

Friday 13 September 2024.

(10.00 am)

**LADY JUSTICE THIRLWALL:** Ms Blackwell.

Opening Statement by MS BLACKWELL

**MS BLACKWELL:** My Lady, this opening statement is made on behalf of Ian Harvey, the former Medical Director of the Countess of Chester Hospital; Alison Kelly, the former Director of Nursing and Quality for the Countess of Chester Hospital; Anthony Chambers, the former Chief Executive of the Countess of Chester Hospital; and Susan Hodgkinson, the former director of People and Organisational Development for the Countess of Chester Hospital.

Collectively I shall refer to them throughout as "senior managers".

We will use our time this morning to provide an overview of the way in which matters unfolded when the mortality rates in the neonatal unit arose, the action that was taken and the reasons behind the decisions that were made. But before we turn to these, each of the senior managers wishes to express their deepest sympathies to the Families of the babies who were harmed so cruelly by Letby. They are mindful of the trauma that the Families have gone through and continue to go through. They have read the statements produced by the

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They have furnished the Inquiry, as my Lady knows, with extensive witness statements, answering all of the questions asked of them. These statements run into hundreds of pages referring to many, many other documents. They have done so willingly so that the Inquiry has the best possible evidence on which to make findings of fact and recommendations.

The senior managers hope, as no doubt do all Core Participants, that this Inquiry will fulfil its Terms of Reference fully, and through the evidence it has gathered and the evidence it will call for the first time produce a comprehensive account of what happened at the Countess of Chester Hospital so that the right lessons are learned, and real changes implemented where needed. They continue to hope that the Inquiry will do so unblinkered by hindsight bias and with an open mind.

In assessing the evidence, it is of the utmost importance that the Inquiry does so with an understanding of the somewhat detached circumstances of a procedure such as this. Words on pages cannot evoke the reality within which everyone was working over the relevant period. The senior managers, the consultants, the doctors and the nurses and others were ordinary, professional people working in a busy, demanding hospital environment and doing their best to react to an

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Families and have been deeply affected by the accounts of their experiences. They have read and listened carefully to the oral openings made by those who represent the Families. They recognise and pay tribute to the dignity and courage of all those Families.

Mr Harvey, Ms Kelly, Mr Chambers and Ms Hodgkinson have reflected on their time at the Countess of Chester Hospital and will continue to reflect on their actions and decisions as, through this Inquiry, all the evidence relevant to the story of what happened will be brought together and examined for the first time. They know they will be asked difficult questions and they will answer those questions openly and honestly.

Indeed, this Inquiry, my Lady, has provided the senior managers with the first real opportunity to tell their story and they are grateful for this. They have deliberately refrained from responding to criticisms made of them by a number of individuals and organisations which have been reported in the media as they recognise that this is a complex case, the facts of which need to be carefully scrutinised by this Inquiry. They have made, and will continue to make, every effort to engage with and assist the Inquiry and the Families in understanding what they knew, when they knew it, and what informed their decision-making.

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unfolding picture where an apparently well-liked, caring, popular, experienced nurse was noted as having been on duty during the time when certain babies had collapsed or died.

They did not have the benefit of all the evidence to which the Inquiry now has access, neither did they have the time to reflect in the way that the Inquiry is now able. On any view, the circumstances of what happened as events developed in 2015, 2016 and 2017 were unique, challenging and complex.

There have been submissions made to the Inquiry that the senior managers lacked professional curiosity. On the other hand, criticism has also been made that there were too many reviews and reports commissioned as a reaction to the increased mortality rate.

There were a number of investigations, as my Lady knows. Concerns were not ignored. And it was rational, the Inquiry may find, for there to be investigations into the causes of a heightened mortality rate which didn't jump to the immediate conclusion that there was a single cause, that these deaths were being deliberately caused by an individual on the ward, but rather looked to the more likely one that there would be a complex and multifactorial explanation, as previous experience had shown.

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1 That being said, my Lady, the senior managers accept  
2 that they believed that they needed to investigate so as  
3 to obtain evidence of wrongdoing before taking this  
4 matter to the police. There was nothing tangible being  
5 alleged beyond Letby's presence for a long period of  
6 time, they struggled to know what they might say to  
7 justify a criminal investigation. This was the cause of  
8 a significant delay in contacting the police, and for  
9 this they are truly sorry.

10 But the reviews were commissioned in good faith, not  
11 to conceal the truth, but to uncover it. Suggestions to  
12 the contrary run, in my respectful submission, against  
13 rhyme and reason. On the issue of when such matters  
14 should properly be brought to the attention of the  
15 police in a hospital setting, guidance is overdue and  
16 such recommendations as the Inquiry sees fit to make  
17 will be well appreciated.

18 We are confident that, having heard the evidence,  
19 the Inquiry will have a better understanding of the  
20 following five factors.

21 One, at all times, patient safety was prioritised.

22 Two, at all times, the senior managers acted  
23 honestly and in good faith.

24 Three, at all times, decisions were taken following  
25 the gathering of information and intense consideration

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1 those affected. And for this, the senior managers are  
2 deeply sorry. This was not done with an intention to  
3 deliberately cause anguish, nor did it involve  
4 a conspiracy of dishonesty.

5 At the time, they believe that they were providing  
6 the right level of information. They wanted to make  
7 sure that what they were saying was clear and accurate.  
8 In hindsight they could and should have communicated far  
9 better than they did.

10 The senior managers were all painfully aware that  
11 the Families had gone through the most unimaginable  
12 devastating experience of losing a beloved child and  
13 that they could potentially make this worse by sharing  
14 information that was inaccurate or incomplete.

15 They were conscious that every contact or  
16 communication from them caused huge distress and as  
17 a result, they sought to make contact when they had  
18 something of substance to report.

19 There were times when the picture was simply not  
20 clear and they did not actually know very much as  
21 investigations proceeded, but they appreciate that this  
22 resulted in long periods of silence, and would have left  
23 families feeling as if they were being kept in the dark.

24 **LADY JUSTICE THIRLWALL:** Can I just ask you, Ms Blackwell,  
25 because I appreciate you represent, as you've set out,

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1 of the available options. These decisions about what  
2 would be appropriate and proportionate were taken in  
3 close consultation with those who had raised the  
4 concerns.

5 Four, at no time did senior managers prioritise the  
6 reputation of the Trust. They had no motive so to do,  
7 and this was not a driving factor.

8 And five, at no time did the senior managers seek to  
9 suppress concerns or attempts to blow the whistle and it  
10 will be a matter of exploration for this Inquiry as to  
11 why those who held concerns about criminality did not  
12 contact the NMC, the police or any of the other relevant  
13 external bodies.

14 **LADY JUSTICE THIRLWALL:** And who are you referring to there?

15 **MS BLACKWELL:** My Lady?

16 **LADY JUSTICE THIRLWALL:** Who is it that you're saying didn't  
17 refer, apart from obviously the --

18 **MS BLACKWELL:** Those who were involved in carrying out the  
19 clinical duties on the wards.

20 **LADY JUSTICE THIRLWALL:** So that's the doctors and nurses?

21 **MS BLACKWELL:** Yes.

22 As to the contact, my Lady, between some senior  
23 managers and some parents, it is accepted with regret  
24 that this was inadequate, both in terms of frequency and  
25 manner, and that this has caused hurt and anxieties to

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1 a number of senior managers, are they all involved in  
2 this communication --

3 **MS BLACKWELL:** No.

4 **LADY JUSTICE THIRLWALL:** -- of apology?

5 **MS BLACKWELL:** Well, they are all involved in the apology  
6 but --

7 **LADY JUSTICE THIRLWALL:** No, no, I understand that but in  
8 terms of the communication?

9 **MS BLACKWELL:** Yes. I started by saying "some senior  
10 managers" and as my Lady will know the evidence that  
11 you've heard so far relates primarily to Ian Harvey.

12 **LADY JUSTICE THIRLWALL:** I see. I just wanted to know  
13 whether the others were involved at all. I hadn't  
14 picked that up, but they weren't.

15 **MS BLACKWELL:** They were involved to a lesser extent.

16 **LADY JUSTICE THIRLWALL:** All right.

17 **MS BLACKWELL:** But they all offer their sincere apologies  
18 for the poor communication that took place.

19 The plain fact is, my Lady, that the Families should  
20 have had more support, the hospitals should have  
21 appointed a single point of contact early on so that the  
22 Families could contact someone at any time with any  
23 queries or concerns, and the additional benefit of that  
24 would have been the appointment of someone who could  
25 offer help and support, someone who could get to know

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1 the parents and how and when they would prefer to be  
2 contacted.

3 This could also have improved the bereavement  
4 services which, from the witness statements of the  
5 Families which the senior managers have now had the  
6 opportunity of considering, appears was lacking. These  
7 lessons have been learned but the senior managers wish  
8 me to repeat on their behalf that they are sorry for the  
9 distress that their ill-conceived approach has caused.

10 I now turn to the actions taken by the senior  
11 managers and hope to put them in their proper context.

12 As my Lady knows, at the time relevant for this  
13 Inquiry, the Countess of Chester was a 683-bed hospital  
14 with over 3,900 staff members, delivering services to  
15 over 450,000 residents in the Chester and West Cheshire  
16 area. The senior managers were there to provide  
17 strategic leadership in respect of to the entirety of  
18 the hospital and were responsible with the board for  
19 ensuring the provision of high quality patient care and  
20 ensuring there was a system to enable the escalation of  
21 concerns. Your Counsel has carefully described the  
22 layers of management in place to deliver this objective  
23 which included a neonatal Management Team and clinical  
24 lead.

25 And as you have heard, the increase in mortality  
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1 a complex set of circumstances, or something more  
2 lacking.

3 On 11 May 2016 there was a significant meeting  
4 between Ian Harvey, Alison Kelly, the manager of the  
5 NNU, Eirian Powell, the Manager of Children's Services,  
6 Anne Murphy, and Dr Brearey, in which the Thematic  
7 Review was discussed. An action plan was agreed by all  
8 present at the meeting, which included action to be  
9 taken by those directly responsible for the management  
10 of the NNU. There was to be a review of any other  
11 babies who suddenly collapsed or deteriorated and  
12 a further deep dive into the neonatal deaths which had  
13 taken place. It was agreed that a follow-up meeting  
14 would be convened after a period of two months, that is  
15 in July 2016, to review the situation, and it was clear  
16 to senior managers in attendance that careful  
17 consideration had been given to each of the cases,  
18 including by specialist clinicians in neonatology.

19 All of the actions going forward from that meeting  
20 were considered appropriate and proportionate by all  
21 and, as my Lady knows, after the meeting, Dr Brearey  
22 sent an email in which he stated he'd found the meeting  
23 to have been helpful and informative.

24 As can be seen by consideration of the Thematic  
25 Review documents and the record of this subsequent  
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1 rates on the NNU resulted in a number of recommendations  
2 and investigations which were carried out in 2015 and  
3 2016. These have been set out again in great detail by  
4 your Counsel and others in their opening statements.

5 These included the thematic review led by consultant  
6 neonatologist and clinical lead for the NNU,  
7 Dr Brearey. Several consultants and nurses were  
8 involved together with the Risk and Patient Safety lead,  
9 issues were flagged within these reviews concerning  
10 elements of care, for example delayed cord clamping,  
11 cardio-tachograph interpretation and issues around the  
12 transport of very sick babies. Actions were  
13 subsequently identified in order to remedy these  
14 matters.

15 The Thematic Review had not found any common themes  
16 in relation to the deaths. None of the reviews or  
17 investigations identified any concerns that the increase  
18 in mortality rate was connected to an unnatural event or  
19 the result of foul play. Criticism has been made that  
20 the wrong questions were asked and incomplete  
21 information was provided to those charged with the task  
22 of investigating, and the Inquiry will want to hear from  
23 the senior managers about how decisions were made and  
24 will no doubt explore whether there were reasonable,  
25 albeit perhaps imperfect, attempts to get to grips with  
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1 meeting, no concerns at that stage were raised about the  
2 deaths being unnatural or suspicious, nor were there any  
3 concerns raised in relation to Letby other than in  
4 relation to her wellbeing. The Inquiry will want to  
5 explore why this was the case.

6 Senior managers were aware that Letby had been on  
7 shift when a number of deaths had occurred for some  
8 time. However, it was understood that she was  
9 a specialist practitioner and therefore, because of her  
10 skills and training, more likely to be looking after the  
11 sickest infants on the NNU, often on her own. In  
12 addition to this, her willingness to work overtime when  
13 the acuity on the unit was over capacity meant she was  
14 on shift on a more frequent basis than other nursing  
15 practitioners.

16 Whilst senior managers were made aware that Letby  
17 had been moved to day shifts for three months, they had  
18 understood from what they were told that this was due to  
19 work-related stress and they were also told that there  
20 were no known performance management issues or  
21 complaints against her, and that she was considered by  
22 nursing colleagues to be a diligent nurse with excellent  
23 standards.

24 This picture, however, changed at the end of  
25 June 2016 when concerns were raised for the first time  
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1 to senior managers by Dr Brearey, who as I have said was  
2 present at the 11 May meeting, and Dr Jayaram, about  
3 Letby being concerned directly in the deaths.

4 This triggered numerous meetings, as my Lady is  
5 aware, throughout the remainder of June and July,  
6 attended by senior managers and consultants. However,  
7 aside from the link between Letby's shift pattern and  
8 the deaths, at that stage nothing specific was  
9 articulated by either Dr Brearey or Dr Jayaram, or any  
10 other consultant, to the senior managers, to identify  
11 what that wrongdoing might be.

12 For example, there was never any suggestion by  
13 Dr Jayaram that he had witnessed an event in  
14 February 2016 involving Letby that raised suspicion  
15 about her behaviour towards Child K, about which he kept  
16 silent until March 2017. Nor had there been anything  
17 raised with senior managers about Child F's insulin  
18 results back in August of 2015, for which accidental  
19 administration had been excluded as a cause but then  
20 about which no further action had been taken.

21 There was nothing raised about any failure in the  
22 care that Letby had given to any of the babies to  
23 indicate that her conduct had or might have contributed  
24 in any way to the deaths on the NNU.

25 These undefined concerns were not shared by nursing  
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1 A number of key actions were taken in June and  
2 July 2016, including, as my Lady is aware, the unit  
3 being redesignated as a Level 1 Special Care Unit, which  
4 meant it would no longer be looking after the very sick  
5 babies; a review commissioned with the Royal College of  
6 Paediatrics and Child Health; the coroner, the NMC and  
7 the Care Quality Commission were appraised of the  
8 concerns in relation to the increased number of deaths;  
9 Letby was deployed off the unit into a non-patient  
10 contact role; and there was an internal review and  
11 information-gathering exercise that was undertaken by  
12 a team of individuals as part of a Silver Command-type  
13 operation led by Stephen Cross.

14 A key objective of this operation was to collate  
15 more detailed information about each of the deaths and  
16 collapses which had occurred and the possible  
17 contributory factors, as well as looking at the staff  
18 involved and an analysis of the skill mix. A Position  
19 Paper was prepared by Ruth Millward and co-authored by  
20 Ian Harvey and Alison Kelly focusing on the significance  
21 of any increase in mortality. It was a detailed  
22 document that looked at Datix reporting and the  
23 information relevant to the NNU in the Risk Registers.

24 Of the four babies who suddenly deteriorated during  
25 the period January to June 2016, including Child M,

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1 staff. Indeed, as my Lady is aware, the NNU manager  
2 Eirian Powell was firmly of the view that Letby was  
3 a good and competent nurse.

4 In addition at this stage it appeared that there was  
5 also a doctor who had been on shift at the time of  
6 several of the incidents, and as my Lady knows the  
7 Coroner's Authorisation Form 1 had been issued in  
8 relation to all seven cases in which babies had died,  
9 the coroner had therefore been alerted and had the  
10 opportunity to investigate but no concerns or issues had  
11 been raised during that procedure.

12 In all of these circumstances, the Inquiry will want  
13 to ask what evidence was there available at that time  
14 upon which senior managers could have based a view that  
15 Letby was responsible? Whilst the concerns about Letby  
16 remained undefined, nevertheless, managers took action  
17 to better understand what was going on and to ensure  
18 that the NNU was safe. It was felt important from the  
19 outset that an open mind was preserved about the causes  
20 of the increase in deaths, and that all potential  
21 factors ought to be considered.

22 Incidents or issues within wards or units were, from  
23 their experience, almost always complex and  
24 multifactorial in terms of cause, rather than there  
25 being one single factor or indeed, actor.

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1 Child Q and Child N, none had been reported via the  
2 Datix system. Some of this information was used to  
3 inform a list of clinical reviews undertaken by Dr Gibbs  
4 and Anne Martyn looking at all the clinical records of  
5 all the babies who had collapsed and been transferred  
6 out of the hospital.

7 It was felt that this work, combined with the  
8 independent RCPCH review, would be capable of providing  
9 sufficient levels of information to enable the Senior  
10 Management Team to further consider the concerns raised  
11 about the increased mortality rate and also the as yet  
12 unspecified and unevidenced concerns about Letby.

13 At this time the senior management team had to  
14 balance the primary need to ensure that the NNU was safe  
15 with a need to be fair and have regard to the welfare of  
16 other staff to whom they owed a duty of care.

17 In addition to these aspects of responsibility,  
18 my Lady, the Senior Management Team had to be mindful of  
19 the impact on the whole unit and the hospital of any  
20 action being taken.

21 To be clear, Letby was off duty from 30 June 2016,  
22 due to return on 14 July. As such, there was no risk to  
23 patients during that period of time, and on her return  
24 from annual leave she was never again deployed in  
25 a patient-facing context.

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1 Whilst there was some discussion about her return to  
2 the clinical environment, during the period that  
3 investigations continued, this would only ever have been  
4 contemplated whilst she was under the direct supervision  
5 of another nursing professional and in the event that  
6 could not be accommodated, therefore the decision was  
7 taken to place her in an administrative non-clinical  
8 setting.

9 As your Ladyship is aware, the RCPCH conducted  
10 a two-day visit at the beginning of September 2016 and  
11 carried out a number of interviews of staff, including  
12 the consultants and Letby. RCPCH reviewers never  
13 communicated to Ian Harvey or the hospital that  
14 Dr Brearey and Dr Jayaram had expressed concerns that  
15 there was deliberate harm at play. It was never  
16 communicated to Ian Harvey or the hospital that the  
17 RCPCH reviewers considered aborting their review process  
18 as a result. Had these significant concerns been raised  
19 with the hospital, this may well have altered the  
20 picture and subsequent actions.

21 As was acknowledged yesterday, my Lady, the agreed  
22 terms of reference as between the RCPCH and the hospital  
23 led to a misunderstanding as to what it was believed the  
24 RCPCH would be doing, and this Inquiry will wish to  
25 consider whether this was a missed opportunity for

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1 incidents on the Neonatal Incident Summary. Other areas  
2 of the hospital appeared to report well but the NNU had  
3 for some time been less systematic in reporting. And  
4 for the cluster of 13 to 14 deaths being considered in  
5 the review, not all were reported to the Pan Cheshire  
6 CDOP.

7 The RCPCH sent its recommendations to Ian Harvey,  
8 including that immediate steps be taken to formalise the  
9 investigation being undertaken in respect of Letby  
10 including what the allegation was and what the process  
11 would be to investigate it.

12 The RCPCH suggested that this was a human resources  
13 issue. They felt that Letby had been mis-managed and  
14 had a strong case for a grievance procedure.

15 They also recommended that there be a detailed  
16 forensic Case note Review of each of the deaths since  
17 June 2015 using at least two senior doctors with  
18 expertise in neonatology and pathology in order to  
19 determine all the factors around the deaths. As my Lady  
20 knows, four individuals with the "appropriate expertise  
21 and experience" who would be able to conduct this work  
22 were identified. Attempts were made by Ian Harvey to  
23 contact all four and unfortunately two were unavailable  
24 to assist at the time and the third was uncontactable  
25 but the fourth, Dr Jane Hawdon, was available to carry

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1 reviewers to share in greater deal the concerns that  
2 they have since expressed to the Inquiry.

3 According to the report, the RCPCH review team were  
4 told that Letby was an enthusiastic, capable and  
5 committed nurse who had worked on the unit for four  
6 years. Her nursing colleagues were reported to think  
7 highly of her and there were apparently no issues of  
8 competency or training. According to the report, the  
9 consultants explained that their allegation was based on  
10 Letby being on shift on each occasion an infant died,  
11 combined with a "gut feeling"; there was no other  
12 evidence to link Letby to the deaths.

13 The unit was non-compliant, the report said, on  
14 issues of nursing, medical staffing levels, environment  
15 and accommodation for parents and support from the  
16 community neonatal team and postnatal follow-up.  
17 Leadership at the Trust level appeared to be somewhat  
18 remote, according to the report, from the day-to-day  
19 issues taking place within the unit.

20 The report also made clear that the Trust had  
21 a policy for reporting incidents, and there was a Women  
22 and Children's Care and Governance Board which  
23 considered all incidents and reports; however,  
24 attendance at these meetings by medics at these meetings  
25 was not high. Only 10 of the 13 deaths were reported as

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1 out the work immediately. And so it was decided to  
2 proceed with her to ensure that the work was carried out  
3 as quickly as possible.

4 Dependent upon her findings, consideration would  
5 then be given as to whether a further review or  
6 different course was required and Dr Rennie, one of the  
7 RCPCH's recommended reviewers, had offered to conduct  
8 a second review of any of the cases about which  
9 Dr Hawdon raised a concern.

10 Whilst this was not complete fulfilment of the  
11 RCPCH's proposal, it was felt that it was an appropriate  
12 and pragmatic way to progress matters. As my Lady is  
13 aware, neonatology is a very specialised field and there  
14 is a limited pool of clinicians qualified to undertake  
15 this kind of review. The RCPCH was informed of the  
16 Trust's approach and expressed agreement that this  
17 seemed to be a good plan.

18 In November 2016, as my Lady is aware, Dr Hawdon  
19 reported to Ian Harvey providing her opinion on the  
20 cases and recommending an expert perinatal pathology  
21 review which Dr McPartland, a consultant pathologist at  
22 Alder Hey Hospital, was asked to carry out.

23 In January 2017, Dr McPartland provided her report  
24 which contained a detailed clinical explanation of each  
25 case. She concluded that a cause of death for some

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1 remained unascertained and once senior management  
2 started to receive feedback from these external  
3 investigations via the RCPCH and Dr Hawdon and  
4 Dr McPartland, there were deepening concerns as to how  
5 the NNU was being managed and the care that was being  
6 given.

7 But still, none of the independent experts pointed  
8 to any criminal wrongdoing and the Inquiry will want to  
9 know why.

10 The senior managers relied on clinicians to report  
11 and record clinically significant events as well as  
12 raise concerns in relation to their patients in  
13 accordance with long-established processes. Senior  
14 managers were not and could not have been aware that  
15 a number of objective abnormal clinical findings were  
16 not detected, were not reported or not recorded, nor  
17 were they aware that the near miss incidents were not  
18 being recorded or escalated by the NNU and in particular  
19 that unexplained collapses which had not resulted in  
20 harm had not been recorded by Datix as they should have  
21 been. Had they been visible then this may have alerted  
22 outside agencies as well.

23 Notwithstanding the extensive review work conducted,  
24 questions remained unanswered and by March 2017 it was  
25 felt that further review work would not bring clarity to

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1 Following concerns about Letby being raised, as just  
2 described, the Board of Directors were kept updated as  
3 and when developments occurred and had opportunity to  
4 hold the senior managers to account.

5 The senior managers collectively welcomed this  
6 Public Inquiry. They have faith that your Ladyship and  
7 your legal team will ensure that it is conducted free of  
8 hindsight bias and unrestricted by pre-constructed  
9 narrative. The information which we all now have at our  
10 disposal following the lengthy police investigation, the  
11 trials, and the Inquiry Rule 9 process is quite distinct  
12 from the incomplete information available eight or  
13 nine years ago. We fully expect that decisions made and  
14 actions taken will be put into their proper context and  
15 analysed in a dispassionate and measured way.

16 Ian Harvey, Alison Kelly, Anthony Chambers and  
17 Susan Hodgkinson have worked in the healthcare setting  
18 for many, many years and have never come across criminal  
19 behaviour such as this. Indeed, the vast majority of  
20 professionals within the NHS are motivated with the  
21 highest of aims. They come to work every day, often in  
22 difficult circumstances, to help save lives. They do so  
23 by working long hours in the most challenging of  
24 environments. There is a tremendous amount of trust  
25 within the NHS between professionals, which will be

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1 the situation. In particular, as my Lady is aware, the  
2 consultants were now making it plain that only  
3 investigation by the police would suffice, and at this  
4 stage the Trust sought legal advice about approaching  
5 the police. In hindsight, and whilst done with the best  
6 of intentions, this was unhelpful and it led to further  
7 delay in speaking with the police representative on the  
8 CDOP.

9 This meeting was eventually arranged for the  
10 27 April 2017. Stephen Cross, Dr Jayaram and Dr Holt  
11 were in attendance, together with Ian Harvey, and  
12 Superintendent Wenham indicated that he would speak to  
13 the Chief Constable about the concerns raised and  
14 provide guidance as to how the matter should be  
15 reported.

16 There were then a number of meetings with the police  
17 during which it's believed the consultants shared key  
18 documents and even then the police considered that there  
19 was no, and I quote:

20 "... direct allegation or suggestion of significant  
21 negligence or act that could constitute a criminal act."

22 It is crucial to understand, my Lady, that the  
23 responsibility to keep babies safe is shared by everyone  
24 from those who work on the ward all the way up to the  
25 board. It is a collective responsibility.

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1 acknowledged by this Inquiry.

2 The senior managers have however all been deeply  
3 affected by what happened at the hospital. Whilst I do  
4 not suggest in any way that there is any parity  
5 whatsoever with what the Families of those killed and  
6 harmed by Letby have experienced, it has been the most  
7 significant event of any of their professional lives.  
8 They all chose to work in the NHS to help deliver  
9 exceptional care to patients and to save lives, and that  
10 a nurse could be responsible for these heinous crimes is  
11 profoundly disturbing. It is not something that any of  
12 them ever expected to be happening on the neonatal ward  
13 of the hospital, it being so against the natural order  
14 of what was contemplated or foreseen.

15 My Lady, that completes the opening.

16 **LADY JUSTICE THIRLWALL:** Thank you very much indeed,  
17 Ms Blackwell.

#### Opening Statement by MS RICHARDS

19 **LADY JUSTICE THIRLWALL:** Ms Richards.

20 **MS RICHARDS:** My Lady, this opening statement is based on  
21 behalf of the Care Quality Commission.

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

23 **MS RICHARDS:** Before going any further it's right that the  
24 CQC acknowledges at the outset, as others have done, the  
25 profound and terrible loss and suffering of the Families

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1 of the babies harmed and killed at the Countess of  
2 Chester Hospital by Lucy Letby.

3 The depth of and the enduring nature of those losses  
4 and of that suffering was evident from the submissions  
5 yesterday made on behalf of the Families by  
6 Mr Skelton KC and Mr Baker KC. It is even more  
7 powerfully evident from the witness statements that have  
8 been made to this Inquiry by the parents, and we wish to  
9 express our deepest and heartfelt sympathies to them.

10 What I will say this morning draws primarily on the  
11 CQC's written opening statement of 30 August, but I also  
12 intend to touch on some of the matters raised in the  
13 opening statements made by Counsel to the Inquiry  
14 insofar as they relate to the CQC, and there are five  
15 matters which I will briefly address.

16 First, and in very brief terms, the role and  
17 responsibilities of the Care Quality Commission.

18 Secondly, the evidence which the CQC has provided to  
19 the Inquiry thus far and in particular whether further  
20 evidence may be necessary in order to answer some of the  
21 questions posed by Counsel to the Inquiry's opening  
22 statement.

23 Thirdly, the CQC's involvement in those matters  
24 which fall within Part B of the Terms of Reference,  
25 primarily its inspection of the hospital in

25

1 and social care services that are described within the  
2 regulatory remit of the 2008 Act.

3 I should perhaps make clear that what CQC regulates  
4 is the bodies that provide the services, not the  
5 individuals who work within those services; those  
6 individuals will be subject to separate professional  
7 regulation from bodies such as the Nursing and Midwifery  
8 Council and the General Medical Council.

9 Providers of healthcare and social care are required  
10 to register with the CQC and to give an indication of  
11 the scale of that, as at 19 August there were over  
12 35,000 registered providers on CQC's register, 222 of  
13 which were NHS Trusts.

14 Those registered providers are required to meet  
15 certain fundamental standards which are set out in the  
16 2014 Regulated Activities Regulations. Those are the  
17 standards which the Countess of Chester Hospital was  
18 expected to meet, and they include standards of  
19 person-centred care, dignity and respect, safe care and  
20 treatment, safeguarding service users from abuse and  
21 neglect, receiving and acting on complaints, good  
22 governance, the fit and proper persons requirement and  
23 the duty of candour.

24 Part of CQC's role is to conduct inspections of  
25 registered providers and having regard to those

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1 February 2016 and its resultant report of that  
2 inspection published in June 2016.

3 Fourthly, I'll refer briefly to some of the issues  
4 which the Inquiry is exploring under Part C of its Terms  
5 of Reference.

6 And fifthly, I will address the recent review  
7 commissioned by the Department of Health and Social  
8 Care, which published an interim report into the  
9 operational effectiveness of the Care Quality Commission  
10 in late July 2024.

11 So my Lady, beginning with the role and  
12 responsibilities of the Care Quality Commission, this is  
13 an outline only. These are matters set out in rather  
14 more detail in the first witness statement Ian Trenholm,  
15 the CQC's then Chief Executive, in a statement dated  
16 12 February 2024.

17 The Care Quality Commission is an executive  
18 non-departmental public body, it is established under  
19 the Health and Social Care Act 2008, sponsored by the  
20 Department of Health and Social Care and accountable to  
21 Parliament through the Secretary of State for Health and  
22 Social Care. It is the independent regulator of health  
23 and social care in England. It has a range of functions  
24 but its primary functions focus on registration,  
25 monitoring, inspection and regulation of those health

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1 standards, make findings about the quality of care being  
2 delivered, and make recommendations for improvement.  
3 Those findings and recommendations are then published in  
4 a report and that was the process that was undertaken in  
5 2016 in relation to the Countess of Chester Hospital.

6 CQC's statutory objective under the 2008 Act in  
7 performing its functions is to protect and promote the  
8 health, safety and welfare of people who use health and  
9 social care services.

10 There are then two bodies whose work are relevant to  
11 this Inquiry which are independent of CQC but hosted by  
12 it. Again, these are matters set out in Mr Trenholm's  
13 statement. They are Healthwatch England, that operates  
14 as a statutory committee of the Care Quality Commission  
15 but operationally independent of it, although its Chair  
16 sits on the CQC's board. That's a champion for health  
17 and social care with a mandate to ensure the voices of  
18 people who use services are listened to and responded  
19 to.

20 And then the National Guardian's Office, in response  
21 to Sir Robert Francis' Freedom to Speak Up Report and  
22 you, my Lady, will be hearing evidence from the  
23 National Guardian, Dr Jayne Chidgey-Clark, in December  
24 2024. The National Guardian's Office is supported by  
25 CQC's infrastructure but it operationally independent

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1 of it.

2 My Lady, turning then to my second topic, the  
3 provision of evidence to this Inquiry. The following  
4 statements have so far been requested by and provided to  
5 the Inquiry by CQC.

6 Two statements from Mr Trenholm, the then Chief  
7 Executive of the CQC, which provide a more detailed  
8 account of the CQC's role and responsibilities, how it  
9 approaches the task of inspection, and reporting, and  
10 also give a chronological description of CQC's  
11 interactions with the Countess of Chester Hospital  
12 during the relevant period.

13 There are two statements from Ann Ford. Whilst  
14 these deal predominantly with matters of disclosure and  
15 document searches, her second statement also addresses  
16 the question which I'll come back to, of what  
17 information CQC had before, during and after the  
18 February 2016 inspection on the issues that lie at the  
19 heart of this Inquiry.

20 You then have a statement from Elizabeth Childs, the  
21 Inspection Chair for the February 2016 inspection; from  
22 Helen Cain who was the Lead Inspector for Children and  
23 Young People's Services in that inspection; and then  
24 from two specialist advisers who formed part of the  
25 inspection team for Children and Young People's

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1 in November. We have indicated we will write to your  
2 team next week with some suggestions as to who may be  
3 able to assist, but if I can just, in the interests of  
4 transparency, identify those four areas that we think  
5 further evidence may be required.

6 The first is this: the existing statements which you  
7 have described, the information that was specifically  
8 provided by the Trust to the CQC for the inspection and  
9 information that was specifically requested by the CQC  
10 of the Trust for the purposes of the inspection. But  
11 Counsel to the Inquiry's opening statement has rightly  
12 pointed out that there will have been data available to  
13 CQC through one or more of the reporting mechanisms that  
14 have been discussed this week.

15 It seems to us it may be that the Inquiry would be  
16 assisted by the provision of evidence describing the  
17 systems for ensuring that such data is available to  
18 those conducting the inspection, and how or indeed  
19 whether that system worked in the circumstances of the  
20 present case. We're looking into whether those are  
21 matters that can be addressed by the existing witnesses  
22 but it may be that the Inquiry would be assisted, for  
23 example, by the provision of a statement from one of  
24 CQC's data analysts.

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

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1 Services, Mary Potter and Dr Odeka. All those witnesses  
2 are scheduled to give evidence to this Inquiry in the  
3 oral hearings in November 2024.

4 You then have a statement from another member of the  
5 inspection team from February 2016, Julie Hughes, and  
6 a statement which the CQC volunteered to the Inquiry  
7 from Deborah Lindley, the relationship owner with the  
8 Care Quality Commission for the Countess of Chester  
9 Hospital. That means she was the main point of contact  
10 between them, and that statement describes a call  
11 received from the Countess of Chester Hospital on  
12 29 June 2016 which again I'll come on to.

13 My Lady, the Care Quality Commission is of course  
14 willing to provide any further statements or documents  
15 that the Inquiry may require, and that's a matter which  
16 has been the subject of some internal reflection in the  
17 course of this week, in particular in light of some of  
18 the questions identified by Ms Langdale in her  
19 meticulous and thorough opening statement.

20 We've had some brief discussion with your team but  
21 it does seem to us that not all of the questions raised  
22 by Ms Langdale -- very properly and pertinently raised  
23 by Ms Langdale -- will necessarily be capable of being  
24 answered by those who have so far given statements to  
25 the Inquiry, or who are scheduled to give oral evidence

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1 **MS RICHARDS:** My Lady, the second matter is this: Counsel to  
2 the Inquiry's opening asked questions -- again very  
3 properly -- about aspects of the overall regulatory  
4 judgments recorded in CQC's report of June 2016. Some  
5 of those judgments are not specific to the Children and  
6 Young Person's services and were not made therefore by  
7 or on the basis of the work undertaken by the Children  
8 and Young Person's inspection team. There are some  
9 overarching judgments in terms of in particular matters  
10 of governance, candour, and so on.

11 It may therefore be that those are questions which  
12 the individuals currently scheduled to give evidence  
13 will not be able to answer, and we will make suggestions  
14 to your team next week of an appropriate witness  
15 involved in the inspection who may be able to give some  
16 form of overarching perspective on the judgments that  
17 were recorded in the CQC's report.

18 **LADY JUSTICE THIRLWALL:** Is that the person who actually  
19 made those judgments or is it somebody else?

20 **MS RICHARDS:** My Lady, our aim would be to have someone who  
21 has direct knowledge of the making of those judgments.

22 **LADY JUSTICE THIRLWALL:** Good. Thank you.

23 **MS RICHARDS:** My Lady, then the third area for evidence  
24 arises out of Counsel to the Inquiry's Part C opening,  
25 paragraph 49. Ms Langdale has identified a specific

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1 issue for the CQC arising out of the statement of  
2 Professor Sir David Spiegelhalter in relation to  
3 a system for the collection of data which his statement  
4 suggests he helped the CQC set up in 2007.

5 **LADY JUSTICE THIRLWALL:** Yes.

6 **MS RICHARDS:** Ms Langdale has identified a number of  
7 questions. I don't know as I stand here the answer to  
8 those questions, but we will ascertain the answers and  
9 identify an appropriate witness to provide a written  
10 statement to the Inquiry addressing that.

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

12 **MS RICHARDS:** Then finally in relation to further evidence,  
13 reference has been made by Counsel to the Inquiry and  
14 indeed by Counsel for the Department of Health and  
15 Social Care, and indeed in our own written opening, to  
16 the recent review undertaken which is very critical of  
17 the work of the Care Quality Commission. That, the  
18 interim report which was published at the end of July,  
19 post-dates the corporate evidence which the CQC provided  
20 to the Inquiry and we've indicated to your team,  
21 my Lady, that we'll provide a statement from the CQC's  
22 proposed corporate witness, who is the interim Chief  
23 Executive Kate Terroni, and that will address matters  
24 relating to that review.

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

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1 Services.

2 Prior to that inspection, in accordance with its  
3 standard process, CQC received from the hospital  
4 a provider information return. That contained data and  
5 information relevant to the eight services to be  
6 inspected, so including Children and Young Person's  
7 Services.

8 And then again, in accordance with standard  
9 procedure on 15 February a further request was made to  
10 the trust by CQC for some additional information. That  
11 included information in relation to paediatric  
12 incidents, and there was data provided which included  
13 information on incidents occurring in the neonatal unit.

14 My Lady, those who were involved in the infants of  
15 the Children and Young Person's Services have explained  
16 in their statements their understanding of the  
17 significance of that information. Whether that  
18 information should have led to further requests or  
19 questions or given rise to concerns on the part of the  
20 inspection team will plainly be a matter to be explored  
21 in their oral evidence to this Inquiry.

22 The main inspection itself then took place between  
23 16 and 19 February. It included an inspection of the  
24 neonatal unit. There were two further unannounced  
25 visits, one out of hours on 26 February, that did not

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1 **MS RICHARDS:** My Lady, if I can then turn to my third topic  
2 which is the February 2016 inspection and the CQC's  
3 interactions with the Trust prior to that inspection.

4 As Counsel to the Inquiry's opening statement  
5 pointed out, and it's paragraph 820 of chapter 4, an  
6 engagement meeting between the CQC and the Trust took  
7 place on 21 July 2015. That was from CQC's perspective  
8 an entirely routine engagement meeting at which a number  
9 of matters were discussed. It was attended by, from the  
10 Trust, Mr Harvey, Mr Chambers, Ms Kelly and Ms Millward.  
11 Mr Trenholm's statement explains that one purpose of  
12 such engagement meetings with Trusts is to provide an  
13 opportunity for them to raise any significant concerns  
14 outside of the inspection cycle.

15 There is a relatively full set of minutes of that  
16 meeting referred to in Counsel to the Inquiry's opening  
17 statement, and it's not I think disputed that no issue  
18 about neonatal deaths was drawn to CQC's attention  
19 during that meeting.

20 The inspection which the CQC then undertook in  
21 February 2016 was a routine, planned inspection. It was  
22 part of the CQC's programme of announced inspections  
23 which took place between 2013 and 2016. Eight core  
24 services were inspected of which one was Children and  
25 Young People's Services and that includes Neonatal

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1 include the neonatal unit, and then one on 4 March which  
2 did include a visit of Neonatal Services.

3 There were no particular triggers for those visits;  
4 they were again part and parcel of what CQC seeks often  
5 to do on an inspection visit.

6 As part of the inspection of Children and Young  
7 People's services, inspectors spoke to a wide range of  
8 staff including nurses -- not Letby -- the neonatal unit  
9 manager Ms Powell and number of junior doctors and  
10 consultants including Dr Brearey and Dr Jayaram. On the  
11 neonatal unit, inspectors spoke with six parents.  
12 Details of who was spoken to and who attended the  
13 various meetings are set out in the exhibits to the  
14 statement of Mr Trenholm and in the documents that have  
15 been provided to the Inquiry.

16 During the inspection on the afternoon of the  
17 17 February 2016 -- and the significance of that date  
18 does not need to be spelled out -- the inspection team  
19 held a focus group, and that was attended by a number of  
20 consultants working at the hospital across a range of  
21 different services. It was not specifically concerned  
22 with children's or neonatal services alone, but there  
23 were consultants working in those services who attended  
24 the meeting.

25 The contemporaneous handwritten notes that would or

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1 should have been made from that meeting have not been  
2 found despite extensive searches, but we do have images  
3 of a member of the inspection team's notes in her diary,  
4 which have been disclosed to the Inquiry and addressed  
5 in a statement she has provided.

6 These suggest that some concerns were raised about  
7 the staffing levels, of bullying culture, and a lack of  
8 support from the leadership team. It is not CQC's  
9 understanding that those were specifically related to  
10 either the children's services or neonatal, but were  
11 part of the more general expression of concerns.

12 On 29 June, CQC published its report on the  
13 hospital, the overall rating was "requires improvement",  
14 services for children and young people were rated as  
15 overall as "good", but in response to sub-question "Are  
16 services for children and young people safe?" The  
17 assessment there was "requires improvement", that was  
18 for a number of reasons, including the nursing staffing  
19 levels on the neonatal unit.

20 My Lady, Core Participants were invited by the  
21 Inquiry to address a number of topics in their written  
22 opening statements. We have done so. I want to make  
23 clear that what's set out in the CQC's written opening  
24 represented its preliminary thinking, but the CQC will  
25 wish to reflect further on those, and indeed other

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1 not told on that date of any such concerns, so the  
2 materials supplied on 29 June identified issues in  
3 relation to neonatal mortality but nothing in relation  
4 to possible deliberate wrongdoing or harm.

5 As far as CQC can ascertain, it first became aware  
6 of the suspicion of criminal activity only in May 2017,  
7 following an engagement call with the Trust in mid-May  
8 2017, and CQC then became aware that contact had been  
9 made with the police a few weeks previously, and on  
10 16 May the Trust shared with the CQC a briefing on the  
11 involvement of the police which said:

12 "We're acting from a position of caution to check  
13 nothing's been missed. Police input is the only avenue  
14 left open to us to ensure we've been completely thorough  
15 in this process."

16 So in sum, CQC currently understand the position to  
17 be that specific concerns regarding increased neonatal  
18 mortality were not expressly raised with the CQC by  
19 anyone within the Trust before or during the inspection  
20 or at any time prior to 29 June 2016, and that the  
21 possibility of criminal activity or deliberate harm was  
22 not raised with the CQC until May 2017.

23 We will of course keep that understanding under  
24 review in light of the evidence that emerges during the  
25 oral hearings, and for the avoidance of doubt, it is

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1 matters in light of the opening statements and in  
2 particular in light of the oral hearings over the coming  
3 12 weeks, and to return to these issues in its closing  
4 submissions in rather greater depth.

5 That being the case, I don't propose to say very  
6 much about some of these topics but before I leave the  
7 question of the February 2016 inspection, I do wish to  
8 say something on behalf of the CQC in relation to one of  
9 the key issues posed: when did you know about the  
10 suspicions or concerns at the Countess of Chester  
11 Hospital?

12 As far as the CQC can ascertain, it first became  
13 aware that the Trust had concerns about mortality and  
14 increased numbers of deaths on the neonatal unit on  
15 29 June 2016, the day its inspection report was  
16 published, when Alison Kelly phoned CQC Inspector  
17 Deborah Lindley to inform her of an increased number of  
18 deaths on the neonatal unit. That was followed by  
19 a telephone call between Alison Kelly and Ann Ford of  
20 the CQC, and then an email from Alison Kelly to Ann Ford  
21 on 30 June which provided the CQC had requested an  
22 overview of the issues and of the actions that were  
23 being taken.

24 CQC had not been told previously of any concerns  
25 regarding Letby or possible criminal activity, and were

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1 CQC's position that the concerns which it has now seen  
2 through the disclosure made in this Inquiry, being  
3 ventilated within the Trust in the second half of 2015  
4 and early 2016, should have been clearly and  
5 unambiguously drawn to CQC's attention, whether by  
6 management or clinicians.

7 However, and importantly, the CQC fully recognises  
8 that the question of what the CQC was as a matter of  
9 fact told or not told by the Trust before, during and  
10 after the inspection, is by no means the end of the  
11 story, and that further questions arise for CQC to  
12 answer. Those questions will include: what should the  
13 CQC have understood from the underlying data it had  
14 received from the Trust or the data it had from the  
15 reporting mechanisms? Should that data have put it on  
16 notice that there were potential areas of concern?  
17 Should the CQC have asked the Trust for more or  
18 different information, or should it have asked more  
19 specific questions about neonatal mortality than those  
20 it spoke to during the inspection?

21 My Lady, one theme this week has been that of  
22 curiosity, professional curiosity, and the Inquiry will  
23 no doubt ask whether the CQC in its interactions with  
24 the Trust should have displayed more professional  
25 curiosity in relation to neonatal mortality.

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1 My Lady, in addressing this matter in our written  
2 opening we drew attention to, and I'm not going to  
3 repeat, various matters set out in the witness  
4 statements that the CQC has provided to the Trust from  
5 those involved in the inspection.

6 But it's apparent to the CQC in particular having  
7 reflected on Counsel to the Inquiry's opening statement  
8 that it cannot at this stage give "yes" or "no" answers  
9 to these "should" questions, to this issue of whether  
10 the inspection represented a missed opportunity or  
11 series of missed opportunities.

12 We wish to hear the evidence, the oral evidence of  
13 the witnesses whose testimony will be material to those  
14 questions and continue to reflect on those questions in  
15 light of the oral evidence.

16 My Lady, in our written opening we did allude to  
17 a concern that the fact that, as far as we can  
18 ascertain, matters were not expressly raised with the  
19 CQC during the inspection, whether that in itself raises  
20 questions for CQC as well as for those involved on  
21 behalf of the Trust. Was the CQC at that time  
22 sufficiently visible as an organisation that encouraged  
23 and would be responsive to whistleblowing concerns? Was  
24 there something about the CQC at that time, either as an  
25 organisation or in terms of how it conducted this

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1 common theme, but added:

2 "These reviews were submitted as part of our recent  
3 CQC inspection data pack."

4 My Lady, we didn't think that's right. We've listed  
5 the relevant evidence in our written opening, I won't go  
6 back through it. But we understand from the evidence  
7 available to the Inquiry, which we did not see at the  
8 time, that the Thematic Review was primarily produced by  
9 Dr Brearey and we've seen from Dr Brearey's evidence, he  
10 says he wanted to make Mr Harvey aware of it before the  
11 CQC inspection.

12 There may be some factual dispute in relation to  
13 that, between Dr Brearey and Mr Harvey, but that as we  
14 understand, it is what Dr Brearey says. We have found  
15 no evidence that a Thematic Review or peer review was  
16 provided to CQC. The inspectors themselves have  
17 addressed that in their statements; as I say, I won't go  
18 through that. Dr Odeka met with Dr Brearey and  
19 interviewed him during the course of the inspection. He  
20 has no recollection of it. We have searched our records  
21 and not found any contemporaneous documentation to  
22 suggest the Thematic Review was provided. Nothing that  
23 we have seen in Mr Harvey's evidence to this Inquiry  
24 suggests that having been sent the Thematic Review by  
25 Dr Brearey, he provided it or asked that it be provided

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1 inspection, that discouraged or appeared to discourage  
2 whistleblowing? Those are not easy questions to answer.  
3 Again I do not have an answer at this stage but we will  
4 continue to reflect on those questions as the evidence  
5 is explored by the Inquiry over the coming weeks.

6 There is one factual matter about which CQC does  
7 take a more definite position, and that is in relation  
8 to the provision of the Thematic Review that was  
9 undertaken by the Trust, and discussed as you've heard,  
10 at a meeting on the 8 February only a week or so before  
11 the inspection.

12 Counsel to the Inquiry's opening said at  
13 paragraph 882 that it's presently unclear whether CQC  
14 accepts it received the review in advance of the  
15 inspection or not. My Lady, I hope it is clear from our  
16 written opening -- and if not I make it clear now --  
17 that CQC's position is that it did not receive that  
18 Thematic Review in advance of or indeed during that  
19 inspection.

20 The issue arises because in Alison Kelly's email to  
21 the CQC on 29 June 2016, she said "an in-depth Thematic  
22 Review has been undertaken internally".

23 She then made reference to a subsequent peer review  
24 by a consultant from Liverpool Women's Trust. Ms Kelly  
25 recorded these had failed to identify any cause or

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1 to Dr Brearey. And we're not aware of the basis for the  
2 assertion in Alison Kelly's email about the Thematic  
3 Review and whether that was mere speculation on her part  
4 because she would have expected that to happen. Those  
5 are all no doubt matters that will be clarified or  
6 examined further during the evidence.

7 My Lady, then just briefly moving on from 2016, you  
8 will have seen from our written opening that in relation  
9 to the period after May 2017, we have reflected on what  
10 CQC did or didn't do, and have concluded that once it  
11 was informed of the police involvement, it should have  
12 been more proactive in seeking assurance as to the  
13 safety of the newborns on the neonatal unit and that its  
14 own role at that stage was too passive.

15 We've set out in the written statement, and I won't  
16 repeat it now, the approach that would now be adopted by  
17 reference to CQC's Specific Incident guidance and  
18 Criminal Cases Assessment Progression Panel guidance,  
19 both of which post-date the events in question.

20 My Lady, turning then briefly to the fourth topic,  
21 areas for consideration in Part C. Ms Langdale has in  
22 her opening explained that there are a number of issues  
23 where the Inquiry will wish to hear the views of the  
24 witnesses being called in Part C and that will include  
25 CQC's corporate witness. I won't anticipate that

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1 evidence. I'll just say something very briefly on  
2 whistleblowing, candour, culture and CCTV.

3 In relation to whistleblowing, that is an area where  
4 substantial work has been undertaken by CQC since the  
5 events in question. Whistleblowing plays a more key  
6 role in CQC's practice now. There are a number of  
7 inspections that have either been solely triggered on  
8 the basis of whistleblowing concerns or have been partly  
9 triggered in response to whistleblowing concerns.

10 We have issued guidance to both providers and staff,  
11 as to how matters can be raised with the CQC. We are  
12 however keen to consider, reflect on and learn from the  
13 evidence that you will be hearing in Part C and indeed  
14 from the experts who have provided reports to the  
15 Inquiry. It is apparent to us, not least from the  
16 statements of Dr Chidgey-Clark, the National Guardian,  
17 and Mr Behrens, the former Parliamentary and Health  
18 Service Ombudsman, that more needs to be done and we  
19 will be carefully considering the evidence that the  
20 Inquiry gathers and anticipate returning to  
21 whistleblowing in our closing submissions.

22 On the question of candour, your Ladyship knows that  
23 the CQC has the power to take regulatory action where it  
24 believes there's been a breach of the duty of candour by  
25 a registered provider. It has issued updated guidance

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1 My Lady, we've detailed in the written opening, so  
2 I won't repeat it here, what CQC's role is in relation  
3 to that. CQC does not itself assess individuals to  
4 determine whether they are fit and proper persons. Its  
5 role is to ensure that the NHS bodies being inspected  
6 address that issue properly and have proper processes in  
7 place, and it has a role in feeding back information to  
8 Trusts if it has concerns about the processes being  
9 undertaken.

10 My Lady, lastly on Part C matters, CCTV. The CQC's  
11 position on the provision of CCTV in neonatal units is  
12 that that is a complicated and fact-specific question  
13 for individual Trusts. The CQC does not have a position  
14 on its universal adoption in neonatal units. But we  
15 have got published guidance on how CCTV should be used  
16 for those Trusts who introduce it, and that explains  
17 that the use of CCTV or indeed other forms of  
18 surveillance will be checked by CQC against the seven  
19 principles articulated in that guidance which I won't  
20 repeat.

21 My Lady, then the fifth and final topic: the review  
22 of the Care Quality Commission. The Inquiry will be  
23 aware that on 26 July the Department of Health and  
24 Social Care published an interim report of its review  
25 into the operational effectiveness of the Care Quality

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1 on the statutory duty of candour that post-dates the  
2 events in question, that's June 2022.

3 We've noted and are considering further  
4 Professor Dixon-Woods' observations regarding the  
5 monitoring of compliance with the duty of candour and  
6 the difficulties that can arise.

7 Your Ladyship knows that the Department of Health  
8 and Social Care has undertaken a review of the statutory  
9 duty of candour, the Care Quality Commission responded  
10 to the Inquiry's call for evidence at the end of  
11 May 2024, that again post-dates the provision of a CQC's  
12 corporate statements so we anticipate if it is an issue  
13 we will address in a statement from the Interim Chief  
14 Executive, Ms Terroni, so that you have well before  
15 December a copy of or information about the evidence  
16 that the CQC submitted to the Department on issues  
17 relating to and problems relating to the duty of  
18 candour.

19 My Lady, then briefly in relation to the question of  
20 culture, we agree, of course, that leadership and  
21 culture can impact on patient safety. CQC's perspective  
22 is it's highly specific to institution, it's  
23 particularly sensitive to changes in leadership and  
24 closely related to that is the Fit and Proper Persons  
25 Test and CQC's role in that regard.

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1 Commission. That review examines in particular the  
2 suitability of the single assessment framework  
3 introduced by the CQC in November 2023. For the  
4 avoidance of doubt, that was not the approach to  
5 inspection that applied at the time of the inspection at  
6 the Countess of Chester Hospital.

7 The report finds in its interim review significant  
8 failings in the internal workings of CQC, and  
9 a deterioration in the ability of CQC to identify poor  
10 performance and supported drive to improve quality.

11 My Lady, the Care Quality Commission has accepted in  
12 full the findings set out in that interim review. It  
13 has accepted the recommendations and work is under way  
14 to address the problems identified. Amongst other  
15 steps, it has appointed Professor Sir Mike Richards to  
16 conduct a targeted review of how the single assessment  
17 framework is currently working for NHS Trusts and where  
18 CQC can make improvements. That was an interim review  
19 and the final report of the review is expected shortly.  
20 We understand it is likely to be published in early  
21 October.

22 The consequence of that review is that a significant  
23 process of internal reflection and/or a programme of  
24 work is under way within the Care Quality Commission to  
25 address the problems that have been identified. As

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1 indicated earlier, the corporate witness, Kate Terroni,  
2 who gives evidence to you in December, will be able to  
3 explain the work that is being carried out by CQC and  
4 the changes being implemented. But we fully expect that  
5 there will be more for the CQC to learn as an  
6 organisation from this Inquiry's examination of the  
7 evidence relevant to Parts B and C and from the findings  
8 and recommendations which this Inquiry will no doubt  
9 make in due course.

10 **LADY JUSTICE THIRLWALL:** Thank you very much indeed,  
11 Ms Richards.

12 Just before you go, I'm very conscious that there's  
13 a lot being done and a lot of effort being put into  
14 dealing with our questions as well as the other very  
15 important matters that you've identified.

16 Just one additional question, if I may, I hope it  
17 won't make too much work for anyone, but you say,  
18 correctly, that the February 2016 inspection found that  
19 children's services were "good" but that safety  
20 "required improvement", and that was on account of  
21 staffing levels. Now, it's my recollection from reading  
22 other CQC reports at about that time, irrespective of  
23 this Inquiry, that that was not an uncommon finding that  
24 safety requires improvement because of staffing levels.  
25 It seems to have been a problem --

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1 the way information was shared by the hospital, and for  
2 the lack of support provided to the Families and all  
3 those affected by these unspeakable events.

4 You have rightly asked that Core Participants are  
5 candid and that they meaningfully reflect on their own  
6 role and recognise where responsibility lies. In the  
7 course of responding to the Inquiry, NHS England has  
8 reflected on its role, and that of the legacy bodies  
9 that now form part of it, and the ways in which it may  
10 have contributed to the missed opportunities, including  
11 those that may have contributed to a delay in the  
12 commencement of the police investigation.

13 NHS England continues to learn more about the events  
14 that took place at the Countess of Chester Hospital and  
15 it's committed to listening, to learning and to  
16 implementing change where it is found to be needed.

17 Over the course of this week, we have heard from all  
18 those who are Core Participants in the Inquiry. What we  
19 have heard has been distressing.

20 NHS itself has sought to be candid. It has set out  
21 its position in its written opening statement and does  
22 not intend to repeat any of that detail through me now.

23 Instead, in reflecting on what others have said, it  
24 has focused on the central themes it considers to  
25 underpin the events at the Countess of Chester Hospital

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1 **MS RICHARDS:** My Lady, that --

2 **LADY JUSTICE THIRLWALL:** -- which was more widespread --

3 **MS RICHARDS:** That is certainly my understanding as well and  
4 I will take further instructions and we will ascertain  
5 whether there is further evidence that we can put before  
6 the Inquiry relevant to that particular question.

7 I imagine there will be.

8 **LADY JUSTICE THIRLWALL:** Thank you very much indeed.

9 **MS RICHARDS:** Thank you, my Lady.

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

#### 11 **Opening Statement BY MR BEER**

12 **MR BEER:** This is the opening statement on behalf of  
13 NHS England. I hope my speaking note has found its way  
14 to you in advance of that.

15 **LADY JUSTICE THIRLWALL:** It has, for which thank you very  
16 much.

17 **MR BEER:** Thank you. At the heart of this Inquiry are the  
18 Families whose babies were harmed or killed by Letby at  
19 the Countess of Chester Hospital. On behalf of the  
20 entire NHS, NHS England wishes again unreservedly to  
21 apologise to all of the parents and the Families  
22 affected for what they've been through, and for the  
23 mistakes and system failures in the way these crimes  
24 were reported and investigated.

25 This includes the lack of compassion and candour in  
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1 and the questions requiring exploration through oral  
2 evidence, and these include firstly where the balance  
3 lies between trust and curiosity from ward to board and  
4 beyond.

5 Secondly, how safeguarding and a culture of safe and  
6 supported curiosity can be enabled and facilitated,  
7 whilst recognising the limits of process and policy  
8 without the right culture.

9 Thirdly, the significance of how patient safety  
10 incidents are reported, investigated, and learned from.  
11 Fourth, the importance of timely and accurate data  
12 alongside clear and robust governance for review,  
13 interrogation, triangulation and sharing.

14 Fifth, the openness of providers of NHS services to  
15 external scrutiny and advice, and the ways in which  
16 culture and leadership impact on this.

17 Sixth, the role of senior leaders in advancing the  
18 right culture, including through proactive assurance and  
19 direct engagement between frontline staff and managers.

20 And lastly, the approach to involving the police  
21 when unexplained harm has occurred to patients.

22 Compassion and candour should be the touchstones for  
23 all engagements with parents of neonatal babies, and  
24 indeed all patients. Neonatal care can be especially  
25 stressful and daunting for parents. Kindness and an  
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1 emphasis on ensuring that the voices of parents are  
 2 heard are essential to ensuring personalised care.  
 3 Neonatal babies are vulnerable and do not have  
 4 a voice of their own. They are reliant on others  
 5 speaking for them. This includes their parents, but  
 6 also all staff, clinical or otherwise, who have a vital  
 7 role in safeguarding babies from harm, in advocating for  
 8 their interests and ensuring that clinical information  
 9 is shared openly and clearly with parents and agencies.  
 10 Neonatal services and the NHS more widely are very  
 11 different today compared to 2015. In a neonatal context  
 12 specifically, 2015 and 2016 were pivotal years with the  
 13 publication of the Morecambe Bay Investigation Report in  
 14 March 2015, and the Better Births Report in  
 15 February 2016, shining a light into services that had in  
 16 many cases not been subject to the same degree of  
 17 scrutiny as other services.  
 18 This signalled the beginning of a sustained and  
 19 ongoing focus by NHS England and others on improving NHS  
 20 neonatal services with the findings of subsequent  
 21 investigations in the period from 2016, including the  
 22 Neonatal Critical Care Review in 2019, contributing to  
 23 this work.

24 It also raised the profile of neonatal services with  
 25 provider Trusts. This was further strengthened through

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1 Freedom to Speak Up, the duty of candour, and the  
 2 Fit and Proper Person Test were all relatively new  
 3 concepts at that time and were at varying degrees of  
 4 implementation and sophistication across the NHS.  
 5 **LADY JUSTICE THIRLWALL:** Mr Beer, just before you move on,  
 6 can I just ask you a couple of questions, if I may?  
 7 **MR BEER:** Yes.  
 8 **LADY JUSTICE THIRLWALL:** When you set out that the Countess  
 9 of Chester was ostensibly a high performing Trust, where  
 10 is that taken from? I'm sure we've got the evidence  
 11 somewhere.  
 12 **MR BEER:** Yes, I think that's reflected in either the first  
 13 or the second corporate witness statements --  
 14 **LADY JUSTICE THIRLWALL:** Thank you very much.  
 15 **MR BEER:** -- of Professor Sir Stephen Powis, the National  
 16 Medical Director, and there is underlying material  
 17 referred to there which essentially stands up what he  
 18 says.  
 19 **LADY JUSTICE THIRLWALL:** Thank you.  
 20 **MR BEER:** Now, the three-year delivery plan for maternity  
 21 and neonatal services requires clear and consistent  
 22 actions for the system across four themes, one of which  
 23 is to grow, retain and support the neonatal workforce.  
 24 Foundation and NHS Trusts are subject to the same single  
 25 oversight framework that strengthened internal assurance

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1 measures including the introduction of board level  
 2 maternity and neonatal champions.  
 3 In 2015, Foundation Trusts like the Countess of  
 4 Chester were afforded considerable autonomy. This was  
 5 even more so for ostensibly high-performing Trusts, as  
 6 the Countess of Chester was considered to be at the  
 7 time. Although Foundation Trusts had to comply with  
 8 quality governance arrangements, in accordance with the  
 9 provider licence, there was a strong emphasis on  
 10 financial performance and organisational autonomy.

11 As Lord Darzi's report has noted, the commissioning  
 12 and regulatory landscape was complicated with a number  
 13 of bodies, each with separate responsibilities. By  
 14 2016, steps had been taken to try to address this, but  
 15 there remained a split between NHS England as  
 16 commissioner and Monitor as the regulator of Foundation  
 17 Trusts.

18 Serious incident reporting, to which I shall return  
 19 in more detail, was one of the primary ways that  
 20 external bodies, including NHS England, clinical  
 21 commissioning groups and the CQC would be alerted to  
 22 serious patient safety incidents.

23 However, the effectiveness of this system relied on  
 24 providers like the Countess of Chester reporting  
 25 incidents appropriately.

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1 within each Trust through the range of measures  
 2 introduced in the period since 2015, including the  
 3 requirements that the Perinatal Quality Surveillance  
 4 Model processes must be integrated into board  
 5 governance.

6 The previous provider regulators, Monitor and  
 7 NHS Trust Development Authority, no longer exist and  
 8 their responsibilities now lay in one body: NHS England.

9 The NHS system working has been further  
 10 strengthened, including through the establishment of  
 11 integrated care boards, ICBs. All NHS providers,  
 12 regardless of whether they're an NHS Trust or an NHS  
 13 Foundation Trust, our partners within their relevant  
 14 integrated care system and ICBs provide an important  
 15 role in ensuring system oversight.

16 Independent enhanced external scrutiny measures  
 17 continue to be developed and implemented, including the  
 18 National Medical Examiner system and the rollout of  
 19 Martha's Rule, the ongoing development and trialling of  
 20 faster and more advanced signalling tools and defined  
 21 governance to support the interpretation of signals  
 22 through the Perinatal Quality Surveillance Model. And  
 23 lastly, a new way of responding to patient safety  
 24 incidents through the Patient Safety Incident Response  
 25 framework and associated changes to the reporting

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1 systems used, including the recognition that a defined  
2 "serious incident" threshold is unhelpful, and the  
3 adoption of one single reporting platform called the  
4 Learn From Patient Safety Events Service, used at both  
5 local, regional, and national levels.

6 **LADY JUSTICE THIRLWALL:** And again, just for my  
7 understanding, the Perinatal Quality Surveillance Model,  
8 how does that fit with what we were hearing about  
9 yesterday from Counsel to the Inquiry, or the day  
10 before, the work of Professor Knight and others?

11 **MR BEER:** Yes. As I understand it, the MBRRACE led by  
12 Professor Knight is essentially a subset of that.

13 **LADY JUSTICE THIRLWALL:** Very good. So maybe there needs  
14 just to be a bit more explanation, not now, but in due  
15 course, so we can see what's actually happening.

16 **MR BEER:** Yes, I'm going to mention another monitoring  
17 system later in my oral address, and one issue that your  
18 Counsel has identified is the issue of whether it can be  
19 extended or not.

20 **LADY JUSTICE THIRLWALL:** Yes.

21 **MR BEER:** So as to capture neonates, essentially.

22 **LADY JUSTICE THIRLWALL:** Very good. Well, thank you, you'll  
23 deal with that in due course.

24 **MR BEER:** Thank you.

25 The hospital's approach to incident identification,  
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1 Framework removed the requirement previously specified  
2 in the Framework routinely to report unexpected neonatal  
3 deaths as a serious incident. This is correct.

4 And the change reflected and move away from an  
5 approach where certain types of incident were  
6 automatically classified as a serious incident to  
7 encourage a broader approach to incident response with  
8 the focus being on learning from incidents.

9 But as the updated Framework made clear:

10 "There is no definitive list of events or incidents  
11 that constitute a serious incident. Where lists are  
12 created, there is a tendency to not appropriately  
13 investigate things that are not on the list, even where  
14 they should be investigated, and equally, a tendency to  
15 undertake full investigation of incidents where that may  
16 not be warranted, simply because they seemed to fit  
17 a description of an incident on a list."

18 The removal of a requirement to report unexpected  
19 neonatal deaths was, therefore, part of this overall  
20 change, and reflected the removal of all previously  
21 specified categories of serious incident, unexpected  
22 neonatal deaths being one category on that list.

23 To be clear, however, the Serious Incident Framework  
24 was not ambiguous. It defined a "serious incident" as:

25 "An event in healthcare where the potential for  
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1 reporting and investigation will be a key issue for  
2 exploration in the oral evidence. It seems to be  
3 generally acknowledged that there was under-reporting of  
4 incidents in the neonatal unit. The reason for this and  
5 what steps were taken to address this issue by those in  
6 leadership positions at the hospital will require  
7 careful consideration.

8 We note the points of factual disagreement around  
9 what was reported, when, and how. All providers,  
10 including this hospital, were required to comply with  
11 the Serious Incident Framework and to report incidents  
12 that met the threshold for declaration as a serious  
13 incident.

14 Reporting was undertaken via the Strategic Executive  
15 Information Management System, known as StEIS. NHS  
16 England, Clinical Commissioning Groups and the CQC all  
17 had access to the StEIS and were alerted in that way to  
18 incidents raised as Serious Incidents by providers,  
19 meaning that this was one of the primary ways in which  
20 patient safety could be monitored and acted upon by NHS  
21 England and others.

22 The NHS Serious Incident Framework was updated in  
23 2015 in response to the Morecambe Bay Investigation  
24 report. NHS England is aware that some witnesses have  
25 referred to the fact that the 2015 Serious Incident  
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1 learning is so great, or the consequences to patients,  
2 families, carers, staff or organisations are so  
3 significant, that they warrant using additional  
4 resources to mount a comprehensive response."

5 Clearly, the deaths and other incidents involving  
6 unexpected harm suffered by babies on this neonatal unit  
7 met that definition.

8 What is known in this case is that only a very small  
9 number, of neonatal deaths -- four -- were reported as  
10 Serious Incidents during the relevant period. None of  
11 the incidents involving harm, short of death, were  
12 reported as Serious Incidents. None of the four cases  
13 reported as Serious Incidents indicated a concern about  
14 a specific individual or about potential foul play more  
15 generally, and it was not until the final serious  
16 incident raised on 5 July 2016 that broader concerns  
17 about a general increase in morbidity and mortality were  
18 reported.

19 The evidence describes starkly how individuals  
20 within the hospital, its executive, corporate and ward  
21 roles, were made aware in the period between June 2015  
22 and June 2016 of at least 13 deaths on the neonatal  
23 unit. The neonatal unit at the hospital was at that  
24 time a Level 2 Neonatal Unit, meaning that it was not  
25 treating the most critically ill babies.  
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1 The annual mortality rate for the unit in the years  
2 prior to 2015/16 was around three deaths. An unexpected  
3 increase in mortality of the scale seen therefore  
4 warranted greater and more intense scrutiny. Despite  
5 this, as I've said, only four incidents were reported as  
6 Serious Incidents, one of these being the 7 July 2016  
7 report relating to the overall increase in mortality on  
8 the unit.

9 Given the national focus on maternity and neonatal  
10 services in the period from 2015 onwards, including the  
11 role of robust incident investigation, in supporting  
12 gave care and enabling learning, NHS England finds it  
13 all the more surprising that so few incidents were  
14 reported as Serious Incidents. It considers the failure  
15 by the hospital to report each incident in the period  
16 June 2015 to June 2016 of unexpected harm or death as  
17 a serious incident was a missed opportunity.

18 The failure to report earlier the overall increase  
19 in mortality and morbidity via the Serious Incident  
20 Framework, including whilst Letby remained on the unit  
21 and continued to offend, was a further missed  
22 opportunity by the hospital, which Counsel to the  
23 Inquiry has highlighted as a key area for exploration  
24 during oral evidence.

25 After Letby was removed from the neonatal unit, NHS  
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1 them to get on with it", rather than deferring to them.  
2 But it may, be from what you say, that I may have  
3 misjudged that.

4 **MR BEER:** I think that may be right. As I understand our  
5 evidence and our position, it wasn't a question of  
6 institutional separation, "And that's their role and not  
7 ours", it was that an assessment was made of what they  
8 were doing and what they were saying, and as I've said,  
9 there was a belief that they were actually demonstrating  
10 the right behaviours and taking the right action. So it  
11 wasn't, I think, a simple "That's their responsibility  
12 and not ours."

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

14 **MR BEER:** As your Counsel has rightly identified, an  
15 important issue to be explored in the oral hearings is  
16 the extent to which, if at all, Working Together was  
17 applied in relation to any of the deaths with which this  
18 Inquiry is concerned, particularly in relation to the  
19 reporting and investigation of sudden and unexpected  
20 deaths.

21 NHS England has engaged actively with Dr Joanna  
22 Garstang, who will be one of the first witnesses to give  
23 evidence after the parents in relation to designing and  
24 developing a document, to be called a protocol, that  
25 will aim to give clearer and easier-to-understand  
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1 England was made aware in early 2016, July 2016, of an  
2 increase in mortality on the unit.

3 As the Commissioner, NHS England, should have been  
4 made aware sooner. The fact that NHS England was not  
5 made aware reflects a significant failure of the  
6 hospital's governance.

7 From the point of NHS being first made aware to  
8 March 2017, there was an ongoing lack of candour by the  
9 hospital in the terms of the information it shared with  
10 external bodies. However, NHS England has also  
11 reflected on its response to the information that it was  
12 given in early June 2016. Having done so, it considers  
13 that it gave too much deference and placed too much  
14 reliance on a belief that those in senior leadership  
15 roles at the hospital were demonstrating the right  
16 patient safety behaviours and culture.

17 It did not apply sufficient curiosity to what it was  
18 told, and there were missed opportunities when different  
19 regulatory levers could have been considered, but were  
20 not.

21 **LADY JUSTICE THIRLWALL:** Can I just ask you, interesting use  
22 of the word "deference" there from NHS England to the  
23 Foundation Trust, and I would just like to explore it  
24 a little bit with you. I mean, I wondered, before  
25 I read this, that perhaps it was more that, "Well, leave  
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1 guidance on Child Death Reviews.

2 Turning to the police, it took too long for the  
3 hospital, or any of the individuals who held serious  
4 concerns about the potential reasons for the unexpected  
5 increase in mortality on the unit, to involve the  
6 police.

7 Reflecting now, particularly with the knowledge it  
8 now has, about the criminal offences committed, NHS  
9 England considers, on its own and on behalf of NHS  
10 Improvement, that it could have done more to scrutinise  
11 the actions being taken by the hospital during the nine  
12 months that elapsed between when it first became aware  
13 that there was an unexplained increase in mortality and  
14 morbidity to when the police became involved.

15 Your Counsel has referred to the work that's  
16 currently under way by the Department of Health and  
17 Social Care to develop an updated Memorandum of  
18 Understanding between the NHS, the police and other  
19 stakeholders. We agree that this update is necessary,  
20 and will be valuable in helping to guide how the system  
21 works together when carrying out investigations.

22 Culture and leadership play a central role in how  
23 effectively patient safety incidents are responded to.  
24 NHS England interprets culture to mean the values,  
25 beliefs and shared ways of thinking held, and how those  
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1 influence decisions, actions and behaviours. That  
2 includes how things are arranged and accomplished,  
3 including the processes followed and the policies in  
4 place, as well as how they are talked about, actioned  
5 and modelled, and may vary, based on the organisation,  
6 work role, profession or speciality.

7 It's clear in this case that the culture and  
8 leadership of the Countess of Chester did not support an  
9 effective response. It also seems that the events  
10 illustrate the limits of processes and structures  
11 without the right leadership and culture to underpin  
12 them.

13 Turning to potential recommendations.

14 NHS England recognises that there are some areas  
15 where the Inquiry may wish to consider making  
16 recommendations to address some of the missed  
17 opportunities discussed in the opening statement. These  
18 include further guidance and training to be provided to  
19 NHS staff to deal with concerns about unexplained  
20 clinical events resulting in patient harm and/or near  
21 misses, including a framework for reporting these  
22 concerns to the police.

23 As I've said, a new Memorandum of Understanding  
24 between the police and NHS may assist in this.

25 Secondly, a new duty on providers to share invited  
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1 That includes, firstly, the establishment of  
2 a task-specific working group with a broad range of  
3 stakeholders in the group.

4 Secondly, close and sustained working, in this case  
5 with Dr Bill Kirkup, who wrote the recommendation that  
6 the group was then tasked with implementing.

7 Thirdly, ongoing and active involvement from subject  
8 matter experts as part of that working group approach,  
9 particularly in the case of the MOSS, Professor David  
10 Spiegelhalter.

11 And fourthly, ensuring that, as part of the group's  
12 implementation work, there's clear guidance to govern  
13 how the MOSS tool is used, that roles and  
14 responsibilities for all those using the MOSS, local,  
15 regional and national, are clear, and that the wider  
16 infrastructure for implementation has been planned for,  
17 including training and support on deployment.

18 NHS England will continue to reflect on  
19 recommendations during the oral evidence provided during  
20 the Inquiry and may, if we may, make further suggestions  
21 on recommendations in our closing statement.

22 In terms of concluding reflections, NHS England  
23 finishes by reflecting on what all those participating  
24 in this Inquiry owe to the Families of Letby's  
25 offending: a candour, a willingness, an openness to

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1 clinical reviews with, and report suspected criminality  
2 or significant unexplained events, where patient harm is  
3 identified, to other statutory bodies such as NHS  
4 England, ICBs and the CQC.

5 We note in this regard that the Department of Health  
6 and Social Care is also currently considering the  
7 operation, including compliance and enforcement of the  
8 Statutory Duty of Candour to Health and Social Care  
9 providers in England.

10 Third, existing social media, communication and  
11 professional policies, including those of professional  
12 bodies such as the GMC and NMC, should be strengthened  
13 to ensure appropriate use and increase safeguards around  
14 sharing of information; a requirement for a minimum  
15 number of non-executive directors on the board to have  
16 a clinical background, and for one of those Directors to  
17 chair the Trust's Quality Committee.

18 In her Part C opening, Counsel to the Inquiry raises  
19 important considerations on the factors that have the  
20 highest likelihood of ensuring effective implementation  
21 of recommendations made by an Inquiry. In our view, the  
22 Maternity Neonatal Outcomes Group's development of the  
23 MOSS tool provides a good, ongoing working example of  
24 translating an Inquiry's recommendation into the real  
25 world.

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1 reflect and learn, and a commitment to ensuring areas  
2 for further remedial action are identified and taken  
3 forward.

4 NHS England welcomes the opportunity to work with  
5 the Inquiry, to continue to learn and reflect on the  
6 awful events at the Countess of Chester, and to  
7 contribute to the development of recommendations for  
8 future action.

9 **LADY JUSTICE THIRLWALL:** Thank you very much indeed,  
10 Mr Beer. You're the last of the opening statements, so  
11 I'll just take the opportunity to say that I'm grateful  
12 to everyone for the opening statements that I have  
13 received, and obviously what goes into an opening  
14 statement is entirely a matter for the Core  
15 Participants.

16 I did, however, ask that the opportunity might be  
17 taken for reflection and views on recommendations, and  
18 I am grateful in particular to those who have taken the  
19 opportunity to do that, and who have provided thoughtful  
20 and useful reflection and helpful suggestions in  
21 relation to recommendations at this early stage.

22 So thank you very much indeed.

23 Now, Ms Langdale, would you just like to briefly say  
24 what's going to happen next week?  
25

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1 **Housekeeping by MS LANGDALE**

2 **MS LANGDALE:** Yes. Next week we will start to hear from the

3 parents. As my Lady knows, the public will not be in

4 the building and people will not be present in the

5 building; it will be simply Counsel to the Inquiry, my

6 Lady and the representatives of the parents. Some of

7 the parents' evidence will be audio available to the

8 media; some of it won't be, in some cases, but it will

9 be available on the transcript as soon as reasonably

10 practicable. It may have to have some jigsaw

11 identification redactions at various points, but the

12 evidence of the parents will be available on the

13 transcript in due course for everyone.

14 **LADY JUSTICE THIRLWALL:** Thank you. And then, when we

15 return to being open in the building, we are moving from

16 this very fine Council Chamber to a different room

17 upstairs, and all of that will be explained no doubt on

18 the website or at the door.

19 **MS LANGDALE:** That's right, my Lady. We're upstairs in

20 a room that may be more appropriate for taking witness

21 evidence.

22 **LADY JUSTICE THIRLWALL:** Very good. Thank you very much

23 indeed, Ms Langdale. Thank you all very much, we'll

24 adjourn now until 10.00 next Monday.

25 **(11.33 am)**

1 **(The hearing adjourned until 10.00 am the following Monday)**

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<p><b>W</b></p> <p><b>Wenham [1]</b> 22/12</p> <p><b>were [106]</b></p> <p><b>weren't [1]</b> 8/14</p> <p><b>West [1]</b> 9/15</p> <p><b>what [41]</b> 2/10 2/24 2/25 3/12 4/8 5/6 6/1 7/7 12/18 13/11 14/13 14/17 17/23 19/10 19/10 24/3 24/5 24/14 25/10 27/3 29/16 36/4 40/8 40/12 43/14 44/9 47/2 50/22 51/18 51/23 55/17 57/8 58/5 58/9 60/8 62/17 63/2 63/7 63/8 67/23 68/13</p> <p><b>what's [3]</b> 37/23 57/15 68/24</p> <p><b>whatsoever [1]</b> 24/5</p> <p><b>when [21]</b> 1/17 2/24 4/3 5/13 7/17 7/19 9/1 12/7 12/12 12/25 23/3 38/9 38/16 52/21 55/8 58/9 62/18 64/12 64/14 64/21 69/14</p> <p><b>where [17]</b> 3/14 4/1 44/23 45/3 45/23 48/17 51/6 51/16 52/2 55/9 59/5 59/11 59/13 59/15 59/25 65/15 66/2</p> <p><b>whether [18]</b> 8/13 10/24 17/25 20/5 25/19 31/19 31/20 35/17 40/5 40/23 41/9 41/19 42/13 44/3 47/4 50/5 56/12 57/18</p> <p><b>which [77]</b></p> <p><b>whilst [10]</b> 12/16 14/15 17/1 17/4 20/10 22/5 24/3 29/13 52/7 61/20</p> <p><b>whistle [1]</b> 6/9</p> <p><b>whistleblowing [8]</b> 41/23 42/2 45/2 45/3 45/5 45/8 45/9 45/21</p> <p><b>who [43]</b> 1/22 2/3 6/3 6/11 6/14 6/16 6/18 8/24 8/25 11/11 13/1 14/5 15/24 16/5 18/5 19/21 22/24 27/5 28/8 28/18 29/22 29/24 30/24 30/25 31/2 32/15 32/18 32/20 33/22 35/14 36/12 36/12 36/23 45/14 47/16 49/2 51/18 53/6 63/22 64/3 67/5 68/18 68/19</p> <p><b>whole [1]</b> 16/19</p> <p><b>whom [1]</b> 16/16</p> <p><b>whose [3]</b> 28/10 41/13 50/18</p>	<p><b>why [3]</b> 6/11 12/5 21/9</p> <p><b>wide [1]</b> 36/7</p> <p><b>widely [1]</b> 53/10</p> <p><b>wider [1]</b> 67/15</p> <p><b>widespread [1]</b> 50/2</p> <p><b>will [69]</b> 1/16 2/8 2/10 2/12 2/12 2/22 3/9 3/11 3/15 5/17 5/19 6/10 8/10 10/22 10/24 12/4 14/12 17/24 21/8 23/7 23/14 23/25 25/10 25/15 26/6 27/6 28/22 30/23 31/1 31/12 32/13 32/13 33/8 33/23 35/20 37/24 39/23 40/12 40/22 41/13 42/3 44/5 44/8 44/23 44/24 45/19 46/13 47/18 47/22 49/2 49/5 49/8 50/4 50/4 50/7 58/1 58/6 63/22 63/25 64/20 67/18 69/2 69/3 69/4 69/5 69/7 69/8 69/12 69/17</p> <p><b>willing [1]</b> 30/14</p> <p><b>willingly [1]</b> 3/5</p> <p><b>willingness [2]</b> 12/12 67/25</p> <p><b>wish [8]</b> 9/7 17/24 25/8 37/25 38/7 41/12 44/23 65/15</p> <p><b>wishes [2]</b> 1/21 50/20</p> <p><b>within [15]</b> 3/21 10/9 14/22 18/19 23/20 23/25 25/24 27/1 27/5 39/19 40/3 48/24 56/1 56/13 60/20</p> <p><b>without [2]</b> 52/8 65/11</p> <p><b>witness [12]</b> 3/2 9/4 25/7 26/14 32/14 33/9 33/22 41/3 44/25 49/1 55/13 69/20</p> <p><b>witnessed [1]</b> 13/13</p> <p><b>witnesses [6]</b> 30/1 31/21 41/13 44/24 58/24 63/22</p> <p><b>Women [1]</b> 18/21</p> <p><b>Women's [1]</b> 42/24</p> <p><b>won't [8]</b> 43/5 43/17 44/15 44/25 47/2 47/19 49/17 69/8</p> <p><b>wondered [1]</b> 62/24</p> <p><b>Woods' [1]</b> 46/4</p> <p><b>word [1]</b> 62/22</p> <p><b>Words [1]</b> 3/20</p> <p><b>work [26]</b> 12/12 12/19 16/7 19/21 20/1 20/2 21/23 21/25 22/24 23/21 24/8 27/5 28/10 32/7 33/17 45/4</p>	<p>48/13 48/24 49/3 49/17 53/23 57/10 64/15 65/6 67/12 68/4</p> <p><b>work-related [1]</b> 12/19</p> <p><b>worked [3]</b> 18/5 23/17 31/19</p> <p><b>workforce [1]</b> 55/23</p> <p><b>working [12]</b> 3/21 3/24 23/23 36/20 36/23 48/17 56/9 63/16 66/23 67/2 67/4 67/8</p> <p><b>workings [1]</b> 48/8</p> <p><b>works [1]</b> 64/21</p> <p><b>world [1]</b> 66/25</p> <p><b>worse [1]</b> 7/13</p> <p><b>would [26]</b> 4/23 6/2 7/22 8/24 9/1 11/14 15/4 16/8 17/3 17/24 19/11 19/21 20/4 21/25 22/3 22/12 31/15 31/22 32/20 36/25 41/23 44/4 44/16 54/21 62/23 68/23</p> <p><b>write [1]</b> 31/1</p> <p><b>written [13]</b> 25/11 33/9 33/15 37/21 37/23 41/1 41/16 42/16 43/5 44/8 44/15 47/1 51/21</p> <p><b>wrong [1]</b> 10/20</p> <p><b>wrongdoing [4]</b> 5/3 13/11 21/8 39/4</p> <p><b>wrote [1]</b> 67/5</p> <hr/> <p><b>Y</b></p> <p><b>year [1]</b> 55/20</p> <p><b>years [5]</b> 18/6 23/13 23/18 53/12 61/1</p> <p><b>yes [10]</b> 6/21 8/9 33/5 41/8 55/7 55/12 57/11 57/16 57/20 69/2</p> <p><b>yesterday [3]</b> 17/21 25/5 57/9</p> <p><b>yet [1]</b> 16/11</p> <p><b>you [44]</b> 6/14 7/24 7/25 9/25 24/16 24/22 28/22 29/20 30/4 31/6 32/22 33/11 38/9 44/7 45/13 46/14 49/2 49/10 49/12 49/17 50/8 50/9 50/10 50/14 50/15 50/17 51/4 55/5 55/6 55/8 55/14 55/19 57/22 57/24 62/21 62/24 63/2 63/13 68/9 68/22 68/23 69/14 69/22 69/23</p> <p><b>you'll [1]</b> 57/22</p> <p><b>you're [2]</b> 6/16 68/10</p> <p><b>you've [4]</b> 7/25 8/11 42/9 49/15</p>	<p><b>young [10]</b> 29/23 29/25 32/6 32/8 34/25 35/6 35/15 36/6 37/14 37/16</p> <p><b>your [14]</b> 9/21 10/4 17/9 23/6 23/7 30/20 31/1 32/14 33/20 45/22 46/7 57/17 63/14 64/15</p>
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