

Thursday, 12 September 2024.

(10.00 am)

**LADY JUSTICE THIRLWALL:** Good morning.

**MR SKELTON:** Good morning, my Lady.

**LADY JUSTICE THIRLWALL:** Mr Skelton.

**Opening statement by MR SKELTON**

**MR SKELTON:** My Lady, I represent the Families of Children A, B, L, M, N and Q. Over the last two days your Counsel have provided a detailed and invaluable overview and summary of the events that occurred at the Countess of Chester Hospital from the murder of Child A on 8 June 2015 to the commencement by Cheshire Police of Operation Hummingbird in May 2017.

They have set out with impressive clarity how there was a spike in the number of deaths in the neonatal unit in 2015 and 2016, what steps were taken to investigate its causes and how concerns grew in 2015 and further into 2016 that the deaths may have been connected with Lucy Letby. With great care and acuity, they have also identified the key healthcare governance policies and procedures that were applicable at the time, and have raised important questions about whether they were properly applied by the hospital.

This Inquiry has not yet heard oral evidence from the many key witnesses who worked at the hospital so

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the next two years.

First, there was a failure to conduct swift, careful and methodical investigations into why each death occurred, whether there were connections between the deaths, whether there were connections between the deaths and other deteriorations and collapses that had occurred on the unit, specifically Child B on 10 June.

That was a major and catastrophic failing. As your Counsel have explained in detail, many reviews, many discussions and investigations took place, but they were not conducted systematically and consistently, and so, as I will come on to, vital information was overlooked with fatal consequences for other children.

Second, the cluster of deaths and collapses should have been escalated to the Senior Trust Management immediately: the Medical Director, Ian Harvey; the Director of Nursing and Quality, Alison Kelly; the Chief Executive, Anthony Chambers; and right up to the board.

They should have overseen the investigations and they should have ensured that they were fully and fearlessly conducted until all possible connections had been identified and excluded. And if they felt this could not be done internally, then they should have ensured that it occurred externally as a matter of urgency and that such an investigation, as I have said,

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your Counsel must, of necessity, exercise caution lest it be thought that they are unfairly pre-judging the culpability of those witnesses. For the time being at least, their focus must be on the incontrovertible facts and the many serious questions that those facts give rise to.

My Lady, on behalf of the Families of Lucy Letby's victims, I need have no such professional reservations. So building on the invaluable foundations of your Counsel's opening I'm going to summarise and identify briefly and bluntly what went wrong at the hospital, why it went wrong, and the difficult task that you now face.

First, what went wrong.

The spike in mortality that occurred with the deaths of Child A on 8 June, Child C on 14 June and Child D on 22 June 2015 was, as to be expected, recognised straight away by the staff on the neonatal unit including the consultants, nurses and managers.

As Counsel to the Inquiry set out on Tuesday, this prompted various reviews and investigations which it was no doubt intended should have determined the causes of death in each case and identified any common factors between them.

There were, however, five basic failures which occurred right from the start and which continued for

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directly addressed all possible causes of death, including deliberate harm.

Third, from the outset, and without prejudice and without pre-judgment, it should have been in the minds of those conducting and overseeing the investigations that the cluster of unexpected and unexplained deaths might have been caused by the criminal acts of a member of the hospital staff.

My Lady, neonates are by definition tiny and highly vulnerable patients, often born prematurely and with a range of problems that for at least a time put their little lives at grave risk. But most of them are successfully treated and most of them survive.

More importantly, if they do collapse or suffer any life-endangering conditions, those collapses and conditions and even their deaths will have identifiable medical causes and will not be unexpected.

As you will in due course hear from the medical witnesses, unexpected and unexplained collapses and deaths are rare and several such incidents at the same place in a short space of time are by definition even rarer.

Murders and assaults of patients by healthcare staff are rare too. But they do happen, and when they do, they attract immense public attention. In 1991,

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1 Beverley Allitt, a nurse, murdered four infants,  
2 attempted to murder three others, and caused grievous  
3 bodily harm to a further six. Sir Robert Francis in his  
4 first report to this Inquiry has summarised the findings  
5 of the Inquiry that then ensued, chaired by  
6 Sir Cecil Clothier. Recommendation 13 of that Inquiry,  
7 which Sir Robert notes was described by its Chair as its  
8 "principal recommendation", states:

9 "Beverley Allitt's actions should serve to heighten  
10 awareness in all those caring for children the  
11 possibility of malevolent intervention as a cause of  
12 unexplained clinical events."

13 My Lady, this was a deliberately low bar. The  
14 Allitt Inquiry was not advising that the positions of  
15 crime should be uppermost in the minds of healthcare  
16 staff responding to any unexplained events involving  
17 children. That would be an unnecessary and unrealistic  
18 expectation in the context of a national system of  
19 healthcare and would create a culture of misplaced  
20 blame, fear and criminal investigation. But rather, the  
21 report was seeking to ensure that healthcare staff were  
22 prepared to think the unthinkable. That in certain  
23 situations, they kept their minds open to the  
24 possibility, rare as it might be, that criminal conduct  
25 was occurring.

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1 out that possibility, however remote it might be, for  
2 the sake of the patients' ongoing safety.

3 Fourth, the police and the coroner should have been  
4 informed at the outset. Not because a crime was  
5 suspected, but automatically and without blame or  
6 accusation, because the deaths were unexpected and they  
7 were unexplained.

8 This would, you may feel, have had a profound effect  
9 on the course of the subsequent events. It would have  
10 meant that external bodies were actively engaged from  
11 the start and able to provide advice and guidance on how  
12 the investigations should proceed at each stage, able to  
13 ensure that the investigations considered and ruled out  
14 criminal conduct, and most critically, it would have  
15 allowed the police to intervene and take over as soon as  
16 it was suspected that Letby had killed or harmed babies.

17 Fifth, the Families should have been told by the  
18 hospital that it was investigating the deaths with  
19 a view to finding out why they occurred and whether or  
20 not they were connected.

21 You will hear from some of the patients over the  
22 next few weeks about how they were kept in the dark  
23 about the collapses of their babies and the concerns and  
24 investigations that were being undertaken into their  
25 babies' deaths, both internally in the hospital and

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1 That did not occur at the Countess of Chester  
2 Hospital in June 2015 and even when it did, on the part  
3 of some of the paediatric consultants, they were met  
4 with the obdurately closed minds of their managers and  
5 senior managers.

6 My Lady, whether or not the memory of  
7 Beverley Allitt and the Clothier Report's 13th  
8 recommendation was properly embedded in NHS culture in  
9 June 2015, a more pressing reality check had occurred  
10 any three weeks previously on 19th May 2015, when  
11 Mr Justice Openshaw had sentenced Victorino Chua to life  
12 imprisonment. Chua, as you know, was a nurse at  
13 Stepping Hill Hospital in Stockport, 43 miles away from  
14 the Countess of Chester. He'd been found guilty of  
15 murdering two patients, poisoning 19 other patients and  
16 attempting to poison seven others in 2011.

17 Like Allitt, he had done so insidiously, and he had  
18 used insulin. It had taken a protracted period of time  
19 to catch him and his prosecution and conviction  
20 attracted national attention.

21 It is difficult to understand why the events at  
22 Stepping Hill did not at the very least alert those at  
23 the Countess of Chester from the start that the cluster  
24 of unexpected deaths were the result of potential  
25 criminality and that active steps were required to rule

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1 externally ultimately by the Royal College of  
2 Paediatrics and Child Health and others.

3 They should have been told, not when those  
4 investigations had concluded, but as soon as they were  
5 initiated. Not telling them was morally indefensible.  
6 It is indicative of a healthcare culture that remains,  
7 even now, paternalistic and secretive. Additionally and  
8 of more practical importance it meant that the  
9 investigations themselves did not capture information  
10 that only the parents could have given or answered  
11 questions that only the parents would have asked.

12 My Lady, it is beyond the scope of this brief  
13 opening to provide fully what a full and fearless  
14 investigation of a child's death in hospital should have  
15 entailed in 2015 and what guidance should have been  
16 followed. That is a matter for this Inquiry to examine  
17 and to formulate.

18 **LADY JUSTICE THIRLWALL:** Presumably you'll have some views  
19 about that in due course?

20 **MR SKELTON:** Indeed, my Lady.

21 You may feel as a starting point that the blueprint  
22 has been set out by Dr Joanna Garstang in her statement  
23 to this Inquiry when she discusses the Joint Agency  
24 Response, JAR, or Sudden Unexpected Death in Infancy or  
25 Childhood, SUDIC. As I have stated, several of the key

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1 features of those types of investigations -- urgency,  
 2 open-mindedness, thoroughness, engagement with the  
 3 police and the coroner, engagement with the Families --  
 4 are notable by their absence in the present case.  
 5 Turning to the remaining months of 2015. The key  
 6 failings I have identified were made all the more  
 7 defensible by the inexorable increase in the numbers of  
 8 unexpected neonatal collapses and deaths. Child E  
 9 collapsed on 3 August and died the next day. Child F  
 10 collapsed on 5 August and survived. Child G collapsed  
 11 and survived on 21 September. Child H collapsed and  
 12 survived on 26 September. Child I collapsed and  
 13 recovered on 30 September, but collapsed again and died  
 14 on 23 October. And finally Child J collapsed and  
 15 survived on 27 November.  
 16 These deaths were compounded by two factors. First,  
 17 as with the unusual rashes that occurred in the first  
 18 babies that Letby attacked, there was in fact important  
 19 information in the possession of the medical staff that  
 20 could and should have been readily identified and  
 21 recognised as significant, namely Child F's abnormal  
 22 blood results, the insulin combined with the low  
 23 C-peptide. These were clear and objective indications  
 24 for the first time that someone had deliberately or  
 25 inadvertently administered insulin to the child and

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1 why those concerns arose, and when and how they were  
 2 informally shared in unminuted meetings, in informal  
 3 conversations, by email, and by messages.  
 4 Dr Jayaram, for example, states in his written  
 5 evidence to the Inquiry that it was not until his return  
 6 to work in November 2015 after the death of Child I in  
 7 October that he first thought that Letby could be  
 8 deliberately harming babies. But you will see what  
 9 followed was more whisper than deliberate and practical  
 10 investigation into the deaths.  
 11 For present purposes, from the Families'  
 12 perspectives, as soon as it was suspected that Letby was  
 13 harming babies, several steps should have been taken  
 14 immediately. It was incumbent on the consultants to  
 15 bring that concern unambiguously to the attention of the  
 16 unit manager and the hospital's Executives who should in  
 17 turn have briefed the board.  
 18 Safeguarding procedures should have been initiated  
 19 with other view to protecting patients from potential  
 20 harm. Letby should have been suspended from her nursing  
 21 duties.  
 22 The police should have been notified by the  
 23 hospital's Chief Executive or by any other Executive  
 24 officer with the authority of the board. A plan should  
 25 have been formulated for an investigation into whether

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1 thereby endangered his life.  
 2 Its importance is accepted, for example, by Dr Gibbs  
 3 and Dr Brearey and emphasised, you may feel somewhat  
 4 self-servingly, by Ian Harvey. It was indeed a major  
 5 opportunity, finally, to identify potential criminality.  
 6 Precisely the kind of information should have been  
 7 captured by a robust investigation, particularly if, as  
 8 should have been the case, the Clothier warning about  
 9 potential staff malevolence had been heeded and the  
 10 mechanism of murder by both Allitt and Chua had been  
 11 properly heeded.  
 12 As your Counsel explained on Tuesday, a similarly  
 13 clear and concerning blood result was obtained but not  
 14 recognised in respect of Child L in April 2016,  
 15 a further missed opportunity to sharpen up the mounting  
 16 suspicion that babies were being deliberately harmed.  
 17 The second point is that at some point, in the  
 18 latter months of 2015, the paediatric consultants began  
 19 to suspect that Letby was the direct cause of the  
 20 collapses and deaths, and that her actions had been  
 21 deliberate, or, to call them by their proper name, that  
 22 she had murdered or attempted to murder the babies.  
 23 Over the next few weeks you will be closely  
 24 examining the evidence of the consultants and their  
 25 medical and nursing colleagues about precisely when and

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1 Letby had in fact harmed babies.  
 2 Whistleblowing policies should have been put in  
 3 place to ensure there were no adverse and unjust  
 4 repercussions and disincentives for any staff member,  
 5 including the consultants, to provide information that  
 6 would support or undermine the investigations, and the  
 7 plan should have been made to approach the parents of  
 8 the babies concerned so they were fully apprised of what  
 9 might have happened to their children, however  
 10 distressing and inflammatory that may have been.  
 11 In 2016, as your Counsel have set out, Child K  
 12 collapsed on 17 February and died. Child L and M  
 13 collapsed on 19 April and survived. Baby N collapsed  
 14 and survived on 3 June and again on 15 June. Child O  
 15 collapsed and died on 23 June, Child P collapsed and  
 16 died on 24 June. Child Q collapsed on 25 June and  
 17 survived.  
 18 Throughout these months, the five principal failings  
 19 I have identified that arose in 2015 were continuing.  
 20 But by this stage, they were also magnified by denial,  
 21 defection and delay on the part of the hospital's  
 22 Executives. There was denial that the babies had been  
 23 killed or assaulted by Letby or by anyone else, and  
 24 denial that anything needed to be done to investigate  
 25 that possibility directly until the consultants produced

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1 clear evidence that a crime had been committed.  
 2 There was delay in convening a meeting between the  
 3 paediatric consultants and the Executives, including  
 4 Alison Kelly and Ian Harvey. There was delay in  
 5 initiating independent investigations into what  
 6 happened, for example, by the Royal College of  
 7 Paediatrics and Child Health, and there was of course  
 8 delay in informing Cheshire Police. And there was  
 9 deflection of the problem, as a statistical anomaly, or  
 10 an as yet unidentified medical or system failure, or an  
 11 unfounded and oppressive allegation against a junior  
 12 nurse by senior doctors that justified a formal  
 13 grievance procedure, not a safeguarding intervention.  
 14 These three failings by the Executives were also  
 15 magnified by the utterly indefensible failure by anyone  
 16 to trigger the hospital's whistleblowing and  
 17 safeguarding policies which, as I've said, would have  
 18 protected the paediatric consultants and other staff  
 19 members and would have mandated measures to protect  
 20 babies and find the root causes of their collapses and  
 21 deaths, and just as critically, there was an  
 22 inexplicable failure to provide clear information and  
 23 instruction to external healthcare bodies and  
 24 investigators, the CQC, the Royal College, the NHS,  
 25 Dr Hawdon, that Letby was suspected as being a potential

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1 consultants were in a position to initiate robust and  
 2 comprehensive investigations of the deaths and collapses  
 3 on the unit, but did not do so.  
 4 They were also in a position to trigger  
 5 whistleblowing and safeguarding policies themselves, but  
 6 did not do so.  
 7 Most critically, as soon as they suspected Letby had  
 8 harmed babies deliberately, they should have articulated  
 9 their suspicions clearly and formally in writing, and  
 10 made sure that they were brought to attention of the  
 11 senior managers and the board, and when those managers  
 12 refused to take immediate and appropriate action, the  
 13 consultants should have gone to the coroner or spoken to  
 14 the police.  
 15 A key example of this failure, you may feel, was the  
 16 inquest into the death of Child A which took place  
 17 before coroner Nicholas Rheinberg on 10 October 2016.  
 18 At that inquest, hospital staff, including Dr Jayaram,  
 19 gave evidence under oath, but for reasons that will  
 20 require clear justification when they give evidence, no  
 21 one told the coroner there had been a concerning cluster  
 22 of deaths at the hospital, that this was being  
 23 investigated, and most critically, there was concern  
 24 that a member of staff was involved and was harming  
 25 babies deliberately.

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1 cause of the deaths and collapses and that they needed  
 2 to investigate that possibility. At the very least,  
 3 advice could have been given by each of those bodies as  
 4 to what next steps should have been taken, for example  
 5 the need to contact the police.  
 6 Why did this happen? As is always the case with  
 7 healthcare disasters from Bristol to Mid Staffordshire,  
 8 the catastrophic failure to stop patients suffering harm  
 9 resulted from a combination of human shortcomings,  
 10 systemic weaknesses and damaging cultural norms.  
 11 Addressing all of these fully is far beyond the scope of  
 12 this opening statement but I'll seek to summarise at  
 13 least some of the key issues.  
 14 First, human shortcomings. The paediatric  
 15 consultants. My Lady the consultants deserve the  
 16 gratitude of the Families for being the first to  
 17 identify Letby as the connecting factor between the  
 18 unexpected deaths and then the person who deliberately  
 19 harmed the babies.  
 20 They acted with tenacity and courage in the face of  
 21 difficult and defensive managers and, as Dr Jayaram  
 22 makes clear in his statement, in genuine fear of adverse  
 23 consequences for themselves, including the threat of  
 24 professional misconduct proceedings.  
 25 However, it must also be recognised that the

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1 Pausing there, it must be acknowledged that  
 2 Dr Jayaram and others should never have found themselves  
 3 in that position. It was a very difficult step for  
 4 anyone to take in a court, given what was happening  
 5 internally at the hospital. As I have already stated,  
 6 the coroner should have been informed months before  
 7 about all of these matters, and his guidance and  
 8 intervention sought. Or at the very least, you may  
 9 feel, the hospital's legal representatives should have  
 10 been instructed to tell him before or during the inquest  
 11 about what was occurring, or its Medical Director,  
 12 Ian Harvey, should himself have attended and addressed  
 13 the issue directly.  
 14 The most serious failings however must fall squarely  
 15 on the managers of the neonatal unit, the hospital's  
 16 Executive Management and its board, in particular,  
 17 Eirian Powell, Alison Kelly and Ian Harvey. They failed  
 18 to heed the lessons of Grantham and Stepping Hill and  
 19 failed to act with professional curiosity and open minds  
 20 when mortality increased in the neonatal unit and  
 21 suspicions began to grow that Letby was the cause.  
 22 It is most striking that even now, eight or nine  
 23 years later, they show so little insight into their own  
 24 roles into what went wrong. So, for example, in his  
 25 long and detailed statement to the Inquiry, Ian Harvey

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1 simply doesn't accept personal responsibility for the  
2 fact that Letby wasn't caught sooner. He does not  
3 address the obvious applicability of safeguarding  
4 obligations or the whistleblowing policies, despite  
5 being one of the hospital's "Speak Up" champions.

6 He does not recognise that Letby's criminality was  
7 never adequately excluded as a possibility because he  
8 did not ensure that it was directly investigated, both  
9 internally in the hospital and externally by the Royal  
10 College and Dr Hawdon.

11 He does not accept that when he was told of  
12 suspicions about Letby he should have informed the  
13 police. Instead, he and others repeat the mantra that  
14 the paediatric consultants never presented evidence that  
15 she was connected to the deaths.

16 That is a misconceived argument for several reasons.

17 First, this was group of respected senior doctors  
18 with many years of experience treating a very large  
19 number of sick babies.

20 They were telling him and his fellow managers that  
21 they could find no other explanation for the deaths or  
22 connections between them other than one of the  
23 hospital's nurses. Absent obvious malice or  
24 irrationality, the authority, experience and unanimity  
25 with which they spoke should have been sufficient to

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1 I have given.

2 So over time, an upside down situation evolved in  
3 which the consultants' suspicions were never  
4 satisfactorily allayed and meanwhile they themselves  
5 were put under investigation for making unfounded  
6 allegations against an innocent junior nurse to whom, in  
7 a quite extraordinary turn of events, they were forced  
8 to apologise.

9 My Lady, it is difficult to conceive of a more  
10 unfortunate and indefensible response to allegations of  
11 the utmost gravity: the murder and assault of multiple  
12 babies by a healthcare professional. Ian Harvey and his  
13 colleagues should have readily appreciated how difficult  
14 it was, professionally and personally, for the  
15 consultants to pursue their suspicions about Letby, and  
16 they should have supported, not undermined, them.

17 Turning then to the systems of governance. I have  
18 already outlined that the Inquiry will need to look  
19 carefully at the relevant policies from investigating  
20 neonatal deaths in the hospital in 2015 and 2016. An  
21 important and conspicuous theme of your Counsel's  
22 opening is that data collection, correlation, and  
23 discussion was patchy and inconsistent within the  
24 hospital. Little or no thought was given to the  
25 whistleblowing and safeguarding policies and from the

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1 warrant speaking to the police and an agreed plan of  
2 investigation.

3 Second, it wasn't the consultants' job to provide  
4 the evidence. They had of course missed the abnormal  
5 blood results of Child F and Child L. But it was their  
6 job to raise concerns, and it was then for others,  
7 Ian Harvey, his colleagues and the board, to implement  
8 the governance policies, the mechanisms and  
9 investigations that were required to ensure that those  
10 concerns were addressed, and that patients were properly  
11 protected.

12 Third, it wasn't for Ian Harvey to judge the  
13 validity of the consultants' concerns and suspicions and  
14 whether the evidence amounted to sufficient proof of  
15 Letby's guilt. He was not a neonatologist,  
16 a pathologist, a police officer or prosecutor; rather it  
17 was incumbent upon him to respond without judgment and  
18 with the 13th Clothier recommendation uppermost in his  
19 mind.

20 Instead, as I've said, the consultants were treated  
21 by him as a problem that wouldn't shut up and go away.  
22 The edict to them from Ian Harvey on 29 June 2016, that  
23 emails should "cease forthwith" was inappropriate and  
24 oppressive, and external investigations by the  
25 Royal College and Dr Hawdon were flawed for the reasons

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1 witness evidence so far obtained, this appears to have  
2 been driven by a combination of ignorance, oversight and  
3 avoidance that should simply not have occurred in  
4 a modern NHS hospital.

5 Yesterday, Counsel to the Inquiry raised serious  
6 questions about the efficacy of the board's grip and  
7 challenge in respect of the raised mortality in the  
8 neonatal unit, despite the degree of authority,  
9 experience and knowledge that they individually and  
10 collectively held.

11 Further, as they outlined, at the relevant time  
12 there was a multitude of procedures and forums for the  
13 consideration of infant deaths and other serious  
14 incidents, such as unexpected and unexplained collapses.  
15 You've heard, for example, about Datix, Sudden  
16 Unexpected Death in Childhood, serious untoward  
17 incidents, informal debriefs, formal hot debriefs.

18 You've also heard about the various groups that  
19 capture and discuss relevant issues and themes both  
20 inside and outside the hospital such as the neonatal  
21 mortality meetings, the Quality, Safety and Patient  
22 Experience Committee, the Urgent Care Risk Register, the  
23 Executive Risk Register, the Cheshire Clinical  
24 Effectiveness Group and the Local Child Death Overview  
25 Panels and Safeguarding Children's boards.

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1 The plethora of procedures and forums is in itself  
2 striking. To the lay observer, it is unclear which one  
3 of these procedures and forums were the right ones, or  
4 the most important ones, for capturing and assisting the  
5 type of problem that arose in the neonatal unit at the  
6 Countess of Chester; namely a cluster of unexpected and  
7 unexplained infant deaths and collapses.

8 As your counsel have indicated, it is also unclear  
9 how the systems of alert and analysis of incidents  
10 interrelated and shared data effectively.

11 While each of them had obvious purpose and value  
12 their combination, if used properly, placed a heavy and  
13 potentially impossible bureaucratic burden on healthcare  
14 staff, including the paediatric consultants themselves.  
15 This created an obvious risk that they would not be  
16 used, or that they would be used inadequately or  
17 inconsistently, thereby of course undermining their  
18 efficacy with the result that significant issues would  
19 inevitably be missed.

20 You will in due course hear from Dr Brearey,  
21 Dr Jayaram and others as to how stretched and  
22 unsupported the medical staff felt and how they needed  
23 to carve out time to give attention to the  
24 investigations.

25 Cultural norms. I will deal with this very briefly  
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1 forthwith" is an example of this.

2 So too is the absence of clear and unambiguous  
3 information provided to the Royal College to Dr Hawdon,  
4 the CQC and the NHS, and of course the delay contacting  
5 the police.

6 Demonisation and lack of support of the perceived  
7 whistleblowers.

8 The deterioration of interpersonal and professional  
9 relationships, into conflict.

10 The emotion and anger expressed at meetings.

11 The growing schisms between the doctors and nurses  
12 and doctors and managers.

13 And above all, the appalling loss of perspective  
14 within the management team about the manifest priority  
15 of patient safety, the need to protect babies from what  
16 could have been, and turned out to be, a determined and  
17 ruthless serial killer.

18 My Lady, you have the task of determining how the  
19 interplay of human weakness, poor governance and  
20 unhelpful cultural norms led to the failure to stop  
21 Lucy Letby from murdering and attempting to murder the  
22 children in her care.

23 The facts relating to those matters will no doubt  
24 crystallise over the next 12 weeks. But more formidable  
25 is the task of making recommendations to ensure that the  
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1 because you will be hearing expert evidence in short  
2 order.

3 **LADY JUSTICE THIRLWALL:** Thank you.

4 **MR SKELTON:** It is another complex issue, but it appears  
5 obvious from the evidence that your Inquiry has so far  
6 gathered that the effective and timely response of the  
7 hospital to concerns that Letby was harming children was  
8 undermined by several cultural factors.

9 Sense-making, whereby healthcare staff and managers  
10 failed to recognise transgressive behaviour and instead  
11 focused on other causes.

12 Comfort-seeking behaviour and confirmation bias  
13 whereby staff rejected suspicions about Letby,  
14 approached the available information without  
15 objectivity, dismissed dissent and focused on  
16 reputational and employment grievance issues.

17 Professional reticence, both in the ways that  
18 concerns and suspicions were articulated and discussed,  
19 and how they were escalated.

20 I note in this regard how few written records there  
21 were about the specific concerns that rose in respect of  
22 Letby and even fewer that deal directly in terms with  
23 her potential criminality.

24 Institutional secrecy, both within and without the  
25 hospital. Ian Harvey's email to "cease communications  
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1 interplay of those factors doesn't recur. There you are  
2 up against longer standing cultural forces, including  
3 the profound reticence to call out colleagues who may be  
4 harming patients. I will address you on these matters  
5 of course fully next year.

6 My Lady, in conclusion, I'd like just to say two  
7 things.

8 First, on behalf of the Families I would like to  
9 acknowledge that in its written opening statement, the  
10 Countess of Chester has clearly reflected carefully on  
11 the events of 2015 and 2016 and has appropriately  
12 acknowledged the serious mistakes that were made and the  
13 serious consequences that those mistakes had.

14 As will be apparent from this opening statement, the  
15 Families consider that these mistakes arose from the  
16 start of the in-depth events in June 2015, and that  
17 Letby should have stopped much sooner. Precisely when  
18 will be a critical question for you to determine.

19 But also on behalf of the Families, having heard or  
20 read the long and detailed opening statements of Counsel  
21 to the Inquiry, I would urge that the hospital's Chief  
22 Executives exercise a greater degree of reflection and  
23 insight than they have demonstrated in their written  
24 evidence and their written opening. Their continuing  
25 denials and deflections are painful to bear. It is  
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1 hoped and expected that by the time they appear to give  
2 evidence before you in a few weeks' time they will  
3 demonstrate far greater understanding of what went wrong  
4 at their hospital and acceptance of their personal  
5 accountability.

6 My Lady, finally I must make a request to the public  
7 and to the media. As you've said in your opening  
8 remarks on Tuesday, of recent weeks and days there has  
9 been a great deal of speculation about Lucy Letby's  
10 guilt and there are strongly held and articulated  
11 questions in some quarters that she may be the unlucky  
12 victim of a miscarriage of justice.

13 You rightly said that those raising those questions  
14 would not have been present at Lucy Letby's trials, and  
15 so unlike the juries that convicted her, they are not in  
16 a position to weigh up the evidence and reach an  
17 informed view.

18 They are not, for example, aware that Lucy Letby was  
19 not convicted on the basis of questionable statistics  
20 but because the factual and expert medical evidence  
21 demonstrated beyond reasonable doubt that she had harmed  
22 the children at the hospital. You are not conducting an  
23 assessment of all the available evidence about  
24 Lucy Letby's guilt, and this Inquiry will not consider  
25 those matters over its forthcoming evidence. But she

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1 murder.

2 Those witnesses who give evidence to you will be  
3 seeking to explain why those suspicions arose and why  
4 she was not caught sooner. That, not Letby's  
5 conviction, must now be the focus of everyone's  
6 attention. Thank you, my Lady.

7 **LADY JUSTICE THIRLWALL:** Thank you very much indeed,  
8 Mr Skelton.

9 **Opening statement by MR BAKER**

10 **MR BAKER:** My Lady, I speak on behalf of the Families of  
11 Child C, Child D, Child E, Child F, Child G, Child H,  
12 Child J, Child K, Child O, Child P and Child R.

13 I am also instructed by the Family of Child U,  
14 a child not named on the indictment, but whose Family  
15 are assisting the Inquiry. I have prepared a written  
16 opening, I will not read it out. I have also prepared  
17 a speaking note which I will send to the Inquiry at the  
18 conclusion of these openings.

19 **LADY JUSTICE THIRLWALL:** Thank you very much.

20 **MR BAKER:** You have heard over the course of two days of an  
21 opening presentation by the Counsel to the Inquiry and  
22 her team, Rachel Langdale KC and her team are to be  
23 congratulated on preparing and delivering an impressive,  
24 meticulous and forensic introduction to these events.

25 The Families are grateful for the care that has been put

27

1 was assisted at the time by a first rate defence team,  
2 and it is important for the public to understand the  
3 decision-making that occurred within that trial about  
4 the use of expert evidence, for example, before coming  
5 to a view about what may now amount to a miscarriage.

6 It is also important that people monitoring the  
7 Letby case don't demonstrate precisely the type of  
8 mindset and fallibilities that I have described in this  
9 opening statements; fallibilities that demonstrated  
10 closed-mindedness when it comes to facts that don't  
11 support your own opinions.

12 I would urge those people as a starting point to  
13 consider the Court of Appeal judgment that has rejected  
14 outright Letby's application to appeal her convictions.  
15 It takes about 90 minutes to read. It is the result of  
16 very careful analysis by very experienced senior judges;  
17 in the clearest terms it upholds the convictions and  
18 arguments that continue to underpin speculation about  
19 her trial.

20 Finally I'd also urge you to follow the evidence  
21 that will be given to this Inquiry. As you, my Lady,  
22 stated in your opening remarks, you are not  
23 investigating her guilt. But you are investigating  
24 those that worked with her, those that knew her, and  
25 ultimately those who suspected that she was committing

26

1 into operation of this Inquiry by all concerned, but  
2 also for a very genuine empathy shown by the Inquiry  
3 team towards their needs.

4 In the time allocated to me I cannot match the level  
5 of detailed analysis that is contained within that  
6 opening.

7 Letby was convicted of murdering five of the babies  
8 whose Families I represent, and attempting to murder  
9 four more. The convictions and indeed the indictments  
10 do not however tell the full story. Child K died when  
11 she was only a few days old, having been attacked by  
12 Letby, and her parents believe with justification that  
13 she was murdered by her. The position is also  
14 complicated by the fact that the jury could not reach  
15 a verdict in relation to the charge that Letby attacked  
16 Child J, causing her to collapse twice on  
17 27 November 2015. I have indicated in my written  
18 opening that the parents have no doubt that Letby  
19 attacked their daughter on that date, but also that  
20 a further collapse on 17 December 2015 which did not  
21 form part of the indictment was caused by the actions of  
22 Letby.

23 Both are entitled to reach those views based on the  
24 evidence that they have seen.

25 My Lady, the position of the Families in this

28

1 Inquiry is unique. They are anonymised by ciphers, as  
2 are their children. Some are concerned that this has  
3 the effect of dehumanising them in the eyes of the  
4 public and media, and has cultivated an environment  
5 where people feel able to express vile opinions through  
6 social media, an environment where the serial killer who  
7 murdered or attacked their children is, by contrast  
8 humanised or even venerated.

9 My Lady, you have met the Families. You will know  
10 that they are real people. You will understand that  
11 they have a simple and reasonable aim: to live normal  
12 lives as disconnected from the monster who harmed them  
13 as possible. They have no interest in becoming  
14 permanent attractions at a ghoulish sideshow. Their  
15 request is to be allowed to grieve in private or for  
16 their surviving children to never know of the role that  
17 they played in this story.

18 More tragically still, they feel that revealing  
19 their identities would cause them to become the focus  
20 for ill-will. My Lady, what has society come to, where  
21 the parents of murdered or injured children should live  
22 with this fear? Everybody who recklessly promotes  
23 conspiracy theories, or who parrots without questioning  
24 the same tired misconceptions about this case, should be  
25 ashamed of themselves.

29

1 There is, however, some measure of relevance in this  
2 background noise, as Mr Skelton, King's Counsel, pointed  
3 out. It reveals a common and basic cognitive bias. As  
4 a society, we are too quick to make judgments debated  
5 upon first impressions. We idolise or demonise those  
6 who fit our own stereotypes. We prefer our monsters to  
7 look like monsters, to be easy to identify and to be far  
8 removed from ourselves. It creates a profound cognitive  
9 dissonance when monsters do not fit a stereotype. It is  
10 sometimes hard to accept that evil can be banal.

11 The cognitive biases of individuals who see a young  
12 woman working in a caring profession and cannot conceive  
13 of a darkness that may lay beneath the surface are easy  
14 to understand, but we should not be so naive: to be  
15 successful, a serial killer must hide in plain sight.

16 In her opening Rachel Langdale, King's Counsel,  
17 marked upon the respect that so many patients expressed  
18 towards Harold Shipman who they regarded as a diligent  
19 and caring doctor; until, that is, the truth was known.

20 We can add to that list many other superficially  
21 charming or apparently normal individuals who were later  
22 revealed to be monsters. It should be no surprise to  
23 this Inquiry that in so far as other respectable and  
24 responsible professions may attract sexual predators, so  
25 healthcare professions may equally allow those

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1 The Families, along with the jury, collectively sat  
2 through ten months of evidence and in the case of  
3 Family K, two trials. They did so with impressive  
4 dignity. They heard the evidence against her and have  
5 no doubt that she was guilty. The jury had no doubt  
6 that she was guilty. The trial was overseen by an  
7 experienced High Court judge and reviewed  
8 comprehensively and with care by the Court of Appeal.

9 This process conducted with scrupulous fairness and  
10 with exhausting detail is arrogantly ignored by those  
11 who criticise the outcome. Those individuals offer  
12 superficial opinions based upon second or thirdhand  
13 accounts, expressing conclusions that it might be  
14 generous to call on occasion "half-baked".

15 In the meantime, the Families, the jury, the judge,  
16 the Court of Appeal, and even the team who represented  
17 Letby at trial, must remain silent while others use the  
18 losses suffered by those Families as currency to build  
19 their own reputations. This is an intolerable burden  
20 for the Families to bear, and as I have said before, it  
21 is harmful and toxic to them.

22 The complexity of the open anything of this Inquiry  
23 demonstrates the depth of analysis that is required to  
24 understand the events at the Countess of Chester. This  
25 is not an issue to express casual opinions about.

30

1 harbouring malign or homicidal ideations to live out  
2 their fantasies unchecked. It is, as Mr Skelton points  
3 out, thankfully rare, but it is a risk that hospitals  
4 and Trusts should be alive to.

5 In examining this issue we should guard against the  
6 notion that a serial killer such as Letby was entirely  
7 unpredictable, or unthinkable, in 2015 and 2016.  
8 Counsel to the Inquiry was correct in her opening  
9 statement to refer to the case of Beverly Allitt. Her  
10 name appears within a list that includes Harold Shipman,  
11 Colin Norris, Ben Geen and Victorino Chua.

12 The latter case, as Mr de la Poer and Mr Skelton  
13 observed, is particularly apposite, because the  
14 sentencing remarks made by Mr Justice Openshaw were made  
15 a matter of weeks before Letby commenced her killing  
16 spree.

17 You may conclude that it is surprising in the  
18 extreme that individuals working at a Hospital Trust  
19 a little over 40 miles away and a matter of weeks or  
20 months later might regard the possibility that a nurse  
21 or healthcare worker would harm patients as  
22 unforeseeable or unthinkable.

23 Allitt will remain a constant presence throughout  
24 this Inquiry and the facts of that case are remarkably  
25 similar to this one. The Families note that the

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1 Clothier Report was particularly critical of the  
 2 Grantham Hospital's response to those remarkably similar  
 3 events and that a delay in two weeks before calling the  
 4 police, having received the same abnormal insulin  
 5 results that were received by the Countess of Chester  
 6 Hospital following the collapse of Child F in July 2015.  
 7 The Clothier Report described that delay as "feeble and  
 8 indecisive". It allowed further crimes to be committed,  
 9 including a further murder. The Family will say that  
 10 albeit feeble and indecisive, in its reaction to these  
 11 events, the Grantham and Kesteven Hospital did  
 12 considerably better than the Countess of Chester did  
 13 25 years later, even though the Countess of Chester  
 14 Hospital should have had the benefit of accumulated  
 15 knowledge that had been acquired in the intervening  
 16 period.

17 There was and is no upswelling of the public opinion  
 18 in support of Beverley Allitt who was convicted of  
 19 murdering four children, attempting to murder three  
 20 others by various means, and causing grievous bodily  
 21 harm to six more, all remarkably similar to this case.  
 22 Following her conviction, she eventually confessed to  
 23 her crimes.

24 The Families will begin by asking not only why did  
 25 this happen, why did it happen again?

33

1 to investigate Child F's case. He is ultimately  
 2 responsible for the lack of proper investigation into  
 3 the collapses and deaths that preceded and followed  
 4 Child F.

5 Although the response of the individuals and  
 6 organisations when concerns were felt or expressed is  
 7 clearly a key issue, the Families would not want the  
 8 Inquiry to lose sight of the fact that greater curiosity  
 9 from the outset had the potential to prevent harm at  
 10 a very early stage and may have prevented harm  
 11 altogether.

12 The Families say this for the following reasons:  
 13 The deaths and collapses were unexpected and  
 14 unexplained. You will hear evidence that death is far  
 15 from common in the neonatal setting. Dr Davies,  
 16 an obstetrician, observed in her analysis of Child D's  
 17 case that it is simply not normal for a term baby to  
 18 die. Dr Brearey in his evidence commented that  
 19 unexpected neonatal collapse is extremely unusual. You  
 20 would not normally expect it to happen without some  
 21 warning first.

22 He would not normally expect a baby born in good  
 23 condition beyond 30 weeks' gestation to collapse  
 24 suddenly and he felt that survival rates for babies born  
 25 in a good condition at 33 weeks should be 98%.

35

1 Why was a reaction to these crimes palpably worse in  
 2 2015 and 2016 than it had been in 1991?

3 Why did the Trust fail to recognise what was  
 4 happening sooner?

5 Why did it not exercise greater curiosity over the  
 6 events, and investigate them more clearly?

7 Why did it not avail itself of structures and  
 8 systems that should have safeguarded children?

9 Why did the Trust not call the police as soon as  
 10 suspicions were actually raised?

11 Why did a culture develop that put reputation and  
 12 personal promotion above the need to protect vulnerable  
 13 patients?

14 Why had a culture been allowed to develop whereby  
 15 a hospital saw the need to focus on grievances expressed  
 16 by a serial killer as taking priority over investigating  
 17 their crimes?

18 A set of circumstances described by Mr Skelton as  
 19 "unfortunate", but which I would describe as "surreal".

20 Why did the failsafe that led to Allitt being  
 21 apprehended not work in this case?

22 The Families are aware of Mr Harvey's comment that  
 23 all would have been different if he had known about the  
 24 insulin and C-peptide results of Child F. They have no  
 25 sympathy. They would say that he had every opportunity

34

1 The babies involved were not critically unwell  
 2 despite what may be said in the media. In some cases  
 3 they were vulnerable but in others not even particularly  
 4 vulnerable. Some were waiting to go home. The  
 5 collapses when they occurred were unforeseen and  
 6 unexpected. These were not babies who had been  
 7 predicted to be at risk of collapse and sudden death.

8 An account of babies given over and over again by  
 9 their Families and medical professionals is that they  
 10 were stable, improving. Child E and Child F were almost  
 11 ready to go home. They all seemed to be doing well and  
 12 nobody can understand why they were collapsing and  
 13 dying. Resonance again to Allitt and all those who  
 14 followed her.

15 Collapses occasionally involved complications that  
 16 were in themselves unusual, such as the dislodgement of  
 17 endotracheal tubes.

18 Given the prevalence of dislodgment of endotracheal  
 19 tubes in this case, my Lady may see it as a common  
 20 evidence but the evidence suggests that it is not at all  
 21 common, it is very uncommon. You will hear evidence  
 22 that it generally occurs in less than 1% of shifts. As  
 23 a sidenote, you will hear that an audit carried out by  
 24 Liverpool Women's Hospital recorded that whilst Lucy  
 25 Letby was working there, dislodgment of endotracheal

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1 tubes occurred in 40% of shifts that she worked.

2 One may wonder why. This is a relevant issue, we  
3 would say, for Part C and a potential for systems to  
4 identify such profound variations from the norm.

5 The babies did not respond to timely resuscitation  
6 manoeuvres in a way that would be expected. Child C,  
7 for example, showed signs of life after a prolonged and  
8 unsuccessful resuscitation in a way that was at odds  
9 with what would be expected. The medical professionals  
10 who witnessed it couldn't understand it. There was no  
11 natural mechanism to explain it.

12 The collapses and deaths involved unusual features  
13 that could not be explained by those who witnessed them,  
14 including unexplained skin changes. Two babies who  
15 collapsed were found to have been given manufactured  
16 insulin to cause hypoglycaemia. The deaths occurred at  
17 a rate that was entirely at odds with experience on the  
18 unit through previous years: three deaths occurred in  
19 June 2015 alone, the same number or more as had occurred  
20 annually in preceding years. The Families would ask why  
21 the unexpected spike in deaths did not trigger greater  
22 curiosity or investigation, and why established systems  
23 were ignored or failed.

24 The Families asked why was there not greater  
25 curiosity, why were the collapses and deaths not

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1 senior clinicians on the unit. They will ask why the  
2 existence of those concerns did not lead to earlier  
3 escalation and safeguarding and insofar as concerns were  
4 raised and escalated, as it was clear as time went on  
5 that this did happen in a more persistent and vocal way,  
6 why were these concerns not acted upon sooner or and  
7 more effectively?

8 To all the Families affected by Lucy Letby's crimes  
9 it is an anathema that those that provide healthcare to  
10 children would owe strict safeguarding duties and have  
11 a clear structure to deal with safeguarding concerns  
12 where they suspected that parents or other family  
13 members were causing harm to their children, but would  
14 not regard themselves as owing similar duties or have  
15 similar structures that were concerned relating to harm  
16 caused by a colleague.

17 As a sidenote, my Lady, when considering your  
18 recommendations, it is important to note that the IICSA  
19 final report of 2022, Recommendation 13, suggests that  
20 there be mandatory safeguarding reporting for suspected  
21 sexual offences. That is an issue we would flag up now  
22 but return to later.

23 The reason why steps were not taken to recognise and  
24 act upon suspicions sooner is a key issue for this  
25 Inquiry to explore. The Families believe that attempts

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1 properly investigated?

2 Why were Families and coroners offered definite  
3 conclusions as to why their babies had collapsed or  
4 died?

5 Why is it that in some cases Families were  
6 encouraged not to have post-mortems and to accept  
7 a natural cause of death? Was this due to a lack of  
8 insight? A lack of curiosity? Or was that because  
9 somebody was covering something up?

10 Why were the external bodies not better informed?  
11 Why were they misled, as the Families believe they were?

12 Looking at the reaction to suspicions when they were  
13 actually raised, it is clear that there is evidence to  
14 suggest that from the point of October 2015 onwards,  
15 consultants were beginning to feel or express concern  
16 that there may be a malign influence at work in the  
17 unit.

18 The Families of Child J, K and Children O and P, who  
19 follow on from the death of Child I in 2015, are  
20 obviously concerned to discover that there were  
21 suspicions that Lucy Letby was deliberately harming  
22 patients before their children suffered harm.

23 They considered there was a failure to safeguard  
24 their children in the presence of a suspected or known  
25 threat, or at least one that had been identified by some

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1 to blow the whistle and escalate concerns were  
2 suppressed by the management at the Countess of Chester  
3 Hospital at the cost of further harm to victims. They  
4 believe that seven babies were murdered or harmed in the  
5 period following October 2015 because proper steps were  
6 not taken to explore those concerns, and that each  
7 successive delay allowed more harm to be caused.

8 The Families who are represented within this group  
9 believe that proper safeguarding in response to those  
10 concerns would have avoided harm and saved lives.  
11 I will come on now, my Lady, to talk about  
12 communications, candour, honesty and transparency.

13 **LADY JUSTICE THIRLWALL:** Thank you.

14 **MR BAKER:** The failure to provide clear, complete and  
15 truthful information to the Families about the condition  
16 of their children, and any issues that have arisen in  
17 relation to their care in hospital, causes genuine and  
18 persistent harm. It causes parents to speculate as to  
19 why their children came to suffer harm, it prevents  
20 further questions being asked by parents that might have  
21 highlighted other concerns. It causes them to blame  
22 themselves for passing on illness or disease or genetic  
23 abnormalities to their children. It erodes the trust  
24 that they have in their own judgment and public trust in  
25 the probity of medical professionals or healthcare

40

1 organisations and institutions.

2 It affects the parents' relationships with other or  
3 future children, their experience of childbirth and  
4 pregnancy. It causes them to worry about the health of  
5 their surviving children, and their safety and the  
6 safety of others who are in the healthcare system.

7 If the Families accepted the information given to  
8 them by medical professionals at the Countess of Chester  
9 Hospital, they feel guilt and shame now that the truth  
10 has been revealed. They feel that they failed their  
11 children by not advocating more persistently on their  
12 behalf.

13 That sense is wrong but it is nonetheless potent.  
14 By the time the truth became known some, such as the  
15 parents of Child G, had made decisions and taken  
16 irrevocable steps based on incomplete, dishonest or  
17 fraudulent information.

18 If the Families questioned the advice they were  
19 given, they were put into conflict with the Trust, left  
20 to fight battles on their own with all the stress and  
21 anxiety that accompanies that process.

22 The truth when it was revealed did not provide them  
23 with comfort, as the damage had already been done. When  
24 the truth was revealed for the Families, it was done in  
25 a hurried and unexpected way, often not through proper

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1 leading to her collapse on 7 September 2015, was  
2 "neonatal sepsis" and there was no evidence to support  
3 that conclusion, and it remains a dubious one in the  
4 eyes of those who treated her. Her collapse was  
5 unexplained but they were not told.

6 The Family of Child K were not informed that their  
7 child's endotracheal tube had dislodged on three  
8 occasions causing her to desaturate or that she required  
9 active resuscitation. Her parents believed that had  
10 this information been provided to them, they would have  
11 asked questions about how this could have occurred and  
12 were left with the sense that this information could  
13 have provided them with an opportunity to advocate for  
14 their daughter, and question why the tube was repeatedly  
15 dislodged.

16 The Family of Child F were not informed that he had  
17 suffered a prolonged episode of hypoglycaemia and were  
18 instead told that he had suffered an infection in his  
19 long line, but was responding well to antibiotics. The  
20 first time that Mother F discovered that her child had  
21 suffered an episode of hypoglycaemia coincided with  
22 being told by the police that he required an MRI scan to  
23 look for signs of hypoglycaemic damage to his brain.  
24 She was then left to work out how this damage may have  
25 occurring by undertaking her own research.

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1 channels but through leaks to the media and newspapers  
2 and some even during the course of Lucy Letby's criminal  
3 trial. All the Families continued to discover new  
4 information during the Crown Court trial, and some will  
5 continue to discover it through this Inquiry.

6 The first issue identified by the Families in this  
7 group is that information wasn't provided about their  
8 children's condition. That's distinct from the duty of  
9 candour which I will discuss in a moment because it  
10 relates to the Families' experience about not being  
11 informed about their children's condition. It does not  
12 relate to failures to inform them of instances of poor  
13 healthcare or near misses, nor does it relate to  
14 failures to inform them about suspicions surrounding  
15 Lucy Letby.

16 Multiple examples in the Families' witness  
17 statements had family members discovering information  
18 about their baby's condition years after the event. And  
19 some Families, such as the Families of Child D, Child J  
20 and Child G, they were unaware of the number of times  
21 their children had collapsed until they heard evidence  
22 given at the Crown Court. Others were not kept up to  
23 date with the condition of their children despite  
24 attending the ward regularly. The Family of Child G  
25 were informed that the deterioration in her condition,

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1 This is important. Providing accurate and timely  
2 information permits parents to take part in  
3 decision-making, consent to treatment, and provides them  
4 with the opportunity to advocate for their children. It  
5 is therefore an important element in achieving  
6 person-centred care in accordance with Regulation 9 of  
7 the Health and Social Care Act Regulations of 2014.

8 On a more basic level, providing accurate  
9 information to parents is a bedrock of compassionate  
10 healthcare. Parents should have the opportunity to know  
11 as much or as little about the condition of their child  
12 as they choose. Discovering that a child who you  
13 assumed to be doing well is in fact critically unwell is  
14 shocking and traumatising.

15 Discovering years after the event that your child's  
16 learning disabilities were caused by an episode of  
17 hypoglycaemia as a newborn deprives you of the  
18 opportunity to understand their condition and seek  
19 appropriate rehabilitation or support and advocate on  
20 their behalf through healthcare and education systems.

21 It may also dispel an insidious sense experienced by  
22 many Families that their condition was in some way  
23 caused by them. The effects of removing agency from  
24 parents are obvious and stark but eloquently summed up  
25 by Mother H in her witness statement and I quote:

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1 "I felt as though [Child H] was not my baby because  
2 I did not have much of a say. I had to hand over all  
3 care and I was limited to seeing her at visiting hours."

4 The lack of support persisted beyond the point where  
5 harm had been caused. The Families whose children  
6 survived were provided with little, if any, information  
7 about what had happened to them. Those who lost babies  
8 were not provided with adequate bereavement support. It  
9 is not asking much that a hospital provide bereavement  
10 support to those who have suffered loss.

11 Mother EF was so moved by the inadequacy of the  
12 support provided to her following the death of Child E  
13 that she trained to become a bereavement counsellor.

14 Coming on to candour, you have heard, my Lady -- and  
15 will hear -- about the duty of candour as it was  
16 introduced in December 2014, and what it is intended to  
17 achieve. The duty was not followed, my Lady, in respect  
18 of any of the Families whom I represent at any point.  
19 The Families would like to know why this was the case,  
20 and whether the duty of candour is sufficiently robust  
21 in its present formulation.

22 It is notable that many parents found out about the  
23 suspicions regarding Lucy Letby for the first time  
24 through news reports, or when they were contacted by the  
25 police. Father C heard about investigations into the

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1 in the unit when they read about it in the newspapers.

2 There are also examples of parents not being  
3 informed about suspected substandard care in relation to  
4 their children.

5 Mother OPR was unaware that Datix reports had been  
6 created in respect of her son's care until she attended  
7 the Crown Court trial.

8 The Family of Child H were unaware that their  
9 daughter had been the victim of suboptimal or negligent  
10 care.

11 Mother D was told that there was no requirement for  
12 IV antibiotics earlier, during her labour, despite this  
13 being contrary to guidelines, and despite it having been  
14 identified in a Datix report complete following the  
15 death of Child D.

16 Mother D was not given any explanation as to why her  
17 daughter, who was stable when Mother D was sent away  
18 from the unit, had suddenly and unexpectedly  
19 deteriorated and died. Within the same Datix report, it  
20 is noted there had been an opportunity to provide an  
21 additional dose of intravenous antibiotics to Child D.

22 Her parents were never informed about this.  
23 Jane Hawdon's report in October 2016 identified the  
24 delay in providing antibiotics as "major suboptimal  
25 care" and "probably relevant" to outcome. Despite this,

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1 unit when a friend sent him a link to an article in the  
2 Cheshire Chronicle. Mother C first became aware of the  
3 article when she received it from him. She was heavily  
4 pregnant at the time and had attended multiple  
5 appointments at the Countess of Chester Hospital. She  
6 attended, on her own will, the Bereavement Office at the  
7 Countess of Chester Hospital, and then refused to leave  
8 until she had been seen.

9 It was only then, after waiting, that she was  
10 informed that her son was part of a police  
11 investigation. She should not have been put in that  
12 position. She should not have been forced to be  
13 "difficult" in order to find out such basic information  
14 about her child.

15 Mother and Father C were only informed that there  
16 was a suspicion of deliberate harm by a member of  
17 nursing staff when they received a telephone call from  
18 Cheshire Police between 6 am and 7 am on the day of  
19 Lucy Letby's arrest.

20 Mother and Father G had the same experience, as did  
21 Mother and Father H.

22 Child K's parents were unaware that there had been  
23 any issues with their daughter's care until they were  
24 contacted by the police in May 2017.

25 The Family of Child J first became aware of issues

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1 Mother and Father D were not informed of issues in  
2 relation to the care provided to their daughter. In  
3 February 2018, Child D's case was discussed at a meeting  
4 with Margaret Bowron, Queen's Counsel, and described by  
5 her as "indefensible".

6 There is no evidence that the parents were shown  
7 proper candour and that this conclusion was communicated  
8 to them at this time.

9 This lack of transparency, we would say, extended to  
10 the interactions with the coroner, who was provided with  
11 witness statements from the Trust in 2016 that  
12 identified that no errors were involved in the care  
13 provided to Child D, an impression that was not  
14 corrected until the coroner was informed of police  
15 investigations in 2017.

16 The Families were unaware that the Countess of  
17 Chester Hospital had requested an investigation from the  
18 Royal College of Paediatrics and Child Health and the  
19 Royal College of Nursing and many have heard about that  
20 for the first time when they received a letter from  
21 Ian Harvey dated 8 February 2017. The full report was  
22 not sent to the Families and they were not able to  
23 access this for many months.

24 The Families were not provided with Jane Hawdon's  
25 report which was available from October 2016 and which

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1 had been provided to the consultant paediatricians at  
2 the hospital, along with the Royal College report on  
3 3 February 2017.

4 The Families were given little, if any, notice that  
5 a report would have been released before they received  
6 a letter in 2017, with some only being contacted after  
7 the report had been released to the public, and this  
8 caused considerable distress, and in the case of  
9 Family OPR, had been directly contrary to an undertaking  
10 given to the coroner's office. The lack of proper  
11 communication was woeful. It compounded the harm to the  
12 Families, and eroded what trust, if any, was left.

13 When the version of the RCPCH report was finally  
14 provided to the Families, it was different. It had been  
15 redacted from the final report that had been provided to  
16 the Countess of Chester Hospital, and all references to  
17 the suspicions regarding Letby had been removed.

18 The Families regard the decision to redact the  
19 report before sending it to them as a blatant lack of  
20 transparency and candour on the part of the Trust. They  
21 regard it as dishonest. If they had known about these  
22 concerns, they would have asked why the police had not  
23 been contacted. Had the Families been aware that  
24 suspicions expressed were in the unredacted RCPCH  
25 report, they would have contacted the police themselves.

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1 reputation of a hospital and of the NHS as a wider  
2 organisation is predicated upon its ability to serve its  
3 community. Dishonesty corrupts its reputation and  
4 erodes trust in both the hospital and the NHS.

5 The Families will say that the Trust's interactions  
6 with them, especially following June 2016, were lacking  
7 in transparency and were dishonest. There are numerous  
8 examples of this, but the experiences of Mother C we  
9 will say are particularly apposite. She was contacted  
10 by Sian Williams on 3 February 2017 and informed that  
11 there had been a leak of information regarding  
12 investigations in the unit, and that an article would be  
13 published in the Sunday Times that weekend.

14 Having picked up a copy of the report upon returning  
15 from holiday, she wrote a long letter to Ian Harvey on 7  
16 February 2017. That letter set out a poor history of  
17 communication from the Trust and included the words:

18 "The report does strike me as having some suspicion  
19 that there were some unusual features of the deaths of  
20 the babies on the unit and that perhaps there was  
21 something going on in the unit that caused or at least  
22 contributed to the increase in mortality."

23 Mother C subsequently attended a meeting with  
24 Ian Harvey in February 2017. She describes that meeting  
25 in her witness statement. I quote:

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1 They were similarly concerned that the report and the  
2 Royal College did not itself recognise that the  
3 suspicions raised by the consultants warranted immediate  
4 involvement of the police.

5 Finally coming on to honesty.

6 The Families do not regard the lack of candour or  
7 transparency in the Countess of Chester Hospital's  
8 communications with them as a product of uncertain  
9 principles, rules or policies. They believe that the  
10 management of the Countess of Chester Hospital were  
11 dishonest, that they covered up and suppressed the  
12 concerns that were being expressed about Lucy Letby's  
13 conduct in the unit, and the harms she had caused to  
14 their children. The motives for doing this may be  
15 multifarious, but the need to protect reputations  
16 appears to be a common refrain.

17 If that was the motive, it should be condemned in  
18 the strongest possible terms. The reputation of a Trust  
19 and its managers is subordinate to the need to protect  
20 patient safety and the need to provide injured parties  
21 with truth and recompense.

22 The Families will say that the excuses advertised in  
23 some statements that it is better to protect the  
24 reputation of an NHS hospital because of the greater  
25 good that it serves are feeble and self-serving. The

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1 "Ian Harvey apologised to us for the poor  
2 communication. He advised us that some small areas that  
3 could be improved upon had been noted in the review of  
4 Child C's care but nothing of concern. There was  
5 nothing that could have been changed about his care that  
6 would have affected the outcome and prevented his death.  
7 We were relieved to hear this. This is what we wanted  
8 to hear and we are aware that nothing ever goes  
9 perfectly, so we had expected some areas of improvement  
10 to be noted. The conclusion of the investigation would  
11 allow us to move forward and not have this investigation  
12 and uncertainty hanging over us."

13 If the Inquiry accepts Mother C's evidence on this  
14 issue, Ian Harvey lied to her. At the time of the  
15 meeting, he was in possession of a report from  
16 Jane Hawdon that criticised the quality of care provided  
17 to Child C, and concluded that his death may have been  
18 preventable, had the standard of care been better.  
19 Ian Harvey was aware at the time of this meeting that  
20 serious concerns had been expressed by consultants in  
21 the unit that Lucy Letby had been deliberately involved  
22 in harming patients on the unit, including Child C. He  
23 was aware that the Mother and Father C had been provided  
24 with an incomplete version of the Royal College report  
25 which omitted references to that issue.

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1 Ian Harvey wrote to Mother and Father C, as he did  
2 to other affected Families, on 3 March 2017 stating that  
3 the review had "indicated that a small number of areas  
4 of investigation are required and I aim to undertake  
5 this as quickly as possible". This is despite him  
6 advising some media outlets in February 2017 that the  
7 Trust had acted swiftly and that the reviews had been  
8 complete.

9 You may think it notable that Tony Chambers had  
10 received a letter on 1 March 2017 signed by seven  
11 consultants on the unit, expressing their concerns that  
12 "the unexpected collapses had not even yet been  
13 adequately investigated", levelling legitimate criticism  
14 of the quality and independence of investigations  
15 undertaken thus far and requesting a "broad forensic  
16 review".

17 My Lady, it is implausible that Mr Harvey was  
18 unaware of the strength of feeling amongst the  
19 consultants in the unit at this stage, or that he did  
20 not recognise the limits of the investigation  
21 undertaken.

22 His letter to the parents was therefore at best  
23 a serious distortion of the truth; at worst, an outright  
24 lie.

25 Mother C requested a full and unredacted copy of the

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1 The Families also believe that the lack of  
2 transparency shown towards them is evidenced in the  
3 Countess of Chester Hospital's interactions with other  
4 individuals and organisations. The Families note that  
5 Jane Hawdon does not appear to have been informed of the  
6 suspicions regarding Lucy Letby when she prepared her  
7 report, information that she would have regarded as  
8 relevant. Had she been informed, she would have  
9 contacted Ian Harvey and urged him to follow the  
10 appropriate Trust safeguarding and governance processes.

11 She was not informed of the pattern of deaths and  
12 unusual incidence had ceased with the removal of  
13 a member of staff. Had she been informed, she said she  
14 would have contacted Ian Harvey and urged him to follow  
15 appropriate Trust safeguarding and governance  
16 procedures.

17 The Families are concerned the Countess of Chester's  
18 motivations in providing imperfect information to  
19 Jane Hawdon were motivated by a desire to whitewash the  
20 truth and the Families will say there is no other or  
21 better explanation.

22 The Families also note that inaccurate or incomplete  
23 information was provided to the coroner. They are  
24 concerned that this information was hidden from the  
25 coroner as a means of avoiding scrutiny that an inquest

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1 Royal College report having appreciated the one she had  
2 seen was incomplete. When Ian Harvey wrote to her on  
3 28 April he did not attach a full copy of the report but  
4 referred to the earlier disclosure.

5 His letter is notable in two respects. Firstly, the  
6 version of Jane Hawdon report attached to the letter is  
7 incomplete and omits a supplementary conclusion  
8 categorising the standard of care received by Child C,  
9 and secondly and perhaps more importantly it omitted to  
10 mention that he had on the previous day attended  
11 a meeting with the representatives of the Cheshire  
12 Constabulary following which he had been advised to  
13 write a formal letter to the Chief Constable of the  
14 Cheshire Constabulary requesting a forensic review.

15 A specifically incomplete and misleading letter was  
16 sent to Mother E and F on the same date.

17 The Families regard the approach of the Trust during  
18 this period as going beyond a lack of candour. They  
19 believe that the senior management of the Countess of  
20 Chester deliberately misled them in order to hide the  
21 truth, in order to protect their own reputations and  
22 those of the Trust. Their actions represented a gross  
23 derogation of their duties of managers of a public body,  
24 and the families would like to know why a culture has  
25 developed that would allow this to happen.

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1 might bring to bear.

2 And the Families are also concerned that the use of  
3 external bodies such as the Royal College and review by  
4 Jane Hawdon were not undertaken with a genuine desire to  
5 find out the truth behind the incidents that had  
6 occurred; they were concerned that they were chosen  
7 because they would undertake a superficially  
8 comprehensive but in reality incomplete review of the  
9 issues being complained of since the Royal College in  
10 particular was entirely ill-equipped to explore whether  
11 crimes were being committed by a member of staff.

12 The report from the Royal College when it was  
13 obtained emphasised the positive more loudly than the  
14 negative issues, allowing censure to be drowned out by  
15 congratulation.

16 The process by which the report was redacted and  
17 edited before being provided to the Families might  
18 provide them with the impression that the Royal College  
19 and the Countess of Chester were fulfilling their key  
20 duties whilst hiding key facts from them.

21 My Lady, in conclusion, the Families fully support  
22 the aims of this Inquiry. The themes discussed above  
23 are a summary of their key concerns, which should not be  
24 taken to be final or comprehensive.

25 I of course adopt every word and submission made on

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1 behalf of the other Families by Mr Skelton, and agree  
2 with him entirely.

3 The Families are indeed thankful of the  
4 opportunities to give their accounts of their  
5 experiences and in due course, hear the accounts of  
6 others and their explanations for their actions.

7 The Families' ultimate goal is to ensure that their  
8 experiences are not repeated. The desire is however  
9 tainted by the sadness of events that brought the  
10 Families to this Inquiry.

11 In my final words, I would like to return to one  
12 central theme that runs through the evidence of all the  
13 parents.

14 To them, their babies were miracles. They were  
15 often conceived against the odds, sometimes facing  
16 adversity from the moment of their births. Lives that  
17 were hoped for and cherished, every moment filled with  
18 hope and potential.

19 The babies had conquered considerable adversity when  
20 they were attacked or murdered, and this sense of hope  
21 interrupted is profoundly poignant. This is  
22 encapsulated perfectly in the words of Father G:

23 "For me, what happened has damaged my faith as every  
24 day I would sit there and pray. I would pray for God to  
25 save her. He did. He saved her. But the devil found

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1 babies were harmed or murdered by Letby. As we said in  
2 that opening statement, the traumatic nature of the  
3 events was laid bare in the statements that the parents  
4 provided for the criminal proceedings. This impression  
5 is magnified by the statements that they had provided  
6 for your Inquiry. They bring home the horror of these  
7 events.

8 As we said in our written opening, the babies, their  
9 parents and Families have been and will remain in the  
10 Trust's thoughts throughout. The Trust has the utmost  
11 sympathy for their suffering.

12 We agree with Mr Skelton, King's Counsel, when he  
13 echoes the words of the Secretary of State when  
14 commissioning this Inquiry, that "losing a child is the  
15 greatest sorrow any parent can experience".

16 But we would add this: those who have not  
17 experienced that loss will never truly understand the  
18 magnitude of their loss, nor will they truly understand  
19 the impact of hopes for the future being destroyed.

20 My Lady, the Trust is committed to being open,  
21 honest and transparent in its contribution to this  
22 Inquiry. It does not and will not seek to shirk or  
23 avoid its responsibilities for the events you are about  
24 to inquire into.

25 In our written opening we identified failings on

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1 her."

2 My Lady, that's all I have to say.

3 **LADY JUSTICE THIRLWALL:** Thank you very much indeed,  
4 Mr Baker.

5 If I can thank you and Mr Skelton for the  
6 considerable efforts that you have made on behalf of the  
7 parents, which is no more than they deserve,  
8 I appreciate, but the Inquiry is grateful for the fact  
9 that we have so many witness statements from them  
10 despite the rollercoaster of emotions that they must  
11 have been through in recent weeks and months, and of  
12 course in the years before that, so I am grateful to you  
13 both.

14 **MR BAKER:** Thank you, my Lady.

15 **LADY JUSTICE THIRLWALL:** We will rise now until 11.30.  
16 (11.15 am)

(A short break)

18 (11.30 am)

19 **LADY JUSTICE THIRLWALL:** Mr Kennedy?

Opening statement by MR KENNEDY

21 **MR KENNEDY:** My Lady, I make this opening statement on  
22 behalf of the Countess of Chester NHS Foundation Trust.

23 My Lady, at the time that we drafted our written  
24 opening note, we had not had sight of many of the  
25 statements provided to the Inquiry by parents whose

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1 behalf of the Trust. As the evidence unfolds, we will  
2 continue to review the Trust's position so that when we  
3 come to prepare closing submissions, we hope to be able  
4 to provide you and the Families with our considered and  
5 reasoned analysis of where things went wrong, how things  
6 should have been done better, what lessons the Trust has  
7 learned and still needs to learn.

8 That said, my Lady, you will understand, and I hope  
9 the Families will appreciate also, that we represent  
10 a range of different disciplines amongst the Trust  
11 employees and former employees, and navigating and  
12 reconciling their different perspectives and positions  
13 may be a challenging task and it may at times be  
14 an impossible task, but we will do the best that we are  
15 able to do.

16 My Lady, I don't propose to read out my written  
17 opening, nor to revisit the all the issues that we  
18 addressed. What I propose to do in this opening is just  
19 to touch on three or four key aspects of the Inquiry as  
20 revealed by either the opening statement of your  
21 counsel, or by the written openings of other  
22 Core Participants.

23 Those are: firstly communication; secondly, the  
24 chronology of what was known or suspected about Letby  
25 and when; thirdly, investigations; and finally, I will

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1 say a word or two, if I may, about changes.

2 My Lady, I can provide an electronic copy of my  
3 speaking note in due course.

4 **LADY JUSTICE THIRLWALL:** Thank you.

5 **MR KENNEDY:** My Lady, in terms of communication, the opening  
6 statements on the part of the Families and the opening  
7 statement on the part of your counsel identify multiple  
8 concerns so far as communication is concerned. They are  
9 amplified by what my learned friend Mr Baker,  
10 King's Counsel, has said to you just now.

11 We anticipated some of those points, and I would  
12 like, if I may, just to reiterate those points now, as  
13 we set out in our written opening.

14 The Trust accepts that from July 2016, there were  
15 significant communication failings, such that it failed  
16 in its duty of candour towards parents.

17 I identify six points.

18 First, in July 2016, when the neonatal unit was  
19 downgraded and the RCPCH review was commissioned, for  
20 some parents, there was no contact at all. For others,  
21 efforts to make contact were unsuccessful, whether  
22 because they were half-hearted or ill thought through.

23 Second, again as Mr Baker has told you, some parents  
24 learned about the downgrading of the unit or the RCPCH  
25 review through the news media.

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1 without reservation.

2 My Lady, the Family Groups have flagged three  
3 further communication issues, and if I may just address  
4 those briefly with my observations.

5 First, they have questioned the provision of  
6 information at around the time of the collapses. I have  
7 in mind particularly what my learned friend Mr Baker has  
8 said to you just before the break.

9 In our written opening we concluded, largely based  
10 on the statements the parents had made to the police,  
11 that communication at around the time of collapses  
12 and/or death was generally satisfactory.

13 Now that we have seen the statements from the  
14 Families, we will review that position. We have  
15 endeavoured, as part of the evidence outline exercise  
16 that you indicated, to flag to your counsel the  
17 additional evidence that may exist which may clarify or  
18 assist in understanding the issue that is raised. We  
19 will continue to do that as part of the evidence outline  
20 exercise.

21 Second --

22 **LADY JUSTICE THIRLWALL:** Sorry to interrupt you, Mr Kennedy.

23 Endeavour to flag the additional evidence which may  
24 exist?

25 **MR KENNEDY:** Endeavour to point to evidence which may

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1 Third, in many instances, the communication plan put  
2 in place was reactive rather than proactive; that is,  
3 the focus appeared to be on families and patients who  
4 were likely to make contact with the Countess, rather  
5 than on those who could reasonably be identified as  
6 being intimately affected by the issues that had  
7 resulted in the downgrade.

8 Fourth, between July 2016 and the announcement of  
9 the downgrade and the College review and February 2017,  
10 there does not appear to have been any formal  
11 communication strategy at all, with the effect that  
12 there was no or no meaningful communication provided to  
13 the Families.

14 When there was communication in February 2016 it was  
15 frankly haphazard and for a parent to have the College  
16 report delivered by taxi out of the blue was  
17 inexcusable.

18 Finally, when information was provided, it was  
19 provided in an inaccessible form and I have in mind  
20 Dr Howden's review, which was comprehensible only by the  
21 informed reader or doctor, but certainly not by the  
22 layperson and which omitted to include, vitally, her  
23 conclusions in relation to the particular child that she  
24 was addressing.

25 My Lady, for those failings the Trust apologises

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1 assist.

2 **LADY JUSTICE THIRLWALL:** Assist. I'm so sorry, I misheard  
3 you.

4 **MR KENNEDY:** Assist in clarifying the position.

5 I have in mind that in the core bundle, there are,  
6 is a more limited set of medical records and there is  
7 a greater bundle albeit not a complete bundle, available  
8 on relativity and we are doing an exercise of  
9 cross-checking both to try and assist.

10 **LADY JUSTICE THIRLWALL:** Thank you.

11 **MR KENNEDY:** Thank you.

12 Second, both my learned friend Mr Skelton and  
13 Mr Baker have raised the question of what could the  
14 Trust and what should the Trust have said about  
15 suspicions about Letby both before and after July 2016?  
16 As we observed in our written opening, this is a complex  
17 issue. It involves balancing of competing interests.  
18 In our written opening we identified the following  
19 issues that the Inquiry may wish to consider.

20 First, the need to be open and transparent to  
21 further patient choice and autonomy and promote patient  
22 safety.

23 Second, the risks of inaccuracy in communication, or  
24 unhelpful vagueness, if disclosure is made at an early  
25 stage.

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1 Third, a loss of confidence in service provision if  
2 concerns turn out to be misplaced.

3 And fourth, the impact that such communication may  
4 have on the potentially innocent individual concerned,  
5 both from a wellbeing and employment perspective.

6 We don't have an easy answer to that, and it may be  
7 that is something we can return to when we provide our  
8 closing submissions.

9 The third point that has arisen through the  
10 Families, particularly the Families' opening statements,  
11 is the lack of information provided by the Trust once  
12 the police investigation commenced in May 2017. We  
13 recognise that from material disclosed by the Inquiry  
14 that similar concerns were expressed through the Family  
15 Liaison Officer in the course of the criminal  
16 proceedings.

17 Now that this issue has been identified, we will  
18 endeavour to clarify what instructions, if any, the  
19 Trust was given about communication or not communicating  
20 with the Families.

21 We would observe at this stage, subject to that  
22 further clarification, that it would seem likely that  
23 there would have been some restrictions imposed by the  
24 police on the Trust about providing information to the  
25 Families concerning Letby. But again, we will revisit

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1 in December.

2 In February 2016, the thematic review of neonatal  
3 mortality attended by Dr Brearey and Dr Subhedar had  
4 identified a higher than expected mortality rate on the  
5 neonatal unit for 2015.

6 The results of that review, and the follow-up  
7 exercise, were communicated to members of the Senior  
8 Management Team on 21 March 2016. Therefore, by  
9 21 March 2016, the information available to those in  
10 senior clinical, managerial and Executive posts was such  
11 that we recognise that there were legitimate questions  
12 concerning the Trust's response to concerns about  
13 mortality. More importantly, there was a clear  
14 opportunity to act.

15 Whether actions should have been taken before  
16 March 2016 will clearly need to be explored in oral  
17 evidence. Without hearing obviously the evidence, we  
18 suggest at this stage that up to that point the  
19 reasonable focus was on identifying a clinical  
20 explanation for events. It is, we submit, important to  
21 keep in mind the realities of medical practice in a busy  
22 acute hospital.

23 Whilst periods of elevated morbidity and mortality  
24 will occur from time to time, instances of deliberate  
25 harm by healthcare staff are exceedingly rare. When

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1 that if we may, in the course of your Inquiry.

2 My second point was that the suspicions and concerns  
3 about Letby, as is apparent from the title to Chapter 1  
4 of your counsels' submissions, that is the core theme  
5 for this Inquiry. We have suggested that March 2016 is  
6 an important date and a point after which there was an  
7 opportunity to act.

8 My Lady, I don't propose to revisit the detailed  
9 chronological review that my learned friends undertook  
10 on Tuesday and Wednesday; nor indeed the features that  
11 I set out in our opening. We would just point out the  
12 following points as being relevant to a consideration of  
13 the position by March 2016.

14 Firstly, there had been what is referred to as an  
15 Executive Serious Incident Panel on the 2 July 2015.  
16 That considered the deaths of Babies A, C and D. This  
17 had been attended by Dr Brearey, Ms Powell, Ms Millford,  
18 Ms Peacock and Alison Kelly. There would be a further  
19 Serious Incident Panel for Baby E in August.

20 By October 2015, Ms Powell's review of the mortality  
21 in the neonatal unit had identified Letby as being  
22 present at the events reviewed.

23 In November 2015, Dr Brigham's review had notified  
24 "a perceived increase in the number of stillbirths and  
25 neonatal deaths", and that review was discussed at QSPEC

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1 a period of elevated mortality is observed, the cause is  
2 therefore likely to be a product of random variations in  
3 outcome due to medical factors, particularly where  
4 numbers are small. Insofar as the cause is related to  
5 a member of staff, it is far, far more likely to be  
6 a competency issue than be due to criminality.

7 The criticism is made that there was an  
8 unwillingness to think the unthinkable. My Lady, that  
9 may well be a valid criticism but it is one that we  
10 suggest that carries greater force the later in the  
11 chronology one proceeds.

12 Earlier in the chronology -- and I bear in mind  
13 everything that my learned friend Mr Skelton in  
14 particular has said about Allitt and others, but earlier  
15 in the chronology, you may feel that it was  
16 understandable to be reluctant or to fail to think the  
17 unthinkable.

18 My Lady, we identified in our written submissions  
19 the themes that we believe the Inquiry should explore  
20 concerning the adequacy of the Trust's subsequent  
21 response. I don't propose to repeat them. They've been  
22 set out in similar terms, and amplified by your counsel  
23 in her opening on Tuesday.

24 A word, if I may, about investigations, reporting  
25 and debriefs.

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1 My Lady, a common theme from the written opening  
2 statements are questions about the quality of the local  
3 investigations, and whether there was a failure properly  
4 to utilise the reporting structures within the Trust.  
5 This too, clearly, will be an important issue for the  
6 Inquiry to address.

7 I want, if I may, just to address three points.

8 First, the use of Datix and internal investigation;  
9 second, the failure to use accepted or normal reporting  
10 mechanisms; and thirdly, as I indicated, the question of  
11 debriefs.

12 Your counsel in her review on Tuesday, for  
13 understandable reasons, took you through a chronological  
14 review of deaths and responses to deaths. It may be  
15 helpful just briefly to look at matters from the  
16 perspective of the actions that were taken, to try to  
17 perhaps bring together the points that she was making.

18 I just identify these points. Firstly, the deaths  
19 of Babies A, C, D, E, I, O and P, so that is all of the  
20 deaths on the indictment, were all reported under the  
21 Trust's Datix system.

22 Second, for all of those babies, save for Baby I,  
23 there was a Serious Incident Panel meeting, or as it's  
24 sometimes termed, an Executive Serious Incident Panel  
25 meeting. That was attended by a clinician or

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1 "All infants who suffer a sudden and unexpected  
2 cardio-respiratory collapse within the first week of  
3 life should undergo comprehensive investigation to  
4 determine the underlying cause."

5 My Lady, we understand from the evidence of  
6 Dr Brearey that that guidance may not be applicable in  
7 the non-fatal cases or some of the non-fatal collapses  
8 that you are considering. That is because that guidance  
9 is directed at term, or near term, babies. I think in  
10 2011 the guidance was babies born at or after 37 weeks.  
11 But significantly who were deemed well enough to have  
12 routine postnatal care. The updated guidance which was  
13 published in 2022 is available on Relativity.

14 It differs, at least to this extent, to the 2011  
15 guidance, in that the threshold for a term of near term  
16 baby is lower, so that it captures babies born at or  
17 after 35 weeks' gestation.

18 That said, so acknowledging the points made by my  
19 learned friend Mr Skelton and the point made by  
20 Dr Brearey perhaps in response, we acknowledge that it  
21 will be an important question for your Inquiry as to  
22 whether non-fatal collapses should have been reported on  
23 Datix, and if the Trust did not uniformly do that,  
24 whether it was an outlier.

25 We just make these three short points at this stage.

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1 clinicians, by members of the Risk and Patient Safety  
2 Team, and by one or both of Alison Kelly and Ian Harvey.

3 Third, the deaths of Babies A, E, D and I were  
4 reported to the Neonatal Incident Review Group. The  
5 deaths of Babies O and P were recorded as National  
6 Patient Safety Alert Incidents Level 2.

7 The deaths of all babies on the indictment who died  
8 at the Countess of Chester were reported to the coroner.  
9 Your core bundle contains the relevant form for each of  
10 those babies.

11 Finally, in terms of actions at the hospital, the  
12 deaths of Babies D, O and P were recorded on  
13 NHS England's Strategic Executive Information System.

14 Briefly as to what happened locally, so outside the  
15 hospital, in terms of wider investigation the available  
16 witness evidence indicates that each of the deaths was  
17 notified, whether under the CDOP procedure in England,  
18 or the CDRP process in Wales.

19 In contrast, we accept that the available evidence  
20 suggests that non-fatal collapses were not or not  
21 consistently reported on Datix.

22 The opening note for Family Group 1 refers to  
23 a section of the RCPCH report which cites guidance from  
24 the British Association of Perinatal Medicine to the  
25 effect that:

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1 First the Inquiry will need to consider whether the  
2 Datix reporting system is or should be outcome driven.  
3 Is it intended to capture failings in care regardless of  
4 the harm which results, or should it constitute a record  
5 of patient deteriorations?

6 Second, the Inquiry will need to bear in mind that  
7 premature babies who require care on a neonatal unit,  
8 such as at the Countess, are likely to experience  
9 deteriorations or episodes of instability. Some of  
10 those episodes will be more serious than others. There  
11 may be a difficulty, we suggest, and the Inquiry may  
12 wish to consider, in articulating the threshold for  
13 a "reportable" deterioration.

14 And third, how those two factors should be balanced  
15 so that significant patient safety incidents are not  
16 lost in the reporting or potential reporting of common  
17 or more routine occurrences.

18 My Lady, if I may, a word about the root of  
19 reporting.

20 Your counsel and others have questioned an apparent  
21 failure to follow normal reporting structures and  
22 provides devised by the Trust and set out in its  
23 policies. We make three brief points that we would  
24 invite you to bear in mind.

25 First, you may want to consider whether the nature

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1 of the concerns being reported, or being raised, were  
2 such that they did not fit neatly into the reporting  
3 processes or structures in place.

4 Second, even if it is correct that an inappropriate  
5 reporting process was followed, so sending an email  
6 rather than reporting through a recognised structure,  
7 even if an inappropriate process was followed, that  
8 could not and should not detract from or diminish the  
9 seriousness of the issue that was being raised, ie, the  
10 substance of the concern is more important than the  
11 mechanism of its delivery.

12 Third, you may wish to consider that given the  
13 nature of the concerns being raised, can it be said that  
14 an email to an individual or individuals at the top of  
15 the reporting structure is inappropriate?

16 My Lady, a word or two, if I may, about debriefs.  
17 My learned friends for Family Group 1 have flagged up  
18 the use or non-use of debriefs. We agree that that is  
19 an issue that the Inquiry will wish to investigate. The  
20 evidence in your core bundle shows that there was what  
21 is sometimes referred to as a "hot debrief", following  
22 the death of Baby C and the death of Baby I. And there  
23 is evidence, as your counsel indicated on Tuesday, of  
24 attempts to organise a debrief following the death of  
25 Baby D.

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1 support for those involved. And, my Lady, you'll recall  
2 what my learned friend Ms Langdale said on Tuesday about  
3 the effects on those who were providing care during  
4 these events.

5 So debrief, we would suggest, is intended to be  
6 a source of peer-to-peer support, to improve staff  
7 wellbeing and learn lessons after traumatic events.  
8 It's unlikely to be appropriate mechanism for  
9 establishing that an individual's acts or omissions  
10 caused the event.

11 My Lady, a word, if I may, again arising from what  
12 has been said in the written openings of others, about  
13 hindsight. I touched on it in my written opening.  
14 I don't propose to reiterate what I've said there.

15 The point is just this: in the evidence that we have  
16 seen, at times a contrast is drawn between the  
17 information provided by clinicians about the causes of  
18 death or collapse and the information that the Families  
19 learned from the criminal trial.

20 It is sometimes said that it was only following the  
21 criminal investigations that Families have had answers  
22 about what happened to their children. Mr Baker  
23 particularly has mentioned that before the break.

24 We recognise how distressing it must be to discover  
25 this so many years later. But we say we would suggest

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1 Again, as this issue has arisen as perhaps an  
2 important one, we will endeavour to do some more work  
3 behind the scenes and see if we can assist you further  
4 as to whether there is any additional information about  
5 debriefs, and whether, for instance, the plan for  
6 a debrief for Baby D was successful. And if we may,  
7 my Lady, we'll liaise with your counsel in that regard.

8 **LADY JUSTICE THIRLWALL:** Thank you.

9 **MR KENNEDY:** But may I just say this at this stage: we  
10 understand why it might be felt that a debrief can serve  
11 as an adjunct to an investigation into the cause of  
12 death or it may serve to prevent future deaths. We  
13 particularly understand that point being made when it is  
14 felt that the investigation that was in fact carried out  
15 was deficient.

16 However, it is important to understand and bear in  
17 mind the purpose or objective of a debrief. It was set  
18 out in the Royal College report at paragraph 4.3.5 in  
19 the following terms:

20 "Following an incident, there is a team debrief  
21 organised almost immediately to reflect on the situation  
22 and provide support and learning."

23 There is other guidance available that indicates  
24 that there is a need for acknowledgment of traumatic  
25 events, and the provision of practical and emotional

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1 it must be borne in mind that the criminal justice  
2 process brought to bear a different magnitude of  
3 investigation and analysis. Whilst you will obviously  
4 wish to inquire into the adequacy of the information  
5 provided by the clinicians at the Countess of Chester at  
6 the time of collapses or death, we suggest that they  
7 should not be faulted simply because they did not  
8 provide the answers that were subsequently provided  
9 through the criminal justice process, with, as I say,  
10 its much greater focus on the investigation of causes of  
11 death.

12 My Lady, can I then turn as my last point just to  
13 say a word or two about changes.

14 We appreciate, because it was an issue you asked us  
15 to address, and it is obviously an issue that is at the  
16 forefront of the Inquiry's mind, it will also be an  
17 important issue for the Families and perhaps for the  
18 wider public.

19 We address this in our written opening and so, if  
20 I may, I just highlight one or two points, again, trying  
21 to pick up, if I may, what has been said in opening  
22 statements by others.

23 Firstly, there have been changes in the divisional  
24 structure within the Countess of Chester to bring  
25 paediatrics -- and that includes neonatology -- and

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1 obstetrics into a single division. As your counsel  
2 explained in, in 2015 and 2016, obstetrics was within  
3 a Planned Care Division, and paediatrics and neonatology  
4 within an Urgent Care Division.

5 A new Women and Children's Division is now led by  
6 a tripartite management team who are members of the  
7 Operational Management Board that provides assurance on  
8 effective management to the Trust board.

9 Second, the Trust has opened a neonatal unit which  
10 is larger and more modern where it is possible to  
11 facilitate family integrated care. You may hear more  
12 about that in the course of this Inquiry.

13 Third, a new Women and Children's Unit is under  
14 construction.

15 Fourth, there have been changes in what I will refer  
16 to as service oversight. The Clinical Lead for Neonatal  
17 Risk has dedicated time to oversee risk management, and  
18 a Perinatal Assurance and Improvement Board oversees  
19 perinatal services generally. There are Executive and  
20 Non-Executive Safety Champions for the neonatal unit and  
21 maternity services and the Executive Champion is the  
22 Deputy Chief Executive.

23 Fifth, the current board has implemented a programme  
24 of governance changes from ward level to board level.

25 And finally, the Trust has endeavoured to strengthen

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1 child's life is sacred and protecting babies and  
2 children from harm is fundamental. To have a baby's  
3 life intentionally harmed or taken away is devastating.  
4 It grossly undermines basic human morals and should  
5 never, ever be allowed to happen. Our thoughts are with  
6 the Families of those involved in this Inquiry who are  
7 rightly front and centre of the Inquiry's investigatory  
8 process.

9 As your Ladyship will know, the NMC is the  
10 regulatory body for individual nursing and midwifery  
11 professionals in the UK. Our overarching objective is  
12 the protection of the public. Our principal functions  
13 are to establish high professional standards of  
14 education, training, conduct and performance for nurses,  
15 midwives and nursing associates and to ensure the  
16 maintenance of those standards.

17 The NMC maintains a register of over 826,000 nursing  
18 and midwifery professionals eligible to practice. The  
19 NMC investigates fitness to practise concerns about  
20 individual nurses, midwives and nursing associates.

21 We welcome the Inquiry and its wide Terms of  
22 Reference and we will do all we can to cooperate and  
23 assist your Ladyships and Counsel to the Inquiry in its  
24 important work.

25 We agree with your Ladyship's opening message last

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1 its Speak Up initiatives, and has replaced previous  
2 initiatives with the Freedom to Speak Up Initiative.

3 My Lady, can I end my opening in this way: the Trust  
4 welcomes your Inquiry. Its work is vitally important in  
5 providing answers to the parents of babies harmed or  
6 murdered by Letby. The Trust remains committed to  
7 assist in any way it can, and it recognises that the  
8 Inquiry will identify failings on its part and  
9 potentially on the part of others. That is a vital  
10 exercise, so that it, and the wider NHS, may learn from  
11 those failings.

12 My Lady, that is the opening statement on behalf of  
13 the Trust.

14 **LADY JUSTICE THIRLWALL:** Thank you very much indeed,  
15 Mr Kennedy.

16 Opening statement by MS JONES

17 **MS JONES:** My Lady, I, with Victoria Butler-Cole, King's  
18 Counsel, represent the Nursing and Midwifery Council  
19 instructed by the NMC's in-house legal team. May  
20 I first take this opportunity to express on behalf of  
21 everyone at the NMC our sincere and heartfelt  
22 condolences to the Families and loved ones of the babies  
23 who were harmed or killed by Lucy Letby.

24 We know that having a baby is one of, if not the  
25 most, important moment in any parents' life. Every

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1 year that babies in neonatal units absolutely must be  
2 kept safe and well and that any barriers that hinder  
3 that proposition must be identified and eradicated so  
4 that the unacceptable and heinous acts committed by  
5 Lucy Letby can never be repeated.

6 On the request of the Inquiry team we have already  
7 provided four witness statements, three from  
8 Andrea Sutcliffe, former Chief Executive and Registrar  
9 of the NMC, and one from Helen Herniman, Acting Chief  
10 Executive and Registrar of the NMC who was present on  
11 the first day of the Inquiry and who sits with me today.  
12 Tony Newman, Regulation Adviser for the NMC's Employer  
13 Link Service has also provided a statement to you and we  
14 will support him in giving evidence. We have also  
15 provided a significant number of documents by way of  
16 disclosure.

17 In this opening statement, I will not seek to repeat  
18 what we have already said in our written submissions and  
19 I do hope that a copy of this opening note has now been  
20 provided to your Ladyship.

21 **LADY JUSTICE THIRLWALL:** It is in front of me.

22 **MS JONES:** Excellent. Instead I would like to focus our  
23 submissions on four key matters that have been raised by  
24 Counsel to the Inquiry and Core Participants in their  
25 written statements.

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1 Before I turn to those matters it is important for  
2 me to say that the NMC has reflected on the steps it  
3 could and should have taken at the time it became  
4 involved in 2016, and we have identified a number of  
5 areas of improvement. At the end of 2022 we established  
6 an internal working group to prepare for and learn the  
7 lessons arising from Lucy Letby's trial.

8 As we have outlined in our opening written statement  
9 and witness statements, the NMC has taken serious steps  
10 to review its processes, to learn lessons and to  
11 implement or begin to implement practical measures to  
12 ensure that it can play its part in the prevention of  
13 the deplorable acts committed by Lucy Letby but the NMC  
14 continues to reflect and learn lessons and we intend to  
15 listen closely to the evidence of the Inquiry and learn  
16 from any further evidence that the Inquiry uncovers.

17 We stand ready to engage with the Inquiry on  
18 implementing any recommendations that the Inquiry  
19 considers necessary to direct towards us.

20 We are also in a process of reflection. As your  
21 Ladyship will know, the NMC commissioned Nasir Azfal and  
22 Rise Associates to undertake a review into our  
23 organisational culture. That review was published on  
24 9 July this year. It made 36 recommendations to us.  
25 The commissioning of the review was unconnected to the

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1 We agree. We have accepted all of the  
2 recommendations and I will speak later about the steps  
3 we are taking to work towards their implementation.

4 Turning then to the four matters, if I may. First,  
5 I will seek to briefly explain our fitness to practise  
6 investigation process and update the Inquiry on the  
7 regulatory actions that the NMC has taken.

8 Having heard Counsel to the Inquiry's excellent  
9 opening submissions, we appreciate that it is  
10 a particular focus of this Inquiry to understand why the  
11 NMC did not impose any condition on Lucy Letby's  
12 practice or suspend her from practising until she was  
13 charged with murder, and why an NMC fitness to practise  
14 investigation was not commenced until 5 July 2018.

15 The Nursing and Midwifery Order 2001 grants the NMC  
16 powers to take action where a concern is raised about  
17 a nurse, a midwife, or nursing associate's fitness to  
18 practise and where action needs to be taken to protect  
19 the public and maintain public trust and confidence in  
20 the profession. We have powers of self-referral and  
21 disclosure but we can only investigate and reach  
22 a decision in a case if we have sufficient evidence of  
23 a concern to commence an investigation. We rely on the  
24 referrer to provide the information to us because the  
25 referrer is closest to the source of the risk and events

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1 Lucy Letby case, but the review has raised serious  
2 concerns over how we regulate.

3 We have already, but do so again, apologise  
4 wholeheartedly with the failings identified in that  
5 review. We are committed to learning the lessons  
6 identified, to improve the cultural behaviours that  
7 strike at the heart of our organisation, and to better  
8 our regulatory performance.

9 The review included number of recommendations  
10 relevant, we believe, to the Inquiry's Terms of  
11 Reference, particularly in respect of safeguarding and  
12 collaborative working with other agencies; recommending  
13 that complex and serious cases should be managed by  
14 a specialist team; recommending that there needs to be  
15 a clearly defined process for managing fitness to  
16 practise cases when a criminal case is under way; and  
17 that all staff should have an awareness of their  
18 safeguarding obligation.

19 The review also noted the lack of a clinical voice  
20 in decision making, and recommended that the NMC, and  
21 I quote:

22 "... must ensure that the right people are in the  
23 right place at the right time to enable the right  
24 decisions to be made, whether that's clinical,  
25 safeguarding, legal, or other specialist areas."

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1 happening on the ground.

2 The advice that the Employer Link Service or anyone  
3 responding to an enquiry about a fitness to practise  
4 concern is dependent on the quality of the information  
5 on which it is based.

6 Before taking action, the NMC expects employers to  
7 act first to deal with concerns unless the risk to  
8 patients or the public is so serious that the NMC must  
9 step in to make immediate action.

10 Once a referral has been made to the NMC, the NMC  
11 can place a case on hold if the registrant is subject to  
12 an investigation by a third party, for example the  
13 police, where there are clear and compelling reasons to  
14 do so, and if it is in the public interest.

15 Where criminal proceedings are likely, it is common  
16 practice for the police to ask the NMC to put on hold  
17 the fitness to practise investigation until the  
18 conclusion of the criminal trial. This is because there  
19 is often a real and significant risk that our  
20 investigation will prejudice the other investigation and  
21 it is impractical to run the investigations  
22 concurrently.

23 It is also often the case that the outcome of  
24 a police investigation will be relevant to our own  
25 decision on whether to take regulatory action.

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1 As you heard from your counsel, my Lady, throughout  
2 a fitness to practise investigation, the NMC does have  
3 the power to seek and impose an Interim Order,  
4 temporarily suspending practice or restricting the  
5 practice of the registrant. An Interim Order will be  
6 imposed where there is sufficient evidence of a case  
7 against a registrant and if it is necessary to protect  
8 the public or if it is otherwise in the public interest  
9 or the registrant's own interest. The registrant has  
10 the right to appeal that Interim Order.

11 Turning to the Lucy Letby investigation. The  
12 information we received from Alison Kelly in 2016 was  
13 that there was not sufficient evidence to initiate  
14 a referral. On 6 July 2016, when Alison Kelly first  
15 told the NMC's Employer Link Service of the concerns  
16 regarding a rise in neonatal mortality rates and  
17 concerns that Lucy Letby may present a serious risk to  
18 public safety, we were told that there was no evidence  
19 available at that time to support those concerns. As  
20 the Link Service advisor recalls in his witness  
21 statement, "the whole tenor of the call was that there  
22 was no specific evidence".

23 Alison Kelly stated that the Countess of Chester  
24 Executive Team was to meet on 6 July that day to decide  
25 whether to report Letby to the police. We were not

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1 identified from a "thorough internal review", and  
2 although Lucy Letby had been placed on non-clinical  
3 duties there had been "no indication to discuss the  
4 matter with the police" and the medical director had  
5 commissioned an external review. No referral was made  
6 at that time.

7 Similarly, on 29 November 2016, at a meeting between  
8 Alison Kelly and others and our Employer Link Service  
9 advisor, Alison Kelly explained that "initial feedback"  
10 from the review by the Royal College of Paediatrics and  
11 Child Health was that there was "no immediate risk to  
12 patient safety which had been identified and therefore  
13 no referral will be made" and "no grounds for referral  
14 for the individual involved, ie, Letby". We were not  
15 sent the RCPCH reports.

16 We do appreciate Counsel to the Inquiry's concern  
17 that we did not initiate an investigation at this point,  
18 and it is worth stating that had we commenced a fitness  
19 to practise investigation, our legislative powers limit  
20 the scope of our investigation to narrowly focus on the  
21 professionals on our register. And we would welcome the  
22 Inquiry's careful scrutiny of who in this type of  
23 situation is best placed to investigate an unexplained  
24 increase in mortality rates and who would have had the  
25 Investigatory Powers Act jurisdiction to do so.

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1 informed that discussions surrounding reporting Letby to  
2 the police had already taken place on 29 June. We were  
3 not provided with crucial documentation we now know the  
4 hospital possessed, such as the table prepared by  
5 Eirian Powell dated 19 January that year or the schedule  
6 preparing on 15 February. We were not told of the  
7 meetings that had been taking place between senior  
8 management, which Counsel to the Inquiry outlined in her  
9 opening statement.

10 As a result, our Employer Link Service advisor  
11 advised Alison Kelly that we needed to know both the  
12 Trust board's decision, whether to report to the police,  
13 and any subsequent action taken by the police.

14 **LADY JUSTICE THIRLWALL:** Yes, I'm just wondering, Ms Jones,  
15 if a call is received with the information that a nurse  
16 may present a serious risk to public safety, is there no  
17 sort of natural curiosity as to, you know, "Well, why  
18 are you saying that? Why are you phoning?"

19 **MS JONES:** And I will come on to that actually later on in  
20 my opening note, my Lady.

21 **LADY JUSTICE THIRLWALL:** Very well.

22 **MS JONES:** To proceed with the chronology, if I may, on  
23 31 August 2016 when Alison Kelly replied to a request  
24 for an update from our Employer Link Service advisor,  
25 she explained that there was nothing significant

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1 On 18 May 2017, we received a Countess of Chester  
2 Hospital press release that Cheshire Police have  
3 announced its own investigation into the neonatal deaths  
4 at the hospital. Our Employer Link Service spoke to  
5 Alison Kelly to obtain further information.  
6 Alison Kelly advised that Letby had been placed on  
7 restricted duties, that the police investigation had  
8 just begun, and that Letby had, and I quote:  
9 "... not been arrested, charged, or suggested to be  
10 a suspect as yet. She is a witness and she as well as  
11 numerous other colleagues will be interviewed as  
12 witnesses by the police."

13 The Employer Link Service advised Alison Kelly to  
14 keep us regularly updated with any meaningful  
15 developments.

16 As your Ladyship knows, it was only on 5 July 2018  
17 when a fitness to practise referral was made to the NMC  
18 by Alison Kelly and that referral was made on the NMC's  
19 request after the NMC had learned through regular media  
20 monitoring of Lucy Letby's police arrest. The NMC  
21 opened a fitness to practise investigation that day.

22 My Lady, we fully accept that we should have been  
23 more proactive in this period. We should have asked for  
24 an update on what decision had been made within a few  
25 days of Alison Kelly making initial contact with us, and

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1 we should have found out whether the Countess of Chester  
2 Hospital were taking all the appropriate steps to  
3 protect patients and to ensure concerns were being fully  
4 investigated.

5 However, without a fitness to practise referral  
6 about Lucy Letby, the NMC did not have the power to  
7 apply for an Interim Order and restrict or suspend her  
8 from practice, but we absolutely accept, my Lady, that  
9 we could have provided and should have provided greater  
10 critical scrutiny and we could have done more to support  
11 Alison Kelly and the hospital to raise the concerns with  
12 the police sooner.

13 We now have a more robust process in place for the  
14 quality review of advice line calls through benchmarking  
15 and peer review and calls like the one that Alison Kelly  
16 made to the Employer Link Service are discussed at those  
17 meetings.

18 We are also continuing to reflect in our approach to  
19 clinical and safeguarding advice being sought at  
20 appropriate times during our regulatory process.

21 An improvement that we have made very recently,  
22 my Lady, that we hope will address the concern you just  
23 raised with me about why was there not the professional  
24 curiosity that should have been displayed at that time,  
25 is that we have now published guidance to address

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1 **MS JONES:** As I understand it -- but certainly our corporate  
2 witness can update you further when she comes to give  
3 evidence, my Lady -- is that this guidance is new for  
4 the organisation to particularly promote that culture of  
5 curiosity.

6 **LADY JUSTICE THIRLWALL:** Very well. Well, I'll look forward  
7 to hearing about that.

8 **MS JONES:** Thank you, my Lady.

9 Once the fitness to practise investigation in  
10 respect of Lucy Letby had been opened, we conducted an  
11 immediate Interim Order Risk Assessment, as you have  
12 heard from your Counsel. However, we decided not to  
13 apply for an Interim Order because at the time we  
14 considered that the fact of the arrest alone did not  
15 provide the evidence needed to apply for one.

16 As your Ladyship knows, the police had informed us  
17 that the rest was a step taken to gather evidence and  
18 interview under caution.

19 The police did not provide any further detail to us  
20 explaining the information they had to form the grounds  
21 to arrest Lucy Letby, and we were reassured that  
22 Lucy Letby was subject to bail conditions that we  
23 understood prevented her from working in any healthcare  
24 setting as we were told by the police on two occasions  
25 in 2018 and 2019, though we do appreciate that this did

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1 learnings that we have in fact identified from  
2 a different review, that we believe translate to this  
3 Inquiry as well. The learnings that we have identified  
4 are through engaging with families involved in the  
5 second Ockenden Maternity Review on the Nottingham  
6 University NHS Trust Maternity Services.

7 Our guidance is titled Our Culture of Curiosity, is  
8 available on our website, and it promotes and emphasises  
9 the need for a culture of curiosity in our fitness to  
10 practise investigations, and that is right at the start  
11 of that screening process when we first hear of concerns  
12 from places like the Countess of Chester Hospital.

13 We are rolling out this guidance across the  
14 organisation and our intention is that it will ensure  
15 that those receiving fitness to practise concerns will  
16 scrutinise more closely the information they are being  
17 told and the conclusions reached by others before we  
18 decide not to investigate.

19 We further hope that it encourages staff to consider  
20 if there are other reasonable and proportionate  
21 investigative steps that we should take to clarify what  
22 has happened.

23 **LADY JUSTICE THIRLWALL:** So should I infer from that that  
24 this is the first time that this sort of guidance has  
25 been given to people who take the calls?

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1 not accurately reflect the exact bail conditions imposed  
2 on Lucy Letby at the time, and we fully accept that we  
3 should have formally requested the bail sheet sooner.  
4 This is an area where we need to provide further  
5 training and guidance to colleagues.

6 Multiple Interim Order Risk Assessments were carried  
7 out at regular intervals while the substantive fitness  
8 to practise investigation was on hold awaiting outcome  
9 of the police investigation and once Lucy Letby was  
10 charged by the police, the NMC applied for and obtained  
11 on 20 November 2020 an Interim Order suspending her from  
12 practicing as a nurse. That order remained in force  
13 until she was struck off the register until  
14 12 December 2023 after having been found guilty of  
15 numerous counts of murder and attempted murder on  
16 18 August 2023.

17 My Lady, whilst the bail conditions were a factor in  
18 our decision not to apply for an Interim Order, the key  
19 reason for our decision not to apply prior to charges  
20 being laid against Lucy Letby was that we considered we  
21 had insufficient evidence to do so. At the time, our  
22 guidance on Interim Orders did not expressly refer to an  
23 evidential threshold that needed to be reached, but it  
24 was our view at the time, based on our interpretation of  
25 case laws, that sufficient evidence or prima facie

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1 evidence was required for an Interim Order application.  
 2 On 2 October 2019, our guidance was updated to state  
 3 as such, following challenges that had been made to  
 4 a number of interim orders in the High Court in Northern  
 5 Ireland.

6 My Lady, we have seriously reflected on the decision  
 7 not to apply for an Interim Order until Lucy Letby was  
 8 charged and we have determined that our guidance in  
 9 place at the time was not sufficiently clear to allow us  
 10 to act on an extraordinary case such as this one, in  
 11 which a serious police investigation was under way in  
 12 relation to potentially multiple incidences of murder.

13 We accept that it was not right for the NMC to wait  
 14 to apply for an Interim Order until Lucy Letby was  
 15 charged, and we consider that in this case, the fact of  
 16 the arrest could have been sufficient to justify  
 17 an Interim Order application given the serious nature of  
 18 the concerns and the absolute importance of maintaining  
 19 public safety, and also public confidence in the  
 20 profession and the NMC.

21 On 25 March of this year, my Lady, we amended our  
 22 Interim Order guidance to take account of this learning.  
 23 The guidance now makes clear that we do not always need  
 24 to wait until a person has been charged before applying  
 25 for an interim order, but the seriousness of the

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1 when our corporate witness attends to give evidence.  
 2 **LADY JUSTICE THIRLWALL:** Who is your corporate witness? Can  
 3 we have a --

4 **MS JONES:** I believe it's currently being decided with  
 5 Counsel to the Inquiry, we are in discussions. It will  
 6 either be Andrea Sutcliffe or Helen Herniman.

7 **LADY JUSTICE THIRLWALL:** Thank you.

8 **MS JONES:** Thank you.

9 With the exception of Alison Kelly, no other  
 10 referrals have been made to the NMC in respect of nurses  
 11 connected with the neonatal unit at the Countess of  
 12 Chester Hospital.

13 We appreciate that the Families raise concern that  
 14 there has not been disciplinary action of the senior  
 15 members of the Countess of Chester Hospital Management  
 16 Team. Alison Kelly is the only senior member of that  
 17 Management Team that is currently registered with the  
 18 NMC.

19 The other professionals named in Lucy Letby's trial  
 20 are no longer on the NMC's register. Although  
 21 Anthony Chambers was previously registered as a nurse,  
 22 he relinquished his registration on 30 April 2003,  
 23 Eirian Powell came off the register on 1 February 2013  
 24 and Karen Rees came off the register on 31 May 2020,  
 25 therefore we have no powers to take any action against

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1 concerns and the importance of maintaining public safety  
 2 and public confidence must be considered. We have moved  
 3 the emphasis of the guidance away from a prima facie  
 4 evidence test, we now guide decision-makers to focus  
 5 more on the cogency of evidence and to give more  
 6 flexibility to our decision-makers to act on the basis  
 7 of the known risk, where there is evidence that the risk  
 8 being seriously considered by other agencies such as the  
 9 police.

10 My Lady, there is still no clear case law though on  
 11 whether an Interim Order suspending someone who has not  
 12 been arrested or who has been arrested but not charged,  
 13 might be proportionate, and they, the interim orders,  
 14 are always subject to a review by the High Court.

15 While it is our view that the amended Interim Order  
 16 guidance should address the concerns that arise from  
 17 this matter, we would very much welcome the Inquiry's  
 18 view as to its appropriateness.

19 However, we have also heard from Counsel to the  
 20 Inquiry's opening that there is concern that a further  
 21 hurdle to applying for an Interim Order may have been  
 22 the fact of the lack of an investigation or evidence  
 23 gathering by the NMC to support an application.

24 The NMC will seriously reflect on this concern, and  
 25 seek to assist your Ladyship on whether it was a barrier

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1 any of these individuals currently. However, we do have  
 2 an alert system in place for all three individuals, so  
 3 if they were to return to our register, we are able to  
 4 consider any allegations at that stage.

5 In respect of the fitness to practise investigation  
 6 of Alison Kelly, the investigation is progressing as  
 7 expediently as possible but we fully appreciate that the  
 8 length of fitness to practise investigations can be  
 9 frustrating for all parties involved.

10 As your Ladyship knows, we received a referral from  
 11 the doctors of the hospital on 20 May 2020 in respect of  
 12 Alison Kelly, and on advice from the police, we were  
 13 asked to put our investigation on hold on  
 14 15 February 2021 to allow them to conduct investigations  
 15 and that stay continued until the conclusion of  
 16 Lucy Letby's trial on 18 August 2023, after which the  
 17 fitness to practise investigation was restarted.

18 The NMC did apply for an Interim Conditions  
 19 of Practice Order in respect of Ms Kelly, which was  
 20 considered by an NMC panel on 27 and 28 March this year,  
 21 but the panel decided to make no order.

22 The NMC continues to investigate the matter in line  
 23 with its normal processes and procedures, the  
 24 investigation has moved past the screening stage and it  
 25 is now at the investigation stage.

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1           However, the police have indicated to us that they  
2 would wish to interview certain key witnesses to our  
3 investigation ahead of us, which has impacted on the  
4 pace of our investigation, but we are continuing to work  
5 closely with the police, giving the police investigation  
6 primacy so as not to pre-judge their lines of inquiry.

7           Secondly, my Lady, I will address the advice and  
8 help that is available through the NMC for clinicians to  
9 raise concerns. The NMC provides general guidance  
10 through its website on raising concerns. It also  
11 operates a referrals helpline to help those who are  
12 considering raising a concern. The Employer Link  
13 Service offers advice to employers about whether to make  
14 a referral, and a telephone helpline and website offer  
15 advice to individuals about what steps to take in  
16 respect of concern.

17           It is right to state, as has been stated by the  
18 Countess of Chester Hospital in their opening written  
19 statement, that the scope of the NMC advice to those who  
20 hold suspicions of deliberate harm being caused to  
21 patients by a staff member is limited.

22           We are limited to explaining how a referral can be  
23 made and whether the NMC should intervene, but not on  
24 what the organisation should do to address the concerns  
25 locally. The NMC has to ensure that it can maintain its

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1           heard the opening statement of Counsel to the Inquiry,  
2 we would like to understand what, if any, barriers the  
3 consultants face in making a direct referral to us at  
4 the time, and whether there is anything further that the  
5 NMC can do to ensure that anyone who has a concern in  
6 the future feels able to contact us directly to initiate  
7 a referral.

8           Third, my Lady, I'd like to address some short  
9 matters regarding information-sharing with parents and  
10 the duty of candour.

11           We have heard and read of the Families' terrible  
12 experiences of information not being shared with them  
13 either at all or in a timely way.

14           We note that NHS England has stated in their opening  
15 written statement that between 2015 and 2017 the NMC  
16 could have played a role in how information was shared  
17 with parents in respect of regulatory referral made to  
18 the professional regulatory body and as part of  
19 revalidation. Respectfully, we disagree with that  
20 submission. The NMC only received referrals as your  
21 Ladyship knows from the hospital in respect of  
22 Lucy Letby in July 2018 and in respect of Alison Kelly  
23 in May 2020.

24           And it is only once a referral has been received by  
25 us that we can begin an investigation and engage with

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1           independence.

2           However, the NMC has learned from its actions in  
3 this matter that, as I've said earlier, we needed to be  
4 more proactive when employers raised concerns with us to  
5 find out what happened steps they are taking locally to  
6 address the issues. We should have proactively  
7 scrutinised the information provided to us by  
8 Alison Kelly and we could and should have contacted the  
9 General Medical Council and the Care Quality Commission  
10 to discuss the concerns.

11           Since Lucy Letby's conviction, we have introduced  
12 measures to ensure that these lessons are embedded in  
13 guidance, training and practice which are outlined in  
14 Ms Herniman's statement.

15           In listening to the Counsel to the Inquiry's  
16 opening, we have been struck by the repeated and  
17 numerous occasions when the consultants raised concerns  
18 about Lucy Letby with the Management Team of the  
19 hospital. The NMC was not contacted by any of those  
20 consultants. Though in saying that, we do not seek to  
21 criticise them in any way.

22           We have already identified that we should and could  
23 have advised Alison Kelly to ask the consultants who had  
24 raised concerns to contact the NMC directly so we could  
25 have discussed the concerns with them. But on having

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1           those parties affected by it thorough our fitness to  
2 practise process. Our discussions with Alison Kelly in  
3 2016 through the Employer Link Service would not have  
4 been prompted information-sharing with parents, because  
5 no referral was made, and the Trust had commissioned its  
6 own investigation.

7           However, if and when a fitness to practise  
8 investigation does contact those involved, we now have  
9 in place the public support service where we provide  
10 dedicated support to those who are involved in the  
11 fitness to practise process including families.

12           In respect of the duty of candour, we welcome the  
13 Department of Health and Social Care review into the  
14 effectiveness of the statutory duty of candour and on  
15 29 May this year, we responded to their call for  
16 evidence.

17           Fourth and finally, my Lady, if I may, I would like  
18 to return to the independent culture review. In  
19 response to the comments made by the DHSC in its opening  
20 written statement, I would like to explain the actions  
21 that the NMC has already taken in respect of the  
22 independent cultural review, which was only published  
23 some months ago.

24           We understand the importance of culture in relation  
25 to our role of protecting the public and promoting and

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1 maintaining the health, safety and wellbeing of the  
2 public. The NMC's Open Council will sit in less than  
3 two weeks on 24 September to review the 36  
4 recommendations of the review, and to approve the plan  
5 that will address the delivery of those recommendations.

6 This plan will be subject to further review and  
7 refinement as we receive feedback from stakeholders, and  
8 recommendations from this Inquiry. In addition, we have  
9 already taken a number of immediate actions to address  
10 the findings which I don't have time to repeat fully  
11 here but which are set out in Ms Herniman's statement  
12 and on our website, and some of those immediate actions  
13 consist of the following and I'll just highlight three.

14 First, we are actively working on a new behavioural  
15 framework for launch imminently.

16 Second, we are doubling the amount we spend on  
17 learning and development so that by October we should be  
18 able to start rolling out improvements in leadership,  
19 line management, safeguarding, casework and tackling  
20 some behaviours such as micro-aggressions.

21 Thirdly, we are addressing the pace and quality of  
22 our fitness to practise casework which remains  
23 a significant priority.

24 In conclusion, we are grateful for the opportunity  
25 to appear at this Inquiry and we stand ready to assist

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1 My Lady, you have a written note of my submissions,  
2 which I shall deviate from slightly, but not entirely.

3 **LADY JUSTICE THIRLWALL:** Thank you very much.

4 **MS SCOLDING:** I start these submissions by expressing the  
5 sincerest and deepest condolences to the parents and  
6 family who are here today or who are listening remotely.

7 As an organisation whose role and existence is  
8 dedicated towards the health and wellbeing of children,  
9 it is a source of profound shock and sadness that  
10 someone whose role was to protect and preserve life,  
11 then chose instead to take it.

12 We recognise that the death of a child is  
13 devastating, and we thank all parents for nevertheless  
14 having the courage to want to institute this Inquiry,  
15 and to seek answers and ensure that lessons are learned.

16 For our part, the Royal College stands ready to  
17 assist you, my Lady, in this task as much as we are  
18 able, to cooperate in the work and to implement your  
19 recommendations.

20 As you already know, from the powerful and eloquent  
21 opening of my learned friends on Tuesday and Wednesday,  
22 the College submitted an Invited Review Report in  
23 respect of the neonatal service at the Countess of  
24 Chester in final form in November 2016. This report did  
25 not directly assist in uncovering the causes of the

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1 your Ladyship and Counsel to the Inquiry.

2 That concludes our opening submissions unless I can  
3 be of any further assistance.

4 **LADY JUSTICE THIRLWALL:** Thank you very much indeed,  
5 Ms Jones.

6 **MS SCOLDING:** Good afternoon, my Lady. I note the time.  
7 I am not sure, my Lady, if you want me to start now, as  
8 it is 12.40, or whether you would rather I commenced  
9 after the lunch adjournment.

10 **LADY JUSTICE THIRLWALL:** Well, you choose. Either start now  
11 and go all the way through to 1.10 or --

12 **MS SCOLDING:** I'm happy to start now.

13 **LADY JUSTICE THIRLWALL:** Whichever you'd prefer.

14 **MS SCOLDING:** That's fine by me, my Lady, as long as  
15 everyone can cope with not being fed quite as quickly as  
16 they may be.

17 **LADY JUSTICE THIRLWALL:** I will give them an hour.

#### 18 Opening statement by MS SCOLDING

19 **MS SCOLDING:** I am grateful. I represent the Royal College  
20 of Paediatrics and Child Health. With me today are my  
21 instructing solicitor Mr Stuart Marchant, the Chief  
22 Executive of the Royal College, Mr Okunnu and  
23 Professor Steve Turner, the current President. I shall  
24 call the organisation either the "Royal College" or the  
25 "RCPCH" during the course of my submissions.

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1 children's injury and death, and in some ways, we  
2 recognise, contributed to both the uncertainty and delay  
3 which had continued after the concerns had been raised  
4 about the death of these children.

5 We are profoundly sorry for that.

6 We also apologise for our actions in relation to the  
7 paediatricians on the neonatal unit, all of whom are  
8 College members. Several decisions made at the time,  
9 the decisions to produce the Invited Review Report in  
10 two versions, and not to reference the concerns about  
11 Letby in the dissemination or public version of the  
12 report, dissemination being the term used at the time,  
13 compounded their anxieties and doubtless made their  
14 decisions about next steps more difficult.

15 Because the Royal College saw the report as being  
16 owned by the commissioning client, the Countess of  
17 Chester Medical Director, it did not directly share  
18 a copy of the report with the paediatricians who  
19 participated with the review, or with the parents about  
20 whose children the review concerned.

21 When the paediatricians approached the College to  
22 express their concerns about the issues about the  
23 Countess of Chester they were not given a full enough  
24 hearing. Again, we are profoundly sorry for those  
25 mistakes.

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1 My Lady, you have already heard that the Royal  
2 College of Paediatrics and Child Health is a registered  
3 charity and membership organisation whose aims are:  
4 To advance the teaching and practice of paediatric  
5 medicine; to improve the health of children; and to  
6 improve the standards of care towards them.  
7 It provides the relevant accreditation and training  
8 standards for paediatricians working in the  
9 United Kingdom, and also undertakes policy work,  
10 research and advocacy on behalf of its members, of which  
11 there are over 23,000.  
12 It also undertakes an amount of work internationally  
13 in respect of child health and paediatrics. It would  
14 not however, describe itself as the UK's specialist  
15 organisation for neonatology, that is the British  
16 Association for Perinatal Medicine whose membership  
17 consists both of neonatal paediatricians and other  
18 associated clinicians, but a number of our members are  
19 also members of that organisation.  
20 The Royal College today seeks to split its oral  
21 submissions into two areas. The first concerns the  
22 review of September 2016. We wish to be clear about  
23 what should or should not have happened before, during  
24 and after that visit and with the report that was then  
25 produced and we wish to be both open and reflective

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1 The Royal College, like a number of other Medical  
2 Royal Colleges, provides this service as a mechanism for  
3 peer review of the workings and functioning of  
4 paediatric care in various settings and to recommend  
5 various improvements and alterations. The review  
6 process usually involves, and did in this case,  
7 interviewing staff members, managers and other relevant  
8 individuals, examining various documents and reaching  
9 conclusions usually after a one or two-day visit.

10 In this case, the review team included two  
11 experienced paediatricians, one of whom was a leading  
12 neonatologist, the other a more general paediatrician.  
13 One was a specialist neonate nurse and there were two  
14 lay reviewers, both of whom had backgrounds in  
15 regulation and standards setting within the NHS and  
16 hospitals, and in particular in paediatric care.

17 Following the review, two other paediatricians  
18 quality assured the review by reading it and commenting  
19 upon it.

20 You will be hearing oral evidence from those  
21 reviewers in due course.

22 The College notes that in her opening statement,  
23 Counsel to the Inquiry set out that communication from  
24 the Countess of Chester to parents was poor, and that  
25 the Families were not told about the Invited Review

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1 about the mistakes that were made.

2 The second of our submissions concerns the College's  
3 role as the membership organisation for paediatricians  
4 and allied professionals. Our role is to try to help  
5 and communicate their expertise to the Inquiry, to  
6 assist it in making recommendations about improving both  
7 patient safety and parent care in neonatology but also  
8 in paediatric services more generally. We hope that you  
9 will find our submissions on what needs to change in the  
10 health service both constructive and useful.

11 We have filed detailed written submissions on both  
12 these subjects, my Lady, and also filed evidence about  
13 them so I don't intend to go word for word and given the  
14 approach of lunchtime it would be rash for me to do so.  
15 But I will highlight certain areas which I consider are  
16 of particular importance.

17 My Lady, you have heard from Counsel to the Inquiry  
18 who has expressed with clarity the essence of the issues  
19 which arise in respect of the review of 2016. I now  
20 turn to that.

21 The Royal College was asked by Ian Harvey, the then  
22 Medical Director of the Countess of Chester Hospital, to  
23 conduct an Invited Review in July 2016 into its neonatal  
24 service following concerns raised by paediatricians  
25 about the rise in neonatal mortality.

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1 process. We entirely share this conclusion. It is not  
2 Royal College's practice as part of an Invited Review to  
3 inform parents or indeed paediatricians within  
4 a healthcare organisation that we have been commissioned  
5 to undertake such. It is the responsibility of the  
6 commissioning healthcare organisation to make any  
7 communications to parents, families and employees.

8 The College however accepts that it did not follow  
9 up after the 2016 Invited Review to check that this  
10 report was shared with parents and others, and we  
11 apologise for this. The College's 2024 Invited Review  
12 practice requires much more rigorous follow-up and  
13 documentation of such.

14 The Invited Review made a number of criticisms of  
15 the Countess of Chester neonatal unit. It concluded  
16 that there was considerable understaffing both of  
17 doctors and nurses, there was insufficient consultant  
18 presence to safely cover the paediatric wards, and  
19 insufficient junior and training doctors available.

20 The review also found that the unit only partially  
21 adhered to a culture of safety, and that the governance  
22 was only partially adequate.

23 Obviously that review will be gone through in some  
24 detail when the reviewers come to find the report. In  
25 particular, there was no clear responsibility for

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1 following up lessons learned, which had been undertaken  
 2 by the Morbidity and Mortality Panel of the hospital.  
 3 There was no systematic reporting of all deaths to the  
 4 relevant systems and organisations and the internal  
 5 review of deaths which had taken place did not use  
 6 a recognised process, nor did it include examination of  
 7 all staff on the unit at that time.

8 The Invited Review made a number of recommendations  
 9 to improve the processes for investigations into  
 10 neonatal deaths more generally with the requirement for  
 11 all such deaths to be treated as a serious incident,  
 12 which would then lead to greater examination, and if  
 13 required, formal investigation, with a clear forum for  
 14 recommendations being actioned, including letting the  
 15 relevant Clinical Commissioning Group, as the body which  
 16 was responsible for organising and paying for the  
 17 patients' care at the time, know of all deaths.

18 The review also revealed that the Management Team of  
 19 the hospital had not realised how busy the neonatal unit  
 20 was and only identified this issue when it reviewed the  
 21 data. The Royal College again made various  
 22 recommendations about better data-gathering in this  
 23 respect.

24 The report also identified that not every case of  
 25 death or serious injury had involved either

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1 in this opening.

2 Firstly, the written evidence of the reviewers  
 3 before you, my Lady, is that the Senior Executive Team  
 4 of the hospital underplayed concerns about Letby before  
 5 and during the review. The reviewers in their evidence  
 6 describe there being disbelief displayed by the senior  
 7 team that intentional harm may be occurring.

8 Second, the reviewers were given information by  
 9 Dr Brearey and Dr Jayaram about their suspicion that the  
 10 deaths on the unit were intentional. The review was not  
 11 aborted after this information was provided. Knowing  
 12 this on the first morning of the review, the  
 13 Royal College considers that the review should have been  
 14 halted and the reviewers reporting back to the College  
 15 urgently.

16 Third, the review team interviewed Letby.

17 Fourth, in discussions between the review team and  
 18 the Medical Director of the hospital, he identified that  
 19 he had advice from colleagues within the Trust not to  
 20 involve the police until after the Royal College had  
 21 completed their review.

22 The Royal College has very carefully considered what  
 23 should have happened in the light of the subsequent  
 24 criminal investigation, and commissioned an independent  
 25 review of its Invited Review Service in 2019. This has

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1 a post-mortem or a thorough investigation and  
 2 examination, and in particular, that the post-mortem  
 3 process had not included systematic tests for  
 4 toxicology, blood electrolytes or blood sugar.

5 The Royal College was also concerned that the Child  
 6 Death Overview Panel had not been alerted to the cluster  
 7 of deaths at the hospital.

8 What the review team did not however conclude was  
 9 that there were any common factors that it could pursue  
 10 to explain the increase in that mortality but found that  
 11 as there had not been a systematic exploration of the  
 12 deaths, it made a recommendation of a detailed case  
 13 review by two separate specialist experts. The nature  
 14 of what the Royal College recommended was set out by  
 15 Ms Langdale in her opening statement on Tuesday and  
 16 I shall not repeat it here.

17 But the Royal College also recommend also, as was  
 18 the need to inquire -- I apologise, my Lady --

19 **LADY JUSTICE THIRLWALL:** That's all right.

20 **MS SCOLDING:** -- as to whether what was commissioned by the  
 21 hospital was then adequate. The Royal College's  
 22 submissions is that the Case Note Review recommendation  
 23 was not fully implemented by the Countess of Chester.

24 There are four particular factors with the conduct  
 25 of the review that the Royal College wishes to highlight

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1 led to changes which I will touch on briefly this  
 2 afternoon, in the way that the service is operated and  
 3 run.

4 I stress here that the views of the Royal College in  
 5 respect of what I'm about to say are not those of the  
 6 individual reviewers whose evidence you will hear, as  
 7 some of whom --

8 **LADY JUSTICE THIRLWALL:** Hear from many of them or some of  
 9 them?

10 **MS SCOLDING:** You are going to hear from all of them who are  
 11 able to come and give evidence. I think there is one  
 12 individual who is too unwell to do so.

13 **LADY JUSTICE THIRLWALL:** Very well.

14 **MS SCOLDING:** You will hear from some of whom have differing  
 15 perspectives about what should have happened before,  
 16 during and after the review.

17 The Royal College's view, however, is that all the  
 18 reviewers acted both in good faith and made reasonable  
 19 professional observations. They were, however, never in  
 20 a position to determine Letby's culpabilities, nor to  
 21 validate the allegations made by Dr Brearey and  
 22 Dr Jayaram. College reviews are not forensic tools.

23 Fundamentally, therefore, the review by its nature  
 24 and as recorded in its Terms of Reference, were never  
 25 intended to answer the questions of Letby's culpability.

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1 We are sure that we shall hear from the hospital as  
2 to why they commissioned the review and the rationale  
3 for it, but ultimately, it was a sidestep rather than  
4 a step forward.

5 The Royal College accepts that the review was flawed  
6 in the following ways.

7 Firstly, it was set up quickly without the usual  
8 expected due diligence. In particular, there was no  
9 meeting between the Medical Director and lead reviewer  
10 to discuss the issues, and the Terms of Reference were  
11 not discussed as they should have been.

12 That meeting may well have revealed that the review  
13 could not provide what the hospital wanted, as the  
14 review could not have determined if the deaths were  
15 suspicious, and the Invited Review Team obviously did  
16 not have the expertise, governance, methodology or  
17 skills to undertake such a quasi-criminal investigation.

18 The College now considers that if more probing  
19 questions had been asked in advance of the review, it  
20 would quickly have been realised that the information  
21 shared by the hospital to the Royal College was  
22 inadequate, and that the review could not have solved  
23 the problems with which the hospital faced, and  
24 ultimately, it is likely that the review would not have  
25 been commissioned.

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1 Three of the reviewers were not told of the concerns  
2 about Letby until the day of the review itself. That  
3 was not right. All the reviewers should have known  
4 about and discussed these issues in advance of the  
5 review.

6 Fourth, the review should have been aborted after  
7 the full review team heard the views of Dr Brearey and  
8 Dr Jayaram on the morning of 1 September 2016. They set  
9 out their view that there was some form of foul play, as  
10 is described in the contemporaneous notes taken by the  
11 reviewers at the time, and available to you, my Lady, on  
12 Relativity.

13 The review team discussed aborting the review but  
14 decided to carry on in order to examine the issues which  
15 could have given rise to unexpected or unexplained  
16 deaths. At the time, the guide for reviewers was not  
17 clear. It recommended that criminal issues should not  
18 be investigated in a review, but did not instruct  
19 reviewers to terminate such a review if criminal acts  
20 came to light.

21 The Royal College now sets out in its handbook that  
22 a review should not be carried out where criminality is  
23 suspected, as it is not the right body to carry out such  
24 a task.

25 The Royal College accepts that it did not provide

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1 Second, the Terms of Reference as agreed sought to  
2 do something which the reviewers could not have  
3 undertaken, which was to find a reason for the deaths.

4 The Terms of Reference and the way that they were  
5 drafted, the Royal College submits, led to  
6 a misunderstanding between the hospital and itself. The  
7 hospital thought that the review would be in effect an  
8 analysis of the deaths by way of a Case Note Review.  
9 That term was never mentioned by the Royal College,  
10 whose approach was to take a standard review as set out  
11 within its Invited Review guide to examine whether  
12 factors such as poor hygiene, understaffing, may have  
13 contributed to the deaths which occurred on the unit in  
14 2015 and 2016. A Case Note Review is a very different  
15 beast, and one which is very different from the review  
16 commissioned by the hospital.

17 Third, the head of the Invited Review service,  
18 Ms Eardley, and the lead clinical reviewer, Dr Milligan,  
19 were aware and had been told that there were concerns  
20 raised about Letby, but no significant detail was  
21 provided. Dr Milligan, in his written evidence to you,  
22 my Lady, does remember seeing a staff rota which  
23 identified that Letby was on duty during the shifts when  
24 the babies died, but did not consider this particularly  
25 significant at the time.

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1 adequate advice to the reviewers in respect of how to  
2 manage the situation which arose in September 2016  
3 during the course of a review in the training or advice  
4 that it provided, or in the guide that it supplied, and  
5 that there should have been an adequate escalation  
6 process to the Royal College's programme board of senior  
7 clinicians to provide advice if necessary.

8 The Royal College also considers that it was  
9 a mistake by the review team to interview Letby as part  
10 of the review. The rationale given by the reviewers is  
11 that Letby had not been suspended from duties; she had  
12 been moved from clinical duties on the neonatal unit  
13 which was considered to be highly unusual in the  
14 experience of the reviewers, without adequate Human  
15 Resources process being followed, and no investigation  
16 having been undertaken of the allegations raised.

17 Nursing staff had praised to the reviewers her care  
18 of the children, and she had been on shifts when the  
19 deaths had taken place. The review team considered it  
20 was important to hear from her about the culture of the  
21 ward, the staffing and the events that led to the  
22 deaths.

23 Letby had understood from colleagues at the Countess  
24 of Chester, and Counsel to the Inquiry identified those  
25 particular assurances that were given, that the review

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1 would decide if she could return to clinical duties on  
2 the neonatal ward.

3 The Royal College recognises that it did not provide  
4 adequate advice in the guidance it gave to reviewers  
5 about interviewing individuals in this situation. The  
6 reviewers proceeded in good faith but without  
7 recognising the significant risks of undertaking this  
8 review.

9 Immediately following the review, the team provided  
10 written and oral feedback to the Medical Director. The  
11 recommendation made was for a detailed forensic Casenote  
12 Review of each of the deaths since July 2015. There was  
13 also a recommendation made that steps should be taken to  
14 formalise the investigation in respect of Letby,  
15 including setting out what the allegations were, and the  
16 processes to be followed.

17 The review team recognised that there were  
18 passionate staff committed to providing high quality  
19 care to patients, that the paediatric team and nurses  
20 were highly regarded and that they were a strong team  
21 which was cohesive and supported each other.

22 The hospital's focus at the meeting where oral  
23 feedback was discussed was, from the handwritten notes  
24 of the reviewers made at the time on what the cause or  
25 causes could be of the unexpected deaths. As I have

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1 being managed reasonably and appropriately. How  
2 consistent that view is with the finding that the Royal  
3 College identified that not all deaths were explicable  
4 and required a detailed Casenote Review is a matter for  
5 you, my Lady, to consider and make decisions upon.

6 The final reports, one of which did not contain  
7 details about Letby and the other one which did, albeit  
8 without naming her, was sent to the Medical Director in  
9 November 2016. At that time, the Royal College did not  
10 disseminate the report any further, but it did set an  
11 expectation that it would be shared by stakeholders who  
12 had participated in the review, and those affected by  
13 it, even if it was not to be made public.

14 As far as the report, the written report, is  
15 concerned, the Royal College wishes to acknowledge the  
16 following.

17 Firstly, it should have recommended that the police  
18 were called, or a forensic investigation proceeded with,  
19 given the allegations made. It was a mistake not to do  
20 so. In particular, while quality assuring the report,  
21 the Programme Director for the Invited Reviews Team at  
22 the Royal College, a distinguished paediatrician,  
23 observed somewhat presciently in November 2016 when he  
24 was in the process of reading it that the situation  
25 reminded him of Grantham, where Beverley Allitt had

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1 already explained, that was not the purpose of the  
2 review.

3 The report did not address the allegations against  
4 Letby made by the paediatricians, and whilst there were  
5 informal discussions between the review team about the  
6 possibility of directly inflicted injury leading to the  
7 death of infants, this was not something that they  
8 further explore.

9 Some of the 2016 team and the evidence that they  
10 will give to you, my Lady, consider that with hindsight,  
11 there was a much clearer indication of the evidence and  
12 what conclusions should have been reached, but the focus  
13 of the review, as far as they were concerned, was on the  
14 other factors which could have led to the deaths.

15 It is the view of the College in 2024, shared to  
16 varying degrees by the 2016 reviewers, that the report  
17 was too light touch, given the issues it had raised  
18 about relevant child death procedures not having been  
19 followed through thoroughly.

20 It did not take seriously enough the prospect that  
21 criminal activity could have taken place, and the next  
22 steps that followed from that understanding.

23 The opening written submission of Mr Harvey,  
24 Mr Chambers and Ms Kelly characterised the report as  
25 providing a level of reassurance that the situation was

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1 murdered children, and where he had been involved in the  
2 aftermath of the arrest of Beverley Allitt, and queried  
3 why the police were not involved given the context of so  
4 many unexplained deaths.

5 The Royal College's expectation was that the full  
6 report, ie, the version which mentioned Letby, sent to  
7 the Medical Director, would be shared with consultants  
8 and senior nurses and others who had contributed to the  
9 review.

10 The Royal College did not know that the full version  
11 was not shared with clinicians and nurses until  
12 February 2017 when Dr Brearey and Dr Jayaram asked for  
13 the notes of the review team. The Royal College did not  
14 own the report once it had been submitted; it was for  
15 the Trust to do with as they wished because of the  
16 confidentiality terms governing invited reviews.

17 The Royal College accepts that it should have  
18 insisted that this full version was shared with staff  
19 and parents, and we understand why this may lead, as  
20 Mr Baker KC indicated this morning, to the College being  
21 seen as hiding key facts.

22 The College usually followed up on Invited Reviews  
23 more thoroughly than happened in this case. It knew  
24 that an independent Casenote Review was being  
25 commissioned by the Trust, and considered that the Trust

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1 had therefore undertaken the follow-up. It did not ask  
 2 to see the Casenote Review or to have it sent to the  
 3 relevant reviewers, nor did it undertake any further  
 4 follow-up. It should have done so, asking what steps  
 5 were being taken to allay suspicions and/or to ensure  
 6 that the clinicians saw the full unredacted version of  
 7 its November 2016 report. There should have been the  
 8 follow-up to ensure that relevant investigations had  
 9 taken place, and its recommendations had been  
 10 implemented. That now happens in all reviews undertaken  
 11 by the College.

12 The Royal College also accepts that it did not  
 13 inform regulators or other bodies about what they'd  
 14 found, even after the paediatricians contacted the  
 15 Royal College in January 2017, to ask for the notes of  
 16 their interview and to identify that they hadn't seen  
 17 the full report. They should have done so.

18 The College also accepts that whilst there was  
 19 limited discussion of the report at its Programme Review  
 20 Board immediately after the review had been undertaken,  
 21 there were no formal lessons learned, report or guidance  
 22 given to the future until 2020 when an external review  
 23 commissioned by the Royal College, which Counsel to the  
 24 Inquiry identified on Tuesday and Wednesday, identified  
 25 several changes that should be made. The

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1 has been in place since 2018 which could have been used  
 2 by the hospital to assess the deaths, as opposed to the  
 3 system undertaken at the time, which the Royal College  
 4 found to be *ad hoc* and not consistent.

5 There is also now realtime data provided by MBRRACE  
 6 which could again have assisted in identifying  
 7 concerning trends at the time that they were happening.

8 The work following NHS England's Neonatal Critical  
 9 Review of 2001 in respect of both Neonatal Networks and  
 10 individual Neonatal Ward units and the development of  
 11 a Patient Safety Alert System known as MOSS also may be  
 12 of some use to my Lady when examining whether there are  
 13 now greater safeguards in place to identify, as  
 14 Dr Bill Kirkup so memorably says, the signals from the  
 15 noise.

16 Part C, however, of your terms of reference, my Lady  
 17 involves the effectiveness of NHS management, governance  
 18 structures and processes in the external scrutiny and  
 19 regulation in keeping babies in hospital safe and  
 20 whether changes are necessary, including the role that  
 21 NHS culture may have played.

22 You raised specific questions in the Terms of  
 23 Reference about the effectiveness of current culture,  
 24 and its impact upon the safety of babies and what  
 25 changes to regulations should be made.

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1 contemporaneous discussion at the Invited Review  
 2 Programme Board in 2016 and 2017 was not as detailed as  
 3 it should have been about this review, given the  
 4 problems and issues which arose.

5 The Royal College has made significant changes since  
 6 2016 in the way that the review programme is run and  
 7 commissioned, as I've identified, a Lessons Learned  
 8 report. As a result of this, the Royal College has  
 9 changed its handbook to clarify the interviewing of  
 10 staff, provided an escalation process for reviewers who  
 11 come across difficult situations whilst reviewing,  
 12 adopted new guidance on when to cease a review in the  
 13 light of findings, provided more guidance and more  
 14 training to reviewers, ensured more due diligence before  
 15 a review and better briefing of the review team, has  
 16 established a Casenote Review service so that people can  
 17 come and have that provided to them, if that's what they  
 18 wish to do, and implemented greater accountability and  
 19 oversight of this review process.

20 Alongside this, my Lady, there have been some  
 21 changes in NHS practice which the Inquiry may wish to  
 22 consider as to whether, if they had been in place in  
 23 2016, the review of deaths and the pattern of  
 24 difficulties may have come to light earlier. For  
 25 example, there is now a perinatal mortality tool which

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1 The Royal College, in seeking to answer these  
 2 questions, has drawn upon the expertise of its members  
 3 to seek to assist you. In particular, to understand the  
 4 background to the delivery of paediatric and neonatal  
 5 services within the NHS, which may assist you to  
 6 understand the systemic and cultural issues which arise  
 7 in this case.

8 Last Friday, the Royal College published a Case For  
 9 Change in Children's Health Services in England. Its  
 10 findings are disappointing. It found that children are  
 11 waiting longer than adults to access healthcare,  
 12 paediatric services are not recovering at the same rate  
 13 as adult services post the pandemic, and there is  
 14 a growing gap between demand and capacity. This has  
 15 also coincided with an unprecedented increased demand  
 16 for Children's Health Services which is forecast to grow  
 17 further due to both preventable and non-preventable  
 18 increases in childhood illness.

19 The College's overall view is that children's  
 20 healthcare has not, over the past 15 years, been  
 21 a priority, either in respect of community, hospital, or  
 22 specialist care services, particularly in comparison to  
 23 adult health services. It has been too easy for  
 24 paediatric services, which are often only a small part  
 25 of the operation of most large, general, geographic area

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1 hospitals, to be sidelined or not given sufficient  
2 oversight.

3 This is particularly the case at board level where  
4 there is no requirement at present to have  
5 a representative on the board whose role is to look at  
6 children's healthcare.

7 There is also significant variation, my Lady, in the  
8 extent to which the integrated care systems and bodies  
9 consider the needs of children and young people in their  
10 strategies, priorities and funding decisions. There is,  
11 for example, no ring-fence funding for neonatal units at  
12 present.

13 In respect of structures, cultures and training, the  
14 Royal College has, in its written submissions and in its  
15 evidence to you, set these out in some detail, but  
16 highlights a number here.

17 Firstly, it considers that the culture of hospitals  
18 still militates against speaking up and raising  
19 concerns. A culture of safety, furthermore, relied upon  
20 organisational resourcing and prioritisation, which is  
21 not always present.

22 The safety culture in place in many paediatric  
23 services are, according to our members, reactive rather  
24 than proactive in nature. Most structures currently in  
25 place tend to deal with what happened has gone wrong,

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1 children waiting for outpatient care for over a year and  
2 over 400,000 children on the waiting list for consultant  
3 treatment.

4 There is also a significant shortage of  
5 professionals, such as psychologists and counsellors,  
6 available to support families in neonatal and paediatric  
7 units during what is often an exceptionally emotionally  
8 difficult period, whilst their children are in intensive  
9 or special care. And many units do not have such  
10 support staff in place. You heard from the parents'  
11 counsel, and you will have seen in the parents' witness  
12 statements, the limited support they often had after  
13 their children's death. That is all unacceptable but  
14 unfortunately far too common.

15 Community paediatricians, who are often the  
16 designated safeguarding doctors within hospitals or  
17 within local community services, to whom safeguarding  
18 referrals should be made and who are responsible for  
19 organising safeguarding training and escalating  
20 concerns, have had their numbers reduced by a third over  
21 the past 15 years.

22 More worryingly, the long-term workforce plan for  
23 the National Health Service published in June 2023 says  
24 little to nothing about the Children's Health Workforce.  
25 No additional places were promised for child nursing,

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1 rather than seeking to stop events happening in the  
2 first place. Royal College members report that while  
3 their managers are supportive of patient safety in the  
4 abstract, where the money, time or staff is then needed,  
5 those resources can often not be found.

6 In respect of the regulation of hospital managers,  
7 the Royal College supports their formal regulation but  
8 does not consider that it's best placed to assist you on  
9 how that regulation should work in practice.

10 Essential, however, to any good patient safety  
11 culture is to have sufficiently well trained staff who  
12 operate to the required standards and are provided with  
13 adequate support. Without these, patient safety  
14 suffers.

15 The 2023 General Medical Council Training Survey  
16 found that just over 50% of paediatric trainees consider  
17 their workload to be "heavy" or "very heavy".

18 10% of units had gaps in medical staffing in 2020,  
19 with 15% of units having gaps in nurse staffing.

20 The National Neonatal Audit Programme, run in part  
21 by the Royal College, observed in 2022 that the  
22 continuing decline in neonatal staff levels is of  
23 serious concern.

24 Paediatric waiting lists have doubled over the past  
25 two years so that there are now more than 50,000

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1 despite the shortages plainly identified by the  
2 profession.

3 Turning to some other matters, in respect of data,  
4 the Royal College considers that the exchange of data  
5 between maternity and neonatal settings is not  
6 sufficient, something which the Royal College considers  
7 needs to improve in order to improve patient outcomes  
8 more generally. The Royal College considers that there  
9 should be a national audit tool to report neonatal  
10 outcomes in maternity care to provide better data and  
11 create improvements in patient safety.

12 Turning to patient safety training materials, there  
13 are national patient safety materials, there are patient  
14 safety training materials run by, organised and promoted  
15 by the Royal College, and there is a National Patient  
16 Safety Syllabus. However, this does not always  
17 translate in a sufficient training for frontline staff,  
18 in particular given the staffing shortages I have  
19 outlined, as it makes it more difficult to free up staff  
20 for this sort of training.

21 There have been many recommendations, and there are  
22 many recommendations, made by different bodies to  
23 prevent future deaths.

24 Clinicians need to be given the time and space to  
25 digest and learn from all these different sources.

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1 Alongside the numerous bodies making recommendations,  
2 the Royal College's view is that the current system of  
3 regulation of NHS staff, and the different individuals  
4 within it, are Byzantine in its nature.

5 You may well be familiar, my Lady, with the  
6 implementation of what has become known as Martha's  
7 Rule, which gives the right of a patient to request  
8 a further review in the event of a suspected  
9 deterioration. We recognise and welcome this change,  
10 but consider that for it to be implemented adequately,  
11 there must be a full complement of staffing, and that in  
12 respect of children, the review must ensure that those  
13 with paediatric training are involved in the second  
14 opinion.

15 The Royal College has been asked by the Inquiry  
16 about CCTV observation of neonates. We do not have an  
17 official position on the use of CCTV, but their use  
18 within mental health settings has been the subject of  
19 research, and evidence to show that it offers  
20 significant benefits for patient safety and care quality  
21 is inconclusive in that setting.

22 If CCTV surveillance in a paediatric ward were to be  
23 introduced, it would need to be seen as a pressing  
24 requirement and to be supported by clear evidence of  
25 benefit, given that it would lead to significant

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1 **LADY JUSTICE THIRLWALL:** Yes. Thank you.

2 **MR COHEN:** And I don't propose to repeat the content of that  
3 in its entirety.

4 Before establishing this Inquiry, the then Secretary  
5 of State for Health and Social Services met with the  
6 victims' Families. In announcing the Inquiry, he  
7 explained that collectively, we have a duty to get those  
8 Families answers, to hold people to account, and to make  
9 sure lessons are learned.

10 You and the Inquiry Legal Team have rightly placed  
11 the Families at the heart of this process. The  
12 Department welcomes and endorses that approach.

13 My Lady, the events at the Countess of Chester  
14 Hospital pose profound questions for the healthcare  
15 system, how that system operated, and how the various  
16 oversight mechanisms and bodies failed to prevent and  
17 detect more quickly what had occurred.

18 The Department comes to the Inquiry in a spirit of  
19 candour, and welcomes your clear expectation that all  
20 others should do likewise.

21 In considering how the healthcare system operated,  
22 the Department acknowledges that the Inquiry will wish  
23 to consider the role it played. For its part, the  
24 Department accepts that recent investigations such as  
25 the Independent Review of Maternity Services at the

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1 intrusion into the child and the family's right to  
2 privacy, as what we have already described as  
3 a particularly difficult time in their lives.

4 I end this submission, my Lady, as I began it: to  
5 express our heartfelt condolences and sympathies to the  
6 families of those who lost babies or whose babies were  
7 injured, and whose lives have been irreparably damaged  
8 by the events at the Countess of Chester Hospital.

9 Thank you, my Lady.

10 **LADY JUSTICE THIRLWALL:** Thank you very much indeed,  
11 Ms Scolding, and for continuing over into the lunch  
12 break. We will break now and we will start again at  
13 2.15.

14 (1.18 pm)

(The Short Adjournment)

15 (2.15 pm)

16 **LADY JUSTICE THIRLWALL:** Mr Cohen.

17 **Opening statement by MR COHEN**

18 **MR COHEN:** My Lady, as you know, I act for the Department of  
19 Health and Social Care and I begin, on behalf of the  
20 Department and the Secretary of State, by expressing our  
21 sincere sympathy and condolences for the families of all  
22 those affected by these matters.

23 My Lady, the Department has previously provided you  
24 with a written opening statement.

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1 Shrewsbury and Telford Hospital NHS Trust, and the  
2 Independent Investigation into Maternity and Neonatal  
3 Services in East Kent, demonstrate a failure to learn  
4 from past incidents.

5 The new Secretary of State has acknowledged that, in  
6 the past, recommendations had been made but action has  
7 not been taken. That is not good enough. The system  
8 must change. The Secretary of State has spoken  
9 candidly, describing how the NHS is "broken".

10 Recent investigations into the Care Quality  
11 Commission and Nursing and Midwifery Council have  
12 identified serious deficiencies within those  
13 organisations.

14 Getting it back on its feet and building an NHS that  
15 is fit for the future is the mission of the Government.  
16 To that end, the Secretary of State commissioned  
17 Professor the Lord Darzi to conduct an immediate and  
18 independent investigation of the NHS. And, my Lady, you  
19 will know that report was released and announced this  
20 morning.

21 **LADY JUSTICE THIRLWALL:** Yes.

22 **MR COHEN:** In this opening statement, the Department seeks  
23 to address, so far as is possible, the matters in  
24 respect of which you have specifically invited comment  
25 from Core Participants, though the Department

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1 anticipates it will have more to say at the conclusion  
2 of the evidence and the time for making detailed closing  
3 submissions.

4 My Lady, taking the first of those headlines,  
5 patient safety. Patient safety is a priority for the  
6 Government's vision for the NHS. The Inquiry will hear  
7 detailed evidence about the many initiatives in patient  
8 safety undertaken in the last decade or so. These are  
9 summarised at paragraph 11 of the Department's written  
10 opening.

11 The NHS Patient Safety Strategy, led by NHS England  
12 and first published in July 2019, is the first whole NHS  
13 strategy designed to support the entire NHS system to  
14 achieve continuous improvement in safety and the  
15 reduction of patient harm, whilst embracing an ethic of  
16 learning.

17 Measures have also been taken to raise patient  
18 safety in the specific context of maternity and neonatal  
19 care, including through the establishment of NHS England  
20 Maternity Transformation Programme, now the Maternity  
21 and Neonatal Programme.

22 Further initiatives have since been introduced as  
23 set out in NHS England's three-year delivery plan for  
24 neonatal and maternity services, including increased  
25 neonatal cot capacity and responsibility for Integrated

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1 the NHS long-term plan between 2020/21 and 2023/24.

2 Then in July 2018 the Department assumed, from the  
3 Department of Education, responsibility for the Child  
4 Death Review process.

5 My Lady, although many initiatives have been  
6 introduced to promote safety in the NHS, it is equally  
7 clear, and the Department acknowledges this, that  
8 progress is unevenly distributed, as demonstrated by  
9 recurring problems highlighted in various inquiries.  
10 The Department acknowledges that the development of  
11 cultures of safety and learning in the NHS needs to be  
12 improved.

13 The frequency of major patient safety crises and  
14 systemic problems in the NHS are a reminder that safety  
15 culture development has proved to be, and continues to  
16 be, very challenging.

17 Turning now to the Countess of Chester Hospital. In  
18 October 2016 the Department became aware of the change  
19 in admission arrangements to the Countess of Chester  
20 Hospital Neonatal Unit to focus predominantly on  
21 lower-risk babies which had been introduced in  
22 July 2016, and of the request for an independent review.

23 On 16 May 2017 the Department was first notified by  
24 NHS Improvement about the planned announcement of the  
25 police investigation into deaths at the Countess of

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1 Care Boards to consider national guidance, such as  
2 implementing the recommendations of the Neonatal  
3 Critical Care Transformation Review when agreeing  
4 staffing levels with Trusts.

5 My Lady, the Department and NHS England have  
6 introduced changes to the investigatory reporting and  
7 review processes to improve patient safety in maternal  
8 and neonatal care. These include the Perinatal Quality  
9 Surveillance Model and the Neonatal Quality Process, the  
10 National Perinatal Mortality Review Tool, launched in  
11 England, Wales and Scotland in early 2018 and adopted in  
12 Northern Ireland in the autumn of 2019, the Maternity  
13 Services Dashboard, published from 2016, to help local  
14 maternity systems track, benchmark and improve the  
15 quality of maternity services.

16 As of 1 October 2023, the Healthcare Safety  
17 Investigation branch's Maternity Investigations  
18 Programme transitioned into the CQC and became the  
19 Maternity and Newborn Safety Investigations Programme,  
20 ensuring the continuation of independent, single-case  
21 maternity investigations with greater consistency and  
22 more systematic learning to spur system improvements and  
23 prevent avoidable deaths and injuries in the future.

24 The Neonatal Critical Care Review was published by  
25 NHS England 2019 and led to significant investment by

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1 Chester Hospital. The Department is not routinely  
2 involved in day-to-day events in Trusts. At the  
3 relevant time, this was the responsibility of the Trusts  
4 and Foundation Trusts themselves; Monitor, the NHS Trust  
5 Development Authority; and sometimes NHS England,  
6 through their regional teams.

7 The Department had arrangements in place to keep  
8 track of performance and quality issues in the NHS. And  
9 then, as now, it was expected that, where significant  
10 issues were identified, the Department would be  
11 informed.

12 However, the Department acknowledges that it would  
13 have been better if there had been more robust  
14 arrangements to share information between the Trust, NHS  
15 England, and the Department at the time, and will  
16 continue to work with NHS England and others to identify  
17 further opportunities for improvement.

18 **LADY JUSTICE THIRLWALL:** Can I just ask you; you say it  
19 would have been better. Well, yes, but should it have  
20 been, otherwise?

21 **MR COHEN:** My Lady, I think that's implicit, yes.

22 **LADY JUSTICE THIRLWALL:** Well, it could be explicit. You  
23 could say the arrangements should have been more robust.  
24 That's really the position.

25 **MR COHEN:** My Lady, yes, and there are now more

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1 sophisticated processes in place.

2 **LADY JUSTICE THIRLWALL:** Yes.

3 **MR COHEN:** With providers, Integrated Care Boards, regions,  
4 and nationally, intended to support intelligence  
5 sharing, risk mitigation, management and escalation of  
6 quality and safety concerns.

7 It is Government's policy that these working  
8 relationships should be closer to promote greater  
9 information sharing, including with the Department, and  
10 increase provider and system challenge.

11 The Inquiry will wish to explore whether there is  
12 scope to improve the way Trust boards work, including  
13 but their accountability and transparency and their  
14 engagement across the wider system, so that they can  
15 proactively raise the alarm and have the confidence to  
16 refer to the wider system when issues of equivalent  
17 severity to this case occur.

18 That brings me, my Lady, to the escalation of  
19 concerns and whistleblowing. As previous inquiries have  
20 identified, an essential element in promoting patient  
21 safety is the ability of staff to escalate concerns and,  
22 more broadly, for complaints to be made and handled  
23 appropriately. The health of an institution may be  
24 judged by the way that it treats whistleblowers.

25 In response to a recommendation of Sir Robert  
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1 A separate NHS staff survey by the National  
2 Guardians Office revealed the percentage of workers  
3 feeling secure enough to raise concerns about unsafe  
4 clinical practices reached a five-year low in 2023. The  
5 Government will consider what further action required to  
6 make speaking up the norm in the NHS.

7 **LADY JUSTICE THIRLWALL:** So this is beyond what the  
8 Department are doing, is it? This is a Government --  
9 I noticed several times in this document there's  
10 reference to the "Government" rather than the  
11 "Department".

12 **MR COHEN:** My Lady, I think that's not intended to indicate  
13 that matters are going beyond the Department. The  
14 Department speaks for the Government in this regard.

15 **LADY JUSTICE THIRLWALL:** Very well. Thank you.

16 **MR COHEN:** Turning to culture. At paragraphs 33-37 of our  
17 written opening, we address this matter.

18 Issues of poor leadership and workforce culture have  
19 been raised repeatedly in previous investigations,  
20 inquiries, and reports of maternity and neonatal  
21 services, and undermine the safety improvements which  
22 have been made. It is clear that solutions are required  
23 which all Trusts can implement and consistently  
24 adopt. The Government will consider what further  
25 actions are required to achieve this.  
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1 Francis, King's Counsel, in his Freedom to Speak Up  
2 Review of 2015, the then Government established an  
3 independent National Guardian in July 2016 to help drive  
4 positive cultural change across the NHS. In addition to  
5 driving cultural change, the National Guardian provides  
6 support and leadership to a network of local Freedom to  
7 Speak Up Guardians, which cover every Trust.

8 It is vital that any staff member who is worried  
9 about the safety of a baby is able to voice concerns,  
10 and that these concerns are thoroughly considered and,  
11 where appropriate, investigated by the Trust.

12 Each Trust must have clear processes in place within  
13 an environment that is open and transparent, and we  
14 accept that more needs to be done to achieve this. The  
15 NHS England Culture and Leadership Programme that is  
16 being implemented in maternity and neonatal services is  
17 integral to this. Whilst it is too early to assess its  
18 impact, the Government will take further action if  
19 required.

20 The National Guardian's latest report on speaking up  
21 to Freedom to Speak Up Guardians for 2023 to 2024 showed  
22 that guardians handled more cases than ever before.  
23 However, there remain a persistent number of cases where  
24 guardians indicate that the person may be experiencing  
25 detriment for speaking up.  
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1 My Lady, you may consider that various reviews and  
2 inquiries have, over many decades, identified persistent  
3 issues of culture, painting a broadly consistent picture  
4 of incurious boards, unresponsive to key patient safety  
5 concerns, of defensive -- and on some occasions  
6 bullying -- behaviour, which does not create a culture  
7 in which speaking up is easy or welcomed, and  
8 professional tribalism with associated tolerance of poor  
9 behaviour and poor care.

10 It will be for the Inquiry to consider whether these  
11 matters played any part in the events at the Countess of  
12 Chester.

13 Turning now to management in the NHS.

14 My Lady, NHS Senior Managers are expected to ensure  
15 the delivery of safe, high-quality care, and best  
16 outcomes for patients, as well as creating the  
17 conditions for a positive, open and learning  
18 organisational and workforce culture through effective  
19 governance and assurance.

20 Boards have primary responsibility for oversight of  
21 the conduct of executive leaders, and take appropriate  
22 disciplinary action when it is required. Executive  
23 leaders who are healthcare professionals are also  
24 subject to statutory regulation by professional  
25 regulatory bodies.  
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1 In 2013 Sir Robert Francis recommended the  
 2 implementation of a Fit and Proper Person Test for NHS  
 3 Directors to improve the accountability of Directors.  
 4 The Health and Social Care Act 2008 Regulated Activities  
 5 Regulations 2014 require all Trusts to ensure that all  
 6 executive and non-executive director posts, or anyone  
 7 performing similar or equivalent functions, are filled  
 8 by people that meet the requirements of the Fit and  
 9 Proper Persons Test. The Care Quality Commission may  
 10 take enforcement action if it considers that a Trust has  
 11 not complied.

12 In August 2023 NHS England published the Fit and  
 13 Proper Persons Framework, which introduced  
 14 a standardised reference system and a means of retaining  
 15 information regarding background checks for individual  
 16 Directors. Since 31 March 2024, organisations are  
 17 expected to have fully implemented this framework.

18 In the light of the events at the Countess of  
 19 Chester Hospital, there has been a renewed focus on  
 20 whether additional measures are required to enhance the  
 21 accountability of Senior NHS Managers, and whether  
 22 extending regulation to Senior Managers would be an  
 23 effective means of ensuring patient safety.

24 The new government committed in its manifesto to  
 25 introducing professional standards for, and regulation

1 with. So I will rise now and we will start again at  
 2 10.00 tomorrow.

3 (2.35 pm)

4 (The hearing adjourned until 10.00 am the following day)

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1 of, NHS Managers, ensuring those who commit serious  
 2 misconduct can never do so again.

3 Detailed work will be required to determine the most  
 4 appropriate and effective means of regulating Senior NHS  
 5 Managers.

6 My Lady --

7 **LADY JUSTICE THIRLWALL:** I know that there was a process  
 8 ongoing last year looking at regulation for  
 9 accountability of senior managers, but I just  
 10 wondered -- I assume some of the detailed work has  
 11 already done -- when we might expect an outcome.

12 **MR COHEN:** My Lady, yes. It may be that that is a matter  
 13 that the Department's witness can address when he comes  
 14 to speak to you in the course of this Inquiry.

15 **LADY JUSTICE THIRLWALL:** Very well.

16 **MR COHEN:** My Lady, the Department has sought to prove  
 17 assistance to this Inquiry. It will continue to do so.

18 **LADY JUSTICE THIRLWALL:** Thank you very much indeed,  
 19 Mr Cohen.

20 There are still three more opening submissions to be  
 21 made, but they will be tomorrow starting at 10.00. So  
 22 I hope, unusually for this Inquiry, we will have an  
 23 early finish which I think may be welcome to quite a few  
 24 people in the room, and allow you to get on with the  
 25 enormous amount of preparation that you have to get on

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