructed. He has been asked by the  
18 Inquiry to consider, in the first part of his report,  
19 the extent to which past recommendations of relevant  
20 inquiries have been implemented.

21 A second expert, Professor Dixon Woods, has been  
22 instructed in relation to the specific issue of culture  
23 within the NHS. She was asked to define both healthy  
24 and unhealthy cultures, to consider how definitions of  
25 a healthy culture have changed over time, and comment on

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1 consideration of safeguarding, the Review of Child Death  
2 Overview Panels, and the reporting of sudden and  
3 unexpected deaths by Dr Joanna Garstang, who will be  
4 called to give oral evidence after the parents and at  
5 the beginning of the Inquiry.

6 Witness evidence.

7 A large number of witness statements have been  
8 sought in order to assist the Inquiry in Part C. In  
9 some cases, as I've said, witnesses will be called to  
10 give additional oral evidence but in the vast majority,  
11 their written statements will stand as their evidence to  
12 the Inquiry.

13 Statements have been sought from professional  
14 bodies, notably the General Medical Council, the Nursing  
15 and Midwifery Council, who are a core participant, the  
16 British Association of Perinatal Medicine, the British  
17 Medical Association, and the Royal College of Nursing.

18 As we have heard earlier, inspections of the  
19 neonatal unit were carried out in February 2016 by the  
20 Care Quality Commission, and following Letby's removal  
21 from the ward by the Royal College of Paediatrics and  
22 Child Health in September 2016.

23 As such, their evidence bridges events at the  
24 Countess of Chester Hospital being considered in Part B,  
25 and also the wider NHS issues being explored in Part C.

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1 any accepted practices for improvement in this area.

2 Professor Dixon Woods raises the issue of voiceable  
3 and unvoiceable concerns. We will explore in oral  
4 evidence with Professor Dixon Woods whether and, if so,  
5 why, concerns related to behaviour or conduct are harder  
6 to articulate, and the culture required with the NHS to  
7 enable people to do so.

8 As you have already heard, one of the factual areas  
9 that the Inquiry will consider is how the hospital  
10 responded to the grievance raised by Letby. In order to  
11 assist the Inquiry with areas of relevant employment  
12 law, the treatment of whistleblowers, and the handling  
13 of grievance allegations in hospitals,  
14 Professor John Bowers, King's Counsel, has been  
15 instructed. Whether and how grievance and disciplinary  
16 processes should be managed in situations where there is  
17 an underlying safeguarding issue is an area the Inquiry  
18 will need to report upon.

19 All of the experts, Sir Robert Francis,  
20 Professor Dixon Woods and Professor John Bowers, will be  
21 giving oral evidence to the Inquiry.

22 In addition, the Inquiry has received evidence from  
23 a number of witnesses expert in their field and  
24 independent from the events at the Countess of Chester.  
25 For example, the Inquiry will be greatly assisted in its

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1 The role of both organisations in safeguarding is  
2 obviously important. Oral evidence will be heard from  
3 individuals from each organisation about their  
4 respective roles in the prevention of the deliberate  
5 acts of harm towards babies by a member of staff.

6 Where babies die in hospital, the issue of referral  
7 to the coroner arises. An investigation into a death by  
8 a coroner can provide an important check on whether, or  
9 to what extent, safeguarding procedures are being  
10 implemented properly. But to be effective, the  
11 investigation has to be provided with all the relevant  
12 information. The right questions have to be asked, and  
13 the answers given must be free of the desire to avoid  
14 criticism or prevent so-called reputational damage.

15 In short, coroner's inquests are opportunities to  
16 learn lessons. Are those opportunities taken? Evidence  
17 has been sought from the coroners, Mr Moore and  
18 Mr Rheinberg, and consideration given to the  
19 interactions between the hospital and the coroner to  
20 assist with the wider issue as to the operation of the  
21 coronial process following neonatal deaths.

22 Individual parents and healthcare professionals may  
23 feel challenged, ignored or sidelined when raising  
24 safeguarding issues. Without support, they may feel  
25 that it is difficult to pursue concerns, especially if

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1 they do not have a close understanding of an  
2 organisation's practices and procedures.  
3 The Inquiry has received evidence from organisations  
4 who offer support to families, such as the Patient  
5 Safety Commissioner, Stillbirth and Neonatal Death  
6 Charities such as BLISS, Sands, Spoons, and Tommy's.  
7 The parents of the babies named on the indictment have  
8 much to contribute in their evidence on the issue of  
9 bereavement as they have on many other issues relevant  
10 to the wider NHS. What services were offered to the  
11 parents and what services are offered nationally now to  
12 bereaved parents is a matter we will be hearing oral  
13 evidence about. It is an area upon which my Lady may  
14 wish to make recommendations in due course.

15 Organisations that support medical staff, including  
16 Doctors in Distress, the Hospital Consultants and  
17 Specialists Association, and NHS Practitioner Health,  
18 have been asked for statements. The Inquiry is  
19 interested to know what support is available for doctors  
20 on the ground facing difficult and challenging  
21 situations.

22 There are a large number of organisations that are  
23 involved in safety and monitoring in the widest sense,  
24 and many have provided evidence to the Inquiry. This  
25 includes MBRRACE, the National Neonatal Research  
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1 dispassionately, and with a proper regard for the  
2 safeguarding issues that need to be detected.

3 Data is dangerous if incomplete or unreliable.  
4 Healthcare professionals need to understand its  
5 importance and the damage to safeguarding if collection  
6 of data is slipshod or not prioritised.

7 The Inquiry has obtained statements from a number of  
8 organisations and individuals concerned with the  
9 collection and analysis of data as it relates to  
10 neonates. These include Professor Feltblower;  
11 Professor Elizabeth Draper and Dr Sarah Seaton, on  
12 behalf of PICANet, the Paediatric Intensive Care Audit  
13 Network; Professor Modi on behalf of National Neonatal  
14 Research Database; Karen Luyt on behalf of the National  
15 Child Mortality Database; Dr Murdoch on behalf of the  
16 Maternity and Neonatal Outcomes Group; and  
17 Professor Knight on behalf of MBRRACE UK, Mothers and  
18 Babies Reducing Risk Through Audit and Confidential  
19 Enquiries.

20 Among those the Inquiry has contacted is  
21 Professor Sir David Spiegelhalter. Sir David is the  
22 Emeritus Professor of Statistics at the University of  
23 Cambridge. His work mainly involves the medical sector.  
24 Among other important projects, he led the Statistical  
25 Team at the Inquiry into deaths of babies with  
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1 Database and Paediatric Intensive Care Audit Network.  
2 These organisations, along with the National Guardians  
3 Office, the National Association of Designated  
4 Safeguarding Leads, NHS Resolution and the National  
5 Institute for Health and Care Excellence, NICE, have all  
6 provided evidence to the Inquiry.

7 Since external scrutiny is an area that falls within  
8 the Inquiry's terms of reference, we have obtained  
9 evidence from Healthwatch England, Healthwatch Cheshire  
10 West and the Health Services Safety investigations Body.  
11 The Parliamentary Health Service Ombudsman and the  
12 Professional Standards Authority have also provided us  
13 with evidence, and the former ombudsman, Rob Behrens,  
14 will also be giving evidence to the Inquiry.

15 Data and statistics.

16 May I now turn to the topic of data. The  
17 collection, analysis and use of data is crucial to  
18 safeguarding and improving practice. Without data  
19 patterns, trends become difficult to detect.  
20 Effectiveness of policies cannot be determined. Lessons  
21 learned become lost and unlearned. But data can too  
22 easily become a burdensome mass of material that acts as  
23 a drag on expedition and innovation. It must be  
24 relevant and timely. It must be accessible. And most  
25 of all, it must be analysed objectively, promptly and  
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1 congenital heart disease at the Bristol Royal Infirmary,  
2 and he worked on the Statistical Team for the  
3 Shipman Inquiry.

4 In his statement, Sir David draws attention to the  
5 value of what he calls "formal statistical process  
6 control" as a more efficient means of detecting  
7 "clusters of failure". He points out that numerous  
8 previous inquiries have called for the establishment of  
9 statistical monitoring systems, and says that there are  
10 two broad types of system: retrospective audit and  
11 real-time prospective monitoring.

12 Sir David memorably remarks in his statement there  
13 are "a bewildering array" of retrospective audit systems  
14 for neonatal and perinatal outcomes. However, as a  
15 matter of common sense, when it comes to the early  
16 detection of a member of staff intent on causing harm,  
17 it will be the real-time prospective monitoring which  
18 will be most valuable.

19 Accordingly, while the Inquiry has collected  
20 substantial amounts of information about data collection  
21 in the NHS as it relates to maternity and neonatal  
22 services, given the Terms of Reference and central  
23 subject matter, our focus will necessarily be on  
24 real-time monitoring. What is feasible, what can it do,  
25 and what are the limitations?  
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1 The Care Quality Commission, an organisation we have  
2 already mentioned in the context of inspections which  
3 took place at the hospital during 2016 and 2017,  
4 monitors data gathered by other organisations. In terms  
5 of real-time data monitoring, according to  
6 Professor Spiegelhalter, during the period of the  
7 Inquiry's focus, the CQC utilised a sophisticated  
8 statistical method to monitor thousands of mortality  
9 indicators, including neonatal metrics. Sir David was  
10 involved in setting this tool up in 2007. He believes  
11 this tool is no longer in use. Is that the case? If  
12 so, why is it no longer in use, and with what has it  
13 been replaced, if anything?

14 This is something we will be exploring further with  
15 the CQC.

16 Dr Bill Kirkup's investigation into maternity  
17 services in East Kent led to the publication of "Reading  
18 the Signals" in 2022. Dr Kirkup's first recommendation  
19 was the establishment of a taskforce "to drive the  
20 introduction of valid maternity and neonatal outcome  
21 measures capable of differentiating the signals among  
22 the noise to display significant trends and outliers for  
23 mandatory national use."

24 This recommendation led to the creation of the  
25 Maternity and Neonatal Outcomes Group. Professor David  
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1 those born before 37 weeks' gestation) and those who  
2 died more than 28 days after birth.

3 Accordingly, in its current form, it would not be  
4 capable of capturing or identifying any anomaly in  
5 relation to the deaths of Child A, B, E, I, O or P, who  
6 were all born pre-term.

7 MOSS represents an essential step forward,  
8 addressing a key concern of Dr Kirkup in relation to NHS  
9 maternity services. The data used by MOSS is taken from  
10 that gathered by MBRRACE, together with data taken from  
11 the Neonatal Data Analysis Unit, in relation to  
12 hypoxic-ischaemic encephalopathy at birth. Questions  
13 for the inquiry are: is this real-time system capable of  
14 being revised so that it would be capable of capturing  
15 patterns or trends or all neonates, whether full term or  
16 premature? Or, in fact, does MBRRACE already provide  
17 what is necessary?

18 Professor Knight will be called during the oral  
19 hearings. Professor Knight has provided a witness  
20 statement on behalf of MBRRACE answering a number of  
21 questions posed by the Inquiry. She deals with the  
22 position in 2015 to 2017, as well as the developments  
23 which have been made since that time.

24 MBRRACE undertakes surveillance of all stillbirths,  
25 late foetal losses and neonatal deaths up to 28 days of  
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1 Spiegelhalter is one of the specialist advisers to this  
2 group. In a statement to the Inquiry, Dr Murdoch, the  
3 Chair of the Maternity and Neonatal Outcomes Group,  
4 describes a data driven early warning system in this  
5 way:

6 "Safety signals systems work through monitoring  
7 real-time changes in the trends of defined critical  
8 safety outcomes. A signal prompts an early critical  
9 review to understand the causes of the signal change.  
10 It is the subsequent assessment and review that will  
11 identify if there are safety issues to act upon."

12 In other words, automated analysis of data can draw  
13 attention to a potential safety issue but further  
14 investigation will be needed to see what is going on.

15 As Dr Murdoch says later in her statement:

16 "A safety signal system demonstrates unusual changes  
17 in signals, but cannot explain why the signal has  
18 changed."

19 The real-time system being developed by the  
20 Maternity and Neonatal Outcomes Group is called the  
21 Maternity Outcomes Signal System, or MOSS. As with any  
22 data system, parameters of which data is to be analysed  
23 need to be set. The agreed parameters for MOSS, no  
24 doubt developed after careful consideration of the  
25 objectives of the project, exclude pre-term babies (ie  
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1 age. Accordingly, all of the babies named on the  
2 indictment except Child I fell within the parameters of  
3 the data which MBRRACE considered.

4 Reports are made online, with responsibilities for  
5 reporting the deaths sitting within the Trust in which  
6 the death occurred. The data provided is analysed and  
7 then presented as both "a crude mortality rate" and "a  
8 stabilised mortality rate" or as "stabilised and  
9 adjusted mortality rate". The latter refers to the  
10 process whereby local risk factors are taken into  
11 account.

12 The figures provided by hospitals for the year 2015  
13 were reported by MBRRACE in June 2017. The figures  
14 provided for 2016 were reported in June 2018.

15 It follows that MBRRACE's approach to data during  
16 the period we are examining was not capable of raising  
17 an alert to Letby's crimes at the time. Why did it take  
18 18 months or more to produce such figures? Could the  
19 earlier production of this data have had an impact on  
20 what happened at the hospital?

21 In 2019 MBRRACE provided all NHS Trusts and Health  
22 Boards access to a real-time data viewer. It permits  
23 a user to log on and look at the most recent figures for  
24 their hospital, but it is reliant upon the timely  
25 provision of accurate data. Were staff at the hospital  
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1 reporting all the deaths properly? If not, why not? Is  
2 that now happening?

3 Professor Knight suggests that to make this tool  
4 more effective, a nominated person at each Trust should  
5 have responsibility for regularly logging into the  
6 real-time data viewer. Professor Knight proposes that  
7 such a person receives training in the interpretation of  
8 that data. Further, she suggests that there should be  
9 a pre-determined route to senior management in the event  
10 of any concern with a view to an action plan being  
11 developed.

12 At the conclusion of her statement, Professor Knight  
13 informed the Inquiry that during the first quarter of  
14 this year, MBRRACE were trialing a "process control  
15 function" which would automatically identify and flag  
16 unusual clusters of death. In other words, a real-time  
17 monitoring tool of the kind spoken about by  
18 Professor Spiegelhalter and Dr Murdoch. The Inquiry  
19 hopes that Professor Knight will be able to provide the  
20 Inquiry with an update as to the progress of that  
21 signalling function when she comes to give evidence at  
22 the end of the year.

23 Themes for recommendations.

24 I turn finally, my Lady, to the issue of  
25 recommendations. You will be considering what changes  
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1 it is to be valuable in the context of safeguarding.  
2 What can be done to ensure expedition? Once analysed,  
3 there must be a coherent and straightforward way of  
4 bringing the information to the notice of senior  
5 managers. What can be done to achieve that?

6 Senior managers bear the responsibility for ensuring  
7 that safeguarding is prioritised, that there are  
8 concrete and specific protocols in place ensuring that  
9 everyone knows in advance what will happen and within  
10 what timescale when a safeguarding issue is raised, that  
11 investigations are carried out expeditiously, and that  
12 any healthcare professional who may be affected  
13 adversely by such investigations is appropriately  
14 supported. They must ensure that patients and staff are  
15 encouraged to voice concerns. They must guard against  
16 the desire to protect the institution or to equate  
17 criticism with condemnation.

18 How is that to be achieved? How is the culture of  
19 senior managers to be improved? Are individual duties  
20 of candour required? Should the senior managers  
21 themselves be regulated? If so, how is that regulation  
22 to be implemented and enforced?

23 There is a clear relationship between safeguarding,  
24 criminal investigation, and employment rights and  
25 obligations. Lengthy processes damage morale and  
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1 are expressly indicated as a consequence of the evidence  
2 you read and hear in Part B, and any findings or  
3 conclusions you may make. Furthermore, you will  
4 determine what is necessary to keep babies in hospital,  
5 having heard the wider evidence in Part C.

6 As I have stated previously, we have asked all those  
7 who have provided written evidence or responded to  
8 questionnaires what recommendations they think this  
9 Inquiry should make. We will pick up on the various  
10 suggestions made within the oral evidence.

11 Whilst specific recommendations will be considered  
12 once the evidence has been heard, you may think that  
13 certain themes suggest themselves already.

14 CCTV, access to controlled drugs, and reporting of  
15 insulin results are highly relevant issues arising from  
16 our facts. Would CCTV in the neonatal units improve the  
17 safety of babies against malicious acts and deliberate  
18 harm? Should laboratory detection of exogenous insulin  
19 in a neonate raise an immediate alarm?

20 Data collection and analysis is crucial, both to  
21 identify matters of concern and to cross-check concerns  
22 that may be expressed as to the activity of a particular  
23 healthcare professional. What can be done to ensure  
24 that reliable and complete data is obtained?

25 The analysis of such data has to be expeditious if  
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1 arguably divert attention from the very purpose of  
2 neonatal wards, namely looking after the health and  
3 safety of babies.

4 What can be done to ensure that risk is  
5 appropriately managed without at the same time  
6 condemning a unit or ward to oppressive and  
7 time-consuming grievances or counter-grievances, or  
8 never-ending allegations or unlawful dismissal cases?

9 In terms of governance, how should hospitals ensure  
10 safety-critical information reaches the board level  
11 quickly and in a way that is easily understood so that  
12 it is acted upon?

13 Should the role of external regulators and  
14 inspectors be strengthened? If so, how is that to be  
15 achieved, particularly in circumstances where the  
16 regulators and investigators are subject to criticisms  
17 themselves of being ineffective?

18 What can be done with written procedures and  
19 protocols so that there is a clear, straightforward,  
20 coherent and predictable process when a safeguarding  
21 issue is raised, whether it be from data analysis or the  
22 concerns expressed by staff?

23 Is there a problem with public inquiries in that  
24 recommendations are not implemented or do not change the  
25 culture of the NHS, or are too detailed or individual to  
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1 be of practical value? Is there a problem with  
 2 corporate memory so that lessons learned become  
 3 unlearned over time? If so, how can that be prevented?  
 4 How do we ensure the recommendations of this Inquiry  
 5 are implemented? Some inquiries monitor their  
 6 recommendations to help ensure change. Is that the role  
 7 and purpose of an inquiry? Should there be an Inquiries  
 8 Unit to implement and monitor inquiry recommendations?  
 9 Is the desire to protect an institution's reputation  
 10 or to avoid rocking the boat such that there needs to  
 11 be, and embedded within each Trust, those with unique  
 12 responsibility for safeguarding? Should those who have  
 13 responsibility for safeguarding have access to data,  
 14 potential whistleblowers, witnesses, and to senior  
 15 managers, with the support of an external organisation  
 16 and to whom they are responsible?  
 17 Should the NHS or Integrated Care Boards, for  
 18 example, have a specific safeguarding unit that works  
 19 within Trusts but is separate from them to ensure that  
 20 data management is adequate, to review employment  
 21 processes, and ensure protection for families and  
 22 whistleblowers?  
 23 In terms of external scrutiny, how do we ensure that  
 24 those bodies with responsibility for commissioning and  
 25 oversight within the NHS are promptly notified if there  
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1 remaining Core Participants on Friday.  
 2 **LADY JUSTICE THIRLWALL:** Thank you very much indeed. So  
 3 we're moving on to the next stage with all the openings.  
 4 That's just for those who are not familiar with the  
 5 process. Thank you very much indeed. I will look  
 6 forward to seeing everyone tomorrow morning at 10.00.  
 7 **(4.22 pm)**  
 8 **(The hearing adjourned until 10.00 am the following day)**  
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1 is an issue so that they can, where appropriate, support  
 2 investigation and resolution of concerns?  
 3 Does the culture of the NHS need to change? If so,  
 4 how? Does an inquiry such as this change it, not for  
 5 now and the near future, but permanently?  
 6 My Lady, these questions and many more will be  
 7 canvassed in the evidence in Part C. The answers are  
 8 important to all those who work in the NHS and all of us  
 9 that use its services. We look forward to the  
 10 assistance of all of the Core Participants and their  
 11 representatives in the months ahead.  
 12 **LADY JUSTICE THIRLWALL:** Thank you very much indeed,  
 13 Ms Langdale.  
 14 **MS LANGDALE:** My Lady, can I give you an indication of whom  
 15 you'll be hearing from tomorrow?  
 16 **LADY JUSTICE THIRLWALL:** Yes, please.  
 17 **MS LANGDALE:** Give me one moment.  
 18 In the morning it's Mr Skelton, King's Counsel, and  
 19 Mr Baker, King's Counsel, on behalf of Families; moving  
 20 on to Mr Andrew Kennedy, King's Counsel, for the  
 21 Countess of Chester; Ms Samantha Jones on behalf of the  
 22 Nursing and Midwifery Council; Ms Fiona Scolding, King's  
 23 Counsel, on behalf of the Royal College; and then  
 24 Mr Robert Cohen on behalf of the Department of Health  
 25 and Social Care. And then you'll be hearing from the  
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68/12 82/2 90/15 91/3	<b>whether [71]</b> 1/16 7/2	200/5 201/15	33/11 34/8 34/12	202/10 203/9 205/11
91/9 98/13 98/20	7/8 21/1 25/12 32/4	<b>while [5]</b> 17/9 19/7	44/12	205/19 205/25
98/20 99/3 101/20	44/13 46/21 46/25	28/2 46/20 196/19	<b>will [129]</b> 1/3 1/7 1/15	<b>without [14]</b> 77/10
109/21 109/21 114/5	47/1 48/21 48/22 49/2	<b>whilst [11]</b> 52/10	2/18 6/21 7/2 7/8 8/9	78/8 109/10 113/5
114/6 114/23 115/19	56/6 70/7 74/20 86/10	72/10 86/19 90/11	9/12 11/12 15/8 17/4	128/24 148/20 149/12
117/1 120/15 122/14	86/11 89/7 90/13	137/23 151/22 152/5	19/6 19/7 19/8 20/3	149/15 152/22 153/15
124/12 124/19 127/25	92/18 98/18 99/2	160/9 182/8 182/17	21/1 24/8 25/6 25/11	181/15 192/24 194/18
140/15 140/16 141/8	101/2 101/9 101/21	202/11	30/3 30/17 30/20	204/5
143/3 151/18 158/18	102/12 103/3 105/3	<b>whistleblower [1]</b>	37/25 40/6 41/4 44/21	<b>witness [17]</b> 3/7 3/9
160/3 162/20 164/7	107/17 112/5 115/19	142/1	45/11 47/2 47/16 49/8	4/2 9/8 19/21 19/25
164/24 171/15 178/18	120/13 122/4 122/15	<b>whistleblowers [3]</b>	53/24 57/11 57/21	31/23 32/6 34/9 83/24
179/8 179/14 179/25	123/10 123/19 124/3	190/12 205/14 205/22	59/1 59/2 59/13 59/21	158/10 160/5 184/12
180/2 180/20 181/4	126/14 127/2 128/14	<b>whistleblowing [2]</b>	60/2 61/23 62/16	187/7 191/6 191/7
181/5 183/10 183/11	129/19 130/13 131/17	66/24 185/18	62/20 63/25 65/9	199/19
185/3 185/8 187/10	132/9 132/19 135/23	<b>who [43]</b> 3/3 5/2 22/1	65/22 66/15 67/25	<b>witnesses [8]</b> 4/11
192/9 193/10 193/11	138/2 138/10 140/11	22/2 45/3 45/11 51/4	68/23 70/5 73/1 74/19	90/18 180/16 183/2
193/19 196/5 196/24	142/17 143/5 143/14	71/11 83/25 84/20	76/12 86/2 86/15	188/18 190/23 191/9
196/24 196/25 197/12	148/14 148/23 151/12	98/8 98/25 99/14	90/12 91/3 91/20	205/14
198/14 199/17 200/20	153/18 154/19 160/20	104/6 105/18 105/20	91/22 98/11 98/24	<b>women [18]</b> 22/19
201/25 202/4 202/8	162/21 165/1 178/14	110/2 115/11 128/16	100/24 101/9 104/7	22/23 23/11 23/16
202/23 203/2 203/5	178/17 179/18 180/2	131/25 142/4 143/11	104/11 105/3 106/11	25/21 27/2 27/11
203/9 203/10 204/4	183/1 190/4 190/15	143/11 149/20 151/24	114/15 114/18 115/19	28/14 29/15 29/23
204/18	192/8 199/15 204/21	159/13 163/10 165/9	116/25 119/6 122/1	30/4 30/12 34/19 35/2
<b>Whatever [1]</b> 108/15	<b>which [134]</b> 3/20 4/7	168/15 185/3 186/9	128/23 129/6 130/17	42/7 42/18 42/22
<b>when [45]</b> 2/21 36/23	4/14 4/23 7/9 9/2	188/25 189/14 191/3	130/25 146/22 147/24	113/15
46/5 46/12 46/23 47/5	10/24 11/8 11/12	191/15 193/4 199/1	148/12 149/15 160/15	<b>Women's [1]</b> 80/1
47/16 54/8 66/5 68/11	11/17 12/4 13/19	199/5 202/7 203/12	166/9 169/2 170/14	<b>wonder [3]</b> 53/21
69/4 82/25 99/16	14/11 14/20 15/2 15/5	205/12 206/8 207/4	170/15 172/7 174/13	157/25 175/18
102/25 106/16 110/21	15/22 16/5 20/20	<b>whole [5]</b> 7/25 13/1	175/3 177/23 178/5	<b>Woods [4]</b> 189/21
112/21 118/13 122/12	20/22 21/4 22/16 25/5	18/16 100/22 188/13	178/13 178/15 180/16	190/2 190/4 190/20
124/24 128/22 132/9	25/21 27/5 27/6 30/3	<b>wholly [4]</b> 54/19	180/25 183/3 183/20	<b>word [1]</b> 64/4
133/16 140/22 140/25	30/18 32/18 33/6	168/20 169/3 173/19	184/19 185/21 186/8	<b>words [4]</b> 5/16 15/14
141/2 146/3 151/10	38/20 41/23 45/10	<b>whom [6]</b> 9/10 10/1	186/11 186/13 187/24	198/12 201/16
151/18 152/15 156/9	45/20 46/4 47/25 49/9	29/2 43/15 205/16	189/5 190/3 190/9	<b>work [25]</b> 17/9 33/17
159/21 164/22 173/18	50/2 50/18 50/19 52/1	206/14	190/18 190/20 190/25	49/15 49/20 52/12
179/21 185/4 185/7	54/20 55/1 55/10	<b>whose [3]</b> 35/3 51/1	191/3 191/9 191/11	104/24 105/4 112/3
185/9 186/14 188/17	55/13 56/10 56/14	140/21	192/2 193/12 194/14	113/3 119/5 149/11
192/23 196/15 201/21	57/12 58/10 59/21	<b>why [38]</b> 6/21 6/22	196/17 196/18 196/23	149/15 150/21 153/13
203/10 204/20	60/9 62/1 62/21 63/5	8/20 15/9 19/6 26/7	197/14 198/10 198/14	153/17 164/5 180/9
<b>where [67]</b> 9/18 11/7	65/3 67/25 69/8 70/11	30/17 36/23 40/11	199/18 201/19 201/25	181/9 181/10 188/22
19/2 20/10 23/22	71/7 72/5 72/11 73/17	46/10 46/12 47/6	202/3 202/9 202/11	188/25 189/2 195/23
26/13 26/15 38/5 41/5	74/6 75/21 79/21	62/16 62/17 70/5	203/9 206/6 207/5	198/6 206/8
41/14 49/1 51/17	82/15 90/17 90/20	70/22 74/20 76/12	<b>Williams [3]</b> 62/8	<b>worked [1]</b> 196/2
	90/22 91/23 92/4 95/5	81/12 86/2 91/6 98/12	105/7 136/5	<b>worker's [1]</b> 67/7

<p><b>W</b></p> <p><b>Workers [1]</b> 66/24</p> <p><b>workforce [2]</b> 17/25 18/3</p> <p><b>working [38]</b> 12/2 50/7 55/6 55/15 55/16 55/18 55/21 56/3 56/8 56/16 57/13 57/20 58/2 58/11 60/10 62/12 62/13 63/13 63/14 63/20 66/2 67/13 70/24 71/16 103/17 144/7 150/18 152/2 153/15 154/1 154/4 154/9 154/10 184/25 187/18 188/6 189/7 189/10</p> <p><b>works [1]</b> 205/18</p> <p><b>worrying [1]</b> 168/24</p> <p><b>worst [1]</b> 109/1</p> <p><b>would [121]</b> 4/4 11/8 11/9 16/4 25/22 28/19 32/19 33/6 33/7 33/21 34/25 36/4 38/5 38/6 38/8 38/11 39/10 42/23 43/5 47/9 49/1 49/19 49/20 50/22 53/21 59/13 61/14 67/22 68/20 68/22 69/23 71/1 71/3 71/7 71/12 72/9 74/6 74/25 76/2 76/5 78/7 80/8 80/9 84/11 85/3 86/12 88/16 97/17 98/2 106/11 107/16 107/17 107/23 107/24 108/10 111/6 111/19 112/11 113/3 113/13 114/11 114/12 116/9 117/18 122/16 122/20 122/22 123/18 131/12 131/17 132/9 134/9 135/21 138/7 138/8 140/5 140/6 141/7 141/24 142/3 142/5 142/6 143/9 143/20 144/1 145/22 146/5 146/6 146/10 146/19 146/22 148/11 149/3 152/13 153/12 154/13 155/10 156/20 157/25 159/13 159/23 163/18 163/20 163/21 163/23 163/25 164/2 164/5 164/6 169/12 169/16 176/10 177/18 177/20 187/13 187/15 187/19 199/3 199/14 201/15 202/16</p> <p><b>write [1]</b> 134/20</p> <p><b>writing [2]</b> 8/15 135/4</p> <p><b>written [6]</b> 45/7 127/21 171/22 191/11 202/7 204/18</p>	<p><b>wrong [3]</b> 67/2 182/15 186/2</p> <p><b>wrongdoing [1]</b> 159/11</p> <p><b>wrongly [1]</b> 127/13</p> <p><b>wrote [3]</b> 133/10 155/4 170/9</p> <hr/> <p><b>X</b></p> <p><b>X-ray [1]</b> 164/14</p> <hr/> <p><b>Y</b></p> <p><b>year [11]</b> 6/23 34/3 110/11 171/23 182/1 184/15 184/17 188/3 200/12 201/14 201/22</p> <p><b>years [7]</b> 52/22 52/25 77/19 92/10 157/6 178/21 179/25</p> <p><b>yellow [1]</b> 82/23</p> <p><b>Yes [3]</b> 47/11 158/2 206/16</p> <p><b>yesterday [7]</b> 1/4 10/1 22/2 39/8 50/14 80/17 178/23</p> <p><b>yet [12]</b> 29/9 29/21 44/6 62/10 84/4 87/11 88/13 98/10 123/5 133/2 138/21 186/22</p> <p><b>you [57]</b> 1/15 13/17 14/3 21/17 21/17 30/3 41/4 43/25 44/2 44/21 47/10 47/12 53/23 58/21 62/22 64/11 64/13 64/15 65/9 65/10 66/9 66/11 66/14 66/22 67/2 67/2 70/22 80/17 81/11 81/11 93/5 100/10 104/10 116/25 157/5 158/2 174/13 177/25 178/3 178/5 178/17 179/21 180/25 183/12 184/19 187/5 187/24 190/8 201/25 202/2 202/3 202/3 202/12 206/12 206/14 207/2 207/5</p> <p><b>you'll [2]</b> 206/15 206/25</p> <p><b>young [15]</b> 47/22 65/13 65/17 65/20 65/23 66/4 66/5 66/12 66/23 81/21 82/8 82/10 83/23 84/19 89/12</p> <p><b>your [5]</b> 25/6 66/9 66/17 128/23 128/24</p> <p><b>Yoxall [2]</b> 79/24 80/6</p> <hr/> <p><b>Z</b></p> <p><b>ZA [5]</b> 85/16 114/21 158/22 162/3 167/6</p> <p><b>zero [3]</b> 74/15 79/15</p>	<p>79/22</p>		
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